CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 620

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: JULY 29, 2005

Change Request 3925

SUBJECT: New Fiscal Intermediary (FI) Edit to Identify Potentially Excessive Medicare Payments

I. SUMMARY OF CHANGES: Effective for claims received on or after January 3, 2006, FIs shall edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of $50,000.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : Claims received on or after January 3, 2006

IMPLEMENTATION DATE : January 3, 2006

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/Fiscal Intermediary (FI) Edits Affecting Multiple Bill Types.
N	1/140.1/Threshold Edit for Outpatient and Inpatient Part B Claims

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 620	Date: July 29, 2005	Change Request 3925

SUBJECT: New Fiscal Intermediary (FI) Edit to Identify Potentially Excessive Medicare Payments.

I. GENERAL INFORMATION

A. Background:

A study performed by the Office of the Inspector General (OIG) found that simple clerical provider billing errors resulted in $12 million in excessive outpatient Medicare payments to institutional providers. The May 2001 OIG Report was the result of a review of high dollar outpatient claims paid during calendar years 1997, 1998, and 1999.

Cited in the report are 13 outpatient claims that generated the $12 million in overpayments. The errors were identified as follows:

- 3 claims had overstated service units because the providers incorrectly entered the claims' dates of service in the "SERVICE UNITS" field, resulting in $11,075,686 in overpayments.
- 5 claims had overstated the charges entered in the "TOTAL CHARGES" field, resulting in $642,175 in overpayments.
- 5 claims had overstated service units for various reasons, resulting in $316,230 in overpayments.

Historically, reliance of recovering these overpayments has been placed on the providers or beneficiaries to notify the FI. Even if reported, an additional concern is the loss of interest to the Medicare trust fund during the period of time the overpayments are outstanding.

More recently, informal findings by the OIG reviewing claims data from fiscal year 2003 indicate that the problems still exist today. The OIG has recommended that CMS install edit(s) to alert FIs to claims that may have excessive payments and stress the importance of standard Medicare claims processing system edits to FIs.

B. Policy:

Effective for claims received on or after January 1, 2006, FISS shall install a threshold edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of $50,000. The edit shall be applied to the following providers and bill types:

Provider Type	Types of Bills
• Hospitals	12X, 13X, 14X
• Skilled Nursing Facilities	22X, 23X
• Home Health Agencies	32X, 33X, 34X
• Religious Nonmedical Health Care Institutions	43X
• Rural Health Clinics	71X

- Renal Dialysis Facilities 72X
- Federally Qualified Health Centers 73X
- Outpatient Rehabilitation Facilities 74X
- Comprehensive Outpatient Rehabilitation Facilities 75X
- Community Mental Health Centers 76X
- Hospice Providers 81X, 82X
- Non-OPPS Hospitals Ambulatory Surgery 83X
- Critical Access Hospitals 85X

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

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	
3925.1	Medicare systems shall edit for outpatient and inpatient Part B claim bill types 12X, 13X, 14X, 22X, 23X, 32X, 33X, 34X, 43X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X that meet or exceed a reimbursement amount of $50,000.					X				
3925.2	Medicare systems shall allow FIs to override the edit.					X				
3925.3	FIs shall suspend those claims receiving the threshold edit for development.	X	X							
3925.3.1	FIs shall contact providers to resolve billing errors.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3925.4	If the FI determines that the reimbursement is excessive and claim corrections are required, the FI shall return the claim to the provider.	X	X							
3925.5	If the FI determines that the billing is accurate and the reimbursement is not excessive, the FI shall override the FISS edit.	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3925.6	A 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. 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces:

D. Contractor Financial Reporting /Workload Impact:

E. Dependencies:

F. Testing Considerations:

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: **Claims received on or after January 3, 2006** **Implementation Date: January 3, 2006** **Pre-Implementation Contact(s):** Wendy Tucker Wendy.Tucker@cms.hhs.gov, 410-786-3004 or Wil Gehne, Wilfried.Gehne@cms.hhs.gov, 410-786-6148. **Post-Implementation Contact(s):** Appropriate RO Contact.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev.620, 07-29-05)

140 – Fiscal Intermediary (FI)Edits Affecting Multiple Bill Types

(Rev. 620, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

140.1 - Threshold Edit for Outpatient and Inpatient Part B Claims

(Rev. 620, Issued: 07-29-05, Effective: 01-03-06, Implementation: 01-03-06)

Effective for claims received on or after January 1, 2006, intermediaries shall edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of $50,000. The edit shall be applied to the following providers and bill types:

Provider Type	*Types of Bills*
• *Hospitals*	*12X, 13X, 14X*
• *Skilled Nursing Facilities*	*22X, 23X*
• *Home Health Agencies*	*32X, 33X, 34X*
• *Religious Nonmedical Health Care Institutions*	*43X*
• *Rural Health Clinics*	*71X*
• *Renal Dialysis Facilities*	*72X*
• *Federally Qualified Health Centers*	*73X*
• *Outpatient Rehabilitation Facilities*	*74X*
• *Comprehensive Outpatient Rehabilitation Facilities*	*75X*
• *Community Mental Health Centers*	*76X*
• *Hospice Providers*	*81X, 82X*
• *Non-OPPS Hospitals Ambulatory Surgery*	*83X*
• *Critical Access Hospitals*	*85X*

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