Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – Health care providers, health plans, clearinghouses and vendors should be finished with their internal testing of the Version 5010 HIPAA electronic health care transaction standards by the first recommended deadline for internal testing, December 31, 2010, and be ready to start testing with their external partners, beginning in January 2011, just about four months away. Please visit *http://www.cms.gov/icd10* for the latest news and sign up NOW for Version 5010 and ICD-10 e-mail updates!

MLN Matters® Number: MM7046

Related Change Request (CR) #: 7046

Related CR Release Date: September 10, 2010

Effective Date: Phase 1 - January 1, 2011; Phase 2 – April 1, 2011

Related CR Transmittal #: R767OTN

Implementation Date: Phase 1 - January 3, 2011; Phase 2 – April 4, 2011

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 (FI) and Part A Medicare Administrative Contractors (A/B MAC)

Provider Types Affected

Critical Access Hospitals (CAH) submitting claims that include attending, operating, other physician or non-physician practitioner provider that order and refer to Medicare contractors (FIs and A/B MACs) for services provided to Medicare beneficiaries are affected.

Provider Action Needed

This article is based on Change Request (CR) 7046. You should know that Medicare contractors will expand claims editing to verify that the attending, operating, or other physician or non-physician practitioner provider on a CAH claim is eligible 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 will allow a claim to be paid, if the billed service requires an attending,

operating, or other physician or non-physician practitioner and the information is not on the claim. However, remittance advice (RA) messages will notify the billing provider that claims of this nature may not be paid in the future if the required data is not provided accurately on the claim. Phase 1 covers dates of service on or after January 1 through March 31, 2011.

- In phase 2, the claims will not be paid if the required information is missing or not accurate on the claim. Phase 2 will be effective for claims with dates of service on or after April 1, 2011.

Please ensure that your billing staffs are aware of these changes.

Background

The Centers for Medicare & Medicaid Services (CMS) is expanding the claims 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 that the attending, operating, or other physician or non-physician practitioner provider on a CAH claim is eligible and enrolled in Medicare by allowing Medicare's Fiscal Intermediary Shared System (FISS) to match data (combination of the National Provider Identifier (NPI) and provider name will be matched) on a provider billed claim to that of a national PECOS file.

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 editing expansion will be done in two phases. Phase 1 will allow a claim to be paid, if the billed service requires an attending, operating, or other physician or non-physician practitioner and the information is not on the claim. However, RA messages will notify the billing provider that claims of this nature may not be paid in the future if the required data is not provided accurately on the claim. Those RA messages may include the following, as appropriate:

- Remittance Advice Remark Code (RARC) N272 (Missing/incomplete/invalid other payer attending provider.);
- RARC N273 (Missing/incomplete/invalid other payer operating provider identifier.);
- RARC N274 (Missing/incomplete/invalid other payer other provider identifier.); and/or
- Claim Adjustment Reason Code 16 (for adjusted claims).

In phase 2, the claims will not be paid if the required information is missing or not accurate on the claim. The same RA messages cited above will appear on rejected services in phase 2.

Additional Information

If you have questions, please contact your FI or MAC at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

The official instruction issued to your FI or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R767OTN.pdf* on the CMS website.