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New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI – Phase 2

MLN Matters Number: MM12889 Revised

Related Change Request (CR) Number: 12889 & 13219

Related CR Release Date: October 6, 2022

Effective Date: April 1, 2023

Related CR Transmittal Number: R11633CP & R12107CP

Implementation Date: April 3, 2023 – CR 12889 and January 2, 2024 – CR 13219

Related CR Title: New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Provider National Provider Identifier (NPI)

What's Changed? We removed type of bill 71X (Rural Health Clinic) claims as an exception and added over-the-counter (OTC) HCPCS K1034 claims, MAC adjustments, and claims with AB modifier on all lines to the exceptions list (pages 2-3). Substantive changes appear in dark red.

Affected Providers

- Hospitals
- Other institutional providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Action Needed

Make sure your billing staff knows about:

- A new consistency edit that validates the attending provider NPI.
- Organizational NPIs can't be used in place of individual NPIs, unless exception conditions are met.

Background

An attending provider is the individual who has overall responsibility for the patient's medical care and treatment reported on institutional claims. Institutional providers can't use an organizational NPIs in place of individual NPIs, unless conditions for exception are met.

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Institutional providers must indicate the attending provider name and Identifiers for the patient's medical care and treatment on institutional claims for any services other than nonscheduled transportation claims. Also, on outpatient claims, institutional providers must send the referring provider NPI and name when the referring provider for the services is different from the attending provider.

Effective for claims Medicare gets on or after April 1, 2023, Medicare systems will edit institutional claims to make sure the institutional provider hasn't used any other organizational NPI in the Attending Provider NPI Data Element.

We included similar criteria for the edits we use for matching the attending provider as found in CR 6856 and CR 8387 with this newly created edit. These edits are in the Fiscal Intermediary Shared System (FISS). FISS matches data on the provider-billed claim to data in PECOS.

PECOS provides FISS a file of the following physician and non-physician practitioner specialties eligible as an attending physician enrolled in PECOS in an approved status:

- Doctor of medicine or osteopathy
- Dental surgery (19)
- Podiatric medicine (48)
- Optometry (41)
- Chiropractic medicine (35)
- Physician assistant (97)
- Certified clinical nurse specialist (89)
- Nurse practitioner (50)
- Clinical psychologist (68)
- Certified nurse midwife (42)
- Licensed clinical social worker (80)
- Certified registered nurse anesthetist (43)
- Registered dietitian/nutritional professional (71)

FISS also uses this process to see if the attending physician on the claim matches the providers in the national PECOS file. If FISS finds a match, it then compares the NPI, first letter of the first name, and the first 4 letters of the last name to the matched record. We consider attending physician valid if the specialties are eligible and the claim verified if the NPI and names match for the attending physician.

You may use the billing provider NPI in the following exceptions:

- Roster Bill (Condition Code M1 is present)
- Covid-19 vaccine, influenza and PPV shots and their administration (Condition Code A6 is present)
- Covid-19, OTC claims with K1034 for the following TOBs only: 013x, 014x, 023x, 034x, 072x, 075x, and 087x
- The TOB is 41X (Religious Non-Medical Healthcare Institutions)

- Veterans Administration claims
- Only Screening Mammography services are billed (revenue code 0403)
- MAC submitted adjustments (transaction type equal to D with an ADJ REQ ID other than H-hospital/provider)
- Cancel claims (transaction type equal to C)
- Demo code 31 is present on the claim
- Home health TOB 32X
- TOB 13X, 22X, 23X, or 85X with ambulance services only (revenue code 0540).
- Critical access hospital Method II TOB 85X with only professional services (revenue code 96X, 97X, 98X)
- Any claim with no covered charges present
- Any claim where all the lines on the claim contain an "AB" modifier
- Foreign providers (state codes 56, 59, and 99)
- Military treatment facilities (6th position of CMS Certification Number is F)

More Information

We issued CR 12889 and CR 13219 to your MAC as the official instructions for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
June 29, 2023	We removed type of bill 71X (Rural Health Clinic) claims as an exception and added OTC HCPCS K1034 claims, MAC adjustments, and claims with AB modifier on all lines to the exceptions list (pages 2-3).
April 27, 2023	We added information to explain how we verify attending physician information on a claim (page 2). Substantive changes appear in dark red.
October 6, 2022	Initial article released.