CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1244	**Date: May 31, 2013**
	Change Request 8165

Transmittal 1231, dated May 3, 2013, is being rescinded and replaced by Transmittal 1244 to update the new and established patient CPT codes in BR 8165.1 and 8165.2. All other information remains the same.

SUBJECT: Common Working File (CWF) Informational Unsolicited Response (IUR) or Reject for a new patient visit billed by the same physician or physician group within the past three years.

I. SUMMARY OF CHANGES: The contractor claim data identified claims with "New Patient" Evaluation and Management (E&M) services that have improper payments. As a result of overpayment for new patient E&M services that should have been paid as established patient E&M services, CMS will implement an Informational Unsolicited Response (IUR) from the Common Working File (CWF) to prompt the system to validate that there are not two new patient CPTs being paid within a three year period of time.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 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-*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; 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: 1244	Date: May 31, 2013	Change Request: 8165

Transmittal 1231, dated May 3, 2013, is being rescinded and replaced by Transmittal 1244 to update the new and established patient CPT codes in BR 8165.1 and 8165.2. All other information remains the same.

SUBJECT: Common Working File (CWF) Informational Unsolicited Response (IUR) or Reject for a new patient visit billed by the same physician or physician group within the past three years.

EFFECTIVE DATE: October 1, 2013
IMPLEMENTATION DATE: October 7, 2013

I. GENERAL INFORMATION

A. Background: The CMS Recovery Audit Contractor (RAC) program is responsible for identifying and correcting improper payments in the Medicare Fee-For-Service payment process. The contractor claim data identified claims with "New Patient" Evaluation and Management (E&M) services that have improper payments. Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 30.6.7 provides that "Medicare interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years. For example, if a professional component of a previous procedure is billed in a three year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit." As a result of overpayment for new patient Evaluation and Management services that should have been paid as established patient Evaluation and Management services, CMS will implement an Informational Unsolicited Response (IUR) from the Common Working File (CWF) to prompt the system to validate that there are not two new patient CPTs being paid within a three year period of time.

B. Policy:
1) Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.7, Subsection A

According to Pub 100-04, Medicare Claims Processing Manual Ch. 12, Physicians/Non-Physicians Practioners, Section 30.6.7, Subsection A, a new patient is defined as a patient who has not received any professional services, i.e., E/M services or other face-to-face services from the physician or physician group practice within the previous three years.

2) AMA CPT Manual Evaluation and Management Services Guidelines Appendix E

The AMA Current Procedural Terminology (CPT) Manual, Evaluation and Management Services Guidelines further supports that a new patient is one who has not received any professional services from the same physician or another physician of the same specialty and same group practice within the past three years.

3) AMA CPT Manual Assistant (July 2011) New vs. Established Patients Appendix C

The AMA Current Procedural Terminology (CPT) Manual, New vs. Established Patients also states that a new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice with in the past three years.

CWF will create an Informational Unsolicited Response (IUR) for all claims where there are two new patient CPTs being paid within a three year period of time. And, that if in the last three years the earliest

claim has an established CPT Code then the current claim for the new patient CPT is to be rejected.

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	
8165.1	The Common Working File (CWF) shall use the list below of New Patient CPT Codes for the following business requirements within this Change Request: 1. 99201 – 99205 2. 99324 – 99328 3. 99341 – 99345 4. 99381 – 99387 5. 92002 6. 92004										X	
8165.2	The Common Working File (CWF) shall use the list below of established patient CPT codes for the following business requirements within this change request: 1. 99211 – 99215 2. 99334 – 99337 3. 99347 – 99350 4. 99391 – 99397 5. 92012 6. 92014										X	
8165.3	The Common Working File (CWF) shall create a new 10-byte field in the header of the HUBC (Pt. B) claim that will contain the Billing Provider NPI.								X		X	
8165.4	The Common Working File (CWF) shall provide a new 1-byte field in the detail line of the HUBC (Pt. B)								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	
	claim that will contain the following values: 1. Y- The Rendering provider NPI is a member of the group practice Billing NPI on the claim; 2. N- The Rendering Provider is not associated with Billing provider NPI; 3. Blank- For historical claims where there is no billing provider NPI available.											
8165.5	The Common Working File (CWF) shall create an IUR utility for the line items on paid professional claim (HIPAA 837P) for New Patient CPT code(s), when the following conditions exist: 1. There are multiple claims (837P) for the same beneficiary HICN; 2. AND the Rendering Provider NPI is the same within the prior three years (3x365= 1,095 days) from the current system date; 3. AND There is one or more New Patient CPT codes existing within the prior claims; 4. OR There are Established Patient CPT Codes with Dates of Service (DOS) earlier than the earliest DOS for the New Patient CPT Code; 5. Create an IUR for all New Patient CPT codes detail line items except the earliest DOS for the New Patient CPT code line item, which does not get an IUR. ***NOTE: (refer to Req 8165.1 for the relevant list of New Patient CPT Code and refer to Req 8165.2 for the relevant list of Established Patient CPT Codes)***								X		X	
8165.6	The Common Working File (CWF) shall execute the utilities prior to the full implementation of the remaining business requirements.										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8165.7	The Common Working File (CWF) shall create a Rejection for the New Patient CPT code line item on a professional claim (837P) for the following conditions: 1. There is a current claim with a line item with a New Patient CPT code*(regardless of the DOS);* 2. AND The new patient CPT codes do not have one of the following Beneficiary Liability Modifiers associated with it: 3. Modifier GA (Waiver of liability statement on file); 4. Modifier GX (Notice of liability issues, voluntary under payer policy); 5. AND There is one or more claims (837P) for the same beneficiary HICN within the prior three years (3x365=1,095 days) from system date; 6. AND The Rendering providers NPI are the same; 7. OR The rendering Providers NPI are different; 8. AND The rendering providers' specialty code are the same; 9. AND The rendering providers' group flag equals "Y"; 10. AND There is a New Patient CPT or Established Patient CPT code in history; 11. Create a rejection for all line items on the current claim for the New Patient CPT codes (the error codes generated will not be overridden). ***NOTE: (refer to Req 8165.1 for the relevant list of New Patient CPT Code and refer to Req 8165.2 for the relevant list of Established Patient CPT Codes)***										X	

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8165.8	The Common Working File (CWF) shall create a rejection for the New Patient CPT code line item on a professional claim (837P) for the following conditions: 1. There is a current claim with multiple line items with a New Patient CPT code; 2. AND The new patient CPT codes do not have one of the following Beneficiary Liability Modifiers associated with it: 3. Modifier GA (Waiver of liability statement on file); 4. Modifier GX (Notice of liability issues, voluntary under payer policy); 5. AND There are no prior claims (837P) for the same beneficiary HICN and the Rendering provider for the New Patient CPT codes; 6. AND the Rendering providers are the same; 7. OR The rendering Providers NPI are different; 8. AND The rendering providers' specialty code is the same; 9. AND The rendering providers' group flag equals "Y"; 10. Create a rejection for all New Patient CPT codes detail line items except for the New Patient CPT code with the earliest DOS (the error codes generated will not be overridden). ***NOTE: (refer to Req 8165.1 for the relevant list of New Patient CPT Code and refer to Req 8165.2 for the relevant list of Established Patient CPT Codes)***										X	
8165.9	The Medicare claims processing contractors shall use the appropriate CARCs and RARCs per instructions in the claims processing manual Pub 100-04, Chapter 22,		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	
	Section 60/60.1/60.2.											
8165.10	The Medicare contractors shall recoup on all claims being billed as a New Patient visit billed by the same physician or physician group within the past three years according to the IUR using automated processes currently in use for IURs. If automated processes are not available, the claims are to be manually adjusted.		X			X						
8165.11	The Medicare claims processing contractors shall use the appropriate MSN message as provided by CMS per instructions in the claims processing manual Pub 100-04, Chapter 21.		X			X						
8165.12	The CMS shall provide updates to the list of CPT codes used by CWF for the business requirements within this Change Request through a recurring CR.										X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8165.13	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		

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): Pamela Durbin, 410-786-6333 or Pamela.Durbin@cms.hhs.gov , Carla David, 410-786-4799 or carla.david@cms.hhs.gov

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:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 do 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.