CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 284	**Date: JUNE 22, 2007**
	Change Request 5621

Subject: Limiting Numbers of Letters Automatically Generated For Claims Suspended When There is No One-to-One Match of National Provider Identifier (NPI) to Legacy Provider Number

I. SUMMARY OF CHANGES: CR 5333 implemented the capability to permit the carriers, FIs, and A/B MACs to opt for having the shared systems automatically generate development letters when a claim suspends because the NPI supplied matches to more than one legacy number and a one-to-one match cannot be made. The capability in the Multi-carrier System results in one letter per claim. This CR will refine the capability such that there will be only one letter per day per provider when the local contractors invoke the capability.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007, and January 7, 2008. The implementation dates indicate that the work for this CR will be completed over the October 2007 and January 2008 releases.

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:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 284	Date: June 22, 2007	Change Request: 5621

SUBJECT: Limiting Numbers of Letters Automatically Generated for Claims Suspended When There Is No One-to-One Match of National Provider Identifier (NPI) to Legacy Provider Number

Effective Dates: October 1, 2007

These dates do not relate to dates of service. They apply to the releases during which the requirements of this CR will be implemented, with the work begun for the October 2007 release and the balance completed for the January 2008 release.

Implementation Dates: October 1, 2007, and January 7, 2008. The implementation dates indicate that the work for this CR will be completed over the October 2007 and January 2008 releases.

I. GENERAL INFORMATION

A. Background:

(1) The HIPAA Law and NPI Final Rule

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of the Department of Health and Human Services adopt standards providing for a standard unique health identifier for each health care provider for use in the healthcare system and to specify the purpose for which the identifiers may be used. The National Provider Identifier (NPI) final rule published on January 23, 2004, establishes this standard for a unique health identifier, announces the adoption of the NPI as that standard, and establishes implementation specifications for obtaining and using the NPI (45 CFR Part 162, CMS-0045-F).

(2) Failures to Find Appropriate Legacy Number Among Multiples for One NPI

a. Problem Identified

For Pay-To, Billing, and Rendering Provider Loops, there are situations where the NPI supplied on the claim matches more than one legacy number on the NPI crosswalk. This situation also occurs for paper claims, in the fields where the NPI is supplied to identify these providers.

b. CMS Solution

Change Request (CR) 5333, Pub. 100-20, Rev. 270, issued April 6, 2007, indicates the capabilities to be developed and actions to be taken for this situation. In general, the Centers for Medicare and Medicaid Services (CMS) shared systems will attempt to narrow down the possible legacy numbers for the provider to only one for the supplied NPI. However, when the shared systems cannot narrow down the possible legacy numbers to only one for the supplied NPI for the claim, the shared systems shall suspend the claim for development, and the local contractors shall attempt to determine the appropriate legacy number. For carriers, fiscal intermediaries (FIs), and A/B MACs, one of the options for determining the appropriate legacy number is to have the shared systems automatically generate a letter to the provider requesting the appropriate legacy number for the claim. CR 5333 also details other options available for developing the claims for all local contractors, including DMERCs and DME MACs.

The automatic letter generation capability will be available to the carriers, FIs, and A/B MACs as of July 2007. For carriers and A/B MACs processing professional claims, the capability results in one letter per suspended claim. For professional providers having multiple claims suspending for this reason on the same day, the current capability will result in the provider receiving multiple letters for that day.

The purpose of this CR is to refine this capability in the Multi-carrier System (MCS) such that there will be only one letter per day when the carriers or A/B MACs invoke the automatic letter capability. The letter shall indicate all affected claims for that day for that provider and supply the information the provider needs in order to provide the appropriate legacy number for each claim.

B. Policy: FIs, carriers, A/B MACs, and DMERCs /DME MACs shall suspend and develop the claim to determine the correct legacy number when a legacy number is required to ensure correct payment and/or send payment, documentation, and correspondence, and this legacy number is unknown because the provider has multiple legacy numbers and a reliable match cannot be made between the NPI on the claim and the legacy number needed. FIs, carriers, and A/B MACs have the option of having the shared systems automatically send a development letter for such suspensions.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5621.1	MCS shall refine the automatic letter generating capability implemented through CR 5333 such that only one letter per day per provider is generated.								X			
5621.1.1	The letter generated shall provide sufficient information about all of the provider's claims suspended that day for the match failure described in CR 5333, such that the provider will be able to supply the appropriate legacy numbers for the claims								X			
5621.1.2	Shared systems maintainers shall consult with local contractors as necessary to develop and implement this refined capability.	X			X				X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

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:
5621.1	CR 5333

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Claudette Sikora, CMM/PBG/DPCP, 410-786-5618

Post-Implementation Contact(s): Regional Offices

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)***

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 and FY 2008 operating budgets as appropriate to the release indicated.

B. ***For Medicare Administrative Contractors (MAC)*****:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.