CMS Manual System

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Pub. 100-08 Medicare Program Integrity

Transmittal 86 | **Date: NOVEMBER 5, 2005**

CHANGE REQUESTS 3437

NOTE: Transmittal 84, dated October 22, 2004, is rescinded and replaced with Transmittal 86, dated November 5, 2004.

SUBJECT: Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services

I. SUMMARY OF CHANGES: Instructs that for an item or service provided by a hospital or critical access hospital pursuant to section 1867of the Social Security Act (EMTALA) on or after January 1, 2004, FIs must make determinations of whether the item or service is reasonable and necessary on the basis of information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not only on the patient's principal diagnosis). The frequency with which an item or service is provided to the patient before or after the time of the service shall not be a consideration.

NEW/REVISED MATERIAL - EFFECTIVE DATE: November 22, 2004
***IMPLEMENTATION DATE: November 22, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	3/5.1.1/Prepayment Edits

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-08	Transmittal: 86	Date: November 5, 2004	Change Request 3437

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SUBJECT: Payment for Emergency Medical Treatment and Labor Act (EMTALA) - Mandated Screening and Stabilization Services

I. GENERAL INFORMATION

A. Background: This issuance advises fiscal intermediaries (FIs) of provisions contained in the Medicare Modernization Act (MMA) at section 944(a), Payment for EMTALA-Mandated Screening and Stabilization Services. This section requires that determinations of whether items and services provided in emergency departments (EDs) are reasonable and necessary be made on the basis of information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not only on the patient's principal diagnosis). When making such determinations with respect to such item or service, the law specifies that contractors shall not consider the frequency with which the service was provided to the patient before or after the time of admission or visit. However, contractors may continue to target their data analysis on EDs to ensure that there are no aberrant patterns of outliers.

B. Policy: We are updating the Program Integrity Manual with new requirements at chapter 3, section 5.1.1 C. To ensure that current LMRPs/LCDs do not inappropriately deny ED claims, FIs are instructed to discontinue LMRP/LCD automated frequency edits for items and services, including diagnostic tests, performed under EMTALA and/or when billed with revenue codes 045X, 0516, or 0526. Frequency may not be considered. Medical review can be targeted at potentially aberrant ED billing, but decisions must be based on the information available to the ED physician, including the patient's presenting conditions, as required by the MMA provision. We are also updating the manual to instruct FIs to provide guidance on how to bill for the patient's presenting conditions. The National Uniform Billing Committee designated Form Locator 76 of the UB-92 claim form (837i 2300 HI segment, HI02-2. HI02-1 (the qualifier for HI02-2) must = ZZ. This HI02 is used only once per claim.), to be used for the ICD-9-CM code that represents the patient's reason for the visit in 1999. Recently CMS added edit criteria to require this on an outpatient claim Types of Bill (TOBs) 13X, 14X, 23X, 71X, 73X, 83X, and 85X. Only one diagnosis code may be shown on a claim as the reason for the visit, and that is recorded in Form Locator 76. At the provider's discretion, additional signs and symptoms codes not inherent in the principal diagnosis may be reported in Form Locators 68 through 75 (837i 2300 HI segment, HI01-2. HI01-1 (the qualifier for HI01-2) must = BF. Additional codes may be added in HI02 through HI12). The FIs shall instruct providers that they may use these fields when billing for items or services, including diagnostic tests, performed under EMTALA, and/or when billed with revenue codes 045X, 0516, or 0526 to assure appropriate payment. The system must scan these fields as well for payable diagnosis codes. For LCDs with frequency edits, you must turn off those frequency edits for these services.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. FIs 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 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. In addition, contractors are encouraged, within available resources, to provide education through seminars, conferences, etc. as they deem appropriate.

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3437.1.	FIs shall discontinue automated frequency edits resulting from LMRPs/LCDs with a 45X, 0516, or 0526 revenue code, or for items or services, including diagnostic tests, performed under EMTALA, to ensure that current LMRPs/LCDs do not inappropriately deny ED claims.	X								
3437.2.	FIs shall consider the diagnoses in Form Locator 76 and Form Locators 68 – 75 for payment decisions.	X								
3437.3.	FIs may target medical review at ED billing, when data indicates there may be a problem.	X								
3437.4.	FIs shall make decisions based on the information available to the ED physician or practitioner, including the patient’s presenting conditions, when performing medical review.	X								
3437.5.	FIs shall reopen claims for ED services provided on or after January 1, 2004 that were previously denied prior to the issuance of this instruction if the provider so requests.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
3437.6.	FIs shall educate providers through the Medlearn Matters article, and shall supplement the Medlearn Matters article with localized information that would benefit their provider community in billing correctly.	X								

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: November 22, 2004 **Implementation Date:** November 22, 2004 **Pre-Implementation Contact(s):** Sandra Latimer, 410-786-9178, SLatimer@cms.hhs.gov Dan Schwartz, 410-786-4197 DSchwartz2@cms.hhs.gov **Post-Implementation Contact(s):** Regional offices	**Medicare contractors shall implement these instructions within their current operating budgets.**

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3.5.1.1 - Prepayment Edits

(Rev. 86, Issued: 11-05-04, Effective: 11-22-04, Implementation: 11-22-04)

Prepayment edits are designed by contractor staff and put in place to prevent payment for non-covered and/or incorrectly coded services and to select targeted claims for review prior to payment. Medical review (MR) edit development is the creation of logic (the edit) that is used during claims processing prior to payment that validates and/or compares data elements on the claim.

Contractors may not install edits that result in the automatic denial of services based solely on the diagnosis of a progressively debilitating disease where treatment may be reasonable and necessary. The appearance of a progressively debilitating disease on a claim or history does not permit automated prepay denials that presume a stage of that disease that negates the effectiveness of treatment. Additionally, when a beneficiary with a progressively debilitating disease experiences an illness or injury unrelated to their progressively debilitating disease, the provider should submit a claim with a primary diagnosis that most accurately reflects the need for the provided service. For example, following a hip replacement in a patient with Alzheimer's Disease, a physical therapy provider should submit a claim using ICD-9 Code *V54.81 (aftercare following joint replacement)* as the primary diagnosis, not ICD-9 Code 331.0 (Alzheimer's Disease). Automated denials may only be used when the service, in that circumstance, is never reasonable and necessary. For example, an EMG for Alzheimer's may be auto denied because it will never be reasonable and necessary for that ICD code; but EMG may not be auto denied when the claim shows "focal muscular weakness" -- even though that claim also shows Alzheimer's. Physical therapy may not be auto denied solely because multiple sclerosis appears on the claim, but may be if there is no other justification for the service listed. There are stages of the disease at which, for example, physical therapy for gait training will not be effective, but MR must look into the claims history or examine records to make that determination**.**

A. Ability to Target

Contractors must focus edits to suspend only claims with a high probability of being denied on medical review. Focused edits reduce provider burdens and increases the efficiency of medical review activities. Edits should be specific enough to identify only the services that the contractor determines to be questionable based on data analysis. Prepayment edits must be able to key on a beneficiary's Health Insurance Claim Number (HICN), a provider's identification (e.g., Provider Identification Number (PIN), UPIN) and specialty, service dates, and medical code(s) (i.e., HCPCS and/or ICD-9 diagnoses codes). Intermediary edits must also key on Type Of Bill (TOB), revenue codes, occurrence codes, condition codes, and value codes.

Carrier systems must be able to select claims for prepayment review using different types of comparisons. By January 2001 *(*unless otherwise specified*)*, FI systems must be able to perform these comparisons as well. At a minimum, those comparisons must include:

- Procedure-to-Procedure – This relationship permits contractor systems to screen multiple services at the claim level and in history. Intermediaries on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.

- Procedure to Provider – For a given provider, this permits selective screening of services that need review.

- Frequency to Time – This allows contractors to screen for a certain number of services provided within a given time period. Intermediaries on the FISS system are waived from this requirement until the FI Standard System is updated to include this capability.

- Diagnosis to Procedure – This allows contractors to screen for services submitted with a specific diagnosis. For example, the need for a vitamin Bl2 injection is related to pernicious anemia, absence of the stomach, or distal ileum. Contractors must be able to establish edits where specific diagnosis/procedure relationships are considered in order to qualify the claim for payment.

- Procedure to Specialty Code (Carrier) or TOB (Intermediary) – This permits contractors to screen services provided by a certain specialty or type of bill.

- Procedure to Place of Service – This allows selective screening of claims where the service was provided in a certain setting such as a comprehensive outpatient rehabilitation facility.

Additional intermediary edits include, but are not limited to, the following:

- Diagnoses alone or in combination with related factors, e.g., all ICD-9-CM codes XXX.X-XXX.X with revenue code (REV) XXX and units greater than X;

- Revenue and/or HCPCS codes, e.g., a REV with a selected HCPCS (REV XXX with HCPCS XXXXX);

- Charges related to utilization, e.g., an established dollar limit for specific REV or HCPCS (REV XXX with HCPCS XXXXX with charges over $500);

- Length of stay or number of visits, e.g., a selected service or a group of services occurring during a designated time period (bill type XXX with covered days/visits exceeding XX); and

- Specific providers alone or in combination with other parameters (provider XX-XXXX with charges for REV XXX).

B. Evaluation of Prepayment Edits

Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The contractor must evaluate all service specific and provider specific prepayment edits as follows:

- Automated edits must be evaluated annually.
- All routine or complex review edits must be evaluated quarterly.

These evaluations are to determine their effectiveness and contribution to workload. Contractors shall consider an edit to be effective when an edit has a reasonable rate of denial relative to suspensions and a reasonable dollar return on cost of operation or potential to avoid significant risk to beneficiaries. Revise or replace edits that are ineffective. Edits may be ineffective when payments *or claims* denied are very small in proportion to the volume of claims suspended for review. It is appropriate to leave edits in place if sufficient data are not available to evaluate effectiveness, if a measurable impact is expected, or if a quarter is too brief a time to observe a change. Contractors should analyze prepayment edits in conjunction with data analysis to confirm or re-establish priorities. Contractors should replace, if appropriate, existing effective edits to address problems that are potentially more costly.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ESTABLISHED AUTOMATED** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal, etc. Contractors must maintain and make available to RO (for PSCs, the GTL, Co-GTL, and SME) and CO staff documentation demonstrating that they consider appeals in their edit evaluation process; and
- Specificity of edits in relation to identified problem(s).

Contractors should note that even an automated edit that results in no denials may be effective so long as the presence of the edit is not preventing the installation of other automated edits.

FACTORS CONTRACTORS MUST CONSIDER IN LOOKING AT EDIT EFFECTIVENESS FOR **ALL OTHER** EDITS:

- Time and staff needed for review, including appeals reviews. Contractors must implement mechanisms (e.g., manual logs, automated tracking systems) to allow the appeals unit to communicate to the MR unit information such as which denial categories are causing the greatest impact on appeals, the outcome of the appeal,

etc. Contractors must maintain and make available to RO and CO staff documentation demonstrating that they consider appeals in their edit evaluation process.

- Specificity of edits in relation to identified problem(s);

- Demonstrated change in provider behavior, e.g., the contractor can show the decrease in frequency of services per beneficiary, the decrease in the number of beneficiaries receiving the services, the service is no longer billed, or another valid measure can be used to reflect a change in provider behavior over time;

- Impact of educational or deterrent effect in relation to review costs; and

- The presence of more costly problems identified in data analysis that needs higher priority than existing edits considering the number of claims/days/charges reviewed in comparison to claims/days/charges denied.

Contractors must test each edit before implementation and determine the impact on workload and whether the edit accomplishes the objective of efficiently selecting claims for review.

C. Adding LMRP/LCD and NCD ID Numbers to Edits

By January 1, 2004, FISS FIs must ensure that any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD or NCD ID number(s) associated with the denial.

By April 1, 2004, FISS FIs must ensure that any edit that may result in a denial based on a lab negotiated NCD includes the NCD ID number(s) associated with the denial.

By October 4, 2004, VMS carriers and PSCs must ensure the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

By October 4, 2004, MCS carriers must ensure that the analysis and design is completed for any edit that may result in a denial based on an LMRP/LCD or NCD includes the LMRP/LCD ID number(s) or NCD ID number(s) associated with the denial.

D. Payment for Emergency Medical Treatment and Labor Act (EMTALA)-Mandated Screening and Stabilization Services

Under section 1862 of the Social Security Act, as amended by section 944 of the Medicare Modernization Act, in the case of an item or service provided by a hospital or critical access hospital pursuant to section 1867of the Social Security Act (EMTALA) on or after January 1, 2004, FIs must make determinations of whether the item or service is reasonable and necessary on the basis of information available to the treating physician

or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not only on the patient's principal diagnosis). The frequency with which an item or service is provided to the patient before or after the time of the service shall not be a consideration.

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The FIs may target medical review for potentially aberrant ED billing, but decisions must be based on the information available to the treating physician or practitioner, including the patient's presenting conditions. FIs will continue to perform their data analysis on EDs to ensure that there are no aberrant patterns of outliers.

The FIs shall reopen claims for ED services provided on or after January 1, 2004 that were previously denied prior to the issuance of this instruction if the provider so requests.