CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 952

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MAY 19, 2006

Change Request 5068

SUBJECT: Administrative Simplification Compliance Act (ASCA) Review Revisions

I. SUMMARY OF CHANGES: Modification of Shared System Processing of the Administrative Simplification Compliance Act (ASCA) Enforcement Review Quarterly Reports, Recording of Review Results and Contractor ASCA Enforcement Review Requirements

NEW/REVISED MATERIAL

EFFECTIVE DATE: October 1, 2006

IMPLEMENTATION DATE: October 2, 2006

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	24/Table of Contents
R	24/90/90.2/Exceptions
R	24/90/90.3.1/Unusual Circumstance Waivers Subject to Provider Self-Assessment
R	24/90/90.3.3/Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision
R	24/90/90.5/Enforcement
N	24/90/90.5.1/Fiscal Intermediary Shared System (FISS) Role in ASCA Enforcement
N	24/90/90.5.2/MCS & VMS Roles in ASCA Enforcement
N	24/90/90.5.3/Contractor Roles in ASCA Reviews

R	24/90/Exhibit A/Response to a Non-"Unusual Circumstance" Waiver Request
R	24/90/Exhibit B/Denial of an "Unusual Circumstance" Waiver Request
R	24/90/Exhibit C/Request for Documentation from Providers Selected for Review to Establish Entitlement to Submit Claims on Paper
R	24/90/Exhibit D/Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of non-response to that letter
R	24/90/Exhibit E/Notice that Paper Claims Will be Denied Effective with the 91st Calendar Day after the Original Letter as Result of Determination that the Provider is Not Eligible to Submit Paper Claims
R	24/90/Exhibit F/Notice that Determination Reached that the Provider is Eligible to Submit Paper Claims
N	24/90/90.5.4/Submission of Claims that May Always be Submitted on Paper by Providers Not Otherwise Eligible to Submit Paper Claims

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 952	Date: May 19, 2006	Change Request 5068

SUBJECT: Administrative Simplification Compliance Act (ASCA) Review Revisions

I. GENERAL INFORMATION

A. Background: Due to the much smaller number of paper claims sent to fiscal intermediaries (FIs), FIs were not required to conduct as many ASCA enforcement reviews as carriers and DMERCs. The existing format for FI quarterly review reports prepared by the Fiscal Intermediary Shared System (FISS) does not require changes at this time. FISS is to continue to prepare quarterly reports as at present. As result, only a small number of the business requirements in this CR apply to FIs: 5068.1, .9, .10, .13.1, .15.1, .16, .16.1, .17 and .20.

Carriers and DMERCs however, have recommended a number of changes to the ASCA Enforcement review processes as result of their experiences with these reviews to date. They advise that the recommended changes should improve the effectiveness of the reviews, issuance of review letters, recording of pending reviews and results of completed reviews, enable processing of types of paper claims that are permitted when a provider has otherwise been determined ineligible for payment of paper claims, and reduce contractor manual efforts to conduct these reviews. These modifications should enable identification of those providers that would most likely be ineligible for submission of large quantities of paper claims earlier in the ASCA review cycle to maximize review results earlier rather than later and increase program savings to be realized in FY 2007 and later.

B. Policy: Section 3 of ASCA, Pub.L. 107-105, the implementing regulation at 42 CFR 424, and the Medicare Claims Processing Manual Chapter 24, §§ 90-90.6 and its Exhibits, require submission of claims to Medicare electronically, except in limited situations. The regulation and the manual sections require that mandatory electronic submission of Medicare claims be enforced on a post-payment basis. Providers were directed to self-assess to determine whether they met a set of published exception and waiver criteria, or to submit an application to their carrier, DMERC or fiscal intermediary for waiver if they attributed their inability to submit all or some of their claims electronically to an "unusual circumstance." Providers were also notified that their paper claim submission history would be reviewed and used to identify whether they would be contacted to justify their submission of paper claims.

II. BUSINESS REQUIREMENTS

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

ASCA enforcement review quarterly reports are produced based upon the date of submission, or alternately, the date of adjudication or processing, of claims during a calendar quarter, and not based upon the date of services contained in those claims. The only time dates of service would be germane during as ASCA review would be when a provider is determined to be eligible to submit paper claims, but the date when the provider becomes eligible is later than the date that denial of paper claims began for that provider as result of an ASCA review. If that was to occur, and the provider was to resubmit claims that

had been denied as on paper, the provider could not be paid for services between the dates when the paper claims began to be denied and the date the provider became eligible to submit paper claims.

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5068.1	Contractors shall modify ASCA enforcement information on their Web sites to the extent necessary to correspond to the manual revisions being made in this CR to §§90.2, 90.3.1, 90.3.3 and the Exhibit letters A-F.	X	X	X	X					D-MACs
5068.2	Shared systems shall add the following fields to the provider master file: 1. Date (CCYYMMDD) the most recent ASCA enforcement review began. (If a prior review is in the record, entry of a new review date shall overlay the record of any prior review start date.) 2. Date (CCYYMMDD) the denial of paper claims began or is to begin (when a new review is underway) as the provider found ineligible to submit paper claims. 3. Date (CCYYMMDD) provider established eligibility to submit paper claims if after the effective date that the provider was initially determined be ineligible to submit paper claims. 4. Result of the most recently completed review. (2 alpha characters: either NE, SM, WA, or UC)						X	X		
5068.3	Shared systems shall prepare an online quarterly report (printable at contractor discretion) of billing provider paper claim submission information by the end of the month following the end of a calendar quarter.						X	X		
5068.4	Shared systems shall divide the report into four parts.						X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5068.4.1	Part 1 of the report shall contain data on providers that submitted both electronic and paper claims that quarter--identify each provider by name, TIN, legacy ID (PIN, NSC, OSCAR; not NPI), # of paper claims submitted under that legacy identifier that quarter , # of EMC submitted under that legacy identifier that quarter, percentage of paper claims submitted under that legacy identifier that quarter, date (CCYYMMDD) most recent prior ASCA review began, date (CCYYMMDD) most recent prior ASCA review completed, and result code (NE, SM, WA or UC) from that ASCA review.						X	X		
5068.4.1.1	If a provider has more than one PIN or NSC, and claims under those PINs/NSCs for that provider are covered by the same TIN, the listings for those PINs/NSCs are to be listed in the report in successive entries.						X	X		
5068.4.1.2	Providers are to be listed in Part 1 of the report in declining order according to the number of paper claims each submitted.						X	X		
5068.4.1.3	When a single TIN is used to pay for claims submitted under more than one PIN/NSC, the shared systems shall first report the information that applies to the PIN/NSC under which the most paper claims were submitted, followed by the other PINs/NSCs paid under that TIN in declining order according to the number of claims submitted under each of that provider's PINs/NSCs.						X	X		
5068.4.1.4	Shared systems may report additional data elements in Part 1 of the report at their discretion if requested by their users, such as any additional data elements originally required in the quarterly report prior to this CR that are not now required, or that the shared system had previously been reporting as supplemental data						X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	in the quarterly report.									
5068.4.2	Part 2 of the report shall contain information on those providers that submitted all of their claims on paper and submitted 100 or more claims that quarter—identify each provider by name, TIN, legacy #, the # of paper claims submitted under that legacy identifier that quarter, date (CCYYMMDD) most recent prior ASCA review began, date (CCYYMMDD) most recent prior ASCA review completed, and result code (NE, SM, WA or UC) from that ASCA review.						X	X		
5068.4.2.1	Providers are to be listed in Part 2 of the report in declining order according to the number of paper claims each submitted.						X	X		
5068.4.2.2	When a single TIN is used to pay for claims submitted under more than one PIN/NSC, the shared systems shall first report the information that applies to the PIN/NSC under which the most paper claims were submitted, followed by the other PINs/NSCs paid under that TIN in declining order according to the number of claims submitted under each of that provider's PINs/NSCs.						X	X		
5068.4.3	Part 3 of the report shall contain information on those providers that submitted all of their claims on paper and submitted fewer than 100 claims that quarter—identify each provider as in BR 4.2.						X	X		
5068.4.3.1	Providers are to be listed in Part 3 of the report in declining order according to the number of paper claims each submitted.						X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5068.4.3.2	When a single TIN is used to pay for claims submitted under more than one PIN/NSC, the shared systems shall first report the information that applies to the PIN/NSC under which the most paper claims were submitted, followed by the other PINs/NSCs paid under that TIN in declining order according to the number of claims submitted under each of that provider's PINs/NSCs.						X	X		
5068.4.4	Part 4 of the report shall contain the total number of providers (counted according to the total of different legacy identifiers) that submitted one or more paper claims that quarter.						X	X		
5068.5	Shared systems shall include a check block or field for contractor use to identify each provider in the report being selected for review, including the separate listings for a provider that has a single TIN but submits claims under multiple PINs/NSCs.						X	X		
5068.6	Contractors shall check the block or complete the field to identify those providers selected for ASCA review by the end of the second month of each quarter.			X	X					D-MACs
5068.6.1	Shared systems shall permit a contractor to erase a check or completion of the field in case completed in error, and the correction is made the same business day as the selection.						X	X		
5068.7	Shared systems shall trigger the contractor's correspondence system to release Exhibit letter C when the block/field has been completed by a contractor.						X	X		
5068.8	Shared systems shall add a field for contractor entry of date 3 (CCMMYYDD) from 5068.2 as applicable.						X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5068.8.1	Shared systems shall add a field to enable contractors to reset date 2 from 5068.2 when needed due to approval of an extension by a contractor or CMS. The date to be entered in this case will be the date immediately following expiration of the extension.						X	X		
5068.8.2	Shared system shall add a field for contractor entry of a single ASCA review result code (NE, SM, WA, or UC).						X	X		
5068.8.2.1	Shared systems shall trigger the contractor's correspondence system to release Exhibit letter E when a contractor enters review result "NE."						X	X		
5068.8.2.2	Shared systems shall trigger the contractor's correspondence system to release Exhibit letter F when a contractor enters any of the following review results: SM, WA or UC.						X	X		
5068.8.3	Shared systems shall add a 60 alphanumeric character field for mandatory contractor entry of the Unusual Circumstance when an ASCA review result of UC is entered.						X	X		
5068.8.4	Shared systems shall reject an entry of UC if at least 6 alphanumeric characters are not entered in the Unusual Circumstance field and UC was entered in the ASCA review result field.						X	X		
5068.9	Contractors shall keep confidential the information about whether they have been funded for ASCA reviews, the amount of the funding and the approximate number of reviews that can be completed with that funding.	X	X	X	X					D-MACs
5068.10	Contractors shall determine how many ASCA reviews they can afford to initiate and complete each quarter depending upon the amount of CMS funding approved for these reviews.	X	X	X	X					D-MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5068.10.1	Contractors shall combine the number of paper claims submitted under different PINs/NSCs covered by the same TIN for the same provider (see 5068.4.1.3, .4.2.2 and .4.3.2) when determining which providers to select for ASCA enforcement review.			X	X					D-MACs
5068.10.2	Contractors shall complete selection of the providers to be reviewed and trigger release of letter C to those providers by the end of the second month of each quarter.			X	X					D-MACs
5068.11	The number of provider quarterly report selection blocks/fields completed for providers by contractors shall correspond to the number of reviews that a contractor can afford based on the amount of funding approved, i.e., each contractor must conduct all reviews for which funded and does not have discretion to curtail the number of reviews conducted. When providers have been selected for review that have one TIN but submitted claims under more than one PIN or NSC for the quarter, even though multiple listings in the report are involved (one listing for each PIN or NSC), the review is to be counted as only one review even though it will be necessary to select the block/field for each of those listings.			X	X					D-MACs
5068.12	Of the total providers they can afford to review, contractors shall select two-thirds of the providers from Part 1 and one-third from Part 2 of the shared system quarterly report.			X	X					D-MACs
5068.12.1	If every provider is selected from Part 1 that is eligible for review, and there are still review slots left, contractors shall select additional providers from Part 2 for review.			X	X					D-MACs
5068.12.2	If all providers eligible for review from Parts 1 and 2 have already been selected, contractors shall select providers from Part 3 for review, beginning with those that submitted the most			X	X					D-MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	paper claims.									
5068. 13	Carriers and DMERCs shall modify their correspondence system for ASCA letters A, B, C, D, E and F to insert local information or URLs as noted in the Exhibits for each letter and to insert the start and end dates supplied by the shared system of the quarter that was the basis for the provider selection for review in letter C.			X	X					D-MACs
5068.13.1	FIs shall modify the content of ASCA letters A-F as contained in this CR, and begin to issue the revised letters by the effective date of this CR. They may begin to use the revised letters prior to that date if they wish, but are not to reissue letters A-F that were previously sent to providers.	X	X							
5068.14	If a provider responds to letter C or D and establishes eligibility to submit paper claims, before paper claim denials begin, the contractor shall enter the applicable reason (SM, WA or UC) in the ASCA review result field furnished by the shared system.			X	X					D-MACs
5068.14.1	If a provider responds to letter C or D but does not establish eligibility to submit paper claims, or does not respond to the letters, the contractor shall enter NE in the ASCA review result data entry field furnished by the shared system.			X	X					D-MACs
5068.14.2	If a provider establishes eligibility to submit paper claims after paper claims denials began, and eligibility is established retroactively to at least the date that paper claim denials began, the contractors shall delete the denial of paper claims date in the provider master file.			X	X					D-MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5068.15	If a contractor selects the block/field at the beginning of a provider's listing in the quarterly report listing line, the shared system shall trigger the contractor's correspondence system to release letter C and shall set the 91st day after release of letter C was triggered as the paper claim denial effective date.						X	X		
5068.15.1	If a contractor determines that most of the paper claims submitted by a provider as contained in the quarterly report were for a reason contained in §90.2 or .3 of chapter 24, AND the number of other submitted paper claims that did not meet those exception or waiver criteria for the quarter would not have been high enough on their own to have resulted in selection of that provider for ASCA review, then the contractor shall terminate the review, note the review result in the spreadsheet, and if a carrier or DMERC, shall enter a review result of WA.	X	X	X	X					D-MACs
5068.16	Contractors shall maintain an Excel spreadsheet locally that records information on each provider that requested an ASCA waiver, either as part of, or independent of, an ASCA enforcement review, and the provider claimed that an "unusual circumstance" applied.	X	X	X	X					D-MACs
5068.16.1.1	Contractors shall enter the following for each listing in the spreadsheet: the name, legacy identifier and NPI (if available) of the provider, the date the waiver was requested, the unusual circumstance alleged, whether the request was approved or denied, the expiration date if a temporary waiver, and the date the determination was made.	X	X	X	X					D-MACs
5068.17	If a provider's paper claims are being denied due to submission on paper, and the provider contacts a contractor to question non-receipt of payment for paper claims or certain services on a paper claim submitted for permitted reasons	X	X	X	X					D-MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	per §90.2-90.3.1, and identifies each affected paper claim, the contractor shall reprocess those paper claims manually and issue appropriate payment if the paper claim(s) or certain included services meet all other requirements for payment. If only certain services are eligible for payment, only those services shall be paid, and not ineligible services on the same paper claims.									
5068.18	Shared systems shall automatically trigger release of letter D by a contractor's correspondence system 45 days after release of letter C.						X	X		
5068.18.1	Shared systems shall automatically eliminate release of letter D if a contractor enters review result NE, SM, WA or UC in the provider master provider file prior to the 45th day after release of letter C.						X	X		
5068.19	If contacted by a provider following denial of paper claims and the provider establishes eligibility to submit paper claims, but the provider did not become eligible until a date later than the effective date of denial of their paper claims, the contractor shall enter the effective date after which paper claims may be approved in the provider master file			X	X					D-MACs
5068.20	Each contractor shall review their ASCA waiver Excel spreadsheet when selecting providers on a quarterly report for review to determine if there is information in that spreadsheet that indicates a provider's review should be delayed until a subsequent quarter, or indicates that a provider's temporary waiver may have expired and that the provider should be reviewed if the quarterly report suggests the provider has not corrected their improper paper billing practices as agreed as a condition for the waiver.	X	X	X	X					D-MACs

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	NONE									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Thomas Latella 410-786-1310 or Thomas.Latella@cms.hhs.gov **Post-Implementation Contact(s):** Thomas Latella 410-786-1310 or Thomas.Latella@cms.hhs.gov	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual

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

Table of Contents
(Rev. 952, 05-19-06)

90.2 - Exceptions

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

It has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be possible in some cases to submit certain claims to Medicare electronically. Providers are to self-assess to determine if they meet these exceptions. At the present time, only the following claim types are considered to meet this condition for self-assessment purposes:

1. Roster billing of inoculations covered by Medicare—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, some suppliers have been permitted to submit a single claim on paper with the basic provider and service data and to attach a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. This is referred to as roster billing. The claim IGs adopted under HIPAA *provide for submission of single claims to a payer for single individuals, but cannot be used to submit a roster bill* for multiple individuals.

   Flu *and pneumonia inoculations* are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable a HIPAA-compliant claim to be submitted electronically in such field situations, *particularly when a single individual is responsible for collection of the data and administration of the inoculations*. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

   It is in the interest of Medicare and public health to make it as simple as possible for mass inoculation activities to continue. Although suppliers are encouraged to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required except in the case of multi-state companies that signed an agreement with a single Medicare contractor for submission of all flu shots to that single contractor for those states, and who agreed to submit those claims electronically as a condition for centralized billing of those inoculations. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for inoculations.

   This inoculation waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections including flu shots when furnished in a traditional medical setting such as a

doctor's office or an outpatient clinic as a component of other medical care or an examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, a flu shot or other inoculation is also to be included in the electronic claim sent to Medicare for the patient.

2. Claims for payment under a Medicare demonstration project that specifies paper submission—By their nature, demonstration projects test something not previously done, such as coverage of a new service. As a result of the novelty, the code set that applies to the new service may not have been included as an accepted code set in the claim implementation guide(s) adopted as HIPAA standards. The HIPAA regulation itself makes provisions for demonstrations to occur that could involve use of alternate standards. In the event a Medicare demonstration project begins that requires some type of data not supported by the existing claim formats adopted under HIPAA, Medicare could mandate that the claims for that demonstration be submitted on paper. In the event demonstration data can be supported by an adopted HIPAA format, Medicare will not require use of paper claims for a demonstration project. Demonstrations typically involve a limited number of providers and limited geographic areas. Providers that submit both demonstration and regular claims to Medicare may be directed to submit demonstration claims on paper. Non-demonstration claims must continue to be submitted electronically, unless another exception or waiver condition applies to the provider.

3. *"Obligated to Accept as Payment in Full" (OTAF) Medicare Secondary Payer (MSP) Claims when There is More than One Primary Payer— An OTAF adjustment (also see the Medicare Secondary Payment Manual) is made when a provider, physician or supplier agrees as result of negotiation or otherwise to receive a payment rate that is higher or lower than a payer's normal allowed amount as payment in full for particular services or supplies. By regulation, if a primary payer's OTAF amount is lower than the charge for the related service that appears on the claim, Medicare must include the OTAF adjustment when calculating the amount of Medicare's secondary payment.*

There is not a single claim adjustment reason code specifically reserved for OTAF adjustments. Different payers have chosen to report this in an X12 835 using a variety of existing claim adjustment reason codes or in a paper RA/Explanation of Benefits (EOB), using a variety of proprietary codes or text messages. The HIPAA requirement for reporting of standard claim adjustment reason codes in X12 835 and 837 transactions does not apply to paper RAs/EOBs. As result, it can be difficult for Medicare to automatically detect when an adjustment reported in an MSP claim was the result of an OTAF agreement, but a provider should know when an OTAF-type agreement is in place.

To make sure that OTAF adjustments can be identified in MSP claims, providers were directed to enter any applicable OTAF adjustment from a payer in the CN1 segment in an X12 837 version 40101A1 MSP claim. When there is more than one primary payer, however, it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF

adjustment in the event more than one primary payer made an OTAF adjustment. As result of this X12 837 limitation, when there is more than one primary payer and an OTAF adjustment applies, providers are to submit OTAF claims on paper, with the RAs/EOBs from the primary payers attached.

4. *MSP Claims When There is More than One Primary Payer and More Than One Allowed Amount—In an MSP situation, Medicare needs to use a primary payer's allowed and paid amounts to calculate the supplemental amount that can be paid by Medicare. In some cases, a beneficiary is covered by more than one other primary payer. Each of those other payers must complete adjudication before Medicare can process those claims. The ASC X12 837 version 40101A1 IG permits reporting of payment information from more than one other payer, but not for reporting of separate allowed amounts at the line or claim level for more than one payer. As result of this limitation, when there is more than one primary payer, and the allowed amounts differ, a provider is permitted to submit the claim to Medicare on paper, with the RA/EOB from each of the primary payers attached.*

   Except for OTAF claims when there is also more than one primary payer, or if a provider is small or meets one of the temporary exception criteria, such as disruption of electricity or communications, no other types of MSP claims, such as MSP claims when there is only one primary payer, may be submitted to Medicare on paper.

5. *Home Oxygen Therapy Claims for Which the CR5 Segment is Required in an X12 837 version 40101A1 Claim but for Which the Requirement Notes in Either CR513, CR 514 and /or CR 515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. –Completion of these data elements as required in the X12 837 professional IG is an assertion that the required condition for inclusion of these data elements is met. Non-completion of these data elements, however, cannot be interpreted as a statement that the required condition for inclusion of these data elements is not met. There is no means to answer "no," enter the actual oxygen saturation rate or the arterial PO_2 measurement, but a patient can sometimes qualify for oxygen even if each of these conditions is not met.*

   This will be corrected in a post-40101A1 version of the IG, but until that is implemented, covered entities are permitted to submit their claim to Medicare on paper in this situation.

6. Claims submitted by Medicare beneficiaries.

90.3.1 - Unusual Circumstance Waivers Subject to Provider Self-Assessment

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

The following circumstances always meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type or the period when an "unusual situation" exists. A provider is to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may submit claims to Medicare on paper or via other non-electronic means when one of these circumstances applies. A provider is not expected to pre-notify their Medicare contractor(s) that one of the circumstances applies as a condition of submission of non-electronic claims.

1. Dental claims—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically.

2. Disruption in Electricity or Phone/Communication Services--In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than 2 business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, providers should simply hold claims for submission when power and/or communication are restored.

3. A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.

4. Non-Medicare Managed Care Organizations that are able to bill Medicare for copayments may continue to submit those claims on paper. These claims are not

processable by the MSPPay module and must be manually adjudicated by Medicare contractors.

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

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

A provider may submit a waiver request to their Medicare contractor claiming other types of "unusual circumstances" outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit documentation appropriate to establish the validity of a waiver request in this situation. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the Medicare contractor agrees that the waiver request has merit, the request must be forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 for Review and issuance of the decision. The contractor must forward an explanation as to why contractor staff recommends CMS approval to DDIS with the waiver request. The contractor will be copied on the decision notice DDIS issues to the requestor.

If the contractor does not consider an "unusual circumstance" to be met, and does not recommend DDIS approval, the contractor must issue a form letter (Exhibit B). As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (whether a sole practitioner, employee, or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or that is used to obtain an EIN.

"Unusual Circumstances" that Require CMS Review:

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the IG deficiency.)

   NOTE: A 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 Medicare contractor for evaluation by that contractor, and if approved at that level, for subsequent review by CMS. In the event other situations are identified *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.

90.5 – Enforcement

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

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

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Enforcement will be conducted on a post-payment basis. FISS will prepare quarterly reports for the FIs 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. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

As result of the substantially higher number of paper claims sent to carriers and DMERCs than to FIs, somewhat different ASCA quarterly report requirements are being applied for the carrier and DMERC 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, DMERC, or Medicare Administrative Contractor (MAC) as applicable when operational. 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.

MCS and VMS shall add the following fields to the provider master file to assist with preparation of these reports and contractor tracking of report history, and shall establish fields to permit contractors to enter information as indicated below:

- *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);*
- *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 is triggered, or a contractor shall reset that date to the date after an approved extension period expires; see §90.5.3.B);*
- *Date (CCYYMMDD) provider established eligibility to submit paper claims if effective after the date the provider was initially determined to be not eligible to submit paper claims (see §90.5.2.C; contractor must populate using a shared system field established for reporting of this date);*
- *Result of the most recently completed ASCA enforcement review—An ASCA review result field must be made available 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);
  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 (does not include a section 90.3.3, chapter 24 unusual circumstance; contractors shall populate); or
  UC--Provider determined eligible for an "unusual circumstance" waiver per section 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, the percentage of those claims that were on paper, date the provider's most recent ASCA enforcement review began, date the provider's most recent ASCA enforcement review was completed (date Exhibit letter F triggered or date paper claim denials began; see §90.5.2.B), and the *result code from that most recent review. 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 NSCs 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 NSCs or the number of paper claims submitted under the PIN or NSC with the highest number of paper claims, followed immediately by the separate entries for each of the other PINs/NSCs associated with that same TIN. The listings for the other PINs/NSCs 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) the number of paper claims submitted for each listed provider that quarter under that identifier, date the provider's most recent ASCA enforcement review began, date the provider's most recent ASCA enforcement review was completed, 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 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), the number of claims submitted for each listed provider that quarter, date the provider's most recent ASCA enforcement review began, date the provider's

most recent ASCA enforcement review was completed (i.e., either date 2 or date 3 from 90.5.2), 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 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 block or field will be completed by the contractors to identify those providers chosen for ASCA review. When a contractor completes that block/field the shared system will notify the contractor's correspondence system by the next business day to release Exhibit letter C 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 C.) The shared system will automatically begin counting days since letter C was triggered and will trigger release of letter D 45-days after letter C (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 was triggered.

The shared system must permit a carrier or DMERC to cancel this block/field 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. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

A. Identification of Those Providers to be Reviewed

Separate funding will be issued for these reviews annually. Funding will be distributed where CMS determines reviews are most needed, or where the largest returns are likely to be achieved, i.e., where the most providers incorrectly billing the most claims on paper are likely to be identified. Information concerning which contractors are selected to conduct these reviews, the amount of funding issued each for this purpose, the number of providers selected for review, and the identity of those providers is confidential and may not be made public. Some contractors may not be funded to conduct these reviews each quarter or each year.

Each quarter, those contractors that have been funded for reviews will determine the number of reviews they can afford to initiate based upon the funding allocated. The following providers will be included in the quarterly report, but neither FIs, carriers,nor DMERCs are to select a provider for review that quarter if:

- *A prior quarter review is underway and has not yet been completed for that provider (start date of prior review is listed in the report but not yet a completion date);*
- *The provider has been reviewed within the past two years, determined to be a "small" provider, and there is no reason to expect the provider's "small" status will change for at least two years (provider file past ASCA review result was "SM" and completion date of that review is less than 24 months in the past); or*
- *Fewer than 30 paper claims were submitted by the provider for the quarter.*

1. ***Carrier and DMERC-Specific Selection Requirements**--Carriers and DMERCs 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 and DMERCs 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 or DMERC*

shall combine the number of paper claims submitted under each of those PINs/NSCs when determining which providers to be selected for review. For ASCA evaluation purposes, consider all of those paper claims as submitted by the same provider even though under different PINs or NSCs. Complete the block/field for each of the provider's lines in that case, but apply the same review result for each of the affected PINs/NSCs recorded for that provider. In terms of number of reviews conducted, a review that involves multiple PINs or NSCs for the same provider is to be treated as 1 review, even though multiple copies of letter C are issued.

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

Carriers and DMERCs are to complete selection of providers to be reviewed by the end of the second month of each quarter.

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

B. Conducting the Reviews

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

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

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

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

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

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

When the contractor finishes each provider's ASCA review, a carrier or DMERC must enter the outcome to the provider file (see §90.5.2), except where identified as shared system responsibility, as well as enter the specific unusual circumstance when result code UC applies. FI, carriers and DMERCs must also document the ASCA review spreadsheet (see below) with the outcome of the review.

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

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

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

1. *Were for MSP claims when there is more than one primary payer, or for mass inoculations, or similar types of claims allowed to be submitted on paper; or*

2. *Were submitted on a temporary basis as result of power and communication disruption resulting from a natural disaster or similar problem outside the control of the provider;* ***AND***

3. *The number of paper claims submitted for the provider during that quarter that did not meet such criteria would not have been high enough to have resulted in selection of that provider* for ASCA review *in the absence of the excepted/waived claims, the contractor is to terminate that review.* ***THEN,***

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

   NOTE: *WA or issuance of letter F to a provider that is being excepted or waived for a reason on than the number of FTEs employed does not preclude the provider from carrier or DMERC selection for review during subsequent quarters.*

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

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

local Excel spreadsheet for ASCA review results with column headings for provider name, provider number, address, date of enforcement review determination of each provider listed, whether continued submission of paper claims was approved or denied, the exception/waiver condition claimed by the provider, and if denied, date rejection of paper claims is/was to begin.

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

Contractors are to consult these spreadsheets when selecting providers for ASCA reviews as they may contain information to assist with an ASCA review or to lead a contractor to postpone review of a provider until a later quarter. For example, there may have been a temporary waiver decision which was still in effect for all or most of the quarter being considered for review, so it would be better to postpone the review until a quarter after expiration of the temporary waiver. Or the temporary waiver period expired prior to the beginning of the quarter being analyzed but the provider does not appear to have reduced the number of paper claims submitted as expected at the time of approval of the temporary waiver, in which case, the provider should be selected for re-review.

C. Post-Review Actions

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

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

90.5.4 Submission of Claims that May Always be Submitted on Paper by Providers Not Otherwise Eligible to Submit Paper Claims

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

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.*

Exhibits of ASCA Letters

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

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Date:

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

To: Organizational Name of Provider

Subject: Electronic Claim Submission Waiver Request

You recently submitted a request for waiver of the Administrative Simplification and Compliance Act (ASCA) requirement that claims be submitted electronically effective October 16, 2003 to qualify for Medicare coverage. Providers are to self-assess to determine if they meet the criteria to qualify for a waiver. A request for waiver is to be submitted to a Medicare contractor only when an "unusual circumstance," as indicated in c, d, or e below applies. Medicare will only issue a written waiver determination if c, d, or e applies.

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

1. Small providers—To qualify, a provider required to submit claims to Medicare FIs must have fewer than 25 full time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;
2. Dental Claims;
3. Participants in a Medicare demonstration project, when paper claim filing is required by that demonstration project as result of the inability of the HIPAA claim implementation guide to handle data essential to that demonstration;
4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;

5. *Providers that submit claims to Medicare when more than one other insurer was liable for payment prior to Medicare*;
6. Providers of home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;
7. Those few claims that may be submitted by beneficiaries;
8. Providers that only furnish services outside of the United States;
9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
10. Providers that can establish that some other "unusual circumstance" exists that precludes submission of claims electronically.

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

Examples of "unusual circumstances" include:

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

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

If a provider's self-assessment does not indicate that an exception or waiver criteria apply, the provider must submit their claims to Medicare electronically. *This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. See (contractor to enter the URL) for further information on enrollment for use of EDI, use of free billing software or other EDI information. There is also commercial software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs.*

Sincerely,

Contractor Name

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

(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Date:

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

To: Organizational Name of Provider

Subject: Request for Waiver of Electronic Claim Filing Requirement Decision

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

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

2. Dental Claims;

3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;

4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;
5. *Providers that submit claims to Medicare when more than one other insurer was liable for payment prior to Medicare*;

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

7. Those few claims that may be submitted by beneficiaries;

8. Providers that only furnish services outside of the United States;

9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and

10. Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically.

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

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

    b. Providers that submit fewer than 10 claims per month to a Medicare contractor on average;

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

    d. Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

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

We have determined that you do not meet any of these criteria for waiver of the ASCA requirement for electronic submission of Medicare claims. ASCA did not establish an

appeal process for waiver denials, but you can re-apply for an "unusual circumstance" waiver if your situation changes.

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

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

Sincerely,

Contractor Name

Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper
(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Date:

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

To: Organizational Name of Provider

Subject: Review of Paper Claims Submission Practices

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

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

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

2. Dentists;

3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;

4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;

5. *Providers that submit claims to Medicare when more than one other insurer was liable for payment prior to Medicare*;

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

7. Those few claims that may be submitted by beneficiaries;

8. Providers that only furnish services outside of the United States;

9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and

10. Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically.

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

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

b. Providers that submit fewer than 10 claims per month to a Medicare contractor on average;

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

d. Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

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

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

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

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

In some of these situations, permission to submit paper claims applies only to a specific claim type, e.g., flu shots, *or* for a temporary period. In those cases, only *that type of claim or claims for that period may* be submitted on paper. Providers that received waivers for a specific claim type or for a specific period are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, dentist, or otherwise qualify for a waiver under a situation that applies to all of their claims.

If you cannot provide acceptable evidence to substantiate that you are eligible under the law to continue to submit paper claims to Medicare, we will begin to deny all paper claims you submit to us effective with the 91st calendar day after the date of this notice. *ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes.*

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

Sincerely,

Contractor Name

Exhibit D—Notice that Paper Claims will be Denied Effective with the 91st *Calendar* Day after the Original Letter as Result of Non-Response to that Letter
(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Date:

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

To: Organizational Name of Provider

Subject: Review of Paper Claims Submission Practices

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

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting justification to establish that you qualify for submission of paper claims to Medicare. Nor do we have information available to us that

would substantiate that you meet any of the limited exceptions that would permit you to legally submit paper claims to Medicare.

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

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

Sincerely,

Contractor Name

Exhibit E—Notice that Paper Claims will be Denied Effective with the 91st Calendar Day after the Original Letter as Result of Determination that the Provider is Not Eligible to Submit _Paper C*laims*
(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Date:

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

To: Organizational Name of Provider

Subject: Review of Paper Claims Submission Practices

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

electronic form. Entities determined to be in violation of the statute or this rule may be subject to claim rejections, overpayment recoveries, and applicable interest on overpayments.

We have reviewed your response to our initial letter requesting *that* you submit evidence to substantiate that you qualify for submission of paper claims under one of the exception criteria listed in that letter. Upon review, we determined that you do not meet the paper *claims waiver/exception criteria as stated in our prior letter. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if such a change in your situation occurs.*

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

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

Sincerely,

Contractor Name

Exhibit F—Notice That Determination Reached that the Provider is Eligible to Submit Paper Claims
(Rev. 952, Issued: 05-19-06; Effective: 10-01-06; Implementation: 10-02-06)

Date:

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

To: Organizational Name of Provider

Subject: Review of Paper Claim Submission Practices

Thank you for your response to our previous letter regarding the prohibition against the submission of paper claims to Medicare. Based on *the information you supplied*, we agree that you meet one or more exception criteria to the requirements in section 3 of the

Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, that require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions.

If your situation changes to the point where you no longer meet *at least one of these* criteria, you will be required to begin submission of your claims electronically within 90 calendar days from that change in your status.

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

Sincerely,

Contractor Name