CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1209	**Date: April 11, 2013**
	Change Request 8153

Transmittal 1190, dated February 15, 2013, is being rescinded and replaced by Transmittal 1209 to remove A/B MAC Part A and FI from business requirement 8153.6.1 and A/B MAC, FI, and FISS from business requirement 8153.7. All other information remains the same.

SUBJECT: Recovery of Annual Wellness Visit (AWV) Overpayments

I. SUMMARY OF CHANGES: For claims with dates of service on and after January 1, 2011, processed on and after April 4, 2011, the business requirements in CR 7079 allowed for an AWV visit (HCPCS G0438 or G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases, this has resulted in overpayments. CR 8107 has updated those business requirements in order to prevent future overpayments. This CR provides instructions for recovering AWV overpayments that have been made.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

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

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; Contractors activities are to be carried out with 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 obliged 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: 1209	Date: April 11, 2013	Change Request: 8153

Transmittal 1190, dated February 15, 2013, is being rescinded and replaced by Transmittal 1209 to remove A/B MAC Part A and FI from business requirement 8153.6.1 and A/B MAC, FI, and FISS from business requirement 8153.7. All other information remains the same.

SUBJECT: Recovery of Annual Wellness Visit (AWV) Overpayments

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

I. GENERAL INFORMATION

A. Background: Change Request (CR) 7079, Transmittal 2159, provided billing instructions for Annual Wellness Visit (AWV) services. Per CR 7079 providers may provide an initial AWV visit (HCPCS code G0438) to a beneficiary once in a lifetime. In addition, providers may provide a subsequent AWV (HCPCS code G0439) if the beneficiary has not received an Initial Preventive Physical Examination (IPPE) or an AWV within the past 12 months.

For claims with dates of service on and after January 1, 2011, processed on and after April 4, 2011, the business requirements of CR7079 allowed an AWV visit (HCPCS G0438 and G0439) on an institutional claim and a professional claim for the same patient on the same day. In some cases, this resulted in double billing of the same service, since institutional and professional claims may be submitted for the same service. As a response to double billing of AWV services, CMS issued CR 8107, Transmittal 2575, to provide instructions for edits to be modified to only allow payment for either the practitioner or the facility for furnishing the AWV. CR 8107 will be implemented on April 1, 2013. In the interim period from April 4, 2011 through March 31, 2013, double billings have occurred and may continue to occur. This CR provides instructions to contractors to initiate a recovery process for these overpayments of AWV services.

B. Policy: Section 4103(c)(3)(A) of the Affordable Care Act specifically excludes the AWV from payment under the OPPS and establishes payment for the AWV when performed in a hospital outpatient department under the Medicare Physician Fee Schedule (MPFS). CMS will accept claims for payment from facilities furnishing the AWV in a facility setting if no physician claim for professional services has been submitted to CMS for payment. That is, Medicare will pay either the practitioner or the facility for furnishing the AWV in a facility setting, and only a single payment under the MPFS will be allowed. Where an AWV overpayment for a beneficiary has been made, that is an overpayment that must be recovered.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8153.1	CWF shall develop and run a utility to identify by A/B MAC/carrier/ FI, and by beneficiary HICN, claims for paid AWV G0438 services when more than one paid claim, either institutional or professional, appears in history for the same beneficiary for claims with the same date of service, for dates of service on or after January 1, 2011, processed on or after April 4, 2011 through March 31, 2013.										X	
8153.1.1	The CWF host shall not purge claims records until all adjustments from the utility has finalized.										X	
8153.2	CWF shall develop and run a utility to identify by A/B MAC/carrier/ FI, and by beneficiary HICN, claims for paid AWV G0438 services where more than one paid claim, either institutional or professional, appears in history for the same beneficiary, for claims with different dates of service, for dates of service on or after January 1, 2011, processed on or after April 4, 2011 through March 31, 2013.										X	
8153.2.1	The CWF host shall not purge claims records until all adjustments from the utility have finalized.										X	
8153.3	CWF shall develop and run a utility to identify by A/B MAC/carrier/ FI, and by beneficiary HICN, claims for paid AWV G0439 institutional or professional services, where a paid G0438 or G0439 claim, either institutional or professional, appears in history for the same beneficiary for claims with the same date of service, for dates of service on or after January 1, 2011, processed on or after April 4, 2011 through March 31, 2013.										X	
8153.3.1	The CWF host shall not purge claims records until all adjustments from the utility have finalized.										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8153.4	CWF shall develop and run a utility to identify by A/B MAC/carrier/ FI, and by beneficiary HICN, claims for paid AWV G0439 institutional or professional services where an earlier date of service paid G0438 or G0439 institutional or professional claim appears in history for the same beneficiary within the past 12 months for claims with dates of service on or after January 1, 2011, processed on or after April 4, 2011 through March 31, 2013. **Note:** CWF shall count 11 months starting with the month that a beneficiary's previous G0438 or G0439, either professional or institutional, is paid in the history file.										X	
8153.4.1	The CWF host shall not purge claims records until all adjustments from the utility have finalized.										X	
8153.5	CWF shall generate an IUR based on results from utilities required in 8153.1, 8153.2, 8153.3, and 8153.4.										X	
8153.6	Contractors shall, upon receipt of the CWF-generated IUR, initiate recoupment procedures using automated processes currently in use for IURs.	X	X		X	X		X	X		X	
8153.6.1	Contractors shall recoup overpayments made to providers for AWV HCPCS G0438 or G0439 in accordance with established procedures for recovering overpayments as provided in Pub. 100-06, Medicare Financial Management Manual, Chapter 3, Overpayments and Chapter 4, Debt Collection.		X			X						
8153.7	When issuing a Medicare Summary Notice concerning AWV recoupment, contractors shall inform the beneficiary that he/she is not responsible for paying the denied amount to the provider using the following message: MSN 31.18 “This adjustment has resulted in an overpayment to your provider/supplier. Your		X			X						

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	provider/supplier has been requested to repay $_____ to Medicare. You do not have to pay this amount. "(**NOTE:** This message shall be used in conjunction with other messages concerning the claim adjustment and/or limitation of liability. This message shall not be used alone. Spanish Version: Este ajuste ha resultado en un pago excesivo a su proveedor/suplidor. Se le ha pedido a su proveedor/suplidor que devuelva $ _____ a Medicare. Usted no tiene que pagar esta cantidad											
8153.8	CWF shall make frequency edits for each AWV HCPCS codes G0438 and G0439 overrideable.							X			X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8153.9	MLN Article: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to	X	X		X	X		

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): William Ruiz, 410-786-9283 or william.ruiz@cms.hhs.gov (Part A Claims Processing), Thomas Dorsey, 410-786-7434 or thomas.dorsey@cms.hhs.gov (Part B Claims Processing)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs), and/or Carriers:
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