Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims

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(Rev. 1601, 09-19-08)
(Rev. 1614, 10-03-08)

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10 - Electronic Data Interchange (EDI) General Outreach Activities

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and Fiscal Intermediaries (FIs) are to actively encourage providers to increase their use of EDI transactions. Also see § 60 of this Chapter. Specific outreach requirements are included in the CMS requirements for implementation of new or (Revised EDI standards. Carriers, DMERCs and FIs are also required to notify providers about the need to file most claims with Medicare electronically (see §90). In general, carriers, DMERCs, and FIs must:

- Feature information on EDI during trade shows, vendor fairs, educational forums, and vendor association meetings that they sponsor or in which they participate;

- Provide educational information on EDI to providers identified in internal analysis described in §10.1 as well as to the software vendors and clearinghouses that serve or market services to Medicare providers;

- Make themselves available whenever possible, and invited to participate as an EDI speaker on the agenda of organized provider group meetings, such as state or local chapters of AAHAM, HFMA, MGMA, EDI user groups, state and local medical societies, and other provider and related vendor trade groups. DMERCs shall participate in regional meetings that entail supplier use of EDI; and

- Include specific and meaningful EDI messages in provider newsletters, addressing the themes described in §10.3 below, other issues that may be pertinent to the carrier, DMERC, or FI's geographic area, and as directed in individual EDI instructions issued by CMS. Carriers, DMERCs, and FIs are expected to point out the advantages to providers in the use of EDI transactions.

See the Medicare Beneficiary and Providers Communication Manual (100-09) for definitive guidance on Medicare's provider outreach requirements. Provider outreach activities, including those that involve EDI are funded through the Provider Education and Training budget issued to Medicare contractors. This EDI-specific information is included in this chapter as a reminder to the Medicare contractors.

10.1 – Carrier, DMERC, and FI Analysis of Internal Information

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

10.1.1 - Systems Information

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Shared system maintainers must prepare quarterly reports for the carriers, DMERCs, and FIs that list each provider's name, provider number, address, number of paper claims received under each provider number, the percentage of all claims submitted on paper by each provider, and the period for which data is being reported. The first report is due for the period July through September, 2005, and must be issued to the users of each shared system in October, 2005. The reports must be arrayed by provider in decreasing volume order (from highest to lowest) of paper claims. (See § 90.5 of this chapter for use of these reports for Administrative Simplification Compliance Act [ASCA] enforcement).

Carriers, DMERCs, and FIs may share this information with vendors who market EDI services to providers, and may charge vendors for costs they incur to distribute this information. No personally identifiable beneficiary data or sensitive provider data, such as social security numbers, taxpayer identifications numbers, or annual income from Medicare payments, may be included in the records shared with these vendors. As permitted by their provider outreach budget, and as required and budgeted under §90 of this chapter for ASCA enforcement (Reviews, carriers, DMERCs, and FIs must contact providers with the highest number of paper claim transactions to have them begin submission of claims electronically. Carriers, DMERCs, and FIs are also to strongly encourage providers to conduct their claims status, beneficiary eligibility, payment and remittance advice transactions electronically.

Efforts to increase use of EDI must be documented to p(Revent duplicate contacts, to provide a basis for future discussions with those providers, and to substantiate those instances where the provider refuses to submit claims or other transactions electronically. Systems information may also identify specific markets, e.g., specialties, to target for EDI campaigns.

Recognizing that this process, from initial contact to implementation, may span a varying duration of time, staff must be able to judge, from the provider's cues, when to intensify activities and when to withdraw for a period of time. Carriers, DMERCs and FIs are expected to use professional sales techniques:

- Know their EDI products;
- Know their customer's business;
- Question and listen to determine customer needs and interest;
- Use demonstrations;
- Create interest and overcome objections;
- Prove the benefits of EDI; and
- Successfully resolve issues if appropriate to enable use.

Also, carriers, DMERCs, and FIs must identify providers that have previously committed to use EDI but have not begun transition within an appropriate period, e.g., 30 days after successful EMC testing is completed, for follow-up to determine the reason for delay.

10.2 - Contact With New Providers

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must conduct an analysis of the capability of each provider (including physicians and suppliers) that contact a Medicare contractor to begin submission of Medicare claims, or for DMERCs, when notified by the National Supplier

Clearinghouse that new supplier identification numbers have been issued. EDI transactions are to be presented as the normal mode of business for Medicare claims, claim status, remittance, and EFT as the normal mode for funds transfer. See Chapter 31 for information on eligibility verification queries. Where the provider does not have the related capability, carriers, DMERCs, and FIs are to inform the providers of available options to begin use of EDI, e.g., list of vendors and clearinghouses and billing services, availability of Medicare's free software.

Carriers, DMERCs, and FIs should make EDI materials available to newly enrolled providers, and carriers and FIs (not DMERCs) are encouraged to work with local medical schools where possible to introduce EDI to medical students by:

- Conducting EDI seminars for medical students;
- Demonstrating Medicare's free software;
- Extending invitations to vendor trade fairs; and
- Distributing EDI literature.

10.3 - Production and Distribution of Information to Increase Use of EDI

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to post information on their provider web page to educate and influence providers in all aspects of EDI. They must include the following information at a minimum:

- Earlier payment of electronic claims that comply with Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification standards requirements;
- The benefit of earlier detection of errors via edits conducted upon submission of electronic transactions;
- The relative ease of use of EDI and the support available from the contractor to assist them in beginning use of EDI transactions;
- Advantages of online correction of errors (FIs only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (FIs only);
- Availability of free software; and
- Availability of batch claims status inquiries.

- The information must be updated on a regular basis. Carriers, DMERCs, and FIs are encouraged to issue these materials via the Internet or E-Mail when possible, but paper copies may be distributed where most cost effective or when a provider may not have Internet or E-Mail access.

10.4 - Production and Distribution of Material to Market EDI

(Rev. 1, 10-01-03)

B3-3023.7, AB-01-19

Carriers and FIs are required to produce and distribute material to educate and influence providers in all aspects of EDI.

They must include the following themes in published material:

- Earlier payment of claims because of different payment floor requirements;
- The benefit of earlier detection of errors via edits;
- The relative ease of EDI and support available;
- Advantages of online correction of errors (FIs only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (FIs only);
- Availability of free software;
- Claims status inquiry; and
- Eligibility query.

They must include in written materials testimonials and/or case studies from providers and facilities that have benefited from using EDI transactions.

These materials may be produced in-house or by local printing companies. The contents must be maintained up to date. Therefore, carriers and FIs must carefully plan print quantities to match planned distribution to avoid unnecessary waste.

They must make the material available to staff that have contact with the provider community and make arrangements for distribution at trade shows and seminars that the carrier or FI does not attend as well as those that they do attend.

20 - EDI Enrollment

(Rev. 1283, Issued: 07-06-07; Effective/Implementation Dates: 10-01-07)

Carriers, MACs, and FIs are required to furnish new providers that request Medicare claim privileges information on EDI. DME MACs are to furnish such information to new providers when contacted by providers, or by the National Supplier Clearinghouse to identify new suppliers that have been issued new identifiers. Carriers, A/B MACs and FIs are required to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in §50), and enroll and assign submitter EDI identification numbers to those approved to use EDI.

When providers contact a contractor to submit/receive transactions electronically using a billing agent or a clearinghouse/network services vendor, carriers, MACs or FIs must notify those providers that they are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare, but are to be retained by the providers.) The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor; to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim; and that no other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from those Medicare contractors to whom they will send or from whom they will receive EDI transactions.

A provider must obtain an NPI and furnish that NPI to their Medicare contractor prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. The Medicare contractor is not required to verify that NPI in the NPI Crosswalk or another location with the understanding that if the provider attempts to use an incorrect NPI, the provider's claims will reject. It would be counterproductive for a provider to furnish an incorrect NPI at the time of EDI enrollment. A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password.

20.1 - EDI Enrollment Form

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)
A3-3601.4, B3-3021.4

20.1.1 - New Enrollments and Maintenance of Existing Enrollments

(Rev. 1283, Issued: 07-06-07; Effective/Implementation Dates: 10-01-07)

The Medicare EDI Enrollment process provides for collection of the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners and also establishes the expectations for both parties in the exchange. This agreement must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form and submit it to the carrier, MAC, or FI with which EDI transactions will be exchanged before the carrier, MAC, or FI will accept production claims or other incoming EDI transactions from that provider, or a third party for that provider, or send outbound EDI transactions. Carriers, MACs, and FIs may accept a signed EDI Enrollment Form from providers via fax or hard copy. The EDI Enrollment Form is effective as specified in the terms of the agreement.

NOTES:

1. Although a type of electronic transaction, electronic funds transfers (EFTs) between a carrier, MAC, or FI and a bank are not considered EDI for EDI Enrollment Form purposes. A provider that uses EFT but no EDI transactions should not complete an EDI Enrollment Form.

2. Medicaid state agencies are not required to complete an EDI Enrollment Form as a condition for receipt of COB claims.

3. Due to the unique beneficiary Zip Code rule that applies to processing of supplier claims, a supplier is sometimes required to submit claims to DME MACs that do not have a copy of their EDI Enrollment Form. Suppliers are also more likely to become confused and submit a beneficiary claim to their local MAC even though the claim falls under the jurisdiction of a different DME MAC. Unlike carriers or FIs, DME MACs are not permitted to reject claims when received from out of area suppliers, but must transfer those misdirected claims to the proper DME MAC.

Providers who have a signed EDI Enrollment Form on file with a particular carrier, MAC or FI are not required to submit a new signed EDI Enrollment Form to the same carrier, MAC, or FI each time they change their method of electronic billing or begin to use another type of EDI transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. However, contractors must inform providers that providers are obligated to notify their contractor(s) by fax or hardcopy in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of EDI. Providers are not required to notify their Medicare contractor if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance. When a contractor receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third party, the contractor must verify that an EDI Enrollment Form is already on file for that provider or supplier, and that the third party has already been issued an EDI number and password to permit submission/receipt of EDI transactions. The request cannot be processed until both are submitted/issued.

The binding information in an EDI Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that carrier, MAC or FI is no longer associated with the Medicare program. Medicare responsibility for EDI oversight and administration is simply transferred in that case to that entity that CMS chooses to replace that carrier, MAC or FI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

An organization comprised of multiple components that have been assigned more than one Medicare provider number, supplier number, or NPI may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which such numbers have been assigned. The organization is responsible for the performance of its components.

The note at the end of the enrollment agreement language indicates that either party can terminate that agreement by providing 30 days advance notice. There is an exception to that requirement. In the event a Medicare carrier, MAC or FI detects abuse of use of an EDI system ID or password, or discovers potential fraud or abuse involving claims submitted electronically, electronic requests for beneficiary eligibility data, or other EDI transactions, that Medicare contractor is to immediately terminate system access for submission or receipt of EDI transactions by that individual or entity. A decision by a Medicare contractor to terminate or suspend EDI access in such a situation is not subject to appeal by the individual or entity that loses EDI access.

Electronic Data Interchange (EDI) Enrollment Information Required for Inclusion at a Minimum in Each Carrier, MAC **and FI EDI Enrollment Form**

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, MACs**, or FIs:**

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor by itself, its employees, or its agents;

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its carriers, MAC s, FIs, or another contractor if so designated by CMS without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law;

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required

beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

   - Beneficiary’s name;
   - Beneficiary’s health insurance claim number;
   - Date(s) of service;
   - Diagnosis/nature of illness; and
   - Procedure/service performed.

5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, MAC FI, or other contractor if designated by CMS has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider’s submissions, including the beneficiary’s authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines;

6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer;

7. That it will submit claims that are accurate, complete, and truthful;

8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid;

9. That it will affix the CMS-assigned unique identifier number (submitter identifier) of the provider on each claim electronically transmitted to the carrier, MAC, FI, or other contractor if designated by CMS;

10. That the CMS-assigned unique identifier number (submitter identifier) or NPI constitutes the provider’s legal electronic signature and constitutes an assurance by the provider that services were performed as billed;

11. That it will use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access;

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law;

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its carrier, MAC, FI, or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, MAC, or FI (in accordance with §1106(a) of Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier, MAC, FI, or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgment of claim receipt;

2. Affix the FI/carrier/ MAC or other contractor if designated by CMS number, as its electronic signature, on each remittance advice sent to the provider;

3. Ensure that payments to providers are timely in accordance with CMS' policies;

4. Ensure that no carrier, MAC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, MAC, or FI or from any subsidiary of the carrier, MAC, FI, other contractor if designated by CMS, or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI, or other contractor if designated by CMS will make alternative means available to any electronic biller to obtain such services;

5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare carriers, MACs, FIs, or other contractors if designated by CMS to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the carrier, MAC, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTE: Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document.

This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the carrier, MAC, FI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name

Title

Address

City/State/Zip
By ______________________________ ______________________________
(signature) (printed name)

Title

Date

20.2 - Submitter Number

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, FIs, or other contractors if designated by CMS will assign an EDI submitter/receiver number and a periodically renewable password to each entity (provider, clearinghouse, billing agent) submitting or receiving electronic transactions. Provision must be made to return claim remittance files either to the provider or to a designated receiver (which may be the submitter or another entity). If electronic remittance advice transactions will be issued, the profile must indicate where the carrier, DMERC, FI, or other contractor if designated by CMS is to send the remittance advice transactions.

20.3 - Release of Medicare Eligibility Data

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

The CMS is required by law to protect all Medicare beneficiary-specific information from unauthorized use or disclosure. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and HIPAA. CMS instructions allow release of eligibility data to providers or their authorized billing agents for the purpose of preparing an accurate claim. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed.

Clearinghouses or other third parties that obtain beneficiary eligibility data on behalf of providers that serve those beneficiaries are sometimes referred to as Network Service Vendors (NSVs). See section 80.3 for further information regarding NSVs. carriers, DMERCs, FIs, or other contractors if designated by CMS must give access to any network service vendor that requests access to eligibility data on behalf of providers as long as they adhere to the following rules:

- Each network service vendor/clearinghouse must sign a Network Service Vendor (NSV) Agreement (below);

- Each provider that contracts with an NSV must sign a valid EDI Enrollment Form before eligibility data can be sent to the third party;

- The provider must explain the type of EDI services to be furnished by its clearinghouse/network service vendor in a signed statement authorizing the vendor's access to eligibility data;

- The clearinghouse/NSV must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a clearinghouse/NSV, that vendor must be able to identify the correct provider making the request for each beneficiary's information and be able to assure that eligibility responses are routed only to the provider that originated each request; and

- There is no record of prior violation of a clearinghouse/NSV agreement by this clearinghouse/NSV with the Medicare contractor to whom a request for access to the eligibility data is submitted that would indicate that beneficiary data could be at risk of improper disclosure if access was approved for this clearinghouse/NSV.

A. All providers and clearinghouses/NSVs that wish to obtain Medicare beneficiary eligibility data must apply to a FI/carrier/DMERC, or other contractor if designated by CMS for access to the eligibility records.

B. Providers and clearinghouses must submit each eligibility query to the carrier, DMERC or FI to which each provider is required to submit its claims for that beneficiary. They are not currently permitted to access Medicare beneficiary eligibility information for the entire U.S. via a single carrier, DMERC, FI, the Combined Working File (CWF), or another Medicare contractor or system pending availability of the X12N 270/271 version 4010A1. (See Chapter 31.)

C. When an inquiry enters into the carrier, DMERC, FI, or other contractor if designated by CMS system, the FI, carrier, DMERC, or other contractor if designated by CMS must be able to ensure that:

- An EDI agreement has been signed by the provider;
- A clearinghouse/NSV agreement has been signed by the vendor; and
- Each inquiry identifies the provider that initiated the query and to which the response will be routed.

D. Pending completion of Medicare implementation of the X12N 270/271 version 4010A1 implementation Guide (IG), FIs must include the CMS-specified eligibility institutional data set in a proprietary format to electronically issue eligibility data. Carriers must issue eligibility data in the X12N 270/271 Health Care Eligibility/Benefit Inquiry and Response version 3051 IG Format. DMERCs must continue to use a proprietary format to respond to electronic eligibility data queries.

E. Providers must be notified that: they may obtain eligibility data only for the approved use of preparing accurate Medicare claims; Access to eligibility data is limited to individuals within a provider's organization who are involved in claim preparation and submission; and that providers and their authorized third party agents must agree not to request eligibility data for a beneficiary unless the provider has been contacted by the beneficiary, a personal representative of a beneficiary such as a relative or friend, or a health care provider currently treating the beneficiary concerning provision of health care services or supplies to the beneficiary.

Carriers, DMERCs, FIs, or other contractors if designated by CMS must notify all providers that request electronic receipt of eligibility data of these requirements. Carriers, DMERCs, FIs, or other contractors if designated by CMS must remind providers that they must let them know when they change from one clearinghouse/NSV to another, cease arrangements with a clearinghouse/NSV, or leave the Medicare program. Carriers, DMERCs, FIs, or other contractors if designated by CMS must delete each provider from their EDI eligibility security file if the carrier, DMERC, FI, or other contractor will no longer be responsible for processing of the provider's claims or if the provider or the carrier/DMERC/FI/other contractor is no longer serving the Medicare program. Carriers, DMERCs, FIs, and other contractors if designated by CMS must remind providers, clearinghouses/NSVs and other third parties that they can lose access rights to beneficiary eligibility data if they fail to adhere to the requirements for access.

20.4 - Network Service Vendor (NSV) Agreement

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Third party agents that represent providers, including NSVs, certain value-added networks, clearinghouses, and billing agents that will obtain Medicare beneficiary eligibility data, must sign an agreement that includes the following wording:

The third party provider agent agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974, which requires Federal information systems to establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims, remittance advice, online claims correction, and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically;

2. It is has no ownership rights and is not a user of the data, but merely a means of transmitting data between users that have a need for the data and are already identified as legitimate users under a “routine use” of the system; that is, disclosure for purposes that are compatible with the purpose for which Medicare collects the information;

3. The beneficiary eligibility data submitted to them by the carrier, DMERC, FI, or other contractor if designated by CMS are owned by Medicare;

4. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than (a) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider’s patient, (b) CMS, or (c) CMS’ carriers, DMERCs, FIs, or other contractors as designated by CMS;

5. It will promptly notify the carrier, DMERC, FI, or other contractor if designated by CMS of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure;

6. The data will not be stored for any duration longer than that required to assure that they have reached their destination, and no more than 30 days for any purpose;

7. It has identified to the carrier, DMERC, FI, or other contractor if designated by CMS in writing of any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks;

8. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. Reports may be written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date;

9. It will guarantee that an authorized user may be deleted within 24 hours in the event that person leaves their employment, no longer has a need to access this information, or there is a possible security breach. It will specify in writing other standards of performance, including, but not limited to, how quickly a user may be added to the network;

10. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing, signed by the provider, submitted to the provider's carrier, DMERC, intermediary, or other contractor if designated by CMS, and each provider has a valid EDI enrollment form on file with that CMS contractor;

11. It has safeguards in place to assure each eligibility response is sent only to the provider that initiated the inquiry;

12. It will furnish, upon request, documentation that assures the above privacy and security concerns are being met;

13. It will adhere to the regulations on security and privacy standards for health information under the Health Insurance Portability and Accountability Act of 1996;

14. It will require its subcontractors, agents, and business associates to comply with all applicable current requirements of this agreement as well as any future requirements or changes to this agreement; and

15. It will comply with CMS Internet policy. (CMS does permit the transmission of protected health data between providers and other parties who are not Medicare contractors over the Internet if it is authenticated and encrypted. The CMS policy requires written notification of intent from organizations anticipating use of the Internet. The CMS reserves the right to require the submission of documentation to demonstrate compliance with requirements, or to conduct on-site audits to ascertain compliance.)

NOTE: Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document. This document shall become effective when signed by the third party agent. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with a carrier, DMERC, FI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days notice of its intent to terminate.

SIGNATURE: I am authorized to sign this document on behalf of the indicated party, and I have read and agree to the forgoing provisions and acknowledge same by signing below.

Sole Proprietor or Company Name:

Address:

City/State/ZIP code:

Signed By: ____________________________ ____________________________

(signature) (printed name)

Title:

Date:

Carrier, DMERC, FI/other contractor if designated by CMS to whom this is being submitted:

20.5 - EDI User Guidelines

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

FIs, carriers, and DMERCs must make EDI information available to new users that describe the various steps in the testing process (see §30 and §60) and discloses:

- The names and telephone numbers of appropriate staff to contact when:
  - Getting started with EDI;
  - Needing on-going support for electronic transactions; and
  - Needing support for general billing issues;
- Testing requirements and the submitter's and carrier, DMERC, or FI's level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
  - American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) X12N transactions adopted under HIPAA; and
  - National Council for Prescription Drug Programs Format (NCPDP) adopted under HIPAA.
- The availability of free Medicare electronic claim submission software upon request;
- Instructions for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp
- Login requirements;
- Telecommunications options and requirements; and
- Frequently asked questions and answers about EDI.

20.6 - Directory of Billing Software Vendors and Clearinghouses

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must maintain a directory of electronic billing software vendors and clearinghouses that have successfully completed software and/or submission testing for the X12 837 version 4010A1 and NCPDP (applies to DMERCs only) Telecommunication standard 5.1 and Batch standard 1.1 claim transactions adopted as national claim standards for HIPAA. Carriers, DMERCs, and FIs must make this directory available to their providers via a Web page or electronic bulletin board. Carriers, DMERCs, and FIs must update the directory whenever software from additional software vendors and additional clearinghouses is moved into production. At a minimum, the directory must include the vendor/clearinghouse name, phone number, address, software product name, and production version. Carriers, DMERCs, and FIs should also note any additional transactions for which the tested software can be used for submission or receipt of HIPAA transactions other than the claim.

20.7 – EDI Enrollment and EDI Claim Record Retention

(Rev. 1213, Issued: 03-30-07; Effective: 07-01-07; Implementation: 07-02-07)

In order for an entity to become an EDI trading partner, an EDI enrollment form must be completed, approved, and on file with a Medicare contractor. Contractors are required to retain all EDI enrollment forms according to the same CMS Records Schedule retention requirements that apply to the CMS-855 Medicare Enrollment Application. The CMS Records Retention Schedule for Provider Records can be found at the following URL: http://www.cms.hhs.gov/manuals/downloads/pim83c10.pdf in Section 17.3

Once a trading partner has been tested and approved for electronic submission of claims, they can begin submitting electronic claims to Medicare. Contractors are required to retain electronically filed claims under the same CMS Records Retention Schedule retention requirements that apply to hardcopy claim. The CMS Records Retention Schedule for Medicare Records can be found at the following URL: http://www.cms.hhs.gov/manuals/downloads/ge101c07.pdf in Section 30.30.

30 - Technical Requirements - Data, Media, and Telecommunications

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs may not differentiate between a subsidiary of a parent organization and direct EDI transaction submitters when providing EDI support, but must provide the same level of support and quality of service to both.

30.1 - System Availability

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Access to lookup files (e.g., HCPCS codes, fee schedules) may be dependent upon hours the core processing system is available. Where EDI functions are dependent upon the operation of the host processing system, the host system’s hours of operation determine system availability. Carriers, DMERCs, and FIs shall inform users of system availability schedules including any planned downtime for system maintenance.

30.2 - Media

(Rev. 1081, Issued: 10-20-06; Effective/Implementation Dates: 04-02-07)

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of a carrier, DMERC, or FI and the details as negotiated between carrier/DMERC/FI and electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see §30.3).

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

Carriers, DMERCs, and FIs are not permitted to classify the following as electronic claims for CROWD reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;

- Adjustment bills (FIs only);

- Misdirected bills transferred to another carrier, DMERC, or FI;

- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);

- Bills paid by an HMO and processed by the contractor; and

- Transactions submitted on diskettes, CDs, DVDs or similar storage media that should only be accepted as part of a disaster recovery process.

Carriers, DMERCs, DME MACs, A/B MACs, and FIs are no longer permitted to accept claims via fax-imaging, tape/diskette/similar storage media. Carriers, DMERCs, DME MACs, A/B MACs, and FIs are to assist billers using such media to transition to more efficient electronic media, such as the free Medicare claim submission or commercially available software that are considered to be more cost effective.

30.3 - Telecommunications and Transmission Protocols

(Rev. 1283, Issued: 07-06-07; Effective/Implementation Dates: 10-01-07)

Carriers, MACs, and FIs must support transfers for Medicare using 56 K connections for their asynchronous communications lines. For asynchronous communications, carriers, MACs, and FIs must support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP), compliant with Internet Request for Comment (RFC) number 1122 and 1123, using Serial Line Internet Protocol (SLIP) or Point-to-Point Protocol (PPP). For any EDI transfers over TCP/IP connections, carriers, MACs, and FIs must support a File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication through user ID/password mechanisms. The carrier, MAC or FI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. Any user should be able to use TCP/IP for asynchronous communication at any Medicare site. The Internet may not be used for beneficiary sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project. Carriers, MACs and FIs must provide asynchronous telecommunications to any requesting EDI user.

Any carriers or MACs (B portion of A/B MACs) that continue to support a proprietary fixed length format for submission and response to eligibility queries pending termination of the Medicare Eligibility HIPAA Contingency Plan, that were asked prior to October 1, 2007 to permit data compression by a provider, clearinghouse or billing agent for exchange of those proprietary format transactions, is required to continue to offer data compression, either through the use of a v.90 56 K modem, PKZIP version 2.04x or higher, WinZip or V.42 bis data compression until support of that proprietary format(s) is terminated. While these are the most frequently used means of data compression, carriers and MACs may, but are not required to, accommodate other compression software which an eligibility proprietary transaction submitter may have requested in the past. Carriers and MACs that supported compression in the past for exchange of still supported proprietary format(s) for eligibility queries and responses must enable hardware compression support in their v.90 modems (the actual use is negotiated between the carrier and MACs modem and the provider/billing agent's modem at startup). In addition, when hardware compression is used, it is possible for the effective data rate to the host system to be as much as four times the line rate (e.g., 4 times 56 K). Therefore, carriers and MACs to which this may apply must have adequate processing capacity to handle this amount of data for each connection.

NOTE: Contractors need not support file compression for X12N or NCPDP (DME MACs only) transactions. Compression is permitted between the contractor and its data center, if applicable. Since FIs and the A portion of A/B MACs are not permitted to support proprietary formats for eligibility queries, they are not required to offer data compression.

For asynchronous traffic, carriers, MACs and FIs may not limit the number of 837 transactions or the number of providers with transactions included in a single transmission, but they may limit a single transmission to 5,000 claims if that is necessary for efficient operations. Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

For asynchronous communications, carriers, MACs and FIs must accept and send all X12 transactions as a continuous byte stream or as a variable length record. Carriers, MACs and FIs are not permitted to require that provider EDI transaction data be broken down into 80 byte segments and may not require any other deviation from the variable length format or the continuous byte stream format. For example, submitters may not be forced to create each segment as its own record by inserting carriage returns or line feeds. Only standard X12 envelopes may be used with X12 transactions. Only standard National Council for Prescription Drug Programs (NCPDP) envelopes may be used with NCPDP transactions (applies to DME MACs only).

The X12 and NCPDP transactions are variable-length records designed for wire transmission. Medicare contractors must be able to accept them over a wire connection. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

Unless approved for participation in a limited demonstration program, carriers, MACs and FIs are not permitted to accept EDI transactions via the Internet at this time.

30.4 - Toll-Free Service

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Toll free lines are not available for submission or receipt of EDI transactions. Providers and their agents are responsible for costs they incur, including telephone line costs for delivery of EDI transactions to carriers, DMERCs, and FIs or to pick up outgoing Medicare EDI transactions that have been deposited to an electronic mailbox for downloading.

30.5 - Initial Editing

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to edit submitted transactions at the front end to determine whether they are sufficiently complete to enable processing. Transactions that are not legible, or do not include adequate data to be considered an acceptable EDI transaction, must be rejected or returned as unprocessable. “Rejected” or “returned” transactions are not classified as “received” by Medicare. Carrier, DMERCs, and FIs are not required to assign a control number or a receipt date to those transactions. Nor are they required to retain any record of those transactions pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

30.6 - Translators

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

The FIs, carriers, and DMERCs must accept HIPAA compliant transactions into their front-end system and translate that data into the appropriate flat file format for the transaction type to enable processing by their shared system. HIPAA compliant transactions may include Medicare data (data sent to the core shared system) and non-Medicare data (data not sent to the core shared system). Translators are required to validate the syntax compliance of each inbound transaction against the ANSI accredited organization standards upon which the implementation guides adopted by HIPAA are based. Syntax edits must be limited to those syntax requirements specified in those ANSI accredited standard implementation guides (IGs).

The FIs, carriers, and DMERCs must use the X12 997 Functional Acknowledgment to report X12 transaction standard level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgements for claims without errors. FIs, carriers, and DMERCs may purge X12 997 transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to retain these as long as 30 days if system capacity permits. Once purged, a contractor is not required to be able to recreate that 997. A provider or clearinghouse that failed to download the 997 timely may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new 997 issued. Requirements for the X12 997 are located in Appendix B at the rear of each X12 IG adopted under HIPAA. Carriers, DMERCs, and FIs are required to meet those Appendix B requirements when issuing 997s.

When receiving claims in the HIPAA adopted NCPDP formats, DMERCs must produce a response file in the NCPDP format containing one Transaction Header and one Transaction Trailer with the appropriate syntax error noted in the message field.

The FIs, carriers, and DMERCs must accept the basic character set on an inbound X12N transaction adopted under HIPAA, plus lower case and the "@" sign which are part of the extended character set. Refer to Appendix A, page A2, of each IG for a description of the basic character set. All other character sets may be rejected at the translation level. If FIs and/or carriers/DMERCs cannot accept more than 9,999 loops or segments per loop in an X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the X12 997 AK3 segment with a value of "4" in data element "04." Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. FIs, carriers, and DMERCs are not required to accept multiple functional groups (GS/GE) within one transmission for X12 transactions.

Translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map "Not Used" data elements for carriers/DMERCs based upon that segment's definition only, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped; "Not Used" data elements are not to be mapped to the FI flat file;
- Remove the hyphen from all range of dates with a qualifier of "RD8" when mapping to the flat file;
- Accept multiple interchange envelopes within a single transmission; and
- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case requirements noted for incoming translation. FIs and carriers are not required to accept or process X12 997 transactions from trading partners for any outgoing X12 transactions.
- See§ 70 for additional FI, carrier, and DMERC translator edit requirements that may be specific to individual standards.

30.7 – Claim Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Mapping to X12N Based Flat File

(Rev. 162, 4-30-04)

CMS will cease support of the NSF once the Health Insurance Portability and Accountability Act (HIPAA) contingency plan ends. Therefore, migration to the either the X12N-based flat file or the HIPAA 837 as the output format for key shop and OCR/ICR claims will need to occur.

Carrier and DMERC key shop operations, that do not use either the HIPAA 837 or X12N-based flat file as output, must create the output from paper claims in the X12N-based flat file format or the HIPAA 837. When the X12N-based flat file is the output the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (key shop) or "O" (OCR/ICR).

Carriers and DMERCs who support telephone claim submission shall convert the output to the X12N-based flat file. The value in REF02 shall contain a "T" (teleclaim).

The carrier/DMERC shared system shall apply implementation guide edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

40 - Required Electronic Data Exchange Formats

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

40.1 - General HIPAA EDI Requirements

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

The following HIPAA transaction standards shall be supported by the Medicare carriers, Medicare Administrative Contractors (MACs), FIs, and RHHIs for the electronic exchange of data with Medicare providers/submitters/receivers/COB trading partners. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected:

- X12N 837 implementation guide (IG) version 004010A1 for Institutional(I) and Professional (P) claims can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp and coordination of benefits (COB) with other payers can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp;

- NCPDP Telecommunication Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (billed to DME MACs only) and COB (see § 40.1 of this chapter for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp;

- X12N 835 IG version 004010A1 for Remittance Advice (see Chapter 22 for additional information) and can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp; and

- X12N 276/277 IG version 004010A1 for Claim Status Inquiry & Response (see Chapter 31 for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp

Although not mandated by HIPAA, as noted in § 30.6, CMS also requires that carriers, MACs, RHHIs and FIs issue an X12 997 transaction to electronic claim submitters to acknowledge receipt of claims (except where waived by a submitter) and to report syntax errors related to any X12N transactions submitted to Medicare.

The initial HIPAA transactions regulation required that covered entities eliminate use of electronic formats and versions not adopted as national standards under HIPAA by October 16, 2002 (applies only to the transaction types addressed by HIPAA). A subsequent provision in the Administrative Simplification Compliance Act (ASCA) permitted covered entities to apply for a 1-year extension to October 16, 2003, to enable them to complete implementation of the standards mandated by HIPAA. Most covered entities, including Medicare, did request that extension. As a significant number of covered entities had still not completed implementation by October 16, 2003, to avoid disruption in health care payments and services, the Secretary of Health and Human Services (HHS) allowed payers to implement contingency plans effective October 16, 2003 to temporarily continue to support pre-HIPAA transaction standards. The contingency plans were permitted to allow additional implementation time for those providers and clearinghouses making a good faith effort to become compliant with the HIPAA transaction requirements to complete work in progress.

Medicare fee-for-service plans were required to end the contingency plan for inbound and outbound (COB other than Medigap) claims effective October 1, 2005. Use of a non-HIPAA format for Medigap claims ended October 1, 2007 with the transfer of responsibility to the single Medicare COB Contractor (see the Medicare Secondary Payer Manual Pub.100-04, chapter 28, §70.6.4 for further information.) The contingency plan for the X12N 835 (Health Care Claim Payment/Advice) ended on October 1, 2006. In March 2007, it was verified that there were no remaining users of the X12N 276/277 version 004010 and that no proprietary EDI formats were being used any longer for claim status queries; the 276/277 version 4010A1 is the only electronic format, other than DDE, being supported for EDI claim status inquiries and responses. The X12N 276/277 contingency plan in effect expired on its own, without the need for establishment of a target date for termination.

The contingency plan for the 270/271 transaction remains in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate this last remaining Medicare HIPAA transaction standard contingency plan.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing Medicare claim free billing and remittance advice print software updates information to providers via the Internet and alternate methods to be used to furnish information to those providers that lack Internet access. Contractors are permitted to charge providers up to $25 to recoup their costs for manual distribution of free billing, PC Print and MREP software via diskette, CD, or other hard media which providers are normally expected to download via the Internet. Contractors are to notify new users of EDI that they should make arrangements to enable them to download later format and most related coding updates via the Internet.

An overview of any changes to existing specifications, including effective dates will be issued to providers via carriers, MACs, FI, and RHHI bulletins, on contractor Web pages, and will also be available via the Internet as Manual transmittals which can be viewed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp to the separate page for each EDI transaction format supported by Medicare fee-for-service plans.

40.1.1 - Submitting Change Requests for the UB-92

(Rev. 1, 10-01-03)

A3-3602.6

Change requests must be submitted on the electronic UB-92 Change Request Form. The form must be completed properly and any necessary documentation attached. FIs may also submit change requests for non-Medicare commercial operations. Complete the form as follows:

Line 1 - Enter the Region Number (e.g., Regions I-X) and the date of the request.

Line 2 - Enter the name/organization.

Line 3 - Enter the name of a contact person in the organization that can answer questions concerning the request.

Line 4 - Enter the contact person's telephone number.

Line 5 - Enter the record type (record identifier) and field that is requested to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field.

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation.

Indicate whether this change is the result of a CMS mandate.

ELECTRONIC UB-92 CHANGE REQUEST FORM

1. Region: ___________________ Date:_____________________

2. Name/Organization: ____

3. Contact Person: ____

4. Phone #: ____________________

5. Record Type & Field:
_________________________ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:

____

Reason for Change:

____

Impact Statement: (Volume, lines of business involved, field attributes/values, definition, validation, etc.)

____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a CMS Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: ___________________

Final Disposition: [___] Approved for Electronic UB-92 Release Date:

____

[___] Denied

Remarks:

NOTE: **Send this form to the RO EDI Coordinator.**

40.1.2 - Submitting Change Requests for the NSF

(Rev. 1, 10-01-03)
B3-3025

Central office (CO) maintains the National Standard Format (NSF) for electronic media claims (EMC) and for electronic remittance advice (ERA) transactions.

Change requests must be submitted to the RO EDI Coordinator on the NSF Change Request Form. The form must be completed properly and any necessary documentation attached. Carriers may also use this form to submit change requests for non-Medicare commercial carriers.

The form is completed as follows:

Line 1 - Enter the region number (e.g., Regions I-X) and the date of the request;

Line 2 - Enter the name/organization;

Line 3 - Enter the name of a contact person in the organization that can answer questions concerning the request;

Line 4 - Enter the contact person's telephone number;

Line 5 - Enter the record type (record identifier) and field that is requested to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field;

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation. Indicate whether this change is the result of a CMS mandate.

NATIONAL STANDARD FORMAT CHANGE REQUEST FORM

1. Region: ______________________________________

Date: _________________________________

2. Name/Organization: ____

3. Contact Person: ____

4. Phone #: ____

5. Record Type & Field:

________________ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:
____

Reason for Change:
____

Impact Statement: (Volume, lines of business involved, field attributes/values, definition, validation, etc.)

____

____

____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a **CMS** Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: ____

Final Disposition: [___] Approved for NSF Release

Date: __________

[___] Denied

Remarks:

____

____

____

____

NOTE: Send this form to the RO EMC Coordinator. Non-Medicare commercial carriers may send this form to a Medicare carrier or CMS CO.

40.1.3 - FI HIPAA Claim Level Edits
(Rev. 49, 12-19-03)

The FIs must reject 837 claims with implementation guide (IG) errors at the claim level. FIs must install the APASS IG edit module in order to reject claims that have implementation guide (IG) errors at the claim level (see example below). If a batch of claims passes the basic syntax edits, the APASS IG edit module will be invoked and only claims that fail the IG edits will be rejected and appropriate reports generated.

```
ISA     (example 1)
 GS            (example 2)
  ST           (example 3)
   PROV A
      SUBSCRIBER A     (example 5)
     CLAIM A1      (example 6)
     CLAIM A2
     CLAIM A3
      SUBSCRIBER AA
       CLAIM AA1
       CLAIM AA2
   PROV B   (example 4)
      SUBSCRIBER B
     CLAIM B1
     CLAIM B2      (example 6)
     CLAIM B3
  SE
  ST
   PROV C
      SUBSCRIBER C
     CLAIM C1
     CLAIM C2
     CLAIM C3      (example 6)
   PROV D
      SUBSCRIBER D
     CLAIM D1
```

CLAIM D2

CLAIM D3

SE

GE

IEA

Example 1 (ISA-IEA level IG edit): Any errors found at this level (envelope) will result in all claims within the ISA-IEA being rejected.

Example 2 (GS-GE level IG edit): Any errors found at this level will result in all claims within the GS-GE being rejected. In this example all claims would be rejected. If a second GS-GE loop followed the first and passed all edits, then any claims within the second GS-GE would be entered into the system providing they passed the IG edits.

Example 3 (ST-SE level IG edit): Any errors found at this level will result in all claims within the ST-SE being rejected. In this example assume only the first ST had errors. In this case claims A1, A2, A3, B1, B2, B3 would be rejected. Claims C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits.

Example 4 (Provider level IG edit): Any errors found at this level will result in all claims for this provider being rejected. In this example assume only the Provider B had errors (such as an invalid provider number). In this case, claims A1, A2, A3, C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits and claims B1, B2, B3 would be rejected.

Example 5 (Subscriber level IG edit): Any errors found at this level will result in all claims for this subscriber being rejected. In this example, claims for Subscriber A (A1, A2, and A3) would be rejected. Claims for Subscriber AA (AA1 and AA2) would be entered into the system providing they passed IG edits.

Example 6 (Claim level IG edit): Any errors found at this level will result in only that claim(s) being rejected. In this example assume only claims A1, B2 and C3 had errors. All of the other claims would be entered into the system providing they passed IG edits.

40.2 - Continued Support of Pre-HIPAA EDI Formats

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Medicare carriers, MACs, FIs, and RHHIs will not be involved in Medicare acceptance and processing of the X12N 270/271 IG version 004010A1 transactions for Beneficiary Eligibility Inquiry & Response but information on that transaction is available at www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp. The 270 transaction will be accepted and processed, and a 271 returned by a CMS Enterprise Data Center (EDC) directly. See Chapter 31 of this manual for further information.

Pending termination of the Medicare contingency plan for the HIPAA eligibility standard transaction, carriers, MACs, FIs and RHHIs are required to temporarily continue to support use of the following pre-HIPAA electronic transaction formats until the earlier of the effective date for CMS elimination of the HIPAA eligibility contingency plan, or the date when no further providers, billing agents, or clearinghouses are using a non-HIPAA electronic eligibility format:

- X12N 270/271 IG version 003051 for eligibility query and response (carriers only); and

- Proprietary format for eligibility data responses using the CMS standard eligibility data set.

See Chapter 31of this manual for additional information on eligibility queries. Specifications for the X12 270/271 version 3051 can be found on the Washington Publishing Company Web site at http://www.wpc-edi.com/HIPAA.

40.3 - National Council for Prescription Drug Program (NCPDP) Claim Requirements

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

A. NCPDP Batch Transaction

The NCPDP batch transaction format is intended to provide a file transmission standard for submission in a non-real-time mode of the telecommunications standard transaction for drug claims from retail pharmacies. DME MACs will not accept retail pharmacy drug claims that are not submitted as batch transactions.

NCPDP users are required to transmit National Drug Codes (NDCs) in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy. NDCs replace the drug HCPCS codes for retail pharmacy drug transactions billed to DME MACs via the NCPDP standard. The DME shared system (VMS) will convert NDCs to HCPCS codes for internal claim processing. The CMS will provide the HCPCS codes for these drugs, and an NDC to HCPCS crosswalk for use by VMS and the DME MACs.

B. Generating a Batch NCPDP Response

DME MACs will return the NCPDP batch response for all NCPDP transmissions received. The NCPDP term “transaction” is equivalent to a Medicare service or line item and the NCPDP term “transmission” is equivalent to a Medicare claim. The NCPDP implementation guide allows for up to 4 transactions (line items) per transmission (claim). This means that each claim can have up to 4 line items. Therefore, if one transaction (line item) rejects, the entire transmission (claim) will be returned. Each NCPDP batch can have up to 9,999,999,997 transmissions (claims). All transactions (up to 4) in the transmission will be treated as one claim, and each transmission in a batch will be treated as a separate claim. For a transmission (claim) where one or more claim transactions (lines) have errors, the following will occur:

1. DME MACs will reject all claim transactions (line items) in the transmission (claim) if any one claim (transmission) has detail errors.

2. The response status for all transactions will equal R (rejected).

3. DME MACs will send up to 5 reject codes for claim transactions (line items) that have detail errors.

4. For the claim transactions (line items) that have no errors but are not being processed because of errors in other claim transactions (line items), the response status will equal R and the reject code will equal 84 (claim has not been paid/captured.)

5. Only the claim that rejected will have the reject codes other than 84. The other claims will have an 84 reject code indicating the claims were not paid/captured.

C. NCPDP Implementation Guide (IG) Edits

DME MACs shall allow segments to be submitted in any order including AM07, AM03 and AM11 as permitted by the NCPDP standard.

D. NCPDP Narrative Portion of Prior Authorization Segment

Certain informational modifiers are required to identify compound ingredients in locally prepared medication. The NCPDP format does not currently support reporting modifiers in the compound segment. Therefore, the narrative portion in the prior authorization segment is being used to report these modifiers. The following shall be entered in positions 001-003 of the narrative (Example, MMN or MNF). Starting at position 355, indicate the two-byte ingredient number followed by the two-position modifier:

<u>CMN</u> - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information

<u>CNA</u> - Indicates that the supporting documentation that follows is Medicare required CMN or DIF and narrative information

<u>CFA</u> - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and facility name and address

<u>CSA</u> - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and supplier name and address

<u>CNF</u> - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and facility name and address

CNS - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and supplier name and address

FAC - Indicates that the supporting documentation that follows is Medicare required facility name and address

FAN - Indicates that the supporting documentation that follows is Medicare required facility name and address and narrative information

SAC - Indicates that the supporting documentation that follows is Medicare required supplier name and address

SAN - Indicates that the supporting documentation that follows is Medicare required supplier name and address and narrative information

NAR - Indicates that the supporting documentation that follows is Medicare required narrative information

MMN - Indicates that the supporting documentation that follows is Medicare modifier information and CMN or DIF information

MNA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and narrative information

MFA - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information and facility name and address

MNF - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and facility name and address

MAC - Indicates that the supporting documentation that follows is Medicare modifier information and facility name and address

MAN - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and facility name and address

MFA - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and facility name and address

MNS - Indicates that the supporting documentation that follows is Medicare modifier information, CMN or DIF information, narrative information and supplier name and address

MSC - Indicates that the supporting documentation that follows is Medicare modifier information, and supplier name and address

MSN - Indicates that the supporting documentation that follows is Medicare modifier information, narrative information and supplier name and address

MAR - Indicates that the supporting documentation that follows is Medicare modifier information and narrative information

MOD - Indicates that the supporting documentation that follows is Medicare modifier information

E. Misdirected Claims

A DME MAC is required to forward claims to the appropriate DME MAC for processing when it is determined that the claim submitted is for a beneficiary that resides in a state that is outside the receiving DME MAC's processing area. These claims are referred to as "misdirected claims". When these claims are submitted in the NCPDP format they will be forwarded to the appropriate DME MAC in the NCPDP flat file format. These forwarded claims will not be re-translated. The NCPDP flat file format output will be produced by VMS, and it will be the responsibility of the DME MAC that receives a misdirected claim to move it through the Medicare Data Communication Network (MDCN) to the appropriate DME MAC. Misdirected claims shall be subjected to all levels of editing by the original DME MAC and rejected if found to be non-compliant. Only those claims that are determined to be HIPAA NCPDP format compliant will be forwarded.

40.3.1 - Remittance Advice

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Remittance advice records shall be provided to explain claim adjudication decisions, including for NCPDP format claims. All Medicare contractors shall send the Electronic Remittance Advice (ERA) in the ANSI ASC X12N 835 version 004010A1 format or as a Standard Paper Remittance (SPR) Advice. HIPAA version implementation guides are available from the Washington Publishing Company. Their Web site is: http://www.wpc-edi.com/HIPAA. See Chapter 22 of this manual for further remittance advice information.

40.3.2 - Standard Paper Remittance (SPR) Notices

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

By October 2003, shared systems must use the HIPAA version flat file, rather than any earlier flat file, to generate SPRs to avoid data variations between SPRs and ERAs in fields shared by both formats. The FI Shared System must furnish the FIs/RHHIs at least 90 days advance notice of their SPR changeover date. FIs/RHHIs must in turn furnish their SPR users with advance notice of the effective date of the change and any differences they can expect to see in their SPRs as result of the flat file change over or any other change.

The Medicare core system will continue to record a maximum of 17 characters for patient account numbers. Patient account numbers in excess of 17 characters will be populated from the repository established for coordination of benefits for both SPRs and ERAs. If a provider requests a SPR or ERA after a 20-character patient account number has been purged from the repository, the SPR/ERA will report the first 17-characters only. A similar limitation applies to reporting of provider line item control numbers in ERAs.

All other data elements included in SPRs and ERAs will be populated from the Medicare core system. By October 2003 shared systems must assure that all data elements that appear in both the SPR and the ERA for the same claim contain identical data. Fields shared by both formats for the same claim may not contain different data. As in the past, data not available in an ERA may not be reported in a SPR. SPRs like ERA will also be limited to reporting of one secondary payer, even when payment information for a claim is shared with more than one secondary payer under COB trading partners agreements.

40.3.3 - Remittance Advice Remark Codes

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

Contractors can download the currently approved remark code list from http://www.wpc-edi.com/codes/. These messages may be used in both HIPAA format ERAs and standard paper remittances as soon as programming changes are completed. If carriers, DMERCs, DME MACS, FIs and RHHIs begin to use any of these codes for the first time, they must furnish advance notice to providers, including the code, the text, and under what situations the code will be used. Carriers, DMERCs, DME MACS, FIs and RHHIs must use only currently valid codes available at the WPC Web site mentioned above. CMS issues code update instruction every four months, informing of the changes made in the previous four months. In addition, contractors will be notified of new/modified codes that Medicare initiated in conjunction with a policy change, in the form of a Change Request (CR or manual instruction implementing the policy change.

Any remark code may be reported at either the claim or the line level in the MOA/MIA or the LQ segment respectively.

40.4 - COB Trading Partner and Medigap Plan Crossover Claim Requirements

(Rev. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

A. X12 837 COB and Medigap Claims

Outbound 837 Coordination of Benefit (COB) and Medigap claims are sent to COB trading partners and Medigap plans on a post-adjudicative basis. This type of transaction includes incoming claim data, as modified during adjudication if applicable, as well as payment data. *All Medicare contractors* are required to accept all 837 segments and data elements permitted by those implementation guides on an initial 837 professional or institutional claim from a provider, but are not required to use every segment or data element for Medicare adjudication. Those supplemental segments and data elements shall be retained, however, because they could be needed by a Medicare COB trading partner or a Medigap Plan. The shared systems shall maintain a store-and-forward repository (SFR) for retention of such supplemental data. Data shall be subjected to standard syntax and applicable IG edits prior to being deposited in the SFR to assure non-compliant data are not sent to another payer. SFR data shall be re-associated with those data elements used in Medicare claim adjudication as well as with payment data in order to create an 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall retain the data in the SFR for a minimum of 6 months.

The 837 version 4010A1 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer shall equal the billed amount for the services in the claim. A tertiary payer to which Medicare may forward a claim *may well* need all data and adjustment codes Medicare receives on a claim. A tertiary payer could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer claims if the paid and adjusted amounts do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.

The shared system maintainers shall populate an outbound COB/Medigap file as an 837 flat file with the Tax ID or SSN (for a sole practitioner) present in the provider's file. Once the National Provider Identifier (NPI) is available, qualifier XX shall be reported in NM108 and the NPI in NM109, and the taxpayer identification number *shall be* reported in the REF segment of the billing provider loop. Prior to completion of NPI implementation, when an NPI is reported in NM109 for any of the types of providers for which data *are* included in a claim, Medicare will also send the legacy number (UPIN, PIN, National Supplier Clearinghouse or OSCAR) for each provider enrolled in Medicare in the REF segment of the loop used to supply identifying information for that provider.

The shared systems shall populate outbound claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, in the event of any discrepancy with the inbound 837.

*Effective with the Coordination of Benefits Agreement (COBA) eligibility file-based crossover process, e*ach *COBA trading partner* specifies the types of claims it wants the COBC to transfer. Examples of claims most frequently excluded from the crossover process are:

- *Fully* denied claims;
- Adjustment claims;
- MSP claims; and

- Claims *that are fully paid without deductible or co-insurance remaining.*

The COBC is the single contractor responsible for COB trading partner agreements and transmission of COB/Medigap claims to *Coordination of Benefits Agreement (COBA) trading partners*. Refer to Chapter 28, § 70.6 and accompanying subsections of this manual for further details about specific *Medicare contractor* crossover-related responsibilities when interacting with the COBC. Each shared system will *generate* COB/Medigap flat files *for its Medicare contractors* and will forward those flat file records to the COBC. The COBC's translator will translate those flat files into outbound 837 COB/Medigap transactions.

The HIPAA implementation guides (IGs) state that the ISA08 is an "identification code published by the receiver of the data; when sending, it is used by the sender as *its* sending ID, thus other parties sending to *that entity* will use this as a receiving ID to route data to them." The ISA08 is a 15-position alphanumeric data element. *The Medicare contractors* and their shared systems shall populate 15 positions of ISA08 data (as published by the receiver of the data) on outbound X12N HIPAA transactions, including electronic COB and Medigap claims. *All Medicare contractors* shall also make the necessary changes to be able to ensure that each Medigap plan and COB trading partner sent a claim electronically has a unique ISA08. *All Medicare contractors* and the COBC shall inform their trading partners and Medigap plans that the CMS cannot allow two trading partners to have the same ISA08.

HIPAA required that any payer that conducts electronic COB including in Medicare's case, electronic Medigap transactions, for other than retail pharmacy drug claims use the X12 837 version 4010A1 format for COB by October 16, 2003 (subsequently extended by the ASCA extension request process and the Medicare HIPAA contingency period). HIPAA did not give payers the option to exclude claims received on paper or received in a pre-HIPAA electronic format from compliancy requirements for X12 837 version 4010A1 COB/Medigap transactions. An inbound claim received on paper could lack data elements, or contain data that do not meet the data attribute (alpha-numeric, numeric, minimum or maximum lengths, etc.) requirements needed to prepare a HIPAA-compliant outbound X12 837 COB/Medigap transaction, however. Paper claims do not contain as many data requirements as the claim versions adopted as the national standards under HIPAA.

In most cases, electronic claims received with invalid data are rejected, but in limited cases such as for a claim received on paper, a claim could be accepted and adjudicated that lacks one or more pieces of data needed for a HIPAA-compliant COB/Medigap transaction. It is also possible to receive invalid data from the Medicare Common Working File (CWF) database. For example, a State abbreviation in an address transferred from the Social Security Administration (SSA) for Medicare enrollment might contain one letter rather than two in the State abbreviation. A one letter State abbreviation violates the X12 requirements that two letters appear in a State abbreviation, but due to the Medicare prohibition against modification of beneficiary addresses supplied by SSA, the shared system is left with a dilemma. Such errors cannot be corrected unless the beneficiary contacts SSA and requests correction, but this is not a priority for many beneficiaries since they receive their SSA payments electronically.

When a paper claim does not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB/Medigap claim, the shared systems maintainers (other than MCS) and the *contractors* that use MCS shall gap-fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXXX" and a 5-character numeric data element would contain "99999."

When paper claims do not contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB/Medigap transaction, the shared system maintainers (other than MCS) and MCS Carriers shall gap fill the phone number data element with "8009999999".

Data elements with pre-defined IG values such as qualifiers, and data elements that refer to a valid code source shall not be gap filled. Paper claims do not usually contain qualifiers but do contain explicit field names that provide information equivalent to qualifiers or that identify valid code sources. For COB/Medigap purposes, those field names shall be mapped to the appropriate qualifier or code source for reporting to trading partners and Medigap plans in the 837 version 4010A1 format.

B. NCPDP COB/Medigap Transactions

The NCPDP has approved the following use of qualifiers in the Other Payer Paid Amount field for reporting Medicare COB/Medigap amounts:

"07" = Medicare Allowed Amount
"08" = Medicare Paid Amount
"99" = Deductible Amount
"99" = Coinsurance Amount
"99" = Co-Payment Amount

NOTE: The first occurrence of "99" will indicate the Deductible Amount.

The second occurrence of "99" will indicate the Coinsurance Amount.

The third occurrence "99" will indicate the Co-Payment Amount.

40.4.1 - Payment Floor Requirement

(Rev. 1, 10-01-03)
A3-3600.1 - partial, A1-1430, B3-4430

Carriers and FIs must transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They must designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

40.4.2 - Alternative to EFT
(Rev. 1, 10-01-03)
A3-3600.1 - partial, A1-1430, B3-4430

The only acceptable alternative to EFT is paper check mailed by first class mail.

40.4.3 - Tri-Partite Bank Agreement
(Rev. 1, 10-01-03)
A3-3600.1 - partial, 1430, B3-4430

The FIs and carriers must ensure that Tri-partite bank agreements (three-party agreements between the contractor, the bank, and the provider) include wording that allows funding of the letter of credit to include EFT as well as paper checks. The agreement must clearly state that all references to checks in the agreement include checks and/or electronic funds transfer.

For more information, refer to the Medicare Financial Management Manual, Pub. 100-06, Chapter 5.

40.5 - Direct Data Entry (DDE) Screens
(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

HIPAA does not require, but does permit payers to maintain DDE screens for claim submission, correction, claim status determination, and eligibility verification. Medicare FIs are required to maintain claim submission, claim correction and claim status screens, but not Medicare carriers or DMERCs. (See chapter 31 for eligibility verification DDE requirements.)

Medicare considers transactions conducted via DDE screens to meet HIPAA-compliancy requirements. DDE claims are considered HIPAA-compliant EDI transactions for application of the 14-day payment floor. (See §70.2.B of this chapter for further FI DDE information.)

Data entered via DDE screens are not subject to the syntax (format) requirements of the standards, but must meet “applicable data content” requirements for comparable HIPAA transactions. FIs may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA. DDE systems are proprietary by definition. They are a direct link between a particular health plan (Medicare) and its providers, and the software (and sometimes hardware) is unique to and maintained by the plan. The widespread use of the standard HIPAA transactions should make it economically feasible for more providers to procure or develop their own EDI products that can be used with all plans. The use of DDE should decrease over time as a result. The requirement for “applicable data content” is meant to facilitate that eventual conversion. Adopting the data content requirements of HIPAA in DDE screens will facilitate eventual migration of providers from DDE to use of EDI transaction software (or to use of a clearinghouse).

This will also permit maintenance of DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, “applicable data content” means shared system-maintained DDE screens and the CWF maintainer eligibility screens must:

- Collect all data elements that are required in the IG as well as those situational elements that are needed for Medicare processing (unless the data is already available to the payer’s system);

- Use only the internal and external code sets designated in the IG with no additions or substitutions;

- Provide for at least the field size minimums noted in the IG, but no more than the maximum sizes (Do not expand the size of a shared system’s internal claim records);

- Permit at least the minimum number of field repeats noted in the IG, but no more than the maximum number;

- Allow for only one investigational device exemption number (IDE) per claim (at the claim level);

- Remove employment status code, employer name, and employer address information;

- Allow Other Subscriber Demographic Information (date of birth and gender) if the other subscriber is a person;

- Allow for discharge hour and minute information in the numeric form of HHMM; and

- Allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

Data elements not used by-Medicare are not currently collected in Medicare DDE screens. Claims correction via DDE should be limited to Medicare data (non-Medicare data in error should be purged with an appropriate error message to the DDE user). With Medicare data plus some information from shared system files, an IG compliant COB transaction can be written.

NOTE: See section 70.2.B for additional DDE edit requirements.

40.6 - Use of Imaging, External Key Shop, and In-House Keying for Entry of Transaction Data Submitted on Paper

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

At one time, all imaged claims, and claims entered via external key shops or in-house contractor staff members were produced only in the NSF or UB-92 flat file format. In anticipation of termination of the Medicare incoming claim HIPAA contingency plan, carriers, DMERCs, and FIs were to convert their output from their imaging and external key shops into the 837 institutional and professional claims flat files to enable continued processing by the shared systems by October 1, 2004. Carriers, DMERCs, and FIs must bypass IG edits that do not apply to claims received on paper since paper claims are not required to comply with X12 837 segment and data element requirements.

40.7 – Electronic Funds Transfer (EFT)

(Rev. 1601; Issued: 09-19-08; Effective/Implementation Date: 10-20-08)

EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and *for existing providers that are submitting a change to their existing enrollment data but are not currently receiving payments via EFT.*

Once a provider begins to receive Medicare payments via EFT, the contractor shall not issue any routine, ongoing payments to the provider via check. (For purposes of this instruction, the term "routine, ongoing payments" means those payments that are not considered to be "special payments," as that latter term is used in section 4 of the CMS-855 application.) This means, therefore, that - with the exception of special payments – a provider that receives payments via EFT must continue to receive payments via EFT and cannot switch back to receiving paper checks, even in cases of a MAC transition or other CMS-initiated action. Medicare contractors shall not approve any requests to change the provider's payment method from EFT to check.

An exception to this process is when CMS is implementing a new MAC and moving workload from existing intermediaries and carriers to the MAC. The incoming MAC shall obtain and retain a signed CMS-588 from each provider, physician, or supplier requesting EFT. As cutover approaches, the MAC is expected to follow up and personally contact those providers who have not returned a completed CMS-588, especially the high volume submitters. The incoming MAC shall not stop any provider/supplier's EFT for lack of a new CMS-588 until authorized by CMS to do so. If, after all efforts have failed, the provider does not submit a new CMS-588, the MAC - at the direction of CMS - must issue and mail a paper check. Provider or supplier pick-up of checks, next day delivery, express mail, and courier services are not allowed unless there exists a special situation that is approved by CMS.

Note that the contractor shall abide by the instructions in Pub. 100-08, chapter 10, sections 4.4 and 8 on all provider enrollment issues relating to EFT. This includes the requirement that carriers, A/B MACs, FIs, and RHHIs compare the information and signature on the provider's Form-CMS-588 (Electronic Funds Transfer Authorization Agreement), to that on the provider's CMS-855 form on file. For changes of information, DME MACs shall verify the authorized official on the CMS 855.

A carrier, A/B MAC, DME MAC, FI or RHHI shall use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then contractors shall use National Automated Clearinghouse Association (NACHA) format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) to make sure that the addenda record is sent with the EFT. Providers need the addenda record to reassociate dollars with data. Carriers, A/B MACs, DME MACs, FIs, and RHHIs shall transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They shall designate a payment date (the date on which funds are deposited in the provider’s account) of two business days later than the date of transmission.

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 1614; Issued: 10-03-08: Effective: 10-01-08; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The FI shared system shall edit (via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims, TOBs 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date of service (LIDOS) for each revenue code. Outpatient claims not containing a LIDOS for each revenue code shall be rejected from the flat file with an appropriate error message.

The FI shared system shall edit outpatient claims submitted via direct data entry (DDE) to ensure each contains a LIDOS for each revenue code. Any outpatient claims found without a LIDOS for each revenue code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. These claims containing an ICD-9 procedure shall be rejected by the shared system with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all outpatient claims to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a “ZZ” qualifier are accepted (not just HIPPS skilled nursing facility rate codes).

The FI shared system shall edit all outpatient claims to ensure each does not contain Covered Days (QTY Segment). Outpatient claims containing Covered Days shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit outpatient claims submitted via DDE to ensure all occurrences of the data element do not contain Covered Days. Any outpatient claims submitted via DDE containing Covered Days shall be subject to an appropriate on-line error message.

The FI shared system shall edit all claims to ensure each does not contain a NPP000 UPIN. Claims containing a NPP000 UPIN shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN. Any claims submitted via DDE containing a NPP000 UPIN shall be subject to an appropriate on-line error message.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system shall edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system shall edit all claims to ensure each does not contain an invalid E-code. Claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims found containing an invalid E-code shall be subject to an appropriate on-line error message.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid E-code, condition code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any outpatient claim found containing an ICD-9 procedure code shall be subject to an appropriate on-line error message.

The FI shared system shall edit outpatient HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code, condition code, value code, occurrence code, or occurrence span code. These shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs and FI shared system, as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update 2 times per year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and FI shared system shall edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 institutional IG, and are contained in the approved list of HPTCs. HPTCs are not required data elements. Claims received with invalid HPTCs shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all outpatient claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of “ZZ”, along with a compliant “Patient Reason for Visit” diagnosis code. Outpatient claims containing an invalid “Patient Reason for Visit” code (a “Patient Reason for Visit” code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound HIPAA X12N 837 COB transaction, the FI shared system shall ensure a “ZZ” qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and FI shared system shall be responsible for editing to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.

For bill types 12X and 22X, the FI shared system shall edit to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via DDE (these are already required for other inpatient bill types). Claims not containing this data shall be subject to an appropriate on-line error message.

40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits

(Rev. 1614; Issued: 10-03-08: Effective: 10-01-08; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The Part B carriers and durable medical equipment regional carriers (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to a specific detail line or not.

The Part B carriers and DMERCs shall reject inbound electronic claims that contain a space, dash, special character, or 1 byte numeric in any ZIP Code.

The Part B carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

40.7.3 – National Council for Prescription Drug Program (NCPDP) Implementation

(Rev. 84, 02-06-04)

A. NCPDP Implementation Guide (IG) Edits

The DMERCs must allow segments to be submitted in any order including the AM07, AM03 and AM11 according to the NCPDP standard.

B. NCPDP Narrative Portion of Prior Authorization Segment

The DMERCs must allow the value "MOD" to be entered in positions 001-003 of the narrative portion of the prior authorization segment indicating that the supporting documentation that follows is Medicare modifier information.

40.8 - Claim Implementation Guide Edits

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

40.8.1 – X12N 837 Institutional Implementation Guide and Direct Data Entry Edits

(Rev. 1614; Issued: 10-03-08: Effective: 10-01-08; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The FI shared system shall reject (via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) and TOBs 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims that lack a line item date of service (LIDOS) for each revenue code with an appropriate error message. The FI shared system shall reject outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims that contain an ICD-9 procedure code with an appropriate error message.

The FI shared system shall accept all outpatient claims that include any applicable Health Insurance Prospective Payment System (HIPPS) Rate Code and a "ZZ" qualifier and shall not reject HIPPS codes just because they are not HIPPS skilled nursing facility rate codes.

The FI shared system shall reject all outpatient claims that contain Covered Days (QTY segment in an X12N 837 and equivalent DDE screen field entry) with an appropriate error message.

The FI shared system shall reject all claims that contain a NPP000 UPIN with an appropriate error message.

The FI shared system shall ensure each COB/Medigap claim containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system shall reject all claims that contain an invalid E-code as referenced by the HIPAA 837 institutional IG with an appropriate error message.

The FI shared system shall reject all claims that contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG) with an appropriate error message.

The healthcare provider taxonomy codes (HPTCs) shall be loaded by the FIs as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are updated twice per year (October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and/or FI shared system shall edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 institutional IG, and are contained in the approved list of HPTCs. Claims received with invalid HPTCs shall be rejected with an appropriate error message.

The FI shared system shall edit all outpatient claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of “ZZ”, along with a compliant “Patient Reason for Visit” diagnosis code. Outpatient claims containing an invalid “Patient Reason for Visit” code (a “Patient Reason for Visit” code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected with an appropriate error message.

When preparing a COB/Medigap flat file transaction, the FI shared system shall ensure "ZZ" is in HI02-1 when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and/or FI shared system shall reject inbound claims if the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are not present (contractors should already be editing other inpatient bill types to ensure these present). Claims not containing these data elements shall be rejected with an appropriate error message.

40.8.2 – X12N 837 Professional Implementation Guide Edits

(Rev. 1614; Issued: 10-03-08: Effective: 10-01-08; Implementation: 10-06-08)

Future updates will be issued in a Recurring Update Notification.

The Part B carriers and MACs shall reject inbound electronic claims that contain invalid diagnosis codes whether or not pointed to a specific detail line.

The Part B carriers and MACs shall reject inbound electronic claims that contain a space, dash, special character, or 1 byte numeric in any ZIP Code.

The Part B carriers and MACs shall reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

40.8.3 – National Council for Prescription Drug Program (NCPDP) Implementation Guide Edits

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

A. NCPDP Implementation Guide (IG) Edits

The DME MACs shall allow segments to be submitted in any order including the AM07, AM03 and AM11 according to the NCPDP standard.

B. NCPDP Narrative Portion of Prior Authorization Segment

The DME MACs shall allow the value "MOD" to be entered in positions 001-003 of the narrative portion of the prior authorization segment indicating that the supporting documentation that follows is Medicare modifier information.

50 - EDI Testing Requirements

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

50.1 - Shared System and Common Working File (CWF) Maintainers Internal Testing Requirements

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

Shared system and CWF maintainers, and their beta testers where appointed, must test shared system releases that include modifications affecting EDI transactions prior to issuance of those releases, unless specific waivers are granted by the CMS. The CWF maintainer's involvement in EDI is limited to programming related to the electronic eligibility transaction. Shared system and CWF maintainers and beta testers must support a testing environment that simulates the production environment as closely as possible. The shared system maintainers must implement system changes to enable carriers, DMERCs, and FIs to conduct automated tests with EDI submitters/receivers of the HIPAA versions of the standard transactions at the same time that submitters/receivers are using an earlier version of a transaction in production.

50.2 - Carrier, DMERC, and FI Internal Testing Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, FIs, and/or their data centers must successfully complete testing of shared system releases that impact their front or back end processing prior to use of that programming in production, or to test with potential users of the transactions. Release testing requirements and completion dates are contained in specific shared system release instructions. Carriers, DMERCs and FIs must use a translator to convert standard data into the flat file format processed by the shared system and to convert flat file data into compliant outbound HIPAA transactions.

Carriers, DMERCs, and FIs must test the effectiveness of their translator, including the syntax editing performed by their translator at the front (incoming transactions) and back (outgoing transactions) ends and any IG level editing if performed by their translator, and to test the effectiveness of those inbound and outbound semantic IG edits they (carrier, DMERC, and to the extent performed by FIs) may use at their front and/or back ends to ensure that both inbound and outbound transactions comply with the standards and the appropriate IGs. Shared system maintainers are responsible for inclusion of all data elements in their flat file that carriers, DMERCs, and FIs require to translate the flat file data into a compliant outbound transaction. Shared systems are also responsible for testing of the effectiveness of those inbound and outbound semantic edits used during the shared system phase of processing.

IG semantic edits test compliance with IG-specific requirements, which may differ in some cases from the underlying standard. For example, a segment or data element identified as optional in the standard may be required in an IG. In addition, an IG indicates which qualifiers and codes are permissible in a transaction, while the standard requirements do not include that level of detail. An invalid code could actually be accepted at the standard level but would be rejected at the IG level. Carrier and DMERC shared system maintainers are responsible for application of IG semantic edits for incoming transactions, and individual carriers and DMERCs are responsible for preparation of IG compliant outbound transactions. Individual FIs are responsible for application of some IG semantic edits prior to transfer of data to their shared system for processing and preparation of IG compliant outbound transactions, and FISS is responsible for application of all other required IG semantic edits. In some cases, individual FIs have separately contracted with their data center to serve as their front and/or back end for receipt or issuance of electronic transactions. In those cases, the data center tests and applies the appropriate institutional syntax and semantic IG edits. The Fiscal Intermediary Shared System (FISS) also performs additional IG editing on behalf of FIs that have a license for use of a version of the Mercator translator supported by FISS.

50.3 - Third-Party Certification Systems and Services

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

There are a number of third-party HIPAA certification systems that market test data and testing services to evaluate a user's compliance with the IG requirements for the HIPAA transaction standards. CMS does not require that submitters/receivers of HIPAA transactions obtain such certification. CMS adopted the national Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) Testing Sub-workgroup's recommendations on the levels of testing (syntax, semantic and application edits) to foster greater testing uniformity within the health care industry overall. More information on the WEDI testing levels is available at www.wedi.org. If a billing service, clearinghouse, or software vendor notifies a carrier, DMERC, or FI that they have successfully tested with an independent HIPAA transactions compliance evaluation company at WEDI levels 1 and 2 at a minimum, and can provide a certificate from that company or the web address where the company identified this party as having passed WEDI level 1 and 2 testing, carriers, DMERCs, and FIs have the option to waive testing of the entities that received such certification.

50.4 - EDI Submitter/Receiver Testing by Carriers, DMERCs, and FIs

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs are required to pre-test submitters planning to use X12 837 version 4010A1 and/or the NCPDP HIPAA claim format to assess system and data compatibility and compliancy prior to submission of "live" electronic claims in those versions for adjudication, except as waived in sections 50.3 and 50.4.1. A "submitter" is the entity that actually transmits transaction data to Medicare, such as a provider or billing agent that transmits to Medicare directly via a modem or other telecommunication connection, or a clearinghouse that may transmit to Medicare on behalf of many providers or billing agents. Carriers, DMERCs, and FIs are not required to pretest submitters or receivers of other EDI formats (835, 276/277, 270/271) adopted under HIPAA, unless requested to do so by a submitter/receiver or the submitter/receiver has never previously used EDI for Medicare transactions. A "receiver" is the entity to which an outbound transaction is sent by a carrier, DMERC, or FI.

Carriers, DMERCs and FIs were required to begin scheduling testing of X12 837 version 4010A1 claim submitters by April 1, 2003, unless given an extension by CMS due to a pending transition to an alternate shared system, such as the APASS to FISS transition or due to some temporary local problem. Carriers, DMERCs, and FIs were to complete that testing by October 16, 2003 (now extended until the end of the contingency period). Carriers, DMERCs, and FIs are not required to retest electronic claim submitters that successfully tested the X12 837 version 4010 claims transaction standard on version 4010A1 unless specifically requested by those users, or the carrier, DMERC, and/or FI considers 4010A1 testing to be advisable to avoid potential later problems. Until further notice, pending a decision to terminate the contingency period, carriers, DMERCs, and FIs are to continue to accept claims submitted in pre-HIPAA electronic formats from providers, billing agents, and clearinghouses that have not yet successfully completed testing of the HIPAA claim format(s) and had previously been approved to submit claims transactions in a legacy format.

50.4.1 - Testing Accuracy

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

All claim submitters must produce accurate electronic test claims before allowed to submit HIPAA format claim transactions in production. All submitters must send the carrier, DMERC, or FI a test file containing at least 25 claims, which are representative of their practice or services. Carriers, DMERCs, or FIs may, based on individual consideration, increase or decrease the number of claims required to adequately test any given submitter. Carriers, DMERCs, or FIs will subject test claims to standard syntax and IG semantic data edits and will provide documentation when edits detect errors.

- Standard syntax testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits. Test files must pass 100 percent of the standard syntax edits before production is approved.

- IG Semantic Data testing validates data required for claims processing, e.g., procedure/diagnosis codes, modifiers. A submitter must demonstrate, at a minimum, a 95 percent accuracy rate in data testing before production is approved where, in the judgment of the carrier, DMERC, or FI, the vendor/submitter will make the necessary correction(s) prior to submitting a production file. For FIs, the minimum 95 percent accuracy rate includes the front-end edits applied using the FISS implementation guide editing module.

Carriers, DMERCs, and FIs must provide test results to the submitter within three (3) business days (use the computation method contained in Chapter 1 of this manual for determination of the age of a claim to compute the number of elapsed days).

50.4.2 – Limitation on Testing of Multiple Providers that Use the Same Clearinghouse, Billing Service, or Vendor Software

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Many claim submitters use the same software, or the same clearinghouse to submit their electronic claims to Medicare. In those cases, carriers, DMERCs, and FIs are not required to test each submitter that uses the same software, or each provider or billing agent that uses the same clearinghouse. Carriers, DMERCs, and FIs may require potential third party submitters to have an approved Medicare provider as a client prior to testing with such third parties, however. It is sufficient to test with a small number of users of the same software to establish that the software is compliant, or to simply test with a single provider using a clearinghouse to establish the compliancy of the clearinghouse's software and connectivity for transmission of claims data. Likewise, once carriers, DMERCs, and FIs have tested the validity of the free/at cost billing software they distribute on request, the carriers, DMERCs, and FIs are not expected to test providers that have elected to use that billing software.

Health care providers that submit transactions directly to more than one Medicare carrier, DMERC, and/or FI, and billing services and clearinghouses that submit transactions to more than one Medicare carrier, DMERC, and/or FI, must contact each carrier, DMERC, and/or FI with whom they exchange EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional EDI transaction, different or significantly modified software for submission of a previously used EDI transaction, or before a billing agent or clearinghouse begins to submit transactions on behalf of an additional provider. Carriers, DMERCs, and/or FIs may need to retest at that time to re-establish compatibility and accuracy, particularly if there will also be a change in the telecommunication connection to be used.

Billing services and clearinghouses are not permitted to begin to submit or receive EDI transactions on behalf of a provider prior to submission of written authorization by the provider that the billing agent or clearinghouse has been authorized to handle those transactions on the provider's behalf. See section 20 of this Chapter for further information on EDI Enrollment.

50.4.3 – Carrier, DMERC, and FI Submitter/Receiver Testing with Legacy Formats during the HIPAA Contingency Period

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Providers, their billing agents, or clearinghouses that contact a carrier, DMERC, or FI to request testing for submission or receipt of electronic transactions for the first time are required to test in a HIPAA format for any EDI transaction, other than eligibility verification, even if they propose use of vendor software currently being used by other providers that are allowed to temporarily submit electronic transactions in a legacy format. Carriers, DMERCs, and FIs may not test "first time" users of any transaction other than eligibility verification (pending CMS announcement of the termination of the Medicare HIPAA 270/271 contingency plan) in a legacy format.

During the contingency period, providers, their billing agents, and clearinghouses are required to make a good faith effort to complete transition to the HIPAA transaction formats as soon as possible. It would be counterproductive and not cost effective for carriers, DMERCs, and FIs to test on both legacy and HIPAA formats in this situation. Nor is it considered cost effective for new providers, billing agents, or clearinghouses to test for the first time at this point on any legacy electronic formats as they would be required to reprogram and retest prior to the end of the contingency period for use of the HIPAA adopted transaction standards.

New physicians that join an existing group practice that still uses a legacy format are permitted to submit electronic transactions in that legacy format and are not considered "new" providers for application of the ban against addition of new providers for use of legacy formats. New physicians hired by an existing group become part of that group, and transactions for group members are submitted under the number for the group rather than under the individual number of the group physician who normally treats a patient.

50.4.4 - Discontinuation of Use of COB Claim Legacy Formats Following Successful HIPAA Format Testing

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end the earliest of the date that:

1. A trading partner completes successful testing on use of the X12 837 version 4010A1 and/or the HIPAA NCPDP format (as appropriate); or

2. The Medicare HIPAA COB contingency plan ends.

* At the current time, none of the COB trading partners are willing to accept NCPDP format transmissions for secondary payment due to the lack of data elements in that format for reporting of a number of data elements required for computation of benefits by the secondary payer. CMS is working with the NCPDP to develop a "workaround" to resolve this problem. Pending release of such a "workaround", NCPDP claims will not be crossed over to other payers. Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.

50.4.5 - EDI Receiver Testing by Carriers, DMERCs, and Intermediaries

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Carriers, DMERCs and FIs are not required to test individuals who request use of outbound electronic remittance advice (ERA) or claim status transactions unless parties that request receipt of those transactions request pre-testing prior to production use of one or more of those outbound transactions. Carriers, DMERCs, and FIs may, at their discretion, require pre-production testing of outbound transactions if there is concern that specific receivers could otherwise experience significant problems. Carriers, DMERCs, and FIs that did test successfully with certain receivers on version 4010 of the 837 for

COB or the 835 are not required to retest on version 4010A1 unless requested by a receiver. 837 COB testing is required with those trading partners prior to transmission of live COB data in the 837 version 4010A1. Even if testing is not normally required, parties that want to begin receipt of an outgoing transaction supported by Medicare must notify their Medicare carrier, DMERC, and/or FI when to begin transmission of the HIPAA version of a specific outgoing transaction.

Terminate transmission of ERAs to those receivers that have not notified you they are able to accept and process X12 835 version 4010A1 transactions by the end of the Medicare contingency period. Also terminate transmission of COB transactions to trading partners that have not successfully tested with you for receipt of the X12 837 version 4010A1 by the end of that contingency period. Likewise, no pre-HIPAA 271 or legacy format electronic claim status EDI responses may be issued after the date when the Medicare contingency plan ends for that transaction type. See Chapter 31 for specific information concerning electronic claim status and eligibility transactions. Terminate issuance of version 4010 X12 277 transactions and acceptance of version 4010 X12 276 transactions when that contingency plan is terminated.

50.5 - Changes in Provider's System or Vendor's Software and Use of Additional EDI Formats

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Health care providers that receive or send transactions directly from/to more than one Medicare carrier, DMERC, and/or FI, and billing services and clearinghouses that receive or send transactions from/to more than one Medicare carrier, DMERC, and/or FI, must contact each carrier, DMERC, and/or FI with which they receive/send EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional type of EDI transaction. A provider must also notify their Medicare carrier, DMERC, or FI in writing (see EDI enrollment in §20 of this chapter) if they will begin to use a billing agent or clearinghouse for the first time, change a billing agent or clearinghouse, discontinue use of any billing agent or clearinghouse, or authorize a billing agent or clearinghouse currently used for some transactions to begin receiving additional transactions. A billing agent or clearinghouse representative is prohibited from signing an authorization on behalf of a provider to allow them to act as the sender or receiver of specific EDI transactions on behalf of a provider, even if a provider has signed a contract with the billing agent or clearinghouse for such services.

60 - Support of EDI Trading Partners

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

60.1 - User Guidelines

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carrier, DMERCs, and FIs must make information available to potential users (preferably via their Web page or the Internet) of each EDI transaction supported by Medicare with detailed information on:

- The telephone numbers of appropriate staff to contact to:
  - Get started with electronic billing and other EDI transactions; and
  - Obtain on-going support for electronic transactions.
- Testing requirements and the submitter's and carrier, DMERC, or FI's level of responsibility throughout each step of the testing process (see §30);
- The availability of the appropriate specifications for this provider and instructions for accessing these via the Internet or other cost effective means;
- The availability of the carrier, DMERC, or FI's provider bulletins via the Internet and/or bulletin board system;
- The availability of the carrier, DMERC, or FI's EDI instructions or procedures via the Internet and/or bulletin board system;
- The availability of the carrier, DMERC, or FI's free Medicare EMC software and the FIs free PC-Print software (PC-Print software for carriers expected to be issued in October 2005) upon request;
- Login requirements;
- Hours of operation, system and support;
- Telecommunication options and requirements;
- Procedures for updating submitters with any billing changes;
- EDI formats required for input to the carrier, DMERC, or FI's system. These specifications must be in sufficient detail for the submitter's use, and must include information regarding code, record length(s), field positioning within record(s), labeling and any other conventions necessary for compatibility with the carrier's, DMERC's or FI's system;
- All acceptance and rejection formats and content for output from the carrier, DMERC, or FI's system that will be returned to the submitter;
- Special instructions related to specific diagnosis or procedure codes, i.e., the necessity for attachments or modifiers and appropriate placement within the electronic record;

- Availability of online claim entry, claim correction (FIs only), claim status check, eligibility verification, claim development via DDE or otherwise, and the procedure for accessing these transactions;

- Specifications of the carrier, DMERC, or FI's front-end editing process (except in those cases when disclosure of specific edits is related to medical (Review or another sensitive area for which disclosure is not advisable) with complete list of error codes and resolution, including those conditions that will result in the rejection of entire EDI transmissions/batches;

- Conventions for acknowledging claims received and for recovering data known to be lost;

- Instructions for submitters to notify their carrier, DMERC, or FI of changes to the submitter profile in regard to use of clearinghouses, billing agents, EDI transactions and software for submission/receipt of those transactions;

- Carrier, DMERC, and FI listings of vendors and clearinghouses that are approved for production;

- Data requirements for reporting third party payers, i.e., Medigap, crossover, Medical Assistance and private insurance; and

- Frequently asked questions and answers about EDI.

60.2 - Technical Assistance to EDI Trading Partners

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs will provide help desk support to assist submitters and receivers with inquiries related to file transmission and acknowledgment, file retrieval, transaction requirements/specifications and the use of free software. Help desk support will be available during normal business hours at a minimum. Time zone differences at the provider's location should be accommodated if possible. Help desk activities are to be controlled and monitored through an automated call management system that provides the following functions:

- Control (login) of all incoming calls: identification of caller, reason for call, date and time;

- Track activities related to the call to the final resolution of the call: identification of routing, callbacks, issues, and resolution;

- Workload distribution of open items;

- Classification of call types for resource planning, provider education, management reporting; and

- Storage of caller-specific audit trails.

In addition to an automated call system, FIs, carriers and DMERCs must provide for receipt of e-mail, voice mail, or fax when the help desk is not available. Receipt of customer service inquiries must be acknowledged within one business day, or attempts to acknowledge the inquiry within this time must be documented if contact has not been made successfully.

Where transmission, retrieval or file problems are reported, a plan of action to resolve the issue must be provided to the inquirer within three (3) business days. This plan should include one or more of the following:

- An indication that the carrier, DMERC, or FI looked into the issue and did not identify a problem;

- The submission of a new corrected file;

- An explanation which either solves the problem or indicates action which the submitter or receiver can take to resolve the problem;

- An indication of the need for further investigation, with an estimated time frame for responding with more information and or a resolution;

- An indication that resolution requires carrier, DMERC, or FI action, and a description of the plan for resolution and estimated completion date.

Where the problem affects multiple submitters the carrier, DMERC, or FI make information on the issue available to all affected submitters.

60.3 - Training Content and Frequency

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

See the CMS Provider Education and Training (PET) manual for the definitive provider outreach and training requirements. Provider training is included in the CMS contractor PET budget and although EDI information must be included in those training efforts as appropriate, the PET requirements contain specific activities that must be completed by carriers, DMERCs, and FIs. When possible, EDI training should be conducted in conjunction with non-EDI training to share training room and trainers' expenses. This EDI-related training information is included in Chapter 24 for reference purposes only. Where appropriate, carriers, DMERCs, or FIs may develop user groups for general EDI users and free software users. Medicare carriers, DMERCs, or FIs are not required to support or train providers on the use of software provided by commercial vendors/trading partners, on X12 format structure or coding, the use of PCs, or other subjects non-specific to Medicare EDI. On an ongoing basis, carriers, DMERCs, and FIs should assess the need for additional training based on:

- Periodic identification and evaluation of common electronic billing errors;

- New software release; or
- The introduction of new EDI functions or changes to existing functions.

60.4 - Prohibition Against Requiring Use of Proprietary Software or DDE

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs will accept and process transactions created from any software as long as the transactions comply with the IG requirements adopted under HIPAA (refer to §40) and CMS requirements. Carriers, DMERCs, and FIs are prohibited from requiring that submitters of EDI transactions use proprietary billing software or specific hardware either before or after expiration of the HIPAA contingency period. Carriers, DMERCs, and FIs may not charge providers that use their own software, hardware, modems, and telecommunication lines to submit and/or receive electronic transactions in a HIPAA-compliant format.

DDE screens generally involve the use of dumb terminals programmed for specific uses, or of PCs that use software issued by a payer to emulate a dumb terminal to permit providers to individually enter claim data and correct claims errors (applies to Medicare institutional claims only), verify beneficiary eligibility (FIs and some carriers), obtain claims status (FIs and some carriers), or possibly perform another function. Since carriers, DMERCs, and FIs incur additional costs to maintain DDE functionality and support, they are allowed to recoup those costs from users and are permitted to charge a reasonable amount for its use. Carriers, DMERCs, and FIs may not require use of DDE, or refuse to accept or discourage submissions of transactions submitted in HIPAA compliant standards.

60.5 - Free Claim Submission Software

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Carriers, DMERCs, and FIs will make available software for their providers that is designed for use on a Windows-based PC for submission of claims to Medicare electronically. This software must also be able to identify when Medicare is a secondary payer and to collect data elements concerning a primary payer's payment, standard claim adjustment reason codes and adjustment amounts made by a primary payer prior to submission of a claim to Medicare for secondary payment.

The software is free but carriers, DMERCs, and FIs may charge a fee up to $25.00 per release to recoup their postage, reproduction, and handling expenses when a provider requests the software be sent via diskette, CD, or other medium, rather than downloaded by a provider from the Medicare contractor's Web page (if not precluded by a software copyright or licensing agreement). FIs, carriers, and, DMERCs were to complete upgrades to their free/at cost billing software to correspond to the requirements of the version 4010A1 X12 837 IG prior to October 16, 2003, and upgrade that software as necessary by October 1, 2004, to enable collection of other payer data. Claims submitted with that software are considered to be HIPAA-compliant. Whenever carriers, DMERCs, and FIs issue a new version of their free billing software, they shall notify providers to terminate use of the earlier version of the Medicare free billing software within 90-days of release of the updated software.

FIs, carriers, and DMERCs are not funded to issue free/at cost software for submissions of NCPDP claims or for any other type of inbound HIPAA transaction. Testimony presented on the NCPDP format when proposed as the HIPAA retail pharmacy drug format indicated that such software was already in widespread use by retail pharmacies and that there was not a need for Medicare to fund development of free billing software for retail pharmacies.

Prior to distributing the initial or updated versions, carriers, DMERCs, and FIs will scan the free billing software with a current anti-virus program. This basic software must, at a minimum, contain the following:

- Edits to prevent incomplete and inaccurate claims from entering the system;
- "User friendly" qualities including:
  - A low initial investment, as well as low-cost upgrades, on the part of the submitter;
  - Minimal effort for both the software installation and training for the submitter; and
  - Clear and understandable software documentation, including information about where to receive additional help.

NOTE: The free-billing software distributed by FIs is maintained by the shared system maintainer. FIs are responsible for testing and distribution of that software only. There is not a similar common source of free billing software or maintenance for the carriers, but carriers are encouraged to contact HGSA, the Pennsylvania carrier, to obtain a copy of the proprietary software developed by that carrier with Federal funds. HGSA has agreed to share that software with other carriers in return for payment of a pro-rata share of the costs that HGSA incurs to distribute and maintain that software. Adminastar has developed a DMERC version of the free billing software. DMERCs are encouraged to contact Adminastar if they need free billing software for distribution to their suppliers.

60.6 - Remittance Advice Print Software

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

60.6.1 - Medicare Remit Easy Print Software for Professional Providers and Suppliers

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

CMS has developed software that gives providers/suppliers a tool to read and print an ERA in a readable format. This software is called Medicare Remit Easy Print (MREP). It has been developed in response to comments CMS received from the provider/supplier community that they need a paper document for accounts reconciliation, and claim submission for secondary/tertiary payments. Providers/suppliers who use the MREP software package, have the ability to print paper documentation that can be used to reconcile accounts receivable, as well as create document(s) that can be included with claim submission to secondary/tertiary payers. The MREP remittance advice is similar to the current Standard Paper Remittance (SPR) format. This software became available on October 11, 2005, through respective Part B contractors and DMERCs.

Carriers, DMERCs, and DME MACs must eliminate issuance of standard paper remittance advice notices (SPRs) to those providers/suppliers (or a billing agent, clearing house, or other entity representing those providers) also receiving ERA transactions for 45 days or more. Providers and suppliers must be encouraged to use MREP or other software to read, view, and print an electronic remittance advice to eliminate any need for SPRs.

This software can be downloaded for free from a CMS Web site. Providers must go through their contractors to access this Web site so that contractors can maintain a list of MREP users. Any MREP related message is communicated using this list, and contractors must create and maintain their individual MREP user list. Contractors are allowed to charge up to $25.00 to recoup their cost if the software has to be sent on a CD or DVD or any other means at the request of a provider when the software is available for download for free.

60.6.2 - Medicare Standard Electronic PC Print Software for Institutional Providers

(Rev. 1063, Issued: 09-22-06, Effective: 10-01-06, Implementation: 10-23-06)

FIs and RHHIs are required to issue Windows-based software that a provider may use to convert an X12N 835 into a print document. See chapter 22 for further information on the content of the print version of institutional paper remittance advice notices.

The FIs and RHHIs must periodically notify providers that free PC Print software is available. An FI or RHHI must make the PC Print software available on their Web site for downloading by providers for free. If a provider has difficulty downloading software, or it cannot be posted on a Web site due to copyright restrictions, the provider may be sent a single copy of the PC Print software; this must be issued within three weeks of the provider’s request. Contractors are allowed to charge up to $25.00 to recoup any cost involved in sending a CD or DVD if a provider requests it and the software is available to download for free.

The FI Shared System (FISS) maintainer distributes PC Print software and a user’s guide to FIs/RHHIs through their data center. The software and instructions are designed to be self-explanatory to providers; it should not be necessary to furnish provider training for use of PC- Print software. Providers are responsible for any telecommunication costs associated with receipt of the X12N 835 and the cost to print paper remittance advices from the X12N 835 transactions they are sent. The FISS PC Print software does not contain copyright restrictions and can be posted on any FIs Web page for provider download.

The PC Print software enables providers to:

- Receive an 835 electronic remittance advice transmission on a personal computer (PC) over a wire connection and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's A (floppy disk) or other drive;

- Print 835 data in an easily readable format;

- View and print provider payment summary information;

- View and print a single claim; and

- View and print a sub-total by bill type.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, i.e., the entire transmission, a single claim, a summary by bill type, and/or a provider payment summary. All file and print formats follow the Medicare national standards described in the SPR specifications (see chapter 22). If software malfunctions are detected, FIs/RHHIs are to report them to the FISS maintainer for correction as needed. FIs/RHHIs and data centers are not permitted to modify the PC Print software. Nor will individual FIs/RHHIs be funded to develop or procure alternate PC Print software.

60.7 - Newsletters/Bulletin Board/Internet Publication of EDI Information

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

To educate providers and encourage the use of EDI, carriers, DMERCs, and FIs must periodically include information about use of EDI in their newsletters and on their Wb site. Their newsletter and Web site shall:

- Announce upcoming EDI changes;

- Point out common EDI billing errors and provide guidelines to eliminate errors; and

- Promote use of each of the Medicare-supported HIPAA EDI transactions.

Carriers, DMERCs, and FIs will provide access to newsletters via bulletin boards and/or the Internet. Carriers, DMERCs, and FIs Web pages must include a link to the CMS' Web site, which provides record formats and transactions information. If the information is available on the CMS Home page, carriers, DMERCs, and FIs should link to it rather than duplicating development and maintenance. See §40.6 for further instructions on Internet use.

60.8 - Provider Guidelines for Choosing a Vendor

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Providers may request assistance in choosing a vendor. Carriers, DMERCs, and FIs must maintain a list of software vendors and clearinghouses that are currently successfully submitting transactions in HIPAA-compliant formats on their Web page (see §20.6), and are encouraged to also provide factual information such as claims volumes, types of providers serviced by those vendors and clearinghouses, and whether the software may permit automatic posting or printing of 835 data. However, carriers, DMERCs, and FIs must take care to avoid making a specific recommendation and to avoid showing favoritism. Providers may select any vendor that provides the necessary services.

Medicare contractors should post the information in §§60.8.1 through 60.8.4 on their Web page. If a provider asks a Medicare contractor what to consider when searching for a software vendor or clearinghouse, the Medicare contractors should refer the provider to that location on the Web page. Alternately, the information may be sent the provider via e-mail.

60.8.1 - Determining Goals/Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Before selecting a vendor, the provider must examine its business needs to identify the EDI, practice management, or other services that the provider is interested in obtaining from a vendor. The provider should consider what services could be easily performed by their in-house staff and which might be more cost effective to obtain through a vendor. The provider should create a written description of the components of its practice that need vendor support and a description of support needed so prospective vendors can design their proposals to best meet the provider's needs. Requirements to consider include the following:

- Future Growth of the Practice;
- Workload;
- Payer Analysis;
- Referral Tracking;
- Fee Schedules;

- Appointment Scheduling;
- Medical Records;
- Interconnections with Physicians/Hospitals and other Networks;
- Word Processing Needs;
- Electronic Billing (formats and versions supported);
- Multiple Practices/Locations;
- High Volume/Low Volume Billing;
- Specific Bill Types;
- Management Reporting;
- Hardware/Software Requirements/compatibility with existing equipment; and
- Data Storage needs.

60.8.2 - Vendor Selection

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Once a provider has determined its own goals and requirements, it must begin the vendor selection process. Selecting a vendor must be as objective and quantitative as possible. Areas to be evaluated should include technical functionality, flexibility, and customer service. The following steps may be used as guidelines for providers to start the vendor selection process:

1. Develop a list of potential vendors:

- Talk to the Medicare carrier, DMERC, or FI;
- Ask other providers of comparable size/specialties what vendors they use for what services and how satisfied they are;
- Ask a consultant;
- Attend standards conferences, follow trade magazines and investigate Web pages.

2. Call or write the vendors selected/recommended to discuss the organization's needs and request a proposal.

3. Tell the vendors how the proposals should be structured so that the various proposals can be more easily compared.

4. Attend demonstrations of at least two to three vendors and pay close attention to:
    - How individual requirements will be met;
    - Ease of understanding;
    - Ease of features - data entry, search features, editing/compliance checking features, help features, error correction features;
    - Security - disaster recovery plans, controls, and audits;
    - Daily Procedures;
    - Reporting/Tracking features.
5. Check vendor references and ask specific questions such as:
    - How long has the business been in operation?
    - How long has the system been in place?
    - What is the quality of the training and ongoing support?
    - Is there a user's group in place?
    - What formats are supported?
6. Check with providers served by the vendor and ask specific questions such as:
    - Have you experienced any problems with the system?
    - Have you experienced any problems with the vendor?
    - How long did it take to get up and running?
    - Are you happy with the system/vendor and would you recommend it/them today?
    - Is there anything else I should know or ask before making my decision?

Make site visits to the vendor as well as other clients of similar size and bill mix that have been running the system for some time.

60.8.3 - Evaluating Proposals

(Rev. 1, 10-01-03)

Vendor proposals should be evaluated on several levels including company reputation/history, system functionality, flexibility, overall costs, and support provided.

Providers should create a checklist that compares the vendor proposals against their original requirements by assigning a relative weight to each requirement and then rating the vendor's ability to meet each requirement based on their written proposals. Although some aspects of each checklist will be highly individual, the following are some of the elements that should be considered:

1. Overall costs:

    - Software costs;
    - Hardware costs (types as well as quality);
    - Licensing fees;
    - Training costs;
    - Installation costs;
    - Cabling;
    - Phone lines (leased line/toll charges);
    - Remodeling/Furniture;
    - Forms;
    - Conversion costs;
    - Electricity costs;
    - Supply costs (diskettes, tapes, paper, ribbons);
    - Annual hardware maintenance;
    - Annual software maintenance;
    - Cost of custom program changes; and
    - Cost of continuous software support.

2. Evaluate hardware differences;

3. Evaluate quality of training and support;

4. Evaluate system documentation;

5. Consider the staff size of the vendor;

6. Determine how well each vendor responded to requirements and questions in the proposals;

7. Determine flexibility (whether the package is proprietary, whether the software can be easily modified, whether the vendor can accommodate changing payer requirements, and if so, at what cost);

8. Determine overall system convenience including hours of customer service, technical support, and connection times;

9. Assess future risks and the vendor mitigation of such risks through system trial periods and source codes placed in escrow.

60.8.4 - Negotiating With Vendors

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Once a vendor has been selected, the provider must negotiate the final costs, services, and implementation dates to be provided by the vendor. All agreements reached between the two parties should be obtained in writing. Providers should add a clause to their agreements that will permit them to obtain a refund in the event the vendor's software does not begin to operate successfully by a specific target date following installation. Providers should also add a clause to their agreements allowing them to delay final payment pending successful operation of the new software for a specified period after successful installation.

70 - EDI Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

70.1 - Carrier, DMERC, and FI X12 Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A. X12 997 Functional Acknowledgment

Syntax errors prevent processing of the data that follow the error within the same functional group or the same transaction set header in a batch. For purposes of these editing requirements, a transmission of only a single transaction, such as one claim, is considered a batch of one. Syntax errors appear high in the data hierarchy in a batch and apply to all lower level data included in either the same functional group (GS-GE, see the AK1and AK9 segments of the X12 997) or transaction set (ST-SE, see the AK2 and AK5 segments of the X12 997). Although not a HIPAA requirement, CMS requires carriers, DMERCs, and FIs to issue an X12 997 to submitters of X12 transactions when syntax errors are detected to facilitate correction of the errors and resubmission by the submitter of the original batch. CMS also requires contractors to issue an X12 997 to acknowledge receipt of a claim for which there are no errors.

The X12 997 requirements are contained in appendix B at the rear of each version 4010A1 IG adopted as a national standard under HIPAA. Appendix A of those guides contains information on the interchange and application control structures used in the design of X12 standards, explains the basic structure of each X12 transmission, and further defines differences between syntax and semantic edits. Translators must reject all transactions contained in the same functional group of a batch when there is a functional group syntax error, and all transactions within the same transaction group header when there is a syntax error at that level.

B. Translation and Date of Receipt Editing

If a shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (carrier, DMERC, FI) by the shared system with an appropriate error message.

The date of receipt of a claim is the date a claim is received by the carrier, DMERC, or FI and not a subsequent date on which the claim may have been received by the shared system. The date of receipt must be an actual calendar date and may not be all zeroes or a future date. See § 80.2.1 of Chapter 1 of this manual for additional information on establishing the date of receipt of a claim.

C. Implementation Guide Edits

In conjunction with front-end translation, FIs are to also conduct IG edits to identify submitted data elements that do not comply with data element requirements added by the IG developers, using either software available from FISS or other software which is able to edit at this level. Carrier and DMERC shared systems conduct IG edits for transactions sent to the carriers and DMERCs. In many cases, IG edits are more restrictive than those established by the X12 standard that served as the platform for development of the IG. For instance, the X12 standard might allow a maximum of 30-digits in a data element, but an IG note could limit the maximum size to 20-digits. Or the number of valid digits that may be entered in a data element as identified by the qualifiers that apply to the data element, might not permit reporting of more than 15-digits even though the standard permits up to 30-digits.

No national standards have been adopted under HIPAA for acknowledgement or error reporting for any of the HIPAA format transactions. At this time, FIs, carriers, DMERCs, and shared system maintainers are allowed to continue to use the proprietary format used pre-HIPAA, or another proprietary format with proprietary messages, to notify submitters of EDI transactions when one or more IG requirements were not met. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, FIs, carriers, and DMERCs are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

FIs share IG editing responsibilities with FISS (shared system documentation indicates which IG edits are conducted by the shared system). Carrier and DMERC shared systems are responsible for IG editing of professional transactions. When editing for IG compliance, the responsible party must verify that:

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;

- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;

- All non-Medicare data field lengths correspond to the maximum IG length.

- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;

- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size;

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system); and

- All decimal data elements are defined as "R" and translators write these data elements to the X12-based flat file at their maximum field size (which is initialized to spaces). The COBOL picture found under the X12 element name must be used to limit the size of the amounts. These positions must be right justified and zero-filled. Contractor translators must convert signed values using the conversion table shown below. This value must be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the X12-based flat file data element is used as a placeholder by Medicare to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are:

    - "X" = value exceeds maximum amount based on the COBOL picture,

    - "Y" = value exceeds maximum decimal places based on the COBOL picture,

    - "Z" = value exceeds x-number of precision places, and

    - "b" blank represents no error.

For example, a dollar amount with the IG maximum of 18-digits would look like 12345678.90. The contractor translator maps this amount to the X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount looks like

23456789{bbbbbbbbX. The “{“ is the converted sign value for positive “0.” The error switch value is “X” since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	**Negative Values**
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

70.2 - Supplemental FI-Specific Shared System Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A. FI Edits

1. Left justify a ZIP Code that exceeds nine positions.

2. FIs must return to the submitter individual transactions identified by their edits that contain data that meets the syntax requirement of the standard on which a HIPAA adopted IG is based, but exceed tighter requirements in the IG as signified by an IG note, internal code list, external code list, or qualifier. An appropriate error message must accompany the returned transactions. Likewise, the shared system is responsible for return of individual transactions in this situation when identified by IG edits applied by FISS, and the issuance of appropriate error messages to describe the reason the transactions are being returned.

3. Reject individual transactions with an appropriate error message if the Employer Identification Number (EIN) exceeds 10 positions.

4. Disregard submitted data if in a data element labeled “NOT USED” in the IG adopted as a HIPAA standard.

5. Enter all spaces in any Medicare flat file fields that the HIPAA IG does not require and which are not submitted in a transaction.

6. Reject dates with an appropriate error message that exceed eight digits (CCYYMMDD), unless used to report date ranges.

7. Flag claims for rejection by the shared system if the attending, referring, or operating physician numbers exceed 16 positions.

8. Flag claims for rejection by the shared system if the units of service exceed seven positions.

9. Flag claims for rejection by the shared system if the number of days (covered, lifetime reserve, etc.) exceeds four positions.

10. Disregard credit card and foreign currency data per note in the HIPAA IG stating that this information must never be sent to the payer. Do not include such disregarded data in any COB transaction.

11. Map translator to convert submitted amounts to the Medicare flat file using the COBOL picture of S9(8)V99 (10 positions). Map other numeric data elements to the data size described within the Medicare flat file documents. Populate numeric data fields larger than the data size described within the Medicare flat file documents with all nines.

12. Write the first 449 lines of an institutional claim submitted with more than 449 lines to the Medicare Part A Claim/COB flat file. The shared system will return the claim to the submitter with an appropriate error message based on the missing 0001 entry in line 450.

13. Round units of service that contain decimals when translating from the X12 claim to the Medicare flat file (i.e., if the number to the right of the decimal is four or less, round down. If the number to the right of the decimal is five or greater, round up). Although the HIPAA IG permits decimals, Medicare does not process units of service that contain any decimals or diagnosis codes containing decimals.

14. If an incoming institutional claim contains a diagnosis code with a decimal in the correct position based on the external code source, the FI must reformat the diagnosis code into a 6-position alphanumeric field as defined in the Medicare Part A/COB flat file (flat file) where the digits are left justified and space filled when translating the data into the flat file format. The decimal will be assumed between the third and fourth digit (i.e., 999V9bb - “V” represents the assumed decimal and “b” represents a space). If an incoming claim contains a diagnosis code with a decimal in an incorrect position based on the external code source populate (flag) the field with ampersands.

15. Suppress the one HCPCS code per (Revenue Code edit in FI translators to prevent rejection of outpatient claims with line level (Revenue codes but no HCPCS code.

16. Suppress the FI translator edit for the absence of a date of service where there are no HCPCS codes.

17. Return claims containing a diagnosis code flagged with ampersands to the provider/submitter, via the FI, with an appropriate error message.

18. Return claims with numeric data elements containing all nines to the submitter via the FI with an appropriate error message.

19. Return claims with S9(8)V99 numeric data elements containing an amount greater than corresponding fields set in the core system at 9 digits (S9(7)V99) to the submitter via the FI with an appropriate error message.

20. Return data residing on the Medicare Part A Claim/COB flat file as a result of data received in loop 2010BD RESPONSIBLE PARTY NAME of the HIPAA claim IG via the FI with an appropriate error message because Medicare policy requires a signature on file for payment.

21. Do not return data not required or not used by Medicare, except as directed when COB applies.

FISS DDE Edit Requirements

1. Edit bill types 12X and 22X to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via DDE (these are already required for other inpatient bill types). Claims not containing this data shall be identified as an error with an appropriate error message.

2. Effective January 1, 2005, edit outpatient claims submitted via DDE to ensure each contains a line item date of service (LIDOS) for each (Revenue code. Any outpatient claims found without a LIDOS for each (Revenue code shall be identified as an error with an appropriate on-line error message.)

3. Effective January 1, 2005, edit outpatient claims submitted via DDE to detect Covered Days. Any outpatient claims submitted via DDE containing Covered Days shall be identified as an error with an appropriate error message.

4. Effective January 1, 2005, edit all claims submitted via DDE to ensure each does not contain a NPP000 UPIN. Any claims submitted via DDE containing a NPP000 UPIN shall be identified as an error with an appropriate error message.

5. Effective October 1, 2004, edit all claims submitted via DDE to detect invalid E-codes (an E-code not listed in the external code source referenced by the HIPAA 837

institutional IG). Any claims found containing an invalid E-code shall be identified as an error with an appropriate error message.

6. Effective October 1, 2004, edit all claims submitted via DDE to detect submission of an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid condition code (a condition code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid condition code, value code, diagnosis code, occurrence code, or occurrence span code shall be identified as an error with an appropriate error message.

7. Edit outpatient claims received via DDE to detect submission of an ICD-9 procedure code. Any outpatient claim found containing an ICD-9 procedure code shall be identified as an error with an appropriate error message. (Note: CR 3264 clarified that this edit applies only to outpatient claims.)

8. The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be identified as an error with an appropriate error message.

70.2.1 - FI HIPAA Claim Level Implementation Guide Edits

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A. FISS IG Edit Module

The FIs must reject 837 claims that contain implementation guide (IG) or Medicare program-only errors at the claim level. FIs that are unable to reject individual claims in a batch that have IG or Medicare program errors when the batch is syntactically correct, and there are no errors higher in the batch hierarchy that would prevent processing, must install the FISS IG edit module. This edit module is able to reject claims that have implementation guide (IG) errors at the claim level (see example below). If a batch of claims passes the basic syntax edits, the FISS IG edit module will be invoked and only claims that fail the IG edits will be rejected and appropriate error messages issued.

ISA (example 1)

GS (example 2)

ST (example 3)

PROV A

SUBSCRIBER A (example 5)

CLAIM A1 (example 6)

CLAIM A2

CLAIM A3

SUBSCRIBER AA

CLAIM AA1

CLAIM AA2

PROV B (example 4)

SUBSCRIBER B

CLAIM B1

CLAIM B2 (example 6)

CLAIM B3

SE

ST

PROV C

SUBSCRIBER C

CLAIM C1

CLAIM C2

CLAIM C3 (example 6)

PROV D

SUBSCRIBER D

CLAIM D1

CLAIM D2

CLAIM D3

SE

GE

IEA

Example 1 (ISA-IEA level edit): Any errors found at this level (envelope) will result in all claims within the ISA-IEA being rejected via a TA1. (See Appendix B, p.11 in an X12 HIPAA IG for TA1 segment requirements.)

Example 2 (GS-GE level edit): Any errors found at this level will result in all claims within the GS-GE being rejected via an X12 997. In this example all claims would be rejected. If a second GS-GE loop followed the first and passed all edits, then any claims within the second GS-GE would be entered into the system providing they passed the IG edits.

Example 3 (ST-SE level edit): Any errors found at this level will result in all claims within the ST-SE being rejected and reported in a proprietary format transmission message. In this example assume only the first ST had errors. In this case claims A1, A2, A3, B1, B2, and B3 would be rejected. Claims C1, C2, C3, D1, D2, and D3 would be entered into the system providing they passed lower level IG edits.

Example 4 (Provider level IG edit): Any errors found at this level will result in all claims for this provider being rejected. In this example assume only the Provider B had errors (such as an invalid provider number). In this case, claims A1, A2, A3, C1, C2, C3, D1, D2, and D3 would be entered into the system providing they passed lower level IG edits and claims B1, B2, and B3 would be rejected.

Example 5 (Subscriber level IG edit): Any errors found at this level will result in all claims for this subscriber being rejected. In this example, claims for Subscriber A (A1, A2, and A3) would be rejected. Claims for Subscriber AA (AA1 and AA2) would be entered into the system providing they passed lower level IG edits.

Example 6 (Claim level IG edit): Any errors found at this level will result in only that claim(s) being rejected. In this example assume only claims A1, B2 and C3 had errors. All of the other claims would be entered into the system providing they passed lower level IG edits.

B. Additional FI IG Edits

1. Neither the FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, nor an FI if editing separately shall reject any outpatient claims reported with the “ZZ” qualifier that contain a Health Insurance Prospective Payment System (HIPPS) Rate Codes. (Note: CR 3264 effective October 1, 2004 clarified that this edit applies to outpatient claims only.)

2. Each FI must operate an edit module developed by the shared system maintainer to edit 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X outpatient (as defined in Pub. 100-04 Transmittal 107, CR 3031) type

claims to ensure each contains a line item date of service (LIDOS) for each (Revenue code. Claims not containing a LIDOS for each (Revenue code shall be rejected back to the submitter with an appropriate error message, and not forwarded to the shared system.

3. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all outpatient claims to identify any that contain a Covered Days (QTY) segment. Outpatient claims containing Covered Days shall be rejected with an appropriate error message, and not forwarded to the shared system.

4. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall reject all claims containing a NPP000 UPIN with an appropriate error message, and not forward those claims to the shared system.

5. For outbound X12N 837 HIPAA COB transactions, the FI shall edit all claims to ensure that any containing service line adjudication information also contain an appropriate service line adjudication date (the paid claim date).

6. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall reject all occurrences in inbound claims of invalid: E-codes, condition codes, value codes, occurrence codes, and occurrence span codes with an appropriate error message, and not forward those claims to the shared system.

7. The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs into a contractor-controlled table designed by the shared system maintainer. HPTCs may not be hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. HPTCs are updated twice a year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington Publishing Company (WPC) for no charge at wwww.wpc-edi.com/codes, or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. FIs are to use the most cost effective means to obtain the list for validation programming and updating purposes.

8. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all claims to ensure that submitted HPTCs comply with both the data attributes for the data element as contained in the HIPAA 837 IG, and are valid. To be valid, a HPTC must appear in the latest HPTCs update FIs were required to implement by CMS. HPTCs are not reported in a required data element, but claims received with invalid HPTCs shall be rejected with an appropriate error message, and not forwarded to the shared system.

9. The FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit all outpatient claims to ensure each containing (Revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code. Outpatient claims containing an invalid "Patient Reason for Visit" diagnosis code that is not listed in the external code source referenced by the HIPAA 837 institutional IG shall be rejected from the flat file with an appropriate error message, and not forwarded to the shared system. (Note: CR 3264 effective October 1, 2004 clarified that this applies to outpatient claims only.)

10. FISS shall ensure that a "ZZ" qualifier is populated in the flat file field for HI02-1 when (Revenue code 045X, 0516, or 0526 is present in an outpatient claim and an outbound X12N 837 COB transaction is being prepared. (Note: CR 3264 effective October1, 2004 clarified that this applies to outpatient claims only.)

11. For bill types 12X and 22X, the FISS edit module designed for FI use independent of the FISS-maintained Med A Translator, the FISS IG edit module designed for use in conjunction with the Med A Translator, and any FI editing separately of either shall edit to ensure admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected with an appropriate error message and not forwarded to the shared system.

70.3 - Supplemental Carrier/DMERC-Specific Shared System Implementation Guide Edit Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

1. Carriers and DMERCs must reject inbound electronic claims that contain invalid diagnosis codes whether or not pointed to a specific detail line.

2. Carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or less than 5 byte numeric in any zip code.

3. Carriers and DMERCs must reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

4. The Carrier and DMERC shared systems shall apply IG edits to paper claims only for those requirements that are applicable to both the HIPAA format for electronic claims as well as to paper claims. IG edits must otherwise be bypassed for claims submitted on paper.

70.4 - Key Shop and Image Processing

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

CMS ceased support of the NSF and UB-92 flat file claims effective October 1, 2005 with termination of the HIPAA incoming claim contingency plan. Medicare contractors were required to migrate to either the X12-based flat file or the HIPAA 837 as the output format for external key shop, claims keyed by their own staff members, and OCR/ICR imaged claims sent their data center effective October 1, 2004.

Key shop, imaging, and contractor in-house data entry operations that do not output directly in the HIPAA 837 or X12-based flat file format, must convert their initial output format into the X12-based flat file or the HIPAA 837 format prior to transmission to their data center. When the X12-based flat file is the output, the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (external key shop or in-house data entry) or "O" (OCR/ICR).

Shared systems shall apply IG edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

An outbound 837 COB transaction built from a paper claim will be produced as a "skinny" COB. Gap filling must occur as needed to enable the file sent to the trading partner to meet minimum data set requirements for a compliant 837 version 4010A1 COB transaction. "Skinny" COBs shall contain all required 837 segments and include post-adjudicated data.

80 - Security

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

80.1 - Carrier, DMERC, or FI Data Security and Confidentiality Requirements

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

All Medicare beneficiary-specific information is confidential and subject to the requirements of §1106(a) of the Act and implementing regulations at 42 CFR Part 401, Subpart B. Those regulations specify that, as a general rule, every proposed disclosure of Medicare information shall be subject to the Freedom of Information Act rules at 45 CFR Part 5. Also all such information, to the extent that it is maintained in a "system of records," is protected under the provisions of the Privacy Act of 1974 (5 USC. 552a) and implementing regulations at 45 CFR Part 5b. Such information is included in claims, remittance advice, eligibility information, online claims corrections, and any other transactions where personal information applicable to a beneficiary is processed or transported. Such information may not be disclosed to anyone other than the provider or supplier that submitted a claim or to the beneficiary for whom a claim was filed. Carriers, DMERCs, and FIs must ensure the security of all EDI transactions and data. See the CMS Business Partners System Security Manual and its Core Security Requirements attachment for more detailed information on system security requirements.

Carrier, DMERC, and FI systems must include the following system security capabilities:

- All data must be password protected and passwords modified at periodic but irregular intervals, as well as when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified;

- Provide mechanisms to detect unauthorized users and prohibit access to anyone who does not have an appropriate user ID and password;

- Maintain a record of operator-attempted system access violations;

- Maintain a multi-level system/user authorization to limit access to system functions, files, databases, tables, and parameters from external and internal sources;

- Maintain updates of user controlled files, databases, tables, parameters, and retain a history of update activity; and

- Protect data ownership and integrity from the detailed transaction level to the summary file level.

80.2 - Carrier, DMERC, and FI EDI Audit Trails

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Carriers, DMERCs, and FIs must maintain an automated transaction tracking and retrieval capability and retain an audit trail that notes each change made to each claim from date of receipt to date of payment or denial and any subsequent adjustments. Carriers, DMERCs, and FIs must be able to retrieve or recreate:

- The claim as received (pre-translation) from the provider, billing service, or clearinghouse;

- The claim as paid to the provider;

- All adjustments made on the claim;

- The check or the electronic funds transfer (EFT) record sent to the provider; and

- The remittance advice as sent to the provider.

Carriers, DMERCs, and FIs must maintain the ability to cross-refer all associated transactions, e.g., EFT or check, claim adjustment, remittance advice, to each related claim being processed. The records may be kept on electronic, computer-output-microfilm, optical disk media, or other reliable and industry accepted types of storage and retrieval media. They may never allow anyone to overlay or erase a record. Each record must be kept intact. All records must be archived in accordance with the instructions in the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-01, Chapter 7. It is important to have a well-defined system for maintaining audit trail data so that data integrity is maintained at all times.

80.3 - Security-Related Requirements for Carrier, DMERC, or FI Arrangements With Clearinghouses and Billing Services

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

A billing service is an entity that markets claim preparation services to providers and may also be able to perform related transactions for providers, such as eligibility and claim status inquiries. The billing service collects a provider's claim information and then bills the appropriate insurance companies, including Medicare. A billing service may submit claims only, or provide full financial accounting and/or other services. Billing services are considered to be provider business associates. As such, HIPAA requires that they comply with each of the privacy and security requirements that apply directly to providers. They are also required to ensure that they require that any clearinghouses, subcontractors or other business associates of their own that may be involved with handling of Medicare beneficiary data also meet those same security and privacy requirements. A billing service may view beneficiary or provider data to carry out their billing obligations for a provider, when a provider authorizes them to have that access. To qualify as a billing service, an entity must at a minimum submit initial claims on the provider's behalf.

A clearinghouse transfers or moves EDI transactions for a provider or billing service, and generally translates the EDI transactions from or into a proprietary format. (HIPAA defines a clearinghouse as a business associate of a provider or a health care plan that translates data from a non-standard format into a standard format or vice versa as preferred by their clients.) A clearinghouse generally accepts multiple types of incoming transactions and sends them to various payers, including Medicare. Clearinghouses often perform general and payer-specific edits on claims, and may handle multiple types of EDI transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgements, remittance advice transactions, and claim status and eligibility queries.

Some entities that refer to themselves as clearinghouses, however, do not edit or translate data, but simply serve as a "telecommunication switch," moving transactions from point A to Point B or wherever directed under the terms of the agreement with a provider. A clearinghouse may also be called a value added network (VAN), or when eligibility data are involved, are sometimes called Network Service Vendors (NSVs). A clearinghouse/VAN/NSV may not view privacy-protected Medicare data unless a signed authorization has been filed by the provider for whom the clearinghouse/VAN/NSV will submit or received Medicare EDI transactions. For EDI, a transaction that contains individually identifiable information about a Medicare beneficiary is considered to be privacy protected data.

That provider may not authorize submission or receipt of data by a third party for a Medicare beneficiary unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider. The provider authorization must be filed with the Medicare contractor to whom EDI transactions will be sent or from whom they will be received. In the case of a DMERC, this authorization need only be submitted to one of the four DMERCs. If multiple carriers or FIs may be involved, an authorization must be submitted to each.

Each clearinghouse/VAN/NSV that will submit or receive Medicare EDI transactions is prohibited from using the EDI number or password issued to any of the providers they serve. Each clearinghouse/VAN/NSV must obtain its own EDI number and password from each carrier, DMERC, or FI with which it will interact.

Some health care providers use or may want to use more than one billing service or clearinghouse/VAN/NSV. Medicare contractor ability to handle more than one agent varies. Some contractors are able to accommodate one or more clearinghouses/VAN/NSV for submission of a provider's claims to Medicare, another agent to receive the provider's remittance advice transactions, and a third clearinghouse/VAN/NSV to verify beneficiary Medicare eligibility for a provider. Others may not be able to accommodate more than one agent for a provider. DMERCs, carriers and FIs are encouraged to support more than one agent for a provider, when permitted by their front end configuration.

Medicare contractors must notify each provider that applies for permission to obtain eligibility data electronically that:

- They are permitted to view Medicare eligibility data only for patients currently being treated by or who have requested treatment or supplies from that provider;

- A provider cannot authorize a billing agent or clearinghouse to submit or obtain data from a Medicare contractor that the provider is not entitled to personally submit or obtain;

- A request for personally identifiable information for any other Medicare beneficiaries would be a violation of Medicare and HIPAA privacy requirements, and subject to the applicable penalties for such violations.

Medicare contractors must notify each billing service and clearinghouse/VAN/NSV at the time of their application for access to Medicare eligibility data and by also posting information on their web site that:

- Their access is limited to submission of transactions and receipt of transactions for those providers that are their clients, but only if those providers authorized the billing agent and/or clearinghouse/VAN/NSV to submit or receive each transaction.

- A billing agent or clearinghouse/VAN/NSV that has provider authorization to submit claim data for a provider cannot obtain eligibility data for that provider unless that was specifically authorized by the provider.

- Likewise, the billing agent or clearinghouse/VAN/NSV cannot be sent remittance advice transactions for a provider unless specifically authorized to do so by that provider.

Providers must submit these authorizations to their Medicare contractor in writing; a Medicare contractor is not permitted to accept a statement signed by a billing agent or clearinghouse/VAN/NSV alleging that they have such provider authorization on file. An original provider signature is required on these authorizations (but a contractor is allowed to accept an authorization signed by a provider by fax or mail). The carrier, DMERC, or FI is responsible for maintenance of files to establish system access for individual providers, identify those billing agents and clearinghouses/VAN/NSV authorized to access systems as the agent of a specific provider, and to record those transactions for which a billing agent or clearinghouse/VAN/NSV is authorized access as the representative of a specific provider.

With authorization, a clearinghouse/VAN/NSV may send inquiries for a provider, and receive responses, but it may not view personally identifiable beneficiary data contained in those queries or responses, store it for longer than necessary to assure delivery to the provider (no longer than 30 days maximum), or use personally identifiable data in any reports. The EDI data sent or received belongs ultimately to the beneficiary, not to the clearinghouse/VAN/NSV that may translate and transport the data for a provider acting on the beneficiary's behalf.

Collection agents that contract with providers to collect "bad debts" and third party entities that may analyze data but do not have a specific initial claim submission role or are not responsible for posting of information in a remittance advice to patient accounts may not be sent beneficiary data by a Medicare contractor. If a collection agent or such a third party has provided adequate privacy and security assurances to protect beneficiary data, the provider may share Medicare payment information with a collection agent, data analysis firm, or similar third party, but the provider would need to furnish that data to that entity agent in this situation, however. The Medicare program may not incur costs to furnish such data to collection agencies or to other entities that perform services that do not directly support Medicare activities. Delinquent collection, analysis of data related to a provider's operations, and expenses related to other activities not directly related to Medicare claims or payments are considered provider business expenses. Such activities do not directly benefit Medicare and Medicare may not incur costs to supply data intended only for such uses.

A provider must sign a valid EDI Enrollment Form (see section 20 of this chapter) prior to authorizing a billing agent or clearinghouse/VAN/NSV to submit/receive any EDI transactions on their behalf. A separate password is to be used for system access by each authorized provider, billing agent or clearinghouse. A vendor provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual providers, billing agent or clearinghouses/VANs/NSVs. Vendors supply the means for Medicare system access but have no right to direct access to Medicare contractor systems.

Vendor software is normally tested when it first begins to be used by providers, billing agents or clearinghouses/VANs/NSVs. At the request of a vendor or a clearinghouse/VAN/NSV, a Medicare contractor may, but is not required to, test new software before a provider has agreed to begin using that software to exchange Medicare EDI transactions with the contractor. When testing software prior to use by a provider, a Medicare contractor may not furnish a software vendor who does not currently submit or receive Medicare transactions with an EDI access number or password which would permit the vendor to access to actual Medicare beneficiary data. That software is to be tested using a test database or by other means that would not disclose actual beneficiary data to the vendor. This EDI access limitation for testing of new software does not apply to a clearinghouse/VAN/NSV with a history of submission/receipt of EDI transactions with the contractor, or when a software vendor is also a clearinghouse/VAN/NSV or a provider billing agent (in which case, testing should only involve data for beneficiaries for which the entity already submit/receives transactions).

90 – Mandatory Electronic Submission of Medicare Claims

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105, and the implementing regulation at 42 CFR 424.32 require that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a Medicare fee-for-service carrier, DMERC, or FI for the first time, including resubmitted previously rejected claims, claims with paper attachments, demand bills, claims where Medicare is secondary, and non-payment claims. Initial claims do not include adjustments or claim corrections submitted to FIs on previously submitted claims or appeal requests.

Medicare is prohibited from payment of claims submitted in a non-electronic manner that do not meet the limited exception criteria. Claims required to be submitted electronically effective October 16, 2003, and later must comply with the appropriate claim standards adopted for national use under HIPAA (see section 40 of this chapter). The mandatory electronic claim submission requirement does not apply to claims submitted by beneficiaries or by providers that only furnish services outside of the United States, claims submitted to Medicare managed care plans, or to health plans other than Medicare.

90.1 – Small Providers and Full-Time Equivalent Employee Self-Assessments

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

A “small provider” is defined at 42 CFR section 424.32(d)(1)(vii) to mean A) a provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or B) a physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs. To simplify implementation, Medicare considers all providers that have fewer than 25 FTEs and that are required to bill a Medicare FI to be small; and considers all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare State and Federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for full-time benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal (Revenue Service (IRS) using an Employer Identification Number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals who perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for full-time benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider (as identified by provider number, UPIN, or national provider identifier (NPI) when implemented) to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers bill FIs and some carriers. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to determine the number of staff who work on a full-time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part-time hours a week worked on average by all staff who furnished services for the provider on a less than full-time basis. Divide that total by 40 hours to determine their full-time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents. For FTE calculation purposes, it is acceptable to include only those staff members of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records, or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

In the event that a provider uses a clearinghouse or a billing agent to submit claims, it is the number of FTEs on the provider's staff, not those on the staff of the billing agent or the clearinghouse, that determine whether the provider may be considered small for Medicare paper claim submission purposes.

90.2 – Exceptions

(Rev. 1194, Issued: 03-09-07; Effective/Implementation Dates: 04-09-07)

It has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be possible in some cases to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition for self-assessment purposes:

1. <u>Roster billing of inoculations covered by Medicare</u>—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, some suppliers have been permitted to submit a single claim on paper with the basic provider and service data and to attach a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. This is referred to as roster billing. The claim IGs adopted under HIPAA provide for submission of single claims to a payer for single individuals, but cannot be used to submit a roster bill for multiple individuals.

   Flu and pneumonia inoculations are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable a HIPAA-compliant claim to be submitted electronically in such field situations, particularly when a single individual is responsible for collection of the data and administration of the inoculations. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

   It is in the interest of Medicare and public health to make it as simple as possible for mass inoculation activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required except in the case of multi-state companies that signed an agreement with a single Medicare contractor for submission of all flu shots to that single contractor for those states, and who agreed to submit those claims electronically as a condition for centralized billing of those inoculations. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for inoculations.

   This inoculation waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections including flu shots when furnished in a traditional medical setting such as a doctor's office or an outpatient clinic as a component of other medical care or an examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, a flu shot or other inoculation is also to be included in the electronic claim sent to Medicare for the patient.

2. <u>Claims for payment under a Medicare demonstration project that specifies paper submission</u>—By their nature, demonstration projects test something not previously done, such as coverage of a new service. As a result of the novelty, the code set that applies to the new service may not have been included as an accepted code set in the claim implementation guide(s) adopted as HIPAA standards. The HIPAA regulation itself makes provisions for demonstrations to occur that could involve use of alternate standards. In the event a Medicare demonstration project begins that requires some type of data not supported by the existing claim formats adopted under HIPAA, Medicare could mandate that the claims for that demonstration be submitted on paper. In the event demonstration data can be supported by an adopted HIPAA format, Medicare will not require use of paper claims for a demonstration project. Demonstrations typically involve a limited number of providers and limited geographic areas.   Providers that submit both demonstration and regular claims to Medicare may be directed to submit demonstration claims on paper.   Non-demonstration claims must continue to be submitted electronically, unless another exception or waiver condition applies to the provider.

3. <u>"Obligated to Accept as Payment in Full" (OTAF) Medicare Secondary Payer (MSP) Claims when There is More than One Primary Payer</u>— An OTAF adjustment (also see the Medicare Secondary Payment Manual) is made when a provider, physician or supplier agrees as result of negotiation or otherwise to receive a payment rate that is higher or lower than a payer's normal allowed amount as payment in full for particular services or supplies. By regulation, if a primary payer's OTAF amount is lower than the charge for the related service that appears on the claim, Medicare must include the OTAF adjustment when calculating the amount of Medicare's secondary payment.

There is not a single claim adjustment reason code specifically reserved for OTAF adjustments. Different payers have chosen to report this in an X12 835 using a variety of existing claim adjustment reason codes or in a paper RA/Explanation of Benefits (EOB), using a variety of proprietary codes or text messages. The HIPAA requirement for reporting of standard claim adjustment reason codes in X12 835 and 837 transactions does not apply to paper RAs/EOBs. As result, it can be difficult for Medicare to automatically detect when an adjustment reported in an MSP claim was the result of an OTAF agreement, but a provider should know when an OTAF-type agreement is in place.

To make sure that OTAF adjustments can be identified in MSP claims, providers were directed to enter any applicable OTAF adjustment from a payer in the CN1 segment in an X12 837 version 40101A1 MSP claim. When there is more than one primary payer, however, it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF adjustment in the event more than one primary payer made an OTAF adjustment. As result of this X12 837 limitation, when there is more than one primary payer and an OTAF adjustment applies, providers are to submit OTAF claims on paper, with the RAs/EOBs from the primary payers attached.

4. MSP Claims When There is More than One Primary Payer and More Than One Allowed Amount—In an MSP situation, Medicare needs to use a primary payer's allowed and paid amounts to calculate the supplemental amount that can be paid by Medicare. In some cases, a beneficiary is covered by more than one other primary payer. Each of those other payers must complete adjudication before Medicare can process those claims. The ASC X12 837 version 40101A1 IG permits reporting of payment information from more than one other payer, but not for reporting of separate allowed amounts at the line or claim level for more than one payer. As result of this limitation, when there is more than one primary payer, and the allowed amounts differ, a provider is permitted to submit the claim to Medicare on paper, with the RA/EOB from each of the primary payers attached.

Except for OTAF claims when there is also more than one primary payer, or if a provider is small or meets one of the temporary exception criteria, such as disruption of electricity or communications, no other types of MSP claims, such as MSP claims when there is only one primary payer, may be submitted to Medicare on paper.

5. Home Oxygen Therapy Claims for Which the CR5 Segment is Required in an X12 837 version 40101A1 Claim but for Which the Requirement Notes in Either CR513, CR 514 and /or CR 515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. Completion of these data elements as required in the X12 837 professional IG is an assertion that the required condition for inclusion of these data elements is met. Non-completion of these data elements, however, cannot be interpreted as a statement that the required condition for inclusion of these data elements is not met. There is no means to answer "no," enter the actual oxygen saturation rate or the arterial PO_2 measurement, but a patient can sometimes qualify for oxygen even if each of these conditions is not met.

This will be corrected in a post-40101A1 version of the IG, but until that is implemented, covered entities are permitted to submit their claim to Medicare on paper in this situation.

6. Claims submitted by Medicare beneficiaries.

7. MSP claims situations when the shared system cannot accept the patient payment amount on an incoming MSP claim. - The shared system is being updated to accept this amount and send the patient payment amount to MSPPAY. Medicare payment reimbursement is paid directly to the beneficiary only when a payment or co-payment was paid to the provider by the beneficiary.

Note: This is a temporary situation. This situation will expire on July 1, 2007.

90.3 – "Unusual Circumstance" Waivers

(Rev. 802, Issued: 12-30-05; Effective: 04-01-06; Implementation: 04-03-06)

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a partial (applies to certain claim types or for a defined period of time) or full waiver of the electronic claim submission requirement would be appropriate. The Secretary delegated that authority to CMS. In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations, providers are encouraged to file claims electronically where possible, but electronic filing is not required.

CMS has in turn delegated certain authority to the Medicare carriers, DMERCs, and FIs to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or FI to whom they submit their claims. The Medicare contractor must issue a form letter (Exhibit A) in the event of receipt of a written waiver request that does not allege an "unusual circumstance."

As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (either a sole practitioner, employee or the owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or the name used to obtain an EIN from the IRS.

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer apply, that provider is again subject to the Medicare electronic claim submission requirement. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as an OTAF secondary claim when there is more than one primary payer. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other exception or unusual circumstance criteria.

90.3.1 - Unusual Circumstance Waivers Subject to Provider Self-Assessment

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

The following circumstances always meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type or the period when an "unusual situation" exists. A provider is to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may submit claims to Medicare on paper or via other non-electronic means when one of these circumstances applies. A provider is not expected to pre-notify their Medicare contractor(s) that one of the circumstances applies as a condition of submission of non-electronic claims.

1. Dental claims—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically.

2. Disruption in Electricity or Phone/Communication Services--In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than 2 business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, providers should simply hold claims for submission when power and/or communication are restored.

3. A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.

4. Non-Medicare Managed Care Organizations that are able to bill Medicare for copayments may continue to submit those claims on paper. These claims are not processable by the MSPPay module and must be manually adjudicated by Medicare contractors.

90.3.2 - Unusual Circumstance Waivers Subject to Medicare Contractor Approval

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

NOTE: The information in this subsection applied in FY 2004, but not for later fiscal years due to the elapsed time since the effective date (October 2003) of the ASCA electronic claim submission requirement. Providers, vendors and clearinghouses would have had more than adequate time to complete necessary systems changes prior to initiation of enforcement (Reviews by Medicare contractors and there should not be any continuing need for temporary waivers of the type listed in this section. The information is being retained here for historical reference purposes only.

Medicare contractors (carriers, DMERCs and FIs could at their discretion approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considered there to be "good cause" that prevented a provider from submitting claims electronically for a temporary period. "Good cause" applied if a provider made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that the provider made reasonable efforts to rectify, the provider was not initially able to submit all affected claims electronically effective October 16, 2003.

Since these waivers could have been for less than 90 days, and contractors might have preferred to insert the basis for the waiver in the letter, Medicare contractors were to use a locally produced letter to notify providers when short-term waivers were approved for this reason. As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision were to have been addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or used to obtain an EIN from the IRS.

In the event that a provider cited an inability to submit certain primary or secondary claims to Medicare electronically as a result of the inability of their commercial software to submit HIPAA-compliant claims, Medicare contractors were allowed to approve a single waiver for up to 180 days after the date of the decision notice to allow adequate time for the provider to obtain and install an upgrade from their vendor, or to transition to software from another vendor that could submit these claims electronically and compliantly. Medicare contractors were to use a locally produced letter to notify providers when short-term waivers were approved for this reason.

If the contractor determined an "unusual circumstance" applied, and an initial provider waiver of 90/180-days or less as described above was not involved, CMS approval was required. The request and the contractor's recommendation were to have been forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 for (Review and issuance of the decision. The contractor was to have been copied on the decision notice issued to the requestor. If the contractor did not consider an "unusual circumstance" to be met, the contractor was to issue a form letter (Exhibit B).

90.3.3 - Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

A provider may submit a waiver request to their Medicare contractor claiming other types of "unusual circumstances" outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit documentation appropriate to establish the validity of a waiver request in this situation. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the Medicare contractor agrees that the waiver request has merit, the request must be forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 for Review and issuance of the decision. The contractor must forward an explanation as to why contractor staff recommends CMS approval to DDIS with the waiver request. The contractor will be copied on the decision notice DDIS issues to the requestor.

If the contractor does not consider an "unusual circumstance" to be met, and does not recommend DDIS approval, the contractor must issue a form letter (Exhibit B). As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee, or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or that is used to obtain an EIN.

"Unusual Circumstances" that Require CMS Review:

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the IG deficiency.)

> **NOTE:** A Medicare contractor is not permitted to prohibit submission of an electronic claim because there is a paper attachment. The X12N 837 IG contains information for provider use of the PWK segment to alert a Medicare contractor that attachment information is being separately submitted. Some Medicare contractors had issued instructions regarding use of the X12 837 NTE segment to report attachment information in lieu of PWK. Submitters of claims for which there are attachments essential for adjudication must comply with the X12 attachment reporting direction issued by their Medicare contractor for the immediate future. System changes will be made for contractor use of PWK in conjunction with implementation of the attachment standard which is scheduled for future adoption as a HIPAA standard. NCPDP claims should not have attachments.
>
> Medicare contractors are required to accept claims electronically for reassociation with attachments submitted separately on paper or via other means such as fax when supported by individual contractors. Medicare contractors must include the process for submission of claims when there are attachments in a newsletter article and on their Web site with other applicable information concerning the ASCA requirement that Medicare claims be submitted electronically.

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims. In this case, the documentation that establishes the disability of those staff members would need to be issued by providers other than the provider requesting the waiver and would need to be submitted for Review.

3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience. The provider must submit a waiver request to their Medicare contractor for evaluation by that contractor, and if approved at that level, for subsequent review by CMS. In the event other situations are identified and approved by CMS for which a requirement for electronic filing would always be considered against equity and good conscience, those situations will be added to the self-assessment list.

90.4 – Electronic and Paper Claims Implications of Mandatory Electronic Submission

(Rev. 615, Issued: 07-22-05, Effective/Implementation Dates: 10-01-05)

Claims providers submit via a DDE screen maintained by a Medicare shared system or transmitted to a Medicare contractor using the free/low cost claims software issued by Medicare are considered electronic. When enforcing the electronic claim submission requirement, CMS will take into account those limited situations where a provider submitted paper claims because the free billing software they were issued may have been temporarily unable to accommodate submission of a secondary or other particular type of claim.

Medicare contractors are prohibited from requiring submission of paper claims in any situations on or after October 16, 2003, except as specifically permitted by CMS.

Medicare carriers, DMERCs, and FIs are to assume for processing purposes that claims submitted by a provider on paper October 16, 2003, and later are submitted by providers that are small or that do meet exception criteria, barring information received from other sources to the contrary. Submission of a paper claim October 16, 2003, or later will be considered an attestation by a provider that waiver criteria are met at the time of submission.

90.5 – Enforcement

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

See §§90.7-90.7.6 for additional requirements specific to the Railroad Medicare Carrier (RMC).

90.5.1 - Fiscal Intermediary Shared System (FISS) Role in ASCA Enforcement

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Enforcement will be conducted on a post-payment basis during those periods when directed by CMS. FISS will prepare quarterly reports for the FIs for those periods as directed by CMS 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.

90.5.2 - MCS & VMS Roles in ASCA Enforcement

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

As result of the substantially higher number of paper claims sent to carriers and DME Medicare Administrative Contractors (MACs) and B (B part of A/B) MACs than to FIs, somewhat different ASCA quarterly report requirements are being applied for the carrier and DME MAC quarterly reports. MCS and VMS will prepare an online (printable at the contractor's discretion) report each calendar quarter (October-December, January-March, April-June and July-September) for each carrier, DME MAC, or MAC as applicable. Each report must identify the months and year for which the data is being reported. The report must be available for contractor use by the end of the month that follows completion of a calendar quarter, e.g., by October 31 for July 1-September 30.

The following fields are in the provider file to assist with preparation of these reports, contractor tracking of report history, and selection of providers for ASCA Enforcement Reviews:

- Date (CCYYMMDD) most recent ASCA enforcement review began (shared system will populate with the trigger date of the most recent initial review letter, Exhibit letter C or H; see §90.7 for information on Railroad Medicare Carrier (RMC) population of this field for letter G);

- Date (CCYYMMDD) denial of paper claims began or is to begin as provider not eligible to submit paper claims (shared system shall populate with the 91st day after letter C, G or H is triggered, or a contractor shall reset that date to the date after an approved extension period expires; see §90.5.3.B);

- Effective date (CCYYMMDD) of provider eligibility to submit paper claims if effective after the date the provider was initially determined to be not eligible to submit paper claims (see §90.5.3.C; contractor must populate using a shared system field established for reporting of this date);

- Result of the most recently completed ASCA enforcement review—The ASCA review result field is used for contractor entry of a 2-character code to identify the result of an ASCA review. When one of the following applies, the later of 1) the date the most recent ASCA enforcement review began or2) the date this decision was effective if after the date a provider was initially determined not to be eligible to submit paper claims will be considered the effective date of the decision:

NE--Provider not eligible to submit paper claims (shared system will populate when paper claim denials begin; see §90.7 for exception when this will be populated by the RMC);

SM--Provider determined to be small based on provider's FTEs (contractors shall populate);

WA--Provider determined to meet an other ASCA exception or waiver condition, including submission of fewer than 10 claims a month on average to Medicare (does not include a § 90.3.3, chapter 24 unusual circumstance; see §90.7.1 for RMC application of the fewer than 10 claims per month waiver; contractors shall populate); or

UC--Provider determined eligible for an "unusual circumstance" waiver per § 90.3.3 of chapter 24 (contractors shall populate). When UC applies, a 60-byte field must be supplied by the shared system for contractor entry of the specific "unusual circumstance." The shared system must reject a UC entry unless an entry of at least 6 alphanumeric characters is entered in the 60-byte unusual circumstance field.

A. Quarterly MCS and VMS Provider Online ASCA Report

The quarterly ASCA report prepared by MCS or VMS must be in four parts:

Part 1—This Part must contain information on those providers that submitted some claims electronically and others on paper that quarter. Part 1 must indicate the: name; taxpayer identification number (TIN); legacy provider identifier (PIN or NSC number used for payment); the number of paper claims submitted that quarter under that identifier); the number of electronic claims submitted that quarter under that PIN or NSC number; the percentage of those claims that were on paper; date the provider's most recent ASCA enforcement review began; date the provider's most recent ASCA enforcement review was completed (date Exhibit letter F triggered or date paper claim denials began; see §90.5.2.B); and the result code from that most recent review. The report sent to the RMC must include the ZIP Code of the provider, extended if available. This part must be organized in descending order according to the number of paper claims submitted for each provider that quarter.

If a provider has more than one PIN or NSC number, but claims under all of those identifiers are covered by the same TIN, the listing for the all PINs or NSC numbers issued that provider are to be reported in successive entries in Part 1. MCS and VMS shall report the first entry for that provider in accordance with the descending order rule based on either the total number of paper claims submitted under all of the PINs or NSC numbers or the number of paper claims submitted under the PIN or NSC number with the highest number of paper claims, followed immediately by the separate entries for each of the other PINs/NSC numbers associated with that same TIN. The listings for the other PINs/NSC numbers associated with that TIN are also to be in descending order according to the number of paper claims submitted under each identifier.

Part 2—This Part must contain information on those providers that submit all of their claims on paper and submitted 100 or more claims that quarter. Part 2 must indicate the name; TIN; legacy provider identifier (PIN or NSC number); the number of paper claims submitted for each listed provider that quarter under that identifier; date the provider's most recent ASCA enforcement review began; date the provider's most recent ASCA enforcement review was completed; if for the RMC, the ZIP Code (extended if available); and ASCA review result code from that most recent review. This part must be organized in descending order according to the number of paper claims submitted for each provider that quarter.

In the case of a provider that has more than one PIN or NSC number used to bill that quarter which are covered by the same TIN, apply the reporting directions located at the end of Part 1.

Part 3—This Part must contain information on those providers that submitted only paper claims and who submitted fewer than 100 paper claims during that quarter. Part 3 must indicate the name; TIN; legacy provider identifier (PIN or NSC number); the number of claims submitted for each listed provider that quarter; date the provider's most recent ASCA enforcement review began; date the provider's most recent ASCA enforcement review was completed (i.e., either date 2 or date 3 from 90.5.2); if for the RMC, the ZIP Code (extended if available); and ASCA review result code from that most recent review. This part must be organized in descending order according to the number of paper claims submitted for each provider during that quarter.

In the case of a provider that has more than one PIN or NSC number used to bill that quarter which are covered by the same TIN, apply the reporting directions located at the end of Part 1.

Part 4—The total number of providers for which one or more paper claims were submitted during the quarter. The number in Part 4 is intended to represent the unduplicated total of all providers that could potentially be considered for ASCA Enforcement Review selection.

NOTE: Shared systems have the option to use adjudicated or processed claims, rather than submitted claims, for preparation of the report if that would take less time or resources to prepare. If using adjudicated or processed claims instead of submitted claims, this must be noted in the report.

B. Identification of Providers to Be Reviewed, Letters to be Issued and Determinations Made

A check block or field that can be used to identify those providers being selected for review must appear at the beginning of the data line for each listed provider. The report produced for the RMC must permit the RMC to designate whether letter C or H is to be issued. The block or field will be completed by the contractors to identify those providers chosen for ASCA review. When a contractor completes that block/field, the shared system will notify the contractor's correspondence system by the next business day to release Exhibit letter C (or H in the case of the RMC) to that provider and will furnish the start and end date of the quarter on which the review is based (for contractor entry in the paragraph that follows "e" in Exhibit letter C.) The shared system will automatically begin counting days since letter C, G (manually triggered by the RMC) or H was triggered and will trigger release of letter D 45-days after letter C, G or H (or the first business day after the 45th day when the 45th day is on a weekend or holiday), and will count elapsed days to begin denying paper claims from that provider effective with the 91st day after letter C, G or H was triggered.

The shared system must permit a carrier or MAC to cancel the block/field for issuance of letter C or H in the event completed in error, as long as the correction is made on the same business day as the erroneous entry.

90.5.3 - Contractor Roles in ASCA Reviews

(Rev. 1284; Issued: 07-09-07; Effective: 07-01-07; Implementation Date: 10-01-07)

A. Identification of Those Providers to be Reviewed

Separate funding will no longer be issued for these reviews annually. Each carrier and DME MAC (not FI) shall conduct an ASCA review annually of 20% of those providers still submitting paper bills. Funding for these reviews is to be included in annual budget requests submitted to CMS for FY 2008 and later years.

The following providers will be included in the quarterly report, but contractors are not to select a provider for review that quarter if:

- A prior quarter review is underway and has not yet been completed for that provider (start date of prior review is listed in the report but not yet a completion date);

- The provider has been reviewed within the past two years, determined to be a "small" provider, and there is no reason to expect the provider's "small" status will change for at least two years (provider file past ASCA review result was "SM" and completion date of that review is less than 24 months in the past); or

- Fewer than 30 paper claims were submitted by the provider for the quarter.

When calculating 20% of providers still submitting paper claims, exclude those providers mentioned above who will not be considered for an ASCA review. For example, a contractor receives claims for 3,200 providers but only 2,000 of those submit any paper claims, and 1,800 submit more than 30 paper claims per quarter. 600 of that 1,800 have been reviewed within 2 years of the quarter in which a Medicare contractor is now determining which providers should be reviewed during that quarter and determined to be small. 75 of the paper billers in the quarterly report had reviews begin the prior quarter which are still open. That leaves a balance of 1,125 providers who could be subject to an ASCA review during the current quarter. 1,125 is the total of the universe of providers that are candidates for review during the current quarter and the number of the universe to be reported to CMS in the contractor's monthly ASCA report. 20% of 1,125 is 225 and ¼ of 225 is 56 ¼. That contractor is expected to begin at least 56 new ASCA reviews during the current quarter. By the end of the fiscal year (FY), that contractor is expected to have begun ASCA reviews of the average of the provider universe totals for the quarters multiplied by 20%. In this example, if 1,125 providers was the average number of providers considered for ASCA review for the 4 quarters of the FY and the contractor began ASCA reviews of 225 of those providers by the end of the FY, that contractor will have met the 20% target for that FY.

90.5.4 - Submission of Claims that May Always be Submitted on Paper by Providers Not Otherwise Eligible to Submit Paper Claims

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

If a provider determined to be ineligible to submit most types of claims on paper contacts a contractor to complain because a claim that contained services permitted to be submitted on paper (see §90.2) was denied, the contractor is to manually process and pay that claim. These claims will only be paid at the provider's request, assuming all other requirements are met for coverage and payment of that claim or certain services included in that claim. Medicare systems are incapable of identifying and paying certain types of paper claims, or only certain services included in paper claims, when a provider has been determined to be otherwise ineligible for payment of all other paper claims.

90.6 - Provider Education

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Medicare contractors were required to include information on their provider Web site and in a newsletter by April 2004 to notify providers of/that:

1. Providers that do not qualify for a waiver as small and that do not meet any of the remaining exception or waiver criteria must submit their claims to Medicare electronically;

2. Small provider criteria and that small providers are encouraged to submit as many of their claims electronically as possible;

3. FTE definition and calculation methodology;

4. Exception criteria;

5. Unusual circumstance criteria;

6. Self-assessment requirements;

7. Process for submission of an unusual circumstance waiver;

8. Additional claims, such as certain claim types not supported by free billing software, that must continue to be submitted on paper pending any contractor or shared system modifications to enable those claims to be submitted electronically;

9. Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criterion applies at the time of submission;

10. Repercussions of submitting paper claims when ineligible for submission of paper claims;

11. Post-payment monitoring to detect providers that submit unusually high numbers of paper claims for further investigation; and

12. Waiver request submitted by providers should include the providers' name, address, contact person, the reason for the waiver, why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information the contractor deems appropriate for evaluation of the waiver request.

90.7 - Application of Electronic Data Interchange Enrollment Information and ASCA Enforcement Review Decisions from Other Medicare Contractors to the Same Providers When They Bill the Railroad Medicare Carrier

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

ASCA did not differentiate among Medicare contractors or between Railroad (RR) and non-RR Medicare for application of the electronic billing requirement. Section 90.3.1 of this chapter indicates that a provider that submits fewer than 10 claims to Medicare per month on average (fewer than 120 claims per year) is permitted to continue to submit paper claims. As result of the distribution of RR retirees though, it is not unusual for a single provider to only treat a small number of RR Medicare patients and to submit fewer than 10 claims to the RR Medicare Carrier (RMC) per month. The same providers that treat RR Medicare patients also treat non-RR Medicare beneficiaries however, and in most cases do submit more than 10 claims per month in total to one or more non-RR Medicare contractors. As result, when selecting providers for an ASCA Enforcement

Review, the RMC shall not exclude a provider from consideration for review simply because the quarterly ASCA report indicates the provider submitted fewer than 10 claims to the RMC. In a departure from the rule as it applies to non-RMC Medicare contractors, submission of fewer than 10 claims per month to the RMC does not automatically qualify a provider for waiver of the electronic claims submission requirement.

Providers that submit paper claims to multiple Medicare contractors, including both RR and non-RR Medicare contractors, could have an ASCA Enforcement Review conducted by each of those contractors. If a non-RR Medicare contractor determines that a provider does not meet any criteria which would permit that provider to continue to submit Medicare claims on paper and notifies a provider (letter E is triggered) that all paper claims submitted on or after a specific date will be denied, that same decision is to be applied to that provider if submitting paper claims to the RMC regardless of whether that provider would submit 10 or more paper claims to the RMC monthly.

Provider enrollment information from non-RR Medicare contractors is sent to the RMC weekly by the MCS maintainer in a Provider Enrollment System file called SuperPES. As a condition for submission of claims to the RMC, a provider must first enroll for submission of claims to non-RR Medicare. The RMC uses SuperPES to determine whether any provider that sends them a claim, but that does not have a record in the RR provider enrollment system (PES), is already enrolled in non-RR Medicare. If so, the RMC then uses the SuperPES information to establish a record for that provider in the RR PES file, or if not, rejects those claims as there is no indication that provider has enrolled in Medicare.

SuperPES is manually searched by RMC representatives. It would be difficult and possibly impossible to automatically update PES due to the differences in RR and non-RR legacy provider numbers. Addition of NPIs may not appreciably improve the ability to make one to one matches since providers can obtain more than one NPI or fewer NPIs than legacy identifiers. Although supplemental information is submitted on claims that can often be used to match between an NPI and a single legacy identifier, there is not as much supplemental information in the SuperPES and PES files that could be used to help make a match between the files in the absence of a claim.

SuperPES includes fields (see the date and ASCA decision fields in §90.5.2) for the reporting of an ASCA review result, the date of that ASCA decision and the NPI associated with the provider's non-Railroad PIN. "Multi" is entered in that field if more than one NPI is associated with a PIN.

The RMC shall check SuperPES for the availability of ASCA Enforcement Review information when selecting providers on PES for ASCA Enforcement Reviews, as well as when first establishing a PES record for a provider. If an ASCA review decision (NE, SM, WA or UC) is in SuperPES, that decision and the effective date of that decision in SuperPES must be entered into that provider's record in PES. In lieu of "NE" however, the RMC shall enter "NR" in PES to indicate that the "not eligible" determination was made by a contractor other than the RMC. If either "SM," "WA" or" UC" applies, the effective date of the decision is the later of the date in SuperPES when that contractor began the most recent ASCA review or the date the provider became eligible to submit paper claims when that is later than the date that the denial of claims began as result of a prior NE/NR decision. A future date may not be entered in PES for a NE/NR decision. A future NE effective date in SuperPES signifies that the contractor has not yet completed the ASCA review and that the decision is still tentative. See §90.7.1 for further use of the ASCA decision codes to determine when to issue ASCA review letters.

If there is more than one entry in SuperPES for the same provider, perhaps as result of the provider's submission of claims to more than one Medicare contractor, the RMC shall compare each of those entries that contains an ASCA decision and enter that decision and that effective date in PES that is the most "negative" in terms of the number of paper claims that would be submitted to the RMC as result of entry of that decision and date. The RMC has discretion to determine which set of ASCA information is the most negative overall.

90.7.1 - RMC Entry of ASCA Enforcement Review Decisions and EDI Enrollment Information from Other Medicare Contractors into PES

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

To take advantage of the information being added to SuperPES, the RMC shall do the following:

1. **When using SuperPES to establish an initial record in PES for a provider--**If available in SuperPES, the RMC shall copy any ASCA review result information and the provider's ZIP Code, (extended if available), as well as those data elements that would have been copied in the past, and include that information in PES. If there is an NE entry in the ASCA review decision field, the RMC shall manually issue letter G to the provider to notify the provider that paper claims submitted to the RMC beginning on the 91st day after the date of the letter will be denied unless the provider can establish eligibility for one of the ASCA exceptions. See information later in this section on use of ASCA decision codes in selection of providers to be sent an ASCA Enforcement review letter. If no evidence has been received by the 45th day after the date of that letter, MCS shall trigger release of letter D. MCS shall trigger release of letter E and begin denying paper claims on the 91st day after the date of letter G as if a normal ASCA review was being conducted, unless the provider submits documentation that results in cancellation of the denial by the RMC.

2. **When a provider for whom a PES record was previously established is selected from the shared system's quarterly paper claim submitters report to initiate a new ASCA Enforcement Review--** The RMC shall look up each selected provider that has been tentatively selected for an ASCA review in the most recent SuperPES file to see if a record can be located based upon the information the RMC has available for that provider. When able to locate a record, the RMC shall add any ASCA review results from another Medicare contractor for that provider and the ZIP Code (extended if available) for that

provider to PES. An "NE" decision shall be converted to "NR." See information later in this section on use of ASCA decision codes in selection of providers to be sent an ASCA Enforcement Review letter. The RMC will use the shared system's quarterly report to trigger release of letter H to notify the provider that paper claims they submit beginning on the 91st day after the date of the letter will be denied. If no response is received after 45 days, MCS shall trigger release of letter D. If no response is received to letter D, or there is a response but it will not result in a decision to allow the provider to continue to submit paper claims, MCS shall trigger release of letter E and begin denying paper claims submitted following the regular procedures for an ASCA Enforcement Review.

3. **If the RMC learns that a provider that sends paper claims to the RMC sends electronic claims to one or more other Medicare contractors—**When this information comes to the attention of the RMC as result of an action other than establishment of an initial record in PES or selection of a provider for review from the quarterly ASCA report, the RMC shall check the provider's record in SuperPES and in the last quarterly paper claim submitters report received from MCS. If there are no ASCA Enforcement Review results in SuperPES that would preclude initiation of an ASCA Enforcement Review (see §90.7.2), the RMC shall use the quarterly report to trigger release of letter H. MCS shall trigger letters D and E as appropriate in a regular ASCA Enforcement Review unless the RMC cancels denial of the paper claims because the provider responded and was able to establish grounds for continued submission of paper claims to the RMC. If the RMC has already initiated all reviews targeted for that quarter, the RMC may initiate this review as part of the next quarter's reviews.

If the ASCA information in SuperPES for a provider indicate that the provider was determined to be eligible for continued submission of paper claims as result of an ASCA review, the RMC shall enter that ASCA exception/waiver decision in PES for future reference. If a provider alleges that contrary to a NE ASCA review determination in SuperPES, they do not submit Medicare claims to any Medicare contractor electronically and that provider furnishes a letter from another Medicare contractor that indicates an ASCA exception/waiver determination that is not yet reflected in SuperPES, the RMC is to enter the appropriate ASCA decision code in PES for the provider and shall not deny the provider's paper claims for ASCA purposes.

In the absence of such a letter however, the RMC is to assume that providers that have an NE entry in SuperPES do submit electronic claims to at least one other Medicare contractor, do submit 10 or more claims electronically to Medicare overall and can also submit claims to the RMC electronically. The RMC is to use the most recent MCS quarterly paper claim submitters report, or if all reviews targeted for that quarter have already been initiated, the next quarterly paper claim submitters report received to trigger release of letter H in that situation. MCS shall trigger letters D and E and begin denial of that provider's paper claims on the 91st day unless the RMC delays or cancels the denial action.

90.7.2 - Selection of Providers to be Sent Initial Letters for the RMC to Begin an ASCA Enforcement Review

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

If a provider is being considered for an ASCA review, the RMC shall check the latest SuperPES file to determine if another Medicare contractor has conducted an ASCA Enforcement Review. If there is an ASCA decision in SuperPES that was made later than any ASCA decision already posted in PES, the RMC shall update the information in PES and determine based upon the new information whether appropriate for them to initiate a new ASCA review of that provider.

The RMC shall not send a letter to a provider to begin an ASCA Enforcement Review if:

a. SuperPES contains a "SM" decision for the provider that is less than two years old;

b. SuperPES contains the date an enforcement review began but does not contain a decision and at least 121 days have not elapsed since the date the review began (this signifies another contractor has an ASCA review underway for that provider); or

c. SuperPES contains a "UC" decision and fewer than 6 months have elapsed since the date of that decision.

When there is an NE decision in SuperPES with a past date, the RMC shall use a MCS quarterly paper claim submitters report to trigger release of letter H to that provider to notify them that their paper claims will begin to be denied on the 91st day after the date of that letter.

The RMC shall use a MCS quarterly paper claim submitters report to trigger release of letter C to a provider to initiate an ASCA Enforcement Review if:

a. There are no SuperPES ASCA field entries for a provider;

b. There is a "UC" decision in SuperPES and more than 6 months have elapsed since the date of that decision;

c. SuperPES contains the date an enforcement review began but does not contain a decision and more than 121 days have elapsed since the date the review began;

d. There is a "SM" decision in SuperPES, more than two years have elapsed since the date of that decision, and the number of paper claims that provider submitted to the RMC as indicated in the most recent ASCA quarterly report is high enough to have resulted in this provider being selected for initiation of an ASCA review in the event that there had not been any ASCA field entries in SuperPES for this provider; or

e. There is a “WA” decision in SuperPES and enough paper claims were submitted to the RMC as indicated by the MCS quarterly paper claim submitters report to have resulted in this provider being selected for initiation of an ASCA review in the event that there had not been any ASCA field entries in SuperPES for this provider.

Use of ASCA review information from SuperPES may result in denial of paper claims submitted by some providers who had been previously told by the RMC that they could submit their claims on paper as they submit fewer than 10 to the RMC per month. This situation is addressed in letter H. Although it would have been preferable to share ASCA paper claim denial decisions with the RMC when ASCA Enforcement Reviews first began, that was not possible at the time. Addition of information about ASCA Enforcement Review results to SuperPES files now makes application of these decisions by the RMC possible.

90.7.3 - Subsequent Reversal of Decision that a Provider is Not Eligible to Submit Paper Claims by a Non-RR Medicare Contractor

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Medicare contractors often begin to deny paper claims because a provider failed to respond to the initial and second request ASCA Enforcement Review letters (see exhibit letters D, G, H and E at the end of this chapter). Providers sometimes furnish that evidence after denial of their paper claims begins. If the evidence shows that the provider actually qualified for one or more exception criteria retroactively to the date when denial of their paper claims was effective, the Medicare contractor shall replace the paper claim denial decision (NE) in the provider’s file with a new decision based upon the submitted evidence. If the provider then resubmits the claims to that contractor that were denied as submitted on paper following receipt of letter F from that contractor, they will be reprocessed and paid if they otherwise meet Medicare requirements.

In this situation, a paper claim denial decision transmitted to the RMC one week may be replaced by a different decision in a subsequent week’s SuperPES file. It is not possible to automatically post the revised decision in the RR PES file based on this change in SuperPES however, and non-RR Medicare contractors do not have access to records that indicate whether particular providers bill the RMC and which might allow them to notify the RMC directly of such a reversal. In this situation, a provider who also bills the RMC and who has been notified that the paper claims sent to the RMC will be or have started to be denied based on the ASCA electronic claim submission requirement would be expected to contact the RMC to report the reversal of the decision made by the non-RR Medicare contractor.

When contacted, the RMC shall:

a. Ask the provider which Medicare contractor made and reversed that ASCA denial decision and furnish the provider with information to mail a copy of that letter to the appropriate person at the RMC;

b. Tell the provider not to begin to submit new paper claims, or resubmit those already denied as submitted on paper, until the provider receives a reversal letter (F) from the RMC; and

c. Update PES accordingly upon receipt of the copy of the reversal letter and trigger release of a new letter F so that the newly submitted and resubmitted RR paper claims from that provider can be processed

90.7.4 - Number of ASCA Enforcement Reviews to be Conducted by the RMC

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Due to the impact of ASCA review decisions made by non-RR Medicare contractors, it would not be reasonable to require that the RMC issue new ASCA review letters for 20 percent of the providers who send them paper bills annually without giving the RMC some credit for the additional effort expended as result of the PES-SuperPES-quarterly paper claim submitters reports reviews the RMC is required to conduct. It takes the RMC longer to identify providers that should be sent letters to initiate a new ASCA review and in some cases, the cross checks performed by the RMC result in disqualification of a provider for selection for a new ASCA Enforcement Review. To adjust for this, the RMC annual ASCA review target is to review the records of 20 percent of those providers who submit paper claims as indicated in the MCS quarterly paper claim submitters reports, and not to necessarily initiate a new ASCA review of 20 percent of the providers that send them paper claims annually.

To compute this 20 percent, the total number of providers for whom reviews are to be conducted shall be computed as directed in § 90.5.3. To gauge the number to be reviewed during a single quarter in the same FY prior to production of the fourth quarterly report for that FY, the RMC shall multiply the total of providers who submitted paper bills in the most recent quarterly report by 0.2 (20 percent), and then multiply again by .25. The number of reviews to be initiated during the fourth quarter shall be computed by subtracting the total reviews identified as conducted for the first three quarters of the FY from the total number of reviews targeted for the FY as a whole; the difference in the totals is the number of reviews to be started during the fourth quarter.

For purposes of the monthly ASCA review report submitted to DDISdata.info prior to the fourth quarter of a FY, the total number of providers in the MCS most recent quarterly paper claim submitters report shall be entered in the “eligible providers” field. The total number of providers in that quarterly report for whom ASCA review letters are actually issued to begin reviews plus those for whom a decision is made that a new review is not warranted at that time due to an ASCA review action taken by another Medicare contractor shall be entered in the “Initial Review Letters Issued for Report Period” field of the monthly DDISdat.info report. CMS realizes that an initial review letter will not actually have been issued by the RMC to each provider in this second situation, but the RMC review of ASCA data in SuperPES for those providers selected from the MCS quarterly paper claim submitters report which result in decisions not to initiate new reviews will be considered as equivalent to initiation of a new review by CMS for comparison purposes with other Medicare contractors and to determine if the annual 20 percent target has been reached by the RMC. The number of ASCA reviews completed total to be entered in the monthly report shall equal the number of ASCA reviews completed during the reporting period that were initiated with an ASCA review letter plus the number of new ASCA reviews that were determined not to be warranted that month as result of review of ASCA information in SuperPES that same month.

For the fourth quarter of the FY, the total number of providers as computed for the FY who are eligible for review, i.e., the total who submitted paper claims in each of the quarterly ASCA reports for the FY divided by four, shall be entered in the DDISdata.info monthly report as the number of “Eligible Providers.” The RMC shall follow the direction in the prior paragraph to calculate the number of ‘Initial Review Letters Issued for Report Period” and the “Reviews Completed” totals to be entered in those fields of the DDISdata.info reports for the months in that final quarter. The remaining fields of the monthly ASCA reports are to be completed by the RMC according to the existing completion instructions for that report which were previously issued to the Medicare contractors.

90.7.5 - RMC Information in ASCA Enforcement Review Letters

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

The letters that apply to ASCA Enforcement Reviews at the end of this chapter did not originally refer to application of decisions made by another Medicare contractor to a provider when billing the RMC. These letters have now been modified to note that an ASCA Enforcement Review made by one Medicare contractor that a provider does not qualify to submit claims on paper also applies to that same provider when billing other Medicare contractors, including the RMC. Two letters (G and H) have been added specifically for RMC use. Letters G and H may not be sent by and do not apply to any contractor other than the RMC.

The ASCA regulation indicated that denial of claims because they were not submitted to Medicare electronically would be applied on a prospective basis. Ninety days is being allowed prior to denial in letters G and H to allow time for those providers that do not have software for submission of electronic claims to the RMC to obtain that software from their vendor. Addition of a RMC module to some commercial electronic claim submission software can reportedly be expensive. As result, wording has also been included in the letters concerning the Medicare free billing software.

The cost charged by a commercial software vendor for a module to enable claims to be submitted to the RMC electronically is not a valid basis for waiver of the requirement that a provider submit their claims to the RMC electronically. The RMC shall encourage a provider who may mention cost to use the RMC’s free billing software if this would be a more cost effective method of electronic submission of their claims to the RMC. The provider shall use either the commercial software of their choice or the Medicare free billing software and shall begin to submit their claims to the RMC electronically if they wish to continue to be paid for services furnished to RR Medicare beneficiaries.

The ASCA Enforcement Review letters now refer to an ASCA electronic claim submission requirement made by one Medicare contractor as applying to all Medicare contractors because that is actually how ASCA decisions are to be applied. CMS has not enforced this across the board due to the lack of a vehicle for sharing decisions across contractor lines, other than in the case of the RMC. If a vehicle becomes available to do this in the future for contractors other than the RMC, CMS will begin to require that this be done. Sharing of these decisions across the board would require coordination to eliminate the possibility that more than one contractor could conduct reviews of the same provider at the same time so this issue would also need to be addressed in any subsequent change request issued for this purpose.

90.7.6 - RMC Costs Related to Use of ASCA Review Information in SuperPES Files

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Due to the release date of this CR, the RMC may not have been able to include costs for this work in their Medicare operations budget for FY 2008. As result, the RMC may submit a supplemental budget request (SBR) for FY 2008 ASCA review costs as required in §§ 90.7-90.7.5. Costs for FY 2009 and later for ASCA review expenses as delineated are to be included in the annual operations budget request submitted by the RMC. If supplemental funding is required for implementation activities related to this subsection that may begin prior to the start of FY 2008, the RMC shall submit a SBR for the FY 2007 costs as soon as the amount of those costs can be determined.

Exhibits of Form Letters

(Rev. 615, Issued: 07-22-05; Effective/Implementation Dates: 10-01-05)

Exhibit A—Response to a non- "unusual circumstance" waiver request

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)
Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Electronic Claim Submission Waiver Request

You recently submitted a request for waiver of the Administrative Simplification and Compliance Act (ASCA) requirement that claims be submitted electronically to be considered for Medicare payment. Providers are to self-assess to determine if they meet the criteria to qualify for a waiver. A request for waiver is to be submitted to a Medicare contractor only when an "unusual circumstance," as indicated in c, d, or e below applies. Medicare will not issue a written waiver determination unless b, c or d applies.

ASCA prohibits payment of service and supply claims submitted to Medicare on paper, except in limited situations that apply either to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers—To qualify, a provider required to use a UB-04 form when submitting claims on paper shall have fewer than 25 full time equivalent employees (FTEs).A physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

8. Claims submitted by beneficiaries;

9. Claims from providers that only furnish services outside of the United States;

10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

11. Providers that can establish that some other "unusual circumstance" exists that precludes 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 as result, 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. Periods when a Medicare contractor's claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider's control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

The request you submitted did not include information to establish that situation b, c or d applies. You are expected to self-assess to determine if one of the other exceptions or unusual circumstances applies. If your self-assessment indicates that you do meet one of those situations, you are automatically waived from the electronic claim submission requirement while the circumstance is in effect. Medicare contractors will monitor your compliance with this ASCA requirement on a post-payment basis.

If your self-assessment does not indicate that exception or waiver criteria apply as listed above, you shall submit your claims to Medicare electronically. This applies to every Medicare contractor to which you submit claims, including the contractor responsible for processing of Railroad Medicare claims. This office can supply you with free billing software for submission of Medicare claims. See (contractor shall insert the URL) for further information on enrollment for use of EDI, use of free billing software or other EDI information. There is also commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs.

Sincerely,

Contractor Name

Exhibit B—Denial of an "unusual circumstance" waiver request

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Request for Waiver of Electronic Claim Filing Requirement Decision

Your request for waiver of the requirement that Medicare claims be submitted electronically has been denied. The Administrative Simplification Compliance Act (ASCA) prohibits Medicare coverage of claims submitted to Medicare on paper, except in limited situations. Those situations are:

1. Claims submitted by small providers—To qualify, a provider required to use a UB-04 form when submitting paper claims shall have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier required to use the CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project, when paper claim filing is

required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare carrier);

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

9. Claims submitted by beneficiaries;

10. Claims from providers that only furnish services outside of the United States;

11. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

12. Providers that can establish that some other "unusual circumstance" exists that precludes 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 as result, 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. Periods when a Medicare contractor's claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider's control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

We have determined that you do not meet any of these criteria for waiver of the ASCA requirement for electronic submission of Medicare claims. ASCA did not establish an appeal process for waiver denials, but you can re-apply for an "unusual circumstance" waiver if your situation changes. This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier. As you do not qualify for a waiver of the ASCA electronic claim submission requirement, Medicare will begin to deny paper claims you may submit beginning on the 91st day after the date of this letter.

Waiver applications are only to be submitted to request a waiver if an "unusual circumstance" applies under b, c or d above. The information submitted with your waiver request did not indicate that circumstance b, c or d any other exception or waiver criteria apply in your case. If your self-assessment indicates that an exception condition, other than b, c or d is met, you are automatically waived from the electronic claim submission requirement and no request should be submitted to a Medicare contractor. Medicare contractors will monitor compliance with the ASCA electronic billing requirements on a post-payment basis.

Paper claims submitted to Medicare that do not meet the exception or unusual circumstance criteria do not qualify for Medicare payment. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. See (contractor shall insert the URL) for further information on enrollment for use of EDI, use of free billing software are other EDI information. There is also commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs.

Sincerely,

Contractor Name

Exhibit C—Request for Documentation from Provider Selected for (Review to Establish Entitlement to Submit Claims on Paper

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

A large number of paper claims were submitted under your provider number(s) 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 from Medicare be submitted electronically with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security 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. This also applies to payments made for beneficiaries who qualify for Medicare based upon their employment in the railroad industry.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers-- To qualify, a provider required to use the UB-04 form when submitting claims on paper shall have fewer than 25 full-time equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare carrier);

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

8. Claims submitted by beneficiaries;

9. Claims from providers that only furnish services outside of the United States;

10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

11. Providers that can establish that some other "unusual circumstance" exists that precludes 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 as result, 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. Periods when a Medicare contractor's claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of 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.
Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they 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 deny all paper claims you submit to us effective with the 91st calendar day after the date of this notice. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes. This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier.

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 free billing software for submission of Medicare claims. See (contractor shall insert the URL) for further information on enrollment for use of EDI, use of free billing software or other EDI information. There is also commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state.

Sincerely,

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

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105 and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security 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.

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting evidence 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 ASCA 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 denied by Medicare. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes. This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier.

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 free billing software for submission of Medicare claims. (Contractor shall insert the URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed.) There is also commercial billing software, and billing agent and clearinghouse services are available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state.

Sincerely,

Contractor Name

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

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

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 from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security 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.

We have reviewed your response to our letter requesting that you 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 determined that you do not meet the paper claims waiver/exception criteria as stated in our prior letter. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if such a change in your situation occurs. This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier.

Consequently, any Medicare paper claims you submit on or after the 91st calendar day from the date of the letter requesting evidence of your eligibility to continue to submit paper claims will be denied by Medicare.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with free billing software for submission of Medicare claims. (Contractor shall insert URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed.) There is also commercial billing software, and billing agent and clearinghouse services are available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state.

Sincerely,

Contractor Name

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

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claim Submission Practices

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

If your situation changes to the point where you no longer meet at least one of the criteria, you will be required to begin submission of your claims electronically by the 91st calendar day after 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 (contractor shall insert phone number) if you would like to discuss use of the Medicare free billing software or other alternatives for submission of claims electronically. You are also encouraged to review information on our Website (contractor shall insert the URL where information on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed) concerning use of Electronic Data Interchange transactions.

Sincerely,

Contractor Name

Exhibit G - Notice from the Railroad Medicare Carrier to a Provider that Has Just Begun to Submit Claims that Paper Claims Submitted by that Provider Will be Denied

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Denial of Paper Claim Submission Practices

You recently began to treat one or more Railroad Medicare beneficiaries and began to submit claims to us for the first time. In the process of establishing a record in our files to indicate that you are eligible to submit Medicare claims, we obtained a copy of your non-RR Medicare enrollment information. That record indicates that you are required to submit your Medicare claims electronically to at least one other Medicare contractor and does not indicate that you were issued a waiver to permit submission of paper Medicare claims. Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 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 did not differentiate among Medicare contractors or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement. As result, we will begin to deny any paper claims you submit to us for Railroad Medicare beneficiaries unless you are able to establish that you meet one or more of the following exceptions to this ASCA requirement:

1. Claims submitted by small providers-- To qualify, a physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 full-time equivalent employees (FTEs). A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

8. Claims submitted by beneficiaries;

9. Claims from providers that only furnish services outside of the United States;

10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

11. Providers that can establish that some other "unusual circumstance" exists that precludes 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 as result, 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. Periods when a Medicare contractor's claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of 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 us. 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.

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they 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 us, we will begin to deny all paper claims you submit to us effective with the 91st calendar day after the date of this notice. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. Commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill us as well as other payers. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state. Some providers have reported that their software vendor or clearinghouse charges a substantial additional amount to allow a provider to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. This office can supply you with free billing software that you can use to submit your claims to us electronically. (Contractor shall insert URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed and/or supply a telephone number the provider can call to obtain comparable information.)

Sincerely,

Contractor Name

Exhibit H—Notice from the Railroad Medicare Carrier to a Provider with a Pre-Established Record in PES that Paper Claims Will Be Denied as Result of the Requirement that a Provider Submit Claims to One or More Other Medicare Contractors Electronically

(Rev. 1353; Issued: 10-15-07: Effective: 01-01-08; Implementation: 01-07-08)

Date:

From: Contractor (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claim Submission Practices

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 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. Paper claims will be denied if submitted by entities determined to be in violation of the statute or this rule. ASCA did not differentiate among Medicare contractors or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement.

We recently discovered that you have been submitting more than 10 Medicare claims per month on average to one or more other Medicare contractors and/or submitting claims to another Medicare contractor electronically. Unless you have been issued a letter by one or more Medicare contractors granting you a waiver of more than 90 days from the

ASCA requirement for electronic submission of your claims, or are now able to establish that you do meet one or more of the criteria for waiver of this ASCA requirement, you are also required to submit your claims to us for Railroad beneficiaries electronically. If you have such a letter, or evidence that you do now qualify for a waiver of this ASCA requirement, please forward a copy of that letter or evidence to this office to enable us to update our records and permit you to continue to submit claims to us on paper if you choose.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers--To qualify, a provider required to use the UB-04 form when submitting claims on paper shall have fewer than 25 full-time equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;

8. Claims submitted by beneficiaries;

9. Claims from providers that only furnish services outside of the United States;

10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

11. Providers that can establish that some other “unusual circumstance” exists that precludes 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 as result, 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. Periods when a Medicare contractor’s claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside of the provider’s control, it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

It is possible that you may previously have contacted this office or had an ASCA Enforcement Review conducted by this office and were informed that you are eligible to continue submitting paper claims to this office since you submit fewer than 10 Medicare claims to us per month. Until recently, we did not have access to ASCA review information from other Medicare contractors that could be used to determine whether you should be submitting your claims to us electronically. As we do now have access to this type of information from other Medicare contractors, we are required to apply that information to you and to other providers that submit paper claims to this office.

As you may not have been notified that an ASCA electronic claim submission requirement that applies to another Medicare contractor also affects your submission of paper claims for Railroad Medicare beneficiaries, we will not begin to deny your paper claims until the 91st day after the date of this letter. This will allow you time to make changes as needed so you can begin to submit your claims to us electronically by the 91st day.

In the event your situation changes and you feel that you do meet one or more of the criteria for an exception from the ASCA electronic claim submission requirement, you should recontact us and any other Medicare contractor that made a determination that you do not currently qualify for an exception. If determined that you do in fact qualify for an exception at that point, you would have the option to again begin to submit some or all of your Medicare claims on paper. The type of exception criteria you meet will determine if the exception applies to only certain types of your claims, all of your claims or applies only for a temporary period. That would be addressed in the decision notice you would be sent.

Some providers have reported that their software vendor or clearinghouse charges a substantial amount to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. This office can supply you with free billing software that you can use to submit your claims to us electronically. (Contractor shall insert URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed and/or supply a telephone number the provider can call to obtain comparable information.)

Sincerely,

Contractor Name

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1614CP	10/03/2008	Healthcare Provider Taxonomy Codes (HPTC) Update October 2008	10/06/2008	6190
R1601CP	09/19/2008	Update to Chapter24 of the Claims Processing Manual	10/20/2008	5974
R1420CP	01/25/2008	Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process	02/01/2008	5837
R1353CP	10/15/2007	Application of ASCA Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contactor	01/07/2008	5606
R1284CP	07/09/2007	Chapter 24 Update and EFT Format Standardization	10/01/2007	5586
R1283CP	07/06/2007	National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), Update of Telecommunication and Transmission Protocols for EDI and Deletion of Obsolete Reference to Medicaid Subrogation Claims	10/01/2007	5637
R1214CP	03/30/2007	Discontinuance of ASCA Excel Spreadsheet Maintenance	07/02/2007	5509
R1213CP	03/30/2007	EDI Enrollment and Electronic Claim Record Retention	07/02/2007	5491
R1194CP	03/09/2007	Temporary Addition to the Administrative Simplification Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims	04/09/2007	5488

Rev #	Issue Date	Subject	Impl Date	CR#
R1081CP	10/20/2006	Electronic Data Interchange (EDI) Media Changes	04/02/2007	5225
R1077CP	10/13/2006	Electronic Data Interchange (EDI) Media Changes	01/16/2007	5225
R1063CP	09/22/2006	Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate Remittance Advice	10/23/2006	5308
R1033CP	08/18/2006	Revise Chapters 22 and 24 to delete references to free downloads of X12 implementation guides adopted as HIPAA standards from Washington Publishing Company (WPC)	11/20/2006	5247
R958CP	05/26/2006	Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment	08/26/2006	5092
R952CP	05/19/2006	Administrative Simplification Compliance Act (ASCA) Review Revisions	10/02/2006	5068
R900CP	04/07/2006	Update to Chapter 24 CMS Website URL References	07/07/2006	4398
R885CP	03/10/2006	Suppression of Standard Paper Remittance Advice to Providers and Suppliers Also Receiving Electronic Remittance Advice for 45 Days or More	06/1/2006	4376
R831CP	02/02/2006	Shared Systems Medicare Secondary Payer (MSP) Balancing Edit, and Administrative Simplification Compliance Act (ASCA) Enforcement Update	07/03/2006	4261
R802CP	12/30/2005	Termination of the Medicare HIPAA Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual Circumstance, Modification of the OTAF Exception, and	04/03/2006	4119

Rev #	Issue Date	Subject	Impl Date	CR#
		Modification of ASCA Exhibit Letters A, B and C		
R615CP	07/22/2005	Complete Revision of Chapter 24, EDI Support Requirements	10/03/2005	3875
R541CP	04/29/2005	Correction to the use of Group Codes for the Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3815
R450CP	01/27/2005	Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3440
R448CP	01/21/2005	Timeframe for Continued Execution of Crossover Agreements and Update on the Transition to the National Coordination of Benefits Agreement (COBA) Program	02/22/2005	3658
R435CP	01/14/2005	Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3440
R238CP	07/23/2004	Intermediary Shared System Changes for Processing HIPAA X12N 837 Transaction	01/03/2005	3321
R199CP	06/10/2004	Rejection of any outpatient claim containing a range of dates in the line item date of service (LIDOS) field	10/04/2004	3337
R175CP	05/14/2004	Instructions for Intermediary Shared Systems Maintainers for Implementation of HIPAA X12N institutional 837 transaction	10/04/2004	3264
R162CP	04/30/2004	Cessation of Support for NSF	10/04/2004	3180
R138CP	04/09/2004	Beta Testing COB Implementation	07/06/2004	3218
R107CP	02/24/2004	Intermediaries and Intermediary Shared System Maintainers must make necessary changes to implement the HIPAA X12N 837 Institutional 837 transaction	07/06/2004	3031

Rev #	Issue Date	Subject	Impl Date	CR#
R099CP	02/09/2004	Contractors and shared systems maintainers must make necessary changes to implement the HIPAA X12N 837 coordination of benefits transaction	07/06/2004	3100
R098CP	02/06/2004	Implementation of National COB Process for Crossover Claims	07/06/2004	3109
R086CP	02/06/2004	Required pre-pass editing processes to prevent certain claim errors from being accepted into the Part B and DMERC shared systems	07/06/2004	3050
R084CP	02/06/2004	Allowing segments to be transmitted in any order	07/06/2004	3095
R057CP	01/02/2004	Accommodating 15 Positions of ISA08 Data on Outbound X12N HIPAA Transactions	04/05/2004	3001
R049CP	12/19/2003	Intermediary Rejection of HIPAA X12N 837 Health Care Claim Transaction When Certain Levels of Errors Are Detected	04/05/2004	2879
R044CP	12/19/2003	Mandatory Electronic Submission of Medicare Claims Based on the Administrative Simplification Compliance Act and Waiver Conditions	01/20/2004	2966
R015CP	10/31/2003	Accommodating 15 Positions of ISA08 Data on Outbound X12N HIPAA Transactions	04/05/2004	2819
R001CP	10/01/2003	Initial Publication of Manual	NA	NA