CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1736	**Date: MAY 15, 2009**
	Change Request 6201

Subject: Chapter 24 Update to Restore Inadvertently Deleted Information and to Remove Outdated Information

I. SUMMARY OF CHANGES: Chapter 24 is being updated to replace information that was inadvertently deleted in section 90.5.3. Chapter 24 is also being updated to remove outdated information in sections 40.1.1 and 40.1.2.

New / Revised Material
Effective Date: August 17, 2009
Implementation Date: August 17, 2009

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	Table of Contents
R	24/40.1.1/Reserved
R	24/40.1.2/Reserved
R	24/90.5.3/Contractor Roles in ASCA Reviews

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1736	Date: May 15, 2009	Change Request: 6201

SUBJECT: Chapter 24 Update to Restore Inadvertently Deleted Information and to Remove Outdated Information

Effective Date: August 17, 2009

Implementation Date: August 17, 2009

I. GENERAL INFORMATION

A. Background: Chapter 24 is being updated to replace information that was inadvertently deleted in section 90.5.3. Chapter 24 is also being updated to remove outdated information in sections 40.1.1 and 40.1.2. Contact the CMS representative listed at www.nucc.org for a CMS 1500 change request form. Contact the CMS representative listed at www.nubc.org for a CMS 1450 change request form.

B. Policy: The Administrative Simplification Compliance Act (ASCA)

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6201.1	Contractors shall be familiar with the updates in Chapter 24, subsections 90.5.3 (this information was previously contained in this section but was inadvertently deleted), 40.1.1, and 40.1.2.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Matt Klischer, Matthew.Klischer@cms.hhs.gov, 410.786.7488

Post-Implementation Contact(s): Matt Klischer, Matthew.Klischer@cms.hhs.gov, 410.786.7488

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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. 1736, 05-15-09)

40.1.1 - *Reserved*

(Rev. 1736; Issued: 05-15-09; Effective/Implementation Date: 08-17-09)

40.1.2 - *Reserved*

(Rev. 1736; Issued: 05-15-09; Effective/Implementation Date: 08-17-09)

90.5.3 - Contractor Roles in ASCA Reviews

(Rev. 1736; Issued: 05-15-09; Effective/Implementation Date: 08-17-09)

A. Identification of Those Providers to be Reviewed

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

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

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

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

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

When calculating 20% of providers still submitting paper claims, exclude those providers mentioned above who will not be considered for an ASCA review. For example, a contractor receives claims for 3,200 providers but only 2,000 of those submit any paper claims, and 1,800 submit more than 30 paper claims per quarter. 600 of that 1,800 have been reviewed within 2 years of the quarter in which a Medicare contractor is now determining which providers should be reviewed during that quarter and determined to be small. 75 of the paper billers in the quarterly report had reviews begin the prior quarter which are still open. That leaves a balance of 1,125 providers who could be subject to an ASCA review during the current quarter. 1,125 is the total of the universe of providers that are candidates for review during the

current quarter and the number of the universe to be reported to CMS in the contractor's monthly ASCA report. 20% of 1,125 is 225 and ¼ of 225 is 56 ¼. That contractor is expected to begin at least 56 new ASCA reviews during the current quarter. By the end of the fiscal year (FY), that contractor is expected to have begun ASCA reviews of the average of the provider universe totals for the quarters multiplied by 20%. In this example, if 1,125 providers was the average number of providers considered for ASCA review for the 4 quarters of the FY and the contractor began ASCA reviews of 225 of those providers by the end of the FY, that contractor will have met the 20% target for that FY.

1. ***Carriers A/B MAC, DME MAC and DMERC-Specific Selection Requirements***—*Carriers, A/B MACs, DME MACs and DMERC will determine the best candidates for review from the quarterly report and will complete the block/field to identify the selected providers in the quarterly report and trigger release of Exhibit letter C to those providers. (The carriers, A/B MACs, DME MACs and DMERC must furnish the appropriate URLs for the last paragraph of the letter.) Select candidates as follows:*

    a. *Two-thirds from Part 1 providers beginning with those that have the largest number of paper claims and issuing letters in descending order; and*

    b. *One third from Part 2 providers also beginning with those that have the largest number of paper claims and issuing letters in descending order.*

    NOTE: *In the case of a provider that submits claims under more than one PIN or NSC number, all of which are under the same TIN, and for which there are multiple entry lines in the quarterly report, a carrier, A/B MAC, DME MAC or DMERC shall combine the number of paper claims submitted under each of those PINs/NSCs when determining which providers to be selected for review. For ASCA evaluation purposes, consider all of those paper claims as submitted by the same provider even though under different PINs or NSCs. Complete the block/field for each of the provider's lines in that case, but apply the same review result for each of the affected PINs/NSCs recorded for that provider. In terms of number of reviews conducted, a review that involves multiple PINs or NSCs for the same provider is to be treated individually and multiple copies of letter C are to be issued.*

    If a carrier, A/B MAC, DME MAC or DMERC exhausts the Part 1 list and still has funds available for additional reviews that quarter, the contractor is to increase the number of initial review letters sent to Part 2 providers. If the Part 2 list is also exhausted for the quarter, and the contractor still has funds available for additional reviews, the contractor will begin to send initial review letters to those providers in Part 3 of the shared system quarterly report, again having letters issued in descending order beginning with those providers with the largest numbers of paper claims.

Carrier, A/B MACs, DME MACs and DMERC are to complete selection of providers to be reviewed by the end of the second month of each quarter.

2. ***FI-Specific Selection Requirements**--FIs shall determine candidates for review in descending order, beginning with those providers that submitted the most paper claims, subject to the previously mentioned exclusions due to a prior review or as result of a provider's submission of fewer than 30 paper claims that quarter.*

B. Conducting the Reviews

If a provider responds to letter C or D (whether triggered by carrier, A/B MAC, DME MAC or DMERC selection of the provider for review in the quarterly report or direct issuance of the letters by an FI), but does not establish eligibility to submit paper claims, an FI shall notify the shared system to begin denying paper claims submitted by that provider beginning on the 91st day after release of letter C and shall issue letter E. A carrier, A/B MAC, DME MAC or DMERC shall enter ASCA review result code NE in the shared system ASCA review result field (see §90.5.s). This will trigger the shared system to have Exhibit letter E released by the contractor's correspondence system.

If a provider's response to letter C or D establishes that the provider is eligible to submit paper claims to Medicare, an FI shall issue provider letter F, and a carrier, A/B MAC, DME MAC or DMERC shall enter ASCA review result code SM, WA or UC (see §90.5.2 as appropriate in the ASCA review result field). This will trigger MCS or VMS to have letter F released.

Contractors have authority to delay imposition of denial of paper claims for up to 30-days if the provider responds the letter C or D and indicates all changes needed to submit their claims electronically cannot be completed by the 90th day after letter C, but will be completed within 30 additional days. An FI, carrier, A/B MAC, DME MAC or DMERC should approve an extension request of up to 30 days, if the contractor has no reason to suspect the provider may not complete the changes by the specified date.

When an extension is approved, an FI must reset the effective date of paper claim denials as needed so FISS does not begin to deny paper claims from that provider prior to expiration of the extension period. A carrier, A/B MAC, DME MAC or DMERC must enter the new effective date (CCYYMMDD) when MCS or VMS is to begin denying paper claims in the paper claim denial date field (see §90.5.2) and also enter NE in the ASCA review result screen/field. MCS or VMS will begin to deny the provider's paper claims on the date entered.

If based on prior experience with the provider or knowledge of the extent of the changes the provider must make, a contractor has reason to doubt the ability of the provider to complete the necessary changes by the 120th day, the contractor is to deny a provider's extension request. An FI shall immediately notify FISS to begin denying paper claims from that provider beginning on the 91st day after issuance of letter C. A carrier, A/B MAC, DME MAC or DMERC shall enter NE in the ASCA review

result screen/field; MCS or VMS shall begin to deny that provider's paper claims on the 91st day after letter C was triggered.

A contractor does not have authority to approve more than one 30-day extension during the same review. Contractors must contact CMS/OIS/BAMG/Division of Medicare Billing Procedures (DMBP) if a contractor representative thinks a provider's request for an extension beyond the 120th day should be approved. If a contractor does not endorse an extension request beyond the 120th day, the contractor should deny the request. A carrier, A/B MAC, DME MAC or DMERC shall enter NE in the ASCA review result screen/field. If DMBP approval is requested by a contractor and DMBP does approve an extension, FIs, carriers, A/B MACs, DME MACs or DMERC are to follow the requirements in the prior paragraph concerning resetting of the effective date for denial of that provider's paper claims.

When the contractor finishes each provider's ASCA review, a carrier, A/B MAC, DME MAC or DMERC must enter the outcome to the provider file (see §90.5.2), except where identified as shared system responsibility, as well as enter the specific unusual circumstance when result code UC applies.

The group code CO (provider financial liability) is to be used with reason code 96 (non-covered charges), remark code M117 (Not covered unless submitted by electronic claim), and remark code MA44 (No appeal rights. Adjudicative decision based on law) for the entire billed amount in the remittance advice sent to the provider for claims when denied as submitted on paper.

If a provider is a candidate for an ASCA enforcement review and the provider is also undergoing a fraud or abuse investigation, a carrier, A/B MAC, DME MAC, DMERC or FI has discretion to exclude that provider from the ASCA enforcement review that quarter if it could interfere with the fraud/abuse investigation, or alternately, may combine the ASCA review with the fraud/abuse investigation. If an ASCA enforcement review is not conducted due to possible interference, and the provider is subsequently cleared of fraud or abuse, the ASCA enforcement review is to be conducted when that fraud/abuse investigation is completed.

Most types of ASCA exceptions/waivers apply to individual claim types only, or to submission of paper claims for temporary periods. If a provider is selected for ASCA review, and the contractor determines that most of the paper claims submitted for that provider for that period:

1. *Were for MSP claims when there is more than one primary payer, or for mass inoculations, or similar types of claims allowed to be submitted on paper; or*
2. *Were submitted on a temporary basis as result of power and communication disruption resulting from a natural disaster or similar problem outside the control of the provider;* ***AND***
3. *The number of paper claims submitted for the provider during that quarter that did not meet such criteria would not have been high enough to have resulted in selection of that provider for ASCA review in the absence of the excepted/waived claims, the contractor is to terminate that review.* ***THEN,***

A carrier, A/B MAC, DME MAC or DMERC must enter provider ASCA review result WA (see §90.5.2) to trigger Exhibit letter F, and an FI must issue letter F.

***NOTE:** WA or issuance of letter F to a provider that is being waived for a reason other than the number of FTEs employed does not preclude the provider from carrier, A/B MAC, DME MAC or DMERC selection for review during subsequent quarters.*

Medicare contractors are not to maintain a provider FTE database, or establish a separate database of waived providers, unless an "unusual situation" waiver decision is made as result of a provider's request for approval of a waiver (see 90.3.2 and 90.3.3), or as result of an ASCA review and either carrier, A/B MAC, DME MAC or DMERC provider ASCA determination WA or UC (see §90.5.1) applies, or an FI has issued letter F for other than the small provider exception.

Each contractor will maintain a local Excel spreadsheet of "unusual situation" waivers and requests with column headings for the name, address, legacy and NPI provider number, whether a requested "unusual circumstance" waiver was approved or denied, the effective and termination dates for an approval (if applicable), and the unusual circumstance identified in the request.

Contractors must be able to submit this spreadsheet to CMS when requested or could be asked to submit data from the spreadsheet in a report to CMS. Provider entries in this spreadsheet shall be retained for the same period that contractors are required to retain claims.

C. Post-Review Actions

If following the start of paper claim denials, a provider subsequently submits documentation to establish that they actually had met criteria for submission of paper claims by that 91st day, a carrier, A/B MAC, DME MAC or DMERC must enter SM, WA or UC as appropriate in the shared system ASCA review result field. This will trigger the shared system to have Exhibit letter F issued and will eliminate further paper claim denials for the provider. An FI must notify FISS to terminate denial of that provider's paper claims. The shared system is not to reprocess any paper claims previously denied as on paper for that provider unless the provider resubmits those claims.

If a provider submits documentation to establish eligibility to submit paper claims but that eligibility is effective after the 91st day, a carrier, A/B MAC, DME MAC or DMERC shall enter the date when the provider actually became eligible to submit paper claims in the appropriate field in the shared system ASCA review result screen (see §90.5.2). There is no corresponding FI process for this, but it is considered unlikely that this situation would occur with an institutional provider. If a carrier, A/B MAC, DME MAC or DMERC provider resubmits denied claims, services furnished on or after the date of eligibility to submit paper claims may be paid but services furnished after the 90th day through the day before the provider became eligible to submit paper claims may not be paid. They must be denied as furnished during a period for which the provider was required to bill Medicare electronically.