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| CMS Manual System | Department of Health & Human Services (DHHS) |
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 406 | Date: NOVEMBER 21, 2008 |
| | Change Request 6289 |

Subject: Analysis Only for New FISS, CWF and NCH System Requirements for All 837 I Claims Related to Rendering Physicians/Practitioners

I. SUMMARY OF CHANGES: This CR requires an analysis by FISS, CWF and NCH of new requirements for all 837 I outpatient claims. This new requirement involves processing, forwarding and storing rendering physician/practitioner information.

New / Revised Material

Effective Date: April 1, 2009 (Analysis Only)

Implementation Date: May 15, 2009 (NOTE: Contractors shall begin analysis at the beginning of the April Release time frame with final delivery on May 15, 2009)

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 | |

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

Not Applicable.

SECTION B: For Medicare Administrative Contractors (MACs):

Not Applicable.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

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|-------------|------------------|-------------------------|----------------------|
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SUBJECT: Analysis Only for New FISS, CWF and NCH System Requirements for All 837 I Claims Related to Rendering Physicians/Practitioners

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I. GENERAL INFORMATION

A. Background: Medicare needs to identify primary physicians/practitioners of service not only for use in standard claims transactions, but also for review, fraud detection, and planning purposes. In order to accomplish this, we must be able to determine the rendering physician/practitioner for each inpatient/outpatient service billed to Medicare and store this information in our databases that serve as the source for data analysis. Until the implementation of the 5010 version of the 837 I, this information can only be collected at the claim level in the other provider field. Optimally, we will begin collecting this information at the line level, following the implementation of the 5010 version of the 837 I. To perform the needed data analysis, it is critical that Fiscal Intermediary Shared System (FISS) be able to associate physician/practitioner identifying information with each line item on all institutional claims, and be able to forward that information to the Common Working File (CWF).

Until implementation of the 5010 version of the 837 I, CWF must be able to edit based on the claim level physician/practitioner information related to the rendering physician/practitioner (from the “other provider” field) and must also forward the information through to the National Claims History (NCH) for storage. With the implementation of the 5010 version of the 837 I, CWF must be able to edit based on the line level physician/practitioner information and must also forward the information through to the National Claims History (NCH) for storage.

The implementation of the required changes will be in two phases. The first phase will be implemented in 2009, requiring use of the current institutional claim specifications, i.e., the 4010A1 version of the 837 I. The second phase will begin on or after the implementation of the 5010 version of the 837 I.

B. Policy: FISS, CWF and NCH must perform the requested analysis and report the required information based on each phase of the project.

Phase I

All physician/practitioner identifying information on all institutional inpatient/outpatient claims related to the rendering physician/practitioner at the claim level, identified as “other provider” must be carried through FISS and CWF to NCH. Additionally, provider education must be used to reinforce the need to meet the Health Insurance Portability and Accountability Act of 1996 requirements when completing 2310 loop on the 837I claim.

Phase II

Beginning with the full implementation of the 5010 version of the 837 I, providers need to report the rendering physician or other practitioner at the line level if it differs from the rendering physician/practitioner reported at the claim level. Effective with the 5010 version of the 837 I, FISS shall accept rendering physician/practitioner information at the line level (loop 2420C). If the information is not provided at the line level (i.e., because it is the same as at the claim level), FISS shall populate its internal records with line level rendering physician/practitioner information from the claim level (loop 2310).

To prepare for this change, CMS is requesting that FISS, CWF and NCH perform an analysis to determine what system changes will be necessary to implement the changes related to the 4010A1 version of the 837 I in Phase I and the changes related to the 5010 version of the 837 I in Phase II. The hours needed for changes being made under the 5010 implementation project should not be counted under this CR. However, if it is not clear that a change needed to implement this CR is part of the 5010 implementation project or not, list the activity and identify it as possibly part of the 5010 implementation project. Also, separately list the hours estimate for that activity. We are asking that each system/contractor submit separate information for the Phase I and the Phase II changes. The information requested is:

1. A summary of edit/programming changes needed;
2. A list of documentation changes needed;
3. A list of affected downstream systems, if applicable;
4. An estimate of the number of hours required;
5. A list of any issues or questions that need to be addressed before changes can be made: and,
6. An estimate of the increase in claims volume if during Phase I only, providers are required to submit separate claims when the rendering physician/practitioner for each date of service on the claim is not the same.

The information being requested in this CR is for planning purposes only and is not to be considered a request for additional systems hours or anything else. It is important that all affected downstream systems be identified. All system owners must identify all systems downstream of their system that could be affected by these changes. To help ensure the smooth and timely implementation of this project, we ask that all system owners submit, as soon as possible, the names of any systems not included in the Business Requirements below that they believe could be affected by these changes. Please submit this information to Gertrude Saunders (Gertrude.Saunders@cms.hhs.gov).

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|----------|--|---|---------------------------|---------------------------|----------------------------|----------------------|---------------------------|-------------|-------------|---|-----------|
| | | A / B M A C | D M M A C | F I I E R | C A R I E R | R H I I | Shared-System Maintainers | | | | OTH ER |
| | | | | | | F I S S | M C S | V M S | C W F | | |
| 6289.1 | This CR is for analysis only. Each of the identified systems shall report separately the following information as it pertains to implementing the new requirements in Phase I (BRs 6289.1.1 – 6289.1.4), and to implement the new requirements in Phase II (BRs 6289.1.5 – 6289.1.8: (a) A summary of edit/programming changes needed; (b) A list of documentation changes needed; (c) A list of affected downstream systems, if applicable; (d) An estimate of system hours required; (e) A list of any issues or questions that need to be addressed before changes can be made; and (f) An estimate of increase in claims volume if during Phase I only, physicians/practitioners are required to submit separate claims when the rendering physician/practitioner for each date of service on the claim is not the same. | | | | | | X | | | X | NCH |
| 6289.1.1 | During Phase I, FISS shall populate the rendering physician/practitioner (other provider) field with the attending provider information, if blank. | | | | | | X | | | | |
| 6289.1.2 | During Phase I, FISS shall forward claim level attending and rendering physician/practitioner information to CWF. | | | | | | X | | | X | |
| 6289.1.3 | During Phase I, CWF shall forward claim level attending and rendering physician/practitioner information to the NCH. | | | | | | | | | X | NCH |
| 6289.1.4 | During Phase I, NCH shall store claim level attending and rendering physician/practitioner information. | | | | | | | | | | NCH |
| 6289.1.5 | During Phase II, if the rendering physician/practitioner information is not provided at the line level (i.e., because it is the same as at the claim level) FISS shall populate their internal record with rendering physician/practitioner information from the claim level (loop 2310). | | | | | | X | | | | |
| 6289.1.6 | During phase II, FISS shall forward line level rendering | | | | | | X | | | X | |

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|----------|--|---|-------------|--------|---------------------------------|-------------|---------------------------|-------------|-------------|-------------|-----------|
| | | A / B | D M E | F I | C A R R I E R | R H I | Shared-System Maintainers | | | | OTH ER |
| | | M A C | M A C | | | | F I S S | M C S | V M S | C W F | |
| | physician/practitioner information to CWF. | | | | | | | | | | |
| 6289.1.7 | During Phase II, CWF shall forward line level rendering physician/practitioner information to the NCH in addition to the claim level information. | | | | | | | | | | X NCH |
| 6289.1.8 | During Phase II, NCH shall store the rendering physician/practitioner at the line level. | | | | | | | | | | NCH |
| 6289.2 | The Information requested in BR 6289.1 regarding the above detailed BRs shall be sent to CMS, to the Attention of: Gertrude Saunders gertrude.saunders@cms.hhs.gov , by COB May 15, 2009. | | | | | | X | | | X | NCH |

III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | |
|--------|-------------|---|-------------|--------|---------------------------------|-------------|---------------------------|-------------|-------------|-------------|-----------|
| | | A / B | D M E | F I | C A R R I E R | R H I | Shared-System Maintainers | | | | OTH ER |
| | | M A C | M A C | | | | F I S S | M C S | V M S | C W F | |
| | None. | | | | | | | | | | |

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

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:

V. CONTACTS

Pre-Implementation Contact(s): Intermediary/Part A MAC claims processing: Gertrude Saunders, gertrude.saunders@cms.hhs.gov or Maria Durham, maria.durham@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

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

Not Applicable

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

Not Applicable.