CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services(CMS)**
Transmittal 1353	**Date: October 15, 2007**
	Change Request 5606

Subject: Application of ASCA Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contractor

I. SUMMARY OF CHANGES: Due to distribution of RR retirees, many providers submit fewer than 10 claims a month to the RR Medicare Carrier (RMC) and have been allowed to continue to submit paper claims to the RMC. The same providers treat non-RR Medicare beneficiaries and in many cases do submit more than 10 claims a month to other Medicare contractors. ASCA electronic claim filing exceptions apply to Medicare overall and do not differentiate based on contractors or between RR and non-RR contractors. By adding ASCA information from SuperPES to the PES file sent the RMC weekly, the RMC can apply decisions that providers are ineligible to submit paper claims and other ASCA decisions to the same providers when they bill the RMC. Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

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/National Council for Prescription Drug Programs (NCPDP) Claim Requirements
R	24/40/40.3.1/Remittance Advice
R	24/40/40.4/COB Trading Partners and Medigap Plan Crossover Claim Requirements
R	24/40/40.8/Claim Implementation Guide Edits

R	24/40/40.8.1/X12N 837 Institutional Implementation Guide and Direct Data Entry Edits
R	24/40/40.8.2/X12N 837 Professional Implementation Guide Edits
R	24/40/40.8.3/National Council for Prescription Drug Programs (NCPDP) Implementation Guide Edits
R	24/90/90.5/Enforcement
R	24/90/90.5.1/Fiscal Intermediary Shared System (FISS) Role in ASCA Enforcement
R	24/90/90.5.2/MCS and VMS Roles in ASCA Enforcement
N	24/90/90.7/Application of ASCA Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When They Bill the Railroad Medicare Carrier
N	24/90/90.7.1/Posting of ASCA Enforcement Review Decisions Made by Other Medicare Contractors to the RR Provider File When the Same Providers Bill the Railroad Medicare Carrier
N	24/90/90.7.2/Selection of Providers to be Sent an Initial Letter for the RMC to Begin an ASCA Enforcement Review
N	24/90/90.7.3/Subsequent Reversal of Decision that a Provider is Not Eligible to Submit Paper Claims by a Non-RR Medicare Contractor
N	24/90/90.7.4/Number of ASCA Enforcement Reviews to be Conducted by the RMC
N	24/90/90.7.5/RMC Information in ASCA Enforcement Review Letters
N	24/90/90.7.6/RMC Costs Related to Use of ASCA Review Information in PES Files
R	24/90/Exhibits of Form Letters/Exhibit A-Response to a Non-"Unusual Circumstance" Waiver Request
R	24/90/Exhibits of Form Letters/Exhibit B-Denial of An "Unusual Circumstance" Waiver Request
R	24/90/Exhibits of Form Letters/Exhibit C-Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper
R	24/90/Exhibits of Form Letters/Exhibit D-Notice that Paper Claims Will Be Denied Effective With the 91st Calendar Day After the Original Letter as Result of Non-Response to that Letter
R	24/90/Exhibits of Form Letters/Exhibit E--Notice that Paper Claims Will Be Denied Effective With the 91st Calendar Day After the Original Letter as Result of Determination that the Provider is Not Eligible to Submit Paper Claims

R	24/90/Exhibits of Form Letters/Exhibit F-Notice that Determination Reached that the Provider is Eligible to Submit Paper Claims
N	24/90/Exhibits of Form Letters/Exhibit G-Notice from the Railroad Medicare Carrier that Paper Claims Will Be Denied Effective With the 91st Calendar Day From the Date of This Letter as Result of the Determination By Another Medicare Contractor that the Provider is Not Eligible to Submit Paper Claims
N	24/90/Exhibits of Form Letters/Exhibit H-Notice from the railroad Medicare Carrier to a Provider with a Pre-Established Record in PES that Paper Claims Will Be Denied As Result of the Requirement that the Provider Submit Claims to One or More Other Medicare Contractors Electronically

III. FUNDING:
Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1353	Date: October 15, 2007	Change Request: 5606

SUBJECT: Application of Administrative Simplification Compliance Act (ASCA) Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Billing the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COB Contractor

Effective Date: January 1, 2008

Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: ASCA requires that providers submit claims to Medicare electronically to be considered for payment, with a limited number of exceptions. ASCA permits HHS to designate certain exceptions. As indicated in Pub. 100-04, Medicare Claims Processing Manual, sections 90-90.6 of Chapter 24, there is an exception that allows providers that submit fewer than 120 claims per year (no more than 10 per month on average) to Medicare to continue to submit paper claims. Due to the dispersion of railroad (RR) retirees in the United States, however, few physicians/practitioners/suppliers treat a large number of RR Medicare beneficiaries. As result, many physicians/practitioners/suppliers submit fewer than 10 claims a month to the Railroad Medicare Carrier (RMC), even though they very often submit more than 10 claims a month to one or more non-RR Medicare contractors. ASCA does not differentiate between RR Medicare and non-RR Medicare. ASCA permits a paper claim denial decision made by one Medicare contractor to apply to the same provider when billing any Medicare contractor, including the RR Medicare carrier.

Chapter 24 of the Medicare Claims Processing Manual indicated that HIPAA transaction contingency plans were still in effect for COB/Medigap transactions and claim status X12N 276/277 transactions. As that will not be the case by the effective date of this CR, the chapter is being updated.

B. Policy: Medicare requires that a provider be enrolled in non-RR Medicare prior to submission of claims to the RMC. To enable the RMC to verify a provider's Medicare enrollment, the Medicare Claim System (MCS) maintainer transfers a Provider Enrollment System (called SuperPES) file with provider data from non-RR Medicare contractors to the RMC. There are already fields in SuperPES for ASCA Enforcement Review information but those fields were never previously populated. ASCA determination information will now be added to SuperPES. . The RMC shall review the most recent SuperPES to see if ASCA information is available and if available, shall take that into consideration when deciding whether to initiate an ASCA Enforcement Review of an individual provider. When ASCA information is located in SuperPES for individual providers the RMC is considering for an ASCA review, the RMC shall update the RR provider enrollment system (PES) file with that information as required in this CR.

The only HIPAA electronic transactions contingency plan still in effect for Medicare applies to eligibility queries.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)							
		A /	D M	F I	C A	D M	R H	Shared-System Maintainers	OTHER

								FISS	MCS	VMS	CWF	
5606.1	FISS shall not generate quarterly ASCA review reports for contractors responsible for receipt of institutional claims unless those contractors are directed to begin conducting ASCA Enforcement reviews.							X				
5606.2	Contractors must use the methodology in the fourth bullet of §90.5.2 to establish the effective date of an ASCA review decision.	X			X				X			
5606.3	The MCS maintainer shall populate the ASCA Enforcement Review fields using the information as identified in subsection 90.5.2 of Chapter 24 of Pub.100-04 (Medicare Claims Processing Manual) in the Provider Enrollment System (SuperPES) file when that information is available in the MCS provider files used to build SuperPES.								X			
5606.4	When using the shared system's quarterly report to select providers for ASCA Enforcement Reviews, and upon receipt of an initial claim from an unknown provider, the RMC shall search for a record for each of these providers in the most recent SuperPES file. (Providers that bill multiple contractors would have more than one entry.)											RMC
5606.4.1	If a record is located in SuperPES for a provider who has just submitted their first claim to the RMC and SuperPES indicates that a NE decision has already been made for that provider by another carrier, the RMC shall manually issue letter G to notify the provider that their paper claims sent to the RMC will begin to be denied on the 91st day after the date of the letter											RMC
5606.4.1.1	The RMC shall follow the directions in §§90.5.2, 90.7 and 90.7.1 for entry of the date of letter G and the date when paper claims submitted by the provider are to be denied unless the provider submits information to override the NE information received from SuperPES.											RMC
5606.4.1.2	The RMC shall manually issue letter D if no response is received from the provider by the 45th day after issuance of letter G.											RMC
5606.4.1.3	MCS shall use the letter G date and the effective date it contains for denial of the provider's paper claims as entered by the RMC to issue letter E on the date when denial of paper claims begins for a recipient of letter G. The same procedure shall be followed to issue letter E in this situation as would be used by MCS to issue letter E when denial of paper claims is to begin for a recipient									X		

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	of letter C.											
5606.4.2	If able to locate a record and there is an ASCA review decision (code NE, SM, WA or UC) and decision date and/or zip code in SuperPES for an individual provider, the RMC shall enter that information in the appropriate fields in the provider's PES record. (See the next BR for an exception.)											RMC
5606.4.2.1	The RMC shall not enter an ASCA review decision and date from SuperPES into PES if a more recent ASCA review was completed by the RMC and the RMC decision is "more negative" than the decision in SuperPES in terms of the number of paper claims the RMC decision would permit to be submitted.											RMC
5606.4.3	If there is more than one ASCA review decision in SuperPES for the same provider because the provider bills more than one contractor and more than one conducted an ASCA review, the RMC shall post the most "negative" decision in PES in terms of the lowest number of paper claims the decision would permit the provider to submit.											RMC
5606.4.4	The RMC shall not enter "NE" information from SuperPES into PES if SuperPES carries a future date for the "NE." A future date indicates that review is still open.											RMC
5606.4.4.1	If the ASCA decision being moved to PES is "NE," the RMC shall convert that to "NR" when entering that information in PES to signify that the decision was made by a contractor other than the RMC.											RMC
5606.4.4.2	If entering code "NR" in lieu of NE, the RMC shall enter the date denial of paper claims began by the contractor that conducted that ASCA review in PES.											RMC
5606.4.4.3	If entering codes "SM, WA or UC," the RMC shall enter the later of the date in SuperPES associated with that review decision if that date is later than the date of the most recent RMC ASCA review of the same provider, or the effective date of provider eligibility to submit paper claims if later than the 91st day after the start of the most recent ASCA review.											RMC
5606.5	If that ASCA review information in SuperPES contains code "SM," that decision was made less											RMC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	than two years ago (as indicated by the later of the date that contractor began the most recent ASCA review or the effective date of provider eligibility to submit paper claims in SuperPES), and SuperPES was checked because the provider is being considered for an ASCA review due to the number of paper claims that provider submitted as indicated in the quarterly paper claim submitter report, the RMC shall not trigger issuance of an initial ASCA letter to that provider that quarter.											
5606.5.1	If that ASCA review information indicates that another Medicare carrier has an ASCA Enforcement Review underway that is not yet completed (shows date most recent ASCA enforcement review began and a future date when denial of paper claims could begin but no decision code entered yet and not more than 121 days have passed since that date), the RMC shall not trigger issuance of an initial ASCA review letter to that provider.											RMC
5606.5.2	If 121 or more days have passed since the date that contractor began an ASCA review for which no decision code has been entered, and SuperPES was checked due to the number of paper claims the provider submitted as indicated by the quarterly paper claim submitter report, the RMC shall use the MCS quarterly paper claim report to trigger issuance of letter C to that provider.											RMC
5606.5.3	If that ASCA review information includes code "WA" and the most recently MCS quarterly paper claim submitter report does not show that the provider submitted 30 or more paper claims during that quarter, the RMC shall not trigger issuance of any initial ASCA review letter to the provider.											RMC
5606.5.4	If that ASCA review information includes code "UC" and the effective date of the UC was 6 or more months ago, and SuperPES was checked due to the number of paper claims submitted by that provider as indicated in the MCS quarterly paper claim submitter report, the RMC shall trigger issuance of letter C.											RMC
5606.5.5	If the ASCA fields in SuperPES for a provider indicate that the provider was determined to be											RMC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	eligible for continued submission of paper claims as result of an ASCA review, the RMC shall enter that ASCA exception/waiver decision in PES and allow that provider to continue to submit paper claims. The RMC shall not issue any letter to the provider in this situation.											
5606.5.6	If there is no ASCA review information in SuperPES for that provider, and the most recent MCS quarterly paper claim submitter report indicates that an ASCA enforcement review is advisable due to the number of paper claims submitted or other information available to the RMC, the RMC shall use the quarterly ASCA report to trigger issuance of letter C.											RMC
5606.6	If a provider is in the MCS quarterly paper submitter report, the RMC checks SuperPES for the provider and there is an NE entry and the provider already has a record in PES, the RMC shall trigger issuance of letter H by selecting that provider in the MCS paper claim submitter report for review and by selecting the letter H field, or other means as devised by MCS for selection of letter H, in that quarterly report.											RMC
5606.6.1	The MCS maintainer shall add a field to the quarterly paper submitter report, or develop some alternate means that will enable the RMC to indicate when letter H should be issued rather than letter C to begin the 90-day period prior to denial of paper claims.								X			
5606.6.2	Letter D shall be automatically sent to the provider after letter C or H if the RMC has not entered a decision by the 45th day to indicate whether the provider responded and qualifies for continued submission of paper claims.								X			
5606.6.2	Except as specifically identified in this CR for the RMC, existing requirements for selection of providers for ASCA review continue to apply. For example, the RMC can consider a provider for an ASCA review if there is a former SM ASCA decision, at least two years have passed since the effective date of that decision and when compared with other providers included in a quarterly ASCA paper claim submitters report, that provider appears to be a good candidate for an ASCA review. Or, there is a WA decision in a											RMC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	provider's PES record but the quarterly report shows that the provider submitted more than 30 paper claims and no other waiver criteria appear to apply to the provider; that provider can be selected for ASCA review if when compared with other providers included in an MCS quarterly paper claim submitters report, that provider appears to be a good candidate for an ASCA review.											
5606.7	Non-RR Medicare contractors and the RMC shall begin to issue the revised ASCA letters, other than letters G and H, as contained in this CR to notify providers that a decision that is reached by one Medicare contractor that they are ineligible to submit paper claims also applies to any other Medicare contractor including the RMC.	X	X		X							RMC
5606.8	If contacted by a provider that reports another Medicare contractor has reversed a decision that the provider is ineligible (code NR in PES) to submit paper claims, the RMC shall ask that provider to submit a copy of the reversal letter (F) from that contractor and tell that provider to hold all new paper claims; and submit those new paper claims and resubmit those paper claims previously denied due to the NR entry as soon as they receive a letter F from the RMC. Upon receipt of the copy of letter F issued by another contractor, the RMC shall change the decision recorded in PES and trigger release of its own letter F.											RMC
5606.9	If the RMC has reason to check SuperPES for a provider with a record in PES that submits paper claims to the RMC, this check is not related to the number of paper claims submitted by that provider in an MCS quarterly paper claim submitter report, and the RMC sees that there is an ASCA review decision (code NE, SM, WA or UC) and decision date, and/or zip code in SuperPES for the provider, the RMC shall enter that information in the appropriate fields in the provider's PES record and shall follow the same requirements that would have applied to the provider if that information was discovered as result of a listing for the provider in the MCS quarterly paper claim submitters report (see											RMC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	business requirements 5606.4--.8).											
5606.10	The RMC shall use a different formula to calculate the number of ASCA Enforcement Reviews to be initiated annually to achieve the 20 percent target in view of the impact of the reviews done by other contractors on the RMC.											RMC
5606.10.1	To compute the 20% on an annual basis, the RMC shall total the number of paper billing providers in the 4 quarterly reports for the FY, divide by 4 and multiply by 0.2.											RMC
5606.10.1.2	To compute the 20% on a per quarter basis prior to issuance of the last quarterly report for a FY, the RMC shall take the number of paper billers in a single quarterly report, multiply by 0.2, and multiply again by .25. (25% of all reviews to be conducted in a year should be done each quarter.)											RMC
5606.10.1.3	To "catch up" during the fourth quarter when the single quarter method in 5606.10.1.2 was used for the first 3 quarters of the FY, the RMC shall subtract the total of the reviews initiated the first 3 quarters of the FY from the total due for the entire year computed as directed in 5606.1. That difference is the number of reviews to be initiated during the 4th quarter.											RMC
5606.11	The RMC shall make changes in how some totals are computed for entry in the monthly DDISdata report. Fields not separately noted below are to be completed as directed in the DDISdata instructions.											RMC
5606.11.1	The RMC shall enter the number of paper billers in the most recent shared system quarterly ASCA paper billers report as the number of "eligible providers" for the three months that follow the quarter represented by the MCS quarterly paper claim submitters report, i.e., if a quarterly report was based upon data for the period October 2007-December 2007, the number of providers who submitted paper claims in that report would be shown as the "eligible providers' in the data entered to DDISdata for January 2008, February 2008 and March 2008.											RMC
5606.11.2	The RMC shall include the number of providers that could have been sent initial ASCA review letters during a month if not disqualified as result of the ASCA information located in SuperPES in											RMC

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	the total number of "Initial Review Letters Issued for Report Period." This total shall also include those new letters actually issued that month because there was nothing in SuperPES to preclude initiation of a new ASCA review of those providers. For RMC performance evaluation purposes, an RMC evaluation of ASCA results from another contractor in SuperPES will be considered as equivalent to initiation of a new ASCA review of a provider. The total of the "Initial Review Letters Issued for Report Period" for an entire FY will be used to determine if the RMC met the 20% target for the FY when divided by the average total of all providers potentially eligible for ASCA review that FY. The following example applies to 5606.11.2 and .11.3. In April 2008, the RMC selects 100 providers from the MCS quarterly paper claim submitters report for January – March 2008 as potential candidates for initiation of new ASCA reviews. During April, the RMC checks the listings for those providers in the most recent SuperPES file. The SuperPES file contains ASCA information for 48 of those providers. In 40 cases, there are ASCA review decisions with dates that preclude initiation of new ASCA reviews. In 7 of those cases, another contractor has a review open and it has been less than 121 days since those were opened, precluding initiation of new ASCA reviews by the RMC. In 1 case, an ASCA review was started by another contractor but 210 days have passed since that began and there is no ASCA decision posted. In this case, the RMC would trigger issuance of 53 initial ASCA review letters. For DDISdata reporting purposes, the RMC would enter 93 (52 with no ASCA review information in SuperPES + 1 where there was ASCA information in SuperPES but it did not preclude starting a new review + 40 where SuperPES contained review decisions to be added											

Number	Requirement	Responsibility (place an “X” in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	to the RR provider file) as “Initial Review Letters Issued for Report Period” in the DDISdata report for April 2008.											
5606.11.3	The RMC shall include the total of providers for whom manual reviews of SuperPES information resulted in decisions not to initiate a new ASCA review in the total of reviews completed that month when reporting performance information to DDISdata. Using the example in § 5606.11.2, 53 initial ASCA review letters would have been triggered in April 2008 and 47 new reviews would have been precluded as recently completed by or still open at other contractors. If 34 reviews were also completed that month by the RMC based upon initial ASCA review letters issued 3 months earlier, the RMC would report that 81 ASCA reviews were completed in April 2008.											RMC
5606.12	If a provider complains about the cost of their vendor’s software for electronic submission of claims to the RMC, or a provider calls to enquire about the Medicare free billing software, the RMC shall inform the provider what they need to do to begin using the Medicare software.											RMC
5606.13	The RMC may submit a supplemental budget request (SBR) for the cost of implementation activities for this CR if begun in FY 2007 as soon as the cost of those activities is known.											RMC
5606.13.1	If not included in the FY 2008 RMC operational budget request, the RMC may submit a SBR for implementation and operation costs related to this CR in FY 2008. That SBR shall be submitted by December 31, 2007. (Operations costs for subsequent years are to be included in the RMC’s annual operations budget requests for those later years. ASCA reviews are included in the FY 2008 BPRs for all other Medicare carriers as they are unaffected by this SuperPES review requirement.)											RMC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an “X” in each applicable column)

		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5606.14	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X							RMC

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Robert Huffman, (410) 786- 6317
Post-Implementation Contact(s): Robert Huffman, (410) 786- 6317

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*****:**
Funding for implementation activities will be provided to the RMC contractor through the regular budget process and they should submit a supplemental budget request.

No additional funding will be provided by CMS to other contractors; contractor activities are to be carried out within their current operating budget.

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

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

Medicare Claims Processing Manual

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

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(Rev. 1353, 10-15-07)

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Exhibits

Exhibit G--Notice from the Railroad Medicare Carrier to a Provider that Has Just Begun to Submit Claims that Paper Claims Will be Denied

Exhibit H--Notice from the Railroad Medicare Carrier to a Provider with a Pre-Established Record in PES that Paper Claims Will Be Denied as Result of the

Requirement that the Provider Submit Claims to One or More Medicare Contractors Electronically

40.1 - General HIPAA EDI Requirements

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

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

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

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

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

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

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

The initial HIPAA transactions regulation required that covered entities eliminate use of electronic formats and versions not adopted as national standards under HIPAA by October 16, 2002 (applies only to the transaction types addressed by HIPAA). A subsequent *provision* in the Administrative Simplification Compliance Act (ASCA) permitted covered entities to apply for a 1-year extension to October 16, 2003, to enable them to complete implementation of the standards mandated by HIPAA. Most covered entities, including Medicare, did request that extension. As a significant *number* of covered entities had still not completed implementation by October 16, 2003, to avoid disruption in health care payments and services, the Secretary of Health and Human

Services (HHS) allowed payers to implement contingency plans effective October 16, 2003 to temporarily continue to support pre-HIPAA transaction standards. The contingency plans were permitted to allow additional implementation time for those providers and clearinghouses making a good faith effort to become compliant with the HIPAA transaction requirements to complete work in progress.

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

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

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

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

40.2 - Continued Support of Pre-HIPAA EDI Formats

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

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

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

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

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

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

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

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

A. NCPDP Batch Transaction

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

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

B. Generating a Batch NCPDP Response

DME MACs will return the NCPDP batch response for all NCPDP transmissions received. The NCPDP term "transaction" is equivalent to a Medicare service or line item and the NCPDP term "transmission" is equivalent to a Medicare claim. The NCPDP

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

1. DME *MACs* will reject all claim transactions (line items) in the transmission (claim) if any one claim (transmission) has detail errors.
2. The response status for all transactions will equal R (rejected).
3. DME MACs will send up to 5 reject codes for claim transactions (line items) that have detail errors.
4. For the claim transactions (line items) that have no errors but are not being processed because of errors in other claim transactions (line items), the response status will equal R and the reject code will equal 84 (claim has not been paid/captured.)
5. Only the claim that rejected will have the reject codes other than 84. The other claims will have an 84 reject code indicating the claims were not paid/captured.

C. NCPDP Implementation Guide (IG) Edits

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

D. NCPDP Narrative Portion of Prior Authorization Segment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Misdirected Claims

A DME *MAC* is required to forward claims to the appropriate DME *MAC* for processing when it is determined that the claim submitted is for a beneficiary that resides in a state

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

40.3.1 - *Remittance Advice*

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

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

40.4 – *COB Trading Partner and Medigap Plan* Crossover Claim Requirements

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

A. X12 837 COB *and Medigap Claims*

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

The 837 version 4010A1 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the

primary payer shall equal the billed amount for the services in the claim. *A* tertiary payer to which Medicare could forward *a* claim could *need all* data *and adjustment codes Medicare receives on a claim*. A *tertiary payer* could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems shall reject inbound Medicare Secondary Payer claims if the paid and adjusted amounts do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.

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

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

Each supplemental insurer specifies the types of claims it wants the 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.

The COBC is a single contractor responsible for COB trading partner agreements and transmission of COB/Medigap claims to tertiary payers. Refer to Chapter 28, § 70.6 *and accompanying subsections* of *this manual* for further details about specific carrier, FI *and MAC* responsibilities *when interacting with the COBC. Each carrier, FI and MAC will be sent COB/Medigap flat files by their shared system and will forward those flat file records to the COBC.* The *COBC's* translator will *translate those flat files into* outbound 837 COB*/Medigap* transactions.

The HIPAA implementation guides (IGs) state that the ISA08 is an "identification code published by the receiver of the data; when sending, it is used by the sender as 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

MACs, and their shared systems shall populate 15 positions of ISA08 data (as published by the receiver of the data) on outbound X12N HIPAA transactions*, including electronic COB and Medigap claims*. FIs, carriers and the *MACs* shall also make the necessary changes to be able to ensure that each *Medigap plan and COB trading partner sent a claim electronically* has a unique ISA08. FIs, carriers, *MACs* and the COBC shall inform their trading partners *and Medigap plans* that the CMS cannot allow two trading partners to have the same ISA08.

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

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

When *a paper* claim do*es* not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB*/Medigap claim*, the shared systems maintainers (other than MCS) and the 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 *paper* claims do not contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB*/Medigap* transaction, the shared system maintainers (other than MCS) and MCS Carriers shall gap fill the phone number data element with "8009999999".

Data elements with pre-defined IG values such as qualifiers, and data elements that refer to a valid code source shall not be gap filled. Paper claims do not usually contain qualifiers but do contain explicit field names that provide information equivalent to

qualifiers or that identify valid code sources. For COB*/Medigap* purposes, those field names shall be mapped to the appropriate qualifier or code source for reporting to trading partners *and Medigap plans* in the 837 version 4010A1 format.

B. NCPDP COB*/Medigap* Transaction*s*

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

"07" = Medicare Allowed Amount

"08" = Medicare Paid Amount

"99" = Deductible Amount

"99" = Coinsurance Amount

"99" = Co-Payment Amount

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

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

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

40.8 – Claim Implementation Guide Edits

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

40.*8*.1 – X12N 837 Institutional Implementation Guide *and Direct Data Entry Edits*

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

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

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

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

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

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

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

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

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

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

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

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

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

40.*8*.2 – X12N 837 Professional Implementation Guide Edits

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

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

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

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

40.*8*.3 – National Council for Prescription Drug Program (NCPDP) Implementation *Guide Edits*

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

A. NCPDP Implementation Guide (IG) Edits

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

B. NCPDP Narrative Portion of Prior Authorization Segment

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

90.5 – Enforcement

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

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

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

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

Enforcement will be conducted on a post-payment basis *during those periods when directed by CMS*. FISS will prepare quarterly reports for the FIs *for those periods as directed by CMS that* list each provider's name, provider number, address, number of paper claims received under each provider number, percentage of paper claims to total claims for each provider, and the period being reported, e.g., claims processed July 1, 2005 – September 30, 2005. The data in the reports must be arrayed in descending order with those providers receiving the highest number of paper claims at the beginning of the report. These reports must be available by the end of the month following completion of a calendar quarter, e.g., on October 31 for July 1-September 30.

90.5.2 - MCS & VMS Roles in ASCA Enforcement

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

As result of the substantially higher number of paper claims sent to carriers and DME *Medicare Administrative Contractors (MACs) and B (B part of A/B) MACs* than to FIs,

somewhat different ASCA quarterly report requirements are being applied for the carrier and DME *MAC* quarterly reports. MCS and VMS will prepare an online (printable at the contractor's discretion) report each calendar quarter (October-December, January-March, April-June and July-September) for each carrier, DME *MAC*, or MAC as applicable. Each report must identify the months and year for which the data is being reported. The report must be available for contractor use by the end of the month that follows completion of a calendar quarter, e.g., by October 31 for July 1-September 30.

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

- Date (CCYYMMDD) most recent ASCA enforcement review began (shared system will populate with the trigger date of the most recent initial review letter, Exhibit letter C *or H*; *see §90.7 for information on Railroad Medicare Carrier (RMC) population of this field for letter G*);
- Date (CCYYMMDD) denial of paper claims began or is to begin as provider not eligible to submit paper claims (shared system shall populate with the 91st day after letter C*, G or H* is triggered, or a contractor shall reset that date to the date after an approved extension period expires; see §90.5.3.B);
- *Effective d*ate (CCYYMMDD) *of* provider eligibility to submit paper claims if effective after the date the provider was initially determined to be not eligible to submit paper claims (see §90.5.*3*.C; contractor must populate using a shared system field established for reporting of this date);
- Result of the most recently completed ASCA enforcement review—*The* ASCA review result field *is used* for contractor entry of a 2-character code to identify the result of an ASCA review. *When one of the following applies, the later of 1) the date the most recent ASCA enforcement review began or2) the date this decision was effective if after the date a provider was initially determined not to be eligible to submit paper claims will be considered the effective date of the decision*:

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

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

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

  UC--Provider determined eligible for an "unusual circumstance" waiver per *§* 90.3.3 of chapter 24 (contractors shall populate). When UC applies, a 60-byte field must be supplied by the shared system for contractor entry of

the specific "unusual circumstance." The shared system must reject a UC entry unless an entry of at least 6 alphanumeric characters is entered in the 60-byte unusual circumstance field.

A. Quarterly MCS and VMS Provider Online ASCA Report

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

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

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

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

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

Part 3—This Part must contain information on those providers that submitted only paper claims and who submitted fewer than 100 paper claims during that quarter.

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

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

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

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

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

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

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

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

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

ASCA did not differentiate among Medicare contractors or between Railroad (RR) and non-RR Medicare for application of the electronic billing requirement. Section 90.3.1 of this chapter indicates that a provider that submits fewer than 10 claims to Medicare per month on average (fewer than 120 claims per year) is permitted to continue to submit paper claims. As result of the distribution of RR retirees though, it is not unusual for a single provider to only treat a small number of RR Medicare patients and to submit fewer than 10 claims to the RR Medicare Carrier (RMC) per month. The same providers that treat RR Medicare patients also treat non-RR Medicare beneficiaries however, and in most cases do submit more than 10 claims per month in total to one or more non-RR Medicare contractors. As result, when selecting providers for an ASCA Enforcement Review, the RMC shall not exclude a provider from consideration for review simply because the quarterly ASCA report indicates the provider submitted fewer than 10 claims to the RMC. In a departure from the rule as it applies to non-RMC Medicare contractors, submission of fewer than 10 claims per month to the RMC does <u>not</u> automatically qualify a provider for waiver of the electronic claims submission requirement.

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

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

SuperPES is manually searched by RMC representatives. It would be difficult and possibly impossible to automatically update PES due to the differences in RR and non-RR legacy provider numbers. Addition of NPIs may not appreciably improve the ability to

make one to one matches since providers can obtain more than one NPI or fewer NPIs than legacy identifiers. Although supplemental information is submitted on claims that can often be used to match between an NPI and a single legacy identifier, there is not as much supplemental information in the SuperPES and PES files that could be used to help make a match between the files in the absence of a claim.

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

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

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

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

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

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

1. ***When using SuperPES to establish an initial record in PES for a provider--****If available in SuperPES, the RMC shall copy any ASCA review result information and the provider's zip code, (extended if available), as well as those data*

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

2. ***When a provider for whom a PES record was previously established is selected from the shared system's quarterly paper claim submitters report to initiate a new ASCA Enforcement Review--*** *The RMC shall look up each selected provider that has been tentatively selected for an ASCA review in the most recent SuperPES file to see if a record can be located based upon the information the RMC has available for that provider. When able to locate a record, the RMC shall add any ASCA review results from another Medicare contractor for that provider and the zip code (extended if available) for that provider to PES. An "NE" decision shall be converted to "NR." See information later in this section on use of ASCA decision codes in selection of providers to be sent an ASCA Enforcement Review letter. The RMC will use the shared system's quarterly report to trigger release of letter H to notify the provider that paper claims they submit beginning on the 91st day after the date of the letter will be denied. If no response is received after 45 days, MCS shall trigger release of letter D. If no response is received to letter D, or there is a response but it will not result in a decision to allow the provider to continue to submit paper claims, MCS shall trigger release of letter E and begin denying paper claims submitted following the regular procedures for an ASCA Enforcement Review.*

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

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

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

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

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

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

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

- a. *SuperPES contains a "SM" decision for the provider that is less than two years old;*
- b. *SuperPES contains the date an enforcement review began but does not contain a decision and at least 121 days have not elapsed since the date the review began (this signifies another contractor has an ASCA review underway for that provider); or*
- c. *SuperPES contains a "UC" decision and fewer than 6 months have elapsed since the date of that decision.*

When there is an NE decision in SuperPES with a past date, the RMC shall use a MCS quarterly paper claim submitters report to trigger release of letter H to that provider to

notify them that their paper claims will begin to be denied on the 91st day after the date of that letter.

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

a. *There are no SuperPES ASCA field entries for a provider;*
b. *There is a "UC" decision in SuperPES and more than 6 months have elapsed since the date of that decision;*
c. *SuperPES contains the date an enforcement review began but does not contain a decision and more than 121 days have elapsed since the date the review began;*
d. *There is a "SM" decision in SuperPES, more than two years have elapsed since the date of that decision, and the number of paper claims that provider submitted to the RMC as indicated in the most recent ASCA quarterly report is high enough to have resulted in this provider being selected for initiation of an ASCA review in the event that there had not been any ASCA field entries in SuperPES for this provider; or*
e. *There is a "WA" decision in SuperPES and enough paper claims were submitted to the RMC as indicated by the MCS quarterly paper claim submitters report to have resulted in this provider being selected for initiation of an ASCA review in the event that there had not been any ASCA field entries in SuperPES for this provider.*

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

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

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

Medicare contractors often begin to deny paper claims because a provider failed to respond to the initial and second request ASCA Enforcement Review letters (see exhibit letters D, G, H and E at the end of this chapter). Providers sometimes furnish that evidence after denial of their paper claims begins. If the evidence shows that the provider actually qualified for one or more exception criteria retroactively to the date when denial of their paper claims was effective, the Medicare contractor shall replace the paper claim denial decision (NE) in the provider's file with a new decision based upon the submitted evidence. If the provider then resubmits the claims to that contractor

that were denied as submitted on paper following receipt of letter F from that contractor, they will be reprocessed and paid if they otherwise meet Medicare requirements.

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

When contacted, the RMC shall:

a. *Ask the provider which Medicare contractor made and reversed that ASCA denial decision and furnish the provider with information to mail a copy of that letter to the appropriate person at the RMC;*
b. *Tell the provider not to begin to submit new paper claims, or resubmit those already denied as submitted on paper, until the provider receives a reversal letter (F) from the RMC; and*
c. *Update PES accordingly upon receipt of the copy of the reversal letter and trigger release of a new letter F so that the newly submitted and resubmitted RR paper claims from that provider can be processed*

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

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

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

To compute this 20 percent, the total number of providers for whom reviews are to be conducted shall be computed as directed in § 90.5.3. To gauge the number to be

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

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

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

90.7.5— RMC Information in ASCA Enforcement Review Letters

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

The letters that apply to ASCA Enforcement Reviews at the end of this chapter did not originally refer to application of decisions made by another Medicare contractor to a provider when billing the RMC. These letters have now been modified to note that an ASCA Enforcement Review made by one Medicare contractor that a provider does not

qualify to submit claims on paper also applies to that same provider when billing other Medicare contractors, including the RMC. Two letters (G and H) have been added specifically for RMC use. Letters G and H may not be sent by and do not apply to any contractor other than the RMC.

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

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

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

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

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

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

that may begin prior to the start of FY 2008, the RMC shall submit a SBR for the FY 2007 costs as soon as the amount of those costs can be determined.

Exhibits of Form Letters

Exhibit A—Response to a Non-"Unusual Circumstance" Waiver Request

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

Date:

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

To: Organizational Name of Provider *and Mailing Address*

Subject: Electronic Claim Submission Waiver Request

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

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

1. *Claims submitted by sm*all providers—To qualify, a provider *required to use a UB-04 form when submitting claims on paper* shall have fewer than 25 full time equivalent employees (FTEs).A physician, practitioner, or supplier *required to use a CMS-1500 (08/05) form when submitting claims on paper* shall have fewer than 10 FTEs. *A small provider can elect to submit all, some or none of their claims electronically;*
2. Dental Claims;
3. *Claims submitted by p*articipants in a Medicare demonstration project *for services or items covered under that demonstration project* when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential *for* that demonstration;
4. *Roster claims for* mass immunizations, such as flu *or pneumonia* injections*--P*aper roster bills cover multiple beneficiaries *on the same claim*. *This exception applies to providers* who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of *mass immunization* claims;
5. Claims *sent* to Medicare when more than one other insurer was liable for payment prior to Medicare;
6. *Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);*

7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;
8. Claims submitted by beneficiaries;
9. *Claims from p*roviders that only furnish services outside of the United States;
10. *Claims from p*roviders experiencing a disruption in their electricity or communication connection that is outside of their control *and is expected to last longer than two days*. *This exception applies only while electricity or electronic communication is disrupted*; and
11. Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.

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

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

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

If *your* self-assessment does not indicate that exception or waiver criteria apply as listed above, *you* shall submit *your* claims to Medicare electronically. *This applies to every Medicare contractor to which you submit claims, including the contractor responsible for processing of Railroad Medicare claims.* This office can supply you with free billing software for submission of Medicare claims. See (*contractor shall insert the URL*) for

further information on enrollment for use of EDI, use of free billing software or other EDI information. There is also commercial software, and billing agent and clearinghouse services *are* available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs.

Sincerely,

Contractor Name

Exhibit B—Denial of An "Unusual Circumstance" Waiver Request

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

Date:

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

To: Organizational Name of Provider *and Mailing Address*

Subject: Request for Waiver of Electronic Claim Filing Requirement Decision

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

1. *Claims submitted by s*mall providers—To qualify, a provider *required to use a UB-04 form when submitting paper claims* shall have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier *required to use the CMS-1500 (08/05) form when submitting claims on paper* shall have fewer than 10 FTEs. *A small provider can elect to submit all, some or none of their claims electronically*;
2. Dental Claims;
3. *Claims submitted by p*articipants in a Medicare demonstration project *for services or items covered under that demonstration project,* when paper claim filing is required *as result of* the inability of the *HIPAA claim* implementation guide to *handle* data essential for *that* demonstration;
4. *Roster claims for* mass immunizations, such as flu *or pneumonia* injections*--P*aper roster bills cover multiple beneficiaries *on the same claim. This exception applies to providers* who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of *mass immunization* claims;
5. *Claims sent to Medicare* when more than one other insurer was liable for payment prior to Medicare;

6. *Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare carrier);*
7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;
9. Claims submitted by beneficiaries;
10. *Claims from p*roviders that only furnish services outside of the United States;
11. *Claims from p*roviders experiencing a disruption in their electricity or communication connection that is outside of their control *and is expected to last longer than two days*. *This exception applies only while electricity or electronic communication is disrupted*; and
12. Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.

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

a. *Periods* when a Medicare contractor's claim system might *temporarily* reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);

b. Documented disability of each employee *of a provider* prevents use of a computer to enable electronic submission of claims;

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

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

We have determined that you do not meet any of these criteria for waiver of the ASCA requirement for electronic submission of Medicare claims. ASCA did not establish an appeal process for waiver denials, but you can re-apply for an "unusual circumstance" waiver if your situation changes. *This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier. As you do not qualify for a waiver of the ASCA electronic claim submission requirement, Medicare will begin to deny paper claims you may submit beginning on the 91st day after the date of this letter.*

Waiver applications are only to be submitted to request a waiver if an "unusual circumstance" applies under b, c or d above. The information submitted with your waiver request did not indicate that circumstance b, c or d any other exception or waiver criteria apply in your case. If *your* self-assessment indicates that an exception condition, other than b, c or d is met, *you are* automatically waived from the electronic claim submission requirement and no request should be submitted to a Medicare contractor. Medicare contractors will monitor compliance *with the ASCA electronic billing requirements* on a post-payment basis.

Paper claims submitted to Medicare that do not meet the exception or unusual circumstance criteria do not qualify for Medicare *payment*. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. See *(contractor shall insert the URL)* for further information on enrollment for use of EDI, use of free billing software are other EDI information. There is also commercial software, and billing agent and clearinghouse services *are* available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs.

Sincerely,

Contractor Name

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

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

Date:

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

To: Organizational Name of Provider *and Mailing Address*

Subject: Review of Paper Claims Submission Practices

A large number of paper claims were submitted under your provider number*(s)* during the last calendar quarter. Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement *from* Medicare be submitted electronically with limited exceptions. The ASCA amendment to § 1862(a) of the *Social Security* Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. *This also applies to payments made for beneficiaries who qualify for Medicare based upon their employment in the railroad industry.*

ASCA prohibits submission of paper claims *except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below*:

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

2. *Dental claims*;

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

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

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

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

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

8. Claims submitted by beneficiaries;

9. *Claims from p*roviders that only furnish services outside of the United States;

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

11. Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.

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

a. *Periods* when a Medicare contractor's claim system might *temporarily* reject a particular type of electronically submitted claim, pending system modifications

(individual Medicare claims processing contractors notify their providers of these situations if they apply);

b. Documented disability of each employee *of a provider* prevents use of a computer to enable electronic submission of claims;

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

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

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

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

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

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, *claims are for dental services*, or *if they* otherwise qualify for a waiver under a situation that applies to all of their claims.

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

ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes. *This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier.*

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with free billing software for submission of Medicare claims. See *(contractor shall insert the URL)* for further information on enrollment for use of EDI, use of free billing software or other EDI information. There is also commercial software, and billing agent and clearinghouse services *are* available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit *(contractor shall insert the URL for vendor information)* to see a list of HIPAA-compliant vendor services available in your state.

Sincerely,

Contractor

Exhibit D—Notice that Paper Claims Will Be Denied Effective With the 91st Calendar Day After the Original Letter as Result of Non-Response to that Letter

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

Date:

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

To: Organizational Name of Provider *and Mailing Address*

Subject: Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105 and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement *from* Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the *Social Security* Act prescribes that “no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services” for which a claim is submitted in a non-electronic form.

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

Consequently, as noted in the initial letter as well as in information issued providers when this *ASCA* requirement was put into effect, any Medicare paper claims you submit more than 90 calendar days from the date of the initial letter requesting evidence to substantiate your right to submit paper claims will be denied by Medicare. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes. *This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier.*

If you did not respond because you realized that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with free billing software for submission of Medicare claims. *(Contractor shall insert the URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed.)* There is also commercial billing software, *and* billing agent and clearinghouse services *are* available on the open market that *can be used to bill* Medicare *as well as other payers* and may better meet your needs. Please visit *(contractor shall insert the URL for vendor information)* to see a list of HIPAA-compliant vendor services available in your state.

Sincerely,

Contractor Name

Exhibit E—Notice that Paper Claims Will Be Denied Effective With the 91st Calendar Day After the Original Letter as Result of Determination that the Provider is Not Eligible to Submit Paper Claims

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

Date:

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

To: Organizational Name of Provider *and Mailing Address*

Subject: Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement *from* Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the *Social Security* Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

We have reviewed your response to our letter requesting that you submit evidence to substantiate that you qualify for submission of paper claims under one of the exception

criteria listed in that letter. Upon review, we determined that you do not meet the paper claims waiver/exception criteria as stated in our prior letter. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if such a change in your situation occurs. *This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the Railroad Medicare Carrier.*

Consequently, any Medicare paper claims you submit on or after the 91st calendar day from the date of the letter requesting evidence of your eligibility to continue to submit paper claims will be denied by Medicare.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with free billing software for submission of Medicare claims. *(Contractor shall insert URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed.)* There is also commercial billing software, *and* billing agent and clearinghouse services *are* available on the open market that *can be used to bill Medicare as well as other payers* and may better meet your needs. Please visit *(contractor shall insert the URL for vendor information*) to see a list of HIPAA-compliant vendor services available in your state.

Sincerely,

Contractor Name

Exhibit F—Notice that Determination Reached that the Provider is Eligible to Submit Paper Claims

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

Date:

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

To: Organizational Name of Provider *and Mailing Address*

Subject: Review of Paper Claim Submission Practices

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

If your situation changes to the point where you no longer meet at least one of the criteria, you will be required to begin submission of your claims electronically *by the 91st* calendar day *after* that change in your status.

Although you are not required to submit claims electronically at the present time, you are encouraged to do so. Please contact us at *(contractor shall insert phone number)* if you would like to discuss use of the Medicare free billing software or other alternatives for submission of claims electronically. You are also encouraged to review information on our Website *(contractor shall insert the URL where information on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed)* concerning use of Electronic Data Interchange transactions.

Sincerely,

Contractor Name

Exhibit G—Notice from the Railroad Medicare Carrier to a Provider that Has Just Begun to Submit Claims that Paper Claims Submitted by that Provider Will be Denied

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

Date:

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

To: *Organizational Name of Provider and Mailing Address*

Subject: *Denial of Paper Claim Submission Practices*

You recently began to treat one or more Railroad Medicare beneficiaries and began to submit claims to us for the first time. In the process of establishing a record in our files to indicate that you are eligible to submit Medicare claims, we obtained a copy of your non-RR Medicare enrollment information. That record indicates that you are required to submit your Medicare claims electronically to at least one other Medicare contractor and does not indicate that you were issued a waiver to permit submission of paper Medicare claims. Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

ASCA did not differentiate among Medicare contractors or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement. As result, we will begin to deny any paper claims you

submit to us for Railroad Medicare beneficiaries unless you are able to establish that you meet one or more of the following exceptions to this ASCA requirement:

1. *Claims submitted by small providers-- To qualify, a physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 full-time equivalent employees (FTEs). A small provider can elect to submit all, some or none of their claims electronically;*
2. *Dental claims;*
3. *Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;*
4. *Roster claims for mass immunizations, such as flu or pneumonia injections-- Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;*
5. *Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;*
6. *Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);*
7. *Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;*
8. *Claims submitted by beneficiaries;*
9. *Claims from providers that only furnish services outside of the United States;*
10. *Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and*
11. *Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.*

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

a. *Periods when a Medicare contractor's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications*

(individual Medicare claims processing contractors notify their providers of these situations if they apply);

b. *Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;*

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

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

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

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

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

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they otherwise qualify for a waiver under a situation that applies to all of their claims.

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

not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. Commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill us as well as other payers.. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state. Some providers have reported that their software vendor or clearinghouse charges a substantial additional amount to allow a provider to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. This office can supply you with free billing software that you can use to submit your claims to us electronically. (Contractor shall insert URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed and/or supply a telephone number the provider can call to obtain comparable information.)

Sincerely,

Contractor Name

Exhibit H—Notice from the Railroad Medicare Carrier to a Provider with a Pre-Established Record in PES that Paper Claims Will Be Denied as Result of the Requirement that a Provider Submit Claims to One or More Other Medicare Contractors Electronically

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

Date:

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

To: *Organizational Name of Provider and Mailing Address*

Subject: *Review of Paper Claim Submission Practices*

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Paper claims will be denied if submitted by entities determined to be in violation of the statute or this rule. ASCA did not differentiate among Medicare contractors or between Railroad and non-

Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement.

We recently discovered that you have been submitting more than 10 Medicare claims per month on average to one or more other Medicare contractors and/or submitting claims to another Medicare contractor electronically. Unless you have been issued a letter by one or more Medicare contractors granting you a waiver of more than 90 days from the ASCA requirement for electronic submission of your claims, or are now able to establish that you do meet one or more of the criteria for waiver of this ASCA requirement, you are also required to submit your claims to us for Railroad beneficiaries electronically. If you have such a letter, or evidence that you do now qualify for a waiver of this ASCA requirement, please forward a copy of that letter or evidence to this office to enable us to update our records and permit you to continue to submit claims to us on paper if you choose.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. *Claims submitted by small providers--To qualify, a provider required to use the UB-04 form when submitting claims on paper shall have fewer than 25 full-time equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 (08/05) form when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;*
2. *Dental claims;*
3. *Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;*
4. *Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;*
5. *Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;*
6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);
7. *Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;*
8. *Claims submitted by beneficiaries;*

9. *Claims from providers that only furnish services outside of the United States;*
10. *Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and*
11. *Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.*

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

a. *Periods when a Medicare contractor's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);*

b. *Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;*

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

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

It is possible that you may previously have contacted this office or had an ASCA Enforcement Review conducted by this office and were informed that you are eligible to continue submitting paper claims to this office since you submit fewer than 10 Medicare claims to us per month. Until recently, we did not have access to ASCA review information from other Medicare contractors that could be used to determine whether you should be submitting your claims to us electronically As we do now have access to this type of information from other Medicare contractors, we are required to apply that information to you and to other providers that submit paper claims to this office.

As you may not have been notified that an ASCA electronic claim submission requirement that applies to another Medicare contractor also affects your submission of paper claims for Railroad Medicare beneficiaries, we will not begin to deny your paper claims until the 91st day after the date of this letter. This will allow you time to make changes as needed so you can begin to submit your claims to us electronically by the 91st day.

In the event your situation changes and you feel that you do meet one or more of the criteria for an exception from the ASCA electronic claim submission requirement, you should recontact us and any other Medicare contractor that made a determination that

you do not currently qualify for an exception. If determined that you do in fact qualify for an exception at that point, you would have the option to again begin to submit some or all of your Medicare claims on paper. The type of exception criteria you meet will determine if the exception applies to only certain types of your claims, all of your claims or applies only for a temporary period. That would be addressed in the decision notice you would be sent.

Some providers have reported that their software vendor or clearinghouse charges a substantial amount to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. This office can supply you with free billing software that you can use to submit your claims to us electronically. (Contractor shall insert URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed and/or supply a telephone number the provider can call to obtain comparable information.)

Sincerely,

Contractor Name