CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1142	**Date: November 2, 2012**
	Change Request 7849

SUBJECT: Editing for Duplicate Payment of Nonphysician Outpatient Services Provided During an Inpatient Hospital Admission

I. SUMMARY OF CHANGES: The Office of the Inspector General (OIG) has identified a need for additional editing to prevent potential duplicate payments for nonphysician outpatient services provided within an IPPS hospital admission.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 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-*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: 1142	Date: November 2, 2012	Change Request: 7849

SUBJECT: Editing for Duplicate Payment of Nonphysician Outpatient Services Provided During an Inpatient Hospital Admission

Effective Date: April 1, 2013
Implementation Date: April 1, 2013

I. GENERAL INFORMATION

A. Background: The Office of the Inspector General (OIG) conducted a nationwide audit to determine whether Medicare payments were correct for non-physician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during Inpatient Prospective Payment System (IPPS) stays. As a result of this audit, the OIG identified a need for additional editing to prevent potential duplicate payments for nonphysician outpatient services provided within an IPPS hospital admission.

The OIG also identified that Medicare contractors incorrectly overrode Fiscal Intermediary Standard System (FISS) edits or took no action to recover or offset overpayments when they received CWF alerts. We are reminding contractors of their on-going responsibility to reject claims, and process and recover overpayments when identified by edits.

B. Policy: This CR does not include new policy. CMS is implementing new editing in the Common Working File (CWF) to detect duplicate billing of nonphysician outpatient services considered included in an inpatient hospital admission in the same facility or in another facility.

All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. This provision applies to all hospitals, regardless of whether they are subject to the prospective payment system (PPS).

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7849.1	CWF shall ensure that A/B crossover edits apply to an incoming outpatient claim (‘12x’) with line item service dates that are after the Part A benefits exhaust date, Occurrence code A3, B3 or C3, of an IPPS, Long Term Care Hospital (LTCH) or Inpatient Rehabilitation Facility (IRF) history claim (excluding the discharge date) that does not have an outlier payment.									X	

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7849.2	In addition to existing bypass criteria for duplicate payment edits, CWF shall ensure that A/B crossover edits are bypassed for an incoming outpatient claim (type of bill 12X) with line item service dates that are after the Part A benefits exhaust date, Occurrence code A3, B3 or C3, of an IPPS, LTCH or IRF history claim (excluding the discharge date) that includes an outlier payment.									X	
7849.3	CWF shall send an informational unsolicited response (IUR) on a history outpatient claim with service dates that are after the Part A benefits exhaust date, Occurrence code A3, B3 or C3, (excluding the discharge date) of an incoming IPPS, LTCH or IRF claim that does not have an outlier payment.									X	
7849.3.1	Upon receipt of the IUR from CWF, contractors shall reject the claim.	X		X							
7849.4	CWF shall modify an existing edit or create a new edit, if an existing edit does not exist, to reject an incoming outpatient claim (TOB '12X', '13X', '85X') from the same provider, with line item service dates that are within the admission and discharge dates of an inpatient stay other than a Skilled Nursing Facility (SNF), excluding any existing bypass criteria, of an inpatient admission in history.									X	
7849.4.1	CWF shall bypass the edit in 7849.4 when any of the following criteria are met: For 12X TOB - • When no Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days **before** admission. • When the admission was disapproved as not reasonable and necessary (and waiver of liability payment was not made); • When the day or days of the otherwise covered stay during which the services were provided were not reasonable and necessary (and no payment was made under waiver of liability); • When the patient was not otherwise eligible for or entitled to coverage under Part A (See the Medicare Benefit Policy Manual, Chapter 1, §150, for services received as a result of noncovered services). • When an incoming from date or OSC '72' from date is greater than the date the Part A benefits									X	

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	exhausted <u>after outlier status is reached.</u> • When the history claim has an Occurrence Span Code '76', and when the incoming claim From Date is equal to or greater than the history claim Occurrence Span Code '76' from Date, and the incoming claim Thru Date is equal to or less than the history claim Occurrence Span Code '76' Thru Date. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span Code '76'. • When the history claim has an Occurrence Span Code '77', and when the incoming claim From Date is equal to or greater than the history claim Occurrence Span Code '77' From Date, and the incoming claim Thru Date is equal to or less than the history claim Occurrence Span Code '77' Thru Date. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span Code '77'. • When the history claim has an Occurrence Span Code '79', and when the incoming claim From Date is equal to or greater than the history claim Occurrence Span Code '79' From Date, and the incoming claim Thru Date is equal to or less than the history claim Occurrence Span Code '79' Thru Date, bypass this edit. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span Code '79'. • When the incoming claim has an Occurrence Span Code '72', and the history claim has an Occurrence Span Code '74' for a **<u>greater</u>** than 3 day interrupted stay in a long term care facility										

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	(LTCH) , and when the Occurrence Span Code '72' From Date is equal to or greater than the history claim Occurrence Span Code '74' From Date, and the incoming claim Occurrence Span Code '72' Thru Date is equal to or less than the history claim Occurrence Span Code '74' Thru Date. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span Code '74'. • When the incoming claim has an Occurrence Span Code '72', and the history inpatient rehabilitation facility (IRF) or inpatient psychiatric facility (IPF) claim has an Occurrence Span Code '74' and when the Occurrence Span Code '72' From Date is equal to or greater than the history claim Occurrence Span Code '74' From Date, and the incoming claim Occurrence Span Code '72' Thru Date is equal to or less than the history claim Occurrence Span Code '74' Thru Date. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span Code '74'. • When the incoming claim has an Occurrence Span Code '72', and the history claim has an Occurrence Span Code '77', and when the Occurrence Span Code '72' From Date is equal to or greater than the history claim Occurrence Span Code '77' From Date, and the incoming claim Occurrence Span Code '72' Thru Date is equal to or less than the history claim Occurrence Span Code '77' Thru Date. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span										

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	Code '77'. • When the incoming claim has an Occurrence Span Code '72', and the history claim has an Occurrence Span Code '79', and when the Occurrence Span Code '72' From Date is equal to or greater than the history claim Occurrence Span Code '79' From Date, and the incoming claim Occurrence Span Code '72' Thru Date is equal to or less than the history claim Occurrence Span Code '79' Thru Date. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR Aux Occurrence Span Codes will be interrogated for Occurrence Span Code '79'. • When the incoming Outpatient claim has an Occurrence Span Code '74' present, compare those dates to the history claim Service Dates, and if the history dates are equal to or within the incoming Occurrence Span Code '74' dates, bypass this edit. NOTE: When the history Inpatient claim has Condition Code 'UU' and there is an OSCR Aux record for the history BENE, Provider, and Admit Date, the OSCR AUX occurrence Span Codes will be interrogated for Occurrence Span Code '74'. • When the date of service on a claim for Screening services (Fecal Occult blood test, Barium enema, Flexible Sigmoidoscopy, Colonoscopy-high risk) is equal to the discharge date of an inpatient admission. • When the date of service for Influenza virus and pneumococcal vaccines equals the benefits exhaust date or discharge date of an inpatient admission. • When Flu and/or Pneumococcal Vaccine roster bill (Condition Code 'M1' with Revenue Code '636') is received. For outpatient TOB ('13x', or '85x')- • When the incoming Outpatient service From Date is equal to, or greater than, the history Inpatient Discharge Date • When the incoming claim Thru Date, or if present										

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	the Occurrence Span Code '72' Thru Date, is equal to the History Inpatient claim Admission Date (this should be picked up by payment window edit) • When the history Inpatient Cancel Date is greater than zero • When the history Inpatient bill source is not equal to '2' or '3' • When the history Inpatient Action Code is equal to '7' • When the incoming Outpatient claim Demonstration Number is equal to '31' • When the incoming Outpatient claim Total Charge equals the Non-covered Charge • When the incoming Outpatient claim is an Encounter and the Inpatient History claim is an IME/GME with Condition Codes '04' and '69' • When the claim is a Flu Vaccine roster bill • When an ambulance date of service is equal to the admission or discharge date on an inpatient claim • When a service is within 74 span code from and through dates plus one day of a **greater** than 3-day interruption of stay in a long term care facility (LTCH) • When a service is within 74 span code from and through dates plus one day of an IPF or IRF claim • When the outpatient claim is part of the New Part A/ Part B Rebilling Demonstration • Incoming '85X' TOB service date is the same as the admission date of the history inpatient claim										
7849.4.2	CWF shall allow this edit to be overridden by the contractors.									X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		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:

X-Ref Requirement Number	Recommendations or other supporting information:
7849.1	CMS would like to draw your attention to CWF edit 7050, 7070 and Alert 7545 which may be impacted.

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

V. CONTACTS

Pre-Implementation Contact(s): Contact Cami DiGiacomo at cami.digiacomo@cms.hhs.gov, Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov or 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)*:

Not Applicable.

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.