CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1051	**Date: February 29, 2012**
	Change Request 7661

NOTE: Transmittal 1033, dated January 27, 2012, is being rescinded and replaced by Transmittal 1051 to delete the dates of the conference call discussions, reduce the number of calls, and add CCI to the requirements in business requirement 7661.1. The conference calls will be held on dates to be determined. All other information remains the same.

SUBJECT: Analysis of Improper Overpayments to Design Edits to Correct these Overpayments in CWF, MCS, and FISS.

I. SUMMARY OF CHANGES: The issues have been identified by the recovery auditors as significant improper payments and require the development of edit to correct improper payments. Edits installed for these issues including claims that have physician place of service codes, E and M services during a global period, untimed codes, and hospital transfers will act as a tool to protect the Medicare Trust Fund by preventing improper billing practices.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 2, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 1051	Date: February 29, 2012	Change Request: 7661

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SUBJECT: Analysis of improper overpayments to design edits to correct these overpayments in CWF, MCS, and FISS.

Effective Date: **July 1, 2012**
Implementation Date: July 2, 2012

I. GENERAL INFORMATION

A. Background:

CMS has the authority under section 1893 of the Social Security Act (42 U.S. C. 1395ddd) that was amended in the Tax Relief Act of 2006, Section 302, to use Recovery Audit Contractors (RACs) for identifying, collecting, and correcting improper payments in the Medicare Fee-For-Service payment process.

The issues listed below have been identified by the recovery auditors as significant improper payments and require the development of edits to correct improper payments. Edits installed for these issues including claims that have physician place of service codes, E&M services during a global period, and hospital transfers will act as a tool to protect the Medicare Trust Fund by preventing improper billing practices.

1) An audit in October 2004 by the Office of the Inspector General (OIG) identified place of service billing by physicians as a payment error. This report stated, "Medicare overpaid physicians due to incorrect place of service coding. Seventy-nine of 100 sampled physician services, selected from a population of services identified as having a high potential for error, were performed in a facility but were billed by the physicians using the "office" place of service code. As a result of the incorrect coding, Medicare paid the physicians a higher amount for these services." Because these claims cannot be denied prior to payment, CMS is implementing an IUR for all claim types to recover these payments.

2) Under the global surgery fee concept, physicians bill a single fee for all of their services usually associated with a surgical procedure and related E&M services provided during the global surgery period. The global surgery fee includes payment for E&M services provided during the global surgery period. An audit by the OIG in March 2007 identified physicians were billing for visits that were included in the global surgery period. Because these claims cannot be denied prior to payment, CMS is implementing an IUR for all claim types to recover these payments.

3) When a beneficiary is transferred from one PPS hospital to another PPS hospital or from a PPS hospital to a hospital or unit excluded from IPPS for certain DRGs (post acute care transfers), the initial acute hospital shall be paid a per diem rate (up to the full DRG) and the receiving facility shall be paid the full DRG payment. The first hospital will receive a portion of the DRG if the hospital length of stay is less than the DRG geometric mean length of stay (GLOS). If the stay is equal to or greater than the GLOS,

the full DRG is paid and the claim would not be selected in the universe. Paying the full DRG payment to each facility is an improper overpayment when billed incorrectly. The discharge status codes identified with this issue are: 01, 02, 03, 04, 05, 06, 07, 43, 50, 51, 62, 63, and 65.

4) Payment for the majority of Skilled Nursing Facility (SNF) services provided to beneficiaries in a Medicare covered Part A SNF stay are included in a bundled prospective payment made through the fiscal intermediary (FI)/A/B Medicare Administrative Contractor (MAC) to the SNF. These bundled services are to be billed by the SNF to the FI/A/B MAC in a consolidated bill. The consolidated billing requirement confers on the SNF the billing responsibility for the entire package of care that residents receive during a covered Part A SNF stay and physical, occupational, and speech therapy services received during a non-covered stay.

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, except for certain excluded services described in §§20.1 – 20.3, and for all physical, occupational and speech-language pathology services received by residents under Part B.

Physician's professional services are excluded from this consolidated billing requirement; however, the technical and facility based components of physician services delivered to SNF inpatients are bundled into the Part A PPS payment and are not paid separately under Part B.

When DME is furnished for use in a SNF during a covered Part A stay, the DME Regional Carriers (DMERCs) shall not make separate payment for DME, since the DME is already included in the payment that the SNF receives for the covered stay itself.

5) Under the Medicare PPS for inpatient psychiatric facilities (IPF), CMS makes an additional payment to an IPF or a distinct part unit (DPU) for the first day of a beneficiary's stay to account for emergency department costs if the IPF has a qualifying emergency department. However, CMS does not make this payment if the beneficiary was discharged from the acute care section of a hospital to its own hospital based IPF. In that case, the costs of emergency department services are covered by the Medicare payment that the acute hospital received for the beneficiary's inpatient acute stay.
Source of admission code 'D' has been designated for usage when a patient is discharged from an acute hospital to their own psychiatric DPU. This code will prevent the additional payment for the beneficiary's first day of coverage at the DPU. An overpayment occurs when source of admission code 'D' is not billed for these transfer claims.

6) The RAC Demonstration Project determined there were several overpayments on claims with untimed codes. The National RAC program continues to identify this improper payment to providers. When reporting service units for the attached list of CPT Codes, reflected as "untimed codes" (excluding claims with Modifiers -KX, and -59) where the procedure is not defined by a specific timeframe (untimed codes), the provider should enter a 1 in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed. MCS will create an edit that denies these codes when billed more than once per day without appropriate modifiers. The untimed codes are as follows but not limited to: 90901, 92506, 92507, 92508,92526, 92597, 92609, 92610, 92611, 92612, 92614, 92616, 95833, 95834, 96110,97001, 97002, 97003, 97004, 97010, 97022, 97026, 97597, 92607, and 96111.

Therefore the purpose of this CR is for CMS to work with the maintainers to perform analysis of the improper payment to design edits to correct these improper payments.

B. Policy:

1) The Medicare physician fee schedule includes two payment amounts depending on whether a service is performed in a facility setting, such as an outpatient hospital department or ambulatory surgical center, or in a non-facility setting, such as a physician's office. The payments to physicians are higher when the services are performed in non-facility settings. The higher payments are designed to compensate physicians for the additional costs incurred to provide the service at an office location as opposed to a facility location.
In order for the physician to receive the higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B), as follows:

> **. . .** The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC [ambulatory surgical center] if the physician is performing a procedure not on the ASC approved procedure list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure . . . .

2) IOM 100-4, Claims Processing Manual, Chapter 12, Physicians/Non-Physician Practitioners, section 40.3.B.

   Surgical services identified in MFSDB with Global Days values of 000, 010, or 090. According to Internet Only Manual 100-04, Medicare Claims Processing Manual, Chapter 12, Physicians/Non-Physician Practitioners, Section 40.1.A, preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures and follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery are included components of the global surgical package and are not separately payable. Internet Only Manual 100-04, Medicare Claims Processing Manual, Chapter 12, Physicians/Non-Physician Practitioners, Section 40.3.B further specifies which Evaluation and Management visits are included in the global surgical package. The AMA CPT Manual, Surgery Guidelines further supports the inclusion of pre-operative and post-operative visits in the global surgical package.

3) IOM 100-4, Claims Processing Manual 100-04, Chapter 3, Section 40.2.4

   Per the Claims Processing Manual, "A transfer between acute inpatient hospitals occurs when a patient is admitted to a hospital and is subsequently transferred to another for additional treatment once the patient's condition has stabilized or a diagnosis established….."
   "Payment is made to the final discharging hospital at the full prospective payment rate. Payment to the transferring hospital is based upon a per diem rate….."

4) IOM 100-04, Claims Processing Manual, Chapter 6 § 10

   All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, posthospital or level of care requirements not met), the SNF is required to bill for all physical therapy, occupational therapy, and/or speech-language pathology services provided to a SNF resident under Part B. The consolidated billing provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF. Other manual references: 100-4; Chapter 6, section 20, 80 and 110.2.2 , CMS Pub 100-04; Chapter 20 § 211

5) IOM 100-4, Claims Processing Manual, Chapter 3, Section 190.6.4 –
   The ED adjustment is incorporated into the variable per diem adjustment for the first day of each stay for IPFs with a qualifying ED. That is, IPFs with a qualifying ED receive a 31 percent adjustment as the variable per diem adjustment for day 1 of each stay. If an IPF does not have a qualifying ED, it receives a 19 percent adjustment as the variable per diem adjustment for day 1 of each patient stay.

6) IOM Publication 100-5, Chapter 5, Section 20.2
When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day)

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7661.1	MCS, FISS, CWF, and CCI shall have 6 one-hour conference call discussions with CMS staff and the contractors on the requirements for implementing edits for the issues.	X		X	X		X	X		X	CCI
7661.2	The contractors, MCS, FISS, and CWF shall work collaboratively to create a design to support these edits.	X		X	X		X	X		X	
7661.3	The contractors, MCS, FISS, and CWF shall provide CMS with information regarding the business requirements for these edits.	X		X	X		X	X		X	
7661.4	The contractors, MCS, FISS, and CWF shall each provide CMS with an hour estimate for the conference call discussions to determine business requirements for edits.	X		X	X		X	X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section a: for any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Pamela Durbin, pamela.durbin@cms.hhs.gov, 410-786-6333 and Carlos Montoya, carlos.montoya@cms.hhs.gov, 410-786-6040.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable. Pamela Durbin, pamela.durbin@cms.hhs.gov, 410-786-6333 and Carlos Montoya, carlos.montoya@cms.hhs.gov, 410-786-6040.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):*

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.