CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 450 **Date: JANUARY 27, 2005**

CHANGE REQUEST 3440

NOTE: Transmittal 435 Dated January 14, 2005 is rescinded and replaced with Transmittal 450, Dated January 27, 2005.

SUBJECT: Enforcement of Mandatory Electronic Submission of Medicare Claims.

I. SUMMARY OF CHANGES: This transmittal contains new instructions for the enforcement of mandatory electronic submission of Medicare claims based on the Administrative Simplification Compliance Act (ASCA) of 2001. These changes impact both Chapter 21 (subsections 50.9 and 90.9) and Chapter 24 (subsection 9.5).

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2005
IMPLEMENTATION DATE: July 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	21/50.9/Failure To Furnish Information MSN Message
R	21/90.9/Falta De Information Sometida MSN Message
R	24/90.5/Enforcement
N	TOC Exhibit C
N	TOC Exhibit D
N	TOC Exhibit E
N	TOC Exhibit F

III. FUNDING: Funding will be distributed to each contractor through their regional budget office in conjunction with the release of this instruction for FY2006 enforcement activities following approval of the final CMS budget for FY2006 by Congress, the President and HHS. Each contractor will be notified at that time of the number of reviews expected to be conducted quarterly. Separate funding will be issued to contractors under activity code 17004 (Productivity Investments) each year, and not included in operational funds for these ASCA electronic claim enforcement reviews.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 450	Date: January 27, 2005	Change Request 3440

NOTE: Transmittal 435 Dated January 14, 2005 is rescinded and replaced with Transmittal 450, Dated January 27, 2005.

SUBJECT: Enforcement of Mandatory Electronic Submission of Medicare Claims.

I. GENERAL INFORMATION

A. Background: The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is received in a non-electronic form. Consequently, absent an applicable exception, paper claims received by Medicare will not be paid. Entities determined to be in violation of the statute or this rule may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

B. Policy: As required by ASCA, with few exceptions, claims must be submitted to Medicare electronically.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

Initial request, no response and inadequate justification letters that must be sent out to the providers are attached.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3440.1	Shared System Maintainers shall modify their system to produce quarterly reports by contractor of the number of Medicare paper claims received per provider number in the order from the provider submitting the highest number of paper claims to the lowest. The report must include each providers name, address, provider number, number of providers' paper claims, percentage of paper claims to total claims submitted by that provider and the report period.					X	X	X		
3440.2	Shared System Maintainers shall produce the quarterly reports by the end of the month following completion of each calendar quarter, i.e., first report due October 31, 2005 for July 1, 2005 through September 30, 2005. Subsequent reports shall be due the last day of the first month following each successive quarter.					X	X	X		
3440.3	Contractors shall obtain and analyze these quarterly reports by the end of the following month to select the appropriate number of providers for review. CMS will notify each contractor of the number of reviews to be performed when funding is issued for these reviews.	X	X	X	X					
3440.4	Contractors shall send an initial letter (exhibit C) to the selected providers requesting information to establish that they are eligible to submit paper claims.	X	X	X	X					
3440.5	If no response is received within 45 calendar days of issuance of the initial letter, contractors shall send the provider a letter (exhibit D) indicating that any Medicare paper claims submitted more than 90 calendar days from the date of the initial letter will be denied and not paid by Medicare.	X	X	X	X					

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3440.6	If a response is received to the initial letter, but it does not establish the provider's eligibility to issue paper claims, contractors shall send the provider a letter (exhibit E) that includes the reason for the denial and indicate that any Medicare paper claims submitted more than 90 calendar days from the date of the initial letter will be denied and not paid by Medicare.	X	X	X	X					
3440.7	Contractors shall enter the appropriate information to the system to begin the denial of Medicare paper claims on the 91st calendar day as specified in the letter to the provider.		X	X	X					
3440.8	If the evidence submitted does substantiate the provider's eligibility to submit paper claims, contractors shall send a notification letter (exhibit F).	X	X	X	X					
3440.9	Contractors shall obtain an EDI agreement, supply free billing software/notify provider of commercial billing software/clearinghouses and test the provider as applicable, if the provider asks to begin submitting claims electronically.	X	X	X	X					
3440.10	Contractors shall retain a record of providers approved for "unusual situation" waivers as well as of providers subjected to paper claims enforcement investigations.	X	X	X	X					
3440.11	Contractors shall not subject a provider that substantiated their right to submit paper claims to review again for at least two years.	X	X	X	X					
3440.12	Shared System Maintainers shall create a screen for the contractors to enter the determination to the system to assure that paper claims from the provider are rejected effective the 91st calendar day as specified in the letter to the provider.					X	X	X		
3440.13	Shared System Maintainers shall make system changes to begin the denial of Medicare paper claims on the 91st calendar day as specified in the letter to the provider.					X	X	X		

Requirement Number	Requirements	Responsibility (place an "X" in the columns that apply)								
						Shared System Maintainers				Other
		FI	RHHI	Carrier	DMERC	FISS	MCS	VMS	CWF	
3440.14	Contractors shall use group code PR with reason code 96 and remark code M117 on claims denied as non-electric.	X	X	X	X					
3440.15	Contractors shall use MSN code 9.9 for these denials.	X	X	X	X					
3440.16	Contractors shall assist beneficiaries to complete an appeal if contacted about a 9.9 denial.	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005	**Funding:** See Section III Funding on

Pre-Implementation Contact(s): Tom Latella (410) 786-1310, tlatella@cms.hhs.gov **Post-Implementation Contact(s):** Tom Latella (410) 786-1310, tlatella@cms.hhs.gov	Transmittal Page.

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50.9 - Failure to Furnish Information

(Rev. 450, Issued: 01-27-05, Effective: 07-01-05, Implementation: 07-05-05)

9.1 - The information we requested was not received.

9.2 - This item or service was denied because information required to make payment was missing.

9.3 - Please ask your provider to submit a new, complete claim to us. (NOTE: Add-on to other messages as appropriate)

9.4 - This item or service was denied because information required to make payment was incorrect.

9.5 - Our records show your doctor did not order this supply or amount of supplies.

9.6 - Please ask your provider to resubmit this claim with a breakdown of the charges or services.

9.7 - We have asked your provider to resubmit the claim with the missing or correct information. (NOTE: Add-on to other messages as appropriate.)

9.8 - The hospital has been asked to submit additional information, you should not be billed at this time.

9.9 - This service is not covered unless the supplier*/provider* files an electronic media claim (EMC).

90.9 - Falta De Información Sometida

(Rev. 450, Publicado: 01-27-05, Efectivo: 07-01-05, Implementación: 07-05-05)

9.1 - La información solicitada no fue recibida.

9.2 - Este artículo o servicio fue denegado porque la información requerida para hacer el pago fue omitida.

9.3 - Por favor solicite a su proveedor que nos envíe una nueva reclamación completa.

9.4 - Este servicio fue denegado debido a que la información requerida para hacer el pago fue incorrecta.

9.5 - Nuestros archivos indican que su médico no ordenó estos suministros o cantidad de suministros.

9.6 - Favor de pedirle a su proveedor que someta esta reclamación con la lista detallada de los cargos o servicios.

9.7 - Le hemos pedido a su proveedor que envíe la reclamación con la información omitida o incorrecta.

9.8 - Le hemos pedido al hospital que nos provea información adicional, por ahora, usted no deberá recibir una factura.

9.9 - Este servicio no está cubierto a menos de que el suplidor*/proveedor* tramite una reclamación de medio electrónico (EMC, por sus siglas en inglés).

90.5 – Enforcement
(Rev. 450, Issued: 01-27-05, Effective: 07-01-05, Implementation: 07-05-05)

Enforcement will be conducted on a post-payment basis. Shared System Maintainers will prepare quarterly reports for the contractors that list each provider's name, provider number, address, number of paper claims received under each provider number, arrayed from the highest to lowest number of paper claims, percentage of paper claims to total claims for each provider, and the period being reported, e.g., claims processed July 1, 2005 – September 30, 2005. These reports must be available by the end of the month following completion of a calendar quarter, e.g., on October 31 for July 1-September 30. Medicare contractors will obtain and analyze these reports by the end of the following month and select providers submitting the highest numbers of paper claims for review.

Contractors are to request information from the selected providers to establish that they meet criteria for submission of paper claims. See exhibit C for a sample request letter. If no response is received within 45 calendar days (30 calendar days with time allotted for initial postal delivery and return postal delivery; see exhibit D for a sample letter), or if a provider's response does not establish eligibility to submit paper claims (see exhibit E for a sample letter), the contractor will notify the provider by mail that:

1. *Any paper claims received more than 90 calendar days after the date of the initial request letter will be denied and not paid by Medicare (see section 90 for remittance advice denial message).*
2. *Free billing software is available for provider use (contractor must furnish contact information for the provider to obtain further information);*
3. *Commercial billing software is also available on the open market for submission of Medicare claims and that clearinghouses and other vendors offer electronic claims services commercially (contractor must insert reference to information available as discussed in section 60.8); and*
4. *A Medicare decision that a provider is ineligible to submit paper claims is not subject to appeal.*

The contractor must enter the determination to the system to assure that paper claims from the provider are denied effective with the 91st calendar day after issuance of the letter. If review of the response determines that the provider is eligible to submit paper claims to Medicare, notify the provider by mail of that determination (see exhibit F for a sample letter).

Medicare contractors are not to maintain a provider FTE database, or establish a database of waived providers, unless an "unusual situation" waiver decision is made (see 90.3.2 and 90.3.3), or an enforcement review is conducted. Each contractor will indefinitely maintain a local Excel record of "unusual situation" waivers, with column headings for the name, address, provider number, whether the "unusual circumstance" waiver was approved or denied, the termination date for an approval (if applicable), and the unusual circumstance identified in the request. Exclude locally approved 90/180-day waivers from this list. Contractors are also to maintain an Excel report with column

headings for provider name, provider number, address, date of enforcement review determination of each provider reviewed, whether continued submission of paper claims is approved or denied, and if denied, date rejection of paper claims to begin. Contractors shall not review the same provider again for at least two years if the provider justified submission of paper claims to Medicare.

Medicare carriers, DMERCs, and intermediaries will be issued separate funding under budget activity 17004 in FY 2006 and subsequent years for enforcement of the ASCA electronic claim submission requirement. Each contractor will be notified of the number of ASCA paper biller reviews to be conducted when the annual funding is issued for these reviews.

ASCA does not preclude provider billing of beneficiaries when provider claims are denied as result of paper submission. The PR group code is to be used with claim adjustment reason code 96 in the provider's remittance advice when a claim is denied for this reason. Nor does ASCA, however, preclude an appeal by or payment to a beneficiary in this situation, or submission of a claim by the beneficiary in the event that the provider does not file any claim to Medicare following notification that future claims will be denied if not submitted electronically.

Although it is preferable that a beneficiary transfers to an alternate provider in this situation, this may not be a reasonable option for some beneficiaries. When a provider's claim is denied for this reason, the beneficiary MSN must contain message 9.9, "This service is not covered unless supplier/provider files an electronic media claim." See Chapter 21 for further MSN information. If contacted by a beneficiary upon receipt of an MSN with this message, a Medicare contractor must assist the beneficiary in filing an appeal request. Unless payment is prevented for another reason, such as not reasonable or necessary for patient care, upon appeal, payment for the services on this claim may be issued to the beneficiary. Likewise, if the beneficiary files an initial claim for services furnished by a provider when the provider has been notified their claims will not be paid unless electronic, the beneficiary is also to be paid directly for those services, unless payment is not warranted for other reasons.

Exhibit C—Request for documentation from provider selected for review to establish entitlement to submit claims on paper

Date:

From:	*Contractor (may be preprinted on a contractor's masthead)*
To:	*Organizational Name of Provider*
Subject:	*Review of Paper Claims Submission Practices*

A large number of paper claims were submitted under your provider number during the last calendar quarter. Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

ASCA prohibits submission of paper claims unless providers are classified as:

1. *Intermediary small providers - To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs). Carrier small providers - To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than 10 FTEs;*
2. *Dentists;*
3. *Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;*
4. *Providers that conduct mass immunizations, such as flu injections, that may be permitted to submit paper roster bills;*
5. *Providers that submit claims when more than one other payer is responsible for payment prior to Medicare payment;*
6. *Providers that only furnish services outside of the United States;*
7. *Providers experiencing a disruption in their electricity and communication connection that is outside of their control; and*
8. *Providers that can establish that an "unusual circumstance" exists that preclude submission of claims electronically.*

The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and therefore, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

a. *Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);*
b. *Providers that submit fewer than 10 claims per month to a Medicare contractor on average;*
c. *Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;*
d. *Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and*
e. *Other circumstances documented by a provider, generally in rare cases, where a provider can establish that due to conditions outside the provider's control it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.*

If you intend to continue to submit paper claims, please respond within 30 calendar days of the date of this letter to indicate which of the above situations is your basis for continuing submission of paper claims to Medicare. Include with your response, evidence to establish that you qualify for waiver of the electronic filing requirement under that situation. For instance, if you are a small provider, evidence might consist of copies of payroll records for all of your employees for (specify the start and end dates of the calendar quarter for which the review is being conducted) that list the number of hours each worked during that quarter. If you are a dentist, evidence might be a copy of your license.

If you are in a Medicare demonstration project, evidence might be a copy of your notification of acceptance into that demonstration. If you are a mass immunizer, evidence might be a schedule of immunization locations that indicates the types of immunizations furnished. If you experienced an extended disruption in communication or electrical services, evidence might consist of a copy of a newspaper clipping addressing the outage. If the paper claims were submitted because this office notified you of a system problem preventing submission of these claims electronically, please note that in your response.

If your continuing submission of paper claims is the result of medical restrictions that prevent your staff from submitting electronic claims, evidence would consist of documentation from providers other than yourself to substantiate the medical conditions. If you obtained an unusual circumstance waiver, evidence would be a copy of your notification to that effect from this office or the Centers for Medicare & Medicaid Services

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In some of these situations, permission to submit paper claims applies only to a specific claim type, e.g., mass immunization claims, all claims during a power or communication outage, the type of claim(s) affected by a system problem. Providers that received waivers for a specific claim type or for a specific period are still required to submit other claims electronically unless they meet another criteria, i.e., the small provider criteria, all staff have a disabling condition that prevents any electronic filing, are dentists, or otherwise qualify for a waiver under a situation that applies to all of their claims.

If you cannot provide acceptable evidence to substantiate that you are eligible under the law to continue to submit paper claims to Medicare, we will begin to reject all paper claims you submit to us effective with the 91st calendar day after the date of this notice. This decision cannot be appealed.

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. (Contractor must insert information on their free billing software, the amount of any handling charge for issuance, how to obtain further information; and the EDI Agreement which will need to be completed.) There are also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs. Please visit www.cms.hhs.gov/providers/edi/hipaavendors.asp to see a list of HIPAA vendor services in your state.

Exhibit D—Notice that paper claims will be rejected effective with the 91st calendar day after the original letter as result of non-response to that letter.

Date:

From:	*Contractor (may be preprinted on a contractor's masthead)*
To:	*Organizational Name of Provider*
Subject:	*Review of Paper Claims Submission Practices*

Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Entities determined to be in violation of the statute or this rule may be subject to claim rejections, overpayment recoveries, and applicable interest on overpayments.

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting justification to establish that you qualify for submission of paper claims to Medicare. Nor do we have information available to us that would substantiate that you meet any of the limited exceptions that would permit you to legally submit paper claims to Medicare.

Consequently, as noted in the initial letter as well as in information issued providers when this requirement was put into effect, any Medicare paper claims you submit more than 90 calendar days from the date of the initial letter requesting evidence to substantiate your right to submit paper claims will be rejected and not paid by Medicare. You may not appeal this decision.

If you did not respond because you realized that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. (Contractor must insert information on their free billing software, the amount of any handling charge for issuance, how to obtain further information; and the EDI Agreement which will need to be completed.) There are also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs. Please visit www.cms.hhs.gov/providers/edi/hipaavendors.asp to see a list of HIPAA vendor services in your state.

Exhibit E—Notice that paper claims will be rejected effective with the 91st calendar day after the original letter as result of determination that the provider is not eligible to submit paper claims.

Date:

From:	*Contractor (may be preprinted on a contractor's masthead)*
To:	*Organizational Name of Provider*
Subject:	*Review of Paper Claims Submission Practices*

Section 3 of the Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Entities determined to be in violation of the statute or this rule may be subject to claim rejections, overpayment recoveries, and applicable interest on overpayments.

We have reviewed your response to our initial letter requesting you to submit evidence to substantiate that you qualify for submission of paper claims under one of the exception criteria listed in that letter. Upon review, we have determined that you do not meet the paper claims waiver/exception criteria because (contractor must insert the reason). This determination is not subject to appeal.

Consequently, any Medicare paper claims you submit on or after the 91st calendar day from the date of the initial letter requesting that evidence will be rejected and not paid by Medicare.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. (Contractor must insert information on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Agreement which will need to be completed.) There are also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs. Please visit www.cms.hhs.gov/providers/edi/hipaavendors.asp to see a list of HIPAA vendor services in your state.

Exhibit F—Notice that determination reached that the provider is eligible to submit paper claims.

Date:

From:	*Contractor (may be preprinted on a contractor's masthead)*
To:	*Organizational Name of Provider*
Subject:	*Review of Paper Claims Submission Practices*

Thank you for your response to our previous letter regarding the prohibition against the submission of paper claims to Medicare. Based on that information, we agree that you meet one or more exception criteria to the requirements in section 3 of the Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, that require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions.

If your situation changes to the point where you no longer meet criteria, you will be required to begin submission of your claims electronically within 90 calendar days from that change in your status.

Although you are not required to submit claims electronically at the present time, you are encouraged to do so. Please contact us at (insert EDI contact information) if you would like to discuss use of the Medicare free billing software or other alternatives for submission of claims electronically.