CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1194	**Date: MARCH 9, 2007**
	Change Request 5488

Subject: Temporary Addition to the Administrative Simplification Compliance Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims

I. SUMMARY OF CHANGES: The shared system is being updated to accept the patient payment amount on incoming MSP claims and sending that amount to MSPPAY. Currently, MCS does not have this data element in its MSP claims processing system. EDS is building this field which will be ready for the July, 2007 release.

New / Revised Material
Effective Date: April 9, 2007 for business requirement 5488.1
April 9, 2007for business requirement 5488.2
July 1, 2007 for MCS System Changes

Implementation Date: April 9, 2007 for business requirement 5488.1
April 9, 2007 for business requirement 5488.2
July 2, 2007 for MCS System Changes

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	24/90/90.2/Exceptions

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1194	Date: March 9, 2007	Change Request: 5488

SUBJECT: Temporary Addition to the Administrative Simplification Compliance Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims

Effective Date: April 9, 2007 for business requirement 5488.1
April 9, 2007 for business requirement 5488.2
July 1, 2007 for MCS System Changes

Implementation Date: April 9, 2007 for business requirement 5488.1
April 9, 2007 for business requirement 5488.2
July 2, 2007 for MCS System Changes

I. GENERAL INFORMATION

A. Background: The shared system is being updated to accept the patient payment amount on incoming MSP claims and sending that amount to MSPPAY. Currently, MCS does not have this data element in its MSP claims processing system. EDS is building this field which will be ready for the July, 2007 release.

MCS contractors will temporarily need to allow these requests for co-payment reimbursement claims to come in on paper to MSPPAY for calculation and to send reimbursement directly to the beneficiary.

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

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5488.1	MCS contractors shall grant a temporary waiver for EMC MSP claims received prior to July 1, 2007, to allow processing of MSP claims for reimbursement of a beneficiary for co-payment paid to the provider when the primary payer is an employer MCO. **Note:** This temporary exception has been added to chapter 24, section 90.2 and may be self assessed.	X			X							
5488.2	Medicare contractors shall reimburse the beneficiary directly for his/her payment when the beneficiary paid a payment to the physician when services were rendered.	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5488.3	MCS shall send the appropriate MSP amounts to MSPPAY in situations when Medicare contractors receive claims from physicians that are requesting direct Medicare payment reimbursement to the beneficiary when the beneficiary made a co-payment, or payment, to the physician (e.g., employer HMO co-payment) when services were rendered.								X			

III. PROVIDER EDUCATION TABLE:

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5488.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X							

IV. SUPPORTING INFORMATION: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tom Latella Thomas.latella@cms.hhs.gov

Post-Implementation Contact(s): Tom Latella Thomas.latella@cms.hhs.gov

VI. FUNDING

A. *For TITLE XVIII Contractors*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

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

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

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. Roster billing of inoculations covered by Medicare—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. Claims for payment under a Medicare demonstration project that specifies paper submission—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. "Obligated to Accept as Payment in Full" (OTAF) Medicare Secondary Payer (MSP) Claims when There is More than One Primary Payer— 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.