CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2346	**Date: November 18, 2011**
	Change Request 7598

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

I. SUMMARY OF CHANGES: This CR is to publish an update to IOM Pub.100-04 Chapter 24 to reflect changes to Medicare Fee-For-Services Electronic Data Interchange (EDI) practices, and corresponding EDI requirements for Medicare contractors that are being implemented as part of the 5010 implementation project.

EFFECTIVE DATE: December 19, 2011
IMPLEMENTATION DATE: December 19, 2011

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	24/Table of Contents
R	24/10.2 /Audience for this chapter
R	24/10.3/Scope of Chapter
R	24/10.4/Acronyms and Definitions
R	24/20/General EDI
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R	24/40.1.2/Transactions Used in the Acknowledgement of Receipt of Inbound Claims
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R	24/40.2.1/Certification Testing and Annual Recertification Activities
R	24/50.1.2/Media
R	24/50.1.3/Telecommunications and Transmission Protocols
R	24/50.2/Translators
R	24/50.3.3/Acknowledgements
N	24/50.3.3.1/Outbound File Compliance Check
N	24/50.3.4/Common Edits and Enhancement Module (CEM) Code Sets Requirements
N	24/50.3.5/Handling of Poorly Formed/Invalid lat File for a 277CA
R	24/50.5.2 EDI Receiver Testing by FIs, Carriers, RHHIs, A/B MACs and CEDI
R	24/50.8/Nulls
R	24/50.10.2.2/Contractor Responsibility
R	24/60.1/Fis,Carriers,RHHIs,A/B MACs and CEDI Edit Requirements
R	24/80.4/HIPAA Transition Reporting
R	24/80.5/Administrative Simplification and Compliance Act (ASCA) Reporting
R	24/90.2/Exceptions
R	24/90.3.2/Unusual Circumstance Waivers Subject to Evaluation and CMS Decision

III. FUNDING:

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

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 2346	Date: November 18, 2011	Change Request: 7598

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

Effective Date: **December 19, 2011**

Implementation Date: December 19, 2011

I. GENERAL INFORMATION

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

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

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

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

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

The purpose of this CR is to publish an update to IOM Pub.100-04 Chapter 24 to reflect changes to Medicare Fee-For-Service's Electronic Data Interchange (EDI) practices, and corresponding EDI requirements for Medicare contractors that are being implemented as part of the 5010 implementation project.

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

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

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7598.1	Contractors shall implement all requirements contained within the IOM Pub. 100-04 Chapter 24 General EDI and EDI Support Requirements, Electronic Claims and Mandatory Electronic Filing of Medicare Claims.	X	X	X	X	X					CEDI

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: NA

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

Pre-Implementation Contact(s): Angie Bartlett (410) 786-2865 Angie.Bartlett@cms.hhs.gov
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Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

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

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

Section B: *For Medicare Administrative Contractors (MACs)*:

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.

Medicare Claims Processing Manual

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

Table of Contents

(Rev.2346, Issued: 11-18-11)

10.2 Audience for this chapter

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

Therefore, the instructions within this chapter are primarily directed to Medicare Administrative Contractors (MACs), Fiscal Intermediaries, Carriers, Durable Medical equipment Medicare Administrative Contractors (DMEMACs), the Common Electronic Data Interchange (CEDI) contractor for DMEMACs, and their shared systems, and are in reference to Medicare requirements for their implementation of the current HIPAA compliant version of the Accredited Standards Committee (ASC) X12N Technical Report Type 3 (TR3) also known as an ASC X12 or ASC X12N Implementation Guide (IG) and NCPDP Telecommunication Implementation Guide, as well as all Medicare and contractor EDI activities related to these transactions. In order to implement the HIPAA administrative simplification provisions, specific ASC X12 and NCPDP transactions have been named under part 162 of title 45 of the Code of Federal Regulations as electronic data interchange (EDI) standards for Health Care. All other EDI formats for health care became obsolete on October 16, 2003. The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the Federal Register on January 16th, 2009, adopted updated versions of HIPAA mandated electronic transactions. Furthermore, the Final Rule conveys inclusion of errata *documents* to the transaction standard*(s)*. Medicare FFS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction*(s)*. *Medicare FFS further adopts the Accredited Standards Committee (ASC) X12 and National Council for Prescription Drug Programs (NCPDP) transaction Standards as Part of its EDI Acknowledgement Model*.

10.3 Scope of this chapter

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

This chapter will provide an overall description of EDI operations, requirements, roles and responsibilities for Medicare FFS.

Medicare FFS is utilizing the following EDI transactions:

Transactions	**Version 4010**	***Version 5010***
270/ 271 Health Care Eligibility Benefit Inquiry and Response	004010X092A1	*005010X279A1*
837 Health Care Claim: Professional	004010X098A1	*005010X222A1*
837 Health Care Claim: Institutional	004010X096A1	*005010X223A2*
TA1	See individual IGs	*005010X231A1*
997 Implementation Acknowledgment For Health Care Insurance	See individual IGs	*NA*
999 Implementation Acknowledgment For Health Care Insurance		*005010X231A1*
835 Health Care Claim Payment/Advice	004010X091A1	*005010X221A1*
276/277 Status Inquiry and Response	004010X093A1	*005010X212*
277CA Claim Acknowledgment		*005010X214*
National Council for Prescription Drug Programs (NCPDP) of the Telecom Standard	Version 5.1	*Version D.0 August 2010*
National Council for Prescription Drug Programs (NCPDP) Batch Standard	Version 1.1	*Version 1.2*

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

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

1. Chapter 22 – 835- Remittance Advice (paper and electronic)
2. Chapter 31 –270/271- Eligibility Inquiry and Response and
3. 276/277 – claim status inquiry and response

Two other related IOM chapters include:

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

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

10.4 Acronyms and Definitions

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

- EDI – Electronic Data Interchange - the process of using nationally established standards to exchange electronic information between business entities. HIPAA – Health Insurance Portability and Accountability Act – legislation that mandated that the healthcare industry use standard formats for electronic claims and claims related transactions.
- MAC – Medicare Administrative Contractor – Section 911 of the Medicare Modernization Act of 2003 mandates that the Secretary for Health & Human Services replace the current contractors administering the Medicare Part A or Part B fee-for-service programs with new Medicare Administrative Contractors (MACs). Part A/Part B Medicare Administrative Contractors (MACs) will replace the current fiscal intermediaries and carriers and handle administration of both the Medicare Part A and Part B programs in specified geographic regions. For more information, please see the CMS overview of Medicare Contracting Reform .
- A/B MAC – Medicare Administrative Contractor servicing both part A and part B lines of business.
- FI – Fiscal Intermediary – Part A Medicare Contractor – Eventually will be replaced by Part A/B MAC.
- Carrier – Part B Medicare Contractor – Eventually will be replaced by Part B MAC.
- DME MAC – Durable Medical Equipment Medicare Administrative Contractor
- CEDI - Common Electronic Data Interchange – Common front end for DME MACs
- Trading Partner – one of two or more participants in an ongoing business relationship (e.g., provider, billing service, software vendor, employer group, financial institution, etc.).
- Submitter – an entity that owns the healthcare data being submitted. It is most likely the provider, hospital, clinic, etc. A submitter is directly linked to each billing NPI.

- Network Services Vendor- an entity that provides connectivity services, but that does not have access to content of the data being transmitted.
- EDI Enrollment – establishes documentation specifying type of transactions and transmission methods to be used in the exchange of electronic administrative transactions.
- EDI Registration – designates the Medicare contractor as the entity they agree to engage *with* for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.
- Trading Partner Agreement – ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.
- Third Party Agreements- an agreement that ensures confidentiality, security, and integrity of Medicare data being shared by third party agents that represent providers, including NSVs, certain value-added networks, clearinghouses, and billing agents.

20 General EDI

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

EDI is the process of using nationally established standards to exchange electronic information between business entities. These national standards are developed and maintained by a group of standards development organizations (SDOs), such as the Accredited Standards Committee (ASC) X12 and the National Council of Prescription Drug Programs (NCPDP). The Department of Health and Human Services (HHS) adopted certain standards for use in health care under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Medicare FFS is required, as are all payers in the US, to adopt the standards specified under HIPAA. However, as part of Medicare FFS' EDI *Acknowledgement Model*, three additional ASC X12 standards will be adopted for error handling (277CA, 999, and TA1) that are not mandated under HIPAA. In addition, there will be one additional standard adopted for NCPDP error handling (Transmission Response) that is not mandated under HIPAA.

30.2 New Enrollments and Maintenance of Existing Enrollments

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

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

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

NOTES:

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

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

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

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

When an FI, Carrier, RHHI, A/B MAC, or CEDI receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third party, the FI, Carrier, RHHI, A/B MAC, or CEDI must verify that an EDI Enrollment Form is already on file for that provider or supplier, and that the third party has already been issued an EDI number and

password to permit submission/receipt of EDI transactions. The request cannot be processed until both are submitted/issued.

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

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

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

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

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

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

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

treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law;

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

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

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

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

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

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

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

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

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

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

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

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

14. That it will research and correct claim discrepancies;

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

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

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

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

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

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

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

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

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

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

C. Signature

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

Provider's Name

Title

Address

City/State/Zip

By _____ _____

(signature) (printed name)

Date

40.1.2 Transactions used in the acknowledgment of receipt of *Inbound* claims

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

With the CMS implementation of the 5010 transactions, the following two transactions shall be used in the acknowledgment of the receipt of claims.

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

40.1.3 Change Request (CR) to Communicate Policy

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

40.2.1 Certification *Test Program and Annual Recertification Activities*

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

CMS has initiated a Certification Test Program comprised of the following: use cases, test cases, and associated test data files to verify that each A/B MACs, DME MACs, or other contractors if designated by CMS is ready to receive and process current transactions as well as other CMS required EDI enhancements.

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

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

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

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

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

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

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

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

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

The modifications and enhancements resulting from changes to the Edit Spreadsheets and deviations resulting from the CTP will be used as part of the annual re-certification. The contractors will utilize the CTP that is updated annually to perform self certification annually. The STC will provide detailed instructions to the A/B MACs, CEDI or other contractors if designated by CMS to be used to perform the re-certification testing. These instructions will be revised as needed and communicated to the A/B MACs, CEDI, or other contractors if designated by CMS. The CMS/STC MAC Re-Certification Instruction Guide will be used as guidance to set up the execution of the Front End system to certify compliance with the standards. As part of re-certification, contractors will use template supplied by the STC for reporting of Re-Certification status, re-certification Checklists Reports, and Deviation Reports. In addition, weekly meetings with the contractors will be established by CMS during the re-certification process for gathering status and other reporting activities.

The STC, utilizing existing processes and guidelines, will continue to provide ongoing administrative support for the 5010 certification/re-certification including building the master Recertification Test Package, review of certification deviations to ensure the chosen Recertification use cases and test cases are in sync with the current edit spreadsheets and complete the final sync (occurring immediately prior to the distribution of the Recertification test package) of the Recertification Test Package with the most recent edit spreadsheet. As future CRs are implemented that impact the 5010 use cases, test cases, or data files, a MAC contractor(s) will be assigned the responsibility of modifying the existing test products and submitting them to the STC for review, validation, and inventorying into DOORS.

Following the annual re-certification activities CMS will be conducting compliance audits of contractor's re-certification files. These audits include but are not limited to weekly status reports, deviation reports, and Use Case/Test Case Data files. Audits may be conducted by CMS staff on-site or remotely using appropriate file storage and exchange sources. Following the contractor audits individual audit reports will be generated.

50.1.2 Media

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

When counting electronic claims for workload reporting, the FI, Carrier, RHHI, A/B MAC, DME MAC and CEDI includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits.

See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA compliant format.

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

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;
- Adjustment bills (FIs only);
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);
- Bills paid by an HMO and processed by the contractor; and
- FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI are not permitted to accept claims via fax-imaging, tape/diskette or similar storage media. FIs, Carriers, RHHIs, A/B MACs, DME MACs and CEDI are to assist billers using such media to transition to more efficient electronic media.

50.1.3 Telecommunications and Transmission Protocols

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

The preferred method of connecting to the EDI front end at an FI, Carrier, RHHI, A/B MAC and CEDI is through a Network Service Vendor. FIs, Carriers, RHHIs, A/B MACs and CEDI may, but are not required to support electronic transfers for Medicare using 56 K connections for their asynchronous communications lines. For asynchronous communications, FIs, Carriers, RHHIs, A/B MACs and CEDI may, but are not required to, support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP). If FIs, Carriers, RHHIs, A/B MACs and CEDI so support TCIP, it must be compliant with Internet Request for Comment (RFC)

number 1122 and 1123, using Serial Line Internet Protocol (SLIP) or Point-to-Point Protocol (PPP). For any EDI transfers over TCP/IP connections, FIs, Carriers, RHHIs, A/B MACs and CEDI must support a File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication through user ID/password mechanisms. The carrier, MAC or FI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. The Internet may not be used for beneficiary sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project.

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

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

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

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

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

50.2 Translators

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

FIs, Carriers, RHHIs, and A/B MACs, and CEDI must use the X12 997 for version 4010 or 999 for version 5010 Functional Acknowledgment to report X12 transaction standard level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgments for claims without errors. FIs, Carriers, RHHIs, and A/B MACs, or CEDI may purge X12 997 for version 4010 or 999 for version 5010 transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to retain these as long as 30 days if system capacity permits. Once purged, a FIs, Carriers, RHHIs, and A/B MACs, or CEDI is not required to be able to recreate that 997 for version 4010 or 999 for version 5010 transactions. A provider or clearinghouse that failed to download the 997 for version 4010 and 999 for version 5010 timely may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new 997 for version 4010 or 999 for version 5010 issued. The X12 999 TR3 005010X231 can be downloaded from WPC-EDI.com. FIs, Carriers, RHHIs, and A/B MACs and CEDI are required to meet the X12 999 TR3 requirements when issuing the 999 for version 5010. The X12 997 requirements are located in Appendix B at the rear of each X12 IG adopted under HIPAA. FIs, Carriers, RHHIs and A/B MACs and CEDI are required to meet those Appendix B requirements when issuing the 997 for version 4010.

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

FIs, Carriers, RHHIs, and A/B MACs, and CEDI must accept the entire extended character set.. Refer to the 5010 TR3 for specifics on the character set. If FIs, Carriers, RHHIs, and A/B MACs, and CEDI cannot accept more than 9,999 loops or segments per loop in an X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the X12 997 for version 4010 or 999 for version 5010 with the IK304 with a value of “4”.

Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. FIs, Carriers, RHHIs, and A/B MACs, and CEDI are not required to accept multiple functional groups (GS/GE) with multiple transaction types within one transmission for X12 transactions.

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

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map "Not Used" data elements for Carriers, A/B MACs, and CEDI based upon that segment's definition only, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped; "Not Used" data elements are not to be mapped to the FI flat file; and
- Accept multiple interchange envelopes within a single transmission. This is only applicable to X12 transactions as NCPDP only processes a single batch per transmission.
- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case requirements noted for incoming translation. FIs, Carriers, RHHIs, and A/B MACs, and CEDI are not required to accept or process X12 997 for version 4010 or 999 for version 5010 transactions from trading partners for any outgoing X12 transactions.

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

50.3.3 Acknowledgements

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

The CEM will receive CMS defined 837 and 276 flat files from the A/B MAC's translator. The CEM will flag any 837 flat file data in error and will report that data back to the submitter via the

277CA. 276 flat file data in error will be reported back to the submitter via a 277 Claim Status Inquiry Response transaction. All accepted data will be sent to the SSM for processing.

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

50.3.3.1 Outbound File Compliance Check

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

The 999 Acknowledgement for Health Care Insurance, the 835 Health Care Payment/Advice, 276/277 Health Care Claim Status Request and Response and the 277CA Health Care Claim Acknowledgement outbound files shall be compliance checked for the following:

- *Basic syntactical integrity and specific syntax requirements on all outbound files;*
- *Balanced field totals, financial balancing of claims or remittance advices, and balancing of summary fields, if appropriate for all outbound file;*
- *Specific inter-segment situations described in the HIPAA Implementation Guides for all Outbound files; and*
- *Valid Implementation Guide specific code set values and other code sets adopted as HIPAA standards for all outbound files.*

50.3.4 Common Edits and Enhancement Module (CEM) Code Sets Requirements

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

The functionality of the CEM is dependent on the standard system maintainers (SSM) providing current code sets for inbound claims and claim status inquiries to be edited against. This requires the Part A Fiscal Intermediary Standard System (FISS) and Part B Multi Carrier System (MCS) maintainers to update the following code sets on a quarterly release basis in order to align with industry:

- *Country Codes (ISO 3166-1)*
- *Country Subdivision Codes (ISO 3166-2)*
- *State Codes (United States, Canada, Mexico)*
- *Not Otherwise Classified (NOC) Procedure Codes (as defined by CMS)*
- *National Uniform Billing Committee (NUBC) Condition Codes (that are valid for use on the 837 Professional claim per the National Uniform Claim Committee (NUCC))*
- *Ambulance Modifiers*
- *Health Insurance Prospective Payment System (HIPPS) (as updated and maintained by CMS)*

FIs, Carriers, and A/B MACs are required to validate the incoming codes listed above against the most recent codes sets provided by the SSM. CMS will notify the shared system maintainers (via Recurring Update Notification) to load the most recent code sets into the CEM environment for download to the A/B MAC local data center (LDC) in conjunction with the quarterly release.

The Part A Fiscal Intermediary Standard System (FISS) and Part B Multi Carrier System (MCS) maintainers also update the following code sets on a frequency basis other then quarterly in order to align with industry:

- *Zip codes*
- *Claim Adjustment Reason Codes (CARC)*
- *Anesthesia Modifiers*
- *Diagnosis Related Groups (DRG) codes*
- *Healthcare Common Procedure Coding System (HCPCS) codes*
- *Health Insurance Premium Payment System (HIPPS) codes*
- *International Classification of Diseases, 9th Revision (ICD-9) codes*
- *National Drug Codes (NDC) (as published by the Federal Drug Administration(FDA))*
- *National Provider Identifier (NPI) crosswalk*
- *Remittance Advice Remark Codes (RARC)*
- *Taxonomy Codes*
- *Procedure Code Modifier Codes*
- *Admission Source Codes*
- *Admission Type Codes*
- *Patient Status Codes*

- *Condition Codes*
- *Occurrence Codes*
- *Occurrence Span Codes*
- *Value Codes*
- *Revenue Codes*
- *Uniform Bill Type codes*
- *Provider Control File (PCF) – Part B only*

FIs, Carriers, and A/B MACs are required to validate the incoming codes listed above against the most recent codes sets provided by the SSM. When the above listed reference code sets are updated, they are sent to the A/B MAC local data center (LDC) as part of nightly code updates.

50.3.5 Handling of Poorly Formed/Invalid Flat Files for a 277CA
(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

When a poorly formed/corrupted invalid flat file for a 277CA outbound transaction is received, the contractor may manually correct the flat file acknowledgement data necessary to produce a valid 277CA. The manually corrected information is then to be submitted to the translator. This process shall be executed on an exception basis to ensure that a 277CA can be produced for an accepted transaction.

50.5.2 EDI Receiver Testing by FIs, Carriers, RHHIs, A/B MACs, and CEDI
(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

Even if testing is not normally required, parties that want to begin receipt of an outgoing transaction supported by Medicare must notify their FIs, Carriers, RHHIs, A/B MACs, DME MACs or CEDI when to begin transmission of the HIPAA version of a specific outgoing transaction.

50.8 Nulls
(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

The null scrubbing of outbound data exiting the Enterprise Data Center (EDC), prior to its delivery to the Local Data Center (LDC) was initiated with Transmittal 702 Change Request 6946, Common Edits and Enhancements Module (CEM) October Release Update for

Test/Production Indicator Activity and Outbound Data Scrubbing. The scrubbing process will apply to HIPAA Version 5010 outbound file structures to the EDC (e.g. 835 and 277 flat files). It will not apply to outbound HIPAA Version 5010 837 COBC files.

The Shared System maintainer shall implement a scrubbing process that occurs after the creating of the HIPAA Version 5010 outbound file structures at the EDC (e.g. 835 and 277 flat files). Once the flat files have been processed through the EDC's receipt, control and balancing jobs they are viewed as ready for transmission to the LDC. At this point in the process null values are to be replaced with spaces.

50.10.2.2 Contractor Responsibility

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

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

Additional documentation received by FIs, Carriers, RHHIs, A/B MACs, and DME MACs via the PWK process will be imaged and made available for view and/or retrieval by claims examiners/medical review staff. FIs, Carriers, RHHIs, A/B MACs, and DME MACs staff adjudicating claims will only review PWK data when the claim encounters an edit/audit requiring additional documentation. The presence of the PWK indicator within the shared system

will alert contractor staff that there is additional documentation which potentially may be used to adjudicate the claim. It is important to note that the simple presence of the PWK on a claim will not cause the claim to suspend.

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

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

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

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

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

A. X12 997/999 Functional Acknowledgment

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

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

The X12 997 requirements are contained in appendix B at the rear of each version 4010A1 IG adopted as a national standard under HIPAA. Appendix A of those guides contains information on the interchange and application control structures used in the design of X12 standards, explains the basic structure of each X12 transmission, and further defines differences between syntax and semantic edits. Translators must reject all transactions contained in the same functional group of a batch when there is a functional group syntax error, and all transactions within the same transaction group header when there is a syntax error at that level.

B. Translation and Date of Receipt Editing

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

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

C. Implementation Guide Edits

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

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

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

No national standards have been adopted under HIPAA for acknowledgement or error reporting for any of the HIPAA format transactions. However, Medicare has adopted the 999 and 277CA for this purpose effective with the implementation of version 5010. *For Version 5010 DME MACs will continue the use of* proprietary error reporting *for* CMN rejection reports, which are returned to DME submitters through CEDI. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, FIs, Carriers, RHHIs, A/B MACs, and CEDI are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

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

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

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

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

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

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

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

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;
- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;
- All non-Medicare data field lengths correspond to the maximum IG length.
- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;
- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size;

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system); and
- All decimal data elements are defined as "R" and translators write these data elements to the X12-based flat file at their maximum field size (which is initialized to spaces). The COBOL picture found under the X12 element name must be used to limit the size of the amounts. These positions must be right justified and zero-filled. Contractor translators must convert signed values using the conversion table shown below. This value must be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the X12-based flat file data element is used as a placeholder by Medicare to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are:
    - "X" = value exceeds maximum amount based on the COBOL picture,
    - "Y" = value exceeds maximum decimal places based on the COBOL picture,
    - "Z" = value exceeds x-number of precision places, and
    - "b" blank represents no error.

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

Conversion Table

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

Positive Values	Negative Values
9 = I	-9 = R
0 = {	-0 = }

80.4 HIPAA Transition Reporting

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

As new HIPAA versions are named, contractors are required to report their implementation progress to CMS via transition reporting. Data collection will be achieved via an external, secure web-based reporting tool designed to support long term, short term, and ad-hoc data gathering efforts, such as Electronic Data Interchange statistics and performance metrics.

The contractor shall obtain access to the web-based reporting tool via self enrollment contingent on CMS approval. Current reports vary in frequency from weekly to monthly; however, any future efforts will reflect the most appropriate time period. Contractors will always be notified via *Technical Direction Letter (TDL)* on the required starting date of any transition reporting, the content of the transition data, and the frequency of the reporting effort.

Contractors will utilize the reporting functionality in their front end systems, in CEM, *in the Shared System Maintainer,* and/or in CEDI to provide CMS with their EDI HIPAA transition reports.

80.5 Administrative Simplification and Compliance Act (ASCA) Reporting

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

Contractors are required to report the status of their ASCA enforcement activities on a monthly basis. ASCA enforcement data will be submitted via an external, secure web-based reporting tool.

The contractor shall obtain access to the web-based reporting tool via self enrollment contingent on CMS approval. Contractors will always be notified via *Technical Direction Letter (TDL)* of any changes in the reporting requirements of the ASCA enforcement reporting, the content of the ASCA enforcement data, and the frequency of the ASCA enforcement reporting effort.

Contractors shall reference Pub 100-04, Chapter 24, Section 90 for the complete details and requirements on ASCA enforcement.

90.2 Exceptions

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

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

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

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

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

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

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

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

The OTAF is identified in the CAS Segment with the Group Code of "CO". The CO is used both on the X12 835 remittance and the 837 claim.

4. MSP Claims When There is More than One Primary Payer and More Than One Allowed Amount—In an MSP situation, Medicare needs to use a primary payer's allowed and paid amounts to calculate the supplemental amount that can be paid by Medicare. In some cases, a beneficiary is covered by more than one other primary payer. Each of those other payers must complete adjudication before Medicare can process those claims. The ASC X12 837 current HIPAA version IGs permit reporting of payment information from more than one other payer, but not for reporting of separate allowed amounts at the line or claim level for more than one payer. As result of this limitation, when there is more than

one primary payer, and the allowed amounts differ, a provider is permitted to submit the claim to Medicare on paper, with the RA/EOB from each of the primary payers attached.

5. 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. Claims submitted by Medicare beneficiaries.

90.3.2 Unusual Circumstance Waivers Subject to Evaluation and CMS Decision

(Rev.2346, Issued: 11-18-11, Effective: 12-19-11, Implementation: 12-19-11)

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

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

"Unusual Circumstances" that Require CMS Review:

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

   NOTE: A Medicare contractor is not permitted to prohibit submission of an electronic claim because there is a paper attachment. The X12N 837 IG contains information for provider use of the PWK segment to alert a Medicare contractor that attachment information is being separately submitted. Some Medicare contractors

had issued instructions regarding use of the X12 837 NTE segment to report attachment information in lieu of PWK. Submitters of claims for which there are attachments essential for adjudication must comply with the X12 attachment reporting direction issued by their Medicare contractor for the immediate future. System changes will be made for contractor use of PWK in conjunction with implementation of the attachment standard which is scheduled for future adoption as a HIPAA standard. NCPDP claims should not have attachments.

Medicare contractors are required to accept claims electronically for reassociation with attachments submitted separately on paper or via other means such as fax when supported by individual contractors. Medicare contractors must include the process for submission of claims when there are attachments in a newsletter article and on their Web site with other applicable information concerning the ASCA requirement that Medicare claims be submitted electronically.

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims. In this case, the documentation that establishes the disability of those staff members would need to be issued by providers other than the provider requesting the waiver and would need to be submitted for review.

3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience. The provider must submit a waiver request to their FI, Carrier, RHHI, A/B MAC or, DME MAC for evaluation by that contractor, and if approved at that level, for subsequent review by CMS. In the event other situations are identified and approved by CMS for which a requirement for electronic filing would always be considered against equity and good conscience, those situations will be added to the self-assessment list.