CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 768	**Date: September 13, 2010**
	Change Request 7032

NOTE to the Contractors: Transmittal 733, dated July 30, 2010, is being rescinded and replaced by Transmittal 768, dated September 13, 2010. The business requirement 7032.4 now indicates when the Escalation report is due and the condition under which this report is required has been modified. All other material remains the same. The attached instruction may be communicated to the public and posted on your Web site as early as today, September 13, 2010.

SUBJECT: Further Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)

I. SUMMARY OF CHANGES: This change request (CR) provides additional instructions to clarify instructions previously sent or not implemented correctly, and to set up a process to follow when corrective actions must be developed and implemented for Out Of Balance situations.

EFFECTIVE DATE: * **January 1, 2011**
IMPLEMENTATION DATE: January 3, 2011

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding for implementation activities will be provided to contractors through the regular budget process.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENT:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 768	Date: September 13, 2010	Change Request: 7032

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SUBJECT: Further Instruction for Implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA) version 5010 for Transaction 835 - Health Care Claim Payment/Advice and Updated Standard Paper Remit (SPR)

Effective Date: January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) is in the process of implementing the next version of the HIPAA Transaction 835 standard – referred to as 835v5010 in this document. The Secretary of the Department of Health and Human Services (DHHS) has adopted ASC X12 version 5010 and NCPDP version D.0 as the next HIPAA standard for HIPAA covered transactions. The final rule was published on January 16, 2009. Some of the important dates in the implementation process are:

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

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

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

CMS shall be fully compliant on January 1, 2012, and complete Level I compliancy by December 31, 2010, and Level II compliancy by December 31, 2011. **The transition period when both versions would be allowed in production mode for Medicare will be from January 1, 2011 – December 31, 2011. The 835v4010A1 and the current SPR shall not be sent on or after January 1, 2012, irrespective of the date of receipt or date of service reported on the electronic or paper claim.**

Transaction 835 or SPR related CRs 6034 (Transmittal 508), 6460 (Transmittal 495), 6376 (Transmittal 511), CR 6589 (Transmittal 577), CR 6473 (Transmittal 494), and CR 6975 (Transmittal 709) have already been published and implemented or are going to be implemented by October 2010. This CR provides additional instructions to clarify instructions previously sent or not implemented correctly, and to set up a process to follow when corrective actions must be developed and implemented for Out Of Balance (OOB) situations.

B. Policy: The Administrative Simplification provisions of HIPAA regulations require the Secretary of DHHS to adopt standard electronic transactions and code sets. The Secretary may also modify these standards periodically. ASC X12 005010 and NCPDP D.0 have been adopted by the Secretary as the next

HIPAA standards. CMS shall be fully compliant and be ready on January 1, 2012, when all covered entities have to be fully compliant.

The purpose of this release is to communicate additional business requirements for Shared System Maintainers to be ready to generate 835 version 5010 flat file to be received and translated by the MACs to generate compliant 835s and related SPRs for testing with trading partners and/or for transitioning early adopters to the new HIPAA standard for Transaction 835. This CR is the eighth 835/SPR CR in the series of instructions for full implementation of the new HIPAA standard after CRs 6034, 6376, 6460, 6473, 6589, 6601, and 6975.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7032.1	VMS shall provide a customer-controlled solution that will allow the DME MACs the ability to enter contact information for use in the 1000A PER segment for Payer Technical Contact Information in the 835v51010 ERA that is different from the COBC contact information that is used in the 1000A PER segment for Submitter EDI Contact Information in the 837 COB transaction files		X						X		
7032.2	FISS shall populate: - Loop 2100 NM1 – Patient Name segment with patient name as received on the claim; and - Loop 2100 NM1 – Corrected Patient/Insured Name segment with the adjudicated name as received from Common Working File if it is different from the name received on the claim						X				
7032.3	FISS, MCS, and VMS shall always create a situational segment if the Situational Rule as stated in the TR3 applies for Medicare. On the other hand, a situational segment shall not be created if the Situational Rule does not apply for Medicare. **EXAMPLE**: The CAS segment is created only when there is at least one adjustment that has made the payment different from the submitted charge.						X	X	X		
7032.4	MACs shall review and monitor the OOB reports received from the Shared Systems, and report to CMS and the Shared System involved (FISS for Part A, MCS for Part B, and VMS for DME) weekly (reports due the following Thursday) using the attached OOB Escalation Report form when:	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	a) There is any OOB situation at the provider level; and/or b) OOB situations at the claim or line level reach more than 2% of total claims or lines included in the 835 as identified by usage of reason code 121 for Part B or A7 for Part A.										
7032.5	FISS, MCS, and VMS shall work with MACs and CMS to review, develop and implement corrective actions to resolve the OOB issues identified by the MACs per BR 7032.4.	X	X	X	X	X	X	X	X		

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Sumita Sen (410) 786-5755 or sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Sumita Sen (410) 786-5755 or sumita.sen@cms.hhs.gov

VI. FUNDING

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

Funding for implementation activities will be provided to contractors through the regular budget process.

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

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

Attachment: OOB Escalation Report Template

(For alternate format, please contact the CR author)

Out Of Balance Escalation Report

(For alternate format, please contact the CR author)

CMS Contact Name: **Sumita Sen** sumita.sen@cms.hhs.gov

CMS Contact Name: **Jason Jackson** **jason.jackson3** **Jason Jackson**

MAC Contact Name:

MAC Contact e-mail address

MAC Contact phone #

* To be filled only for OOB at claim or line. It should show the % of OOB claims/lines out of total claims/lines for the 835

#	Date	Shared System	Transaction Set Control #	ICN/DCN	OOB at Provider/Claim/ Line	Problem	Resolution	Name of Responsible Party	Date of Resolution Implemntation	% of OOB Claims/Lines *