CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2181	**Date: March 25, 2011**
	Change Request 7269

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 24 Update for HIPAA 5010 and EDI Enhancements

I. SUMMARY OF CHANGES: The purpose of this CR is to publish an updated version of Internet Only Manual (IOM) Pub.100-04, Chapter 24. The chapter has been updated to reflect changes in EDI stemming from the implementation of the HIPAA version 5010. This CR also communicates information on Coordination of Benefits that has been shifted from IOM Pub.100-04, Chapter 24 to IOM Pub. 100-04, Chapter 28, section 70.6.

EFFECTIVE DATE: April 25, 2011
IMPLEMENTATION DATE: April 25, 2011

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/Title/Medicare Claims Processing Manual Chapter 24? General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims
R	24/Table of Contents
D	24/10/Electronic Data Interchange (EDI) General Outreach Activities
N	24/10/Introduction to Electronic Data Interchange (EDI) for Medicare Fee For Services (FFS)
D	24/10/10.1/Carrier, DMERC, and FI Analysis of Internal Information
N	24/10/10.1/Requirement for EDI
D	24/10/10.1.1/Systems Information
D	24/10/10.2/Contact with New Providers
N	24/10/10.2/Audience for this chapter
D	24/10/10.3/Production and Distribution of Information to Increase Use of EDI
N	24/10/10.3/Scope of this chapter
D	24/10/10.4/Production and Distribution of Material to Market EDI
N	24/10/10.4/Acronyms and Definitions
D	24/20/EDI Enrollment
N	24/20/General EDI
D	24/20/20.1/EDI Enrollment Form
N	24/20/20.1/HIPAA Legislative Background
D	24/20/20.1.1/New Enrollments and Maintenance of Existing Enrollments
D	24/20/20.2/Submitter Number
N	24/20/20.2/The America Reinvestment and Recovery Act (ARRA)
D	24/20/20.3/Release of Medicare Eligibility Data
N	24/20/20.3/HIPAA and ARRA on Security and Privacy
D	24/20/20.4/Network Service Vendor (NSV) Agreement
N	24/20/20.4/Administrative Simplification and Compliance Act (ASCA)
D	24/20/20.5/EDI User Guidelines
D	24/20/20.6/Directory of Billing Software Vendors and Clearinghouses
D	24/20/20.7/EDI Enrollment and EDI Claim Record Retention
D	24/30/Technical Requirements - Data, Media, and Telecommunications
N	24/30/EDI Enrollment and Registration (AKA Trading Partner Agreements)
D	24/30/30.1/System Availability

R	24/30/30.1/EDI Enrollment
D	24/30/30.2/Media
R	24/30/30.2/New Enrollments and Maintenance of Existing Enrollments
D	24/30/30.3/Telecommunications and Transmission Protocols
R	24/30/30.3/Submitter Number
D	24/30/30.4/Toll-Free Service
R	24/30/30.4/Network Service Vendor (NSV) Agreement
D	24/30/30.5/Initial Editing
D	24/30/30.6/Translators
D	24/30/30.7/Claim Key Shop and Optical Character Recognition (OCR)/Image
D	24/40/Required Electronic Data Interchange Formats
R	24/40/Medicare FFS EDI User Roles and Responsibilities in an EDI environment
D	24/40 /40.1/General HIPAA EDI Requirements
R	24/40 /40.1/Centers for Medicare and Medicaid Services - Medicare Fee-For-Service
D	24/40 /40.1.1/Reserved
R	24/40 /40.1.1/HIPAA transaction standards as designated by CMS
D	24/40 /40.1.2/Reserved
R	24/40 /40.1.2/Transactions Used In the Acknowledgement of Receipt of Claims
D	24/40 /40.1.3/FI HIPAA Claim Level Edits
R	24/40 /40.1.3/Change Request (CR) to Communicate Policy
D	24/40 /40.2/Continued Support of Pre-HIPAA EDI Formats
R	24/40 /40.2/Medicare FFS Contractors (FI, Carriers, RHHI, A/B MAC, DME MAC)
N	24/40 /40.2.1/Certification Purpose and Process of Certification Testing
N	24/40/40.2.2/Security Requirements - Insert SA-9 Language
N	24/40 /40.2.2.1/FI, Carrier, RHHI, A/B MAC, DME MAC, and CEDI Data Security and Confidentiality Requirements
N	24/40 /40.2.2.2/FIs, Carriers, RHIIs, A/B MACs, DME MACs, and CEDI EDI Audit Trails
N	24/40 /40.2.2.3/Security-Related Requirements for FIs Carriers, RHHIs, A/B MACs, and CEDI Arrangements With Clearinghouses and Billing Services
N	24/40 /40.2.2.4/Release of Medicare Eligibility Data
N	24/40 /40.2.2.5/EDI Enrollment and EDI Claim Record Retention

N	24/40 /40.2.3/General EDI Outreach Activities
N	24/40 /40.2.3.1/FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI Analysis of Internal Information
N	24/40 /40.2.3.2/Contact With New Providers
N	24/40 /40.2.3.3/Production and Distribution of Information to Increase Use of EDI
N	24/40 /40.2.3.4/Production and Distribution of Material to Market EDI
N	24/40 /40.2.4/Trading Partner Management
N	24/40 /40.2.4.1/User Guidelines
N	24/40 /40.2.4.2/Technical Assistance to EDI Trading Partners
N	24/40 /40.2.4.3/Training Content and Frequency
N	24/40 /40.2.4.4/Prohibition Against Requiring Use of Proprietary Software or DDE
N	24/40 /40.2.4.5/Free Claim Submission Software
N	24/40 /40.2.4.6/Newsletters/Bulletin Board/Internet Publication of EDI Information
N	24/40 /40.2.4.7/Provider Guidelines for Choosing a Vendor
N	24/40 /40.2.4.7.1/Determining Goals/Requirements
N	24/40 /40.2.4.7.2/Vendor Selection
N	24/40 /40.2.4.7.3/Evaluating Proposals
N	24/40 /40.2.4.7.4/Negotiating With Vendors
N	24/40 /40.2.5/Provision of EDI User Guidelines
N	24/40 /40.2.6/Provision and Maintenance of a Directory of Billing Software Vendors and Clearinghouses
D	24/40/40.3/National Council for Prescription Drug Program (NCPDP) Claim Requirements
R	24/40 /40.3/Trading Partners (reserved)
D	24/40/40.3.1/Remittance Advice
D	24/40/40.3.2/Standard Paper Remittance (SPR) Notices
D	24/40/40.3.3/Remittance Advice Remark Codes
D	24/40/40.4/COB Trading Partner and Contractor Crossover Claim Requirements
D	24/40/40.4.1/Payment Floor Requirement
D	24/40/40.4.2/Alternative to EFT
D	24/40/40.4.3/Tri-Partite Bank Agreement
D	24/40/40.5/Direct Data Entry (DDE) Screens
D	24/40/40.6/Use of Imaging, External Key Shop, and In-House Keying for Entry of Transaction Data Submitted on Paper

D	24/40/40.7/Electronic Funds Transfer (EFT)
D	24/40/40.7.1/X12N 837 Institutional Implementation Guide (IG) Edits
D	24/40/40.7.2/X12N 837 Professional Implementation Guide (IG) Edits
D	24/40/40.7.3/National Council for Prescription Drug Program (NCPDP) Implementation
D	24/40/40.8/Claim Implementation Guide Edits
D	24/40/40.8.1/X12N 837 Institutional Implementation Guide and Direct Data Entry Edits
D	24/40/40.8.2/X12N 837 Professional Implementation Guide Edits
D	24/40/40.8.3/National Council of Prescription Drug Programs (NCPDP) Implementation Guide Edits
D	24/50/EDI Testing Requirements
R	24/50/Technical Requirements
D	24/50/50.1/Shared System and Common Working File (CWF) Maintainers Internal Testing Requirements
R	24/50/50.1/Telecommunications, Internet and Dial-up
N	24/50/50.1.1/System Availability
N	24/50/50.1.2/Media
N	24/50/50.1.3/Telecommunications and Transmission Protocols
N	24/50/50.1.4/Toll-Free Service
R	24/50/50.2/Translators
D	24/50/50.3/Third-Party Certification Systems and Services
R	24/50/50.3/Common Edits and Enhancements Module (CEM) General Description
N	24/50/50.3.1/Claim Numbering
N	24/50/50.3.2/Receipt/ Control/Balancing
N	24/50/50.3.3/Acknowledgements
D	24/50/50.4/EDI Submitter/Receiver Testing by Carriers, DMERCs, and FIs
R	24/50/50.4/DME Unique Specifications
D	24/50/50.4.1/Testing Accuracy
R	24/50/50.4.1/Claim Numbering
D	24/50/50.4.2/Limitation on Testing of Multiple Providers that Use the Same Clearinghouse, Billing Service, or Vendor Software
R	24/50/50.4.2/Receipt Control and Balancing
D	24/50/50.4.3/Carrier, DMERC, and FI Submitter/Receiver Testing with Legacy Formats during the HIPAA Contingency Period

R	24/50/50.4.3/Acknowledgements for X12 5010 and NCPDP D.0 Transactions
D	24/50/50.4.4/Discontinuation of Use of COB Claim Legacy Formats Following Successful HIPAA Format Testing
D	24/50/50.4.5/EDI Receiver Testing by Carriers, DMERCs, and Intermediaries
D	24/50/50.5/Changes in Provider's System or Vendor's Software and Use of Additional EDI Formats
R	24/50/50.5/Testing Accuracy
N	24/50/50.5.1/Limitation on Testing of Multiple Providers that Use the Same Clearinghouse, Billing Service, or Vendor Software
N	24/50/50.5.2/EDI Receiver Testing by FIs, Carriers, RHHIs, and A/B MACs, and CEDI
N	24/50/50.6/Changes in Provider's System or Vendor's Software and Use of Additional EDI Formats
N	24/50/50.7/Delimiters
N	24/50/50.8/Nulls (reserved)
N	24/50/50.9/Direct Data Entry (DDE) Screens
D	24/60/Support of EDI Trading Partners
R	24/60/EDI Edit Requirements
D	24/60/60.1/User Guidelines
R	24/60/60.1/FIs, Carriers, RHHIs, A/B MACs, and CEDI Edit Requirements
D	24/60/60.2/Technical Assistance to EDI Trading Partners
R	24/60/60.2/Claim Implementation Guide Edits
N	24/60/60.2.1/FIs, Carriers, RHHIs, A/B MACs, and CEDI HIPAA Claim Level Edits
N	24/60/60.2.2/X12N 837 Institutional Implementation Guide (IG) Edits
N	24/60/60.2.3/X12N 837 Institutional Implementation Guide and Direct Data Entry Edits
N	24/60/60.2.4/Supplemental FI-Specific Shared System Edit Requirements
D	24/60/60.3/Training Content and Frequency
R	24/60/60.3/Claim Implementation Guide Edits Part B and DME

N	24/60/60.3.1/X12N 837 Professional Implementation Guide (IG) Edits
N	24/60/60.3.2/National Council for Prescription Drug Program (NCPDP) Implementation
D	24/60/60.4/Prohibition Against Requiring Use of Proprietary Software or DDE
R	24/60/60.4/Key Shop and Optical Character Recognition
N	24/60/60.4.1/Claim Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Mapping to X12N Based Flat File
N	24/60/60.4.2/Key Shop and Image Processing
D	24/60/60.5/Free Claim Submission Software
R	24/60/60.5/COB Trading Partner and Contractor Crossover Claim Requirements
D	24/60/60.6/Remittance Advice Print Software
D	24/60/60.6.1/Medicare Remit Easy-Print Software for Professional Providers and Suppliers
D	24/60/60.6.2/Medicare Standard Electronic PC Print Software for Institutional Providers
R	24/60/60.6/Remittance Advice and Standard Paper Remittances
D	24/60/60.7/Newsletters/Bulletin Board/Internet Publication of EDI Information
R	24/60/60.7/Payments
N	24/60/60.7.1/Payment Floor Requirement
N	24/60/60.7.2/Alternative to EFT
N	24/60/60.7.3/Electronic Funds Transfer (EFT)
N	24/60/60.7.4/Tri-Partite Bank Agreement
D	24/60/60.8/Provider Guidelines for Choosing a Vendor
D	24/60/60.8.1/Determining Goals/Requirements

D	24/60/60.8.2/Vendor Selection
D	24/60/60.8.3/Evaluating Proposals
D	24/60/60.8.4/Negotiating With Vendors
D	24/70/EDI Edit Requirements
R	24/70/CMS Defined File Formats
D	24/70/70.1/Carrier, DMERC, and FI X12 Edit Requirements
R	24/70/70.1/General HIPAA EDI Requirements
D	24/70/70.2/Supplemental FI-Specific Shared System Edit Requirements
R	24/70/70.2/National Council for Prescription Drug Program (NCPDP) Claim Requirements
D	24/70/70.2.1/FI HIPAA Claim Level Implementation Guide Edits
D	24/70/70.3/Supplemental Carrier/DMERC-Specific Shared System Implementation Guide Edit Requirements
D	24/70/70.4/Key Shop and Image Processing
D	24/80/Security
R	24/80/Electronic Data Interchange (EDI) Reporting Requirements
D	24/80/80.1/Carrier, DMERC, or FI Data Security and Confidentiality Requirements
R	24/80/80.1/Contractor Reporting of Operational and Workload (CROWD) Reporting
D	24/80/80.2/Carrier, DMERC, and FI EDI Audit Trails
R	24/80/80.2/Common Edits and Enhancements Module (CEM) Reporting
D	24/80/80.3/Security-Related Requirements for Carrier, DMERC, or FI Arrangements with Clearinghouses and Billing Services
R	24/80/80.3/Common Electronic Data Interchange (CEDI) Reporting
N	24/80/80.4/HIPAA Transition Reporting
N	24/80/80.5/Administrative Simplification and Compliance Act (ASCA) Reporting
R	24/90/Mandatory Electronic Submission of Medicare Claims
R	24/90/90.1/Small Providers and Full-Time Equivalent Employee Self-Assessments
R	24/90/90.2/Exceptions
R	24/90/90.3/"Unusual Circumstance" Waivers

R	24/90/90.3.1/Unusual Circumstance Waivers Subject to Provider Self-Assessment
R	24/90/90.3.2/Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision
R	24/90/90.4/Electronic and Paper Claims Implications of Mandatory Electronic Submission
R	24/90/90.5.2/MCS and VMS Roles in ASCA Enforcement
R	24/90/90.5.3/Contractor Roles in ASCA Reviews
R	24/90/90.6 Provider Education
R	24/90/90.7 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
R	24/90/90.7.1 RMC Entry of ASCA Enforcement Review Decisions and EDI Enrollment Information from Other Medicare Contractors into PES
R	28/70/70.6/Consolidation of the Claims Crossover Process

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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. ATTACHMENT:

Business Requirement

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2181	Date: March 25, 2011	Change Request: 7269

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 24 Update for HIPAA 5010 and EDI Enhancements

Effective Date: **April 25, 2011**

Implementation Date: April 25, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the next version of the Health Insurance Portability and Accountability Act (HIPAA) transactions. The Secretary of the Department of Health and Human Services (DHHS) has adopted Accredited Standards Committee (ASC) X12 Version 5010, and the National Council for Prescription Drug Programs (NCPDP) Version D.0 as the next HIPAA transaction standards for covered entities to exchange HIPAA transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

Effective Date of the regulation:	March 17, 2009
Level I compliance by:	December 31, 2010
Level II Compliance by:	December 31, 2011
All covered entities have to be fully compliant on:	January 1, 2012

Level I compliance means "that a covered entity can demonstrate that it could create and receive compliant transactions, resulting from the compliance of all design/build activities and internal testing."

Level II compliance means "that a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards."

DHHS has promulgated in the Final Rules provisions which permit dual use of existing standards (ASC X12 4010A1 and NCPDP 5.1) and the new standards (5010 and D.0) from the March 17, 2009, effective date until the January 1, 2012 compliance date to facilitate testing subject to trading partner agreement.

The purpose of this CR is to publish an update to IOM Pub.100-04 Chapter 24 to reflect changes to Medicare Fee-For-Service's Electronic Data Interchange (EDI) practices, and corresponding EDI requirements for Medicare contractors that are being implemented as part of the 5010 implementation project. Overall, the content of the chapter is for the most part unchanged, just reorganized and updated. However, outdated information has been removed and some new sections have been added where needed.

This CR also communicates information on Coordination of Benefits that has been shifted from IOM Pub. 100-04 Chapter 24 to IOM Pub. 100-04 Chapter 28, section 70.6.

As this is a no systems change CR, this is expected to be an In Scope change request.

B. Policy: CMS will implement the new HIPAA standard as adopted by the Secretary**.** Final Rules were published in the Federal Register on January 16, 2009, by the Department of Health and Human Services: 45 CFR Part 162.

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	
7269.1	Contractors shall implement all requirements contained within the IOM Pub. 100-04 Chapter 24 General EDI and EDI Support Requirements, Electronic Claims and Mandatory Electronic Filing of Medicare Claims	X	X	X	X	X					CEDI
7269.2	Contractors shall be aware of changes to the IOM Pub. 100-04 Chapter 28 Coordination With Medigap, Medicaid, and Other Complementary Insurers	X	X	X	X	X					CEDI

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: N/A
"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Angie Bartlett (410) 786-2865 Angie.Bartlett@cms.hhs.gov
Veronica Harshman (410) 786-2489 Veronica.harshman@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *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),* 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.

70.6 - Consolidation of the Claims Crossover Process

(Rev.2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Background – Medicare Claims Crossover Process--General

Through the Coordination of Benefits Contractor (COBC), Medicare transmits outbound 837 Coordination of Benefit (COB) and Medigap claims COB trading partners and Medigap plans, collectively termed "trading partners," on a post-adjudicative basis. This type of transaction, originating at individual Medicare contractors following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All Medicare contractors are required to accept all 837 segments and data elements permitted by the in- force applicable guides on an initial 837 professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the Medicare contractor within its store-and-forward repository (SFR). Incoming claims data shall be subjected to standard syntax and applicable implementation guide (IG) edits prior to being deposited in the SFR to assure non-compliant data will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

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

As a rule, the shared system maintainers shall populate an outbound COB/Medigap file as an 837 flat file with the Employer Identification Number (EIN)/Tax ID or SSN (for a sole practitioner) present in the provider's file, unless otherwise specified within §70.6.5 or §70.6.6 of this chapter. With the adoption of the National Provider Identifier (NPI), the shared system shall report qualifier XX in NM108 and the NPI value in NM109. The shared system shall report the provider's EIN/TAX ID within the REF segment of the billing provider loop, as appropriate. In addition, unless otherwise stated within §70.6.5

or §70.6.6 of this chapter, the shared systems shall populate the provider loops on outbound 837 claims with the provider's first name, last name, middle initial, address, city, state and zip code as contained in the Medicare provider files, the information for which is derived from the Provider Enrollment Chain and Ownership System (or PECOS)

Background—Specific COBA Crossover Process

The CMS has now streamlined the claims crossover process to better serve its customers. Under the new consolidated claims crossover process, trading partners execute national agreements called Coordination of Benefits Agreements (COBAs) with CMS' Coordination of Benefits Contractor. Through the COBA process, each COBA trading partner will send one national eligibility file that includes eligibility information for each Medicare beneficiary that it insures to the COBC. The COBC will transmit the beneficiary eligibility file(s) to the Common Working File (CWF) via the HUBO maintenance transaction. The transaction is also termed the "Beneficiary Other Insurance (BOI)" auxiliary file. (See Pub.100-4, chapter 27, §80.14 for more details about the contents of the BOI auxiliary file.)

During August 2003, the CMS modified CWF to accept both the HUBO (BOI) transaction on a regular basis and COBA Insurance File (COIF) as a weekly file replacement. Upon reading both the BOI and the COIF, CWF applies each COBA trading partner's claims selection criteria against processed claims with service dates that fall between the effective and termination date of one or more BOI records.

Upon receipt of a BOI reply trailer (29) that contains (a) COBA ID (s) and other crossover information required on the Health Insurance Portability and Accountability Act (HIPAA) 835 Electronic Remittance Advice (ERA), Medicare contractors will send processed claims via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to the COBC. The COBC, in turn, will cross the claims to the COBA trading partner in the HIPAA American National Standards Institute (ANSI) X12-N 837 or NCPDP formats, following its validation that the incoming Medicare claims are formatted correctly and pass HIPAA or NCPDP compliance editing.

In addition, CMS shall arrange for the invoicing of COBA trading partners for crossover fees.

For more information regarding the COBA Medigap claim-based crossover process, which was enacted on October 1, 2007, consult §70.6.4 of this chapter.

I. Contractor Actions Relating to CWF Claims Crossover Exclusion Logic

A. Determination of Beneficiary Liability for Claims with Denied Services

Effective with the January 2005 release, the Part B and Durable Medical Equipment Regional Carrier (DMERC)/DME Medicare Administrative Contractor (DME MAC) contractor shared systems will be required to include an indicator "L" (beneficiary is liable

for the denied service[s]) or "N" (beneficiary is not liable for the denied service[s]) in an available field on the HUBC and HUDC queries to CWF for claims on which all line items are denied. The liability indicators (L or N) will be at the header or claim level rather than at the line level.

For purposes of applying the liability indicator L or N at the header/claim level and, in turn, including such indicators in the HUBC or HUDC query to CWF, the Part B and DMERC/DME MAC contractor shared systems shall follow these business rules:

- The L or N indicators are not applied at the header/claim level if any service on the claim is payable by Medicare;

- The "L" indicator is applied at the header/claim level if the beneficiary is liable for any of the denied services on a fully denied claim; and

- The "N" indicator is applied at the header/claim level if the beneficiary is not liable for all of the denied services on a fully denied claim.

Effective with October 2007, the CWF maintainer shall create a 1-byte beneficiary liability indicator field within the header of its HUIP, HUOP, HUHH, and HUHC Part A claims transactions (valid values for the field="L," "N," or space).

As Part A contractors adjudicate claims and determine that the beneficiary has payment liability for any part of the fully denied services or service lines, they shall set an "L" indicator within the newly created beneficiary liability field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. In addition, as Part A contractors adjudicate claims and determine that the beneficiary has no payment liability for any of the fully denied services or service lines—that is, the provider must absorb all costs for the fully denied claims—they shall include an "N" beneficiary indicator within the designated field in the header of their HUIP, HUOP, HUHH, and HUHC claims that they transmit to CWF. **NOTE:** Part A contractors shall not set the "L" or "N" indicator on partially denied/partially paid claims.

Upon receipt of an HUIP, HUOP, HUHH, or HUHC claim that contains an "L" or "N" beneficiary liability indicator, CWF shall read the COBA Insurance File (COIF) to determine whether the COBA trading partner wishes to receive "original" fully denied claims with beneficiary liability (crossover indicator "G") or without beneficiary liability (crossover indicator "F") or "adjustment" fully denied claims with beneficiary liability (crossover indicator "U") or without beneficiary liability (crossover indicator "T").

If CWF determines that the COBA trading partner wishes to exclude the claim, as per the COIF, it shall suppress the claim from the crossover process.

CWF shall post the appropriate crossover disposition indicator in association with the adjudicated claim on the HIMR detailed history screen (see §80.15 of this chapter).

In addition, the CWF maintainer shall create and display the new 1-byte beneficiary liability indicator field within the HIMR detailed history screens (INPL, OUTL, HHAL, and HOSL), to illustrate the indicator ("L" or "N") that appeared on the incoming HUIP, HUOP, HUHH, or HUHC claim transaction.

CWF Editing for Incorrect Values

If a Part A contractor sends values other than "L," "N," or space in the newly defined beneficiary liability field in the header of its HUIP, HUOP, HUHH, or HUHC claim, CWF shall reject the claim back to the Part A contractor for correction. Following receipt of the CWF rejection, the Part A contractor shall change the incorrect value placed within the newly defined beneficiary liability field and retransmit the claim to CWF.

B. Developing a Capability to Treat Entry Code "5" and Action Code "3" Claims As Recycled "Original" Claims For Crossover Purposes

Effective with July 2007, in instances when CWF returns an error code 5600 to a contractor, thereby causing it to reset the claim's entry code to "5" to action code to "3," the contractor shall set a newly developed "N"(non-adjustment) claim indicator ("treat as an original claim for crossover purposes") in the header of the HUBC, HUDC, HUIP, HUOP, HUHH, HUIP, HUOP, HUHH, and HUHC claim in the newly defined field before retransmitting the claim to CWF. The contractor's system shall then resend the claim to CWF.

Upon receipt of a claim that contains entry code "5" or action code "3" with a non-adjustment claim header value of "N," the CWF shall treat the claim as if it were an "original" claim (i.e., as entry code "1" or action code "1") for crossover inclusion or exclusion determinations. If CWF subsequently determines that the claim meets all other inclusion criteria, it shall mark the claim with an "A" ("claim was selected to be crossed over") crossover disposition indicator.

Following receipt of a Beneficiary Other Insurance (BOI) reply trailer (29) for the recycled claim, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 (Claim Frequency Type Code) segment with a value of "1" (original). In addition, the contractors' systems shall ensure that, as part of their 837 flat file creation process, they do not create a corresponding 2330 loop REF*T4*Y segment, which typically signifies "adjustment."

C. Developing a Capability to Treat Claims with Non-Adjustment Entry or Action Codes as Adjustment Claims For Crossover Purposes

Effective with July 2007, in instances where contractors must send adjustment claims to CWF as entry code "1" or as action code "1" (situations where CWF has rejected the claim with edit 6010), they shall set an "A" indicator in a newly defined field within the header of the HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claim.

If contractors send a value other than "A" or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

Upon receipt of a claim that contains entry code "1" or action code "1" with a header value of "A," the CWF shall take the following actions:

- Verify that, as per the COIF, the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**; and

- Suppress the claim if the COBA trading partner wishes to exclude **either** adjustments, monetary or adjustments, non-monetary, **or both**.

NOTE: The expectation is that such claims do not represent mass adjustments tied to the MPFS or mass adjustments-other.

If contractors receive a BOI reply trailer (29) on a claim that had an "A" indicator set in its header, the contractors' systems shall ensure that, as part of their 837 flat file creation processes, they populate the 2300 loop CLM05-3 ("Claim Frequency Type Code") segment with a value that designates "adjustment" rather than "original" to match the 2330B loop REF*T4*Y that they create to designate "adjustment claim."

If a contractor's system does not presently create a loop 2330B REF*T4*Y to designate adjustments, it shall not make a change to do so as part of this instruction.

Correcting Invalid Claim Header Values Sent to CWF

If contractors send a value other than "A," "N," or spaces within the newly designated header field within their HUBC, HUDC, HUIP, HUOP, HUHH, and HUHC claims, CWF shall apply an edit to reject the claim back to the contractor. Upon receipt of the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claim to CWF for verification and validation.

D. CWF Identification of National Council for Prescription Drug Claims

Currently, the DMERC/DME MAC contractor shared system is able to identify, through the use of an internal indicator, whether a submitted claim is in the National Council for Prescription Drug Programs (NCPDP) format. Effective with January 2005, the DMERC/DME MAC contractor shared system shall pass an indicator "P" to CWF in an available field on the HUDC query when the claim is in the NCPDP format. The indicator "P" should be included in a field on the HUDC that is separate from the fields used to indicate whether a beneficiary is liable for all services that are completely denied on his/her claim.

The CWF shall read the new indicators passed via the HUBC or HUDC queries for purposes of excluding 100 percent denied claims with or without beneficiary liability and NCPDP claims. After applying the claims selection options, CWF will return a BOI reply trailer (29) to the Medicare contractor only in those instances when the COBA trading partner expects to receive a Medicare processed claim from the COBC.

Effective with July 2007, CWF shall reject claims back to DMERCs/DME MACs if their HUDC claim contains a value other than "P" in the established field used to identify NCPDP claims.

E. CWF Identification and Auto-Exclusion of 837 Professional Claims That Contain Only Physician Quality Reporting Initiative (PQRI) Codes

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUBC claim transmission for a 1-byte PQRI indicator (valid values=Q or space).

In addition, CWF shall create a 2-byte field on page 2 of the HIMR claim detail in association with the new category "COBA Bypass" for the value "BQ," which shall designate that CWF auto-excluded the claim because it contained only PQRI codes (see §80.15 of this chapter for more details regarding the bypass indicator).

Prior to transmitting the claim to CWF for normal processing, the Part B shared system shall input the value "Q" in the newly defined PQRI field in the header of the HUBC when **all** service lines on a claim contain PQRI (status M) codes.

Upon receipt of a claim that contains a "Q" in the newly defined PQRI field (which signifies that the claim contains only PQRI codes on all service detail lines, CWF shall auto-exclude the claim from the national COBA eligibility file-based and Medigap claim-based crossover processes. Following exclusion of the claim, CWF shall populate the value "BQ" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screens.

Prior to October 6, 2008, all Medicare contractors shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BQ" by-pass value, which designates that CWF auto-excluded the claim because it only contained PQRI codes.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BQ" code.

F. CWF Identification and Exclusion of Claims Containing Placeholder National Provider Identifiers (NPIs)

Effective October 6, 2008, the CWF maintainer shall create space within the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions for a new 1-byte "NPI-Placeholder" field (acceptable values=Y or space).

In addition, the CWF maintainer shall create space within page two (2) of the HIMR detail of the claim screen for 1) a new category "COBA Bypass"; and 2) a 2-byte field for the indicator "BN." (See Pub. 100-04, chapter 27, §80.15 for more details regarding the "BN" bypass indicator.)

NOTE: With the implementation of the October 2008 release, the CWF maintainer shall remove all current logic for placeholder provider values with the implementation of this new solution for identifying claims that contain placeholder provider values.

As contractors, including Medicare Administrative Contractors (MACs) and Durable Medical Equipment Medicare Administrative Contractors (DME MACs), adjudicate **non VA MRA** claims that fall within any of the NPI placeholder requirements, their shared system shall take the following combined actions:

1) Input a "Y" value in the newly created "NPI Placeholder" field on the HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction if a placeholder value exists on or is created anywhere within the SSM claim record. **NOTE**: Contractor systems shall include spaces within the "NPI Placeholder" field when the claim does not contain a placeholder NPI value; **and**

2) Transmit the claim to CWF, as per normal requirements.

Upon receipt of claims where the NPI Placeholder field contains the value "Y," CWF shall auto-exclude the claim from the national COBA crossover process. In addition, CWF shall populate the value "BN" in association with the newly developed "COBA Bypass" field on page 2 of the HIMR Part B and DME MAC claim detail screen and on page 3 of the HIMR intermediary claim detail screen. (See Pub.100-04, chapter 27, §80.14 for more details.)

Prior to October 6, 2008, all Medicare contractors shall update any of their provider customer service materials geared towards crossover claims related inquiries to reflect the newly developed "BN" by-pass value, which designates that CWF auto-excluded the claim because it contained a placeholder provider value.

The Next Generation Desktop (NGD) contractor shall also modify its user screens and documentation to reflect the new "BN" code.

II. Contractor Actions Relating to CWF Claims Crossover Inclusion or Inclusion/Exclusion Logic

A. Inclusion of Two Categories of Mass Adjustment Claims for Crossover Purposes

All Medicare contractors shall continue to identify mass adjustment claims-MPFS and mass adjustment claims—other by including an "M" (mass adjustment claims—MPFS) or "O" (mass adjustment claims—other) within the header of the HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claim transactions, as specified in Pub.100-04, chapter 27, §80.16. (Refer to Pub.100-04, chapter 27, §80.18 for CWF specific requirements relating to the unique inclusion of mass adjustment claims for crossover purposes.)

Effective January 5, 2009, the COBC, at CMS's direction, will modify the COIF to allow for the unique **inclusion** of mass adjustment claims—MPFS updates and mass adjustment claims—other. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the COBC transmits them as part of its regular COIF updates.

Upon receipt of a HUIP, HUOP, HUHH, HUHC, HUBC, or HUDC claim transaction that contains an "M" or "O" mass adjustment indicator, CWF shall undertake all additional actions with respect to determination as to whether the claim should be included or excluded for crossover purposes as specified in chapter 27, §80.18.

Contractor Flat File Requirements

Before the Part A and Part B shared systems send "mass adjustment claims—MPFS" to the COBC via an 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MP," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

Before the contractors' shared systems send "mass adjustment claims—other" to the COBC via an 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was not a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "MO," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

B. Inclusion and Exclusion of Recovery Audit Contractor (RAC)-Initiated Adjustment Claims

Effective January 5, 2009, at CMS's direction, the COBC will modify the COIF to allow for the unique **inclusion** and exclusion of RAC-initiated adjustment claims. The CWF maintainer shall 1) create these new fields, along with accompanying 1-byte file displacement, within its version of the COIF; and 2) accept and process these new fields when the COBC transmits them as part of its regular COIF updates. In addition, the CWF maintainer shall create a 1-byte RAC adjustment value in the header of its HUIP, HUOP, HUHH, HUHC, HUBC, and HUDC claims transactions (valid values="R" or spaces).

Through this instruction, all contractor systems shall develop a method for uniquely identifying all varieties of RAC-requested adjustments, which occur as the result of post-payment review activities.

NOTE: Currently, fewer than five (5) contractors process RAC adjustments.

Prior to sending its processed 11X and 12X type of bill RAC-initiated adjustment transactions to CWF for normal verification and validation, the Part A shared system shall input the "R" indicator in the newly defined header field of the HUIP claim transaction if the RAC adjustment claim meets either of the following conditions:

1) The claim resulted in Medicare changing its payment decision from paid to denied (i.e., Medicare paid $0.00 as a result of the adjustment performed)**; or**

2) The claim resulted in a Medicare adjusted payment that falls below the amount of the inpatient hospital deductible.

Prior to sending RAC-initiated adjustment claims **with all other type of bill designations to CWF** for normal processing, the Part A shared system shall input an "R" indicator in the newly defined header field of the HUOP, HUHH, and HUHC claim.

Prior to sending their processed RAC adjustment transactions to CWF for normal verification and validation, the Part B and Durable Medical Equipment Medicare Administrative Contractor (DMAC) shared systems shall input the "R" indicator in the newly defined header field of the HUBC and HUDC claim transactions.

Unique COBA ID Assignment to Trading Partners That Accept RAC-Initiated Adjustment Claims Only and Attendant Contractor Responsibilities

The COBC will assign a unique COBA ID range (88000-88999) to COBA trading partners that elect to "include" RAC-initiated adjustment claims for crossover purposes and will **not,** at CMS's direction, charge the trading partner the standard crossover fee for that category of adjustment claims. Therefore, when contractors receive a BOI reply trailer (29) on a claim that contains **only** a COBA ID in the range 88000 through 88999 (which designates RAC adjustment), the contractor shall not establish an accrual or expect payment for the claim.

Before the contractor systems send "tagged" RAC-initiated adjustment claims to the COBC via an 837 flat file transmission, they shall take the following actions with respect to the fields that correspond to the loop 2300 NTE01 and NTE02 segments on the 837 COB flat file only if there was **not** a pre-existing 2300 NTE segment on the incoming Medicare claim:

1) Populate "ADD" in the field that corresponds to NTE01; and

2) Populate "RA," utilizing bytes 01 through 02, in the field that corresponds to NTE02.

III. CWF Crossover Processes In Association with the Coordination of Benefits Contractor

A. CWF Processing of the COBA Insurance File (COIF) and Returning of BOI Reply Trailers

Effective July 6, 2004, the COBC will begin to send initial copies of the COBA Insurance File (COIF) to the nine CWF host sites. The COIF will contain specific information that will identify the COBA trading partner, including name, COBA ID, address, and tax identification number (TIN). It will also contain each trading partner's claims selection criteria along with an indicator (Y=Yes or N=No) of whether the trading partner wishes its name to be printed on the Medicare Summary Notice (MSN). Effective with the October 2004 systems release, the COIF will also contain a 1-digit Test/Production Indicator that will identify whether a COBA trading partner is in test (T) or production (P) mode. The CWF will be required to return that information as part of the BOI reply trailer (29) to Medicare contractors.

Upon receipt of a claim, CWF shall take the following actions:

- Search for a COBA eligibility record on the BOI auxiliary record for each beneficiary and obtain the associated COBA ID(s) [NOTE: There may be multiple COBA IDs associated with each beneficiary.];

- Refer to the COIF associated with each COBA ID **NOTE**: The CWF shall pull the COBA ID from the BOI auxiliary record to obtain the COBA trading partner's name and claims selection criteria;

- Apply the COBA trading partner's selection criteria; and

- Transmit a BOI reply trailer to the Medicare contractor <u>only</u> if the claim is to be sent, via 837 COB flat file or NCPDP file, to the COBC to be crossed over.

B. BOI Reply Trailer and Claim-based Reply Trailer Processes

1. BOI Reply Trailer Process

For eligibility file-based crossover, Medicare contractors shall send processed claims information to the COBC for crossover to a COBA trading partner in response to the receipt of a CWF BOI reply trailer (29). Medicare contractors will only receive a BOI reply trailer (29) under the consolidated crossover process for claims that CWF has selected for crossover after reading each COBA trading partner's claims selection criteria as reported on the weekly COIF submission.

When a BOI reply trailer (29) is received, the COBA assigned ID will identify the type of crossover (see the Data Elements Required for the BOI Aux File Record Table in Chapter 27, §24). Although each COBA ID will consist of a five-digit prefix that will be all zeroes, Medicare contractors are only responsible for picking up the last five digits within these ranges, which will be right justified in the COBA number field. In addition to the trading partner's COBA ID, the BOI reply trailer shall also include the COBA trading partner name (s), an "A" crossover indicator that specifies that the claim has been selected to be crossed over, and a one-digit indicator ["Y"=Yes; "N"=No] that specifies whether the COBA trading partner's name should be printed on the beneficiary MSN. As discussed above, effective with the October 2004 systems release, CWF shall also include a 1-digit Test/Production Indicator on the BOI reply trailer (29) that is returned to the Medicare contractor.

Larger-Scale Implementation of the COBA Process

Medicare contractors should note that the larger-scale COBA process, where additional trading partners are first identified as testing participants with the COBC and then are moved to crossover production with the COBC following the successful completion of testing, may be activated at any time during the COBA smaller-scale parallel production period. Activation of the larger-scale COBA process will most likely not occur before the early months of calendar year 2005.

MSN Crossover Messages

Effective with the October 2004 systems release, the Medicare contractor will begin to receive BOI reply trailers (29) that contain an MSN indicator "Y" (Print trading partner name on MSN) or "N" (Do not print trading partner name on MSN).

Also, effective with the October 2004 systems release, when a Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator of "T," it shall ignore the MSN indicator on the trailer. Instead, the Medicare contractor shall follow its existing procedures for inclusion of trading partner names on MSNs for those trading partners with whom it has existing TPAs.

When a COBA trading partner is in full production (Test/Production Indicator=P), the Medicare contractor shall read the MSN indicator returned on the BOI reply trailer (29). If the Medicare contractor receives an MSN indicator "N," it shall print its generic crossover message(s) on the MSN rather than including the trading partner's name. Examples of existing generic MSN messages include the following:

(For all COBA ID ranges other than Medigap)

MSN #35.1 - "This information is being sent to private insurer(s). Send any questions regarding your benefits to them."

(For the Medigap COBA ID range)

MSN#35.2- "We have sent your claim to your Medigap insurer. Send any questions regarding your Medigap benefits to them."

Beginning with the October 2004 systems release, contractors shall follow these procedures when determining whether to update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "T," it shall not update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

- If the Medicare contractor receives a BOI reply trailer (29) that contains a Test/Production Indicator "P," it shall update its claims history to show that a beneficiary's claim was selected by CWF to be crossed over.

Effective January 5, 2009, when CWF returns a BOI reply trailer (29) to a Medicare contractor that contains **only** a COBA ID in the range 89000 through 89999, the contractor's system shall suppress all crossover information, including name of insurer and generic message#35.1, from all beneficiary MSNs.

Contractors shall **not** update their claims histories to reflect transference of "tagged" claims with COBA ID range 89000 through 89999 to the COBC. Contractors shall, however, accrue for credit (expect payment) on such claims.

Electronic Remittance Advice (835)/Provider Remittance Advice Crossover Messages

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "T" Test/Production Indicator to the Medicare contractors, they shall not print information received from the BOI reply trailer (29) in the required crossover fields on the 835 Electronic Remittance Advice or other provider remittance advices that are in production. Contractors shall, however,

populate the 835 ERA (or provider remittance advice(s) in production) with required crossover information when they have existing agreements with trading partners.

Beginning with the October 2004 release, when CWF returns a BOI reply trailer (29) that contains a "P" Test/Production Indicator to the Medicare contractors, they shall use the returned BOI trailer information to take the following actions on the provider's 835 Electronic Remittance Advice:

a. Record code 19 in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) of the 835 ERA (v. 4010-A1). [**NOTE:** Record "20" in CLP-02 (Claim Status Code) in Loop 2100 (Claim Payment Information) when Medicare is the secondary payer.]

b. Update the 2100 Loop (Crossover Carrier Name) on the 835 ERA as follows:

- NM101 [Entity Identifier Code]—Use "TT," as specified in the 835 Implementation Guide.

- NM102 [Entity Type Qualifier]—Use "2," as specified in the 835 Implementation Guide.

- NM103 [Name, Last or Organization Name]—Use the COBA trading partner's name that accompanies the first sorted COBA ID returned to you on the BOI reply trailer.

- NM108 [Identification Code Qualifier]—Use "PI" (Payer Identification)

- NM109 [Identification Code]—Use the first COBA ID returned to you on the BOI reply trailer. (See line 24 of the BOI aux. file record

If the 835 ERA is not in production and the contractor receives a "P" Test/Production Indicator, it shall use the information provided on the BOI reply trailer (29) to populate the existing provider remittance advices that it has in production.

Effective with January 5, 2009, if CWF returns **only** COBA ID range 89000 through 89999 on a BOI reply trailer (29) to a Medicare contractor, the contractor's system shall suppress all crossover information (the entire 2100 loop) on the 835 ERA.

CWF Sort Routine for Multiple COBA IDs

Effective with January 5, 2009, when a beneficiary's claim is associated with more than one COBA ID (i.e., the beneficiary has more than one health

insurer/benefit plan that pays after Medicare), CWF shall sort the COBA IDs and trading partner names in the following order on the returned BOI reply trailer (29): 1) Eligibility-based Medigap (30000-54999); 2) Medigap claim-based (55000-59999); 3) Supplemental (00001-29999); 4) TRICARE (60000-69999); 5) Other Insurer (80000-88999); 6) Medicaid (70000-79999); and 7) Other-Health Care Pre-payment Plan [HCPP] (89000-89999). When two or more COBA IDs fall in the same range (see element 24 of the "Data Elements Required for the BOI Aux File Record" Table in chapter 27, §80.14 for more details), CWF shall sort numerically within the same range.

2. Medicare Summary Notice (MSN) and Electronic Remittance Advice (ERA) Crossover Messages During the Parallel Production Period

During the COBA parallel production period, which began July 6, 2004: 1) CWF will only return an "N" MSN indicator on the BOI reply trailer (29), in accordance with information received via the COIF submission; 2) If a "Y" indicator is returned, the Medicare contractor shall ignore it; and 3) the Medicare contractor shall follow its existing procedures for the printing of MSN crossover messages.

During the COBA parallel production period, Medicare contractors shall follow their current procedures for the reporting of crossover claims information in CLP-02 (Claim Status Payment) and in the NM101, NM102, NM103, NM108, and NM109 segments of Loop 2100 of the provider ERA. They shall also continue with their current procedure for inclusion of COB trading partner names on other kinds of provider remittance advices that you have in production.

3. Business Rules for Receipt of a CWF BOI Reply Trailer When Other Indicators of Crossover Are Present

COBA Parallel Production Period

During the COBA parallel production period, which began July 6, 2004, the Medicare contractor shall observe the following business rules when it receives a BOI reply trailer 29 and some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer 29 with COBA IDs that fall in the ranges of 00001-89999, it shall continue to cross over claims a) per its existing TPAs and b) when Medigap or Medicaid information is reported on the claim.

NOTE: The preceding claim-based scenario does not apply to Part A contractors. In addition, the Medicare contractor shall send claims for which it receives BOI reply trailers to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

NOTE: The COBA trading partner will only be charged for the claims that the Medicare contractor continues to cross to it during the parallel production period.

During the parallel production period, the Medicare contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The Medicare contractor's Medicaid suppression logic should remain the same as today with its existing trading partners, even when it receives a BOI reply trailer that includes a Medicaid COBA ID.

Larger-Scale Implementation of the COBA Process

Beginning with the October 2004 release, Medicare contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "T" and there is some other indication of crossover eligibility:

If the Medicare contractor receives a BOI reply trailer (29) with COBA IDs that fall in the ranges of 00001-89999 (See Attachment A, element 24), it shall cross over claims 1) per its existing TPAs or 2) when Medigap or Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid).

NOTE: Claim-based crossover scenarios only apply to Part B and DMERC/ DME MAC contractors.

In addition, the contractor shall send claims for which it receives BOI reply trailer to the COBC on the 837 v4010A1 flat file or National Council for Prescription Drug Programs (NCPDP) file.

When a COBA trading partner is in test mode, the contractor shall not change its current procedures regarding suppression of Medicaid claims when a beneficiary has non-Medigap and/or Medigap insurance. The contractor's Medicaid suppression logic should remain the same as with current existing trading partners, even when you receive a BOI reply trailer (29) that includes a Medicaid COBA ID.

Beginning with the October 2004 release, contractors shall follow these rules when they receive a BOI reply trailer (29) that contains Test/Production Indicator "P" and there is some other indication of crossover eligibility:

a. If the Medicare contractor receives a BOI reply trailer (29) with a COBA ID that falls in the Medigap eligibility-based range (30000-54999), it shall not cross over claims based on an existing Medigap TPA or when Medigap information is reported on the claim. Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply

trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.

NOTE: The assumption is that a beneficiary will have only one true Medigap insurer.

b. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999) and it has an existing TPA with a supplemental insurer for the beneficiary, it shall transmit the claim to the COBC for crossover to the COBA trading partner and cross the claim to your existing trading partner.

c. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Supplemental range (00001-29999), and it also receives Medigap crossover information on the claim, it shall cross the claim to the Medigap insurer identified on the claim and transmit the claim to the COBC for crossover to the COBA trading partner based on the Supplemental COBA ID.

d. If the Medicare contractor receives a COBA ID via a BOI reply trailer (29) that falls in the Medicaid range (70000-77999), it shall not cross over claims based on an existing Medicaid TPA or when Medicaid information is reported on the claim (if that is how the Part B or DMERC contractor currently crosses over claims to Medicaid). Instead, the Medicare contractor shall send the claim to the COBC (based on the BOI reply trailer 29) on the 837 v4010A1 flat file or NCPDP file for crossover by the COBC to the COBA trading partner.

e. If the Medicare contractor receives a BOI reply trailer (29) that contains a Medicaid COBA ID (70000-77999) and it has an existing TPA with a supplemental insurer or Medigap insurer, it shall suppress the Medicaid claim from inclusion on the COB 837 flat file or NCPDP file and cross the claim to the supplemental insurer.

f. If the Medicare contractor receives a BOI reply trailer (29) that contains a Supplemental COBA ID (00001-29999) or a Medigap eligibility-based COBA ID (30000-54999) and it has an existing TPA with Medicaid, it shall suppress its crossover to Medicaid but send the claim to the COBC.

NOTE: For the scenarios above, the trading partner shall be responsible for canceling any existing TPA that it has with the Medicare contractor once it has signed a COBA with the Coordination of Benefits Contractor (COBC).

Contractor Actions Relating to the Transition from HIPAA 837 4010-A1 to 5010 and NCPDP 5.1 batch standard 1.1 to NCPDP D.O

1. CWF COIF and BOI Reply Trailer (29) Processes

Effective January 5, 2009, the COBC will, at CMS's direction, create a new 1-byte "5010 Test/Production Indicator" and a new 1-byte "NCPDP D.0 Test/Production Indicator" on the COBA Insurance File [COIF] (valid values= "N"—not applicable or not ready as yet; "T"—test; "P"—production). In addition, the CWF maintainer shall add a new "5010 Test/Production Indicator" and an "NCPDP D.0 Test/Production Indicator" to the BOI reply trailer (29) format. (See Pub.100-04 chapter 27, §80.17 for additional details regarding CWF requirements relating to the new crossover claim formats.)

The CWF shall not post crossover disposition indicators in association with claims whose 5010 and NCPDP D.0 indicators are "N" or "T." (See Pub.100-04 chapter 27, §80.15 for more details regarding claims crossover disposition indicators.)

2. Contractor Actions Regarding Claim Format to Send to COBC

Prior to the initiation of HIPAA 837 5010 or NCPDP D.0 testing with COB trading partners, if CWF returns to a Medicare contractor a BOI reply trailer (29) that contains an "N" 5010 Test/Production indicator or NCPDP D.0 indicator, the contractor's shared system shall 1) ignore the indicator; and 2) continue to send the existing 837 flat file and NCPDP file formats to the COBC.

NOTE: CMS will issue a future instruction that addresses contractor and contractor shared system requirements for receipt of "T" or "P" 5010 and NCPDP D.0 indicators.

C. Transmission of the COB Flat File or NCPDP File to the COBC

Regardless of whether a COBA trading partner is in test mode (Test/Production Indicator returned via the BOI reply trailer 29=T) or production mode (Test/Production Indicator returned via the BOI reply trailer 29=P), Medicare contractors shall transmit all non-NCPDP claims received with a COBA ID via a BOI reply trailer to the COBC in an 837 v.4010A1 flat file, as described in Transmittal AB-03-060. In a separate transmission, DMERCs shall send the claims received in the NCPDP file format to the COBC. Medicare contractors shall enter the 5-digit COBA ID picked up from the BOI reply trailer (29) in the 1000B loop of the NM1 segment in the NM109 field. In a situation where multiple COBA IDs are received for a claim, Medicare contractors shall send a separate 837 or NCPDP transaction to the COBC for each COBA ID. Medicare contractors shall perform the transmission at the end of their regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment. Transmission should occur via Network Data Mover (NDM) over AGNS (AT&T Global Network Services).

Effective with October 4, 2005, when contractor systems transfer processed claims to the COBC as part of the COBA process, they shall include an additional 1-digit alpha character ("T"=test or "P"=production) as part of the BHT03 identifier (Beginning of the

Hierarchical Transaction Reference Identification) that is included within the 837 flat file or NCPDP submissions. The contractor shared systems shall determine that a COBA trading partner is in test or production mode by referring to the BOI reply trailer (29) originally received from CWF for the processed claim. (See §70.6.1 of this chapter for further details about the BHT03 identifier.)

Effective with October 2, 2006, the contractors or their Data Centers shall transmit a combined COBA "test" and "production" 837 flat file and a combined "test" and "production" NCPDP file to the COBC.

NOTE: This requirement changes the direction previously provided in October 2005 through the issuance of Transmittal 586.

Flat File Conventions for Transmission to the COBC

With respect to 837 COB flat file submissions to the COBC, Part B contractors, including MACs, and DME MACs shall observe these process rules:

The following segments shall not be passed to the COBC:

1. ISA (Interchange Control Header Segment);
2. IEA (Interchange Control Trailer Segment);
3. GS (Functional Group Header Segment); and
4. GE (Functional Group Trailer Segment).

The 1000B loop of the NM1 segment denotes the crossover partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the crossover partner information will be unknown to the standard systems, the following fields should be formatted as indicated for the NM1 segment:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and

N4 segment—Use all spaces.

The 2010BB loop denotes the payer name. Per the HIPAA Implementation Guide (IG), this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, given that the payer related to the COBA ID will be unknown by the standard systems, the NM1, N3, and N4 segments should be formatted as follows, with COBC completing any missing information:

NM1 segment—For NM103, use spaces;
NM1 segment—For NM109, include the COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BB loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

With respect to 837 COB flat file submissions to the COBC, Part A contractors shall observe these process rules:

As the ISA, IEA, and GS segments are included in the “100” record with other required segments, the “100” record must be passed to the COBC. However, as the values for these segments will be recalculated, spaces may be placed in all of the fields related to the ISA, IEA, and GS segments.

The 1000B loop of the NM1 segment denotes the crossover trading partner. If multiple COBA IDs are received via the BOI reply trailer, the contractor system shall ensure that a separate 837 transaction should be submitted for each COBA ID received. As the

crossover trading partner information will be unknown to the standard systems, the following fields should be formatted as follows for the NM1 segment on the"100" record:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2010BA loop denotes the subscriber information. If available, the subscriber name, address, and policy number should be used to complete the NM1, N3, and N4 segments. If unknown, the segments should be formatted as follows for the "300" record, with COBC completing any missing information:

NM1 segment – For NM103, NM104, NM105, and NM107, use spaces;
NM1 segment—For NM109, include HICN;
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2010BC loop denotes the payer name. Per the HIPAA IG, this loop should define the secondary payer when sending the claim to the second destination payer. Consequently, since the payer related to the COBA ID will be unknown to the standard systems, the NM1, N3, and N4 segments should be formatted as follows for the "300" record, with COBC completing any missing information:

M1 segment—For NM103, use spaces;
NM1 segment—For NM109, include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29);
N3 segment—Use all spaces; and
N4 segment—Use all spaces.

The 2330B loop of the "575" record denotes other payers for the claim. If multiple COBA IDs are returned via the BOI reply trailer, payer information for the additional COBA IDs will be unknown. As with the 2010BC loop, the NM1 segment should be formatted as follows, with COBC completing any missing information:

NM103—Use spaces; and
NM109—Include COBA ID (5-digit COBA ID picked up from the BOI reply trailer 29).

The 2330B loop shall be repeated to allow for the inclusion of the name (NM103) and associated Trading Partner ID (NM109) for each existing trading partner.

The 2320 loop denotes other subscriber information. Within the SBR segment, the SBR03 and SBR04 segments are used to define the group/policy number and insured group name, respectively. If the information is available for these fields, those values should be propagated accordingly for both current trading partners and COBA trading partners. The COBC will inspect these values for COBA related eligibility based claims and overlay as appropriate. Spaces should only be used for COBA-related situations.

SBR01—Treat as normally do.

D. COBC Processing of COB Flat Files or NCPDP Files

When a Medicare contractor receives the reject indicator "R" via the Claims Response File, it is to retransmit the entire file to the COBC. If the Medicare contractor receives an acceptance indicator "A," this confirms that its entire COB flat file or NCPDP file transmission was accepted. Once COB flat files or NCPDP files are accepted and translated into the appropriate outbound format(s), COBC will cross the claims to the COBA trading partner. The format of the Claims Response File that will be returned to each Medicare contractor by the COBC, following its COB 837 flat file or NCPDP file transmission, appears in the table below. (See §70.6.1 for specifications regarding the receipt and processing of the COBC Detailed Error Reports.)

Claims Response File Layout (80 bytes)				
Field	Name	Size	Displacement	Description
1.	Contractor Number	5	1-5	Contractor Identification Number
2.	Transaction Set Control Number/Batch Number	9	6-14	Found within the ST02 data element from the ST segment of the X12N 837 flat file or in field 806-5C from the batch header of the NCPDP file.
3.	Number of claims	9	15-23	Number of Claims contained in the X12N 837 flat file or NCPDP file. This is a numeric field that will be right justified and zero-filled.
4.	Receipt Date	8	24-31	Receipt Date of X12N 837 flat file or NCPDP file in CCYYMMDD format
5.	Accept/Reject indicator	1	32	Indicator of either the acceptance or rejection of the X12N 837 flat file or NCPDP file. Values will either be an "A" for accepted or "R" for rejected.
6.	Filler	48	33-80	Spaces

Claims response files will be returned to contractors after receipt and initial processing of a claim file. Thus, for example, if a Medicare contractor sends a COB flat file daily, the COBC will return a claim response file to that contractor on a daily basis.

COB 837 flat files and NCPDP files that will be transmitted by the Medicare contractor to the COBC will be assigned the following file names, regardless of whether a COBA trading partner is in test or production mode:

PCOB.BA.NDM.COBA.Cxxxxx.PARTA(+1) [Used for Institutional Claims]
PCOB.BA.NDM.COBA.Cxxxxx.PARTB(+1) [Used for Professional Claims]
PCOB.BA.NDM.COBA.Cxxxxx.NCPDP(+1). [Used for Drug Claims]

Note that "xxxxx" denotes the Medicare contractor number.

Medicare contractors shall perform the 837 flat file and NCPDP file transmission at the end of the regular batch cycle, when claims come off the payment floor, to ensure crossover claims are not processed by the COBA trading partner prior to Medicare's final payment.

Files transmitted by the Medicare contractor to the COBC shall be stored for 51 business days from the date of transmission.

The file names for the Claims Response File returned to the Medicare contractor will be created as part of the NDM set-up process.

Outbound COB files transmitted by COBC to the COBA trading partners will be maintained for 50 business days following the date of transmission.

E. The COBA Medigap Claim-Based Process Involving CWF

Refer to §70.6.4 of this chapter for more information regarding this process.

F. Transition to the National COBA and Customer Service Issues

1. Maintenance of Current Crossover Processes, Including Entry into New Claims Crossover Agreements (also known as Trading Partner Agreements or TPAs)

   Medicare contractors shall keep their present crossover process in place, including invoicing for claims crossed to current trading partners, as described in Pub. 100-06, Financial Management, chapter 1, §450 and §460, until each of their present trading partners has been transitioned to the COBA process. Once CMS has fully consolidated the claims crossover process under the COBC, the COBC will have exclusive responsibility for the collection of crossover claim fees for those Medigap and non-Medigap claims that are sent to the COBC to be crossed over to trading partners. The COBC will also have responsibility for distribution of the collected crossover fees to Medicare Part A contractors and Part B contractors. (See also Pub.100-06, Chapter 1, §450.)

As trading partners are signed on to national COBAs, they will be advised that it is their responsibility to simultaneously cancel current agreements with the Medicare contractors and to cease submission of eligibility files.

NOTE: During the parallel production period, the COBA trading partner will be instructed by CMS to not cancel current TPAs with you.) By current estimates, CMS expects to at least have all current eligibility file-based trading partners in test mode by end of fiscal year 2005 (September 30, 2005.

Medicare contractors shall execute new TPAs only with trading partners that will be converted to full crossover production by April 1, 2005. Therefore, CMS expects contractors to cease execution of new crossover TPAs by January 31, 2005.

Trading partners that either wish to go into live crossover production after January 31, 2005, or have current questions regarding the COBA process shall be referred to the COBC at 1-646-458-6740.

2. Workload and Crossover Financial Reporting In Light of COBA

For workload reporting purposes, Medicare contractors shall provide counts for those claims that they individually cross to current trading partners (including Medicaid), just as they currently do in CAFM II and in CROWD. Medicare contractors shall separately track claims transmitted to the COBC for crossover to the COBA trading partners for future reporting requirements by COBA ID.

Effective with October 4, 2005, contractors or their shared systems shall report the number of claims submitted to the COBC via the 837 flat files or NCPDP files to their associated contractors' financial management staff only for those BHT03 (Beginning of Hierarchical Transaction Reference Identification) indicators that include a "P" in the final position of the BHT03 (position 22).

Reports generated by the contractors or their shared systems to the contractors' financial management staff shall include like data that are submitted following receipt of the COBC Detailed Error Reports to fulfill the necessary provider notification requirements. NOTE: The Detailed Error Reports shall contain the same BHT03 identifier for purposes of reporting to financial management staff as was included by the contractor shared systems on the 837 flat file and NCPDP claim file submissions sent to the COBC.) [See §70.6.1 of this chapter for more information about the COBC Detailed Error Reports]. Minimum information for each BHT03 shall include claim counts sorted by COBA ID and shall be organized into groupings that allow for separate totals by Medicaid (COBA ID range=70000-77999), Medigap (COBA ID range=30000-54999), Supplemental (COBA ID ranges=00001-29999 and 60000-69999), and Other (COBA ID range 80000-89999), as well as grand totals for all less Medicaid.

3. Customer Service

a. COBA Parallel Production or COBA Testing Process

During the parallel production period, and while a COBA trading partner is in test mode with the COBC (Test/Production Indicator="T"), the Medicare contractor shall proceed with its current claims crossover customer service process. In addition, the Medicare contractor's claims history shall not be updated with crossover information based upon the receipt of a CWF BOI reply trailer (29).

b. Updating of the HIMR Detailed History Screens By CWF and the Larger Scale Implementation of COBA

Effective with the October 2004 release, when a COBA trading partner is in production mode (Test/Production Indicator=P), CWF shall annotate each processed claim on detailed history within the Health Insurance Master Record (HIMR) with an indicator that will inform all users of the claim's crossover status. (See Pub.100-04, Chapter 27, §80.15 for more information.) CWF shall allow for repeating of the application of crossover disposition indicators for up to ten (10) COBA IDs.

In addition, CWF shall annotate each processed claim with a 10-position COBA ID (5-digit COBA ID preceded by 5 zeroes) to identify the entity to which the claim was crossed or not crossed, in accordance with the COBA.

CWF shall not annotate processed claims on the detailed history screens in HIMR when a COBA trading partner is in test mode (Test/Production Indicator=T).

Effective with the October 2004 systems release, when a COBA trading partner is in production mode, the Medicare contractor's customer service personnel shall answer provider/supplier and beneficiary questions about a claim's crossover status by referring to your internal claims history. In addition, the Medicare contractor's customer service staff shall access information regarding why a claim did not cross by referring to the detailed history screens on HIMR (e.g., INPH, OUTH, HOSH, PTBH, DMEH, and HHAH). [See Pub. 100-04, chapter 27, §80.15 for a listing of all claims crossover disposition indicators.] These screens will also display indicator "A" when a claim was selected by CWF to be crossed over to the COBA ID shown. The BOI auxiliary file will identify the name associated with the COBA ID. Such information may also be available to contractor customer service staff via the Next Generation Desktop (NGD) application.

The CWF maintainer issued instructions on the use of the new HIMR screens as part of the October 2004 release.

c. Medicare Contractors shall use the COBC and CMS COBA Problem Inquiry Request Form to identify and send COBA related problems and issues to the COB contractor for research.

In order to track trading partner requests for research of 837 X12 issues, CMS requires contractors to submit a COBA Problem Inquiry Request Form to the COBC or CMS. This process is being implemented to reduce the number of duplicate issues being researched and to ensure your requests are processed timely. The standard form enables CMS and COBC to track issues through completion and manage the process of addressing post-COBA production issues. Upon receipt the submitter shall receive a response from the COBC with the assigned contact information.

CMS is also requiring Medicare contractors to use the COBA Problem Inquiry Request Form when requesting a COBC representative to research a COBA issue. The combined COBC-CMS COBA Problem Inquiry Request Form appears below.

MEDICARE CONTRACTOR: COBA PROBLEM INQUIRY REQUEST FORM

(Completed by Submitter – control number if applicable Write in this column only

Contractor ID# **(Enter the Contractor ID # assigned by CMS)**		
Contractor Reference ID (If applicable - BHT03)		
Reported By **(Enter submitter's last name, first name)**		
Date Submitted (Enter current date – MM/DD/YR)		
Contact # (Enter submitter's phone #)		
E-mail Address (Enter submitter's e-mail address)		
COBA ID #		

Description of Problem (Check applicable category)

☐ **HIPAA Error Code**

ICN Date (Date file was transmitted to the COBC)	
HIPAA Error Code(s)	
Part A/Part B/NCPDP Claim	

☐ **Technical Issue** (Claims file transmission failures)

File Name	
Transmission Date	

Summary of Issue- Provide detail of problem and note if back-up information will be faxed, e.g., Sample Claims to be Faxed on MM/DD/YR. Indicate whether you would like your issue on the next HIPAA issues log **– do not include any PHI information on this form if sent via email.** All PHI information must be submitted via fax to the COBC contractor to the attention of your COBC representative at 646-458-6761. **Do not include PHI information on the fax cover sheet.** Claim examples of issues to be addressed must include the beneficiary HICN and the claim ICN/DCN.

COBC USE ONLY. Date: Ticket #:

IV. Identification of Mass Adjustments for COBA Crossover Purposes

All contractors and their systems shall develop a method for differentiating "mass adjustments tied to the Medicare Physician Fee Schedule (MPFS) updates" and "all other mass adjustments" from all other kinds of adjustments and non-adjustment claims.

NOTE: For appropriate classification, all adjustments that do not represent "mass adjustments-MPFS" or "mass adjustments-other" shall be regarded as "other adjustments.") DMERCs/DME MACs and their shared system shall only be required to identify mass adjustments-other, which represents a current functionality available within VMS. This is because DMERCs/DME MACs do not use pricing from the MPFS when processing their claims.

Working Definition of "Mass Adjustment"

For COBA crossover purposes, a "mass adjustment" refers to an action that a contractor undertakes using special software (e.g., Super-Op Events or Express Adjustments) to pull claims with the anticipated purpose of making monetary changes to a high number of those claims. If, however, contractors do not have special software to perform high volume adjustments (i.e., typically adjustments to 100 or more claims), but instead must perform their high volume adjustments manually, this action also fulfills the definition of a "mass adjustment."

Inputting a One-Byte Header Value on Claim Transactions to Designate Mass Adjustment and Associated Processes

Before contractors cable their claims to CWF for verification and validation, they shall populate a 1-byte "mass adjustment" indicator in the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claim transactions. The CWF maintainer shall create a new 1-byte field within the header of its HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC claims transactions for this purpose.

Contractors shall determine whether the "M" or "O" indicator applies in relation to a given claim at the point that they initiate a mass adjustment action on that claim using a manual process or an automated adjustment process; e.g., Super Op Events or Express Adjustments. Upon making this determination, the contractors and their shared systems shall populate one (1) of the following mass adjustment claim indicators, specific to the particular claim situation, within the header of the contractors' processed claims that they will cable to CWF for verification and validation:

"M"—if mass adjustment claim tied to an MPFS update; **or**
"O"—if mass adjustment claim-other.

If contractors send values other than "M" or "O" within the newly designated field within the header of their HUBC, HUDC, HUIP, HUOP, HUHH, or HUHC entry code "5" or action code "3" claims, CWF shall apply an edit to reject the claims back to the contractor. Upon receipt of

the CWF rejection edit, the contractors' systems shall correct the invalid value and retransmit the claims to CWF for verification and validation.

V. Special 835 ERA and MSN Requirements for Health Care Pre-Payment Plans (HCPPs) that Receive Crossover Claims

Effective January 5, 2009, at CMS's direction, the COBC will assign all HCPP COBA participants a unique 5-byte COBA ID that falls within the range 89000 through 89999. The CWF system shall accept the reporting of this COBA ID range.

Upon receipt of a BOI reply trailer (29) that contains **only** a COBA ID in the range 89000 through 89999, the contractor's shared system shall suppress **all** crossover information (including name of the insurer; generic message; and specific code (for 835 ERA, code MA-18; for MSN, code 35.1) indicating that the claim will be crossed over) from the associated 835 ERA and beneficiary MSN. (See §70.6.1 of this chapter for contractor requirements relating to the COBC Detailed Error Report processes and receipt of claims that contain COBA ID range 89000 through 89999.)

VI. Special Suppression Requirements for Part A Credit Claim Portion of Debit-Credit Claim Pairing

Effective with the April 2009 release, the Part A shared system shall suppress sending the credit claim portion of the debit-credit pairing (that transaction which cancels the original claim) associated with each affiliated contractor's adjustment claims to the COBC. Upon suppressing the credit claim, the Part A contractor system shall mark the claims history of its affiliate contractor to reflect this action.

Medicare Claims Processing Manual

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

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(Rev. 2181, Issued 03-25-11)

10 *Introduction to Electronic Data Interchange (EDI) for Medicare Fee For Services (FFS)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

EDI for Medicare FFS is not limited to the submission and processing of claim related transactions, but includes processes such as provider EDI enrollment, beneficiary eligibility, coordination of benefits, as well as security and privacy concerns. So as not to be duplicative, where EDI is a relevant part of a Medicare business process, it will be indicated here, however, the specifics of the business process will be maintained in its respective IOM chapter or comparable communication venue.

10.1 *Requirement for EDI*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

For a provider, business associate, or other trading partner to engage in EDI with Medicare FFS it must first established an EDI agreement with Medicare. There are two ways to do this: 1) complete and submit paper CMS Form 855, or 2) submit an Internet based application via the PECOS system. More information on enrolling in the Medicare Program can be found at http://www.cms.gov/MedicareProviderSupEnroll/01_Overview.asp#TopOfPage).

10.2 *Audience for this chapter*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The information contained in this chapter will be of interest to Medicare providers, business associates or other trading partners, as well as others interested in how Medicare has structured its EDI policies. Other Medicare FFS and CMS partners as well as general audiences may use this as a source of information to determine Medicare FFS' EDI practices. Primarily however, this chapter, and related chapters, are used by Medicare contractors for descriptive guidance to contractual responsibilities they have to CMS.

Therefore, the instructions within this chapter are primarily directed to Medicare Administrative Contractors (MACs), Fiscal Intermediaries, Carriers, Durable Medical equipment Medicare Administrative Contractors (DMEMACs), the Common Electronic Data Interchange (CEDI) contractor for DMEMACs, and their shared systems, and are in reference to Medicare requirements for their implementation of the current HIPAA compliant version of the Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3) also known as an ASC X12 or ASC X12N Implementation Guide (IG) and NCPDP Telecommunication Implementation Guide, as well as all Medicare and contractor EDI activities related to these transactions. In order to

implement the HIPAA administrative simplification provisions, specific ASC X12 and NCPDP transactions have been named under part 162 of title 45 of the Code of Federal Regulations as electronic data interchange (EDI) standards for Health Care. All other EDI formats for health care became obsolete on October 16, 2003. The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the Federal Register on January 16th, 2009, adopted updated versions of HIPAA mandated electronic transactions. Furthermore, the Final Rule conveys inclusion of errata to the transaction standard. Medicare FFS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction.

10.3 *Scope of this chapter*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

This chapter will provide an overall description of EDI operations, requirements, roles and responsibilities for Medicare FFS.
Medicare FFS is utilizing the following EDI transactions:

Transactions	***Current Versions Acceptable in Calendar Year 2011***	***Version Acceptable in Calendar Year 2012 and Beyond***
270/ 271 Health Care Eligibility Benefit Inquiry and Response	*004010X092A1 005010X279A1*	*005010X279A1*
837 Health Care Claim: Professional	*004010X098A1 005010X222A1*	*005010X222A1*
837 Health Care Claim: Institutional	*004010X096A1 005010X223A2*	*005010X223A2*
TA1	*See individual IGs*	*005010X231A1*
997 Implementation Acknowledgment For Health Care Insurance	*See individual IGs*	*NA*
999 Implementation Acknowledgment For Health Care Insurance	*005010X231A1*	*005010X231A1*
835 Health Care Claim Payment/Advice	*004010X091A1 005010X221A1*	*005010X221A1*
276/277 Status Inquiry and Response	*004010X093A1 005010X212*	*005010X212*

277CA Claim Acknowledgment	*005010X214*	*005010X214*
National Council for Prescription Drug Programs (NCPDP) of the Telecom Standard	*Version 5.1 Version D.0 August 2010*	*Version D.0 August 2010*
National Council for Prescription Drug Programs (NCPDP) Batch Standard	*Version 1.1 Version 1.2*	*Version 1.2*

These administrative transactions. require detailed instructions and specifications. General instructions for the institutional and professional claim transactions, the NCPDP transaction, as well as the error handling/acknowledgment transactions are provided within this chapter. All other transactions have separate chapters dedicated to them.

The following IOM Publication 100-04, chapters provide more specific information on the remaining electronic transactions. References to these chapters are provided below. They can be accessed by going to http://www.cms.gov/Manuals/IOM/list.asp and selecting Publication # 100-04.

1. *Chapter 22 – 835- Remittance Advice (paper and electronic)*
2. *Chapter 31 –270/271- Eligibility Inquiry and Response and 276/277 – claim status inquiry and response*

Two other related IOM chapters include:

1. *Chapter 25 – 837 I – Institutional Claim (CMS Form UB04 – paper only)*
2. *Chapter 26 – 837 P – Professional Claim (CMS Form 1500 – paper only)*

Other sources of detailed information for each of these transactions are the Medicare FFS Companion Guide documents and Medicare FFS edits documentation which can be found at http://www.cms.gov/ElectronicBillingEDITrans/.

10.4 *Acronyms and Definitions (in progress)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The following is a list of terms and acronyms if assistance is needed to understand the terminology used in this chapter.

- *EDI – Electronic Data Interchange - the process of using nationally established standards to exchange electronic information between business entities. HIPAA – Health Insurance Portability and Accountability Act – legislation that mandated that the healthcare industry use standard formats for electronic claims and claims related transactions.*
- *MAC – Medicare Administrative Contractor – Section 911 of the Medicare Modernization Act of 2003 mandates that the Secretary for Health & Human Services*

replace the current contractors administering the Medicare Part A or Part B fee-for-service programs with new Medicare Administrative Contractors (MACs). Part A/Part B Medicare Administrative Contractors (MACs) will replace the current fiscal intermediaries and carriers and handle administration of both the Medicare Part A and Part B programs in specified geographic regions. For more information, please see the CMS overview of Medicare Contracting Reform .

- *A/B MAC – Medicare Administrative Contractor servicing both part A and part B lines of business.*
- *FI – Fiscal Intermediary – Part A Medicare Contractor – Eventually will be replaced by Part A/B MAC.*
- *Carrier – Part B Medicare Contractor – Eventually will be replaced by Part B MAC.*
- *DME MAC – Durable Medical Equipment Medicare Administrative Contractor*
- *CEDI - Common Electronic Data Interchange – Common front end for DME MACs*
- *Trading Partner – one of two or more participants in an ongoing business relationship (e.g., provider, billing service, software vendor, employer group, financial institution, etc.).*
- *Submitter – an entity that owns the healthcare data being submitted. It is most likely the provider, hospital, clinic, etc. A submitter is directly linked to each billing NPI.*
- *Network Services Vendor- an entity that provides connectivity services, but that does not have access to content of the data being transmitted.*
- *EDI Enrollment – establishes documentation specifying type of transactions and transmission methods to be used in the exchange of electronic administrative transactions.*
- *EDI Registration – designates the Medicare contractor and/or CEDI as the entity they agree to engage in for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.*
- *Trading Partner Agreement – ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.*
- *Third Party Agreements- an agreement that ensures confidentiality, security, and integrity of Medicare data being shared by third party agents that represent providers, including NSVs, certain value-added networks, clearinghouses, and billing agents.*

Third Party Agreements- an agreement that ensures confidentiality, security, and integrity of Medicare data being shared by third party agents that represent providers, including NSVs, certain value-added networks, clearinghouses, and billing agents.

20 *General EDI*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

EDI is the process of using nationally established standards to exchange electronic information between business entities. These national standards are developed and maintained by a group of standards development organizations (SDOs), such as the Accredited Standards Committee

(ASC) X12 and the National Council of Prescription Drug Programs (NCPDP). The Department of Health and Human Services (HHS) adopted certain standards for use in health care under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Medicare FFS is required, as are all payers in the US, to adopt the standards specified under HIPAA. However, as part of Medicare FFS' EDI enhancements, three additional ASC X12 standards will be adopted for error handling (277CA, 999, and TA1) that are not mandated under HIPAA. In addition, there will be one additional standard adopted for NCPDP error handling (Transmission Response) that is not mandated under HIPAA.

20.1 *Legislative Background*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

EDI practices for healthcare business were embraced more than 20 years ago to standardize electronic formats throughout the healthcare industry. Usage of EDI in Health care claim processing was initiated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104,191. Subtitle F of Title II of HIPAA, added to Title XI of the Social Security Act (the Act) a new part called section C, entitled "Administrative Simplification" and consists of sections 1171 through 1180. This federal legislation adopted standards for electronic transactions under an Administrative Simplification subtitle. HIPAA mandated the adoption of standards for electronically transmitting certain health care administrative transactions between all covered entities.

Sections 1171 through 1179 are described below:

- *Section 1171 of the Act, established definitions for the following: code sets, health care clearinghouses, health care provider, health information, health plan, individually identifiable health information, standard, and standard setting organizations (SSO) such as the American National Standards Institute (ANSI).*

- *Section 1172 made any standard adopted applicable to covered entities that transmit health information in electronic formats. Covered entities include the following;*
  1) health plans
  2) health care clearinghouses
  3) health care providers

- *Section 1173 required the adoption of standards for transactions, code sets, and unique health identifiers for each individual, employer, health plan, and health care provider.*

- *Section 1174 required the adoption of standards for designated transactions, except electronic attachments.*
- *Section 1175 prohibited health plans from refusing to conduct a transaction as a standard transaction, and delaying the processing and or adversely affecting its processing*

- *Section 1176 established civil monetary penalties for violation of the provisions of Part C of Title XI*
- *Section 1177 established penalties for any person that knowingly misuses a unique health identifier, or obtains or discloses individually identifiable health information.*

- *Section 1178 indicated provisions of Part C of Title XI of the Act, as well as any standards or implementation specifications adopted under them generally supersede contrary provisions of State law.*
- *Section 1179 makes these provisions of the Act inapplicable to financial institutions or anyone acting on behalf of a financial institution when "authorizing, processing, clearing, selling, billing, transferring, reconciling, or collecting payments for financial institutions.*

HIPAA mandates all covered entities to comply with the use and maintenance of certain standards. More recently the passing of The America Reinvestment and Recovery Act (ARRA) has further enhanced the definitions and requirements mandated under HIPAA.

20.2 *The America Reinvestment and Recovery Act (ARRA)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The purposes of this Act is to provide guidance with the development of nationwide health information technology infrastructure that allows for the electronic use and exchange of information that

(1) ensures that each patient's health information is secure and protected, in accordance with applicable law;
(2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient centered medical care;
(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information;
(4) provides appropriate information to help guide medical decisions at the time and place of care;
(5) ensures the inclusion of meaningful public input in such development of such infrastructure;
(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;
(7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bio terror events and infectious disease outbreaks;
(8) facilitates health and clinical research and health care quality;
(9) promotes early detection, prevention, and management of chronic diseases;

(10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and
(11) improves efforts to reduce health disparities

The term ‘‘covered entity’’ has the meaning of a health care provider that conducts certain transactions in electronic form, a health care clearinghouse, and a health plan. ARRA extends all requirements applicable to covered entities to their Business Associates.

A business associate as defined by CFR 45, Part 160.103 is, with respect to a covered entity, a person who:

- *performs, or assists in performing a function or activity involving the disclosure of individually identifiable health information, except as a member of the covered entity's workforce. Relevant activities include:*
  - *claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing; or*
  - *provision of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services.*

A covered entity may be a business associate of another covered entity.

Therefore, in compliance with ARRA, a business associate of a covered entity must comply with the same requirements as a covered entity.

20.3 *HIPAA and ARRA on Security and Privacy*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Two aspects of the HIPAA and ARRA legislation are pertinent to this chapter:

1. *Ensuring the security of electronic data transmitted between covered entities, and*
2. *Ensuring the privacy of individuals who are the subject of electronic information being transmitted between covered entities.*

The ARRA legislation states following in reference to actions to be taken by a covered entity or their business associate in case of a breech of protected health information:

H.R. 1-146, Subtitle D, Part 1, Section 13402 states that "a [covered entity or a] business associate of a covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify the covered entity of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed,

acquired, or disclosed during such breach." See section 40.1.2.2 for a description of Medicare security and privacy requirements.

20.4 *Administrative Simplification and Compliance Act (ASCA)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The Administrative Simplification Compliance Act (ASCA) prohibits payment of services or supplies that a provider did not bill to Medicare electronically. "Providers" is used in a generic sense here and refers equally to physicians, suppliers, and other health care providers. Providers are required to self-assess to determine whether they meet certain permitted exceptions to this electronic billing requirement.

ASCA self-assessable situations are described in the ASCA self assessment page in this section of the CMS web site. In some cases, providers are required to submit a written request to their Medicare contractor to receive permission to submit some or all of their claims on paper.

FIs, Carriers, RHHIs, A/B MACs and DME MACs are required to contact providers that appear to be submitting high numbers of paper claims to verify that those providers meet one or more of the exception criteria for continued submission of their claims on paper.

See Section 90 below for further details regarding ASCA requirements, or access www.cms.gov/ElectronicBillingEDITrans for further information on ASCA enforcement reviews, the self assessment, and the waiver application.

30 *EDI Enrollment and Registration (AKA Trading Partner Agreements)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Medicare FFS' Trading Partner Agreement is comprised of two forms: 1) EDI Registration and 2) EDI Enrollment. The forms are identified under CMS form 10164 and can be accessed at:

EDI Registration – https://www.cms.gov/cmsforms/downloads/CMS10164A.pdf and

EDI Enrollment - https://www.cms.gov/cmsforms/downloads/CMS10164B.pdf

FIs, Carriers, RHHIs, A/B MACs, and CEDI must use these two forms, or their own organization specific forms given they are comparable in terms of content, to transmit data files electronically between themselves and their trading partners.

EDI registration and enrollment shall be instituted by the FIs, Carriers, RHHIs, A/B MACs, and CEDI and shall accomplish the following:

1. *Document the specific type of transactions and transmission methods to be utilized and secure authorizations from the provider or other trading partner requesting to exchange electronic administrative transactions, and*
2. *Designate the FIs, Carriers, RHHIs, A/B MACs, and CEDI with whom the provider or other trading partner agrees to engage in EDI and implements standard policies and practices to ensure the security and integrity of the information to be exchanged.*

Under HIPAA, EDI applies to all covered entities transmitting the following administrative transactions: 837I and P, 835, 270/271, 276/277 and NCPDP (and others that are not used by Medicare at this time). Beginning on January 1, 2012, FIs, Carriers, RHHIs, A/B MACs and CEDI will also use the TA1, 999 and 277CA error handling transactions. In addition, CEDI and DME MACs will also use the NCPDP Standard Transmission Response transaction. Entities who prepare and submit the CMS 1500 or UB04 paper claim forms do not need to complete an EDI registration.

30.1 *EDI Enrollment*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and CEDI are required to furnish new providers that request Medicare claim privileges information on EDI. FIs, Carriers, RHHIs, A/B MACs, and CEDI are required to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in §50), and enroll and assign submitter EDI identification numbers to those approved to use EDI. All providers are required to submit their claims electronically, per ASCA, unless they qualify for a waiver (see section 90 below).

The EDI enrollment process for the Medicare beneficiary inquiry system (HETS 270/271) is currently a separate process. Information on the EDI enrollment process for HETS can be found on the CMS HETSHelp website (http://www.cms.gov/HETSHelp/).

A provider must obtain an NPI and furnish that NPI to their FI, Carrier, RHHI, A/B MAC, and CEDI prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. The FIs, Carriers, RHHIs, A/B MACs, and CEDI are required to verify that NPI is on the NPI Crosswalk. If the NPI is not verified on the NPI Crosswalk, the EDI Enrollment Agreement is denied and the provider is encouraged to contact the FI, Carrier, RHHI or A/B MAC provider enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for DME suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password. When leaving the Medicare Program, a provider must notify their MAC to deactivate the EDI number.

If providers elect to submit/receive transactions electronically using a third party such as a billing agent, a clearinghouse or network services vendor, the FIs, Carriers, RHHIs, A/B MACs, or CEDI must notify those providers that they are required to have an agreement signed by that third party. The third party must agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare, but are to be retained by the providers.) The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor. Providers must also not share their personal EDI access number to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim. No other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from those FIs, Carriers, RHHIs, A/B MACs, or CEDI to whom they will send or receive EDI transactions. For a complete reference to security requirements see section 40.1.2.2 below and refer to the Appendix A CMSR High Impact Level Data document (sections IA-2 and SA-9) located on the CMS website (http://www.cms.gov/informationsecurity/downloads/ARS_App_A_CMSR_HIGH.pdf.)

30.2 *New Enrollments and Maintenance of Existing Enrollments*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The Medicare EDI Enrollment process provides for collection of the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners and also establishes the expectations for both parties in the exchange. This agreement must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form and submit it to the FI, Carrier, RHHI, A/B MAC, or CEDI with which EDI transactions will be exchanged before the FI, Carrier, RHHI, A/B MAC, or CEDI will accept production claims or

other incoming EDI transactions from that provider, or a third party for that provider, or send outbound EDI transactions. FIs, Carriers, RHHIs, A/B MACs, and CEDI may accept a signed EDI Enrollment Form from providers via fax or hard copy. The EDI Enrollment Form is effective as specified in the terms of the agreement.

Providers who will be accessing the FIs, RHHIs, or A/B MACs Direct Data Entry (DDE) system will have access to enter and correct claims directly at the FI, RHHI, or A/B MAC and must submit an EDI Enrollment Form to the FI, RHHI, or A/B MAC with their request for this access.

NOTES:

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

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

Providers who have a signed EDI Enrollment Form on file with a particular FI, Carrier, RHHI, A/B MAC, or CEDI are not required to submit a new signed EDI Enrollment Form to the same FI, Carrier, RHHI, A/B MAC, or CEDI each time they change their method of electronic billing or begin to use another type of EDI transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. Additionally, providers are not required to notify their FI, Carrier, RHHI, A/B MAC, or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

FIs, Carriers, RHHIs, A/B MACs, and CEDI must inform providers that providers are obligated to notify their FI, Carrier, RHHI, A/B MAC, or CEDI in writing in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of EDI.

When an FI, Carrier, RHHI, A/B MAC, or CEDI receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third party, the FI, Carrier, RHHI, A/B MAC, or CEDI must verify that an EDI Enrollment Form is already on file for that provider or supplier, and that the third party has already been issued an EDI number and password to permit submission/receipt of EDI transactions. The request cannot be processed until both are submitted/issued.

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

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

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

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

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' *FIs, Carriers, RHHIs, A/B MACs or CEDI*:

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

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its *FIs, Carriers, RHHIs, A/B MACs, DME MACs or CEDI* without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill

insurance primary or supplementary to Medicare, or as required by State or Federal law;

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

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

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

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

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

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

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

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

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

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

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

13. *That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI (in accordance with §1106(a) of Social Security Act (the Act) (See section 40.1.2.2 below for a complete reference to Medicare's security requirements);*

14. That it will research and correct claim discrepancies;

15. That it will notify the *FI, Carrier, RHHI, A/B MAC, CEDI*, or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form *(See section 40.1.2.2 below for a complete reference to Medicare's security requirements)*.

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

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

2. Affix the *FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI* or other contractor if designated by CMS number, as its electronic signature, on each remittance advice sent to the provider;

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

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

5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare *FIs, Carriers, RHHIs, A/B MACs, CEDI*, or other contractors if designated by CMS to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services sold directly, indirectly, or by arrangement by the *FI, Carrier, RHHI, A/B MAC, CEDI*, or other contractor if designated by CMS;

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

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

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

C. Signature

I certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.

Provider's Name

Title

Address

City/State/Zip

By _____ _____

(signature) (printed name)

Date

30.3 *Submitter Number*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, or CEDI will assign an EDI submitter/receiver number and a periodically renewable password to each entity (provider, clearinghouse, billing agent) submitting or receiving electronic transactions. Provision must be made to return claim remittance files either to the provider or to a designated receiver (which may be the submitter or another entity, but not both). If electronic remittance advice transactions will be issued, the profile must indicate where the *FI, Carrier, RHHI, A/B MAC, or CEDI* is to send the remittance advice transactions.

30.4 *Network Service Vendor (NSV) Agreement*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Third party agents that represent providers, including NSVs, certain value-added networks, clearinghouses, and billing agents that will *send and receive Medicare electronic transactions*, must sign an agreement that includes the following wording:

The third party provider agent agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974, which requires Federal information systems to establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims, remittance advice, online claims correction, and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically;
2. It is has no ownership rights and is not a user of the data, but merely a means of transmitting data between users that have a need for the data and are already identified as legitimate users

under a "routine use" of the system; that is, disclosure for purposes that are compatible with the purpose for which Medicare collects the information;

3. The beneficiary data submitted to them by the *FI, Carrier, RHHI, A/B MAC, DME MACor CEDI* are owned by Medicare;
4. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than (a) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider's patient, (b) CMS, or (c) CMS' *FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI*;
5. It will promptly notify the *FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI* of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure;
6. The data will not be stored for any duration longer than that required to assure that they have reached their destination, and no more than 30 days for any purpose;
7. It has identified to the *FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI* in writing of any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks;
8. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. *For example, data cannot be viewed or manipulated by connectivity vendors to create reports for providers, that function is reserved for a provider's clearinghouse or billing service.* Reports may be written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date;
9. It will guarantee that an authorized user may be deleted within 24 hours in the event that person leaves their employment, no longer has a need to access this information, or there is a possible security breach;
10. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing, signed by the provider, submitted to the provider's *FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI* and each provider has a valid EDI enrollment form on file with that CMS contractor;
11. It has safeguards in place to assure each eligibility response is sent only to the provider that initiated the inquiry;
12. *It has safeguards in place to assure that all other outbound transactions such as the TA1 interchange acknowledgment, 999-E accepted functional groups/transaction sets with errors, 999-R rejected functional groups/transaction sets,999-A clean functional acknowledgments, 277CA claims acknowledgment, ANSI 835 electronic remittance advice, and the ANSI 277 claim status inquiry response received from the FI, Carrier, RHHI, A/B MAC or CEDI are sent only to the appropriate authorized entity;*
13. It will furnish, upon request, documentation that assures the above privacy and security concerns are being met;

14. It will adhere to the regulations on security and privacy standards for health information under *HIPAA, and extended to all business associates of a covered entity per ARRA (see section 20 above for a review of these legislative references);*

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

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

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

SIGNATURE: *I certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.*

Sole Proprietor or Company Name:

Address:

Address:

City/State/ZIP code:

Signed By: _____ _____

(signature) (printed name)

Title:

Date:

FI, Carrier, RHHI, A/B MAC, CEDI to whom this is being submitted:

40 *Medicare FFS EDI Users Roles and Responsibilities in an EDI Environment*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Medicare FFS supports EDI as exchanged between all covered entities and Medicare FFS contractors. This chapter provides guidance on how these relationships and the transactions generated by them shall be established, maintained and managed.

40.1 *Centers for Medicare and Medicaid Services – Medicare Fee-For-Service*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs along with the Common Electric Data Interchange (CEDI) contractor must transact versions of the Institutional and Professional Claim (837 I and P), the Remittance Advice (835), the Claim Status Inquiry and Response (276/277), the Eligibility Inquiry and Response (270/271), and the newly adopted error handling transactions (Claims Acknowledgment 277 CA, the 999 and the TA1) within national standards developed by ACS X12. CEDI must transact versions of the National Council for Prescription Drug Program (NCPDP) claims transactions.

Medicare FFS supports EDI as exchanged between all covered entities and Medicare FFS contractors. This chapter provides guidance on how these relationships and the transactions generated by them shall be established, maintained and managed.

40.1.1 HIPAA transaction standards as designated by CMS

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

HIPAA transaction standards shall be supported by the FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS for the electronic data with Medicare providers/submitters/receivers/COB trading partners. The Technical Report 3 (TR3) for all mandated HIPAA transactions may be purchased from Washington Publishing Company. Their website is www.wpc-edi.com.

- *X12N 837 TR3 for institutional (005010X223) and professional claims (005010X222).*
- *X12N 835 TR3 Health Care Payment Advice (005010X221).*
- *X12N 276/277 Claim Status Inquiry and Response (005010X212). See chapter 31 for additional details.*
- *NCPDP Claims Transactions (version D.0*

40.1.2 Transactions used in the acknowledgment of receipt of claims

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The following two transactions shall be used in the acknowledgment of the receipt of claims.

- *X12N 214 TR3 277CA Health Care Claim Acknowledgment; and*
- *X12N 231 TR3 999 Implementation Acknowledgment for Health Care Insurance.*

40.1.3Change Request (CR) to Communicate Policy

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

CMS shall issue Change Request (CR) to communicate CMS policy to the FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS. Additionally, Joint Signature Memos/Technical Direction Letters may be issued by CMS with additional information related to published CRs or guidance to FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS in the administration of Medicare policy.

40.2 *Medicare FFS Contractors (FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS are responsible to support the exchange of CMS approved electronic transactions. This support includes testing, certifying, and retention of an audit trail for the electronic data interchange platforms. FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS must maintain environments according to CMS security policy and guidelines. See Section 40.2.1 and 40.2.2. for specific references to this information.

FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide outreach and education to encourage the use of electronic transactions. FIs, Carriers, RHHIs, A/B MACs, CEDI or other contractors if designated by CMS are responsible for managing the EDI enrollment of entities who will be exchanging electronic transactions and providing support to these entities. FIs, Carriers, RHHIs, A/B MACs, DME MACs, or other contractors if designated by CMS are responsible to support contact with new providers, make available User Guidelines for EDI transactions and EDI provider training, to include information on EDI transactions in newsletters, bulletin boards, and Internet publications. See Section 40.2.2 and 40.2.3 for specific references to this information.

FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide limited support to providers in choosing a vendor, determining goals and requirements for the provider in selecting a vendor and assist in evaluating vendor proposals. See Section 40.2.4 for specific references to choosing a vendor.

FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide support to EDI trading partners through technical assistance and training. Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will

make free claim submission software available to providers and support the software. FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will also support the software to convert the X12 835 into a print document. See Section 40.2.5 and 40.2.6 for specific references to this information.

40.2.1 Certification – Purpose and Process of Certification Testing

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

During implementation of the X12 and NCPDP transactions, CMS has developed use cases, test cases, and associated test data files to verify that each A/B MACs, DME MACs, or other contractors if designated by CMS is ready to receive and process current transactions as well as other CMS required EDI enhancements.

A/B MACs, CEDI or other contractors if designated by CMS will perform certification testing using the Certification Test Package (CTP) and produce reports based on the test results. For each use/test case the actual result must be the same as the expected results and must match the associated transactions. Certification results, reports, and files will be retained by the A/B MACs, CEDI or other contractors if designated by CMS for audit ability in the future. As changes are made in to the 5010 and D.0 transactions, the CTP will be updated and utilized during recertification.

The Single Testing Contractor (STC) will provide detailed instructions to the A/B MACs, CEDI or other contractors if designated by CMS to be used to perform the certification testing. These instructions will be revised as needed and communicated to the A/B MACs, CEDI, or other contractors if designated by CMS. Further information on these instructions can be found at http://www.cms.gov/ElectronicBillingEDITrans/.

A/B MACs, DME MACs, or other contractors if designated by CMS were assigned to develop use cases for each loop (where loop is applicable) according to their assignments. In addition, the use case represents the type of response expected by each of the test cases within the use case. Following the 5010 and D.0 Edit Spreadsheets as a guide, a use case for each loop transaction was developed. There are multiple test cases for each use case.

In most cases, each loop has at least one "accept" (in process/flat file mapping) use case and at least one "reject" use case. The "reject loop" use case contains only one test case for the rejection or first negative test of the entire loop.

Depending on the edit type, additional use cases were necessary. For example, each loop will have one 999 use case with multiple test cases, one accepted ("A") use case for "good clean" claims in process, flat file mapping, and may have one 277CA use case with multiple test cases. It may be necessary to have more than one data file per use case if there are elements which will result in a structural error by the translator. In those cases, there are multiple data files per use case.

For NCPDP, each segment has one "accept (in process/flat file mapping)" use case, one "reject" use case, and one flat file mapping use case.

A test case describes each task that will insure 5010 data elements, qualifiers, and data values conform to the TR3 and the transactions edit spreadsheet. Each valid value, invalid value, and edit as listed in the 5010 edits spreadsheet has an associated test case.

Each test case includes the purpose of the test case, steps (and prerequisites) required to execute the test case, what the expected results are, and any necessary comments to clarify the test case.

As modifications are made to the 5010 Edit Spreadsheets which will impact the Use/Test Cases and associated test data files in the CTP, the STC will coordinate maintenance to the Use/Test Cases and associated test data files with the sponsoring A/B MAC , and CEDI or other contractor assigned to the Change Request (CR). The Shared Systems Maintainers have a list and maintain that list of Sponsoring A/B MACs, CEDI or other contractors. The next sponsoring A/B MAC, CEDI or other contractor is determined by simply rotating through the list of to Change Requests. Should any one component of a CR or the CR itself be too large for a single A/B MA, CEDI or other contractor to accommodate, then they shall request assistance from the STC and/or CMS in securing resources to assist with changes required to maintain the Use/Test Cases and associated test data files with the required changes.

40.2.2 Security Requirements

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI, and entities who conduct business with Medicare contractors (including providers and Trading Partners) are subject to CMS security policies. See §20.1 for specific reference to ARRA/HIPAA.

CMS' information security policy strictly prohibits any trading partner from outsourcing system functions to any resource located outside of the United States or its territories. Prohibited outsourced functions include but are not limited to the transmission of electronic claims, receipt of remittance advice, or any system access to obtain beneficiary PHI and/or eligibility information. Violation of this policy will result in revocation of all methods of system access, including but not limited to EDI front-end access or EDC RACF user access. The Medicare contractor shall notify all affected providers as well as reporting the system revocation to CMS. If access revoked for all submitters associated with those entities – CMS will provide guidance on how revoked access could be restored and also mitigate risk of entities with revoked access from reverting to paper submission.

CMS' information security policy strictly prohibits the sharing or loaning of Medicare assigned IDs and passwords. Users should take appropriate measures to prevent unauthorized disclosure

or modification of assigned IDs and passwords. Violation of this policy will result in revocation of all methods of system access, including but not limited to EDI front-end access or EDC RACF user access. The Medicare contractor shall notify all affected providers as well as reporting the system revocation to CMS.

Medicare contractors will follow CMS guidelines for communicating and enforcement of the security policies.

40.2.2.1 FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI Data Security and Confidentiality Requirements

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

FIs, Carriers, A/B, MACs, DME MACs and CEDI systems must include the following system security capabilities:

- All data must be password protected and passwords modified at periodic but irregular intervals, as well as when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified;
- Provide mechanisms to detect unauthorized users and prohibit access to anyone who does not have an appropriate user ID and password;
- Maintain a record of operator-attempted system access violations;
- Maintain a multi-level system/user authorization to limit access to system functions, files, databases, tables, and parameters from external and internal sources;
- Maintain updates of user controlled files, databases, tables, parameters, and retain a history of update activity; and

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

40.2.2.2 FI, Carrier A/B MAC, DME MACs and CEDI Audit Trails

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

- The claim as received (pre-translation) from the provider, billing service, or clearinghouse *(FIs, Carriers, RHHIs, and A/B MACs only*);
- *The claim as received (post-translation) from CEDI (DME MACs only);*
- The claim as paid to the provider;
- All adjustments made on the claim;
- The check or the electronic funds transfer (EFT) record sent to the provider; and
- The remittance advice as sent to the provider (FIs, Carriers, RHHIs, and A/B MACs only);
- The remittance advice as sent to CEDI (*DME MACs only)*.

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

CEDI must maintain an automated transaction tracking and retrieval capability and retain an audit trail that notes each change made to each claim from date of receipt to date of transfer to the appropriate DME MAC; and the receipt of remittance advice from the DME MAC and delivery to the provider. CEDI must be able to retrieve or recreate:

- *The claim as received (pre-translation) from the provider, billing service, or clearinghouse;*
- *The remittance advice as sent to the provider.*

The records may be kept on electronic, computer-output-microfilm, optical disk media, or other reliable and industry accepted types of storage and retrieval media. They may never allow

anyone to overlay or erase a record. Each record must be kept intact. All records must be archived in accordance with the instructions in the Medicare General Information, Eligibility, and Entitlement Manual, Pub.100-01, Chapter 7. It is important to have a well-defined system for maintaining audit trail data so that data integrity is maintained at all times.

40.2.2.3 Security-Related Requirements for FIs Carriers, RHHIs, A/B MACs, and CEDI Arrangements With Clearinghouses and Billing Services

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

Some entities that refer to themselves as clearinghouses, however, do not edit or translate data, but simply serve as a "telecommunication switch," moving transactions from point A to Point B or wherever directed under the terms of the agreement with a provider. *A clearinghouse may also be called a value added network (VAN), or when eligibility data (but not limited to eligibility data) are involved, are sometimes called Network Service Vendors (NSVs).* A clearinghouse/VAN/NSV may not view privacy-protected Medicare data unless a signed

authorization has been filed by the provider for whom the clearinghouse/VAN/NSV will submit or received Medicare EDI transactions. For EDI, a transaction that contains individually identifiable information about a Medicare beneficiary is considered to be privacy protected data.

That provider may not authorize submission or receipt of data by a third party for a Medicare beneficiary unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider. The provider authorization must be filed with the Medicare contractor to whom EDI transactions will be sent or from whom they will be received. In the case of *a DME claim*, this authorization need only be submitted *to CEDI*. If multiple *FIs, Carriers, RHHIs, or A/B MACs* are involved, an authorization must be submitted to each.

Each clearinghouse/VAN/NSV that will submit or receive Medicare EDI transactions is prohibited from using the EDI number or password issued to any of the providers they serve. Each clearinghouse/VAN/NSV must obtain its own EDI number and password from each *FIs, Carrier, RHHIs, or A/B MACs* with which it will interact. *For, DME, each Clearinghouse/VAN/NSV must obtain its own EDI number and password from CEDI.*

Some health care providers use or may want to use more than one billing service or clearinghouse/VAN/NSV. An *FI, Carrier, RHHI, A/B MAC, and CEDI* ability to handle more than one agent varies. Some *FIs, Carriers, RHHIs, A/B MACs, and CEDIs* are able to accommodate one or more clearinghouses/VAN/NSV for submission of a provider's claims to Medicare, another agent to receive the provider's remittance advice transactions, and a third clearinghouse/VAN/NSV to verify beneficiary Medicare eligibility for a provider. Others may not be able to accommodate more than one agent for a provider. *FIs, Carriers, RHHIs, A/B MACs, and CEDIs* are encouraged to support more than one agent for a provider, when permitted by their front end configuration.

FIs, Carriers, RHHIs, A/B MACs, and DME MACs, or other contractors if designated by CMS must notify each provider that applies for permission to obtain eligibility data electronically that:

- They are permitted to view Medicare eligibility data only for patients currently being treated by or who have requested treatment or supplies from that provider;
- A provider cannot authorize a billing agent or clearinghouse to submit or obtain data from a *FIs, Carriers, RHHIs, A/B MACs, and DME MACs* that the provider is not entitled to personally submit or obtain;
- A request for personally identifiable information for any other Medicare beneficiaries would be a violation of Medicare and HIPAA privacy requirements, and subject to the applicable penalties for such violations.

FIs, Carriers, RHHIs, A/B MACs, and DME MACs must notify each billing service and clearinghouse/VAN/NSV at the time of their application for access to Medicare eligibility data and by also posting information on their web site that:

- Their access is limited to submission of transactions and receipt of transactions for those providers that are their clients, but only if those providers authorized the billing agent and/or clearinghouse/VAN/NSV to submit or receive each transaction.
- A billing agent or clearinghouse/VAN/NSV that has provider authorization to submit claim data for a provider cannot obtain eligibility data for that provider unless that was specifically authorized by the provider.
- Likewise, the billing agent or clearinghouse/VAN/NSV cannot be sent remittance advice transactions for a provider unless specifically authorized to do so by that provider.

Providers must submit these authorizations to their *FIs, Carriers, RHHIs, A/B MACs, DME MACs, CEDI or other contractors* if designated by CMS in writing; an *FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI or other contractor if designated by CMS* is not permitted to accept a statement signed by a billing agent or clearinghouse/VAN/NSV alleging that they have such provider authorization on file. An original provider signature is required on these authorizations (but an *FI, Carrier, RHHI, A/B MAC, DME MAC,CEDI or other contractor* if designated by CMS is allowed to accept an authorization signed by a provider by fax or mail). The *FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, or other contractor* if designated by CMS is responsible for maintenance of files to establish system access for individual providers, identify those billing agents and clearinghouses/VAN/NSV authorized to access systems as the agent of a specific provider, and to record those transactions for which a billing agent or clearinghouse/VAN/NSV is authorized access as the representative of a specific provider.

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

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

A provider must sign a valid EDI Enrollment Form (see Section 30.1 this chapter) prior to authorizing a billing agent or clearinghouse/VAN/NSV to submit/receive any EDI transactions on their behalf. A separate password *and User ID* is to be used for system access by each authorized provider, billing agent or clearinghouse. A vendor provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual providers, billing agent or clearinghouses/VANs/NSVs. Vendors supply the means for Medicare system access but have no right to direct access to the system of a *FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, or other contractor* if designated by CMS.

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

40.2.2.4 Release of Medicare Data

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

FIs, Carriers, RHHIs, A/B MACs, DME MACs or other contractors if designated by CMS must give access to any clearinghouse that requests access to data on behalf of providers as long as they adhere to the following rules:

- Each clearinghouse *requesting access to eligibility data must sign a Trading Partner Agreement (TPA) and agree to adhere to CMS rules of behavior (Refer to www.cms.gov/HETSHelp)*;

- Each provider that contracts with a *clearinghouse* must sign a valid EDI Enrollment Form before data can be sent to the third party *(see Section 30.1)*;
- The provider must explain the type of EDI services to be furnished by its clearinghouse in a signed statement authorizing the *clearinghouse's* access to data;
- The clearinghouse must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a clearinghouse, the *clearinghouse* must be able to identify the correct provider making the request for each beneficiary's information and be able to assure that responses are routed only to the provider that originated each request; and
- There is no record of prior violation of a *TPA* by this clearinghouse with the *FI, Carrier, RHHI, A/B MAC, DME MAC* or other contractor if designated by CMS to whom a request for access to the data is submitted that would indicate that beneficiary data could be at risk of improper disclosure if access was approved for this clearinghouse.

A. All providers and clearinghouses that wish to obtain Medicare beneficiary data must apply to *FIs, Carriers, RHHIs, A/B MACs, DME MACs*, or other contractor if designated by CMS for access to the records.

B. Providers and clearinghouses must submit each query to the *FIs, Carriers, RHHIs, A/B MACs, DME MACs*, or other contractor if designated by CMS *with which they are registered*. *CMS supports multiple EDI and non-EDI methods for obtaining eligibility data, including X12N 270/271 (see IOM Pub. 100-04 Chapter 31 for more information on the 270/271 transaction).*

C. When an inquiry *is submitted*, the FI, Carrier, RHHI, A/B MAC, DME MAC, HETS 270/271, or other contractor if designated by CMS must be able to ensure that:

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

D. Providers must be notified that:

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

E. Medicare contractors, as designated by CMS, must:

- *Provide notification of these requirements to all providers requesting electronic receipt of eligibility data;*
- *remind providers to notify them when there is a change in clearinghouse, arrangements cease with a clearinghouse, or the provider leaves the Medicare program;*
- *delete each provider from their EDI eligibility security file if there is no longer a business relationship between the Medicare contractor and provider, or if the Medicare contractor or the provider is no longer serving the Medicare program; and*
- *remind providers, clearinghouses and other third parties that access rights to beneficiary eligibility data may be revoked if they fail to adhere to the requirements for access*

40.2.2.5 EDI Enrollment and EDI Claim Record Retention

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

Once a trading partner has been tested and approved for electronic submission of claims, they can begin submitting electronic claims to Medicare. *FIs, Carriers, RHHI, A/B MAC, DME MACs, or CEDI* are required to retain electronically filed claims under the same CMS Records Retention Schedule retention requirements that apply to hardcopy claim. The CMS Records Retention Schedule for Medicare Records can be found at the following URL: **http://www.cms.hhs.gov/manuals/downloads/ge101c07.pdf**.

40.2.3 General EDI Outreach Activities

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI are to actively encourage providers to increase their use of EDI transactions. Also see § 60 of this Chapter for EDI Edit Requirements. Specific outreach requirements are included in the CMS requirements for implementation of new or revised EDI standards. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* are also required to notify providers about the need to file most claims with Medicare electronically. See § 90 for specific referenced to Mandatory Submission of Medicare Claims. In general, *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* must:

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

2. Provide educational information on EDI to providers identified in internal analysis described in Section 40.2.3.1 as well as to the software vendors and clearinghouses that serve or market services to Medicare providers;

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

    - Include specific and meaningful EDI messages in provider newsletters, addressing the themes described in Section 40.2.3.4 below, other issues that may be pertinent to the carrier, DMERC, or FI's geographic area, and as directed in individual EDI instructions issued by CMS. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* are expected to point out the advantages to providers in the use of EDI transactions.

See the Medicare Beneficiary and Providers Communication Manual (100-09) for definitive guidance on Medicare's provider outreach requirements. Provider outreach activities, including those that involve EDI are funded through the Provider Education and Training budget issued to Medicare contractors.

40.2.3.1 FI, Carrier, DME MAC, and MAC Analysis of Internal Information

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs and DME MACs must contact providers with the highest number of paper claim transactions to have them begin submission of claims electronically as required under §90 of this chapter for ASCA enforcement Reviews. *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* are also to strongly encourage providers to conduct their claims status, beneficiary eligibility, payment and remittance advice transactions electronically.

40.2.3.2 Contact With New Providers

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, and A/B MACs must conduct an analysis of the capability of each provider (including physicians and suppliers) that contact a Medicare contractor to begin submission of Medicare claims, or for DME MACs, when notified by the National Supplier Clearinghouse that new supplier identification numbers have been issued. FIs, Carriers, RHHIs, and A/B MACs shall use provider education to ensure that all providers/submitters are aware that EDI transactions are to be presented as the normal mode of business for Medicare claims, claim status, and remittance. FIs, Carriers, RHHIs, and A/B MACs shall also use provider education to ensure that all providers/submitters are aware that EFT is the normal mode for funds transfer.

See Chapter 31 for HETS information on eligibility verification 270/271 transaction queries. Where the provider does not have the related capability, FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI are to inform the providers of available options to begin use of EDI, e.g., list of vendors and clearinghouses and billing services, availability of Medicare's free software.

40.2.3.3 *Production and Distribution of Information to Increase Use of EDI*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

- Earlier payment of electronic claims that comply with Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification standards requirements;
- The benefit of earlier detection of errors via edits conducted upon submission of electronic transactions;
- The relative ease of use of EDI and the support available from the contractor to assist them in beginning use of EDI transactions;
- Advantages of online correction of errors (FIs only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (FIs only);
- Availability of free software:
    - PCACE Pro32 – Part A/B *and DME*;
    - Medicare Remit Easy Print Software (MREP) – Part B *and DME*; and
    - Medicare Standard Electronic PC Print Software (PC Print) – Part A/B.
- *Availability of batch claims status inquiries. The information must be updated on a regular basis.*

Availability of batch claims status inquiries. The information must be updated on a regular basis. *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* are encouraged to issue these materials via the Internet or E-Mail when possible, but paper copies may be distributed where most cost effective or when a provider may not have Internet or E-Mail access.

40.2.3.4 *Production and Distribution of Material to Market EDI*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI are required to produce and distribute material to educate and influence providers in all aspects of EDI.

They must include the following themes in published material:

1. Earlier payment of claims because of different payment floor requirements;
2. The benefit of earlier detection of errors via edits;

3. The relative ease of EDI and support available;
4. Advantages of online correction of errors (FIs only);
5. Lower administrative, postage, and handling costs;
6. Electronic adjustments (FIs only);
7. Availability of free software;
8. Claims status inquiry; and
9. Eligibility query.

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

These materials may be produced in-house or by local printing companies. The contents must be maintained up to date. Therefore, *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* must carefully plan print quantities to match planned distribution to avoid unnecessary waste.

They must make the material available to staff that have contact with the provider community and make arrangements for distribution at trade shows and seminars that the *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* do not attend as well as those that they do attend.

40.2.4 Trading Partner Management

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Medicare FFS' Trading Partner Agreement is comprised of two forms: 1) EDI Registration and 2) EDI Enrollment. The forms are identified under CMS form 10164 and can be accessed at:

EDI Registration – https://www.cms.gov/cmsforms/downloads/CMS10164A.pdf and

EDI Enrollment - https://www.cms.gov/cmsforms/downloads/CMS10164B.pdf

40.2.4.1 User Guidelines

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and CEDI must make information available to potential users (preferably via their Web page or the Internet) of each EDI transaction supported by Medicare with detailed information on:

- The telephone numbers of appropriate staff to contact to:
    - Get started with electronic billing and other EDI transactions; and
    - Obtain on-going support for electronic transactions.

- Testing requirements and the submitter's and *FIs, Carriers, RHHIs, A/B MACs, and CEDI* level of responsibility throughout each step of the testing process. See Section 40.1.2.1. for further testing details;
- The availability of the appropriate specifications for providers and instructions for accessing these via the Internet or other cost effective means;
- The availability of the *FIs, Carriers, RHHIs, and A/B MACs* to provide providers bulletins via the Internet and/or bulletin board system;
- The availability of the *FIs, Carriers, RHHIs, A/B MACs, and CEDI* to provide EDI instructions or procedures via the Internet and/or bulletin board system;
- The availability of the *FIs, Carriers, A/B MACs, and CEDI* to provide free Medicare EMC software;
- The availability of the *FIs, RHHIs, and A/B MACs* free PC-Print software and the *Carriers, A/B MACs, and CEDIs* free Medicare Remit East Print (MREP) software for the printing of the Electronic Remittance Advice.
- Login requirements;
- Hours of operation, system and support;
- Telecommunication options and requirements;
- Procedures for updating submitters with any billing changes;
- EDI formats required for input to the *FIs, Carriers, RHHIs, A/B MACs and CEDI* system. These specifications must be in sufficient detail for the submitter's use, and must include information regarding code, record length(s), field positioning within record(s), labeling and any other conventions necessary for compatibility with the *FIs, Carriers, RHHIs, A/B MACs, or CEDI* system;
- All acceptance and rejection formats and content for output from the *FIs, Carriers, A/B MACs, or CEDI*;
- Availability of online claim entry, claim correction (FIs only), claim status check, eligibility verification, claim development via DDE or otherwise, and the procedure for accessing these transactions;
- Availability of claim status check and eligibility verification and the procedure for accessing these transactions (Carriers and A/B MACs only);
- Specifications of the *FIs, Carriers, RHHIs, A/B MACs, and CEDIs* front-end editing process (except in those cases when disclosure of specific edits is related to medical Review or another sensitive area for which disclosure is not advisable) with complete list of error codes and resolution, including those conditions that will result in the rejection of entire EDI transmissions/batches;
- Conventions for acknowledging claims received and for recovering data known to be lost;

- Instructions for submitters to notify their *FIs, Carriers, A/B MACs, and CEDIs* changes to the submitter profile in regard to use of clearinghouses, billing agents, EDI transactions and software for submission/receipt of those transactions;
- *FIs, Carriers, RHHIs, A/B MACs, and CEDI* listings of vendors and clearinghouses that are approved for production;
- Data requirements for reporting third party Medigap payers,
- Frequently asked questions and answers about EDI.

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

- *How to contact CEDI to:*
  - *Get started with electronic billing and other EDI transactions; and*
  - *Obtain on-going support for electronic transactions.*
- *The availability to provide of DME MACs provider bulletins via the Internet and/or bulletin board system;*
- *The availability of CEDIs free Medicare EMC software*
- *The availability of the CEDI free Medicare Remit East Print (MREP) software for the printing of the Electronic Remittance Advice.*
- *Special instructions related to specific diagnosis or procedure codes, i.e., the necessity for attachments or modifiers and appropriate placement within the electronic record and;*
- *Data requirements for reporting third party payers, i.e., Medigap, crossover, Medical Assistance and private insurance.*

40.2.4.2 Technical Assistance to EDI Trading Partners

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

- Control (login) of all incoming calls: identification of caller, reason for call, date and time;
- Track activities related to the call to the final resolution of the call: identification of routing, callbacks, issues(reason for call), resolution, date and time;
- Workload distribution of open items;

- Classification of call types for resource planning, provider education, management reporting; and
- Storage of caller-specific audit trails.

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

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

- An indication that the *FIs, Carriers, RHHIs, A/B MACs, or CEDI* looked into the issue and did not identify a problem;
- The submission of a new corrected file *(FIs, Carriers, RHHI, A/B MAC, or CEDI only*);
- An explanation which either solves the problem or indicates action which the submitter or receiver can take to resolve the problem;
- An indication of the need for further investigation, with an estimated time frame for responding with more information and or a resolution;
- An indication that resolution requires *FIs, Carriers, RHHIs, A/B MACs, or CEDI* action, and a description of the plan for resolution and estimated completion date.

Where the problem affects multiple submitters the *FI, Carrier, RHHI, A/B MAC, or CEDI* makes information on the issue available to all affected submitters.

40.2.4.3 Training Content and Frequency

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

non-specific to Medicare EDI. On an ongoing basis, *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* should assess the need for additional training based on:

- Periodic identification and evaluation of common electronic billing errors;
- New software release; or
- The introduction of new EDI functions or changes to existing functions.

40.2.4.4 Prohibition Against Requiring Use of Proprietary Software or DDE

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI will accept and process *HIPPA EDI* transactions created from any software as long as the transactions comply with the IG requirements adopted under HIPAA and CMS *business* requirements. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* are prohibited from requiring that submitters of *HIPPA* EDI transactions use proprietary billing software or specific hardware. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* may not charge providers that use their own software, hardware, modems, and telecommunication lines to submit and/or receive *EDI* electronic transactions in a HIPAA-compliant format.

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

40.2.4.5 Free Claim Submission Software

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and CEDI will provide free/at cost software for their providers to use on a Windows-based PC for electronic submission of HIPAA-compliant claims to Medicare. At a minimum, this basic software must contain the following:

- Edits to prevent incomplete and inaccurate claims from entering the system;
- "User friendly" qualities including:
  - A low initial investment, as well as low-cost upgrades, on the part of the submitter;

- Minimal effort for both the software installation and training for the submitter; and
- Clear and understandable software documentation, including information about where to receive additional help.

This software must also be able to identify when Medicare is a secondary payer and to collect data elements concerning a primary payer's payment, standard claim adjustment reason codes and adjustment amounts made by a primary payer prior to submission of a claim to Medicare for secondary payment.

FIs, Carriers, RHHIs, A/B MACs, and CEDI are not funded to issue free/at cost software for other than submissions of 837 inbound HIPAA claim transaction. NCPDP has indicated software for billing NCPDP formatted claims was already in widespread use by retail pharmacies and there was not a need for Medicare to fund development of free billing software for retail pharmacies.

The software is free/at cost but *FIs, Carriers, RHHIs, A/B MACs, and CEDI* may charge a fee up to $25.00 per request to recoup their postage, reproduction, and handling expenses when a provider requests the software be sent via diskette, CD, or other medium, rather than downloaded by a provider from the Medicare contractor's Web page (if not precluded by a software copyright or licensing agreement). *FIs, Carriers, RHHIs, A/B MACs, and CEDI* are to complete upgrades to their free/at cost billing software to correspond to the requirements of the current X12 version of the transactions. Prior to distributing the initial or updated versions, *FIs, Carriers, RHHIs, A/B MACs, and CEDI* will scan the free/at cost billing software with a current anti-virus program. Whenever *FIs, Carriers, RHHIs, A/B MACs, and CEDI* issue a new version of their free/at cost billing software, they shall notify providers to terminate use of the earlier version of the Medicare free/at cost billing software within 90-days of release of the updated software.

NOTE: The free-billing software distributed by FIs is maintained by the shared system maintainer. FIs are responsible for testing and distribution of that software only. There is not a similar common source of free billing software or maintenance for the A/B MACS or carriers. A/B MACS or carriers are encouraged to obtain and license for distribution Medicare Part B billing software. This software is available to A/B MACS and carriers for purchase and licensing from software companies.

40.2.4.6 Newsletters/Bulletin Board/Internet Publication of EDI Information

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

To educate providers and encourage the use of EDI *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* must periodically include information about use of EDI in their newsletters and on their Web site. Their newsletter and Web site shall:

1. Announce upcoming EDI changes;
2. Point out common EDI billing errors and provide guidelines to eliminate errors; and

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

FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI will provide access to newsletters via bulletin boards and/or the Internet. *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* Web pages must include a link to the CMS' Web site, which provides record formats and transactions information. If the information is available on the CMS Home page, *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CED*I should link to it rather than duplicating development and maintenance.

40.2.4.7 Provider Guidelines for Choosing a Vendor

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

40.2.4.7.1 Determining Goals/Requirements

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

- Future Growth of the Practice;
- Workload;
- Payer Analysis;
- Referral Tracking;
- Fee Schedules;
- Appointment Scheduling;
- Medical Records;
- Interconnections with Physicians/Hospitals and other Networks;

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

40.2.4.7.2 Vendor Selection

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

1. Develop a list of potential vendors:

- *Ask the Medicare FIs, Carriers, A/B MACs, and CEDI for a list of approved vendors;*
- Ask other providers of comparable size/specialties what vendors they use for what services and how satisfied they are;
- Ask a consultant;
- Attend standards conferences, follow trade magazines and investigate Web pages.

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

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

4. Attend demonstrations of at least two to three vendors and pay close attention to:

- How individual requirements will be met;
- Ease of understanding;
- Ease of features - data entry, search features, editing/compliance checking features, help features, error correction features;
- Security - disaster recovery plans, controls, and audits;

- Daily Procedures;
- Reporting/Tracking features.

5. Check vendor references and ask specific questions such as:

- How long has the business been in operation?
- How long has the system been in place?
- What is the quality of the training and ongoing support?
- Is there a user's group in place?
- What formats are supported?

6. Check with providers served by the vendor and ask specific questions such as:

- Have you experienced any problems with the system?
- Have you experienced any problems with the vendor?
- How long did it take to get up and running?
- Are you happy with the system/vendor and would you recommend it/them today?
- Is there anything else I should know or ask before making my decision?

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

40.2.4.7.3 Evaluating Proposals

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Vendor proposals should be evaluated on several levels including company reputation/history, system functionality, flexibility, overall costs, and support provided. Providers should create a checklist that compares the vendor proposals against their original requirements by assigning a relative weight to each requirement and then rating the vendor's ability to meet each requirement based on their written proposals. Although some aspects of each checklist will be highly individual, the following are some of the elements that should be considered:

1. Overall costs:

    - Software costs;
    - Hardware costs (types as well as quality);
    - Licensing fees;
    - Training costs;
    - Installation costs;
    - Cabling;

- Phone lines (leased line/toll charges);
- Remodeling/Furniture;
- Forms;
- Conversion costs;
- Electricity costs;
- Supply costs
- Annual hardware maintenance;
- Annual software maintenance;
- Cost of custom program changes; and
- Cost of continuous software support.

2. Evaluate hardware differences;

3. Evaluate quality of training and support;

4. Evaluate system documentation;

5. Consider the staff size of the vendor;

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

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

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

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

40.2.4.7.4 Negotiating With Vendors

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

their agreements allowing them to delay final payment pending successful operation of the new software for a specified period after successful installation.

40.2.5 Provision of EDI User Guideline

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, HETS 270/271 and CEDI must make EDI information available to new users that describe the various steps in the testing process (see §30 and §60) and discloses: (This refers to HETS as well)

- The *Help Desk contact information,* including telephone number, *email address* , and website to help with:
    - Getting started with EDI;
    - Needing on-going support for electronic transactions; and
    - Needing support for general transaction issues;
- Testing requirements and the submitter's *and FIs, Carriers, RHHIs, A/B MACs, HETS 270/271 and CEDI* level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
    - American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) X12N transactions adopted under HIPAA; and
    - National Council for Prescription Drug Programs Format (NCPDP) adopted under HIPAA.
- Instructions for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp
- Login requirements;
- Telecommunications options and requirements; and frequently asked questions and answers about EDI.

40.2.6 Provision and Maintenance of a Directory of Billing Software Vendors and Clearinghouses

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and CEDI must maintain a directory of electronic billing software vendors and clearinghouses that have successfully completed software and/or submission testing *for the current* X12 837 version, NCPDP (applies to CEDI only) Telecommunication standard and Batch standard claim transactions adopted as national claim standards for HIPAA. *FIs, Carriers, RHHIs, A/B MACs, and CEDI* must make this directory available to their providers via a Web page or electronic bulletin board. *FIs, Carriers, RHHIs, A/B MACs, and CEDI* must update the directory whenever product offerings from additional

software vendors and/or additional clearinghouses is made available for providers to utilize when submitting transactions for production. At a minimum, the directory must include the vendor/clearinghouse name, phone number, email address and product offerings. *FIs, Carriers, RHHIs, A/B MACs, and CEDI* should also note any additional transactions for which the tested software can be used for submission or receipt of HIPAA transactions other than the claim.

40.3 *Trading Partners (reserved)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Trading Partners must have signed Trading Partner Agreements in place with their Medicare FFS Contractor prior to engaging in EDI.

50 *Technical Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

50.1 *Telecommunications, Internet and Dial-up*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI will support connectivity for EDI functions. These functions include the exchange of EDI transactions at the FIs, Carriers, RHHIs, A/B MACs and CEDI Front End and connectivity of Network Service Vendors to the FIs, Carriers, RHHIs, A/B MACs and DME MACs online systems.

Online systems include the Medicare Part A Direct Data Entry (DDE) used for claim entry, claim correction, claim status checks, and beneficiary eligibility. Medicare Part B offers the Provider Professional Telecommunications Network (PPTN) and DME MAC offers Claim Status Inquiry to check the status of claims and verify beneficiary eligibility.

50.1.1 System Availability

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Access to *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* to exchange electronic transactions and/or lookup files (e.g., HCPCS codes, fee schedules) may be dependent upon hours the core processing system is available. Where EDI functions are dependent upon the operation of the host processing system, the host system's hours of operation determine system availability. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* shall inform users of system availability schedules including any planned downtime for system maintenance.

50.1.2 Media

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of the *FI, Carrier, RHHI, A/B MAC, DME MAC and CEDI* and the details negotiated with electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see Section 50.1.3).

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

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

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;
- Adjustment bills (FIs only);
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);
- Bills paid by an HMO and processed by the contractor; and

FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI are not permitted to accept claims via fax-imaging, tape/diskette or similar storage media. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* are to assist billers using such media to transition to more efficient electronic media.

50.1.3 Telecommunications and Transmission Protocols

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Providers must access FIs, Carriers, RHHIs, A/B MACs and DME MACs online applications Medicare Part A Direct Data Entry (DDE), Medicare Part B Professional Provider Telecommunications Network (PPTN) and DME MAC Claim Status Inquiry (CSI) through a Network Service Vendor approved by the FI, Carrier, RHHI, A/B MAC or DME MAC. A Network Service Vendor provides connectivity to the CMS Enterprise Data Centers to access the providers claim and beneficiary data residing with the FI, Carrier, RHHI, A/B MAC or DME MAC. Network Service Vendors also provide connectivity to the FIs, Carriers, RHHIs, A/B MACs or CEDI Medicare Front End Gateways. FIs, Carriers, RHHIs, A/B MACs and DME MACs are to permit access to DDE, PPTN and DMCS via NSV or by using the most cost-

effective transmission solution, among the CMS-sanctioned options, that meets the needs of their trading partners.

The preferred method of connecting to the EDI front end at an FI, Carrier, RHHI, A/B MAC and CEDI is through a Network Service Vendor. FIs, Carriers, RHHIs, A/B MACs and CEDI may, but are not required to support *electronic* transfers for Medicare using 56 K connections for their asynchronous communications lines. For asynchronous communications, *FIs, Carriers, RHHIs, A/B MACs and CEDI may, but are not required to*, support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP). If *FIs, Carriers, RHHIs, A/B MACs and CEDI so support TCIP, it must be* compliant with Internet Request for Comment (RFC) number 1122 and 1123, using Serial Line Internet Protocol (SLIP) or Point-to-Point Protocol (PPP). For any EDI transfers over TCP/IP connections, *FIs, Carriers, RHHIs, A/B MACs and CEDI* must support a File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication through user ID/password mechanisms. The carrier, MAC or FI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. Any user should be able to use TCP/IP for asynchronous communication at any Medicare site. The Internet may not be used for beneficiary sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project.

FIs, Carriers, RHHIs, A/B MACs and CEDI may but are not required to support file compression for X12N or NCPDP (*CEDI* only) transactions. Compression is permitted between the contractor and its data center.

FIs, Carriers, RHHIs, A/B MACs and CEDI may not limit the number of 837 transactions or the number of providers with transactions included in a single transmission, but they may limit a single transmission to 5,000 claims if that is necessary for efficient operations. *For NCPDP, CEDI may not limit the number of transactions per batch except as noted within the batch standard. However, they may limit a single physical file to having only one batch.* Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

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

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

Unless approved for participation in a limited demonstration program, FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI are not permitted to accept EDI transactions via the Internet at this time.

50.1.4 Toll-Free Service

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Toll free lines are not available for submission or receipt of EDI transactions. Providers and their agents are responsible for all costs they incur for communication and *connectivity as described in Section 50.1*.

50.2 *Translators*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

FIs, Carriers, RHHIs, and A/B MACs, and CEDI must use the X12 997 *for version 4010 or 999 for version 5010* Functional Acknowledgment to report X12 transaction standard level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgments for claims without errors. *FIs, Carriers, RHHIs, and A/B MACs, or CEDI* may purge X12 997 *for version 4010 or 999 for version 5010* transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to retain these as long as 30 days if system capacity permits. Once purged, a *FIs, Carriers, RHHIs, and A/B MACs, or CEDI* is not required to be able to recreate that 997 *for version 4010 or 999 for version 5010 transactions.* A provider or clearinghouse that failed to download the 997 *for version 4010 and 999 for version 5010* timely may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new

997 *for version 4010 or 999 for version 5010 issued. The X12 999 TR3 005010X231 can be downloaded from WPC-EDI.com. FIs, Carriers, RHHIs, and A/B MACs and CEDI are required to meet the X12 999 TR3 requirements when issuing the 999 for version 5010. The X12 997 requirements are located in Appendix B at the rear of each X12 IG adopted under HIPAA. FIs, Carriers, RHHIs and A/B MACs and CEDI are required to meet those Appendix B requirements when issuing the 997 for version 4010.*

When receiving claims in the HIPAA adopted NCPDP formats, *Version D.0,* CEDI must produce a response file in the NCPDP *D.0* format containing one Transaction Header and one Transaction Trailer with the appropriate syntax error noted in the message field*. CEDI must continue to produce the proprietary NCPDP response report for 5.1 formatted claims.*

FIs, Carriers, RHHIs, and A/B MACs, and CEDI must accept the entire extended character set or the entire extended character set must not be used. Refer to the 5010 TR3 for specifics on the character set. If *FIs, Carriers, RHHIs, and A/B MACs, and CEDI* cannot accept more than 9,999 loops or segments per loop in an X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the X12 997 *for version 4010 or 999 for version 5010 with the IK304 with a value of "4".* Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. FIs, Carriers, RHHIs, and A/B MACs, and CEDI are not required to accept multiple functional groups (GS/GE) with multiple transaction types within one transmission for X12 transactions.

For X12 transactions FIs, Carriers, RHHIs, and A/B MACs, and CEDI translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map "Not Used" data elements for *Carriers, A/B MACs, and CEDI* based upon that segment's definition only, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped; "Not Used" data elements are not to be mapped to the FI flat file; and
- Accept multiple interchange envelopes within a single transmission. *This is only applicable to X12 transactions as NCPDP only processes a single batch per transmission.*

- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case requirements noted for incoming translation. *FIs, Carriers, RHHIs, and A/B MACs, and CEDI* are not

required to accept or process X12 997 *for version 4010 or 999 for version 5010* transactions from trading partners for any outgoing X12 transactions.

- See Section 60 for additional *FIs, Carriers, RHHIs, and A/B MACs, and CEDI* translator edit requirements that may be specific to individual standards.

50.3 *Common Edits and Enhancements Module (CEM) – General Description across all versions*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The CEM establishes consistent editing, acknowledgments, and error handling of the electronic data interchange (EDI) transactions across Medicare Administrative Contractor (MAC) jurisdictions. The CEM is implemented by each A/B MAC in their local data center (LDC). The Part A and Part B CEMs were developed by their corresponding Medicare Shared System Maintainers (SSMs). The Durable Medical Equipment (DME) MACs editing, acknowledgment, and error handling of EDI transactions is processed by the Common Electronic Data Interchange (CEDI) contractor. Each A/B MAC has integrated the CEM into their Front-End Systems for both inbound and outbound EDI transaction processing. The CEM, in conjunction with the A/B MAC Commercial Off-the-Shelf (COTS) translator and any additional Front End solution, is responsible for editing current Accredited Standards Committee (ASC) X12 standard transactions established under HIPAA via Technical Report Type 3 (TR3s).

The CEM provides submitters with quicker acknowledgments for the claim transaction(s) version(s) 005010 and beyond inclusive of any adopted errata under HIPAA. This allows submitters to correct any errors and resubmit their transactions without having to wait for a batch cycle.

The CEM includes the following capabilities:

- *Code set editing*
- *Medicare-specific editing*
- *Duplicate submission checking*
- *Claim Control Number assignment of Internal Control Number (ICN) or Document Control Number (DCN)*
- *Creation of the Health Care Claim Acknowledgement (277) hereafter referred to as 277CA flat file*
- *Creation of a CEM-edited transaction flat file*

- *Receipt/Control/Balancing between the LDCs and EDCs for claims, claim status request and responses, and remittance advice*
- *Reporting Capabilities based on the Control Record database*

50.3.1 Claim Numbering

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The CEM will assign a claim control number to each accepted claim. An accepted claim is a unit of work, 2300 loop followed by a 2400 loop, as described in the X12 837 TR3 that has passed all translator syntax/semantic and CEM Medicare business edits and has been assigned a claim control number. The assigned claim control number will be reported back to the submitter via the Health Care Claim Acknowledgement 277CA standard transaction. This will provide the submitter with the claim control number earlier in the adjudication process, thus enabling the submitter to perform more specific claim status inquiries on individual claims instead of entire submissions via standard HIPAA adopted transactions or via traditional IVR/ARU (Interactive Voice Response/Automated Response Unit methods.

50.3.2 Receipt Control and Balancing

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Upon receiving a Health Care Claim Status Request (276) or Health Care Claim –Institutional or Professional (837) current ASC X12 standard transactions established under HIPAA, the A/B MAC will process the file through their Front End EDI solution, composed of at minimum a COTS translator. The COTS translator creates the appropriate CMS defined flat file, based on transaction type. The CMS defined flat file will include a skeleton Control Record, either a Detail Record (CTRD) or a Resubmission Record(CTRR), for each Interchange Control Header/Interchange Control Trailer (ISA/IEA) present, and the MAC then loads/places this file into the designated folder for the CEM to pick up and process.

The CTRD/CTRR record is placed in the designated transaction outbound folder for the A/B MAC LDC to move via Network Data Mover (NDM) to the EDC. The EDC will run a receipt/control/balancing process upon receipt of a file to ensure that what was sent by the LDC is what the EDC received. Once the EDCs have checked the files, the "Received" portion of the Control Records will be populated, and a copy of the Control Record shall be sent back to the LDC and logged in the Control Record database. If the file balances, the Control Records will be stripped off and the file will be queued up to be pulled in to the next processing cycle. If file does not balance, "Received" portion of the Control Records will be populated, and a copy of the Control Record shall be sent back to the LDC and logged in the Control Record database. An alert will be sent to the LDC to indicate there is a problem with a file, and the bad ISA/IEA will be stripped out of the file. Once the LDC has identified and fixed the issues, they resubmit the bad ISA/IEA.

The Receipt/Control/Balancing process will also be in place for outbound Health Care Claim

Payment/Advice (835), and the Health Care Claim Status Request Response (277). The shared system maintainers (SSMs) will create the appropriate CMS defined flat file, based on transaction type. The CMS defined flat file will include the Control Records. The transactions will be sent to the MAC/CEDI local data center, where they will be passed through the receipt/control/balancing process to ensure if the CMS defined flat file is balanced. During the outbound translation process the MACs shall remove the control records prior to translating the CMS defined flat files to ASC X12 EDI format.

50.3.3 Acknowledgements

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The MAC's front end process uses the transaction appropriate CMS edits spreadsheet to determine whether an edit failure necessitates the rejection of the entire transaction set via the Interchange Acknowledgment (TA1) or Implementation Acknowledgment For Health Care Insurance (999) Reject (999R) edit, back to the submitter or whether those errors are accepted and passed onto the CEM for claim level rejection via the Health Care Claim Acknowledgement 277CA. Errors that the translator passes to the CEM are referred to as 999 Accept with errors noted (999E) edits.

The CEM will receive CMS defined 837 and 276 flat files from the A/B MAC's translator. The CEM will flag any 837 flat file data in error and will report that data back to the submitter via the 277CA. 276 flat file data in error will be reported back to the submitter via a 277 Claim Status Inquiry Response transaction. All accepted data will be sent to the SSM for processing.

1. *If the translator sets an edit that does not necessitate rejection of the entire ST-SE transaction set (999E edit), the contractor front end:*
    a. *Creates an 'STC' segment to document the error and inserts it into the 837 CMS defined flat file following the segment containing the error.*
    b. *Returns the Implementation Acknowledgment for Health Care Insurance 999 to the submitter indicating the affected ST-SE transaction was accepted with errors noted.*
    c. *Inserts a receipt date segment (+RC DTP segment) into the 837CMS defined flat file.*
    d. *Creates a skeleton (350 character space filled) Control Record (CTR segment) and, if desired, populates CTR17. The CTR is placed in front of each ISA segment.*
    e. *Submits the 837 CMS defined flat file containing STC error segments to the CEM.*

2. *If the translator does not set any edits, the contractor front end:*

    a. *Returns the Implementation Acknowledgment for Health Care Insurance 999 to the submitter indicating the affected ST-SE transaction was accepted.*

    b. *Inserts a receipt date segment (+RC DTP segment) into the 837 CMS defined flat file.*

    c. *Creates a skeleton CTR segment and if desired, populates CTR17. The CTR is placed in front of each ISA segment.*

    d. *Submits the 837 CMS defined flat file to the CEM.*

50.4 *CEDI – Unique Specifications for DME*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The Common Electronic Data Interchange (CEDI) contractor is the single front end solution for Durable Medical Equipment (DME) electronic transactions including X12 837 claims, NCPDP claims, 835 electronic remittance advice (ERA), 276 claims status requests, 277 claim status responses, and electronic front end reports.

CEDI receives inbound claims (X12 837 and NCPDP), performs all front end editing on the claims, and returns the reports showing accepted and rejected claims to the Trading Partner's CEDI mailbox.

The following front end reports will be returned by CEDI:

- *TRN for X12 version 4010A1 and 5010 837 and 276 transactions; NCPDP version 5.1 and D.0 transactions*
- *TA1 for X12 version 4010A1*
- *997 for X12 version 4010A1 837 and 276 transactions*
- *CEDI GenResponse for X12 version 4010A1 837 transactions*
- *999 for X12 version 5010 837 and 276 transactions*
- *TA1 for X12 version 5010 837 and 276 transactions (when requested)*
- *277CA for X12 version 5010 837 transactions*
- *277 claim status response for X12 version 4010A1 and 5010 transactions*
- *CEDI NCPDP Error Report for NCPDP version 5.1 transactions*
- *CEDI Submission Summary Report NCPDP version 5.1 transactions*
- *NCPDP Transmission Response NCPDP version D.0 transactions*
- *DME MAC Front End Report with accepted claims received and CMN rejections based on X12 4010A1 and 5010 claim submissions*

Claims accepted by CEDI are assigned the Claim Control Number (CCN) to be used by the DME MACs in processing the claim. CEDI translates the claims into the Medicare flat file format and delivers the claims to the appropriate DME MAC based on the beneficiary state code submitted on the claim.

CEDI receives inbound claim status requests (X12 276), performs all front end editing on the transactions, and returns the 277 showing accepted and rejected transactions. 276 transactions accepted by CEDI are translated to the Medicare flat file format and delivered to the DME MAC based on the contractor code submitted on the 276 file.

CEDI receives the DME MAC front end report showing claims received by the DME MACs as well as any CMN rejections and returns this report to the Trading Partner's CEDI mailbox.

CEDI receives the ERA (835) and Claim Status Response (277) flat file formatted transactions from the DME MACs, translates these to the X12 format and delivers them to the Trading Partner's CEDI mailbox.

50.4.1 CEDI Claim Numbering

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

CEDI will assign the CCN to accepted X12 and NCPDP claims utilizing the DME MACs defined range of CCNs. The CCNs are reported back to the Trading Partner on the front end reports and response files. On the 837 flat file, the CCN will be populated in the 2300 loop REF segment for that claim where REF01 = +CN. For NCPDP, the CCN will be populated in the Transaction Header Segment in positions 117-130.

If the number of accepted claims for a given DME MAC exceeds their defined threshold, CEDI will hold the claims in excess of the threshold to be delivered the next business day using the next business day's range of CCNs. Claims held will have the date of receipt when the CEDI received the claim.

50.4.2 CEDI Receipt Control and Balancing

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

CEDI, upon receiving a submitted 5010 837and/or NCPDP D.0 file from a Trading Partner, will run the file through their Commercial Off The Shelf (COTS) translator. The COTS translator creates a 5010 X12 837 or NCPDP D.0 flat file, includes a CTRD record for each ISA/IEA and each Batch Header/Trailer present, forwards the flat file to the EDC, and stores the CTRD record to a database.

The EDC updates the Receipt, Control and Balancing Detail Record (CTRD) creating a CTRD Response. This file is sent back to CEDI who in turn triggers an alert when an out of balance condition has been reported, matches the response to the original CTRD record and stores the updated record to a database. This process will check to be sure what was sent to the EDC is what the EDC received and to update the CTRD record. If it balances, the file continues along through the DME MACs VMS cycle. If it does not balance, the file will not continue. The CTRD record contained in the database is updated with the counts (which identifies which pat of the file

is out of balance). CEDI will review the CTRD response file for the out of balance reason and resolve the issue. If necessary, a CTRR resubmission will be sent.

50.4.3CEDI Acknowledgments for X12 5010 and NCPDP D.O. Transactions

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Trading Partners transmit their X12 5010 transactions and CEDI performs the following functions.

1. *CEDI front end performs Standard and Implementation Guide edits on the X12 837 claims. These edits include, but are not limited to, edits on the 837 Professional edit spreadsheet tagged for TA1, 997/999R and 997/999E responses. Please refer to the CMS website for a copy of the 837 Professional Edit spreadsheet.*
2. *CEDI uses the 837 Professional Edit spreadsheet to determine whether an edit failure necessitates the rejection of the entire 837 transaction set (999R edit) or whether those files should be passed on for further business validation editing, resulting in a claim level rejection via the 277CA (Claim Acknowledgment). Errors that the translator identifies at the 999 level and passes on for further business validation and 277CA issuance are referred to as 999E edits on the 837 Professional Edit spreadsheet.*
3. *If the 837 Professional Edit necessitates rejection of the entire ST-SE transaction set (999R edit), CEDI returns the 997/999 acknowledgment to the Trading Partner indicating the affected ST-SE was rejected. The transaction set is not passed for further processing.*
4. *If the 837 Professional Edit sets an edit that does not necessitate rejection of the entire ST-SE transaction set (997/999E edit), CEDI will:*
    a. *Return the 997/999 acknowledgment to the Trading Partner indicating the affected ST-SE transaction was accepted with errors.*
    b. *Continue with performing the 837 Professional Edits at the Business Validation level.*
    c. *Read the beneficiary state code submitted on the accepted claims for use in performing appropriate Business Validation editing (277CA) at the DME MAC level.*
    d. *If a 997/999E error is listed with a coordinating 277CA, any claims falling subordinate to the level at which the 999E error occurred will be rejected.*
5. *If CEDI does not set any 997/999E edits, CEDI will:*
    a. *Return the 997/999 acknowledgment to the Trading Partner indicating the affected ST-SE transaction was accepted.*
    b. *Continue performing the 837 Professional Edits at the Business Validation level.*
6. *After all 837 Professional Edits have been performed, and claims have successfully passed any 997/999R, 997/999E, or 277CA level editing, CEDI will:*
    a. *Assign the CCN to the accepted 837 claims.*
    b. *Insert a receipt date segment (+RC DTP segment) into the 837 flat file.*
    c. *Create a control record (CTR segment) containing the appropriate counts. The CTR is placed in front of each ISA segment on the 837 flat file.*
7. *CEDI will create the 277CA transactions to be returned to the Trading Partner, containing all 277CA errors that may have occurred at the 997/999E or Business Validation level.*
8. *CEDI will deliver the 837 flat files to the EDC for the appropriate DME MAC.*

Trading Partners transmit their NCPDP D.0 transactions to and CEDI performs the following functions.

1. *CEDI front end performs Standard and Implementation Guide edits on the NCPDP claims. These edits include, but are not limited to, edits on the NCPDP edit spreadsheet tagged for NCPDP Transmission Response.*
2. *CEDI uses the NCPDP Edit spreadsheet to determine whether an edit failure necessitates the rejection of the entire NCPDP batch or an individual claim.*
3. *CEDI will read the beneficiary state code submitted on the accepted claims for use in performing appropriate Business Validation editing at the DME MAC level*
4. *After all NCPDP edits have been performed, CEDI will assign the CCN to the accepted NCPDP claims.*
5. *CEDI will return the NCPDP Transmission Response showing accepted and rejected batches and individual claims as well as the CCN for all accepted claims.*
6. *Create the NCPDP flat file for each DME MAC with claims for their Jurisdiction.*
7. *CEDI will deliver the NCPDP flat files to the EDC for the appropriate DME MAC.*

50.5 *EDI Testing Accuracy*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

- Standard syntax testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits. Test files must pass 100 percent of the standard syntax edits before production is approved.
- IG Semantic Data testing validates data required for claims processing, e.g., procedure/diagnosis codes, modifiers. A submitter must demonstrate, at a minimum, a 95 percent accuracy rate in data testing before production is approved where, in the judgment of the *FI, Carrier, RHHI, A/B MAC, or CEDI*, the vendor/submitter will make the necessary correction(s) prior to submitting a production file. For FIs, the minimum 95 percent accuracy rate includes the front-end edits applied using the FISS implementation guide editing module.

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

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

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

Billing services and clearinghouses are not permitted to begin to submit or receive EDI transactions on behalf of a provider prior to submission of written authorization by the provider that the billing agent or clearinghouse has been authorized to handle those transactions on the provider's behalf. See Section 30 of this Chapter for further information on EDI Enrollment.

50.5.2 EDI Receiver Testing by FIs, Carriers, RHHIs, A/B MACs, and CEDI

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and CEDI are not required to test individuals who request use of outbound electronic remittance advice (ERA) or claim status transactions unless parties that request receipt of those transactions request pre-testing prior to production use of one or more of those outbound transactions. *FIs, Carriers, RHHIs, A/B MACs, and CEDI* may, at their discretion, require pre-production testing of outbound transactions if there is concern that

specific receivers could otherwise experience significant problems. *FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI* that did test successfully with certain receivers on current HIPAA version of the 837 for COB (*excluding CEDI)* or the 835 *(excluding DME MACs)* are not required to retest on version 4010A1 *5010* unless requested by a receiver. 837 COB testing is required with those trading partners prior to transmission of live COB data in the 837 *current HIPAA version 4010A1 5010*. Even if testing is not normally required, parties that want to begin receipt of an outgoing transaction supported by Medicare must notify their *FIs, Carriers, RHHIs, A/B MACs, DME MACs or CEDI* when to begin transmission of the HIPAA version of a specific outgoing transaction.

50.6 *Changes in Provider's System or Vendor's Software and Use of Additional EDI Formats*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Providers who receive or send transactions directly from/to more than one FI, Carrier, RHHI, A/B MAC, and/or CEDI, and billing services and clearinghouses that receive or send transactions from/to more than one FI, Carrier, RHHI, A/B MAC, and/or CEDI, must contact each FI, Carrier, RHHI, A/B MAC, and/or CEDI with which they receive/send EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional type of EDI transaction. A provider must also notify their FI, Carrier, RHHI, A/B MAC, and/or CEDI in writing (see EDI enrollment in Section 30 of this chapter) if they will begin to use a billing agent or clearinghouse for the first time, change a billing agent or clearinghouse, discontinue use of any billing agent or clearinghouse, or authorize a billing agent or clearinghouse currently used for some transactions to begin receiving additional transactions. A billing agent or clearinghouse representative is prohibited from signing an authorization on behalf of a provider to allow them to act as the sender or receiver of specific EDI transactions on behalf of a provider, even if a provider has signed a contract with the billing agent or clearinghouse for such services.

50.7 *Delimiters*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Delimiters – Inbound Transactions

As detailed in the HIPAA adopted X12 implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Medicare (inbound transmissions), these charters are determined by the submitter and can be any characters which are not contained within any data elements within the ISA/IEA Interchange Envelope. Please note, that the delimiters for NCPDP files are dictated by the transaction standard.

Delimiters – Outbound Transactions

Medicare will use the following delimiters in all outbound X12 transactions. Note that these characters will not be used in data elements within an ISA/IEA Interchange Envelope.

Delimiter	***Character Used***	***Dec Value***	***Hex Value***
Data Element Separator	*	*62*	*3E*
Repetition Separator	^	*94*	*5E*
Component Element Separator	:	*43*	*2B*
Segment Terminator	~	*126*	*7E*

50.8 *Nulls (reserved)*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

50.9 *Direct Data Entry (DDE) Screens*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

HIPAA does not require, but does permit payers to maintain DDE screens for claim submission, correction, claim status determination, and eligibility verification. A *MACs /*FIs are required to maintain claim submission, claim correction and claim status screens, but not Medicare carriers or *DME MACs. This section is applicable to claim entry and claims correction* (see chapter 31 for DDE requirements *for formats other than claims)*.

Medicare considers transactions conducted via DDE screens to meet HIPAA-compliancy requirements. DDE claims are considered HIPAA-compliant EDI transactions for application of the 14-day payment floor. (See section *60.2.3* of this chapter for further FI DDE information.)

Data entered via DDE screens are not subject to the syntax (format) requirements of the standards, but must meet "applicable data content" requirements for comparable HIPAA transactions. *A MACs/*FIs may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA. DDE systems are proprietary by definition. They are a direct link between a particular health plan (Medicare) and its providers, and the software (and sometimes hardware) is unique to and maintained by the plan. The widespread use of the

standard HIPAA transactions should make it economically feasible for more providers to procure or develop their own EDI products that can be used with all plans. The use of DDE should decrease over time as a result. The requirement for "applicable data content" is meant to facilitate that eventual conversion. Adopting the data content requirements of HIPAA in DDE screens will facilitate eventual migration of providers from DDE to use of EDI transaction software (or to use of a clearinghouse). This will also permit maintenance of DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, "applicable data content" means shared system-maintained DDE screens must:

- Collect all data elements that are required in the IG as well as those situational elements that are needed for Medicare processing (unless the data is already available to the payer's system);
- Use only the internal and external code sets designated in the IG with no additions or substitutions;
- Provide for at least the field size minimums noted in the IG, but no more than the maximum sizes (Do not expand the size of a shared system's internal claim records);
- Permit at least the minimum number of field repeats noted in the IG, but no more than the maximum number;
- Allow for only one investigational device exemption number (IDE) per claim (at the claim level);
- Remove employment status code, employer name, and employer address information;
- Allow Other Subscriber Demographic Information (date of birth and gender) if the other subscriber is a person;
- Allow for discharge hour and minute information in the numeric form of HHMM; and
- Allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

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

NOTE: See section *60.2.3* for additional DDE edit requirements.

50.10 *Additional documentation Submitted Via Paperwork (PWK) Segment*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

50.10.1 PWK Background

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

In the current CMS claims processing environment, providers have to wait to receive requests for additional information, called automated development request letters, in order to provide additional documentation necessary for the adjudication of their claims. This "solicited" method of requesting documentation adds unnecessary extra days to claims processing. Beginning with the 5010 version of the ASC X12 837I and 837P (electronic healthcare claim transaction), electronic billers can utilize a new methodology for providing CMS with their additional documentation which is required for claims adjudication. This new methodology involves submission of the PWK segment (paperwork) in the 837 to indicate "unsolicited" claim-related documentation is forthcoming.

50.10.2 PWK Workflow

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The PWK segment is the "electronic staple" which connects paper documentation to an electronic claim. Claims are submitted electronically with the PWK segment populated. The additional documentation is then submitted to the FIs, Carriers, RHHIs, A/B MACs, DME MACs or CEDI at the same time or within close proximity of the electronic claim. If needed, the FIs, Carriers, RHHIs, A/B MACs, DME MACs or CEDI will use the additional documentation in their adjudication of the claim. If the claim does not require additional documentation, the claim will be adjudicated without reviewing the additional documentation. If the additional documentation is not received or provides no value, the claim will be handled as it normally would have if the PWK data not been submitted.

50.10.2.1 *Provider Responsibility*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Providers that wish to utilize the PWK process to submit their additional documentation will be required to use a specially designed cover sheet which will be provided to them by their servicing FIs, Carriers, RHHIs, A/B MACs, or DME MACs. Contact your servicing FIs, Carriers, RHHIs, A/B MACs, or DME MACs for details on how/where to obtain the cover sheet. These cover sheets will be required to be completely and accurately filled out or they will be manually returned. It is important to note that the FIs, Carriers, RHHIs, A/B MACs, or DME MACs is not required to return your additional documentation along with the cover sheet. In the instance where the coversheet is returned due to inaccurate or

incomplete information, the claim will be adjudicated according to the normal CMS business policies and procedures without regard for the additional documentation received.

When submitting an electronic claim, the submitter must indicate in the body of the electronic claim their intention to submit additional documentation (at the claim level, line level, or both) along with their claim. This is done by indicating the following in the electronic claim: the PWK elements PWK01 (attachment type), PWK02 (transmission method), PWK05 (the value AC), and PWK06 (a 1-50 byte attachment control number [ACN] of the provider/claim submitter's choosing). PWK data submitted at the claim level will apply to the whole claim, unless overridden at the detail line level. Line level PWK data will only apply to that particular detail line of the claim. Electronic claims submitted with an improperly formatted PWK segment will be rejected back to the submitter via either a 277CA (claims acknowledgement) or a 999 depending on the nature and location of the error. Although the 837 transaction allows for up to 10 iterations of the PWK at both the claim and line level, only the first iteration of the PWK segment will be utilized for claim adjudication. Additional iterations of the PWK segment beyond one will be stored by the claims processing contractor to which the claim was submitted.

Once the electronic claim has been submitted with the PWK, provider/claim submitters are expected to submit their additional documentation as soon as possible. Providers will be required to either fax or mail their additional documentation to the FIs, Carriers, RHHIs, A/B MACs, or DME MACs. The only exception will be for those FIs, Carriers, RHHIs, A/B MACs, or DME MACs which are part of an approved CMS electronic attachment pilot. In that case, your FIs, Carriers, RHHIs, A/B MACs, or DME MACs will notify you of other acceptable methods for submitting your additional documentation. As a rule, the provider/claim submitter is required to provide the additional documentation within 7 calendar days, if utilizing fax, or within 10 calendar days, if utilizing mail. After the 7/10 day waiting period expires, the claim will be adjudicated according to the normal CMS business procedures and policies in place at the time. Documentation submitted late will not be considered for adjudication but will be imaged and sent off for storage as per normal CMS correspondence retention requirements.

50.10.2.2 *Contractor Responsibility*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and DME MACs will be required to establish dedicated fax lines and Post Office boxes for provider/claim submitters to utilize for providing the additional documentation. FIs, Carriers, RHHIs, A/B MACs, and DME MACs will provide the education and outreach support to provider/claim submitters on how to utilize the PWK process.

The FIs, Carriers, RHHIs, A/B MACs, and DME MACs shall provide the coversheet to the provider/claim submitter in whatever manner they feel provides the most effective and efficient method for providing the cover sheet. If the coversheet is not completely and accurately filled out, the FIs, Carriers,

RHHIs, A/B MACs, and DME MACs shall return the coversheet to its originator. FIs, Carriers, RHHIs, A/B MACs, and DME MACs shall indicate that the cover sheet is being returned for incomplete/inaccurate completion and the documentation is not being taken into consideration for the purpose of claims adjudication. The FIs, Carriers, RHHIs, A/B MACs, and DME MACs is free to choose the method of returning the cover sheet which they feel best suits their business operation. It is important to note that the FIs, Carriers, RHHIs, A/B MACs, and DME MACs is not required to return the additional documentation along with the cover sheet. The FIs, Carriers, RHHIs, A/B MACs, and DME MACs is to follow their current correspondence retention requirements and processes regarding the controlling and storage of the additional documentation (whether the documentation is utilized for claims processing assessment or not). If the provider/claim submitter cannot be identified by the FIs, Carriers, RHHIs, A/B MACs, and DME MACs thus making it impossible to return the cover sheet, the documentation will be imaged and sent off for storage as per normal CMS correspondence retention requirements. Documentation submitted late will not be considered for adjudication but will be imaged and sent off for storage as per normal CMS correspondence retention requirements.

Additional documentation received by FIs, Carriers, RHHIs, A/B MACs, and DME MACs via the PWK process will be imaged and made available for view and/or retrieval by claims examiners/medical review staff. FIs, Carriers, RHHIs, A/B MACs, and DME MACs staff adjudicating claims will only review PWK data when the claim encounters an edit/audit requiring additional documentation. The presence of the PWK indicator within the shared system will alert contractor staff that there is additional documentation which potentially may be used to adjudicate the claim. It is important to note that the simple presence of the PWK on a claim will not cause the claim to suspend.

When FIs, Carriers, RHHIs, A/B MACs, and DME MACs staff encounters an edit or an audit within the shared system that could be affected by additional documentation, they will first look to see if a PWK was submitted on the claim. If there is a PWK present, they will retrieve the appropriate additional documentation from their imaging system and review it. If the additional documentation contains the needed information, the FIs, Carriers, RHHIs, A/B MACs, and DME MACs will adjudicate the claim accordingly and flag the claim as dirty. If the additional documentation does not contain the needed information, the claim will then be handled according to the normal CMS business procedures and policies in place at the time. Regardless of whether or not the PWK additional documentation is utilized in adjudicating the claim, the waiting days will not count against the contractor's claims processing timeliness (CPT).

60 *EDI Edit Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

60.1 *FIs, Carriers, RHHIs, A/B MACs, and CEDI Edit Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs, and CEDI are required to edit submitted transactions at the front end to determine whether they are sufficiently complete to enable processing. Transactions that are not legible, or do not include adequate data to be considered an acceptable EDI transaction, must be rejected or returned as unprocessable. "Rejected" or "returned" transactions are not classified as "received" by Medicare.

FIs, Carriers, RHHIs, A/B MACs, and CEDI are not required to assign a control number or a receipt date to those transactions *rejected or returned as unprocessable*. Nor are they required to retain any record of those transactions pending correction and resubmission by the original sender. *See § 50 and § 70* of this chapter for further editing and testing requirements.

CEDI is required to assign a control number and a receipt date to those claims transactions accepted by CEDI. They are required to retain any record of those originally submitted transaction pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

A. X12 997/999 Functional Acknowledgment

This subsection is being retained as applicable to current version 4010 submissions for the 997 functional group acknowledgment. For version 5010 submissions and beyond, section 50 provides a description of the use of the 999 functional group acknowledgment, and specific editing requirements are provided in the 837 Institutional and Professional edits spreadsheets found at http://www.cms.gov/ElectronicBillingEDITrans/. Future updates to this subsection are reserved for relevant 999 editing requirements should they be needed.

Syntax errors prevent processing of the data that follow the error within the same functional group or the same transaction set header in a batch. For purposes of these editing requirements, a transmission of only a single transaction, such as one claim, is considered a batch of one. Syntax errors appear high in the data hierarchy in a batch and apply to all lower level data included in either the same functional group (GS-GE, see the AK1and AK9 segments of the X12 997) or transaction set (ST-SE, see the AK2 and AK5 segments of the X12 997). Although not a HIPAA requirement, CMS requires *FIs, Carriers, RHHIs, A/B MACs, and CEDI* to issue an X12 997 to submitters of X12 4010 transactions when syntax errors are detected to facilitate correction of the errors and resubmission by the submitter of the original batch. CMS also requires *FIs, Carriers, RHHIs, A/B MACs, and CEDI* to issue an X12 997 to acknowledge receipt of a claim for which there are no errors.

The X12 997 requirements are contained in appendix B at the rear of each version 4010A1 IG adopted as a national standard under HIPAA. Appendix A of those guides contains information

on the interchange and application control structures used in the design of X12 standards, explains the basic structure of each X12 transmission, and further defines differences between syntax and semantic edits. Translators must reject all transactions contained in the same functional group of a batch when there is a functional group syntax error, and all transactions within the same transaction group header when there is a syntax error at that level.

B. Translation and Date of Receipt Editing

If a shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (*FIs, Carriers, RHHIs, A/B MACs, and CEDI*) by the shared system with an appropriate error message.

The date of receipt of a claim is the date a claim is received by the *FIs, Carriers, RHHIs, A/B MACs, and CEDI* and not a subsequent date on which the claim may have been received by the shared system. The date of receipt must be an actual calendar date and may not be all zeroes or a future date. See § 80.2.1 of Chapter 1 of this manual for additional information on establishing the date of receipt of a claim.

C. Implementation Guide Edits

1. Implementation Guide Edits ASC X12 Version 005010 and NCPDP D.0

In conjunction with front-end translation, FIs, *RHHIs, and A MACs* are to also conduct IG edits to identify submitted data elements that do not comply with data element requirements added by the IG developers, using either software available from FISS or other software which is able to edit at this level. Carrier and *B MAC* shared systems conduct IG edits for transactions sent to the Carriers and B MACs. *CEDI conducts IG edits for transactions sent to the DME MACs*.

In many cases, IG edits are more restrictive than those established by the X12 standard that served as the platform for development of the IG. For instance, the X12 standard might allow a maximum of 30-digits in a data element, but an IG note could limit the maximum size to 20-digits. Or the number of valid digits that may be entered in a data element as identified by the qualifiers that apply to the data element, might not permit reporting of more than 15-digits even though the standard permits up to 30-digits.

No national standards have been adopted under HIPAA for acknowledgement or error reporting for any of the HIPAA format transactions. *However, Medicare has adopted the 999 and 277CA for this purpose effective with the implementation of version 5010. Until that that time, FIs, Carriers, RHHIs, A/B MACs, and CEDI*, and shared system maintainers are allowed to continue to use the proprietary format *being* used *for current versions*, to notify submitters of EDI transactions when one or more IG requirements were not met. *The one*

exception to the elimination of proprietary error reporting with the implementation of 5010 is the continuation of DME MACs to produce their proprietary CMN rejection reports, which are returned to DME submitters through CEDI. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, *FIs, Carriers, RHHIs, A/B MACs, and CEDI* are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

FIs, *RHHIs, and A MACs* share IG editing responsibilities with FISS (shared system documentation indicates which IG edits are conducted by the shared system). Carriers and *B MACs* shared systems are responsible for IG editing of Part B professional transactions. *CEDI is responsible for IG editing of DME transactions*. When editing for IG compliance, the responsible party must verify that:

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;
- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;
- All non-Medicare data field lengths correspond to the maximum IG length.
- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;
- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size; and
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system).

2. Implementation Guide Edits ASC X12 Version 004010, Version 004010A1 and NCPDP 5.1

CMS' Implementation for ASC X12 Version 004010 and Version 0040101A1 transaction sets in conjunction with front-end translation, FIs, *RHHIs, and A MACs* are to also conduct IG edits to identify submitted data elements that do not comply with data element requirements added by the IG developers, using either software available from FISS or other software which is able to edit at this level. Carrier and *B MAC* shared systems conduct IG edits for transactions sent to the Carriers and B MACs. *CEDI conducts IG edits for transactions sent to the DME MACs*.

In many cases, IG edits are more restrictive than those established by the X12 standard that served as the platform for development of the IG. For instance, the X12 standard might

allow a maximum of 30-digits in a data element, but an IG note could limit the maximum size to 20-digits. Or the number of valid digits that may be entered in a data element as identified by the qualifiers that apply to the data element, might not permit reporting of more than 15-digits even though the standard permits up to 30-digits.

No national standards have been adopted under HIPAA for acknowledgement or error reporting for any of the HIPAA format transactions. Shared system maintainers are allowed to continue to use the proprietary format *being* used *for current versions*, to notify submitters of EDI transactions when one or more IG requirements were not met. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, *FIs, Carriers, RHHIs, A/B MACs, and CEDI* are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

FIs, *RHHIs, and A MACs* share IG editing responsibilities with FISS (shared system documentation indicates which IG edits are conducted by the shared system). Carriers and *B MACs* shared systems are responsible for IG editing of Part B professional transactions. *CEDI is responsible for IG editing of DME transactions*. When editing for IG compliance, the responsible party must verify that:

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;
- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;
- All non-Medicare data field lengths correspond to the maximum IG length.
- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;
- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size;
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system); and
- All decimal data elements are defined as “R” and translators write these data elements to the X12-based flat file at their maximum field size (which is initialized to spaces). The COBOL picture found under the X12 element name must be used to limit the size of the amounts. These positions must be right justified and zero-filled. Contractor translators must convert signed values using the conversion table shown below. This value must be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the X12-based flat file data element is used as a placeholder by Medicare to report an error code if an “R” defined data element exceeds

the limitation that the Medicare system is authorized to process. The error code values are:

- "X" = value exceeds maximum amount based on the COBOL picture,
- "Y" = value exceeds maximum decimal places based on the COBOL picture,
- "Z" = value exceeds x-number of precision places, and
- "b" blank represents no error.

For example, a dollar amount with the IG maximum of 18-digits would look like 12345678.90. The contractor translator maps this amount to the X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount looks like 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0." The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

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

60.2 *Claim Implementation Guide Edits*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

60.2.1 FIs, Carriers, RHHIs, A/B MACs, and CEDI HIPAA Claim Level Edits

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

A. IG Edit Module

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

ISA (example 1)
GS (example 2)
ST (example 3)
PROV A
SUBSCRIBER A (example 5)
CLAIM A1 (example 6)
CLAIM A2
CLAIM A3
SUBSCRIBER AA
CLAIM AA1
CLAIM AA2
PROV B (example 4)
SUBSCRIBER B
CLAIM B1
CLAIM B2 (example 6)
CLAIM B3

SE
ST
PROV C
SUBSCRIBER C
CLAIM C1
CLAIM C2
CLAIM C3 (example 6)
PROV D
SUBSCRIBER D
CLAIM D1
CLAIM D2
CLAIM D3
SE
GE
IEA

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

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

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

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

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

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

B. Additional *Part A* IG Edits

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

2. Each FI must operate an edit module developed by the shared system maintainer to edit 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X outpatient (as defined in Pub. 100-04 Transmittal 107, CR 3031) type claims to ensure each contains a line item date of service (LIDOS) for each (Revenue code. Claims not containing a LIDOS for each (Revenue code shall be rejected back to the submitter with an appropriate error message, and not forwarded to the shared system.

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

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

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

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

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

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

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

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

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

60.2.2 X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

60.2.3 X12N 837 Institutional Implementation Guide and Direct Data Entry Edits

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

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 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.

60.2.4 Supplemental FI-Specific Shared System Edit Requirements

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

A. FI Edits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. FISS DDE Edit Requirements

1. Edit bill types 12X and 22X to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via

DDE (these are already required for other inpatient bill types). Claims not containing this data shall be identified as an error with an appropriate error message.

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

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

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

5. Effective October 1, 2004, edit all claims submitted via DDE to detect invalid E-codes (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims found containing an invalid E-code shall be identified as an error with an appropriate error message.

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

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

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

60.3 *Claim Implementation Guide Edits – Part B and DME*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

60.3.1 X12N 837 Professional Implementation Guide (IG) Edits

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

This subsection is being retained as applicable to current version 4010 edits. For version 5010 edits and beyond, section 50 provides a description of the function of the CEM where these edits will occur.

For detailed information on version 5010 edit requirements see Medicare's transaction specific edits spreadsheets at https://www.cms.gov/ElectronicBillingEDITrans.

1. Carriers, *B MACs and CEDI* must reject inbound electronic claims that contain invalid diagnosis codes whether or not pointed to a specific detail line.

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

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

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

60.3.2 National Council for Prescription Drug Program (NCPDP) Implementation

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

A. NCPDP Implementation Guide (IG) Edits

The DME MAC must allow segments to be submitted in any order including the AM07, AM03 and AM11 according to the NCPDP standard. *CEDI must create the NCPDP flat file segments in numeric order for receipt by the DME MACs shared system maintainer.*

B. NCPDP Narrative Portion of Prior Authorization Segment

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

60.4 *Key Shop and Optical Character Recognition*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

A/B MAC and DME MAC key shop operations, that do not output directly in the HIPAA 837 or X12N-based flat file as output, must convert the initial output from paper claims to the X12N-based flat file format or the HIPAA 837 prior to transmission to their datacenter. When the X12N-based flat file is the output the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (key shop) or "O" (OCR/ICR).

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

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

60.4.2 Key Shop and Image Processing

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

An outbound 837 COB transaction built from a paper claim will be produced as a "skinny" COB. Gap filling must occur as needed to enable the file sent to the trading partner to meet minimum

data set requirements for a compliant 837 COB transaction. "Skinny" COBs shall contain all required 837 segments and include post-adjudicated data.

60.5 *COB Trading Partner and Contractor Crossover Claim Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Through the Coordination of Benefits Contractor (COBC), Medicare transmits outbound 837 Coordination of Benefit (COB) and Medigap claims COB trading partners and Medigap plans, collectively termed "trading partners," on a post-adjudicative basis. This type of transaction, originating at individual Medicare contractors following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All Medicare contractors are required to accept all 837 segments and data elements permitted by the in- force applicable guides on an initial 837 professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the Medicare contractor within its store-and-forward repository (SFR). Incoming claims data shall be subjected to standard syntax and applicable implementation guide (IG) edits prior to being deposited in the SFR to assure non-compliant data will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an 837 IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

(See IOM Pub 100-04, Chapter 28 Sections §70.6 and 70.6.5 for 5010 COB requirements and §70.6.6 for NCPDP D.0 COB requirements.)

60.6 *Remittance Advice and Standard Paper Remittances*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Remittance advice records shall be provided to explain claim adjudication decisions, including for NCPDP format claims. *FIs, Carriers, RHHIs, A/B MACs, and CEDI* shall send the Electronic Remittance Advice (ERA) in the ANSI ASC X12N 835 format. *Or the FIs, Carriers, RHHIs, A/B MACs, and DME MACs* shall send the remittance 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.

60.7 *Payments*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

60.7.1 Payment Floor Requirement

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

60.7.2 Alternative to EFT

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

60.7.3 Electronic Funds Transfer (EFT)

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

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

An FI, Carrier, RHHI, A/B MAC, or DME MAC shall use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an

X12 835 transaction, then FIs, Carriers, RHHIs, A/B MACs, and DME MACs shall use National Automated Clearinghouse Association (NACHA) format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) to make sure that the addenda record is sent with the EFT. Providers need the addenda record to *re-associate* dollars with data. FIs, Carriers, RHHIs, A/B MACs, and DME MACs shall transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They shall designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

For more information on EFT see IOM Pub 100-08 Chapter 10.

60.7.4 Tri-Partite Bank Agreement

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

60.8 *Health Care Provider Taxonomy Code (HPTC) Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Health Care Provider Taxonomy Codes (HPTC) are also called Specialty Codes. HPTCs are 9-digit identifiers assigned by the National Uniform Claim Committee (NUCC) to be used in HIPAA transactions.

FIs, Carriers, RHHIs, A/B MACs, and CEDI are required to validate the incoming HPTC against the most recent taxonomy code list. CMS will notify FIs, Carriers, RHHIs, A/B MACs, CEDI and their shared system maintainers (via Recurring Update Notification) to load the most recent HPTC code list into a contractor-controlled table designed by the shared system maintainer. HPTCs may not be hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future system updates.

HPTCs are updated twice a year (tentatively October and April) by the NUCC and the updates are available for download in a portable document format (PDF) from the Washington

Publishing Company (WPC) for no charge at www.wpc-edi.com/codes, or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. FIs, Carriers, RHHIs, A/B MACs, and CEDI are to use the most cost effective means to obtain the list for validation programming and updating purposes.

70 *CMS Defined File Formats*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

70.1 *General HIPAA EDI Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The following HIPAA transaction standards shall be supported by the *FIs, Carriers, RHHIs, A/B MACs, DME MACs, and CEDI* 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) current HIPAA version *f*or 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 current HIPAA version and Batch Standard for retail prescription drug claims (applicable for CEDI and 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 current HIPAA version *f*or 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 current HIPAA version *f*or 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 *FIs, Carriers, RHHIs, A/B MACs, and CEDI* issue an X12 *997/999* 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.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing Medicare claim 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.
An overview of any changes to existing specifications, including effective dates will be issued to providers via *FIs, Carriers, RHHIs, A/B MACs, and CEDI* bulletins, on contractor Web pages, and will also be available via the Internet as Manual transmittals which can be viewed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp to the separate page for each EDI transaction format supported by Medicare fee-for-service plans.

70.2 *National Council for Prescription Drug Program (NCPDP) Claim Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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. CEDI 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 submitted to CEDI and delivered to the *DME MACs* via the NCPDP standard. The DME MAC 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

CEDI 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. *CEDI* 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. *CEDI* will send up to 5 reject codes for claim transactions (line items) that have detail errors.

4. *No transaction level reject code will be reflected for the line item with no error. Instead, the 504-F4 response message field at the header level is being used to denote acceptance or rejection of the entire claim.*

5. *Only the claim that rejected will have the reject codes other than 84. When a transaction level error occurs, the reject code will only be used in conjunction with the actual line item in error.*

C. NCPDP Implementation Guide (IG) Edits

CEDI shall allow segments to be submitted in any order including AM07, AM03 and AM11 as permitted by the NCPDP standard. CEDI must create the NCPDP flat file segments in numeric order for receipt by the DME MACs shared system maintainer.

D. NCPDP Narrative Portion of Prior Authorization Segment

Certain informational modifiers are required to identify compound ingredients in locally prepared medication. The NCPDP *v5.1* format does not currently support reporting modifiers in the compound segment. Therefore, the narrative portion in the prior authorization segment *498-PP position 355-454* is being used to report these modifiers. The following shall be entered in positions 001-003 of the *498-PP segment* narrative (Example, MMN or MNF). Starting at position 355, indicate the two-byte ingredient number followed by the two-position modifier:

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

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

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

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

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

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

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

E. Misdirected Claims

With the implementation of CEDI, there are no longer "mis-directed" claims. CEDI receives all DME X12 and NCPDP claims, performs all front end editing and translation. Claims accepted by CEDI are assigned the Claim Control Number and delivered to the appropriate *DME MAC* based on the beneficiary state code submitted on the claim.

80 *Electronic Data Interchange (EDI) Reporting Requirements*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Contractors are required to participate in the following EDI reporting efforts as appropriate for their line of business. Each reporting effort has its own defined content and reporting frequency.

80.1 *Contractor Reporting of Operational and Workload (CROWD) Reporting*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

The Contractor Reporting of Operational and Workload (CROWD) is a system that provides CMS automated capabilities for monitoring and analyzing data relating to the Medicare contractors' on-going operational activities. Contractors are required to input their Electronic Data Interchange (EDI) workload statistics into CROWD. Specifically, this data is input into CROWD Form 5. Contractors must prepare and submit to CMS the Medicare Contractor Transaction Report (CROWD Form 5) showing their Electronic Data Interchange (EDI) and manual transactions workload under the health insurance program. A separate report is required for each office assigned a separate contractor number.

Contractors shall reference Pub 100-06, Chapter 6, Section 450 for the complete details and requirements on CROWD Form 5.

80.2 *Common Edits and Enhancement Module (CEM) Reporting*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

FIs, Carriers, RHHIs, A/B MACs are required to support a vigorous reporting system which will provide a full range of routine and ad hoc workload reports and operational reports regarding Electronic Data Interchange (EDI) activities. The types of reports which are required include but are not limited to daily EDI workload statistics, edit exceptions, receipt-control-balancing, provider and submitter transaction version utilization data, transmission and receipt problems, etc.

FIs, Carriers, RHHIs, A/B MACs will utilize the reporting functionality in the CEM to provide CMS with their EDI operational reports.

80.3 *Common Electronic Data Interchange (CEDI) Reporting*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

CEDI is required to support a vigorous reporting system which will provide a full range of routine and ad hoc workload reports and operational reports regarding Electronic Data Interchange (EDI) activities. The types of reports which are required include but are not limited to daily EDI workload statistics, edit exceptions, receipt-control-balancing, provider and submitter transaction version utilization data, transmission and receipt problems, etc.

DME MACs will utilize the reporting functionality in the CEDI to provide CMS with their EDI operational reports.

80.4 *HIPAA Transition Reporting*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

As new HIPAA versions are named, contractors are required to report their implementation progress to CMS via transition reporting. Data collection will be achieved via an external, secure web-based reporting tool designed to support long term, short term, and ad-hoc data gathering efforts, such as Electronic Data Interchange statistics and performance metrics.

The contractor shall obtain access to the web-based reporting tool via self enrollment contingent on CMS approval. Current reports vary in frequency from weekly to monthly; however, any future efforts will reflect the most appropriate time period. Contractors will always be notified via Joint Signature Memorandum (JSM) on the required starting date of any transition reporting, the content of the transition data, and the frequency of the reporting effort.

Contractors will utilize the reporting functionality in their front end systems, in CEM, and/or in CEDI to provide CMS with their EDI HIPAA transition reports.

80.5 *Administrative Simplification and Compliance Act (ASCA) Reporting*

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Contractors are required to report the status of their ASCA enforcement activities on a monthly basis. ASCA enforcement data will be submitted via an external, secure web-based reporting tool.

The contractor shall obtain access to the web-based reporting tool via self enrollment contingent on CMS approval. Contractors will always be notified via Joint Signature Memorandum (JSM) of any changes in the reporting requirements of the ASCA enforcement reporting, the content of the ASCA enforcement data, and the frequency of the ASCA enforcement reporting effort.

Contractors shall reference Pub 100-04, Chapter 24, Section 90 for the complete details and requirements on ASCA enforcement.

90 Mandatory Electronic Submission of Medicare Claims

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

Medicare is prohibited from payment of claims submitted in a non-electronic manner that do not meet the limited exception criteria. Claims required to be submitted electronically effective October 16, 2003, and later must comply with the appropriate claim standards adopted for national use under HIPAA (see section 70 of this chapter). The mandatory electronic claim submission requirement does not apply to claims submitted by beneficiaries or by providers that only furnish services outside of the United States, claims submitted to Medicare managed care plans, or to health plans other than Medicare.

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

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

A “small provider” is defined at 42 CFR section 424.32(d)(1)(vii) to mean A) a provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or B) a physician, practitioner, facility or supplier that is

not otherwise a provider under section 1861(u) with fewer than 10 FTEs. To simplify implementation, Medicare considers all providers that have fewer than 25 FTEs and that are required to bill a Medicare *FI, RHHI or A MAC* to be small; and considers all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a *Carrier, B MAC or DME MAC* to be small.

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

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

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

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider (as identified by provider number, UPIN, or national provider identifier (NPI) to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers may bill *FIs, Carriers, RHHIs, A/B MACs or, DME MACs*. All have

separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

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

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

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

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission

of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

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

90.2 Exceptions

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

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

   It is in the interest of Medicare and public health to make it as simple as possible for mass inoculation activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required except in the case of multi-state companies that signed an agreement with a single Medicare contractor for submission of all flu shots to that single contractor for

those states, and who agreed to submit those claims electronically as a condition for centralized billing of those inoculations. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for inoculations.

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

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

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

The OTAF is identified in the CAS Segment with the Group Code of "CO". The CO is used both on the X12 835 remittance and the 837 claim.

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

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

5. Home Oxygen Therapy Claims for Which the CR5 Segment is Required in an X12 837 current HIPAA version Claim but for Which the Requirement Notes in Either CR513, CR 514 and /or CR 515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. -– Completion of these data elements as required in the X12 837 professional IG is an assertion that the required condition for inclusion of these data elements is met. Non-completion of these data elements, however, cannot be interpreted as a statement that the required condition for inclusion of these data elements is not met. There is no means to answer "no," enter the actual oxygen saturation rate or the arterial PO2 measurement, but a patient can sometimes qualify for oxygen even if each of these conditions is not met.

This will be corrected in *future HIPAA versions* of the IG, but until that is implemented, covered entities are permitted to submit their claim to Medicare on paper in this situation. *Following the implementation of HIPPA version 5010 this exception would be invalid.*

Although the outcome logic will remain unchanged in future X12 versions of the 837, what will change is the ability to indicate a "No" response in the FRM segment, questions 7-9. An additional change in future versions of the 837 involve an adjustment to acceptable range values for PO2 and oxygen saturation; PO2 range will be 56 thru 59, and oxygen saturation thresholds will be defined as greater than or equal to 89.

6. Claims submitted by Medicare beneficiaries.

90.3 "Unusual Circumstance" Waivers

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

CMS has in turn delegated certain authority to the *FIs, Carriers, RHHIs, A/B MACs, or DME MACs* to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the *FIs, Carriers, RHHIs, A/B MACs, or DME MACs* to whom they submit their claims. The *FIs, Carriers, RHHIs, A/B MACs, or DME MACs* must issue a form letter (Exhibit A) in the event of receipt of a written waiver request that does not allege an "unusual circumstance."

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

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

90.3.1 Unusual Circumstance Waivers Subject to Provider Self-Assessment
(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

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

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

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

90.3.2 Unusual Circumstance Waivers Subject to Evaluation and CMS Decision

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

A provider may submit a waiver request to their *FI, Carrier, RHHI, A/B MAC, or DME MAC* claiming other types of "unusual circumstances" outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit documentation appropriate to establish the validity of a waiver request in this situation. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the *FI, Carrier, RHHI, A/B MAC, o, DME MAC* agrees that the waiver request has merit, the request must be forwarded to the Division of Transactions, Applications & Standards/BAMG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 for Review and issuance of the decision. The contractor

must forward an explanation as to why contractor staff recommends CMS approval to DTAS with the waiver request. The contractor will be copied on the decision notice DTAS issues to the requestor.

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

"Unusual Circumstances" that Require CMS Review:

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

   NOTE: A Medicare contractor is not permitted to prohibit submission of an electronic claim because there is a paper attachment. The X12N 837 IG contains information for provider use of the PWK segment to alert a Medicare contractor that attachment information is being separately submitted. Some Medicare contractors had issued instructions regarding use of the X12 837 NTE segment to report attachment information in lieu of PWK. Submitters of claims for which there are attachments essential for adjudication must comply with the X12 attachment reporting direction issued by their Medicare contractor for the immediate future. System changes will be made for contractor use of PWK in conjunction with implementation of the attachment standard which is scheduled for future adoption as a HIPAA standard. NCPDP claims should not have attachments.

   Medicare contractors are required to accept claims electronically for reassociation with attachments submitted separately on paper or via other means such as fax when supported by individual contractors. Medicare contractors must include the process for submission of claims when there are attachments in a newsletter article and on their Web site with other applicable information concerning the ASCA requirement that Medicare claims be submitted electronically.

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

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

90.4 Electronic and Paper Claims Implications of Mandatory Electronic Submission

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

FIs, Carriers, RHHIs, A/B MACs, and DME MACs are prohibited from requiring submission of paper claims in any situations on or after October 16, 2003, except as specifically permitted by CMS.

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

90.5 Enforcement

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

Enforcement will be conducted on a post-payment basis during those periods when directed by CMS. FISS will prepare quarterly reports for the FIs and A (A part of A/B) MACs 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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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 *Carriers, B MACs, and DME MACs* 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, B MAC, and DME 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, *Carriers, B MACs, and DME MACs* tracking of report history, and selection of providers for ASCA Enforcement Reviews:

1. 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);

2. 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 and an ASCA result has not been entered , or a contractor shall reset that date to the date after an approved extension period expires; see §90.5.3.B);

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

   Result of the most recently completed ASCA enforcement review—The ASCA review result field is used for contractor entry of a 2-character code to identify the result of an ASCA review. 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);

4. When one of the following applies, the later of 1) the date the most recent ASCA enforcement review began or 2) 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:

   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; effective date of the provider's most recent ASCA enforcement review decision; 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; effective date of the provider's most recent ASCA enforcement review decision; 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; effective date of the provider's most recent ASCA enforcement review decision; 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 *Carrier, B MAC, and DME MAC* completes that block/field, the shared system will notify the *Carriers, B MACs, and DME MACs* 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, B MAC, and DME MAC* to cancel the block/field for issuance of letter C or H in the event completed in error, as long as the correction is made on the same business day as the erroneous entry.

90.5.3 Contractor Roles in ASCA Reviews

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

A. Identification of Those Providers to be Reviewed

Separate funding will no longer be issued for these reviews annually. Each Carrier, B (B part of A/B) MACs, and DME MAC shall conduct an ASCA review annually of 20% of those providers still submitting paper bills.

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 an enforcement decision effective 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 *Carrier, B MAC, and DME MAC* 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 *Carriers, B MACs, and DME MACs* 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 *Carrier, B MAC, and DME MAC* 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 *Carrier, B MAC, and DME MAC* will have met the 20% target for that FY.

1. *Carrier, B MAC, and DME MAC* **-Specific Selection Requirements**— *Carriers, B MACs, and DME MACs* 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, B MACs, and DME MACs* 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, B MAC, and DME MAC* 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, B MAC, and DME MAC* exhausts the Part 1 list and still has additional reviews to conduct in the 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 additional reviews to initiate, 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.

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

B. Conducting the Reviews

If a provider responds to letter C or D (whether triggered by a FI, Carrier, RHHI, A/B MAC, or DME MAC selection of the provider for review in the quarterly report or direct issuance of the letters by an FI or A MAC), but does not establish eligibility to submit paper claims, an FI or A MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC shall enter ASCA review result code NE in the shared system ASCA review result field (see §90.5.2). 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 or A MAC shall issue provider letter F, and a FI, Carrier, RHHI, A/B MAC, or DME MAC 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.

FIs, Carriers, RHHIs, A/B MACs, or DME MACs have authority to delay imposition of denial of paper claims for up to 30-days if the provider responds to 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, RHHI, A/B MAC, or DME MAC should approve an extension request of up to 30 days, if the FI, Carrier, RHHI, A/B MAC, or DME MAC has no reason to suspect the provider may not complete the changes by the specified date.

When an extension is approved, an FI or A MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC 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 or A MAC shall immediately notify FISS to begin denying paper claims from that provider beginning on the 91st day after issuance of letter C. A FI, Carrier, RHHI, A/B MAC, or DME MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC does not have authority to approve more than one 30-day extension during the same review. FIs, Carriers, RHHIs, A/B MACs, or DME MACs must contact CMS/OIS/BAMG/Division of Transactions, Applications & Standards (DTAS) if a contractor representative thinks a provider's request for an extension beyond the 120th day should be approved. If a c FI, Carrier, RHHI, A/B MAC, or DME MAC does not endorse an extension request beyond the 120th day, the contractor should deny the request. A FI, Carrier, RHHI, A/B MAC, or DME MAC shall enter NE in the ASCA review result screen/field. If DTAS approval is requested by a contractor and DTAS does approve an extension, FIs, Carriers, RHHIs, A/B MACs, or DME MACs are to follow the requirements in the prior paragraph concerning resetting of the effective date for denial of that provider's paper claims.

When FIs, Carriers, RHHIs, A/B MACs, or DME MACs finishes each provider's ASCA review, a FI, Carrier, RHHI, A/B MAC, or DME MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC selection for review during subsequent quarters.

FIs, Carriers, RHHIs, A/B MACs, and DME MACs 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), or as result of an ASCA review and either FIs, Carriers, RHHIs, A/B MACs, or DME MACs provider ASCA determination WA or UC (see §90.5.1) applies, or an FI or A MAC has issued letter F for other than the small provider exception.

Each FI, Carrier, RHHI, A/B MAC, or DME MAC 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.

FIs, Carriers, RHHIs, A/B MACs, and DME MACs 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 FIs, Carriers, RHHIs, A/B MACs, and DME MACs 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 FI, Carrier, RHHI, A/B MAC, or DME MAC 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 or A MAC 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 FI, Carrier, RHHI, A/B MAC, or DME MAC 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 or A MAC process for this, but it is considered unlikely that this situation would occur with an institutional provider. If a FI, Carrier, RHHI, A/B MAC, or DME MAC 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.

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

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

90.6 Provider Education

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

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

3. FTE definition and calculation methodology;

4. Exception criteria;

5. Unusual circumstance criteria;

6. Self-assessment requirements;

7. Process for submission of an unusual circumstance waiver;

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

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

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

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

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

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

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

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

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

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

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

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

If there is more than one entry in SuperPES for the same provider, perhaps as result of the provider's submission of claims to more than one Medicare contractor, the RMC shall compare each of those entries that contains an ASCA decision and enter that decision and that effective

date in PES that is the most "negative" in terms of the number of paper claims that would be submitted to the RMC as result of entry of that decision and date. The RMC has discretion to determine which set of ASCA information is the most negative overall.

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

(Rev. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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

- **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.

- **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.

- **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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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:

- SuperPES contains a "SM" decision for the provider that is less than two years old;
- 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
- 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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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. 2181, Issued: 03-25-11, Effective: 04-25-11, Implementation: 04-25-11)

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.