What's New
CMS Technical Direction Letter (TDL) – 13276
Additional Reference: TDL – 13261

Additional Questions and Answers Related to Sequestration

On March 15, 2013, the Centers for Medicare & Medicaid Services (CMS) issued TDL-13261, with one Q & A to clarify the point in the claims process when the 2% payment reduction is taken:

Question: Does the 2% payment reduction under sequestration apply to the payment rates reflected in Medicare fee-for-service fee schedules or does it only apply to the final payment amounts?

Answer: Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. All fee schedules, Pricers, etc., are unchanged by sequestration; it's only the final payment amount that is reduced.

The following Qs & As have been added based on TDL13276:

Question: How is the 2% payment reduction under sequestration identified on the electronic remittance advice (ERA) and the standard paper remittance (SPR)?

Answer: Claim adjustment reason code (CARC) 223 is used to report the sequestration reduction on the ERA and SPR.

Question: What is the verbiage for CARC 223?

Answer: "Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created."

Question: Will the 2% reduction be reported on the remittance advice in a separate field?

Answer: For institutional Part A claims, the adjustment is reported on the remittance advice at the claim level. For Part B physician/practitioner, supplier, and institutional provider outpatient claims, the adjustment is reported at the line level.

Question: How will the payments be calculated on the claims?

Answer: The reduction is taken from the calculated payment amount, **after the approved amount is determined and the deductible and coinsurance are applied.**

Example: A provider bills a service with an approved amount of $100.00, and $50.00 is applied to the deductible. A balance of $50.00 remains. We normally would pay 80% of the approved amount after the deductible is met, which is $40.00 ($50.00 x 80% = $40.00).The patient is responsible for the remaining 20% coinsurance amount of $10.00 ($50.00 - $40.00 = $10.00). However, due to the sequestration reduction, 2% of the $40.00 calculated payment amount is not paid, resulting in a payment of $39.20 instead of $40.00 ($40.00 x 2% = $0.80).

Question: How are unassigned claims affected by the 2% reduction under sequestration?

Answer: Though beneficiary payments toward deductibles and coinsurance are not subject to the 2% payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2% reduction. The nonparticipating physician who bills on an unassigned basis collects his/her full payment from the beneficiary, and Medicare reimburses the beneficiary the Medicare portion (e.g., 80% of the reduced fee schedule amount. **Note:** The "reduced fee schedule" refers to the fact that Medicare's approved amount for claims from nonparticipating physicians/practitioners is 95% of the full fee schedule amount). This reimbursed amount to the beneficiary would be subject to the 2% sequester reduction just like payments to physicians on assigned claims. Both are claims payments, just to different parties. If the Limiting Charge applies to the service rendered, physicians/practitioners cannot collect more than the Limiting Charge amount from the beneficiary.

Example: A nonparticipating provider bills an unassigned claim for a service with a Limiting Charge of $109.25.The beneficiary remains responsible to the provider for this full amount. However, sequestration affects how much Medicare reimburses the beneficiary. The nonparticipating fee schedule approved amount is $95.00, and $50.00 is applied to the deductible. A balance of $45.00 remains. Medicare normally would reimburse the beneficiary for 80% of the approved amount after the deductible is met, which is $36.00 ($45.00 x 80% = $36.00). However, due to the sequestration reduction, 2% of the $36.00 calculated payment amount is not paid to the beneficiary, resulting in a payment of $35.28 instead of $36.00 ($36.00 x 2% = $0.72).

We encourage physicians, practitioners, and suppliers who bill unassigned claims to discuss with their Medicare patients the impact of the sequestration reductions to Medicare payments.

Question: Is this reduction based on the date of service or date of receipt?

Answer: In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service, or the start date for rental equipment or multi-day supplies, is on or after April 1, 2013.

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