CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1052	**Date: March 1, 2012**
	Change Request 7673

NOTE: Transmittal 1031, dated January 26, 2012, is being rescinded and replaced by Transmittal 1052, dated March 1, 2012, to delete the dates of the conference call discussions from business requirement 7673.1. The conference calls will be held on dates to be determined. All other information remains the same.

SUBJECT: Analysis and Design of Edits to Correct Recovery Auditor Identified Improper Payments in MCS.

I. SUMMARY OF CHANGES: Issues have been identified by the recovery auditors as significant improper payments and require the development of edits to correct these improper payments. Edits installed for these issues include: claims related to pulmonary diagnostic procedures, IV hydration procedures, not a new patient, and global day surgery procedures.

EFFECTIVE DATE: July 1, 2012
IMPLEMENTATION DATE: July 2, 2012

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-

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; Contractor activities are to be carried out within 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 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. ATTACHMENT:

One-Time Notification

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

Attachment – One-Time Notification

Pub.100-20	Transmittal: 1052	Date: March 1, 2012	Change Request: 7673

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SUBJECT: Analysis and Design of Edits to Correct Recovery Auditor Identified Improper Payments in MCS.

Effective Date: July 1, 2012

Implementation Date: July 2, 2012

I. General Information

A. Background:

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 issues listed below have been identified by the recovery auditors as significant improper payments and require the development of edits to prevent. Edits installed for these issues including claims that have more than one untimed code billed per day, pulmonary diagnostic procedures billed with E&M services, and IV hydration services billed will act as a tool to protect the Medicare Trust Fund by preventing improper billing practices.

1) A recovery auditor has identified an improper payment in Fee-For-Service billing for pulmonary diagnostic procedure. If a physician in attendance for a pulmonary diagnostic procedure obtains a history and performs a physical examination related to the pulmonary diagnostic testing, separate reporting of an evaluation and management service is not appropriate. If a significant, separately identifiable E&M service is performed unrelated to the performance of the pulmonary diagnostic test, an E&M service may be reported with modifier 25. MCS will create an edit that denies these codes when billed without modifier -25. The codes involved with the identification of overpayments associated with evaluation and management services are (99211-99215) billed without modifier 25 on the same date of service as a pulmonary diagnostic procedure (94010-94799).

2) The RAC Demonstration Project determined there were several overpayments to providers who billed initial IV hydration codes more than once per day per beneficiary. The National RAC Program continues to identify this improper payment. When reporting services for IV hydration, the initial code should be billed once for the initial infusion lasting up to 1 hour. The additional code should be added to the claim for each additional hour the hydration is infused. The codes identified for this issue are: 96413, 90765, 96365, 90763, and 96369.

3) Medicare interprets the phrase “new patient” to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. New patient CPT codes are only payable for Beneficiaries without office based face-to-face services in the previous 3 years. The codes identified with this issue are: 99201-99205, and 99341-99345.

4) Improper payments exist when two surgeons perform surgery on the same patient; one surgeon added the co-surgeon modifier -62 and other did not.

Therefore the purpose of this CR is for CMS to work with the maintainers to analysis and design edits to prevent these improper payments.

B. Policy:

1) National Correct Coding Initiative (NCCI) Policy Manual For Medicare Services, Chapter 1, Version 16.3 Modifier 25 may be appended to E&M services reported with minor surgical procedure (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E&M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E&M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.

2) IOM Publication 100-04, Chapter 12, pages 31-32 instructs the physician to report only one “initial” service code unless protocol requires that two separate IV sites must be used. If more than one “initial” service code is billed per day, the carrier shall deny the second initial service code unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier 59.

3) IOM Publication 100-04; Chapter 12, Section 30.6.7 provides that Medicare interprets the phrase “new patient” to mean a patient who has not received any professional services from the physician or physician group practice (same physician specialty) within the previous 3 years.

4) IOM Publication 100-04 Chapter 12, Section 40.8 (CM_C0882_1)
The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons: If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.” Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5)

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	
7673.1	**MCS and CCI shall have 6 one-hour conference call discussions with CMS staff and the contractors on the requirements for implementing edits for the issues.**	X			X			X		X	CCI
7673.2	The contractors, MCS, CCI, and CWF shall work collaboratively to discuss a design to support these edits.	X			X			X		X	CCI
7673.3	The contractors, MCS, CCI, and CWF shall provide CMS with information regarding the business requirements for these edits.	X			X			X		X	CCI
7673.4	The contractors, MCS, CCI, and CWF shall each provide CMS with an hour estimate for the conference call discussions to determine business requirements for these edits.	X			X			X		X	CCI

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	
	None										

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:**
	None

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

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) and/or Carriers:

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Section B: *For Medicare Administrative Contractors (MACs)*:

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