CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 767	**Date: September 10, 2010**
	Change Request 7046

SUBJECT: Expansion of the Current Scope of Editing for Attending, Operating, or Other Physician or Non-Physician Practitioner Providers for Critical Access Hospital (CAH) Claims Processed by Medicare Fiscal Intermediaries and Part A Medicare Administrative Contractors (A/B MAC)

I. SUMMARY OF CHANGES: The CMS is expanding the claim editing to meet the Social Security Act requirements for the attending, operating, or other physician or non-physician practitioner when a plan of treatment is needed and submitted from a CAH. The expansion will verify the attending, operating, or other physician or non-physician practitioner provider on a CAH claim is eligible and enrolled in Medicare by allowing FISS to match data on a provider billed claim to that of a national PECOS file. The editing expansion will be done in two phases. Phase 1 will allow a claim to be paid, if the billed service requires this type physician or non-physician provider listed above and the information is not on the claim. A remittance advice message will notify the billing provider that claims of this nature may not be paid in the future if the required data for this type of physician or non-physician provider is not provided accurately or is missing on the claim. Phase 2, will not allow the claims to be paid.

EFFECTIVE DATE: *January 1, 2011 (Phase 1); April 1, 2011 (Phase 2)
IMPLEMENTATION DATE: January 3, 2011 (Phase 1); April 4, 2011 (Phase 2)

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: 767	Date: September 10, 2010	Change Request: 7046

SUBJECT: Expansion of the Current Scope of Editing for Attending, Operating, or Other Physician or Non-Physician Practitioner Providers for Critical Access Hospital (CAH) Claims Processed by Medicare Fiscal Intermediaries and Part A Medicare Administrative Contractors (A/B MAC).

Effective Date: January 1, 2011 (Phase 1); April 1, 2011 (Phase 2)
Implementation Date: January 3, 2011 (Phase 1); April 4, 2011 (Phase 2)

I. GENERAL INFORMATION

A. Background:

The Centers for Medicare & Medicaid Services (CMS) is expanding the claim editing to meet the Social Security Act requirements for the attending, operating, or other physician or non-physician practitioner that is either in an approved or opt out status when a plan of treatment is needed and submitted for a CAH. In this document, the word 'claim', means both electronic and paper claims, since the following are the only providers who can order/refer beneficiary services for CAHs:

- doctor of medicine or osteopathy;
- dental medicine;
- dental surgery;
- podiatric medicine;
- optometry;
- chiropractic medicine;
- physician assistant;
- certified clinical nurse specialist;
- nurse practitioner;
- clinical psychologist;
- certified nurse midwife;
- licensed clinical social worker;
- certified registered nurse anesthetist; and
- registered dietitian/nutritional professional.

The claim editing is being expanded to verify the attending, operating, or other physician or non-physician provider on a CAH claim is eligible and is enrolled and active in the Medicare program's Provider Enrollment, Chain and Ownership System (PECOS). This means providers who are enrolled in the Medicare program must be in the PECOS in an approved or opt out status. The editing expansion will be done in two phases.

Phase 1 - The Fiscal Intermediary Shared System (FISS) will receive a national file from the PECOS of only the physicians who are enrolled in PECOS, and who are one of the specialties listed above. Nightly thereafter, FISS will receive a national PECOS file of newly added physicians whose enrollment data has been updated. When a claim is received, FISS will determine if the attending, operating, or other physician or non-physician practitioner is required for the billed service. If the attending, operating, or other physician or non-physician practitioner's information is on the claim, FISS will verify that the attending, operating, or other physician or non-physician practitioner is on the national PECOS file. If the attending, operating, or other physician non-physician practitioner is not on the national PECOS file during Phase 1, the claim will continue to process but a message will be included on the remittance advice notifying the billing provider that claims may not be paid in

the future if the attending, operating, or other physician or non-physician practitioner is not enrolled in Medicare or if the attending, operating, or other physician or non-physician practitioner is not of the specialty eligible to be an attending, operating, or other physician or non-physician practitioner.

Phase 2 – As stated above, FISS will still receive a national file from PECOS and will determine if the attending, operating, or other physician or non-physician practitioner is required for the billed service. If the billed service requires an attending, operating, or other physician or non-physician practitioner and the attending, operating, or other physician or non-physician practitioner is not on the claim, the claim will not be paid. If the attending, operating, or other physician or non-physician practitioner is on the claim, FISS will verify that the attending, operating, or other physician or non-physician practitioner is on the national PECOS file. If the attending, operating, or other physician or non-physician practitioner is on the national PECOS file, but is not of the specialty eligible to be an attending, operating, or other physician non-physician practitioner, the claim, during Phase 2, will not be paid.

In both phases, FISS will use this process to determine if the attending, operating, or other physician or non-physician practitioner on the claim matches the providers in the national PECOS file. If a match is found, the FISS will then compare the NPI, first letter of the first name and the first 4 letters of the last name of the matched record. The claim is considered verified, if the NPI or names match for the attending, operating, or other physician or non-physician practitioner.

When this change request is implemented, the requirement (Transmittal 270, Change Request 6093, Reporting NPIs for Secondary Providers, dated October 15, 2008) to use the billing provider's NPI as the NPI of the attending, operating, or other physician or non-physician practitioner, and the name of the attending or operating, if the NPI of the attending, operating, or other physician or non-physician practitioner provider cannot be determined by the billing provider is no longer valid.

In addition, FI's and Part A of A/B MACs will need an online look-up to use for inquiry verification of the physician who can be an attending, operating, or other physician or non-physician practitioner provider.

B. Policy: Section 1833(q) of the Social Security Act requires that all physicians that meet the definitions at section 1861(r) and 1842(b)(18)(C) be uniquely identified for all claims for services that are for the attending, operating, or other physician or non-physician practitioner when a CAH plan of treatment is needed. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and unique identifier of the attending, operating, or other physician or non-physician practitioner on the claim. Effective May 23, 2008, the unique identifier must be an NPI. In addition, only Medicare-enrolled physicians and non-physician practitioners as defined above are eligible to be an attending, operating, or other physician or only Medicare-enrolled physicians and non-physician practitioners as defined above are eligible to order/refer services for CAH services for Medicare beneficiaries.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		MAC	MAC		RIER	I	FISS	MCS	VMS	CWF	
7046.1	The PECOS shall provide an initial file of all nationally enrolled physicians or non-physician practitioners eligible as an attending, operating, or other physician provider who is in PECOS only in an approved or opt out status.										PECOS
7046.1.1	The PECOS shall provide a format of the file to FISS consisting of the following data elements: 1. NPI; 2. First, middle and last name; 3. Effective date (if available); 4. Termination date (if available); and 5. CMS specialty code and description. (See attached file layout.)										PECOS
7046.1.2	The PECOS file shall contain a termination date if the attending, operating, or other physician or non-physician practitioner enrollment status changes from approved or opt out.										PECOS
7046.1.3	The implementation plan developed between FISS, CMS, and the PECOS shall determine the PECOS file naming convention and file location.						X				PECOS FISS CMS
7046.2	FISS shall not use the effective date and termination date. These fields are currently information fields only for use in the future.						X				
7046.3	The PECOS shall provide a nightly file of attending, operating, or other physician or non-physician practitioners who are newly added to PECOS or who were on the initial or earlier nightly files and who have a change of information.										PECOS
7046.4	FISS shall determine if attending, operating, or other physician or non-physician practitioner provider is required on a claim which has a statement from date of service on or after the implementation date.						X				
7046.5	FISS shall reject a claim for a service on a claim which requires an attending, operating, or other physician or non-physician practitioner provider and the information is not provided.						X				
7046.6	If a service on a claim requires attending, operating, or other physician or non-physician practitioner provider information and is provided, the FISS shall use the NPI submitted to verify the provider is on the PECOS file.						X				
7046.6.1	FISS shall compare the NPI, first letter of the first name, and the first four letters of the last name of the matched record.						X				
7046.6.2	The claim shall be considered verified if the provider names match for the attending, operating, or other physician or non-physician practitioner provider.						X				

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	
7046.6.3	The claim is rejected if the provider name does not match for the attending, operating, or other physician or non-physician practitioner provider.						X				
7046.7	Phase 1, shall be effective from the date of service on or after January 1, 2011, and implemented on January 3, 2011.	X		X			X				
7046.7.1	Phase 1, FISS shall initially process the claim and add remark message (RARC code) N272 (missing/incomplete/invalid other payer attending provider identifier), (RARC code) N273 (Missing/incomplete/invalid other payer operating provider identifier) or N274 (Missing/incomplete/invalid other payer other provider identifier) to the remittance advice if the attending, operating, or other physician or non-physician practitioner provider is not found on the PECOS file or the contractor's provider file and is not of the specialty eligible to order or refer. For adjusted claims use the CARC code 16 and/or the RARC code N272, N273, or N274.						X				
7046.8	Phase 2, shall be effective from the date of service on or after April 1, 2011, and implemented on April 4, 2011.	X		X			X				
7046.8.1	Phase 2, FISS shall reject the service if the attending, operating, or other physician or non-physician practitioner provider is not found on the PECOS file or the contractor's provider file and is not of the specialty eligible to order or refer. For adjusted claims use the CARC code 16 and/or the RARC code N272, N273, or N274.						X				
7046.9	FISS shall reflect the attending, operating, or other physician or non-physician practitioner name from the file used for the legal name validation on the MSN.						X				
7046.10	FISS shall continue to not include a placeholder NPI on the MSN.						X				
7046.11	FISS shall create an online look-up for contractors to use for inquiry verification of the attending, operating, or other physician or non-physician practitioner provider.						X				
7046.12	PECOS shall create a test file for FISS 6 weeks prior to the implementation date.										PECOS

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	
7046.13	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

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:

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

V. CONTACTS

Pre-Implementation Contact(s): Tolla Anderson 410-786-1786 tolla.anderson@cms.hhs.gov
Post-Implementation Contact(s): Tolla Anderson 410-786-1786 tolla.anderson@cms.hhs.gov

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.

Attachments (2)

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
42	Certified Nurse Midwife
43	Certified Registered Nurse Anesthetist (CRNA)
44	Infectious Disease
46	Endocrinology
48	Podiatry
50	Nurse Practitioner
62	Clinical Psychologist (Ind.)
66	Rheumatology
68	Clinical Psychologist
71	Registered Dietitian/Nutrition Professional
72	Pain Management
76	Peripheral Vascular Disease

77 Vascular Surgery
78 Cardiac Surgery
79 Addiction Medicine
80 Licensed Clinical Socials Worker
81 Critical Care (Intensivists)
82 Hematology
83 Hematology/Oncology
84 Preventive Medicine
85 Maxillofacial Surgery
86 Neuropsychiatry
89 Certified Clinical Nurse Specialist
90 Medical Oncology
91 Surgical Oncology
92 Radiation Oncology
93 Emergency Medicine
94 Interventional Radiology
97 Physician Assistant
98 Gynecological/Oncology
99 Unknown Physician Specialty

File Layout for CR 7046

Description	Length	Start Position	Notes
NPI	10	1	NPI is used as primary matching criteria
First Name	25	11	First letter of first name is used as additional matching criteria
Middle Name	25	36	Providers middle name
Last Name	35	61	First four letters of last name is used as additional matching criteria
Specialty Code	2	96	Specialty code of the provider
Specialty Description	150	98	Description text of given specialty code
Effective Date	10	248	Oldest effective date on PIN for provider, if available in PECOS
Termination Date	10	258	Latest termination date on PIN for provider; will not be included if the provider has an enrollment record in PECOS in the status of “Approved”
Total Length	267		