CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 781	**Date: October 8, 2010**
	Change Request 6856

Transmittal 778, dated September 28, 2010, is being rescinded and replaced by Transmittal 781, dated October 8, 2010. This change request includes a delay in Phase 2 effective and implementation dates. The Phase 2 effective and implementation dates have changed from January 1, 2011 and January 4, 2011 to July 1, 2011 and July 5, 2011, respectively. The dates in BR 6856.8 have changed from "shall be effective from the date of service on January 1, 2011 and implemented on January 4, 2011" to "shall be effective from the date of service on July 1, 2011 and implemented on July 5, 2011." All other information remains the same.

SUBJECT: Expansion of the Current Scope of Editing for Attending Physician Providers for Free-Standing and Provider-Based Home Health Agency (HHA) Claims Processed by Medicare Regional Home Health Intermediaries (RHHIs)

I. SUMMARY OF CHANGES: The CMS is expanding the claim editing to meet the Social Security Act requirements for the attending physician when a plan of treatment is needed and submitted from an HHA. The expansion will verify the attending physician provider on an HHA claim is eligible and is 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 an attending physician and this information is not on the claim. However, an RA message will notify the billing provider that claims of this nature may not be paid in the future if the required data for the attending physician is not provided accurately on the claim. During Phase 2, the claims will not be paid if the required information is missing or not accurate on the claim.

EFFECTIVE DATE: OCTOBER 1, 2010 (PHASE 1); JULY 1, 2011 (PHASE 2)
IMPLEMENTATION DATE: OCTOBER 4, 2010 (PHASE 1); JULY 5, 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. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 781	Date: October 8, 2010	Change Request: 6856

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SUBJECT: Expansion of the Current Scope of Editing for Attending Physician Providers for Free-Standing and Provider-Based Home Health Agency (HHA) Claims Processed by Medicare Regional Home Health Intermediaries (RHHIs)

EFFECTIVE DATE: OCTOBER 1, 2010 (PHASE 1); JULY 1, 2011 (PHASE 2)
IMPLEMENTATION DATE: OCTOBER 4, 2010 (PHASE 1); JULY 5, 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 physician is either a doctor of medicine or osteopathy or podiatric medicine when a plan of treatment is needed and submitted from an HHA. 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 HHAs:

- Doctor of medicine or osteopathy; and
- Podiatric medicine

The claim editing is being expanded to verify the attending physician provider on an HHA 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 physician is required for the billed service. If the attending physician's information is on the claim, FISS will verify that the attending physician is on the national PECOS file. If the attending physician 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 physician is not enrolled in Medicare or if the attending physician is not of the specialty eligible to be an attending physician.

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

In both phases, FISS will use this process to determine if the attending physician 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 physician.

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 physician, and the name of the attending, if the NPI of the attending physician provider cannot be determined by the billing provider is no longer valid.

In addition, FI's, RHHIs and A/B MACs will need an online look-up to use for inquiry verification of the physician who can be an attending physician 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 physician when an HHA 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 physician on the claim. Effective May 23, 2008, the unique identifier must be an NPI. In addition, only Medicare-enrolled physicians who are doctors of medicine, osteopathy, or podiatric medicine are eligible to be attending physician for HHA service for Medicare beneficiaries. The physician who signs the plan of care must be qualified to sign the physician certification as described in 42 CFR 424.22(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function under paragraph (d) of this section. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers: FISS	MCS	VMS	CWF	OTHER
6856.1	The PECOS shall provide an initial file of all nationally enrolled physicians eligible as an attending physician provider who are in PECOS only in an approved or opt out status.										PECOS
6856.1.1	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
6856.1.2	The PECOS file shall contain a termination date if the										PECOS

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	
	physician enrollment status changes from approved or opt out.										
6856.1.3	The implementation plan developed between FISS, CMS, and the PECOS shall determine the PECOS file naming convention and file location.						X				PECOS FISS CMS
6856.2	FISS shall not use the effective date, termination date, CMS specialty code, and description. These fields are currently information fields only for use in the future.						X				
6856.3	The PECOS shall provide a nightly file of only physicians who are newly added to PECOS or who were on the initial or earlier nightly files and who have a change of information.										PECOS
6856.4	FISS shall determine if attending physician provider is required on a claim which has a statement from date of service on or after July 1, 2010.						X				
6856.5	FISS shall reject a claim for a service on a claim which requires an attending physician provider and the information is not provided.						X				
6856.6	If a service on a claim requires attending physician provider information and is provided, the FISS shall use the NPI submitted to verify the provider is on the PECOS file.						X				
6856.6.1	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				
6856.6.2	The claim is considered verified if the provider names match for the attending physician provider.						X				
6856.6.3	The claim is rejected if the provider name does not match for the attending physician provider.						X				
6856.7	Phase 1 shall be effective from the date of service on October 1, 2010 and implemented on October 4, 2010.					X	X				
6856.7.1	For Phase 1, FISS shall initially process the claim and add remark message (RARC code) N272 (missing/incomplete/invalid other payer attending provider identifier) to the remittance advice if the attending physician 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.						X				
6856.8	Phase 2 shall be effective from the date of service on July 1, 2011 and implemented on July 5, 2011.					X	X				
6856.8.1	For Phase 2, FISS shall reject the service if the attending physician 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						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	
	and/or the RARC code N272.										
6856.9	FISS shall check for HHA Requests for Anticipated Payment (RAP) for bill types 32x and 33x when initial claims are submitted only.						X				
6856.10	FISS shall reflect the attending physician name from the file used for the legal name validation on the MSN.						X				
6856.11	FISS shall continue to not include a placeholder NPI on the MSN.						X				
6856.12	This requirement deleted by CMS.										
6856.13	FISS shall create an online look-up for contractors to use for inquiry verification of the physicians who are an attending physician provider.						X				
6856.14	PECOS shall create a test file for FISS at a date determined by FISS, CMS, and PECOS.										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	
6856.15	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					

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 Sandra Olson 410-786-1325 sandra.olson@cms.hhs.gov

Post-Implementation Contact(s): Tolla Anderson 410-786-1786 tolla.anderson@cms.hhs.gov Sandra Olson 410-786-1325 sandra.olson@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.

Attachment

FISS Ordering and Referring Extract File Layout

Description	Field Name	Length	Default Value	Start Position	PECOS Table	PECOS Field
NPI	NPI	10	N/A	1	PEC_NPI	NPI
First Name	FNAME	25	N/A	11	PEC_IND_NAME	FIRST_NAME
Middle Name	MNAME	25	N/A	36	PEC_IND_NAME	MDL_NAME
Last Name	LNAME	35	N/A	61	PEC_IND_NAME	LAST_NAME
Specialty Code	SPCLTY_CD	2	N/A	96	PEC_ENRT_NPHY_SPC, PEC_ENRT_PHY_SPC	PHYSN_SPCLTY_CD
Specialty Description	SPCLTY_DESC	150	N/A	98	PEC_NPHY_SPC_REF, PEC_PHY_SPC_REF	PHYSN_SPCLTY_DESC
PIN Effective Date	EFF_DT	8	N/A	248	PEC_MDCR_NUM	EFCTV_DT
PIN Termination Date	TRM_DT	8	N/A	256	PEC_MDCR_NUM	END_DT
Filler	FILLER	37	N/A	264	N/A	N/A
Total Length		**300**				