CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1705	**Date: August 5, 2016**
	Change Request 9671

NOTE: This Transmittal is no longer sensitive and is being re-communicated May 4, 2017. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Outlier Limitation on Outpatient Prospective Payment System (OPPS) Community Mental Health Centers (CMHC) Services

I. SUMMARY OF CHANGES: This CR implements an Outlier Limitation on Outpatient Prospective Payment System (OPPS) CMHC Services.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017 - for BRs 1 through 10; April 3, 2017 - for BRs 11 through 12

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	N/A

III. FUNDING:
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:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1705	Date: August 5, 2016	Change Request: 9671

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SUBJECT: Outlier Limitation on Outpatient Prospective Payment System (OPPS) Community Mental Health Centers (CMHC) Services

EFFECTIVE DATE: January 1, 2017
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I. GENERAL INFORMATION

A. Background: A limitation on outlier payments for CMHC services under the OPPS was finalized in the 2017 OPPS final rule. Under these requirements, Medicare systems accumulate during claims processing, for each CMHC provider, the overall total payments the CMHC provider has received and the total of outlier payments they have received. The total payment amount includes any outlier payments. These totals are then compared to determine whether a CMHC provider has been paid 8 percent of their total payments in outliers.

To make the outlier limitation more transparent to providers, a detail file of outlier payments will be created that can be viewed by each CMHC provider.

B. Policy: CMHC claims will be subject to an agency level outlier cap such that in any given calendar year, an individual CMHC provider will receive no more than 8 percent of its total CMHC OPPS payments in outlier payments. For each CMHC provider, Medicare systems must maintain a running tally of calendar year-to-date total CMHC OPPS payments and calendar year-to-date actual outlier payments. Medicare systems will ensure that each time a claim for a provider is processed, calendar year-to-date outlier payments do not exceed 8 percent of calendar year-to-date total CMHC OPPS payments for that CMHC provider.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9671.1	Medicare shared systems shall maintain a running total of CMHC provider's OPPS payments for each CMHC provider for each calendar year in a location accessible for use in processing claims. The screen should display the current year and one additional year prior. Initially for 2017, the prior year (2016) should not be displayed since it will not be populated as it is					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	before the effective date of the new policy (e.g. in 2017 we'd only display 2017 amounts, in 2018, both 2018 and 2017 amounts, in 2019, amounts for 2019 and 2018, then 2017 would fall off the screen in 2019).									
9671.1.1	Medicare shared systems shall apply the sum of the total payment amounts for all lines including deductible, coinsurance and value code "17: on each processed claim to each CMHC's year-to-date total CMHC OPPS payment amount.					X				
9671.1.2	Medicare shared systems shall update the total payment amount for a given calendar year if: • The claim type of bill (TOB) is 76x, and • The claim "From" date is on or after January 1 of that calendar year and before January 1 of the following calendar year.					X				
9671.1.3	Medicare shared systems shall display the total of CMHC OPPS payments on a screen that can be accessed by both contractors and providers.					X				
9671.2	Medicare shared systems shall maintain a running total of CMHC provider's OPPS outlier payments for each CMHC provider for each calendar year in a location accessible for use in processing claims.					X				
9671.2.1	Medicare shared systems shall apply the payment amount in value code "17" on each processed claim to each CMHC's year-to-date outlier payment amount.					X				
9671.2.2	Medicare shared systems shall update the total outlier payment amount for a given calendar year if: • The claim TOB is 76x, and • The claim "From" date is on or after January 1 of that calendar year and before January 1 of the following calendar year.					X				
9671.2.3	Medicare shared systems shall display the total outlier payment of CMHC providers on a screen that can be accessed by both contractors and providers.					X				
9671.3	Medicare shared systems shall apply each CMHC's year-to-date outlier payments and year-to-date total CMHC OPPS payment as each claim is processed in normal batch processing, excluding claims with tape-to-tape flag O, T, U, W or Z.					X				
9671.4	Medicare shared systems shall contain, for each CMHC provider, a detail screen of claims for which outliers are paid or capped.					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9671.4.1	When a CMHC PPS claim is paid, Medicare shared systems shall add an entry to the detail screen that shows the value code “17” amount paid, if any, OPPS Pricer Claim Return Code “02”, if applied, and the total CMHC OPPS payment along with the date the claim was paid.					X				
9671.4.2	Medicare shared systems shall ensure that the detail screen can be viewed and searched by CMHCs for purposes of monitoring their payments accrued toward the outlier limitation.					X				
9671.5	Medicare shared systems shall ensure that outlier payments do not exceed 8 percent of a CMHC’s total CMHC OPPS payments.					X				
9671.5.1	Medicare shared systems shall calculate 8 percent of the total CMHC OPPS payment amount, then deduct the total CMHC OPPS outlier payment amount from the result to determine the available ‘outlier pool’ for the CMHC.					X				
9671.5.2	Medicare shared systems shall append condition code “66” to all claims received when the CMHC’s available ‘outlier pool’ for the CMHC exceed the 8 percent outlier limitation. Once the CMHC’s available ‘outlier pool’ no longer exceed the 8 percent outlier limitation, Medicare systems shall no longer append condition code “66” to claims received.					X				
9671.5.3	The IOCE shall assign a new Payment Method Flag (PMF) of ‘6’ when condition code 66 is present.									IOCE
9671.6	Outpatient PPS Pricer shall calculate outlier payments within the Outpatient PPS Pricer but will not send an outlier payment amount in the outbound response for claims with condition code “66” (IOCE Payment Method Flag equals “6”) applied.									OPPS Pricer
9671.7	Outpatient PPS Pricer shall send a new OPPS Pricer Claim Return code of “02” when outlier payments are calculated for a claim, but an outlier payment amount was not sent in the outbound response.					X				OPPS Pricer
9671.8	Outpatient PPS Pricer shall calculate outlier payments within the Outpatient PPS Pricer and shall send an outlier payment amount in the outbound response for claims with condition code “66” and a payer only condition code “MY” bypass is applied (IOCE Payment Method Flag equals “0”).	X								OPPS Pricer
9671.8.1	Contractors shall append payer only condition code “MY” to claims where it has been determined by the contractor that the outlier should be paid even when automated calculations have determined it should not be paid. Payer only condition code “MY” shall bypass	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	logic in the OPPS Pricer to allow an outlier payment in this scenario.									
9671.8.2	Medicare shared systems shall accept for internal claims processing but not send Payer only condition code “MY” in the outbound 837I Benefits Coordination &. Recovery Center (BCRC) file.					X				
9671.9	Medicare contractors shall use claim adjustment reason code 273 along with group code CO, rather than code 45, on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid as noted by the new OPPS Pricer Claim Return code of “02”.					X				
9671.10	Medicare contractors shall use remittance advice remark code N523 in addition to claim adjustment reason code 273 along with group code CO on the remittance advice of CMHC claims with dates of service on or after January 1, 2017, when an outlier amount is calculated but cannot be paid as noted by the new OPPS Pricer Return code of “02”.					X				
9671.11	Medicare shared systems shall perform a quarterly automatic adjustment process to determine whether unpaid outlier amounts have become payable.					X				
9671.11.1	One month following the start of each calendar quarter following the implementation date of this CR, Medicare shared systems shall initiate adjustments to all CMHC claims within the current and previous calendar year that have OPPS Pricer Claim Return code “02” and shall remove Condition Code “66” from the claim prior to processing the adjustment.					X				
9671.11.2	If the adjustment has no payment effect (.i.e. Shared System sets condition code “66” again), Medicare systems shall ensure the adjustment is not reflected on the CMHC’s remittance advice.					X				
9671.11.3	If the adjustment results in an outlier payment (Shared System does not set condition code “66”) Medicare systems shall process the outlier payment normally.					X				
9671.12	Medicare contractor shall create a report that maintains information about whether claims subject to the quarterly automatic adjustment resulted in: 1. An adjustment that triggered an outlier payment, 2. An adjustment that had no payment effect, or					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	3. An adjustment that could not be created for another reason.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9671.13	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0