CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1649	**Date: DECEMBER 18, 2008**
	Change Request 6252

NOTE: Transmittal 1619, dated October 24, 2008, is rescinded and replaced with Transmittal 1649, dated December 18, 2008, to insert this highlighted line into Pub. 100-04, Chapter 3, Section 20.2.1.1.2, sixth bullet point: "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:" All other information remains the same.

Subject: Procedures for Paying Claims Without Passing through the Integrated Outpatient Code Editor (IOCE) or Medicare Code Editor (MCE)

I. SUMMARY OF CHANGES: This Change Request provides formal instruction and reporting requirements to contractors for paying claims without passing through the IOCE or MCE.

New / Revised Material
Effective Date: November 25, 2008
Implementation Date: November 25, 2008

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
R	Table of Contents
N	3/20.2.1.1/Paying Claims Outside of the MCE
N	3/20.2.1.1.1/Requesting to Pay Claims Without MCE Approval
N	3/20.2.1.1.2/Procedures for Paying Claims Without Passing through the MCE
R	Table of Contents
N	4/40.4/Paying Claims Outside of the IOCE
N	4/40.4.1/Requesting to Pay Claims Without IOCE Approval
N	4/40.4.2/Procedures for Paying Claims Without Passing through the IOCE

III. FUNDING:
SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1649	Date: December 18, 2008	Change Request: 6252

NOTE: Transmittal 1619, dated October 24, 2008, is rescinded and replaced with Transmittal 1649, dated December 18, 2008, to insert this highlighted line into Pub. 100-04, Chapter 3, Section 20.2.1.1.2, sixth bullet point: "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:" All other information remains the same.

SUBJECT: Procedures for Paying Claims Without Passing through the Integrated Outpatient Code Editor (IOCE) or Medicare Code Editor (MCE)

Effective Date: November 25, 2008

Implementation Date: November 25, 2008

I. GENERAL INFORMATION

A. Background:

This Change Request provides formal instruction and reporting requirements to contractors for paying claims without passing through the IOCE or MCE. A new detailed report was created by Fiscal Intermediary Shared System to be run by each data center for FI/MACs showing claim information for any claims that bypassed the MCE/IOCE.

B. Policy:

This Change Request provides formal instruction and reporting requirements to contractors for paying claims without passing through the IOCE or MCE.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

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	
6252.1	Contractors shall adhere to the MCE/IOCE override and reporting procedures outlined in the Medicare Claims Processing Manual.	X		X		X					EDC

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:

"Should" denotes a recommendation.

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

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

V. CONTACTS

Pre-Implementation Contact(s): Maria Durham, maria.durham@cms.hhs.gov for the IOCE, Joseph Bryson, joseph.bryson@cms.hhs.gov and Valeri Ritter, Valeri.Ritter@cms.hhs.gov for the MCE.

Post-Implementation Contact(s): Maria Durham, maria.durham@cms.hhs.gov for the IOCE, Joseph Bryson, joseph.bryson@cms.hhs.gov and Valeri Ritter, Valeri.Ritter@cms.hhs.gov for the MCE.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)*:

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

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(Rev. 1649, 12-18-08)

20.2.1.1 - Paying Claims Outside of the MCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

All institutional inpatient claims are routed through the MCE before they are processed to payment. There may be special circumstances, however, when it is necessary to pay claims bypassing MCE edits. The CMS will notify the contractor of these instances. They include:

• New coverage policies are enacted by Congress with effective dates that preclude making the necessary changes timely; and

• Errors are discovered that cannot be corrected timely.

A/B MACs and FIs are responsible for reporting problems timely.

20.2.1.1.1 - Requesting to Pay Claims Without MCE Approval

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

The contractor may also request approval from the RO in specific situations to pay claims without first sending them through the MCE. Examples of such situations are:

• A systems error cannot be corrected timely, and the provider's cash flow will be substantially impacted; and/or

• Administrative Law Judge (ALJ) decisions, court decisions, and CMS instructions in particular cases may necessitate that payment be made outside the normal process.

20.2.1.1.2 - Procedures for Paying Claims Without Passing through the MCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

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. Send a copy of the summary data to: Centers for Medicare and Medicaid Services, Division of Institutional Claims Processing, Mailstop C4-10-07, 7500 Security Blvd. Baltimore, MD 21244-1850.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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(Rev. 1649, 12-18-08)

40.4 - Paying Claims Outside of the IOCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

All institutional outpatient claims are routed through the IOCE before they are processed to payment. There may be special circumstances, however, when it is necessary to pay claims bypassing IOCE edits. The CMS will notify the contractor of these instances. They include:

• New coverage policies are enacted by Congress with effective dates that preclude making the necessary changes timely; and

• Errors are discovered that cannot be corrected timely.

A/B MACs and FIs are responsible for reporting problems timely.

40.4.1 - Requesting to Pay Claims Without IOCE Approval

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

The contractor may also request approval from the RO in specific situations to pay claims without first sending them through the IOCE. Examples of such situations are:

• A systems error cannot be corrected timely, and the provider's cash flow will be substantially impacted; and/or.

• Administrative Law Judge (ALJ) decisions, court decisions, and CMS instructions in particular cases may necessitate that payment be made outside the normal process.

40.4.2 - Procedures for Paying Claims Without Passing through the IOCE

(Rev. 1649; Issued: 12-18-08; Effective/Implementation Date: 11-25-08)

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. Send a copy of the summary data to: Centers for Medicare and Medicaid Services, Division of Institutional Claims Processing, Mailstop C4-10-07, 7500 Security Blvd. Baltimore, MD 21244-1850.