CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 802

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 30, 2005

Change Request 4119

SUBJECT: Termination of the Medicare HIPAA Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual Circumstance, Modification of the OTAF Exception, and Modification of ASCA Exhibit Letters A, B and C.

I. SUMMARY OF CHANGES: These revisions include the termination of the Medicare HIPAA incoming claim contingency plan, correction of typos detected in CR 3875, modification of a free claim software requirement, addition of a self-assessable Unusual Circumstance in which paper claim submission is permitted, modification of the OTAF exception to apply only if more than one payer is primary to Medicare, and modification of ASCA exhibit letters A, B, and C.

NEW/REVISED MATERIAL

EFFECTIVE DATE: April 01, 2006

IMPLEMENTATION DATE: April 03, 2006

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	24/40/40.1/General HIPAA EDI Requirements
R	24/40/40.2/Continued Support of Pre-HIPAA EDI Formats
R	24/40/40.3/D/NCPDP Narrative Portion of Prior Authorization Segment
R	24/40/40.4/A/X12 837 COB
R	24/40/40.4/C/Legacy Formats
R	24/40/40.6/Use of Imaging, External Keyshop, and In-House Keying for Entry of Transaction Data Submitted on Paper
R	24/50/50.4.5/EDI Receiver Testing by Carriers, DMERCs and Intermediaries

R	24/50/50.4.3/Carrier, DMERC, and FI Submitter/Receiver Testing with Legacy Formats during the HIPAA Contingency Period
R	24/50/50.4.4/Discontinuation of Use of COB Claim Legacy Formats following Successful HIPAA Format Testing
R	24/60/60.5/Free Claim Submission Software
R	24/70/70.4/Key Shop and Image Processing
R	24/90/Mandatory Electronic Submission of Medicare Claims
R	24/90/90.2/Exceptions
R	24/90/90.3/Unusual Circumstance Waivers
R	24/90/90.3.1/Unusual Circumstance Waivers Subject to Provider Self-Assessment
R	24/90/Exhibits of Form Letters/Exhibit A
R	24/90/Exhibits of Form Letters/Exhibit B
R	24/90/Exhibits of Form Letters/Exhibit C

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 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: 802	Date: December 30, 2005	Change Request 4119

SUBJECT: Termination of the Medicare HIPAA Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual and Modification of ASCA Exhibit Letters A, B and C

I. GENERAL INFORMATION

A. Background: Chapter 24 is being revised to manualize the requirement for termination of the Medicare HIPAA incoming claim contingency plan, correction of typos detected in CR 3875, addition of a self-assessable unusual circumstance in which paper claim submission is permitted, modification of a free claim software requirement.

B. Policy: Carriers, DMERCs, Fiscal Intermediaries, Shared System Maintainers, and providers must adhere to electronic data interchange (EDI) requirements for Medicare as contained in this chapter.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4119.1	FIs shall reject any UB-92 flat file records for reporting of supplemental ESRD, HH plan of treatment, or outpatient therapy data submitted as part of a UB-92 claim or as a supplement to an 837 version 4010A1 claim.	X								
4119.2	Contractors shall reject any electronic claim sent to Medicare that does not comply with the 837 version 4010A1 IG or the NCPDP Telecommunication Standard 1.1 and the Batch Standard 5.1 (DMERCs only).	X	X	X	X					
4119.3	Pending termination of the Medicare contingency plan for HIPAA mandated transactions types other than claims sent to Medicare, contractors shall continue to support the use of pre-HIPAA electronic transaction formats listed in section 40.2.	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4119.4	DMERCs shall accept modifiers for compound drugs in the narrative portion in the prior authorization segment on the NCPDP standard.				X					
4119.5	Carriers, DMERCs and FIs shall verify that their current free billing software collects claim adjustment reason codes and adjustment amounts for adjustments made by a primary payer when Medicare is the secondary payer. If it is not collecting this information, the software shall be modified to collect it.	X	X	X	X					
4119.6	Contractors shall begin to issue the revised ASCA letters in exhibits A, B and C as appropriate on the effective date of this CR. Contractors shall not issue providers that were sent an A, B or C letter prior to this effective date, a revised A, B or C letter.	X	X	X	X					
4119.7	Contractors shall permit home oxygen therapy claims for which "yes" does not apply in CR513, CR514 and CR515 of the 837-P claim to be submitted on paper.	X	X	X	X					
4119.8	Contractors shall permit claims that contain an OTAF adjustment and more than one payer was primary to Medicare to be submitted on paper.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4119.9	A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: CR 3875

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2006	**Medicare contractors shall implement these instructions**

Implementation Date: April 3, 2006 **Pre-Implementation Contact(s):** Tom Latella Thomas.latella@cms.hhs.gov (410) 786-1310 **Post-Implementation Contact(s):** Kathleen Simmons Kathleen.simmons@cms.hhs.gov (410) 786-6157	**within their current operating budgets.**

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

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**

Table of Contents

(Rev. 802, 12-30-05)

40- Required Electronic Data Interchange Formats

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

40.1 General HIPAA EDI Requirements

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

The following HIPAA transaction standards must be supported by the Medicare FIs, carriers, and DMERCs for the electronic exchange of data with Medicare providers/submitters/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 4010A1 for Institutional(I) and Professional (P) claims and coordination of benefits (COB) with other payers;
- NCPDP Telecommunication Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (billed to DMERCs only) and COB (see § 40.1 of this chapter for additional information);
- X12 835 IG version 4010A1 for Remittance Advice (see Chapter 22 for additional information); and
- X12 276/277 IG version 4010A1 for Claim Status Inquiry & Response (see Chapter 31 for additional information).

Medicare FIs, carriers, and DMERCs will not be involved in Medicare acceptance and processing of the X12 270/271 IG version 4010A1 transactions for Beneficiary Eligibility Inquiry & Response. The 270 transaction will be accepted and processed and a 271 returned by CMS directly. *See* Chapter 31 *for further information.*

Although not mandated by HIPAA, as noted in § 30.6, CMS also requires that carriers, DMERCs, 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). Subsequent legislation 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 portion of the 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.

CMS announced on August 4, 2005 that the Medicare HIPAA inbound claims contingency plan will end on October 1, 2005. That means that all electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the

X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing 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 or PC-Print 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 carrier, DMERC, or FI bulletins, on their Web page, and will also be available via the Internet as Manual transmittals which can be viewed at *www.cms.hhs.gov/providers/edi/hipaadoc2.asp*. These overviews will identify the Web site address and record title where the specifications for the changes will be recorded.

40.2 Continued Support of Pre-HIPAA EDI Formats

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

Pending termination of the Medicare contingency plan for the HIPAA mandated transactions types other than claims sent to Medicare, carriers, DMERCs, and FIs 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 contingency plan that applies to each noted format, or the date when no further providers, billing agents, or clearinghouses are using those formats:

- *X12 837 institutional (FIs only) and professional(carriers and DMERCs only) version 4010 and 3051, National Standard Format (NSF) version 3.01 (carriers and DMERCs only) and the UB-92 version 6.0 flat file claims for coordination of benefits sent to other payers under trading partner agreements;*
- *X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice (FIs only);*
- *X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice (carriers and DMERCs) and NSF versions 1.04, 2.01 and 3.01 (carriers and DMERCs);*
- *X12 270/271 IG version 3051 for eligibility query and response (carriers only);*
- *Proprietary format for eligibility data responses using the CMS standard eligibility data set; and*
- *X12 276/277 version 4010.*

Carriers, DMERCs, and FIs must accept and provide these formats, where applicable for the noted transactions. See Chapters 22 (remittance advice), 25 (UB-92), 26 (CMS-1500), and 31(claim status and eligibility data) for additional information. Specifications for each of these transactions can be found on the CMS Web site at http://www.cms.hhs.gov/providers/edi/hipaadoc2.asp, and on the Washington Publishing

Company web site at http://www.wpc-edi.com/HIPAA for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA. CMS also publishes all HIPAA IG "companion documents" on the hipaadoc Web site. "Companion documents" contain supplemental Medicare requirements and information for providers, vendors, clearinghouses, COB trading partners and/or Medicare carriers, DMERCs, and FIs on application of certain situational requirements, code usage, and Medicare interpretations of certain information in the IGs. Companion documents supplement but may not contradict the IGs. Companion documents are designed to clarify Medicare's expectations about use of situational loops, segments and data elements, and other Medicare-specific information that may impact reporting of data in the HIPAA transactions. Carriers, DMERCs, and FIs are required to adhere to the requirements of the Medicare companion documents as well as the HIPAA standard transaction IGs.

X12 version 4010 IGs were initially adopted as first set of X12 national transaction standards under HIPAA, but were subsequently supplanted by an amended version, 4010A1. Medicare shared system maintainers were required to complete programming changes for implementation of the X12 version 4010A1 IGs that apply to Medicare (837 claim/COB, 835, 276/277) by April 1, 2003. In some cases, individual extensions were approved as result of contractor transitions between shared systems, or due to local issues.

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

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

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. DMERCs 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 DMERCs via the NCPDP standard. The DMERC 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 DMERCs.

B. Generating a Batch NCPDP Response

DMERCs 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. DMERCs 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. The DMERCs 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

DMERCs must 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 must 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:

CMN - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information

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

CFA - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information and Facility Name and Address

CNF - Indicates that the supporting documentation that follows is Medicare required CMN or DIF information, narrative information, and Facility 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

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

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

Under the DMERC contract, a DMERC is required to forward claims to the appropriate DMERC for processing when it is determined that the claim submitted is for a beneficiary that resides in a state that is outside the receiving DMERC'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 DMERC carrier 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 DMERC that receives a misdirected claim to move it through the Medicare Data Communication Network (MDCN) to the appropriate DMERC. Misdirected claims must be subjected to all levels of editing by the original DMERC and rejected if found to be

non-compliant. Only those claims that are determined to be HIPAA NCPDP format compliant will be forwarded.

40.4 – Crossover Claim Requirements

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

A. X12 837 COB

The outbound 837 COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data, as modified during adjudication if applicable, as well as payment data. Carriers, DMERCs, and FIs 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 must be retained, however, because they could be needed by a Medicare COB trading partner. The shared systems must maintain a store and forward repository (SFR) for retention of such supplemental data. Data must be subjected to standard syntax and applicable IG edits prior to being deposited in the SFR to assure non-compliant data are not included in COB transactions. SFR data must be reassociated 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 transaction. The shared systems must retain the data in the SFR for a minimum of 6 months.

The shared system maintainers shall populate an outbound COB file as an 837 flat file with the Tax ID or SSN (for a sole practitioner) present in the provider's file, or in the case of an 837 flat file sent the COBC, present in each associated contractor's provider file. If no TaxID or SSN is available, the shared system(s) shall populate NM109 with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data, *pending availability of the billing provider's National Provider Identifier (NPI). Once the NPI is available, qualifier XX must be reported in NM108 and the NPI in NM109, and the taxpayer identification number reported in the REF segment of the billing provider loop. Prior to May 23, 2007, when an NPI is reported in NM109 for any of the types of providers for which data is included in a claim, Medicare will also send the legacy number (UPIN, National Supplier Clearinghouse or OSCAR) for each of those providers in the REF segment of the loop used to supply identifying information for that provider.*

Contractors shall populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code as contained in their provider files, in the event of any discrepancy with the inbound 837.

Each supplemental insurer specifies the types of claims it wants the carrier, DMERC, FI, or COBC to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;

- Claims denied as duplicates or for missing information;
- Adjustment claims;
- MSP claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

On July 5, 2004, CMS began to transfer claim crossover responsibility from FIs, carriers and DMERCs to a national claims crossover contractor called the COBC. This initiative is titled as the "COB Agreement (COBA) Process." Under this process, carriers, DMERCs and FIs will be sent a CWF Beneficiary Other Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the FI, carrier, or DMERC will transfer the processed claim to the COBC as an 837 COB flat file or NCPDP file to be crossed over to the trading partner. Refer to Chapter 28, section 70.6 of the Claims Processing Manual for further details about specific carrier, DMERC, and FI responsibilities under the COBA process.

The translator used by a carrier, DMERC, FI, and the COBC will build the outbound 837 COB transaction from the flat file data supplied by that contractor's shared system.

Until all trading partners are moved into cross-over production with the COBC, non-transitioned supplemental insurers/payers will continue to provide an eligibility file no less frequently than monthly, preferably weekly, to enable Medicare contractors to identify dually eligible individuals whose claims are to be forwarded for COB/crossover purposes. In addition, until all trading partners are moved into production with the COBC, Medicare contractors shall continue to send COB transactions to their trading partners at least once a week. *Pending completion of the transition to the COBC, carriers, DMERCs, and FIs may transmit COB data to a trading partner in either the HIPAA 837 version 4010A1 format or in a legacy format, according to the trading partner's preference. Upon the earlier of the completion of the COB transition or termination of the Medicare outbound COB claim contingency plan, COB transactions may be sent to trading partners only in the X12 837 version 4010A1 format.*

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 their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them." The ISA08 is a 15-position alphanumeric data element. FIs, carriers, and DMERCs, and their shared systems must populate 15 positions of ISA08 data (as published by the receiver of the data) on outbound X12N HIPAA transactions. FIs, carriers, DMERCs, and the COBC must also make the necessary changes to be able to ensure that each trading partner has a unique ISA08. FIs, carriers, DMERCs, and the COBC must inform their trading partners that the CMS cannot allow two trading partners to have the same ISA08.

HIPAA required that any payer that conducts electronic COB 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 transactions. An inbound claim received on paper or in a non-version 4010A1 electronic format 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 transaction, however. Paper and earlier electronic claim formats do not contain as many data requirements as the claim versions adopted as the national standard 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 or in a legacy electronic format, a claim could be accepted and adjudicated that lacks one or more pieces of data needed for a HIPAA-compliant COB 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. This is not a priority for many beneficiaries since they receive their SSA payments electronically.

To resolve this problem for COB, the shared system must "gap fill" data in certain cases when issuing flat file data for carrier, DMERC, or FI translation into a HIPAA-compliant COB transaction. If data elements are unavailable or incomplete, but are needed to prepare a HIPAA-compliant COB transaction, the shared system must "gap fill."

When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (other than MCS) and the carriers 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 non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB 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 purposes, those field names must be mapped to the appropriate qualifier or code source for reporting to trading partners in the 837 version 4010A1 format.

Until trading partners are fully moved into production with the COBC, carriers, DMERCs, FIs are required to notify their COB trading partners of the common situations when gap filling could occur and of the characters that will be used to gap fill according to data type of the particular X12 data element.

B. NCPDP COB Transaction

The NCPDP has approved the following use of qualifiers in the Other Payer Paid Amount field for reporting Medicare COB 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.

C. Legacy Formats

Prior to implementation of the NCPDP standard in compliance with HIPAA, retail pharmacies were required to use the CMS-1500, NSF, or X12 837 format to bill drugs covered by Medicare Part B to DMERCs. See §40.2 for information on the legacy formats that can be used in lieu of the NCPDP format pending termination of the Medicare COB claim contingency plan.

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.

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.*

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.

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.

80.3 - 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.

90.2 - Exceptions

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

In some cases, it has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be reasonable or possible 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, in the past, some suppliers were allowed to submit a single claim on paper with the basic provider and service data and to attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim IGs adopted under HIPAA can submit single claims to a payer for single individuals, but cannot be used to submit a single claim for multiple individuals.

   Flu shots 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. In some cases, an unaccompanied nurse might inoculate a large number of beneficiaries. 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. Medicare Secondary Payer Claims—Providers may submit their secondary claims to Medicare non-electronically when a primary payer has made an "Obligated to Accept as payment in Full" (OTAF) adjustment *and there is more than one primary payer. Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but 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 they apply to each primary payer.* An OTAF adjustment is made when a provider, physician or supplier accepts or negotiates receipt of a set amount that may be lower than a payer's normal allowed amount as payment in full for particular services or supplies. In any case where an OTAF-type adjustment applies, the physician, supplier or other provider would either have signed an agreement to that effect with the particular payer(s) or would have received notification from the particular payer(s) of this situation and of the services or supplies to which it applies. By regulation, if the OTAF amount is lower that the charge for the *related* service that appears on the claim, Medicare must include an OTAF adjustment when calculating the amount of Medicare's secondary payment.

Providers are required to submit their Medicare secondary claims to Medicare electronically however, when they are for services for which no OTAF rate applies *or when a claim includes an OTAF adjustment but there is only one payer primary to Medicare.*

4. Claims submitted by Medicare beneficiaries.

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

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 prenotify 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.
5. *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 but a combination of factors necessitates use of oxygen. Completion of these data elements as required in the 837-P version 4010A1 implementation guide 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 not each of these conditions needs to be met for a patient to qualify for oxygen therapy. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that this is a deficiency in this implementation guide. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the*

existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

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

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

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 provider cannot be prohibited from submitting an electronic claim for which 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 requirements 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.

This attachment requirement does not apply to submission of paper EOBs or RAs for electronic claims when Medicare is secondary. See #3 in subsection 90.2 for further information.

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 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.

90.6 - Provider Education

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

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.

Exhibits of Form Letters

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

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

Date:

From: Contractor (may be preprinted on a contractor's letter masthead)
To: Organizational Name of Provider
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 effective October 16, 2003 to qualify for Medicare coverage. 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 only issue a written waiver determination if c, d, or e applies.

ASCA prohibits Medicare coverage of service and supply claims submitted to Medicare on paper, except in limited situations. Those situations are:

1. Small providers—To qualify, a provider required to submit claims to Medicare FIs must have fewer than 25 full time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;
2. Dental Claims;

3. Participants in a Medicare demonstration project, when paper claim filing is required by that demonstration project as result of the inability of the HIPAA claim implementation guide to handle data essential to that demonstration;
4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have *an agreement* in place with a Medicare contractor that commits them to electronic submission of flu shot claims;
5. *Providers that submit claims for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as Payment in Full (OTAF) adjustment;*
6. *Providers of 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;*
7. Those few claims that may be submitted by beneficiaries;
8. Providers that only furnish services outside of the United States;
9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
10. *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. Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);
b. Providers that submit fewer than 10 claims a month to a Medicare contractor on average;
c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;
d. Entities that can demonstrate that information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that, due to conditions outside 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 c, d, or e applies. You are expected to self-assess to determine if one of the other exceptions or unusual circumstances apply. 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 provider compliance on a post-payment basis.

If a provider's self-assessment does not indicate that an exception or waiver criteria apply, the provider must submit their claims to Medicare electronically. Free software can be furnished you by this office to enable you to submit claims electronically, and a number of commercial software products and services are available on the open market. Please phone (insert contractor phone number) if you would like to further discuss your options for electronic submission of claims to Medicare.

Sincerely,

Contractor Name

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

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

Date:
From: Contractor Name and address (may appear on masthead)
To: Organizational Name of Provider
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. Small providers—To qualify, a provider required to submit claims to Medicare FIs must have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;
2. Dental Claims;
3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;
4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not

have *an agreement* in place with a Medicare contractor that commits them to electronic submission of flu shot claims;

5. *Providers that submit claims for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as Payment in Full (OTAF) adjustment;*
6. *Providers of 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;*
7. Those few claims that may be submitted by beneficiaries;
8. Providers that only furnish services outside of the United States;
9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
10. *Providers that can establish that an "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 a 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. Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);
b. Providers that submit fewer than 10 claims per month to a Medicare contractor on average;
c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;
d. Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and
e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that due to conditions outside the provider's control it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

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.

Waiver applications are only to be submitted to request a waiver if an "unusual circumstance" applies under c, d or e above. The information submitted with your waiver

request did not indicate that circumstance c, d, e, or any other exception or waiver criteria apply in your case. If provider self-assessment indicates that an exception condition, other than c, d, or e is met, the provider is automatically waived from the electronic claim submission requirement and no request should be submitted to a Medicare contractor. Medicare contractors will monitor provider compliance 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 coverage. Free software can be furnished you by this office to enable you to submit claims electronically, and a number of commercial software products and services are available on the open market. Please phone (insert contractor phone number) if you would like to further discuss your options for electronic submission of claims to Medicare.

Sincerely,

Contractor Name

Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

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

Date:

From: Contractor (May be preprinted on a contractor's masthead)

TO: Organizational Name of Provider

Subject: Review of Paper Claims Submission Practices

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

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

1. FI small providers - To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs).
   Carrier small providers - To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than 10 FTEs;
2. Dentists;

3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;
4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have *an agreement* in place with a Medicare contractor that commits them to electronic submission of flu shot claims;
5. *Providers that submit claims for Medicare payment after receiving payment from more than one other payer and at least one of those payers reduced their payment due to an Obligated to Accept as Payment in Full (OTAF) adjustment;*
6. *Providers of 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;*
7. Those few claims that may be submitted by beneficiaries;
8. Providers that only furnish services outside of the United States;
9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
10. *Providers that can establish that an "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 therefore, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

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

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

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

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

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

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

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. (Contractor must insert information on their free billing software, the amount of any handling charge for issuance, how to obtain further information; and the EDI Agreement which will need to be completed.) There is also commercial billing software, billing agent, and clearinghouse services available on

the open market that often include services other than Medicare billing and may better meet your needs. Please visit www.cms.hhs.gov/providers/edi/hipaavendors.asp to see a list of HIPAA vendor services in your state.

Sincerely,

Contractor Name