CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2965	**Date: May 23, 2014**
	Change Request 8756

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 24 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to publish an update to IOM, Medicare Claims Processing Manual, 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. In addition, changes are being made to correct material that needs general updating.

EFFECTIVE DATE: July 25, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 25, 2014

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	24/30.4 Network Service Vendor (NSV) Agreement
R	24/40.2.2.5 EDI Enrollment and EDI Claim Record Retention
R	24/90.7.4 Number of ASCS Enforcement Reviews to be Conducted by the RRB SMAC
R	24/Exhibit A - Response to a non - "unusual circumstace" waiver request
R	24/Exhibit B - Denial of an "unusual circumstance" waiver request
R	24/Exhibit C - Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper
R	24/Exhibit D - Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of non-response to that letter
R	24/Exhibit E - Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of determination that they provider is not eligible to submit paper claims
R	24/Exhibit F - Notice that determination reached that the provider is eligible to submit paper claims
R	24/Exhibit G - Notice from the Railroad Board Specialty Medicare Administrative Contractor (RRB SMAC) to a Provider that Has Just Begun to Submit Claims that Paper Claims Submitted by that Provider Will be Denied
R	24/Exhibit H - Notice from the Railroad Retirement Board Speciality MAC to a Provider with a Pre-Established Record in PES that Paper Claims Will be Denied as Result of the Requirements that a Provider Submit Claims to One or More Other Medicare Contractors Electronically

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2965	Date: May 23, 2914	Change Request: 8756

SUBJECT: Medicare Claims Processing Pub. 100-04 Chapter 24 Update

EFFECTIVE DATE: July 25, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 25, 2014

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to publish an update to IOM Medicare Claims Processing Manual, 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. Additionally, general updating is contained within this update to standardize EDI Transaction standards and contractor references. Version 4010 has been removed from this update as well.

B. Policy: HIPAA Legislation Published in the Federal Register; 45 CFR Part 162

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8756.1	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					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Jason Jackson, 410-786-6156 or jason.jackson@cms.hhs.gov , Angie Bartlett, 410-786-2865 or angie.bartlett@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual

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

Table of Contents

(Rev.2965, Issued: 05-23-14)

[Transmittals for Chapter 24]

30.4 - Network Service Vendor (NSV) Agreement

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Third party agents that represent providers, including NSVs, certain value-added networks, and a classification of billing agents that will send and receive Medicare electronic transactions, must sign an agreement. Billing services acting as a business associate for a provider who is the initiator of Medicare claims and the final recipient of Medicare Remittance advices should not be considered a billing agent and therefore are not subject to the provisions of signing the NSV agreement.

The NSV agreement includes the following wording:

The third party provider agent agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974, which requires Federal information systems to establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims, remittance advice, online claims correction, and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically;

2. It is has no ownership rights and is not a user of the data, but merely a means of transmitting data between users that have a need for the data and are already identified as legitimate users under a "routine use" of the system; that is, disclosure for purposes that are compatible with the purpose for which Medicare collects the information;

2. The beneficiary data submitted to them by the A/B MAC, DME MAC or CEDI are owned by Medicare;

3. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than (a) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider's patient, (b) CMS, or (c) CMS' A/B MAC, DME MAC or CEDI;

4. It will promptly notify the A/B MAC, DME MAC or CEDI of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure;

5. The data will not be stored for any duration longer than that required to assure that they have reached their destination, and no more than 30 days for any purpose;

6. It has identified to the A/B MAC, DME MAC or CEDI in writing of any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks;

7. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. For example, data cannot be viewed or manipulated by connectivity vendors to create reports for providers, that function is reserved for a provider's clearinghouse or billing service. Reports may be

written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date;

8. It will guarantee that an authorized user may be deleted within 24 hours in the event that person leaves their employment, no longer has a need to access this information, or there is a possible security breach;

9. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing, signed by the provider, submitted to the provider's A/B MAC, DME MAC or CEDI and each provider has a valid EDI enrollment form on file with that CMS contractor;

10. It has safeguards in place to assure each eligibility response is sent only to the provider that initiated the inquiry;

11. It has safeguards in place to assure that all other outbound transactions such as the TA1 interchange acknowledgment, ASC X12 999-E implementation acknowledgment accepted functional groups/transaction sets with errors, ASC X12 999-R implementation acknowledgment rejected functional groups/transaction sets, ASC X12 999-A implementation acknowledgment clean functional acknowledgments, ASC X12 277CA claim acknowledgment, ASC X12 835 electronic remittance advice, and the ASC X12 277 claim status request response received from the A/B MAC or CEDI are sent only to the appropriate authorized entity;

12. It will furnish, upon request, documentation that assures the above privacy and security concerns are being met;

13. It will adhere to the regulations on security and privacy standards for health information under HIPAA, and extended to all business associates of a covered entity per ARRA (see section 20 above for a review of these legislative references);

14. It will require its subcontractors, agents, and business associates to comply with all applicable current requirements of this agreement as well as any future requirements or changes to this agreement; and

15. It will comply with CMS Internet policy. (CMS does not permit the transmission of protected health data between providers and other parties who are not Medicare contractors over the Internet unless it is authenticated and encrypted. The CMS policy requires written notification of intent from organizations anticipating use of the Internet. The CMS reserves the right to require the submission of documentation to demonstrate compliance with requirements, or to conduct on-site audits to ascertain compliance.)

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 third party agent. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with an A/B MAC, DME MAC or CEDI. Either party may terminate this arrangement by giving the other party thirty (30) days notice of its intent to terminate.

SIGNATURE*:* *The signatory hereto represents and warrants that he/she is duly authorized to sign, execute, and deliver this Agreement on behalf of the party it represents for the Medicare Program* 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.

Sole Proprietor or Company Name:

Address:

Address:

City/State/ZIP code:

Signed By: _____ _____
(signature) (printed name)

Title:

Date:

40.2.2.5 - EDI Enrollment and EDI Claim Record Retention

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

In order for an entity to become an EDI trading partner, an EDI enrollment form must be completed, approved, and on file with an A/B MAC or CEDI. A/B MAC or CEDI are required to retain all EDI enrollment forms according to the same CMS Records Schedule retention requirements that apply to the CMS-855 Medicare Enrollment Application.

The paper claim retention schedule can be found at Pub 100-01, Chapter 7, Section 30: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c07.pdf

Once a trading partner has been tested and approved for electronic submission of claims, they can begin submitting electronic claims to Medicare. A/B MAC, DME MACs or CEDI are required to retain electronically filed claims under the same CMS Records Retention Schedule retention requirements that apply to hardcopy claim.

90.7.4 - Number of ASCA Enforcement Reviews to be Conducted by the RRB SMAC

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Due to the impact of ASCA review decisions made by A/B MACs (B), it would not be reasonable to require that the RRB SMAC issue new ASCA review letters for 20 percent of the providers who send them paper bills annually without giving the RRB SMAC some credit for the additional effort expended as result of the PES-SuperPES-quarterly paper claim submitters reports reviews the RMC is required to conduct. It takes the RRB SMAC longer to identify providers that should be sent letters to initiate a new ASCA review and in some cases, the cross checks performed by the RRB SMAC result in disqualification of a provider for selection for a new ASCA Enforcement Review. To adjust for this, the RRB SMAC annual ASCA review target is to review the records of 20 percent of those providers who submit paper claims as indicated in the MCS quarterly paper claim submitters reports, and not to necessarily initiate a new ASCA review of 20 percent of the providers that send them paper claims annually.

To compute this 20 percent, the total number of providers for whom reviews are to be conducted shall be computed as directed in § 90.5.3. To gauge the number to be reviewed during a single quarter in the same FY prior to production of the fourth quarterly report for that FY, the RRB SMAC shall multiply the total of providers who submitted paper bills in the most recent quarterly report by 0.2 (20 percent), and then multiply again by .25. The number of reviews to be initiated during the fourth quarter shall be computed by subtracting the total reviews identified as conducted for the first three quarters of the FY from the total number of reviews targeted for the FY as a whole; the difference in the totals is the number of reviews to be started during the fourth quarter.

For purposes of the monthly ASCA review report submitted to *DTAS*data.info prior to the fourth quarter of a FY, the total number of providers in the MCS most recent quarterly paper claim submitters report shall be entered in the “eligible providers” field. The total number of providers in that quarterly report for whom ASCA review letters are actually issued to begin reviews plus those for whom a decision is made that a new review is not warranted at that time due to an ASCA review action taken by another Medicare contractor

shall be entered in the "Initial Review Letters Issued for Report Period" field of the monthly *DTASdata*.info report. CMS realizes that an initial review letter will not actually have been issued by the RRB SMAC to each provider in this second situation, but the RRB SMAC review of ASCA data in SuperPES for those providers selected from the MCS quarterly paper claim submitters report which result in decisions not to initiate new reviews will be considered as equivalent to initiation of a new review by CMS for comparison purposes with A/B MACs (B) and to determine if the annual 20 percent target has been reached by the RRB SMAC . The number of ASCA reviews completed total to be entered in the monthly report shall equal the number of ASCA reviews completed during the reporting period that were initiated with an ASCA review letter plus the number of new ASCA reviews that were determined not to be warranted that month as result of review of ASCA information in SuperPES that same month.

For the fourth quarter of the FY, the total number of providers as computed for the FY who are eligible for review, i.e., the total who submitted paper claims in each of the quarterly ASCA reports for the FY divided by four, shall be entered in the *DTASdata*.info monthly report as the number of "Eligible Providers." The RRB SMAC shall follow the direction in the prior paragraph to calculate the number of 'Initial Review Letters Issued for Report Period" and the "Reviews Completed" totals to be entered in those fields of the *DTASdata*.info reports for the months in that final quarter. The remaining fields of the monthly ASCA reports are to be completed by the RRB SMAC according to the existing completion instructions for that report which were previously issued to the Medicare contractors.

Exhibits of Form Letters

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Exhibit A - Response to a non- "unusual circumstance" waiver request

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Electronic Claim Submission Waiver Request

You recently submitted a request for waiver of the Administrative Simplification and Compliance Act (ASCA) requirement that claims be submitted electronically to be considered for Medicare payment. Providers are to self-assess to determine if they meet the criteria to qualify for a waiver. A request for waiver is to be submitted to a Medicare contractor only when an "unusual circumstance," as indicated in *b, c or d* below applies. Medicare will not issue a written waiver determination unless b, c or d applies.

ASCA prohibits payment of service and supply claims submitted to Medicare on paper, except in limited situations that apply either to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers—To qualify, a provider required to use a CMS-1450 form when submitting claims on paper shall have fewer than 25 full time equivalent employees (FTEs).A physician, practitioner, or supplier required to use a CMS-1500 form *in a current version* when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare Administrative Contractors (MACs) including the RRB Specialty Medicare Administrative Contractor**.**);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

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

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

a. Periods when a MAC's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual MACs notify their providers of these situations if they apply);

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

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

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

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

If your self-assessment does not indicate that exception or waiver criteria apply as listed above, you shall submit your claims to Medicare electronically. This applies to every MAC to which you submit claims,

including the contractor responsible for processing of Railroad Medicare claims. *The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.*

Sincerely,

Contractor Name

Exhibit B - Denial of an "unusual circumstance" waiver request

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Request for Waiver of Electronic Claim Filing Requirement Decision

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

1. Claims submitted by small providers—To qualify, a provider required to use a CMS 1450 form when submitting paper claims shall have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier required to use the CMS-1500 form *in a current version* when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project, when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all MACs including the RRB Specialty Medicare Administrative Contractor);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

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

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

a. Periods when a MAC's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual MACs notify their providers of these situations if they apply);

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

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

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

We have determined that you do not meet any of these criteria for waiver of the ASCA requirement for electronic submission of Medicare claims. ASCA did not establish an appeal process for waiver denials, but you can re-apply for an "unusual circumstance" waiver if your situation changes. This decision applies to paper claims you may submit to any MAC in the United States, including the RRB Specialty Medicare Administrative Contractor. As you do not qualify for a waiver of the ASCA electronic claim submission requirement, Medicare will begin to deny paper claims you may submit beginning on the 91st day after the date of this letter.

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

Paper claims submitted to Medicare that do not meet the exception or unusual circumstance criteria do not qualify for Medicare payment. *The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.*

Sincerely,

Contractor Name

Exhibit C - Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

A large number of paper claims were submitted under your provider number(s) during the last calendar quarter. Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. This also applies to payments made for beneficiaries who qualify for Medicare based upon their employment in the railroad industry.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers-- To qualify, a provider required to use the Form CMS 1450 when submitting claims on paper shall have fewer than 25 full-time equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 form *in a current version* when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the RRB Specialty Medicare Administrative Contractor ;

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

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

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

a. Periods when a MAC's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual MACs notify their providers of these situations if they apply);

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

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

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

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

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

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

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they otherwise qualify for a waiver under a situation that applies to all of their claims.

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

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. *The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.*

Sincerely,

Contractor

Exhibit D - Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of non-response to that letter

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

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

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting evidence to establish that you qualify for submission of paper claims to Medicare. Nor do we have information available to us that would substantiate that you meet any of the limited exceptions that would permit you to legally submit paper claims to Medicare.

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

If you did not respond because you realized that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. *The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.*

Sincerely,

Contractor Name

Exhibit E - Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of determination that the provider is not eligible to submit paper claims.

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

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

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

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

You have a number of alternatives to consider for electronic submission of your claims to Medicare. *The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.*

Sincerely,

Contractor Name

Exhibit F - Notice that determination reached that the provider is eligible to submit paper claims.

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claim Submission Practices

Thank you for your response to our previous letter regarding the prohibition against the submission of paper claims to Medicare. Based on the information you supplied, we agree that you meet one or more exception criteria to the requirements in §3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, that require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions.

If your situation changes to the point where you no longer meet at least one of the criteria, you will be required to begin submission of your claims electronically by the 91st calendar day after that change in your status.

Although you are not required to submit claims electronically at the present time, you are encouraged to do so. *The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.*

Sincerely,

Contractor Name

Exhibit G - Notice from the Railroad Retirement Board Specialty Medicare Administrative Contractor (RRB SMAC) to a Provider that Has Just Begun to Submit Claims that Paper Claims Submitted by that Provider Will be Denied

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Denial of Paper Claim Submission Practices

You recently began to treat one or more Railroad Medicare beneficiaries and began to submit claims to us for the first time. In the process of establishing a record in our files to indicate that you are eligible to submit Medicare claims, we obtained a copy of your non-RR Medicare enrollment information. That record indicates that you are required to submit your Medicare claims electronically to at least one other Medicare Administrative Contractor and does not indicate that you were issued a waiver to permit submission of paper

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

ASCA did not differentiate among Medicare contractors or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement. As result, we will begin to deny any paper claims you submit to us for Railroad Medicare beneficiaries unless you are able to establish that you meet one or more of the following exceptions to this ASCA requirement:

1. Claims submitted by small providers-- To qualify, a physician, practitioner, or supplier required to use a CMS-1500 form *in a current version* when submitting claims on paper shall have fewer than 10 full-time equivalent employees (FTEs). A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the RRB Specialty Medicare Administrative Contractor);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

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

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

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

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

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

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

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

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

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

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they otherwise qualify for a waiver under a situation that applies to all of their claims.

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

You have a number of alternatives to consider for electronic submission of your claims to Medicare. Commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill us as well as other payers. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state. Some providers have reported that their software vendor or clearinghouse charges a substantial additional amount to allow a provider to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. *This office can supply you with free billing software for submission of Medicare claims. See (contractor shall insert* the *URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed for further information on enrollment for use of EDI, use of free billing software or other EDI information.*

Sincerely,

Contractor Name

Exhibit H - Notice from the Railroad Retirement Board Specialty MAC to a Provider with a Pre-Established Record in PES that Paper Claims Will Be Denied as Result of the Requirement that a Provider Submit Claims to One or More Other Medicare Contractors Electronically

(Rev.2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

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

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claim Submission Practices

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Paper claims will be denied if submitted by entities determined to be in violation of the statute or this rule. ASCA did not differentiate among Medicare Administrative Contractors (MACs) or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement.

We recently discovered that you have been submitting more than 10 Medicare claims per month on average to one or more other MACs and/or submitting claims to another MAC electronically. Unless you have been issued a letter by one or more MACs granting you a waiver of more than 90 days from the ASCA requirement for electronic submission of your claims, or are now able to establish that you do meet one or more of the criteria for waiver of this ASCA requirement, you are also required to submit your claims to us for Railroad beneficiaries electronically. If you have such a letter, or evidence that you do now qualify for a waiver of this ASCA requirement, please forward a copy of that letter or evidence to this office to enable us to update our records and permit you to continue to submit claims to us on paper if you choose.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers--To qualify, a provider required to use the Form CMS-1450 when submitting claims on paper shall have fewer than 25 full-time equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 form *in a current version* when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a MAC that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all MACS including the Railroad Board Specialty Administrative Contractor);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

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

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

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

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

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

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

It is possible that you may previously have contacted this office or had an ASCA Enforcement Review conducted by this office and were informed that you are eligible to continue submitting paper claims to this office since you submit fewer than 10 Medicare claims to us per month. Until recently, we did not have access to ASCA review information from other MACs that could be used to determine whether you should be submitting your claims to us electronically. As we do now have access to this type of information from other MACs, we are required to apply that information to you and to other providers that submit paper claims to this office.

As you may not have been notified that an ASCA electronic claim submission requirement that applies to another MAC also affects your submission of paper claims for Railroad Medicare beneficiaries, we will not begin to deny your paper claims until the 91st day after the date of this letter. This will allow you time to make changes as needed so you can begin to submit your claims to us electronically by the 91st day.

In the event your situation changes and you feel that you do meet one or more of the criteria for an exception from the ASCA electronic claim submission requirement, you should recontact us and any other MAC that made a determination that you do not currently qualify for an exception. If determined that you do in fact qualify for an exception at that point, you would have the option to again begin to submit some or all of your Medicare claims on paper. The type of exception criteria you meet will determine if the exception applies to

only certain types of your claims, all of your claims or applies only for a temporary period. That would be addressed in the decision notice you would be sent.

Some providers have reported that their software vendor or clearinghouse charges a substantial amount to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. *This office can supply you with free billing software for submission of Medicare claims. See (contractor shall insert* the *URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed for further information on enrollment for use of EDI, use of free billing software or other EDI information.*

Sincerely,

Contractor Name