CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 919	**Date: JULY 29, 2011**
	Change Request 7490

SUBJECT: Add Patient Status Codes to Bypass DA02 Edit in Common Working File (CWF)

I. SUMMARY OF CHANGES: This change request (CR) will instruct the CWF to not "set" the DA02 edit when a patient status code of either "06" or "50" is present on an institutional claim on file at the CWF for the same beneficiary when the "Through" date of service on the institutional claim is equal to the "From" date of service on the incoming durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) or durable medical equipment (DME) claim. The edit shall also be revised so that the edit will not "set" on claims for customized prosthetic devices identified by CMS as the Major Category III. D. items (see http://www.cms.gov/SNFConsolidatedBilling/Downloads/2011MajorCatExpl.pdf for reference).

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 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. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 919	Date: July 29, 2011	Change Request: 7490

SUBJECT: Add Patient Status Codes to Bypass DA02 Edit in Common Working File (CWF)

Effective Date: January 1, 2012
Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: In 2007, the Recovery Audit Contractors (RAC) alerted the Centers for Medicare & Medicaid Services (CMS) of an overpayment case involving approximately 5,000 claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The claims were for beneficiaries who received DMEPOS items while in an inpatient stay in a hospital. The payments associated with these claims were considered overpayments because Medicare does not allow separate payment for DMEPOS when a beneficiary is in a Part-A covered inpatient stay (with the exception of certain customized prosthetic devices).

The contractors discovered that many of the claims were returned with the DA02 alert code from the Common Working File (CWF) with the claim already paid/finalized at CWF. The DA02 alert code indicated that a claim for DMEPOS items with service dates that overlap an inpatient stay had been detected.

CMS Change Request (CR) 7189, Transmittal 821, issued December 10, 2010, revised the CWF edit DA02 from an alert code to a reject code thereby allowing the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) the opportunity to deny DMEPOS claims subject to the DA02 edit so as to avoid having to recoup overpayments.

Once the instructions of CR 7189 were fully implemented in April 2011, the DA02 edit was programmed to not "set" when a Patient Status Code (PSC) "01" (Discharged to home or self care) is present on an institutional claim on file at the CWF for the same beneficiary when the "Through" date of service on the institutional claim is equal to the date of service on the incoming DMEPOS or DME claim. Post implementation of CR 7189, the DME MACs discovered that a large volume of DMEPOS claims were being rejected by the revised DA02 reject. To help alleviate the volume of claim rejects, the DME MACs requested that the edit's logic be further revised to include additional PSCs. When these codes are present at the CWF on an inpatient claim for the same beneficiary when the "Through" date of service on the institutional claim is equal to the date of service on the incoming DMEPOS or DME claim, the DA02 edit will not "set".

An exception to the above policy that Medicare does not allow separate payment for DMEPOS when a beneficiary is in a covered stay concerns coverage and payment for certain customized prosthetic devices. These types of prosthetics are excluded from Skilled Nursing Facility (SNF) Consolidated Billing rules and are separately payable under Medicare Part B, even if the patient is in a Part-A covered or non-covered SNF stay. It has come to CMS' attention that, since the implementation of CR 7189 in April 2011, the DME MACs have been inappropriately denying claims for customized prosthetics after they are returned from the CWF with the DA02 reject code. CMS Technical Direction Letter 11331, issued on July 15, 2011, contained instructions for DME MACs to reprocess these inappropriately denied claims for customized prosthetics as the claims were brought to the attention of the DME MACs.

B. Policy: In most instances, Medicare does not allow separate payment for DMEPOS when a beneficiary is in a Part-A covered inpatient stay. There is an exception to this policy concerning customized prosthetic devices. To ensure claims for DMEPOS items are denied appropriately, the CWF edit DA02 shall be revised so that, for claims received on or after January 1, 2012, the edit will not "set" when a Patient Status code of

either "06" (Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care) or "50" (Discharged/transferred to Hospice – home) is present on an institutional claim on file at the CWF for the same beneficiary when the "Through" date of service on the institutional claim is equal to the date of service on the incoming DMEPOS or DME claim's "From" date. The CWF edit DA02 shall also be revised so that the edit will not "set" on claims for customized prosthetic devices identified by CMS as the Major Category III D. items (http://www.cms.gov/SNFConsolidatedBilling/Downloads/2011MajorCatExpl.pdf).

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	
7490.1	The CWF maintainer shall modify edit DA02 so that the edit does not set when an incoming DMEPOS or DME claim received on or after January 1, 2012 has a "From" date of service (only) which is equal to the "Through" date of an inpatient claim on file with CWF for the same beneficiary and the inpatient claim has a Patient Status code of "06" or "50."									X	
7490.2	The CWF maintainer shall modify edit DA02 so that the edit does not set on an incoming claim for customized prosthetic device(s) identified by CMS as the Major Category III D. items (http://www.cms.gov/SNFConsolidatedBilling/Downloads/2011MajorCatExpl.pdf).									X	
7490.3	Contractors shall continue to deny claims for DMEPOS according to the instructions communicated in CR 7189.		X						X		

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:

X-Ref Requirement Number	Recommendations or other supporting information:
7490.3	CMS CR 7189, Transmittal 821, issued December 10, 2010

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Contact Eric Coulson at eric.coulson@cms.hhs.gov or (410) 786-3352.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

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.