CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3021	**Date: August 8, 2014**
	Change Request 8606

Transmittal 2897, dated March 7, 2014, is being rescinded and replaced by Transmittal 3021 dated August 8, 2014, to change the effective and implementation dates for ASC X12 and to delete from this CR sections 40.1, 40.2, and 90.1, which have been updated by CR 8775. All other information in the remaining sections is the same.

SUBJECT: Update to Pub. 100-04, Chapter 10 to Provide Language-Only Changes for Updating ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 10. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 8, 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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/30.1/Health Insurance Eligibility Query to Determine Episode Status
R	10/40/Completion of Form CMS 1450 for Home Health Agency Billing

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: 3021	Date: August 8, 2014	Change Request: 8606

Transmittal 2897, dated March 7, 2014, is being rescinded and replaced by Transmittal 3021 dated August 8, 2014, to change the effective and implementation dates for ASC X12 and to delete from this CR sections 40.1, 40.2, and 90.1, which have been updated by CR 8775. All other information in the remaining sections is the same.

SUBJECT: Update to Pub. 100-04, Chapter 10 to Provide Language-Only Changes for Updating ASC X12

EFFECTIVE DATE: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: September 8, 2014

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 10.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

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	
8606.1	A/B MACs (HHH) shall be aware of the updated language for ASC X12 in Pub. 100 - 04, Chapter 10.			X						

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:
N/A	**N/A**

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

V. CONTACTS

Pre-Implementation Contact(s): Not applicable

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.

30.1 - Health Insurance Eligibility Query to Determine Episode Status

(Rev. 3021, Issued: 08-08-14, Effective: 01-01-12, Implementation: 09-08-14)

Under the HH PPS and home health consolidated billing (described elsewhere in this chapter), one HHA is considered the "primary" home health agency in billing situations. This primary agency is the only agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. When a homebound beneficiary seeks care from an HHA or from an institutional therapy provider subject to home health consolidated billing, the provider needs to determine if the beneficiary is already being served by an HHA - an agency that then would be considered primary.

Providers may send an inquiry to determine the beneficiary's entitlement and eligibility status into the Common Working File or CWF, through their Medicare contractor. They must send the *ASC* X12 270 *Health Care Eligibility Inquiry* transaction set and will receive the *ASC* X12 271 *Health Care Eligibility Response* transaction set in response, in order to comply with the requirements of the Health Insurance Portability and Accountability Act.

Medicare contractors processing institutional claims will create an ELGH record from the 270 to request this data from CWF and will receive the ELGA record from CWF in response. The Medicare contractor will create the 271 response or DDE screen from the ELGA transaction record.

The response shows whether or not the beneficiary is currently in a home health episode of care. If the beneficiary is not already under care at another HHA, he/she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an episode is already open at another HHA if the beneficiary has chosen to transfer.

See chapter 31 for a description of the data elements and related requirements.

40 - Completion of Form CMS-1450 for Home Health Agency Billing

(Rev. 3021, Issued: 08-08-14, Effective: 01-01-12, Implementation: 09-08-14)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the *ASC* X12 837 *i*nstitutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the Form CMS-1450 *hardcopy* form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in chapter 25.

Because claim formats serve the needs of many payers, some data elements may not be needed by a particular payer. This section provides detailed information only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers. In all cases, the provider is responsible for filing a timely claim for payment. (See chapter 1.)