CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1170	**Date: January 31, 2013**
	Change Request 7892

SUBJECT: Common Working File (CWF) Informational Unsolicited Response (IUR) or Reject for place of service billed by physician office and either ambulatory surgical center or inpatient hospital, for the same beneficiary, same date of service, and same procedure, based on sequence received of the Part B claim.

I. SUMMARY OF CHANGES: CMS has the authority under section 1893 of the Social Security Act (42 U.S. C. 1395ddd) that was amended in the Tax Relief Act of 2006, Section 302, to use Recovery Audit Contractors (RACs) for identifying, collecting, and correcting improper payments in the Medicare Fee-For-Service payment process. The issue listed below has been identified by the recovery auditors as significant improper payments and requires the development of an edit to correct these improper payments. The edit for this issue will include claims that have physician place of service code and either ambulatory surgical center (ASC) code and inpatient hospital code. This edit will act as a tool to protect the Medicare Trust Fund by preventing improper billing practices.

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-*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: 1170	Date: January 31, 2013	Change Request: 7892

SUBJECT: Common Working File (CWF) Informational Unsolicited Response (IUR) or Reject for place of service billed by physician office and either ambulatory surgical center or inpatient hospital, for the same beneficiary, same date of service, and same procedure, based on sequence received of the Part B claim.

Effective Date: July 1, 2013

Implementation Date: July 1, 2013

I. GENERAL INFORMATION

CMS has the authority under section 1893 of the Social Security Act (42 U.S. C. 1395ddd) that was amended in the Tax Relief Act of 2006, Section 302, to use Recovery Audit Contractors (RACs) for identifying, collecting, and correcting improper payments in the Medicare Fee-For-Service payment process.

The issue listed below has been identified by the recovery auditors as significant improper payments and requires the development of an edit to correct these improper payments. The edit for this issue will include claims that have physician place of service code and either ambulatory surgical center (ASC) code or inpatient hospital code. This edit will act as a tool to protect the Medicare Trust Fund by preventing improper billing practices.

A. Background:

1) An audit in October 2004 by the Office of the Inspector General (OIG) identified place of service billing by physicians as a payment error. This report stated, "Medicare overpaid physicians due to incorrect place of service coding. Seventy-nine of 100 sampled physician services, selected from a population of services identified as having a high potential for error, were performed in a facility but were billed by the physicians using the "office" place of service code. As a result of the incorrect coding, Medicare paid the physicians a higher amount for these services." Because these claims cannot be denied prior to payment, CMS is implementing an IUR for all claim types to recover these payments.

CWF will create an Informational Unsolicited Response (IUR) for all claims where the dates of service, the beneficiary information, and procedure, are all the same and billed with a physician place of service code 11 - office, and a facility code for inpatient hospital – 21, and ambulatory surgical center (ASC) – 24, that is posted due to an update from CMS.

B. Policy:

1) Pub. 100-04, Medicare Claims Processing Manual, Ch 12, section 20.4.2.

The Medicare physician fee schedule includes two payment amounts depending on whether a service is performed in a facility setting, such as an outpatient hospital department or ambulatory surgical center, or in a non-facility setting, such as a physician's office. The payments to physicians are higher when the services are performed in non-facility settings. The higher payments are designed to compensate physicians for the additional costs incurred to provide the service at an office location as opposed to a facility location.

In order for the physician to receive the higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B).

II. BUSINESS REQUIREMENTS 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	
7892.1	The Common Working File (CWF) shall create a reject or IUR for Part B Professional claims with place of service (POS) 11 when the date of service (DOS), Health Insurance Claim number (HIC #), and CPT surgical procedure code (10021-69990), are identical on an institutional claim with type of bill (TOB) 12x and 83x.									X	
7892.2	CWF shall create a reject or IUR for Part B claims with POS 11 with DOS that is within an inpatient stay not including the admission or discharge date.							X		X	
7892.3	CWF shall set a reject on physician Part B claims with POS 11 if the institutional claim is in history.									X	
7892.4	CWF shall not generate the reject or IUR when the Part B claim's DOS equals the inpatient stay admission or discharge date.									X	
7892.5	CWF shall allow override capabilities of reject or IUR if claims processors determine the claims should be paid.									X	
7892.6	CWF shall not create an IUR for noncovered claims for Part B and Institutional claims.									X	
7892.7	CWF shall use all current trailers for this edit.									X	
7892.8	Medicare claims processors shall follow the payment threshold established by CMS for allowed charges.	X			X						
7892.9	Medicare claims processing contractors shall use the appropriate CARCs and RARCs per CMS instruction in the MAC/Carrier manual.	X			X						
7892.10	Medicare claims processing contractors shall follow the normal accounts receivable (AR) process for recoupment.	X			X						
7892.11	Medicare claims processing contractors shall use the appropriate MSN message as provided by CMS instruction per the MAC/Carrier manual.	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	

7892.12	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 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.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Pamela Durbin, pamela.durbin@cms.hhs,gov, 410-786-6333, Carlos Montoya, carlos.montoya@cms.hhs.gov, 410-786-6040

Post-Implementation Contact(s): Pamela Durbin, pamela.durbin@cms.hhs.gov, 410-786-6333 Carlos Montoya, carlos.montoya@cms.hhs.gov, 410-786-6040
Please contact your Contracting Officer Representative (COR), as necessary.

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.