CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2098	**Date: July 12, 2018**
	Change Request 10426

Transmittal 2029, dated February 2, 2018, is being rescinded and replaced by Transmittal 2098, dated, July 12, 2018 to revise business requirement 10426.30 and 10426.30.2 and to add a new cross reference business requirement-supporting note. All other information remains the same.

SUBJECT: Implementation of Automating First Claim Review in Serial Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

I. SUMMARY OF CHANGES:
The Centers for Medicare & Medicaid Services (CMS) considers serial claims to be claims that are so closely related to one another that the same payment decision should be applied to each claim. In general, serial claims are for the same Healthcare Common Procedure Coding System (HCPCS) code and same beneficiary. CMS plans to implement a system solution in the ViPS Medicare System (VMS) that will enable the Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) to perform a pre-payment complex medical review on a claim line and will then, based on the results of the complex medical review: pay subsequent claim lines in the series after passing existing validation edits, or deny subsequent claim lines in the series unless the provider submits additional documentation with the subsequent claim line. The goals of this initiative are to reduce provider burden, MAC burden, and appeals by increasing the consistency of initial determinations when the same service is provided to the same beneficiary on a recurring basis.

EFFECTIVE DATE: July 2, 2018 - per Shared Systems Release schedule
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 2, 2018 - VMS Implementation of Business Requirements 1, 2, 4, 5 , 6, 7, 8, 9, 10, 12, 14, 15 and 25; October 1, 2018 - Analysis and Coding of all remaining BRs; January 7, 2019 - Coding and Implementation of all the remaining BRs

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

Pub. 100-20	Transmittal: 2098	Date: July 12, 2018	Change Request: 10426

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I. GENERAL INFORMATION

A. Background:

The Centers for Medicare & Medicaid Services (CMS) considers serial claims to be claims that are so closely related to one another that the same payment decision should be applied to each claim. In general, serial claims are for the same Healthcare Common Procedure Coding System (HCPCS) code and same beneficiary. With this Change Request (CR), CMS will implement a system solution in VMS that will enable the DME MACs to perform a pre-payment complex medical review on a claim line and will then, based on the results of the complex medical review, pay subsequent claim lines in the series after passing existing validation edits, or deny subsequent claim lines in the series unless the provider submits additional documentation with the subsequent claim line. The goals of this initiative are to reduce provider burden, MAC burden and appeals by increasing the consistency of initial determinations when the same service is provided to the same beneficiary on a recurring basis

B. Policy: There are no regulatory, legislative, or statutory requirements related to this CR.

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	
10426.1	VMS shall convert the serial HCPCS code spreadsheet to a mainframe file.							X		
10426.2	VMS shall update the following from the initial list of HCPCS codes provided by the contractors: • HCPCS Code; and • Serial Certification Period.							X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10426.3	VMS shall expand the limitations of the VMAP/4D/Group Certificate of Medical Necessity (CMN) Table to allow at least 100 HCPCS codes. **NOTE**: Contractors will be able to designate each serial HCPCS code as a base item or an accessory and will be able to group base items and accessories within the same policy group as serial.							X		
10426.4	VMS shall allow contractors to add or remove serial HCPCS codes.							X		
10426.5	VMS shall require each serial HCPCS code to have a serial certification period.							X		
10426.6	VMS shall allow contractors to update the serial certification period for each serial HCPCS code.							X		
10426.7	VMS shall allow the serial certification period to be indefinite.							X		
10426.8	VMS shall automatically create a daily report containing the following details from the previous day: • All serial HCPCS codes added; • All serial HCPCS codes removed; and • All serial HCPCS code with changed serial certification period.							X		
10426.9	VMS shall automatically create a daily report of any change to any PROC option on any MPR record containing details from the previous day.							X		
10426.10	VMS shall create an integrity report on a monthly basis to inform the contractors and CMS of serial HCPCS codes discrepancies between the contractor jurisdictions.							X		
10426.11	The contractors shall review the integrity report each month to: • Identify discrepancies; • Notify CMS of any discrepancies; and				X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Correct discrepancies.									
10426.12	VMS shall create a job for the Virtual Data Center (VDC) to use to generate the integrity report.							X		
10426.12.1	The VDC shall run the job set up by VMS and send the integrity report to the Baltimore Data Center (BDC) on a monthly basis.									BDC, VDC
10426.13	The BDC shall transmit the integrity report to CMS.									BDC
10426.14	VMS shall follow existing protocols to ensure the integrity report is available to the contractors.							X		
10426.15	VMS shall add a new field for the serial certification period to the layout of the "mini-acemastr" file. **NOTE: The newly formatted miniace file will be availale during the July 2018 release.**							X		CEDI
10426.16	VMS shall allow contractors to establish a series for a beneficiary by updating the CMN with a serial indicator and series start date if the HCPCS code on the CMN is an eligible serial HCPCS code.							X		
10426.16.1	VMS shall store the following information when a series is established for a beneficiary: • Payment Decision • Beneficiary • HCPCS Code • Modifier • Supplier • Start Date • Serial Certification Period							X		
10426.17	VMS shall create a new Custom Call named DUMMYCMN to generate a dummy CMN for the procedure code on the claim line that invoked the Custom Call. When invoked: • The Custom Call will only generate a dummy CMN if the procedure code does not already have a dummy CMN on file and;							X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

	• The new 'SC' processing option is applicable to the claim line.
	• When the Custom Call generates a dummy CMN for the claim line:
	  • The length of need will be established based on the serial certification period for the procedure code on the APPL/4/M3 MPR Processing Options screen.
	  • The new serial indicator on the CMN record will be set to 'Y'.									

10426.18	The contractors shall use SuperOp to link the new Custom Call logic to the medical review edits to establish a series.				X					
10426.19	VMS shall default the serial certification period for the series to the serial certification period of the HCPCS code.							X		
10426.20	VMS shall allow contractors to change the serial certification period for the series.							X		
10426.21	The contractors shall update the serial certification period for the series if necessary.				X					
10426.22	VMS shall identify whether each incoming claim line matches an existing series based on the following conditions: • The beneficiary for the claim line matches the beneficiary for the series; • The supplier on the claim line matches the supplier on the series; **NOTE**: Only a matching criterion if the payment decision for the series is deny and the HCPCS code for the series is not a capped rental code, an Inexpensive Routinely Purchased (IRP) code or parenteral and enteral nutrition (PEN) item code. • The HCPCS code on the incoming claim line is identical to the HCPCS code for the series;							X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	

	• Both the claim line and the series:
	  • Include the KS modifier; or
	  • Include the KX modifier; or
	  • Do not include either the KS or the KX modifier; or
	• The date of service on the claim line is within and inclusive of the start and end dates of the series.
	
	Note: The KS modifier is for diabetic supply HCPCS codes only									

10426.23	VMS shall create separate dummy CMNs for claim lines with the KS modifier and claim lines with the KX modifier.							X		
10426.24	The contractors shall prevent future claims matching the series from being selected by the medical review edit stored on the series.				X					
10426.25	VMS shall allow contractors to view all claims that match a given series.							X		
10426.26	VMS shall deny an incoming claim line on a paper and Optical Character (OCR) claims if: • The incoming claim line matches an existing denied series; and • The provider has not submitted additional documentation.							X		
10426.27	VMS shall allow a paper, OCR or electronic incoming claim line that matches a paid series to pay.							X		
10426.28	VMS shall establish a new edit for paper and OCR claims that meet the following conditions: • The incoming claim line matches an existing denied series; and • The Attachment Indicator is marked (as “Y”); and • The claim line does not include existing line review code ‘K’.							X		

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10426.29	The contractor shall perform a medical review on the suspended paper or OCR claim line.				X					
10426.30	The contractors shall create edits in VMS to suspend incoming electronic claim lines for medical review if: • The PWK02 indicator value is set to EL, FX, FT or BM; and • The NTE02 segment has a value of 'serial'; and • The incoming claim line matches an existing denied series.				X					
10426.30.1	The contractors shall perform medical review on a suspended incoming electronic claim line if additional documentation is submitted.				X					
10426.30.2	The contractors shall deny a suspended incoming electronic claim line without performing a medical review if additional documentation has not been received and: • 7 days have passed, if the PWK02 indicator value is set to FX, EL or FT; or • 10 days have passed, if the PWK02 indicator value is set to BM.				X					
10426.31	VMS shall allow contractors to change the payment decision of an established series.							X		
10426.32	VMS shall allow contractors to establish a separate paid series and denied series for the same HCPCS code and same beneficiary.							X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10426.33	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.				X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
10426.30	Note- As of July 2018, for Electronic Submission of Medical Documentation (esMD) purposes, contractors shall look for a new PWK02 indicator value of 'FT' (file transfer), immediately, and PWK02 indicator 'EL' (electronic), once the esMD system is updated to accommodate such functionality.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Lisa Sullivan, lisa.sullivan@cms.hhs.gov , Jennifer Phillips, jennifer.phillips@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: 1