CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3389	**Date: October 30, 2015**
	Change Request 9306

SUBJECT: Outpatient Mental Health Treatment Limitation Split Claims Fix

I. SUMMARY OF CHANGES: Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amended section 1833(c) of the Social Security Act (the Act) to phase in a 5-year reduction to the payment that Medicare patients are required to make for outpatient mental health services that are subject to the outpatient mental health treatment limitation (the limitation). Effective January 1, 2014, the limitation no longer exists and Medicare pays outpatient mental health services at the same level as other Part B services.

Change Request 6686 provided instructions on how to implement these changes, however did not include the necessary business requirements and changes to the IOM to remove the applicable claims, with dates of service on and after January 1, 2014, from system split logic. The purpose of this CR is to correct these errors.

EFFECTIVE DATE: January 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2016

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
R	Chapter 1/ Section 70.8.1/ Splitting Claims for Processing

III. FUNDING:
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:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: Section 102 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 amended section 1833(c) of the Social Security Act (the Act) to phase in a 5-year reduction to the payment that Medicare patients are required to make for outpatient mental health services that are subject to the outpatient mental health treatment limitation (the limitation). Effective January 1, 2014, the limitation no longer exists and Medicare pays outpatient mental health services at the same level as other Part B services.

Change Request 6686 provided instructions on how to implement these changes, however did not include the necessary business requirements and changes to the IOM to remove the applicable claims, with dates of service on and after January 1, 2014, from system split logic.

Claims with dates of service January 1, 2014 and after have been paid correctly, thus no reprocessing is required. However, CMS is aware that there have been problems when adjustments are necessary. This CR takes the necessary steps to rectify those issues.

B. Policy: Section 102 of MIPPA required that the 62.5% outpatient mental health treatment limitation (under which Medicare paid 50% of the approved amount and the patient paid 50%) was reduced as follows:

2010-2011=68.75% - Medicare pays 55% and the patient pays 45%; **2012**=75% - Medicare pays 60% and the patient pays 40%; **2013**=81.25% - Medicare pays 65% and the patient pays 35%; and, **2014 and onward**=100% - Medicare pays 80% and the patient pays 20%.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9306.1	MCS shall not apply split claims logic to outpatient Mental Health claims (including initial claims, adjustments, and re-openings) with dates of service on and after January 1, 2014.						X			
9306.2	Contractors shall be aware of changes to IOM Pub 100-04, Chapter 1, Section 70.8.1.		X				X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
CR 6686	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mark Baldwin, 410-786-8139 or mark.baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

70.8.1 – Splitting Claims for Processing

(Rev.3389, Issued: 10-30-15, Effective: 01-01-14, Implementation: 04-04-16)

There are a number of prescribed situations where a claim is received for certain services that require the splitting of the single claim into one or more additional claims. The splitting of such a claim is necessary for various reasons such as proper recording of deductibles, separating expenses payable on a cost basis from those paid on a charge basis, or for accounting and statistical purposes. Split a claim for processing in the following situations:

- Expenses incurred in different calendar years cannot be processed as a single claim. A separate claim is required for the expenses incurred in each calendar year;

EXCEPTION FOR DURABLE MEDICAL EQUIPMENT REGIONAL CARRIERS (DMERCs): Expendable items (disposable items such as blood glucose test strips and PEN nutrients) that will be used in a time frame that spans two calendar years and are required to be billed with appropriately spanned "from" and "to" dates of service may be processed on a single claim line. For these types of items, DMERCs must base pricing and deductible calculations on the "from" date, since that is the date when the item was furnished.

- A claim other than a DMERC claim that spans two calendar years where the "from" date of service is untimely but the "to" date of service is timely should be split and processed as follows:

    1. Where the number of services on the claim is evenly divisible by the number of days spanned, assume that the number of services for each day is equal. Determine the number of services per day by dividing the number of services by the number of days spanned. Then split the claim into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

    2. Where the number of services on the claim is not evenly divisible by the number of days spanned and it is not otherwise possible to determine from the claim the dates of services, suspend and develop the claim in order to determine the dates of services. After determining the dates of services, split the claim accordingly into a timely claim and an untimely claim. Deny the untimely claim and process the timely claim.

- A claim containing both assigned and unassigned charges. Split assigned and unassigned services from non-participating physicians/suppliers into separate assigned and unassigned claims for workload counts and processing;

- Assigned claims from different physicians/suppliers (excluding group practices and persons or organizations to whom benefits may be reassigned). Process a separate claim for the services from each physician/supplier. Where the assigned claim is from a person or organization to which the physicians performing the services have reassigned their benefits, process all of the services as a single claim;

- A claim where there is more than one beneficiary on a single claim. There can only be one beneficiary per claim; and

NOTE: Roster bills for covered immunization services furnished by mass immunizers may be submitted for multiple beneficiaries. You must create individual claims for each Medicare beneficiary based on the roster bill information.

- Outpatient physical therapy services furnished on a cost basis by a physician-directed clinic cannot be processed when combined on the same claim with other charge-related services by the clinic. Process the cost related services as a separate claim.

- If an unassigned claim includes services by an independent physical therapist together with other physician services, process the physical therapy services as a separate claim. Process an assigned claim from an independent physical therapist as a single claim.

- A claim that is a duplicate of a claim previously denied is treated as a new claim if there is no indication that the claim is a resubmittal of a previous claim with additional information, or there is no indication on the second claim that the beneficiary is protesting the previous determination.

- In a claim containing services from physicians/suppliers covering more than one carrier jurisdiction, the carrier receiving the claim must split off the services to be forwarded to another contractor and count the material within the local jurisdiction as a claim. The carrier receiving the transferred material must also count it as a separate claim.

- When services in a claim by the same physician/supplier can be identified as being both second/third opinion services and services not related to second/third opinion, the "opinion" services must be split off from the "non-opinion" services and counted as a separate claim. When one physician/supplier in an unassigned claim has provided the "opinion" service and another physician(s)/supplier(s) has provided the "non-opinion" services, the claim may not be split.

- Claims containing any combination of the following types of services must be split to process each type of service as a separate claim. These services are:

  -- Physical therapy by an independent practitioner, ***or***

  -- any services paid at l00 percent of reasonable charges.
  (Any of these types of services may be combined on the same claim with any other type of service.)

Do not deviate from defining claims as described above. Split claims in accordance with the appropriate definition. Throughout the claims process count each of the separate claims, resulting from the split, as an individual claim.