CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2463	**Date: May 4, 2012**
	Change Request 7771

Transmittal 2461, dated April 27, 2012, has been rescinded and replaced by Transmittal 2463 to change the section number for the manual instruction from 140.2 to 140.3. All other information remains the same.

SUBJECT: New Fiscal Intermediary Shared System (FISS) Edit to Review Medicare Outpatient Prospective Payment System (OPPS) Payments Exceeding Charges.

I. SUMMARY OF CHANGES: Effective for claims received on or after October 1, 2012, contractors shall verify claims with OPPS Payments that meet a reimbursement amount greater than submitted charges.

EFFECTIVE DATE: October 1, 2012
IMPLEMENTATION DATE: October 1, 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
R	1/ Table of Contents
N	1/140/140.3/Verification Edit for Claims with OPPS Payments

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:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2463	Date: May 4, 2012	Change Request: 7771

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SUBJECT: New Fiscal Intermediary Shared System (FISS) edit to review Medicare Outpatient Prospective Payment System (OPPS) Payments Exceeding Charges.

Effective Date: **October 1, 2012**

Implementation Date: **October 1, 2012**

I. GENERAL INFORMATION

A. Background: The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), recently issued several final audit reports regarding the "Review of Medicare Payments Exceeding Charges for Outpatient Services Processed" to various A/B Medicare Administrative Contractors (A/B MACs.). Audit findings in these reports include: providers reporting incorrect units of service and/ or incorrect HCPCS codes, or use of HCPCS codes that do not reflect the procedures performed.

Based on findings in these reports, the Center for Medicare & Medicaid Services (CMS) is implementing a verification policy where the Outpatient Prospective Payment System (OPPS) payment is greater than the billed charges.

B. Policy: When the OPPS reimbursement is greater than the claim charges, verification will be needed to ensure that a billing error has not caused this situation.

Effective for claims received on or after October 1, 2012, FISS shall install a verification edit for claims with OPPS Payments that meet a reimbursement amount greater than submitted charges. The edit shall be applied to the following providers and bill types:

Provider Type	Types of Bills
Hospitals	12X, 13X, 14X

Contractors shall suspend those claims receiving the verification edit for development and contact providers to resolve billing errors. If the contractor determines that the reimbursement is excessive and claim corrections are required, the contractor shall return the claim to the provider. If the contractor determines that the billing is accurate and the reimbursement is not excessive, the contractor shall override the FISS edit and submit the claim to the Common Working File (CWF).

II. BUSINESS REQUIREMENTS TABLE

Use of "Shall" denotes a mandatory requirement

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	
7771.1	FISS shall edit outpatient and inpatient Part B claim bill types 12X, 13X, and 14X with an OPPS payment that is greater than the billed charges.	X		X			X				
7771.2	FISS shall allow contractors to override the edit.	X		X			X				
7771.3	Contractors shall suspend those claims receiving the verification edit for development.	X		X							
7771.3.1	Contractors shall contact providers to resolve billing errors.	X		X							
7771.3.2	FISS shall create a report for contractor use that identifies claims that encounter edit from business requirement 7771.1	X		X			X				
7771.4	If the contractor determines that the reimbursement is excessive and claim corrections are required, the contractor shall return the claim to the provider.	X		X							
7771.5	If the contractor determines that the billing is accurate and the reimbursement is not excessive, the contractor shall override the FISS edit.	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	
7771.6	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 site and include information about it in a listserv message within one week of the availability	X		X							

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	
	of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to 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: For any recommendations and supporting information associated with listed requirements, use the box below:

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):
Contact Fred Rooke at fred.rooke@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,* use only one of the following statements:
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)*, include the following statement:

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.

Medicare Claims Processing Manual
Chapter 1 - General Billing Requirements

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(Rev. 2463 05-04-12)

140.3 - Verification Edit for Claims with OPPS Payments

(Rev. 2463, Issued 05-04-12, Effective: 10-01-12, Implementation: 10-01-12)

Effective for claims received on or after October 1, 2012, FISS shall install a verification edit for claims with OPPS payments that exceed a reimbursement amount greater than submitted charges. The edit shall be applied to the following providers and bill types:

Provider Type	***Types of Bills***
Hospitals	*12X, 13X, 14X*

Contractors shall suspend those claims receiving the verification edit for development and contact providers to resolve billing errors. If the contractor determines that the reimbursement is excessive and claim corrections are required, the contractor shall return the claim to the provider. If the contractor determines that the billing is accurate and the reimbursement is not excessive, the contractor shall override the FISS edit and submit the claim to the Common Working File (CWF).