CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2560	**Date: September 28, 2012**
	Change Request 7902

Transmittal 2519, dated August 17, 2012, is being rescinded and replaced by Transmittal 2560, dated September 28, 2012 to correct the effective date in the policy section from April 1, 2013, to January 1, 2013 and to add a business requirement to exempt self-referred screening mammograms. All other information remains the same.

SUBJECT: New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician NPI

I. SUMMARY OF CHANGES: Implementing a new consistency edit to validate that the attending physician NPI is not being fictitiously substituted with the billing provider's NPI to bypass HIPAA standards.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 2013

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	1/80.3.2.2 / Consistency Edits for Institutional Claims

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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: 2560	Date: September 28, 2012	Change Request: 7902

Transmittal 2519, dated August 17, 2012, is being rescinded and replaced by Transmittal 2560, dated September 28, 2012 correct the effective date in the policy section from April 1, 2013, to January 1, 2013 and to add a business requirement to exempt self-referred screening mammograms. All other information remains the same.

SUBJECT: New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician NPI

Effective Date: January 1, 2013

Implementation Date: January 7, 2013

I. GENERAL INFORMATION

A. Background: The U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), recently issued a final audit report regarding the "Questionable Billing by Community Mental Health Centers". Audit findings in this report include: providers reporting their billing NPI in the Attending Provider Data Element in error.

Based on findings in this report, the Center for Medicare & Medicaid Services (CMS) is implementing a consistency edit to enforce the correct billing of the Attending Provider NPI on claims.

B. Policy: Institutional providers are required to indicate the Attending Provider Name and Identifiers for the patient's medical care and treatment reported on institutional claims for any services other than non-scheduled transportation claims. Additionally, institutional providers are required on outpatient claims to send the Referring Provider NPI and name when the Referring Provider for the services is different than the Attending Provider.

Effective for claims received on or after January 1, 2013, FISS shall install a consistency edit for institutional claims to ensure that the institutional provider has not used their billing NPI in the Attending Provider NPI Data Element. Institutional billing of influenza and pneumococcal vaccinations and their administration as the only billed service on a claim or roster billing of influenza and pneumococcal vaccinations and their administrations are exceptions to this process.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	
7902.1	FISS shall create a new consistency edit for all Institutional claims, with the exceptions as noted in business requirement number 2, to ensure that the claim						X				CEM

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF	
	does not contain the billing provider's NPI in the Attending Provider's Data Element.										
7902.2	FISS shall exempt from the newly created consistency edit in requirement 7902.1 an Institutional claim of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on a claim or a roster billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on a roster claim.						X				CEM
7902.3	FISS shall exempt from the newly created consistency edit in requirement 7902.1 an Institutional claim of self-referred screening mammogram when this is the only billed services on a claim.						X				CEM
7902.4	FISS shall allow contractors to override the new edit.	X		X		X	X				
7902.5	FISS shall bypass this new edit on adjustments created by contractors.						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7902.6	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		X					

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Contact Fred Rooke at fred.rooke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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),* include the following statement:

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 1 - General Billing Requirements

Table of Contents

(Rev.2560, Issued: 09-28-12)

80.3.2.2 - Consistency Edits *for Institutional Claims*
(Rev2560. Issued: 09-28-12 Effective: 01-01-13, Implementation: 01-07-13)

In order to be processed correctly and promptly, a bill must be completed accurately. *Medicare contractors processing institutional claims* edit all Medicare required fields as shown below. If a bill fails these edits, *contractors* return it to the provider for correction. If bill data is edited online, the edits are included in the software. Depending upon special services billed, *contractors* may require additional edits.

FL 4. Type of Bill

a. Must not be spaces.

b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

2 - Skilled Nursing

3 - Home Health

4 - Religious Non-Medical (Hospital)

7 - Clinic or Renal Dialysis Facility (requires special information in second digit below)

8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

1 - Inpatient (Part A)

2 - Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)

3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for “nonpatients”)

8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)

Second Digit - Classification (first digit is 7):

1 - Rural Health Clinic (RHC)

2 - Hospital-Based or Independent Renal Dialysis Facility

4 - Other Rehabilitation Facility (ORF)

5 - Comprehensive Outpatient Rehabilitation Facility (CORF)

6 - Community Mental Health Center (CMHC)

7 - Free-Standing Provider-Based Federally Qualified Health Center (FQHC)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For FI use only)

G - CWF Initiated Adjustment Claim (For FI use only)

H - CMS initiated Adjustment Claim (For FI use only)

I - FI Adjustment Claim (Other than QIO or Provider) (For FI use only)

J - Initiated Adjustment Claim-Other (For FI use only)

K - OIG Initiated Adjustment Claim (For FI use only)

M - MSP Initiated Adjustment Claim (For FI use only)

P - QIO Adjustment Claim (For FI use only)

Q – Claim Submitted for Reconsideration Outside of Timely Limits (For FI use only)

0 - Nonpayment/zero claims

1 - Admit Through Discharge Claim

2 - Interim - First Claim

3 - Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)

4 - Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either "From" or "Through" portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The "From" date must be a valid date that is not later than the "Through" date.

c. The "Through" date must be a valid date that is not later than the current date.

d. With the exception of Home Health PPS claims, the statement covers period may not span 2 accounting years.

FL *09*. Patient's Address

a. The address of the patient must include:

City
State (P.O. Code)
ZIP

b. Valid ZIP Code must be present if the type of bill is 11X, 13X, 18X, or 83X or 85X.

c. Cannot exceed 62 positions.

FL *10*. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL *11*. Sex

a. One alpha position.

b. Valid characters are “M” or “F.”

c. Must be present.

FL *12*. Admission Date

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the type of bill is 11X, 12X, 18X, 21X, 22X, 32X, 33X, 41X, 81X or 82X.

FL *14*. *Priority (*Type*)* of Admission *or Visit*

a. One numeric position.

b. Required only if the type of bill is 11X, 12X, 18X, 21X, 22X, or 41X.

FL *15*. *Point of Origin for* Admission *or Visit*.

a. One numeric position

b. Must be present

FL *17*. Patient *Discharge* Status.

a. Two numeric positions

b. Present on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

FL *03b*. Medical/*Health* Record Number

a. If provided by the hospital, must be recorded by the FI for the QIO.

b. Must be left justified in CWF record for QIO.

FLs *18 thru 28*. Condition Codes.

a. Each code is two numeric digits.

b. If code 07 is entered, type of bill must not be hospice 81X or 82X.

c. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

d. If code 40 is entered, the “From” and “Through” dates in FL 6 must be equal, and there must be a “0” or “1” in FL 7 (Covered Days).

e. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

f. Code C1, C3, C4, C5, or C6 must be present if type of bill is 11X or 18X.

FLs *31, 32, 33, and 34*. Occurrence Codes and Dates

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alphanumeric positions.

d. If code 20 or 26 is entered, the type of bill must be 11X or 41X. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

e. If code 27 is entered, the type of bill must be 81X or 82X.

f. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit a "5."

g. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

h. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

i. If code 20 is entered:

- Must not be earlier than "Admission" date ~~(FL 17)~~ or later than "Through" date (FL 6).
- Must be less than 13 days after the admission date ~~(FL 17)~~ if "From" date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

j. If code 21 is entered:

- Cannot be later than "Statement Covers Period" Through date; or
- Cannot be more than 3 days prior to the "Statement Covers Period" From date.

k. If code 22 is entered, the date must be within the billing period shown in FL 6.

l. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

m. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL *35 and* 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

e. If code 71 is entered, the first digit of FL 4 must be "1," "2," or "4" and the second digit must be "1."

f. If code 72 is entered, the type of bill must be 13X, 14X, 32X, 33X, 34X, 71X, 73X, 74X, or 75X.

g. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

h. If code 75 is entered, the first digit of FL 4 must be "1" or "4" and the second digit must be "1."

i. If code 76 is entered, occurrence code 31 must be present (inpatient only).

j. If code 76 is entered, occurrence code 32 must be present (outpatient only).

k. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 73X, 74X, 75X, 81X, 82X, or 85X.

l. Neither the "From" nor the "Through" portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

m. If code M2 is present, the bill type must be 81X or 82X.

n. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. If code 06 is entered, there must be an entry for code 37.

e. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

f. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

g. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

h. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

i. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. Four numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be "0001" for hardcopy claims only.

c. There must be a revenue code adjacent to each entry in FL 47.

d. For bill types 32X and 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X, 043X, 044X, 055X, 056X, 057X, 0601, 0602, 0603, and 0604.

e. For bill type 34X, the following revenue codes require a 5-position HCPCS code:

0271-0274, 42X, 43X, 44X, and 0601-0604.

f. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on types of bill 12X, 13X, 14X, 22X, 23X, 24X, 32X, 33X, 34X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, and 83X.

Exception: LIDOS are not required for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)

c. Accommodation units must equal covered days with the exception of the R No-Pay.

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The “0001” amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare” must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL *56. National* Provider *Identifier – Billing Provider*

a. *Effective May 23, 2007, providers are required to submit their NPI.*

b. Left justified.

FLs 58A, B, and C. Insured's Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 680 or 700 through 728.

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, C, D, E, F, M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code *and Present on Admission Indicator*.

a. Must be four or five positions left justified with no decimal points. FIs validate with MCE and OCE programs.

b. Must be valid ICD-9-CM code.

c. POA is a one position field.

FLs *67 A - Q*. Other Diagnosis Codes *and Present on Admission Indicator*.

a. If present, must be four or five positions, left justified with no decimal points. FIs validate with MCE and OCE programs.

b. POA is a one position field.

FL *74.* Principal Procedure Code and Date

a. If present, must be valid ICD-9-CM procedure code. FIs validate with MCE program.

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL *74 a-e*. Other Procedure Codes and Dates.

a. If present, apply edits for FL *74*

FL *76*. Attending *Provider Name and Identifiers.*

a. The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types. *Effective May 23, 2007, providers are required to submit NPI.*

   ° *An Institutional provider may not submit their own NPI, except for Institutional billing of influenza and pneumococcal vaccinations and their administration as the only billed service on a claim, roster billing of influenza and pneumococcal vaccinations and their administrations, or self-referred screening mammography as the only billed service on a claim.*

FL *77. Operating Physician Name and Identifiers*

a. *Effective May 23, 2007, providers are required to submit NPI. NPI* must be present if:

   • Bill type is 11X and a procedure code is shown in FL *74*;

   • Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC payment limitation or is on the list of codes the QIO furnishes that require approval; or

   • Bill type is 85X and HCPCS code is in the range of 10000 through 69979.

b. If required:

   • *NPI*, last name and first initial must be present; and

   • Left justified.