CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1182	**Date: February 8, 2013**
	Change Request 8056

SUBJECT: Incentive Payment Related to Prior Authorization for Power Mobility Devices (PMD).

I. SUMMARY OF CHANGES: Under this PMD demonstration, if a physician submits the initial prior authorization request, the physician/treating practitioner would be entitled to a G-code (G9156) incentive payment. This incentive payment is for his/her initial prior authorization request for a beneficiary only. The $10 incentive payment is issued to the physician/treating practitioner quarterly.

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Not Applicable

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:

One Time Notification

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

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1182	Date: February 8, 2013	Change Request: 8056

SUBJECT: Incentive Payment Related to Prior Authorization for Power Mobility Devices (PMD).

EFFECTIVE DATE: July 1, 2013
IMPLEMENTATION DATE: July 1, 2013

I. GENERAL INFORMATION

A. Background: CMS has the authority under section 1834(a)(15) of the Social Security Act to develop and periodically update a list of DME items which are subject to prior authorization before claim payment. Under demonstration authority CMS is proposing a three year mandatory prior authorization process for Power Mobility Devices (PMD) in California, Florida, Illinois, Michigan, New York, North Carolina and Texas based on beneficiary addresses, an initiative referred to hereafter as prior authorization. This initiative is designed as a tool to protect the Medicare Trust Fund by deterring fraudulent and abusive billing practices and making the physician or treating practitioner more accountable for the items he or she orders to prevent improper payments.

Under this PMD demonstration the physician/treating practitioner may submit the prior authorization request. If the prior authorization request is submitted by the physician/treating practitioner, the physician/treating practitioner can bill G9156. The physician/treating practitioner would be entitled to a quarterly incentive payment of $10 for each G9156 code that meets all eligibility requirements. G9156 is submitted to the contractor with the PMD prior authorization number. The $10 incentive payment is issued to the physician/treating practitioner quarterly.

A designated Payment Contractor will issue the incentive payments for all Medicare contractors. The incentive payments will be issued from the PMD Demonstration funds.

B. Policy: Under this PMD demonstration, if a physician/treating practitioner submits theinitial prior authorization request, the physician/treating practitioner would be entitled to a G-code incentive payment (G9156). This G-code incentive payment is for his/her initial prior authorization request for a beneficiary only. A $10 incentive payment will be issued quarterly for each G9156 code that meets all the eligibility requirements.

Related CRs are 7495 and 7563.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8056.1	G9156 shall process through all CWF and MCS edits as stated in CR 7495. All G9156 claim lines that are		X			X			X			

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	deemed to be eligible for the $10 incentive payment shall be processed using CARC B11 and RARC (N571) on the Electronic Remittance Advice (835) and the Standard Paper Remit. N571 - Alert: Payment will be issued quarterly by another payer/contractor. MCS shall allow the claims with G9156 to process as stated in CR 7495 and suppress the provider payment for any payable details with G9156. MCS shall suppress the beneficiary Medicare Summary Notice.											
8056.2	Contractors shall establish an edit to reject G9156 when the billed amount does not equal $10. CARC 125 and RARC M79 shall be used on the Electronic Remitance Advice (835) and the Standard Paper Remit.		X			X						
8056.3	All G9156 claim lines that are adjusted and denied shall be processed using a new CARC and RARC (to be determined at a later date) on the Electronic Remittance Advice (835) and the Standard Paper Remit. Contractors shall determine the best CARC/RARC to use. CMS will provide the new CARC/RARC at a later date. MCS shall suppress demand letter and offset. Designated Payment Contractor shall issue demand letter.		X			X			X			Designated Payment Contractor
8056.4	MCS shall automatically split the claim when G9156 is submitted with other codes. Providers shall submit								X			

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
	G9156 on an assigned claim with no other codes.											
8056.5	MCS shall hold all Do Not Forward situations for the incentive payments until the Do Not Forward is resolved.								X			
8056.6	MCS shall develop a user controlled switch to indicate applying or suppressing claims processing timeliness (CPT) interest. MCS shall default suppressing interest until otherwise instructed by CMS.								X			
8056.7	Quarterly, MCS shall generate and EDC shall send using Connect Direct, to the Designated Payment Contractor, an electronic Payment Summary File by the 5th business day after the end of the quarter. MCS shall follow the record layout provided in the attachment to CR8056. The Payment Summary File shall contain initial claims and adjusted claims. MCS shall report 'Adjustment' in the payment category field on the attached record layout to indicate adjusted claims that require payment or recoupment.								X			EDC
8056.8	The Designated Payment Contractor shall perform validation edits on the Payment Summary File within 2 business days of receipt from MCS. The Designated Payment Contractor shall notify MCS within 2 business days of validation errors that require resolution. MCS shall resolve validation errors and notify the Designated Payment Contractor within 2 business days. Attachment to CR8056 contains the list of validation edits.								X			Designated Payment Co

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
												ntractor
8056.9	The Designated Payment Contractor shall process the incentive payments funded from a special funding allocation (PMD Demonstration funds).											Designated Payment Contractor
8056.10	The Designated Payment Contractor shall issue a payment roster.											Designated Payment C

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
												Contractor

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8056.11	MLN Article : 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 sites 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 the contractor's 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		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	CR 7495 and CR 7563.

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

V. CONTACTS

Pre-Implementation Contact(s): Margery Glover, 410-786-1053 or margery.glover@cms.hhs.gov , Sumita Sen, 410-786-5755 or sumita.sen@cms.hhs.gov , Kathy Metrick, 410-786-8041 or kathy.metrick@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:
Not Applicable

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 do 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: 1

Data Element	Required	Data Constraints	Default
Transaction Number	R	15 Max	ICN plus contractor number
NPI	R	11 Max	
Payee TIN	R	9 Max	
Legal Name	R	40 Max	
Provider Name	R	25 Max	
MAC/FI Contractor Number	R	5 Max	
Payment Category	R	13 Max	"INITIAL" or “ADJUSTMENT”
Depository (Bank) Routing Transit Number	O	9 Max	If check then leave blank, when blank then PFDC assumes that payment is Check and then Check Payment info is required
Depository (Bank) Account Number (required)	R	17 Max	If check then leave blank, when blank then PFDC assumes that payment is Check and then Check Payment info is required
Bank Account Type	R	8 Max	"CHECKING" or "SAVINGS"
Dispersal Amount	R	Decimal 14,2	
Provider Number	R	11 Max	
Payment Cycle Date	R	Date/Time	Timestamp when file created.
TIN Type	R	3 Max	“SSN” or “EIN”
Provider Type	R	2 Max	“EP”
Check Payment Payee Address 1	O	40 Max	If Bank Routing # and Account # is blank then send otherwise leave blank
Check Payment Payee Address 2	O	40 Max	If Bank Routing # and Account # is blank then send otherwise leave blank
Check Payment Payee City	O	25 Max	If Bank Routing # and Account # is blank then send otherwise leave blank
Check Payment Payee State	O	15 Max	If Bank Routing # and Account # is blank then send otherwise leave blank
Check Payment Payee Zip Code	O	5 or 9	If Bank Routing # and Account # is blank then send otherwise leave blank
Contact Name	O	40 Max	If Demand is necessary then demand information will go here, otherwise normal contact information here.
Contact Address 1	O	40 Max	If Demand is necessary then demand information will go here, otherwise normal contact information here.
Contact Address 2	O	40 Max	If Demand is necessary then demand information will go here, otherwise normal contact information here.
Contact City	O	25 Max	If Demand is necessary then demand information will go here, otherwise normal contact information here.
Contact State	O	2 Max	If Demand is necessary then demand information will go here, otherwise normal contact information here.
Contact Zip	O	5 or 9	
Contact E-Mail	O	80 Max	
Contact Phone	O	15 Max	
Contact Fax	O	15 Max	
Contractor Name	O	25 Max	
New Information Indicator	R	3 Max	“YES” or “NO”