CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 834	**Date: January 14, 2011**
	Change Request 7251

SUBJECT: Medicare Fee-For-Service (FFS) Companion Guide

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the Medicare Administrative Contractors (MACs) to populate a standard Medicare FFS Companion Guide with individual MAC specific information, and post the Companion Guide document at MAC specific Websites.

EFFECTIVE DATE: February 15, 2011
IMPLEMENTATION DATE: February 15, 2011

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

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

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

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 834	Date: January 14, 2011	Change Request: 7251

SUBJECT: Medicare Fee-For-Service (FFS) Companion Guide

Effective Date: February 15, 2011

Implementation Date: February 15, 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 change request is to instruct the A/B Medicare Administrative Contractors (MACs), Durable Medical Equipment (DME) MACs, and the DME MAC Common Electronic Data Interchange (CEDI) contractor in populating and posting a standardized Medicare FFS Companion Guide. CMS is issuing a newly formatted Companion Guide for the new version to come into alignment with industry standards. The format of Medicare's new companion guide will utilize a standard template and provide consistent language applicable across all MAC jurisdictions, while allowing organization specific information to be included within a common structure for MACs to communicate with their trading partners.

The goal is to provide all Medicare FFS trading partners with a consistent companion guide regardless of MAC jurisdiction. This main Trading Partner (TP) document will be maintained by each individual MAC, and posted on their organization Website.

Also included as part of the companion guide, albeit, contained within a separate document will be transaction specific information for each ASC X12 EDI transaction that Medicare utilizes. The Transaction Information (TI) content will be maintained by CMS. As there will be one TI for each ASC X12 EDI transaction that Medicare utilizes, hyperlinks to each TI will be listed within the TP Companion Guide.

Estimates for this CR should include a breakdown as part of the Level of Effort (LOE) response, utilizing the following table to be included in the "Estimate-Specific Comments" portion of the LOE template, to follow the Investment Lifecycle Phases.

Investment Lifecycle Phase	Total Hours	Total Cost
Pre-Implementation/CR Review		
Design & Engineering Phase		
Development Phase		
Testing Phase		
Implementation Phase		

Note that the Pre-Implementation/CR Review costs will not be funded under the unique funding situation for the 5010/D.0 project, but instead out of the MAC's pot of hours for Pre-Implementation/CR Review.

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	
7251.1	Contractors shall populate parts of the following sections of the attached document (Medicare FFS_Companion_Guide_Trading_Partner_12-20-10), as designated within the document : • Section 1.5 • Section 2.0 • Section 3.0 • Section 4.0 • Section 5.0 • Section 6.0 • Section 7.0 • Section 8.0	X	X								CEDI
7251.2	Contractors shall post the completed TP companion guide document to their Medicare Websites.	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	
	NA										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None

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

V. CONTACTS

Pre-Implementation Contact(s): Amisha Pandya (410) 786-0690, Amisha.Pandya@cms.hhs.gov; Angie Bartlett (410) 786-2865, Angie.Bartlett@cms.hhs.gov

Post-Implementation Contact(s): Amisha Pandya (410) 786-0690, Amisha.Pandya@cms.hhs.gov; Angie Bartlett (410) 786-2865, Angie.Bartlett@cms.hhs.gov

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.

ATTACHMENT

Medicare Fee-For-Service

Standard Companion Guide
Trading Partner Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 1.0, January 03, 2010

User Instructions

Blue text contains instructions to the template user and must be deleted before publishing the final document.

[Bracketed text] identifies variable information and must be replaced with entity-specific text before publishing the final document.

Unbracketed black text is part of the template and must not be modified by the authors and must be included in the published companion guide.

If a section is optional it will be marked as such in the template. If an optional section is not included by the authoring entity, the section heading should be retained to keep the numbering of the sections in the published guide in sync with the numbering of the sections in the template.

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Trading Partner Information) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 Implementation Guide (IG) (Transaction Instructions). Either the Trading Partner Information component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Trading Partner Information component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

Trading Partner Information

1. Introduction

1.1 Purpose

This document is intended to provide information from the author of this guide to trading partners to give them the information they need to exchange EDI data with the author. This includes information about registration, testing, support, and specific information about control record setup.

An Electronic Data Interchange (EDI) Trading Partner is defined as any Medicare customer (e.g., provider/supplier, billing service, clearinghouse or software vendor) that transmits to, or receives electronic data from, Medicare. Medicare's EDI transaction system supports transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as additional supporting transactions as described in this guide.

Medicare FFS is publishing this Companion Guide to clarify, supplement and further define specific data content requirements to be used in conjunction with, and not in place of, the ASCX12N TR3s for all transactions mandated by HIPAA and/or adopted by Medicare FFS for EDI.

This Companion Guide provides communication, connectivity and transaction specific information to Medicare FFS trading partners and serves as the authoritative source for Medicare FFS specific EDI protocols

Additional information on Medicare FFS EDI practices are referenced within Pub. 100-04, Medicare Claims Processing Manual, Chapter 24 on General EDI and EDI Support, Requirements, Electronic Claims and Mandatory Electronic Filing of Medicare Claims. This document can be accessed at http://www.cms.gov/manuals/downloads/clm104c24.pdf.

1.2 Scope

EDI addresses how providers/suppliers, or their business associates, exchange professional and institutional claims, claim acknowledgments, claim remittance advice, claim status inquiry and responses, and eligibility inquiry and responses electronically with Medicare. This guide also applies to electronic transactions that are being exchanged with Medicare by third parties, such as clearinghouses, billing services or network service vendors. Below is a listing of transactions required by Medicare FFS:

Transactions	Version
270/ 271 Health Care Eligibility Benefit Inquiry and Response	005010X279A1
837 Health Care Claim: Professional	005010X222A1
837 Health Care Claim: Institutional	005010X223A2
999 Implementation Acknowledgment For Health Care Insurance	005010X231A1
835 Health Care Claim: Payment/Advice	005010X221A1
276/277 Status Inquiry and Response	005010X212
277CA Claim Acknowledgement	005010X214
National Council for Prescription Drug Programs (NCPDP) Version D.0 of the Telecom Standard	D.0 April 2009

This companion Guide provides technical and connectivity specification for the following above listed transactions:

- 837 Health Care Claim: Institutional
- 837 Health Care Claim: Professional
- 835 Health Care Claim: Payment Advice
- 276/277 Status Inquiry and Response

Technical specifications for the 999 Implementation Acknowledgement for Health Care Insurance and 277CA Claim Acknowledgement are subsumed under the technical specifications for the 837 Institutional and Professional Claim transaction.

The 270/271 Health Care Eligibility Benefit Inquiry and Response has its own companion guide that can be found at: http://www.cms.gov/HETSHelp/.

NCPDP Version D.0 also has its own companion guide that can be found at: http://www.ngscedi.com/.

1.3 Overview

This Companion Guide includes information needed to commence and maintain communication exchange with Medicare. In addition, this Companion Guide has been written to assist you in designing and implementing transaction standards to meet Medicare's processing standards. This information is organized in the sections listed below:

- Getting Started: This section includes information related to hours of operation, data services, and audit procedures. Information

concerning Trading Partner registration and the Trading Partner testing process is also included in this section**.**

- Testing and Certification Requirements: This section includes detailed transaction testing information as well as certification requirements needed to complete transaction testing with Medicare.

- Connectivity/Communications: This section includes information on Medicare's transmission procedures as well as communication and security protocols.

- Contact Information: This section includes EDI customer service, EDI technical assistance, provider services and applicable Websites.

- Control Segments/Envelopes: This section contains information needed to create the ISA/IEA, GS/GE and ST/SE control segments for transactions to be submitted to Medicare.

- Acknowledgments and Reports: This section contains information on all transaction acknowledgments sent by Medicare and report inventory.

- Additional Trading Partner Information: This section contains information related to implementation checklist, transmission examples, Trading Partner Agreements and other resources.

- Trading Partner Information Change Summary: This section describes the differences between the current Companion Guide and the previous Companion Guide(s).

1.4 References

The following Websites provide information for where to obtain documentation for Medicare adopted EDI transactions and code sets.

Resource	Web Address
ASC X12 TR3 Implementation Guides	store.x12.org
Washington Publishing Company Health Care Code Sets	http://www.wpc-edi.com/content/view/711/401/

1.5 Additional Information

[MACs to provide information as appropriate]

The Websites listed below provide additional resources during the transition year for HIPAA version 5010 implementation.

Resource	Web Address
Central Version 005010 and D.0 Webpage on CMS Website	http://www.cms.gov/Versions5010andD0/
Educational Resources (including MLN articles, fact sheets, readiness checklists, brochures, quick reference charts and guides, and transcripts from national provider calls)	http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
Dedicated HIPAA 005010/D.0 Project Web page (including technical documents and communications at national conferences)	http://www.cms.gov/MFFS5010D0/
Frequently Asked Questions	http://questions.cms.hhs.gov/app/answers/list/kw/5010
Responses to Technical Comments	www.cms.gov/TransactionCodeSetsStands
To request changes to HIPAA adopted standards	http://www.hipaa-dsmo.org/

The following website provides operational information for EDI and electronic transaction standards:

- Medicare FFS EDI Operations **http://www.cms.gov/ElectronicBillingEDITrans/**

2. Getting Started

2.1 Working Together

[MAC name] is dedicated to providing several communication channels to ensure communication remains constant and efficient. [MAC name] has several options in an effort to assist the community with their electronic data exchange needs. By using any of these methods [MAC name] is focused on supplying the Trading Partner community with a variety of support tools.

An EDI help desk is established for the first point of contact for basic information and troubleshooting. The help desk is available to support most EDI questions/incidents while at the same time being structured

to triage each incident if more advanced research is needed. An EDI email is also accessible as a method of communicating with [MAC name]. The email account is monitored by knowledgeable staff ready to assist you. When communicating via email, please exclude any Protected Health Information (PHI) to ensure security is maintained. In addition to the [MAC name's] EDI help desk and email access, feel free to communicate via alternative methods (see section 5 below for contact information).

[MAC name] also has several external communication components in place to reach out to the trading partner community. [MAC name] posts all critical updates, system issues and EDI specific billing material to their website, [MAC to provide Website address]. All Trading Partners are encouraged to visit this page to ensure familiarity with the content of the site. [MAC name] also distributes EDI pertinent information in the form of an EDI newsletter or comparable publication, which is posted to the Website every [MAC to provide frequency of update] months. In addition to the Website, a distribution list has been established in order to broadcast urgent messages. Please register for [MAC name's] distribution list by [MAC to insert steps here].

Specific information about the above-mentioned items can be found in the sections below.

2.2 Trading Partner Registration

An EDI Trading Partner is any entity (provider, billing service, clearinghouse, software vendor, employer group, financial institution, etc.) that transmits electronic data to or receives electronic data from another entity.

Medicare FFS, and [MAC name] support many different types of trading partners or customers for electronic data interchange (EDI). To ensure proper registration it is important to understand the terminology associated with each customer type.

A **Submitter** is the entity that owns the submitter ID associated with the healthcare data being submitted. It is most likely the provider, hospital, clinic, supplier, etc., but could also be a third party submitting on behalf of one of these entities. However, a submitter must be directly linked to each billing NPI. Often the terms submitter and trading partner are used interchangeably because a **Trading Partner** is defined as the entity engaged in the exchange or transmission of electronic transactions. Thus, the entity that is submitting electronic

administrative transactions to [MAC name] is a Medicare FFS trading partner.

Provider/Supplier – the entity that renders services to beneficiaries and submits health care claims to Medicare.

A **Vendor** is an entity that provides hardware, software and/or ongoing technical support for covered entities. In EDI, a vendor can be classified as a software vendor, billing or network service vendor or clearinghouse.

Software Vendor – an entity that creates software used by billing services, clearinghouses and providers/suppliers to conduct the exchange of electronic transactions with Medicare FFS.

Billing Service – a third party that prepares and/or submits claims for a provider/supplier.

Clearinghouse – a third party that submits and/or exchanges electronic transactions (claims, claim status or eligibility inquiries, remittance advice, etc.) on behalf of a provider/supplier.

Network Service Vendor – a third party that provides connectivity between a provider, supplier, clearing house or billing service and [MAC name].

Medicare requires all trading partners to complete EDI registration and sign an EDI Enrollment form. The EDI enrollment form designates the Medicare contractor and/or CEDI as the entity they agree to engage in for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged. The forms can be accessed at: [Enter MAC url for forms].

Entities processing paper do not need to complete an EDI registration.

[MACs to provide specific registration/enrollment process].

Under HIPAA, EDI applies to all covered entities transmitting the following administrative transactions: 837I and 837P, 835, 270/271, 276/277 and NCPDP. Beginning on January 1, 2011, Medicare

contractors and CEDI will also use the TA1, 999 and 277CA error handling transactions.

Medicare requires that [insert MAC name or "we"] furnish new providers/suppliers that request Medicare claim privileges information on EDI. Additionally, Medicare requires [insert MAC name or "us"] to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in Section 3.0 below), and enroll and assign submitter EDI identification numbers to those approved to use EDI**.** The EDI enrollment process for the Medicare beneficiary inquiry system (HETS 270/271) is currently a separate process. Information on the EDI enrollment process for HETS can be found on the CMS HETSHelp website (http://www.cms.gov/HETSHelp/).

A provider must obtain an NPI and furnish that NPI to [MAC name] prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. [MAC name] is required to verify that NPI is on the NPI Crosswalk. If the NPI is not verified on the NPI Crosswalk, the EDI Enrollment Agreement is denied and the provider is encouraged to contact [MAC name] provider enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for DME suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password**.**

If providers elect to submit/receive transactions electronically using a third party such as a billing agent, a clearinghouse or network services vendor, they are required to have an agreement signed by that third party. The third party must agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing

or use of Medicare beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers. Providers will notify [MAC name] which third party agents they will be using on their EDI Enrollment form.

Third parties are required to register with [MAC name] by completing the third party agreement form. This will insure that their connectivity is completed properly, however, a separate enrollment may be required for enrollment in mailing lists to receive all publications and email notifications.

This agreement can be downloaded from [MACs to provide link to their third party billing agreement/form].

Providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor. Providers must also not share their personal EDI access number with anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim. No other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from [MAC name]. For a complete reference to security requirements see section 4.4 below and refer to the Appendix A CMSR High Impact Level Data document located on the CMS website (http://www.cms.gov/informationsecurity/downloads/ARS_App_A_CMSR_HIGH.pdf.)

2.3 Trading Partner Testing and Certification Process

[MAC to provide instructions to trading partners on testing expectations, and applicable schedules (frequency and dates/times)]

[MAC to provide the process for testing

- how to "sign up",
- what to expect throughout the process (in terms of communication from the MAC),
- description of delivery and interpretation of results, and

- any follow-up actions required]

3. Testing and Certification Requirements

3.1 Testing Requirements

All claim submitters must produce accurate electronic test claims before being allowed to submit claim transactions in production. All submitters must send a test file containing at least 25 claims, which are representative of their practice or services. The number of claims could be increased or decreased, on a case by case basis, to ensure adequate testing of any given submitter. Test claims are subject to standard syntax and IG semantic data edits; documentation will be provided when this process detects errors.

- Standard syntax testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits. Test files must pass 100 percent of the standard syntax edits before production is approved.
- IG Semantic Data testing validates data required for claims processing, e.g., procedure/diagnosis codes, modifiers. A submitter must demonstrate, at a minimum, a 95 percent accuracy rate in data testing before production is approved where, in the judgment of [MAC name], the vendor/submitter will make the necessary correction(s) prior to submitting a production file. For FIs, the minimum 95 percent accuracy rate includes the front-end edits applied using the FISS implementation guide editing module.
- Test results will be provided to the submitter within three (3) business days; during HIPAA version transitions this time period may be extended, not to exceed ten (10) business days.

Many claim submitters use the same software, or the same clearinghouse to submit their electronic claims to Medicare. [MACs to provide their testing protocols for submitters using the same software]

Providers/suppliers who submit transactions directly to more than one FI, Carrier, RHHI, A/B MAC, and/or CEDI, and billing services and clearinghouses that submit transactions to more than one FI, Carrier, RHHI, A/B MAC, and/or CEDI, must contact each FI, Carrier, RHHI, A/B MAC, and/or CEDI with whom they exchange EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional EDI transaction, different or significantly modified software for submission of a previously used EDI transaction, or before a billing agent or clearinghouse begins to submit transactions

on behalf of an additional provider. The individual FI, Carrier, RHHI, A/B MAC, and/or CEDI may need to retest at that time to re-establish compatibility and accuracy, particularly if there will also be a change in the telecommunication connection to be used.

Billing services and clearinghouses are not permitted to begin to submit or receive EDI transactions on behalf of a provider prior to submission of written authorization by the provider that the billing agent or clearinghouse has been authorized to handle those transactions on the provider's behalf. See section 2.2 above for further information on EDI Enrollment.

3.2 Certification Requirements

Medicare FFS does not certify providers/suppliers, however, [MAC name] does certify vendors, clearinghouses, and billing services in the form of testing with them and maintaining an approved vendor list that can be accessed at:

[MACs to provide Website for approved vendor list]

4. Connectivity / Communications

4.1 Process flows

[MACs to provide a High Level Transaction Flow document and a brief supporting document as what the diagram depicts]

4.2 Transmission Administrative Procedures

[MACs to provide their procedures detailing the technical Internet connectivity specifications for real time processing of each transaction (276/277,837, and 835)]

[MACs to provide where the connectivity specifications are located - (URL) etc.]

4.2.1 Re-transmission procedures

[MACs to provide any procedures relating to re-transmission of files and that might include any statement that submitters can retransmit files at their discretion]

4.3 Communication Protocols

[MACs to provide ***detailed*** specifications and procedures as it relates to each type of Communication Protocol that they support. For example:

1. Transfer Protocols
   a. File Transfer Protocol (FTP)
   b. Secure File Transfer Protocol (SFTP)
2. Transmission Control Protocol/Internet Protocol (TCPIP)
3. Internet/Real-Time-HTTPS-Hypertext
4. Inquiry Transactions]
5. Asynchronous Dial-up

[MAC to provide list of CMS approved AT&T Global Network services Re-sellers]

NOTE: Internet is not currently a Medicare FFS approved communication protocol, except under the internet portal demonstrations, for select transactions and with prior CMS approval.

4.4 Security Protocols

Trading Partners who conduct business with Medicare are subject to CMS security policies.

CMS' information security policy strictly prohibits any trading partner from outsourcing system functions to any resource located outside of the United States or its territories. Prohibited outsourced functions include but are not limited to the transmission of electronic claims, receipt of remittance advice, or any system access to obtain beneficiary PHI and/or eligibility information. Violation of this policy will result in revocation of all methods of system access, including but not limited to EDI front-end access or EDC RACF user access. [MAC name] is responsible for notifying all affected providers/suppliers as well as reporting the system revocation to CMS. See the Appendix A CMSR High Impact Level Data document (**Section SA-9**) located on the CMS website (http://www.cms.gov/informationsecurity/downloads/ARS_App_A_CMSR_HIGH.pdf.)

CMS' information security policy strictly prohibits the sharing or loaning of Medicare assigned IDs and passwords. Users should take appropriate measures to prevent unauthorized disclosure or modification of assigned IDs and passwords. Violation of this policy will result in revocation of all methods of system access, including but not limited to EDI front-end access or EDC RACF user access. [MAC name] is responsible for notifying all affected providers/suppliers as

well as reporting the system revocation to CMS. See the Appendix A CMSR High Impact Level Data document (**Section IA-2**) located on the CMS website (http://www.cms.gov/informationsecurity/downloads/ARS_App_A_CMSR_HIGH.pdf.)

[MACs to provide the following:

- Identify the procedures of assignment of logon IDs and passwords by EDI personnel, and should include any statements regarding that EDI Transactions submitted by unauthorized Trading Partners will not be accepted;
- Describe how TPs should protect password privacy by limiting knowledge of the password to key personnel, and all procedures that should be followed on password requirements, and intervals to change password, and when password should be changed when there are any personnel changes;
- Specifications for providers/suppliers to electronically transmit files (batch and real time); and
- Password duration/expiration, resetting, requirements (FISMA, Audit Security)]

5. Contact information

5.1 EDI Customer Service

[MACs to provide, but not limited to, the following contact information – if any of the below are not supported indicate with "not available."]

Mail Address
Telephone Number both toll free 800 number and regular number
Fax number
Email Address
Time and Day of Operations] – including a link to MAC website for closures and holidays

5.2 EDI Technical Assistance

[MACs to provide, but not limited to, the following contact information – if any of the below are not supported indicate with "not available."]

Mail Address
Telephone Number both toll free 800 number and regular number
Fax Number
Email Address

Time and Day of Operations] – including a link to MAC website for closures and holidays

5.3 Provider Services

[MACs to provide detailed information concerning Provider Services, including contact numbers, if applicable.]

5.4 Applicable Websites / email

[MACs to provide any additional Websites or email addresses relevant to this section – if no additional – state, "See sections [fill in appropriate sections] above for applicable website/email information"]

6. Control Segments / Envelopes

[MACs to review for applicable organization specific control segments/envelopes – in addition to, not in place of, what is provided here]

Interchange Control (ISA/IEA), Function Group (GS/GE), and Transaction (ST/SE) envelopes must be used as described in the national implementation guides. Medicare's expectations for inbound ISAs and a description of data on outbound ISAs are detailed in this chapter. Specific guidelines and instructions for GS and GE segments are contained in each Transaction Information companion Guide.

Note: Medicare only accepts functional groups based upon one TR3 Implementation Guide per Interchange Envelope (ISA/IEA). If transactions based upon more than one TR3 Implementation Guide are being submitted, each must be contained within its own Interchange

For Medicare FFS specific guidance refer the appropriate Medicare FFS transaction specific edit documents found at **http://www.cms.gov/ElectronicBillingEDITrans/.**

6.1 ISA-IEA

Delimiters – Inbound Transactions

As detailed in the HIPAA adopted implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Medicare (inbound transmissions), these characters are determined by the submitter and can be any characters which are not contained within any data elements within the ISA/IEA Interchange Envelope.

Delimiters – Outbound Transactions

Medicare recommends the use of the following delimiters in all outbound transactions; trading partners/submitters should contact their local FI, RHHI, Carrier, A/B MAC or CEDI for any deviations. Note that these characters will not be used in data elements within an ISA/IEA Interchange Envelope.

[MAC to populate with their delimiters as appropriate]

Delimiter	Character Used	Dec Value	Hex Value
Data Element Separator	>	62	3E
Repetition Separator	^	94	5E
Component Element Separator	+	43	2B
Segment Terminator	~	126	7E

Inbound Data Element Detail and Explanation

All data elements within the interchange envelop (ISA/IEA) must follow X12 syntax rules as defined within the adopted implementation guide.

6.2 GS-GE

Functional group (GS-GE) codes are transaction specific. Therefore, information concerning the GS/GE Functional Group Envelope can be found in the transaction specific appendices of this companion guide.

6.3 ST-SE

Medicare has no requirements outside the HIPAA adopted transaction implementation guides.

7. Acknowledgements and Reports

[MACs to provide information and examples on any acknowledgements and/or reports generated for trading partners.]

7.1 ASC X12 Acknowledgments

Medicare has adopted two new acknowledgement transactions, the 999 Implementation Acknowledgment For Health Care Insurance and the 277 Claims Acknowledgement or 277CA. These two acknowledgments will replace proprietary reports previously provided by [MAC name].

Medicare FFS has adopted a process to only reject claim submissions that are out of compliance with the ASC X12 version 5010 standard; the appropriate response for such errors will be returned on a 999 Implementation Acknowledgment transaction. Batch submissions with errors will not be rejected in totality, unless warranted, but will selectively reject the claims submitted in error within it. Thus, Medicare FFS will reject claim submissions and return a 999 Implementation Acknowledgment transaction with the error responses listed within the 837 Institutional or Professional Edits Spreadsheet found at **http://www.cms.gov/ElectronicBillingEDITrans/.**

7.2 Report Inventory

[MAC to provide a listing/inventory of all applicable proprietary acknowledgements including hard-copy reports.]

8. Additional Trading Partner Information

[MAC to provide additional reference information as appropriate.]

8.1 Implementation Checklist

[MAC to provide all necessary steps for going live with EDI exchange.]

8.2 Transmission Examples

[MAC to provide examples of the control segments and envelopes.]

8.3 Trading Partner Agreement

EDI Trading Partner Agreements 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.

Medicare FFS requires all Trading Partners to sign a Trading Partner Agreement with [MAC name]. This agreement can be found at [MAC to provide url for their trading partner agreement forms].

Additionally, [MAC name] requires the following: [MAC to provide any additional trading partner requirements – if a MACs trading partner agreement process is identical to their EDI enrollment and registration process then indicate that here]

8.4 Frequently Asked Questions

Frequently asked questions can be accessed at:

http://www.cms.gov/ElectronicBillingEDITrans/ And
[MAC to provide Website for FAQs – if different from Medicare FFS site]

8.5 Other Resources

[MAC to provide other references or resources as applicable.]

9. Trading Partner Information Change Summary

Version	Date	Section(s) changed	Change Summary
1.0	November 5, 2010	All	Initial Draft
2.0	January 3, 2010	All	1st Publication Version

10. Appendices

A. 837 Institutional Claim Transaction Specific Information

www.cms.gov/ElectronicBillingEDITrans/Downloads/5010A2837ACG.pdf

B. 837 Professional Claim Transaction Specific Information

www.cms.gov/ElectronicBillingEDITrans/Downloads/5010A1837BCG.pdf

C. 276/277 Claim Status Inquiry and Response Transaction Specific Information

www.cms.gov/ElectronicBillingEDITrans/Downloads/5010276277CG.pdf

D. 835 Remittance Advice Transaction Specific Information

www.cms.gov/ElectronicBillingEDITrans/Downloads/5010A1835CG.pdf