CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2117	**Date: December 10, 2010**
	Change Request 7246

SUBJECT: Revisions to the Medicare Code Editor (MCE) and Integrated Outpatient Code Editor (IOCE) Reporting Requirements

I. SUMMARY OF CHANGES: This CR updates the Medicare Claims Processing Manual to remove the requirements for Contractors to submit a copy of the summary data on claims processed outside the MCE/IOCE.

EFFECTIVE DATE: January 12, 2011
IMPLEMENTATION January 12, 2011
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.

II. CHANGES IN MANUAL INSTRUCTIONS: R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE
R	4/40.4.2 - Procedures for Paying Claims Without Passing through the IOCE

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. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

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SUBJECT: Revisions to the Medicare Code Editor (MCE) and Integrated Outpatient Code Editor (IOCE) Reporting Requirements

Effective Date: **January 12, 2011**
Implementation Date: January 12, 2011

I. GENERAL INFORMATION

A. Background:

This CR updates the Medicare Claims Processing Manual to remove the requirements for Contractors to submit a copy of the summary data on claims processed outside the MCE/IOCE.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

III.

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7246.1	Contractors shall no longer submit copies of summary data reports for claims paid outside the MCE/IOCE to CMS Central Office.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Shauntari Cheely, Shauntari.Cheely1@cms.hhs.gov

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: 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.

Section B: *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.

Medicare Claims Processing Manual
Chapter 3 - Inpatient Hospital Billing

20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE
(Rev.2117, Issued: 12-10-10, Effective: 01-12-11, Implementation: 01-12-11)

Before an inpatient claim may be paid without first going through the MCE, the contractor shall obtain approval from CMS Central Office or the RO.

Note: In certain situations, contractors bypass the MCE through an established, CMS-instructed claim processing procedure (e.g., to verify a facility is certified to perform a specified service after a MCE limited coverage edit is applied). Such scenarios do not require approval from the RO as the approval for such a bypass was inherently implied when the established procedure was first implemented.

In all instances involving payment outside the normal inpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the MCE using the appropriate field in FISS.

- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.

- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.

- Monitor MCE software to determine when the impediment to processing is removed.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a report of all inpatient claims paid without processing through the MCE with the exception of override situations explained in the Note above (e.g., for limited coverage edits). The list of claims paid outside of the MCE is to include the following information:

    - HIC
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount

- Receipt Date
- Process Date
- Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports.

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

40.4.2 - Procedures for Paying Claims Without Passing through the IOCE
(Rev. 2117, Issued: 12-10-10, Effective: 01-12-11, Implementation: 01-12-11)

Before an outpatient claim may be paid without first going through the IOCE, the contractor shall obtain approval from CMS Central Office or the RO. In all instances involving payment outside the normal outpatient editing process, the contractor applies the following procedures:

- Contractors shall submit the claim overriding the IOCE using the appropriate field in FISS.

- Pay interest accrued through the date payment is made on clean claims. Do not pay any additional interest.

- Maintain a record of payment and implement controls to be sure that incorrect payment is not made, i.e., when the claim is paid without being subject to normal editing.

- Monitor IOCE software to determine when the impediment to processing is removed.

- Consider the claim processed for workload and expenditure reports when it is paid.

- Submit to the RO Consortium Contractor Manager (CCM) by the 20th of each month a monthly report of all outpatient claims paid without processing through the IOCE. The list of claims paid outside of the IOCE is to include the following information:

    - HIC
    - DCN
    - TOB
    - DOS (From/Through)
    - Provider Number
    - MCE/OCE OVR (Claim/Line)
    - Reimbursement Amount
    - Receipt Date
    - Process Date
    - Paid Date

Also, include summary data for each edit code showing claim volume and payment. Any override approvals received and/or relevant JSM references should be annotated on the reports.