CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11488	**Date: July 7, 2022**
	Change Request 12769

SUBJECT: New Edit for Prospective Payment System (PPS) Outpatient and Inpatient Bill Types Receiving an Outlier Payment When a Device Credit is Reported

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement editing to suspend Outpatient Prospective Payment System (OPPS) and Inpatient Prospective Payment System (IPPS) claims receiving an outlier payment when a device credit is reported. This new edit shall provide a mechanism for the Medicare Contractors to review the charges and device reduction amount submitted on the claim for fully or partially credited devices.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

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

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I. GENERAL INFORMATION

A. Background: The Office of Inspector General (OIG) conducted an audit during the period of July 1, 2015 through September 30, 2018, to determine whether Medicare outlier payments for outpatient and inpatient hospital claims that contain full credits or no cost for replaced medical devices were in accordance with Medicare requirements. The audit covered 381 outpatient and inpatient hospital claims that contained both an operating outlier amount with the presence of value code 17 and a device credit with the presence of value code FD (Credit Received from the Manufacturer for a Medical Device). The OIG selected 346 outpatient outlier claims totaling $1,533,776 and 35 inpatient outlier claims totaling $606,599 for the hospital's self-review. The audit resulted in findings that not all outlier payments for outpatient and inpatient hospital claims that contained full credits, partial credits, or no cost for replaced medical devices were made in accordance with Medicare requirements.

This CR implements a claim level edit for OPPS and IPPS bill types, to validate Medicare outlier overpayment when the claim contains device credit amounts.

B. Policy: No new policy. Section 1862(a)(2) of the Act excludes from Medicare coverage, an item or service for which neither the beneficiary, nor anyone on his or her behalf, has an obligation to pay. Billing guidance may be located in Chapter 4, § 61.3.5, and 61.3.6, (OPPS) and Chapter 3, § 100.8 (IPPS) of the Medicare Claims Processing Manual.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12769.1	The Shared System Maintainer (SSM) shall create a new claim level edit to suspend IPPS and OPPS claims with the following criteria:					X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Bill type: 11X, 12X, or 13X, • Value Code: FD is present with a device reduction dollar amount greater than zero, • A charge (other than a token covered charge less than or equal to $1.00) is reported in error for all medical device revenue codes 0275, 0276, and/or 0278, and, • Value Code: 17 is present with an outlier payment amount greater than zero. Note: Editing shall be effective for claims processed on or after the implementation date of the CR.									
12769.1.1	The SSM shall allow for a contractor override of the new claim level edit.					X				
12769.1.2	The SSM shall ensure the new claim level edit is bypassed for cancels and contractor-initiated adjustments.					X				
12769.2	The Medicare contractors shall review IPPS and OPPS claims suspended by the new claim level edit and validate the covered charges have been reduced by the device credit amount for a full or partial device credit as follows: • For inpatient claims, validate no charges are reported for a medical device found in revenue code 0275, 0276, and/or 0278 that received full credit or was a no cost device, • For outpatient claims, validate charges (other than a token covered charge less than or equal to $1.00) are not reported for a medical device found in revenue code 0275, 0276, and/or 0278 that received full credit or was a no cost device,	X								

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• For claims verified with correct device charges and device credit amount reported (partial credit), use the contractor override to continue processing the claim. • For claims needing a provider correction to the reported device charges or device credit amount reported, Medicare contractors may return the claim to the provider. • Medicare contractors may use discretion in developing internal processes to resolve the claim edit.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12769.3	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	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 , Yvette Rivas, yvette.rivas@cms.hhs.gov

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0