CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4096	**Date: August 3, 2018**
	Change Request 10559

SUBJECT: Update to the Medicare Claims Processing Manual, Chapter 24, Section 90

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to reduce confusion and clarify the ASCA waiver process guideline in the IOM 100-04, Chapter 24, and Section 90. This CR combines two sections, 90.3.2 and 90.3.3, into a new section 90.3.2 with a new title and description. In section 90.3.2, the Mail Stop is eliminated and a new Email Box (ASCAWaiverRequest@cms.hhs.gov*)* is provided.

EFFECTIVE DATE: November 5, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 5, 2018

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
D	24/90.3.3/Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision
R	24/90.3.2/Unusual Circumstance Waivers Subject to a Contractor Evaluation for CMS Decision

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

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4096	Date: August 3, 2018	Change Request: 10559

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I. GENERAL INFORMATION

A. Background: The Internet-Only-Manuals (IOM 100-04, Chapter 24) regarding the Administrative Simplification Compliance Act (ASCA) Waiver Process (waiver validation and related claims submission) is being updated to provide needed clarification after review and discussion with the MACs. This Change Request (CR) will update Chapter 24, and Section 90 of the IOM, updating subsection 90.3.2 with a new title and description, and removing entire subsection 90.3.3. In subsection 90.3.2, the Mail Stop is eliminated and a new Email Box (ASCAWaiverRequest@cms.hhs.gov) is provided.

B. Policy: (ASCA, Section 3 of Pub. L. 107-105, 42 CFR 424.32) requires that all initial claims for reimbursement under Medicare, except for small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Medicare is prohibited from paying claims submitted in a non-electronic manner that do not meet the limited exception criteria. The issuance of waivers under this limited exception criteria to providers has been delegated to the MACs by CMS, under, Chapter 24, Section 90 of the IOM.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10559.1	The MACs shall update their ASCA review and waiver process per new instructions in Chapter 24, Section 90 of the IOM.	X	X	X	X					RRB-SMAC, SMRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10559.2	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mohammad Ullah, 410-786-4143 or mohammad.ullah@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

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.4096, 08-03-18)

90.3.2 - Unusual Circumstance Waivers Subject to *a Contractor* Evaluation *for* CMS Decision

(Rev.4096, Issued: 08-03-18, Effective: 11-05-18, Implementation: 11-05-18)

A provider may submit a waiver request to their *A/B or Durable Medical Equipment Medicare Administrative Contractors (A/B or DME MACs)* claiming other types of "unusual circumstances" outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit *appropriate documentation including request application with Provider name, address, email, and phone number* to establish the validity of a waiver request in this situation. Requests received without documentation *and as above stated information* 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 A/B MAC or, DME MAC agrees that the waiver request has merit, the request must be forwarded *Centers for Medicare and Medicaid Services, Office of Information Technology, Applications Management Group, to the Division of Transactions, Applications & Standards (CMS/OIT/AMG/DTAS) Email box (ASCAwaiverRequest@cms.hhs.gov)* for Review and issuance of the *CMS* decision. The contractor must forward an explanation *letter* as to why *the* contractor *(MAC)* 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 ASC X12 837 claim *Technical Review 3 (TR3)* 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 ASC X12 837-claim 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 ASC 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.

MACs 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. *MACs* 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 *with appropriate documentation* to their 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.