CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 541

Department of Health & Human Services

Center for Medicare & Medicaid Services

Date: APRIL 29, 2005

Change Request 3815

SUBJECT: Correction to the use of Group Codes for The Enforcement of Mandatory Electronic Submission of Medicare Claims

I. SUMMARY OF CHANGES: This transmittal contains a correction to the requirements for the use of Group Code PR (Patient Responsibility) for the enforcement of mandatory electronic submission of Medicare claims based on the Administrative Simplification Compliance Act (ASCA) of 2001.

NEW/REVISED MATERIAL :
EFFECTIVE DATE : July 01, 2005
IMPLEMENTATION DATE : July 5, 2005

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
R	24/90.5/Enforcement

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 541	Date: April 29, 2005	Change Request 3815

SUBJECT: Use of the CO Group Code to Report the Amount of a Claim Denied as Not Submitted Electronically as required by the Administrative Simplification Compliance Act (ASCA)

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 that a provider sends to Medicare will not be paid.

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

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3815.1	Contractors shall use group code CO with reason code 96 and remark code M117 on claims denied as non-electronic.	X	X	X	X					
3815.2	Contractors shall **NOT** use group code PR with reason code 96 and remark code M117 on claims denied as non-electronic.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	A 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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. 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.	X	X	X	X					

IV. 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

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: July 1, 2005 **Implementation Date:** July 5, 2005 **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	**No additional funding will be provided by CMS. This contractor activity is to be carried out within their FY 2005 operating budgets.**

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90.5 - Enforcement

(Rev. 541, Issued: 04-29-05; Effective: 07-01-05; Implementation: 07-03-05)

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, 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. The data in the reports must be arrayed in descending order with those providers receiving the highest number of paper claims at the beginning of the report. 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.

Medicare carriers, DMERCs, and intermediaries will be issued separate funding under budget activity 17004 in FY 2005 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 their staff will be expected to conduct when the annual funding is issued for these reviews.

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, review by the provider, 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;*
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 must be able to submit these reports to CMS if requested. Contractors shall not review the same provider again for at least two years if the provider justified submission of paper claims to Medicare.

NOTE: Some ASCA exceptions apply to individual claim types only, or to submission of paper claims for temporary periods. CMS does not expect that the number of paper claims submitted under those limited range exceptions should be high enough to trigger review of providers allowed to submit claims of that type on paper for an entire quarter or part of a quarter, as long as the balance of the claims submitted by those providers for the quarter are electronic. If a contractor is able to determine that a provider would not have met the criteria for selection for an ASCA review if the number of claims permitted to be submitted on paper under a specific exception in subsections 90.2 or 90.3 were subtracted from the total number of paper claims submitted by the provider for the quarter, the contractor can curtail the review of that provider. In this case, identifying information on the provider, the reason the provider's review was curtailed, and the date of that decision must be recorded in the Excel Enforcement Review Spreadsheet. Contractors must check the Excel Enforcement Review Spreadsheet when determining whether any provider tentatively selected for review after the first review quarter has a prior review history which could result in exclusion of that provider from re-review at that time. If there was a prior review that was curtailed, a contractor must determine if the same exception still applies to the provider (in which case, the provider should not be reviewed), or if that exception should have expired before the quarter for which now selected for review (in which case, the provider must be reviewed).

The group code CO (provider financial liability) is to be used with reason code 96 (non-covered charges) and remark code M117 (Not covered unless submitted by electronic claim) for the entire billed amount in the remittance advice sent to the provider for these claims. 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. Although it is preferable that a beneficiary transfers to an alternate provider when a provider refuses to bill Medicare electronically and does not qualify for an exception for paper billing, this may not be a reasonable option for some beneficiaries. The "Medicare & You" Handbook (section 7, 2005) directs beneficiaries to contact their provider and request the claim be resubmitted electronically if they receive this denial message in an MSN. If

the provider refuses, the beneficiary is then directed to contact 1-800-Medicare for further possible action or guidance.