CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 831

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 2, 2006

Change Request 4261

SUBJECT: Shared Systems Medicare Secondary Payer (MSP) Balancing Edit and Administrative Simplification Compliance Act (ASCA) Enforcement Update

I. SUMMARY OF CHANGES: Shared systems must reject inbound Medicare Secondary Payer claims if the total of the paid amounts and the adjusted amounts does not equal the billed amounts at the line level, the claim level, and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed. As part of ASCA enforcement, contractors must be able to terminate a provider's paper claim denial indicator if the provider submits documentation at any time to establish that they meet criteria for submission of paper claims.

NEW/REVISED MATERIAL
EFFECTIVE DATE: July 01, 2006
IMPLEMENTATION DATE: July 03, 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	24/40/40.4/Crossover Claim Requirements
R	24/90/90.5 Enforcement

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

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SUBJECT: Shared Systems Medicare Secondary Payer (MSP) Balancing Edit and Administrative Simplification Compliance Act (ASCA) Enforcement Update

I. GENERAL INFORMATION

A. Background: In Change Request (CR) 4119, Chapter 24 was revised to manualize the requirement for termination of the Medicare HIPAA incoming claim contingency plan, added self-assessable unusual circumstances in which paper claim submission is permitted, and modified free claim software requirements. Business Requirement 4119.5 was deleted from that CR and has been placed into this CR.

B. Policy: Shared System Maintainers must adhere to electronic data interchange (EDI) requirements for Medicare as contained in this chapter.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4261.1	Shared systems shall reject inbound MSP claims if the total of the primary payer's paid and adjusted amounts does not equal the billed amounts at the line and claim level, and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.					X	X	X		
4261.2	If after applying an ASCA indicator for denial of paper claims, a provider submits documentation to establish that they met criteria for submission of paper claims effective with the 91st day after the initial ASCA letter, the contractor shall remove the paper claim denial indicator. The shared system will not reprocess claims previously denied as submitted on paper unless claims for that period are resubmitted by the provider.	X	X	X	X	X	X	X		

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4261.3	If at any time, the provider submits documentation to establish that they meet criteria for submission of paper claims, the contractor shall notify the provider by mail of that determination (see Exhibit F sample letter).	X	X	X	X					
4261.4	If a provider establishes eligibility to submit paper claims but that effective date is later than the 91st day after the initial ASCA enforcement letter, and the provider resubmits paper claims that had been denied, contractors shall not approve payment for dates of service between that 91st day and the effective date for submission of paper claims.	X	X	X	X	X	X	X		

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	
4261.5	A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: Change Requests 3440, 3875, 4119

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*: July 1, 2006 **Implementation Date:** July 3, 2006 **Pre-Implementation Contact(s):** Tom Latella Thomas.latella@cms.hhs.gov (410) 786-1310 **Post-Implementation Contact(s):** Kathleen Simmons Kathleen.simmons@cms.hhs.gov (410) 786-6157	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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40.4 – Crossover Claim Requirements

(Rev. 831, Issued: 02-02-06; Effective: 07-01-06; Implementation: 07-03-06)

A. X12 837 COB

The outbound 837 COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data, as modified during adjudication if applicable, as well as payment data. Carriers, DMERCs, and FIs are required to accept all 837 segments and data elements permitted by those implementation guides on an initial 837 professional or institutional claim from a provider, but are not required to use every segment or data element for Medicare adjudication. Those supplemental segments and data elements must be retained, however, because they could be needed by a Medicare COB trading partner. The shared systems must maintain a store and forward repository (SFR) for retention of such supplemental data. Data must be subjected to standard syntax and applicable IG edits prior to being deposited in the SFR to assure non-compliant data are not included in COB transactions. SFR data must be reassociated with those data elements used in Medicare claim adjudication as well as with payment data in order to create an 837 IG-compliant outbound COB transaction. The shared systems must retain the data in the SFR for a minimum of 6 months.

The 837 version 4010A1 institutional and professional implementation guides require that claims submitted for secondary payment contain standard claim adjustment reason codes to explain adjudicative decisions made by the primary payer. For a secondary claim to be valid, the amount paid by the primary payer plus the amounts adjusted by the primary payer must equal the billed amount for the services in the claim. Although Medicare does not currently use adjustment information from a primary payer for other than Obligated to Accept payment in Full (OTAF) adjustments, a tertiary payer to which Medicare could forward the claim under a COB trading partner agreement could require that data. A COB trading partner could reject a claim forwarded by Medicare if the adjustment and payment data from the primary payer or from Medicare did not balance against the billed amounts for the services and the claim. As a result, shared systems must reject inbound Medicare Secondary Payer claims if the paid and adjusted amounts do not equal the billed amounts at the line and claim level and if the claim lacks standard claim adjustment reason codes to identify the adjustments performed.

The shared system maintainers shall populate an outbound COB file as an 837 flat file with the Tax ID or SSN (for a sole practitioner) present in the provider's file, or in the case of an 837 flat file sent the COBC, present in each associated contractor's provider file. If no TaxID or SSN is available, the shared system(s) shall populate NM109 with syntactically compliant (all 9s if NM108 = '24' and '199999999' if NM108 = '34') data, pending availability of the billing provider's National Provider Identifier (NPI). Once the NPI is available, qualifier XX must be reported in NM108 and the NPI in NM109, and the taxpayer identification number reported in the REF segment of the billing provider loop. Prior to May 23, 2007, when an NPI is reported in NM109 for any of the types of providers for which data is included in a claim, Medicare will also send the legacy

number (UPIN, National Supplier Clearinghouse or OSCAR) for each of those providers in the REF segment of the loop used to supply identifying information for that provider.

Contractors shall populate the outbound COB files with the provider's first name, last name, middle initial, address, city, state and zip code as contained in their provider files, in the event of any discrepancy with the inbound 837.

Each supplemental insurer specifies the types of claims it wants the carrier, DMERC, FI, or COBC to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- MSP claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

On July 5, 2004, CMS began to transfer claim crossover responsibility from FIs, carriers and DMERCs to a national claims crossover contractor called the COBC. This initiative is titled as the "COB Agreement (COBA) Process." Under this process, carriers, DMERCs and FIs will be sent a CWF Beneficiary Other Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the FI, carrier, or DMERC will transfer the processed claim to the COBC as an 837 COB flat file or NCPDP file to be crossed over to the trading partner. Refer to Chapter 28, section 70.6 of the Claims Processing Manual for further details about specific carrier, DMERC, and FI responsibilities under the COBA process.

The translator used by a carrier, DMERC, FI, and the COBC will build the outbound 837 COB transaction from the flat file data supplied by that contractor's shared system.

Until all trading partners are moved into cross-over production with the COBC, non-transitioned supplemental insurers/payers will continue to provide an eligibility file no less frequently than monthly, preferably weekly, to enable Medicare contractors to identify dually eligible individuals whose claims are to be forwarded for COB/crossover purposes. In addition, until all trading partners are moved into production with the COBC, Medicare contractors shall continue to send COB transactions to their trading partners at least once a week. Pending completion of the transition to the COBC, carriers, DMERCs, and FIs may transmit COB data to a trading partner in either the HIPAA 837 version 4010A1 format or in a legacy format, according to the trading

partner's preference. Upon the earlier of the completion of the COB transition or termination of the Medicare outbound COB claim contingency plan, COB transactions may be sent to trading partners only in the X12 837 version 4010A1 format.

The HIPAA implementation guides (IGs) state that the ISA08 is an "identification code published by the receiver of the data; when sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them." The ISA08 is a 15-position alphanumeric data element. FIs, carriers, and DMERCs, and their shared systems must populate 15 positions of ISA08 data (as published by the receiver of the data) on outbound X12N HIPAA transactions. FIs, carriers, DMERCs, and the COBC must also make the necessary changes to be able to ensure that each trading partner has a unique ISA08. FIs, carriers, DMERCs, and the COBC must inform their trading partners that the CMS cannot allow two trading partners to have the same ISA08.

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

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

To resolve this problem for COB, the shared system must "gap fill" data in certain cases when issuing flat file data for carrier, DMERC, or FI translation into a HIPAA-compliant COB transaction. If data elements are unavailable or incomplete, but are needed to prepare a HIPAA-compliant COB transaction, the shared system must "gap fill."

When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (other than MCS) and the carriers that use MCS shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain “XXXXX” and a 5-character numeric data element would contain “99999”.

When non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12 837 HIPAA COB transaction, the shared system maintainers (other than MCS) and MCS Carriers shall gap fill the phone number data element with “8009999999”.

Data elements with pre-defined IG values such as qualifiers, and data elements that refer to a valid code source shall not be gap filled. Paper claims do not usually contain qualifiers but do contain explicit field names that provide information equivalent to qualifiers or that identify valid code sources. For COB purposes, those field names must be mapped to the appropriate qualifier or code source for reporting to trading partners in the 837 version 4010A1 format.

Until trading partners are fully moved into production with the COBC, carriers, DMERCs, FIs are required to notify their COB trading partners of the common situations when gap filling could occur and of the characters that will be used to gap fill according to data type of the particular X12 data element.

B. NCPDP COB Transaction

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

“07” = Medicare Allowed Amount

“08” = Medicare Paid Amount

“99” = Deductible Amount

“99” = Coinsurance Amount

“99” = Co-Payment Amount

NOTE: The first occurrence of “99” will indicate the Deductible Amount.
The second occurrence of “99” will indicate the Coinsurance Amount.
The third occurrence “99” will indicate the Co-Payment Amount..

C. Legacy Formats

Prior to implementation of the NCPDP standard in compliance with HIPAA, retail pharmacies were required to use the CMS-1500, NSF, or X12 837 format to bill drugs covered by Medicare Part B to DMERCs. See §40.2 for information on the legacy formats that can be used in lieu of the NCPDP format pending termination of the Medicare COB claim contingency plan.

90.5 – Enforcement

(Rev. 831, Issued: 02-02-06; Effective: 07-01-06; Implementation: 07-03-06)

Enforcement will be conducted on a post-payment basis. Shared system maintainers will prepare quarterly reports for the contractors 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. Medicare contractors will obtain and analyze these reports by the end of the following month and select providers submitting the highest numbers of paper claims for review.

Medicare carriers, DMERCs, and FIs will be issued separate funding under budget activity 17004 for enforcement of the ASCA electronic claim submission requirement. Each contractor will be notified of the number of ASCA paper biller reviews their staff will be expected to conduct when the annual funding is issued for these reviews. Information on the number of reviews to be conducted and the identity of the providers selected for review will not be made public.

Contractors are to request information from the selected providers to establish that they meet criteria for submission of paper claims. See exhibit C for the request letter. If no response is received within 45 calendar days (30 calendar days with time allotted for initial postal delivery, review by the provider, and return postal delivery; see exhibit D for the letter), or if a provider's response does not establish eligibility to submit paper claims (see Exhibit E for the letter), the contractor will notify the provider by mail that:

1. Any paper claims received more than 90 calendar days after the date of the initial request letter will be denied and not paid by Medicare;

2. Free billing software is available for provider use (contractor must furnish contact information for the provider to obtain further information);

3. Commercial billing software is also available on the open market for submission of Medicare claims and that clearinghouses and other vendors offer electronic claims services commercially (contractor must insert reference to information available as discussed in section 60.8); and

4. A Medicare decision that a provider is ineligible to submit paper claims is not subject to appeal.

The contractor must enter the determination to the system to assure that paper claims from the provider are denied effective with the 91st calendar day after issuance of the letter. *Contractors have authority to delay this determination until the 121st day if the provider indicates all changes needed to submit their claims electronically will be completed by no later than the 121st day, and based on prior experience with this provider, the contractor has confidence that the provider will comply by that date. Contractors must contact CMS Division of Data Interchange Standards (DDIS) in OIS/BSOG for permission to approve any extension beyond the 121st day.* If review of the response determines that the provider is eligible to submit paper claims to Medicare, notify the provider by mail of that determination (see exhibit F for a sample letter).

If the provider subsequently submits documentation to establish that they actually met criteria for submission of paper claims, effective with that 91st day, the contractor must remove the determination from the system to assure that future paper claims from the provider are not denied. The contractors must notify the provider by mail (see Exhibit F for a sample letter) of that determination. The contractor will not reprocess those paper claims denied during the interim unless those claims are resubmitted by the provider.

If a provider submits documentation to establish eligibility to submit paper claims but that eligibility is effective after the 91st day, and the provider resubmits denied claims, do not approve any claims that contain dates of service that fall between the 91st day and the date when the provider became eligible to submit claims on paper.

Medicare contractors are not to maintain a provider FTE database, or establish a database of waived providers, unless an "unusual situation" waiver decision is made (see §90.3.2 and §90.3.3), or an enforcement review is conducted. Each contractor will indefinitely maintain a local Excel spreadsheet of "unusual situation" waivers, with column headings for the name, address, provider number, whether the "unusual circumstance" waiver was approved or denied, the termination date for an approval (if applicable), and the unusual circumstance identified in the request. Exclude locally approved 90/180-day waivers from this list. Contractors are also to maintain an Excel spreadsheet with column headings for provider name, provider number, address, date of enforcement review determination of each provider reviewed, whether continued submission of paper claims is approved or denied, the exception/waiver condition claimed by the provider, and if denied, date rejection of paper claims to begin. Contractors must be able to submit these reports to CMS when requested. Contractors shall not review the same provider again for at least two years if the provider justified submission of paper claims to Medicare, and that justification is expected to be in force for at least two years.

NOTE: Some ASCA exceptions apply to individual claim types only, or to submission of paper claims for temporary periods. CMS does not expect that the number of paper claims submitted under those limited range exceptions should be high enough to trigger review of providers allowed to submit claims of that type on paper for an entire quarter or part of a quarter, as long as the balance of the claims submitted by those providers for the quarter are electronic. If a contractor is able to determine that a provider would not have met the criteria for selection for an ASCA review if the number of claims permitted to be submitted on paper under a specific exception in §§90.2 or 90.3 were subtracted from the total number of paper claims submitted by the provider for the quarter, the contractor can curtail the review of that provider. In this case, identifying information on the provider, the reason the provider's review was curtailed, and the date of that decision must be recorded in the Excel spreadsheet. Contractors must check the Excel spreadsheet when determining whether any provider tentatively selected for review after the first review quarter has a prior review history which could result in exclusion of that provider from re-review at that time or which could contribute to the current review. If there was a prior review that was curtailed, a contractor must determine if the same exception should still apply to the provider (in which case, the provider should not be reviewed), or if that exception should have expired before the quarter for which now selected for review (in which case, the provider must be reviewed).

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 these claims. When a provider's claim is denied for this reason, the beneficiary MSN must contain message 9.9, "This service is not covered unless supplier/provider files an electronic media claim." See Chapter 21 for further MSN information. Although it may be advisable for a beneficiary to change his/her provider when a provider refuses to bill Medicare electronically and does not qualify for an exception for paper billing, this may not be a reasonable option for some beneficiaries. The "Medicare & You" Handbook (section 7, 2005) directs beneficiaries to contact their provider and request the claim be resubmitted electronically if they receive this denial message in an MSN. If the provider refuses, the beneficiary is then directed to contact 1-800-Medicare for further possible action or guidance.

If a provider is selected for an ASCA enforcement review that is also undergoing a fraud or abuse investigation, a carrier, DMERC or FI has discretion to exclude that provider from the ASCA enforcement review if it would interfere with the fraud/abuse investigation, or to combine the 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.