CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 44 **Date: DECEMBER 19, 2003**

CHANGE REQUEST 2966

I. SUMMARY OF CHANGES: This transmittal contains new instructions for the mandatory electronic submission of Medicare claims based on the Administrative Simplification Compliance Act. The instruction also contains specific conditions under which a waiver may be granted for submission of electronic claims.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 16, 2003
IMPLEMENTATION DATE: January 20, 2004

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. SCHEDULE OF CHANGES (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Chapter24 Table of Contents
N	Chapter24/Section 90 Mandatory Electronic Submission of Claims
N	Chapter24/Section 90.1 Small Providers and Full-Time Equivalent Employee Assessments
N	Chapter24/Section 90.2 Exceptions
N	Chapter24/Section 90.3 "Unusual Circumstance" Waivers
N	Chapter24/Section 90.3.1 Unusual Circumstance Waivers Subject to Provider Self-Assessment
N	Chapter24/Section 90.3.2 Unusual Circumstance Waivers Subject to Medicare Contractor Approval
N	Chapter24/Section 90.3.3 Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision
N	Chapter24/Section 90.4 Electronic and Paper Claims Implications of Mandatory Electronic Submission
N	Chapter24/Section 90.5 Enforcement
N	Chapter24/Section 90.6 Provider Education

III. FUNDING: *Medicare contractors only: No Additional Funding

Funding is available through the regular budget process for costs required for implementation.

IV. ATTACHMENTS:

x	**Business Requirements**
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

Business Requirements

Pub. 100-04	Transmittal: 44	Date: December 19, 2003	Change Request 2966

I. GENERAL INFORMATION

A. Background: The Administrative Simplification Compliance Act (ASCA, Section 3 of Pub. L. 107-105, 42 CFR 424.32) requires that all initial claims for reimbursement under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a Medicare fee-for-service carrier, DMERC, or intermediary for the first time, including resubmitted previously rejected claims, claims with paper attachments, demand bills, claims where Medicare is secondary and there is only one primary payer, and non-payment claims. Initial claims do not include adjustments submitted to intermediaries or previously submitted claims or appeal requests. This requirement does not apply to those claims submitted by beneficiaries or by providers that only furnish services outside of the United States, to Medicare managed care plans, or to health plans other than Medicare.

B. Policy: This transmittal manualizes the requirements based on the Administrative Simplification Compliance Act that requires that Medicare claims be submitted electronically.

C. Provider Education: Required

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
Ch 24, Sec 90.3 Requirement #1	Contractors shall issue a form letter to providers who have submitted waiver requests that do not allege "unusual circumstance". (Exhibit A)	Contractors
Ch 24, Sec 90.3.2 Requirement #2	When an "unusual circumstance" waiver is requested by the provider and the contractor determines it is not an "unusual circumstance", the contract shall issue a form letter to the provider, denying the provider's request. (Exhibit B)	Contractors
Ch 24, Sec 90.3.2 Requirement #3	Contractors shall approve "good cause" waivers up to 90 days.	Contractors
Ch 24, Sec 90.3.2 Requirement #4	Contractors shall approve software-related "good cause" waivers of up to 180 days.	Contractors
Ch 24, Sec 90.3.3 Requirement #5	Contractors shall forward certain contractor approved request for "unusual circumstance" waivers to CMS.	Contractors
Ch 24, Sec 90.6 Requirement #6	Contractors shall include their requirements for provider submission of claims with attachments in their newsletter and on their Web site.	Contractors
Ch 24, Sec 90.5 Requirement #7	Contractors shall maintain an "unusual situation" waiver list on provider's request whether approved or denied.	Contractors

Ch 24, Sec 90.6 Requirement #8	Contractors shall inform their providers in news-letters or on their Web site of items 1-12 in Section 90.6	Contractors

II. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	N/A

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES

Citation	Change
	N/A

SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 16, 2003 **Implementation Date: January 20, 2004** **Pre-Implementation Contact(s): Jean Harris 410-786-6168 or Jharris2@cms.hhs.gov** **Post-Implementation Contact(s): Your Regional Office**	**These instructions should be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 24 - EDI Support Requirements

Table of Contents

(Rev. 44, 12-19-03)

90 – Mandatory Electronic Submission of Medicare Claims

(Rev. 44, 12-19-03)

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 under Medicare, except from small providers, be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a Medicare fee-for-service carrier, DMERC, or intermediary for the first time, including resubmitted previously rejected claims, claims with paper attachments, demand bills, claims where Medicare is secondary and there is only one primary payer, and non-payment claims. Initial claims do not include adjustments submitted to intermediaries on previously submitted claims or appeal requests

Medicare will not cover claims submitted on paper that do not meet the limited exception criteria. Claims denied for this reason will contain claim adjustment reason code 96 (Non-covered charge(s)) and remark code M117 (Not covered unless submitted via electronic claim.)

Claims required to be submitted electronically effective October 16, 2003 and later must comply with the appropriate claim standards adopted for national use under HIPAA or with standards supported under the Medicare HIPAA contingency plan during the period that plan is in effect. The mandatory electronic claim submission requirement does not apply to claims submitted by providers that only furnish services outside of the United States, claims submitted to Medicare managed care plans, or to health plans other than Medicare.

90.1– Small Providers and Full-Time Equivalent Employee Assessments

(Rev. 44, 12-19-03)

A "small provider" is defined at 42 CFR section 424.32(d)(1)(vii) to mean A) a provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or B) a physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs. To simplify implementation, Medicare will consider all providers that have fewer than 25 FTEs and that are required to bill a Medicare intermediary to be small; and will consider all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier or DMERC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare State and Federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for full-time benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal Revenue Service (IRS) using an Employer Identification Number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals that perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for full-time benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider as identified by provider number, UPIN, or national provider identifier (NPI) when implemented to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers bill intermediaries and some carriers. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to determine the number of staff who work on a full time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part time hours a week worked on average by all staff who furnished services for the provider on a less than full time basis. Divide that total by 40 hours to determine their full time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents.

Legal issues regarding the definition of providers, particularly when multiple providers have data reported under the same EIN, will be addressed in the NPI regulation when published in the Federal Register in final. For FTE calculation purposes in the interim, it is acceptable to include only those staff of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply. This process will be modified if warranted by the definitions established in the NPI final rule.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records,or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as "small" automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

The small provider exception for submission of paper claims does not apply to health care claim clearinghouses that are agents for electronic claim submission for small providers. HIPAA defines a clearinghouse as an entity that translates data to or from a standard format for electronic transmission. As such, HIPAA requires that clearinghouses submit claims electronically effective October 16, 2003 without exception.

90.2 – Exceptions

(Rev. 44, 12-19-03)

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

1. *Roster billing of vaccinations covered by Medicare—Although flu shots and similar covered vaccines and their administration can be billed to Medicare electronically, one claim for one beneficiary at a time, in the past, some suppliers have been allowed to submit a single claim on paper with the basic provider and service data to which was attached a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. The claim implementation guides adopted under HIPAA can submit single claims to payer for single individuals, but cannot be used to submit a single claim for multiple individuals.*

   Flu shots are often administered in senior citizen centers, grocery stores, malls, and other locations in the field. It is not always reasonable or hygienic to use a laptop computer to register all necessary data to enable a HIPAA-compliant claim to be submitted electronically in such field situations. In some cases, a single nurse who is not accompanied by support staff might conduct mass immunizations. Due to the low cost of these vaccinations, it is not always cost effective to obtain all of the data normally needed for preparation of a HIPAA-compliant claim. Such suppliers rarely have a long-term health care relationship with their patients and do not have a need for the extensive medical and personal history routinely collected in most other health care situations.

   It is in the interest of Medicare and public health to make it as simple as possible for mass immunization activities to continue. Although suppliers are encouraged

to submit these claims to Medicare electronically, one claim for one beneficiary at a time, this is not required. In the absence of an electronic format that would allow a single claim for the same service to be submitted on behalf of multiple patients using abbreviated data, suppliers currently allowed to submit paper roster bills may continue to submit paper roster bills for vaccinations. Providers or suppliers that furnish vaccinations and other medical services or supplies must bill those other medical services or supplies to Medicare electronically though unless the provider qualifies as "small" or meets other exception criteria.

This vaccinations waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections furnished in a traditional medical setting such as a doctor's office or an outpatient clinic when supplied as a component of other medical care or examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, the flu shot or other vaccination is also to be included in the electronic claim sent to Medicare for the patient.

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

3. *Medicare Secondary Payment Claims (MSP)-MSP claims occur when one or more payers are primary to Medicare. The claim formats adopted for national use under HIPAA include segments for provider or payer use to submit secondary claims as well as initial claims. Since a patient rarely has more than two insurers in total, t he formats were designed for a provider to bill a payer secondarily and include payment data from one primary in the claim. In actuality, there may have been more than one primary payer. The claim formats adopted under HIPAA do not currently contain the ability to report individual service level payments made by more than one primary payer.*

The paper claim format has no fields for reporting of any primary payment data when Medicare is secondary. When paper claims are submitted, a copy of the primary plan's explanation of benefits (EOB) must always be attached if there is one or more payers that pay prior to Medicare. Since the HIPAA claim formats do allow service level data to be submitted electronically when there is only one payer primary to Medicare, those claims can be sent to Medicare electronically. When more than one payer is primary, the formats cannot accommodate this additional reporting and the only alternative is for providers to submit those claims to Medicare on paper with copies of the EOBs/remittance advices (RAs).

The payment segments of the claim formats adopted under HIPAA include fields for reporting of the identity of the primary payer, service procedure code, allowed amount, payment amount, and claim adjustment reason codes and amounts applied by the other payer when the billed amount of the service was not paid in full. These segments correspond to segments reported in the X12 835 remittance advice format. Since the HIPAA requirements apply only to electronic transactions, and not to paper transactions such as paper EOBs or RA notices, there is no requirement that payers use the same codes in their paper EOBs or RAs as in their electronic RAs. Medicare uses the same code set in both paper and electronic RAs, but other payers may not. Payers can elect to use different code sets in their paper transactions than their electronic transactions, or to use text messages in their paper transactions and not use codes at all. Payers that do not use the standard claim adjustment reason codes in their paper EOBs or RAs, generally use proprietary codes or massages for which there is no standard crosswalk to the 835 claim adjustment reason codes.

Providers that receive those paper EOBs/RAs cannot reasonably furnish standard claim adjustment reason codes for use in the HIPAA claim and COB formats. As a result, when there is only one payer primary to Medicare and those claims must be sent to Medicare electronically, those providers cannot complete the situational CAS segment for those claims. The coordination of benefits implementation guide adopted under HIPAA does not require that this segment be completed in this situation. Although this will prevent the primary payer data in the claim from balancing, akin to balancing when the data is reported in an 835 transaction, that is acceptable. There is no requirement in the implementation guide that these payment segments balance in a claim transaction. Providers should not try to convert non-standard messages or codes to standard claim adjustment reason codes to submit these claims to Medicare electronically. Medicare does not use the CAS segment data elements to calculate the Medicare payment in any case. Providers must, however, still report the primary's allowed, contract amount when Obligation to Accept in Full (OTAF) applies, and payment amounts for the individual services to enable Medicare to calculate payment.

4. *Claims submitted by Medicare beneficiaries.*

90.3 – "Unusual Circumstance" Waivers

(Rev. 44, 12-19-03)

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a waiver of the electronic claim submission requirement would be appropriate. The Secretary delegated that authority to CMS. In the event it is determined that enforcement of the electronic claim submission requirement would be against equity and good conscience as result of an "unusual circumstance," CMS will waive the electronic claim submission requirement for temporary or extended periods. In those situations, providers are encouraged to file claims electronically where possible, but electronic filing is not required.

CMS has in turn delegated certain authority to the Medicare contractors (carrier, DMERC, or intermediary) to determine whether an "unusual circumstance" applies. Providers who feel they should qualify for a waiver as result of an "unusual circumstance" must submit their waiver requests to the Medicare carrier, DMERC or intermediary to whom they submit their claims. The Medicare contractor must issue a form letter (exhibit A) in the event of receipt of a written waiver request that does not allege an "unusual circumstance."

As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (either a sole practitioner, employee or the owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or the name used to obtain an EIN from the IRS.

In some cases, an "unusual circumstance" or the applicability of one of the other exception criteria may be temporary; in which case, the related waiver would also be temporary. Once the criteria no longer applied, that provider would again be subject to the requirement that claims be submitted to Medicare electronically. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as secondary claims when more than one other payer is primary. Other claim types not covered by an exception or waiver must still be submitted to Medicare electronically, unless the provider is small or meets other unusual circumstance criteria.

90.3.1--Unusual Circumstance Waivers Subject to Provider Self-Assessment

(*Rev. 44, 12-19-03)*

The following circumstances always meet the criteria for waiver. Providers that experience one of the following "unusual circumstances" are automatically waived from the electronic claim submission requirement. A provider is expected to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may continue to submit claims to Medicare on paper when one of

these circumstances applies. A provider is not expected to prenotify their Medicare contractor(s)that one of the circumstances applies as a condition of paper submission.

1. *Dental claims—Medicare does not provide dental benefits. Medicare does cover certain injuries of the mouth that may be treated by dentists, but those injury treatments are covered as medical benefits. Less than .01 percent of Medicare expenditures were for oral and maxillofacial surgery costs in 2002. The X12 837 professional implementation guide standard for submission of medical claims requires submission of certain data that not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As result, Medicare contractors have not implemented the dental claim standard adopted for national use under HIPAA. Due to the small number of claims they would ever send to Medicare, most dentists have not found it cost effective to invest in software they could use to submit medical claims to Medicare electronically. For these reasons, dentists will not be required to submit claims to Medicare electronically. They can continue to submit claims, when appropriate, to Medicare on paper.*

2. *Disruption in electricity or phone/communication services--In the event of a major storm or other disaster outside of a provider's control, a provider could lose the ability to use personal computers, or transmit data electronically. If such a disruption is expected to last more than 2 business days, all of the affected providers are automatically waived from the electronic submission requirement for the duration of the disruption. If duration is expected to be 2 business days or less, providers should simply hold claims for submission when power and/or communication are restored.*

3. *A provider is not small based on FTEs, but submits fewer than 10 claims to Medicare per month on average (not more than 120 claims per year). This would generally apply to a provider that rarely deals with Medicare beneficiaries.*

4. *Non-Medicare Managed Care Organizations that are able to bill Medicare for copayments may continue to submit those claims on paper. These claims are not processable by the MSPPay module and must be manually adjudicated by Medicare contractors.*

90.3.2—Unusual Circumstance Waivers Subject to Medicare Contractor Approval

(*Rev. 44, 12-19-03*)

Medicare contractors may at their discretion approve a single waiver for up to 90 days after the date of the decision notice for a provider if the contractor considers there to be "good cause" that prevents a provider to submit claims electronically for a temporary period. "Good cause" would apply if a provider has made good faith efforts to submit claims electronically, but due to testing difficulties, or a similar short-term problem that

the provider is making reasonable efforts to rectify, the provider is not initially able to submit all affected claims electronically effective October 16, 2003.

Since these waivers may be for less than 90 days, and contractors may prefer to insert the basis for the waiver in the letter, Medicare contractors will use a locally produced letter to notify providers when short-term waivers are approved for this reason. As required by the Privacy Act of 1974, letters issued to a provider to announce a waiver decision must be addressed to the organizational name of a provider and not to an individual (either a sole practitioner, employee or an owner of the provider organization). The organizational name is generally a corporate name under which the provider is registered as a Medicare provider or used to obtain an EIN from the IRS.

In the event that a provider cites an inability to submit certain primary or secondary claims to Medicare electronically as a result of the inability of their commercial HIPAA-compliant software to submit these claims, Medicare contractors may approve a single waiver for up to 180 days after the date of the decision notice to allow adequate time for the provider to obtain and install an upgrade from their vendor, or to transition to software from another vendor that can submit these claims electronically. Medicare contractors will use a locally produced letter to notify providers when short-term waivers are approved for this reason.

If the contractor determines an "unusual circumstance" applies, and an initial provider waiver of 90/180-days or less as described above is not involved, CMS approval is required. The request and the contractor's recommendation must be forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244 or by e-mail at www.waiverrequest_emc@cms.hhs.gov for review and issuance of the decision. The contractor will be copied on the decision notice issued to the requestor. If the contractor does not consider an "unusual circumstance" to be met, the contractor is to issue a form letter (exhibit B).

90.3.3--Unusual Circumstance Waivers Subject to Contractor Evaluation and CMS Decision

(Rev. 44, 12-19-03)

A provider may submit a waiver request to their Medicare contractor in the following "unusual circumstances." It is the responsibility of the provider to submit documentation appropriate to establish the validity of the waiver request in these situations. Requests received without documentation to fully explain and justify why enforcement of the requirement would be against equity and good conscience in these cases will be denied. If the Medicare contractor agrees that the waiver request has merit, the request must be forwarded to the Division of Data Interchange Standards/BSOG/OIS at Mail Stop N2-13-16, 7500 Security Blvd., Baltimore MD 21244, or by e-mail at www.waiver request_emc@cms.hhs.gov, for review and issuance of the decision. The contractor must forward an explanation as to why contractor staff recommends CMS approval to DDIS

with the waiver request. The contractor will be copied on the decision notice issued to the requestor.

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

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

> ***NOTE:*** *A separate instruction will be issued to Medicare contractors and providers concerning submission of paper medical record attachments with electronic claims, pending national implementation of a standard for electronic submission of attachments with claims. Although the 837-format has a PWK segment for identification of separately submitted attachments, there is no standard control number process to facilitate reassociation of paper attachments with electronic claims submitted at the same time. Contractors currently use a number of different methods. The NCPDP retail drug claim transaction has no segment comparable to PWK or otherwise designed to allow reassociation of paper attachments submitted at the same time as an electronic claim. Pending issuance of the future instructions concerning submission of medical records for electronic claims, providers and Medicare contractors can continue current policies and practices regarding submission of attachments with claims, whether it be in a proprietary format, on paper, via fax, or other means. Medicare contractors must include their requirements for submission of claims with attachments in their newsletter article and on their Web site with other applicable information concerning the requirement that Medicare claims be submitted electronically. (See Section 90.6.)*
>
> *This temporary exception does not apply to submission of paper EOBs or RAs for electronic claims when Medicare is secondary and there is only one primary payer. See the Exceptions section for further information.*

2. A provider is not small, but all those employed by the provider have documented disabilities that would prevent their use of a personal computer for electronic submission of claims.

3. Any other unusual situation that is documented by a provider to establish that enforcement of the electronic claim submission requirement would be against equity and good conscience.

90.4 – Electronic and Paper Claims Implications of Mandatory Electronic Submission

(Rev. 44, 12-19-03)

Claims providers submit via a direct data entry screen maintained by a Medicare contractor or transmitted to a Medicare contractor using the free/low cost claims software issued by Medicare are considered electronic. When enforcing the electronic claim submission requirement, CMS will take into account those limited situations where a provider submitted paper claims because the free billing software they were issued was temporarily unable to accommodate submission of a secondary or other particular type of claim.

Medicare contractors are prohibited from requiring submission of paper claims in any situations on or after October 16, 2003, except as specifically permitted by CMS.

Medicare carriers, DMERCs, and intermediaries are to assume for processing purposes that claims submitted by a provider on paper October 16, 2003 and later are submitted by providers that are small or that do meet exception criteria, barring information received from other sources to the contrary. Submission of a paper claim October 16,2003 or later will be considered an attestation by a provider that waiver criteria are met at the time of submission.

In the event contractor staff members realize that a particular provider does not meet any of the exception criteria, paper claims submitted by that provider may be rejected in the mailroom without entry of those claims. The rejection letter returned to the submitter must state the reason for the rejection.

90.5 – Enforcement

(Rev. 44, 12-19-03)

A separate enforcement instruction will be issued to Medicare contractors. Enforcement will be conducted on a post-payment basis and will entail targeted investigation of providers that appear to be submitting extraordinary numbers of paper claims. If an investigation establishes that a provider incorrectly submitted paper claims, the provider will be notified that any paper claims submitted after a date certain (a reasonable period will be allowed for implementation of necessary provider changes) will be denied by Medicare. The future instruction will indicate how Medicare contractors will detect incorrectly submitted paper claims, and the criteria for selection of providers for investigation. Medicare contractors should not begin provider investigations prior to receipt of that instruction, unless they become aware of non-compliance through alternate channels. In the event a contractor becomes aware of abuse by a particular paper claim submitter prior to receipt of the CMS enforcement instruction, the contractor should contact their Consortium Contractor Management Specialist for further direction.

Medicare contractors are not to maintain a provider FTE database, or establish a database of waived providers, unless an "unusual situation" waiver is approved or denied. For reference purposes, each contractor will maintain a record of "unusual situation" waivers aproved or denied, including the name, address provider number, whether the "unusual circumstance" waiver was approved or denied, the termination date for an approval (if applicable), and the unusual circumstance identified in the request. Exclude locally aproved 90/180-day waivers from this list.

90.6 - Provider Education

(Rev. 44, 12-19-03)

Medicare contractors must include information on their provider Web site and in their next scheduled newsletter prepared after receipt of this transmittal to notify providers of/that:

1. *Providers that do not qualify for a waiver as small and that do not meet any of the remaining exception or waiver criteria must submit their claims to Medicare electronically;*

2. *Small provider criteria and that small providers are encouraged to submit as many of their claims electronically as possible;*

3. *FTE definition and calculation methodology;*

4. *Exception criteria;*

5. *Unusual circumstance criteria;*

6. *Self-assessment requirements;*

7. *Process for submission of an unusual circumstance waiver;*

8. *Additional claims, such as claims with attachments in some cases or certain claim types not supported by free billing software, that must continue to be submitted on paper pending any contractor or shared system modifications to enable those claims to be submitted electronically;*

9. *Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criterium applies at the time of submission;*

10. *Repercussions of submitting paper claims when ineligible for submission of paper claims; and*

11. *Post-payment monitoring to detect providers that submit unusually high numbers of paper claims for further investigation.*

12. *Waiver request submitted by providers should include the providers' name, address, contact person, the reason for the waiver, why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information the contractor deems appropriate for evaluation of the waiver request.*

Exhibits of Form Letters

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

Date:

From: Contractor (may be preprinted on a contractor's letter masthead)

To: Organizational Name of Provider

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 effective October 16, 2003 to qualify for Medicare coverage. 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 c, d, or, e below applies. Medicare will only issue a written waiver determination if c, d, or e applies.

ASCA prohibits Medicare coverage of service and supply claims submitted to Medicare on paper, except in limited situations. Those situations are:

1. *Small providers—To qualify, a provider required to submit claims to Medicare intermediaries must have fewer than 25 full time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;*

2. *Dentists;*

3. *Participants in a Medicare demonstration project, when paper claim filing is required by that demonstration project as result of the inability of the HIPAA claim implementation guide to handle data essential to that demonstration;*

4. *Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries;*

5. *Providers that submit claims when more than one other payer is responsible for payment prior to Medicare payment;*

6. *Those few claims that may be submitted by beneficiaries;*

7. *Providers that only furnish services outside of the United States;*

8. *Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and*

9. *Providers that can establish that an "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. *Limited temporary situations when a Medicare contractor's claim system would 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. *Providers that submit fewer than 10 claims a month to a Medicare contractor on average;*

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

d. *Entities that can demonstrate that information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and*

e. *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 c, d, or e applies. You are expected to self-assess to determine if one of the other exceptions or unusual circumstances apply. 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. Medicare contractors will monitor provider compliance on a post-payment basis.

If a provider's self-assessment does not indicate that an exception or waiver criteria apply, the provider must submit their claims to Medicare electronically. Free software can be furnished you by this office to enable you to submit claims electronically, and a number of commercial software products and services are available on the open market. Please phone (insert contractor phone number) if you would like to further discuss your options for electronic submission of claims to Medicare.

Sincerely,
Contractor Name

Exhibit B—*Denial of an "unusual circumstance" waiver request*

Date:

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

To: Organizational Name of Provider

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. *Small providers—To qualify, a provider required to submit claims to Medicare intermediaries must have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier that bills a Medicare carrier must have fewer than 10 FTEs;*

2. *Dentists;*

3. *Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;*

4. *Providers that conduct mass immunizations, such as flu injections, that submit paper roster bills;*

5. *Providers that submit claims when more than one other payer is responsible for payment prior to Medicare payment;*

6. *Those few claims that may be submitted by beneficiaries;*

7. *Providers that only furnish services outside of the United States;*

8. *Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and*

9. *Providers that can establish that an "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 a 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. *Limited temporary situations when a Medicare contractor's claim system would 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. *Providers that submit fewer than 10 claims per month to a Medicare contractor on average;*

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

d. *Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and*

e. *Other circumstances documented by a provider, generally in rare cases, where a provider can establish that due to conditions outside 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.

Waiver applications are only to be submitted to request a waiver if an "unusual circumstance" applies under c, d or e above. The information submitted with your waiver request did not indicate that circumstance c, d, e, or any other exception or waiver criteria apply in your case. If provider self-assessment indicates that an exception condition, other than c, d, or e is met, the provider is automatically waived from the electronic claim submission requirement and no request should be submitted to a Medicare contractor. Medicare contractors will monitor provider compliance 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 coverage. Free software can be furnished you by this office to enable you to submit claims electronically, and a number of commercial software products and services are available on the open market. Please phone (insert contractor phone number) if you would like to further discuss your options for electronic submission of claims to Medicare.

Sincerely,

Contractor's Name