Medicare Claims Processing Manual

Chapter 24 - EDI Support Requirements

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(Rev. 199, 06-10-04)

10 - Provider Outreach and Marketing

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.7

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. Therefore all the material on outreach that follows applies only to relations with excepted providers.

Electronic transmission of claims and other data significantly reduces Medicare administrative costs. Medicare carriers and FIs are required to continuously conduct an active targeted outreach effort to encourage electronic exchange of Medicare data with providers. This includes Medicare claims as well as related records as described in §40. Specifically, carriers and FIs are required to:

- Perform continual analysis to identify providers that could exchange transactions electronically, but who continue to submit or receive paper; and

- Develop strategies to increase electronic transactions with these providers.

In addition, carriers or FIs are required to analyze capabilities of new providers and assist such providers in determining electronic capability.

10.1 - Carrier or Intermediary (FI) Analysis of Internal Information

(Rev. 1, 10-01-03)

B3-3023.7

10.1.1 - Systems Information

(Rev. 1, 10-01-03)

Carriers or FIs must develop the following data for each provider from claims processing operations:

- Number of claims; and

- Number and percent of paper claims.

This may be developed independently or in connection with other operations analysis information. Monthly, carriers and FIs array the data by volume to identify the providers that create the largest paper transaction workloads. Consistent with the approved budget, they initiate contact beginning with providers showing the highest number of paper transactions.

First, they telephone the provider to discuss the reasons for the paper transactions.

- If the provider has electronic capability but is temporarily submitting paper for reasons such as problems with their automated system or transition to a different system, no further action may be necessary. However, if appropriate, the carrier or FI may offer to facilitate the resolution of the situation with the provider, their data processing staff, or their vendor;

- If the provider is not an electronic biller, initiate a discussion of the advantages of electronic data interchange, including all transaction types. This discussion should focus on the individual provider's needs and determining the electronic solution which best meets those needs. Carriers and FIs must offer, as appropriate, to mail literature to the provider and/or to schedule a personal, on-site visit to discuss automating the provider's office. (See §10.4 for a discussion of marketing materials to send.) They must inform the provider of any EDI seminars scheduled in the near future at a nearby location.

Carriers and FIs must follow through on appropriate fulfillment activities such as mailing literature, conducting onsite visits or demonstrations, and making follow-up phone calls. Marketing efforts should be documented to prevent duplicate contacts, to provide a basis for future discussions, and to substantiate those instances where the provider refuses to participate in EDI.

Recognizing that this process, from initial contact to implementation, may span a varying duration of time, marketing staff must be able to judge, from the provider's cues, when to intensify activities and when to withdraw for a period of time. Carriers or FIs must use professional sales techniques such as:

- Knowing its product;

- Knowing its customer's business;

- Questioning and listening to determine customer needs and interest;

- Using demonstrations;

- Creating interest and overcoming objections;

- Proving the benefits of EDI; and

- Successful resolution.

Systems information may also identify specific markets, e.g., specialties, to target for EDI marketing campaigns.

Also, carriers and FIs must identify providers that have previously committed to EDI but have not begun transition within an appropriate period, e.g., 60 to 90 days, for follow-up to determine the reason for delay.

10.1.2 - Review of Provider Profiles

(Rev. 1, 10-01-03)

Carriers and FIs determine on a continual basis whether any providers use EDI billing but not electronic remittance or other EDI processes. In such a situation they determine whether, and what type of, further discussion with the provider might be helpful. Use of electronic funds transfer (EFT) is not an indicator of electronic capability.

Carriers and FIs must be proactive in encouraging providers, physicians, and suppliers to bill electronically through contractor Web sites and newsletters. Carriers and FIs should contact the largest paper billers and work with them to resolve any obstacles to electronic billing.

10.2 - Contact With New Providers

(Rev. 1, 10-01-03)

As new providers are approved for billing Medicare, carriers, and FIs must conduct an analysis of the providers' EDI capability for Medicare transactions. They propose EDI transactions as the normal mode of business for claims, corrections, remittance, and funds transfer. Where the provider does not have the related capability, they inform the providers of available options for getting started in EDI, e.g., lists of vendors and billing services, availability of Medicare's free software.

Carriers should make marketing materials available to newly enrolled providers. This may also include working with local medical schools where possible to introduce EDI processes to medical students prior to graduation through:

- Seminars conducted specifically for medical students;
- Demonstrations of Medicare's free software;
- Invitations to vendor trade fairs; and
- Distribution of marketing literature.

10.3 - General Outreach and Marketing Activities

(Rev. 1, 10-01-03)

B3-3023.7

Carriers and FIs are required to conduct general outreach and EDI marketing activities. When participating in or conducting these activities, carriers and FIs will distribute marketing materials. They must:

- Sponsor trade shows or vendor fairs for EDI vendors and trading partners in connection with appropriate provider meetings;

- Sponsor seminars for segments of providers identified in internal analysis described in §10.1. If appropriate, include vendors that target the attending provider audience;

- Participate as a speaker on the agenda of organized provider group meetings, such as state or local chapters of AAHAM, HFMA, MGMA, EDI user groups, state and local medical societies, and other provider trade groups; and

- Include specific and meaningful EDI messages in routine bulletins to providers, addressing the themes described in §10.4, below, and other issues that may be pertinent to the FI's or Contractor's area. Point out the advantages to the provider of various aspects of EDI.

10.4 - Production and Distribution of Material to Market EDI

(Rev. 1, 10-01-03)

B3-3023.7, AB-01-19

Carriers and FIs are required to produce and distribute material to educate and influence providers in all aspects of EDI.

They must include the following themes in published material:

- Earlier payment of claims because of different payment floor requirements;

- The benefit of earlier detection of errors via edits;

- The relative ease of EDI and support available;

- Advantages of online correction of errors (FIs only);

- Lower administrative, postage, and handling costs;

- Electronic adjustments (FIs only);

- Availability of free software;

- Claims status inquiry; and

- Eligibility query.

They must include in written materials testimonials and/or case studies from providers and facilities that have benefited from using EDI transactions.

These materials may be produced in-house or by local printing companies. The contents must be maintained up to date. Therefore, carriers and FIs must carefully plan print quantities to match planned distribution to avoid unnecessary waste.

They must make the material available to staff that have contact with the provider community and make arrangements for distribution at trade shows and seminars that the carrier or FI does not attend as well as those that they do attend.

20 - Provider and Vendor EDI Enrollment

(Rev. 1, 10-01-03)

B3-3021.7, B3-3021.8 partial, B3-3022

State Agency and CMS Regional Office (RO) processes for certifying or otherwise approving providers for furnishing and billing for Medicare services do not address requirements for electronic commerce. Carriers and FIs are required to assess the capability of entities that request to submit electronic data, and to establish their qualifications (see test requirements in §50), and enroll and assign submitter identification numbers to those approved (or requesting approval) for electronic submission.

20.1 - EDI Enrollment Form

(Rev. 1, 10-01-03)

A3-3601.4, B3-3021.4

20.1.1 - New Enrollments

(Rev. 1, 10-01-03)

Arrangements for Medicare EMC submission are specified in the CMS standard Electronic Data Interchange (EDI) Enrollment Form. This agreement must be executed by each provider of health care services, physician, or supplier that makes EMC submissions either directly to the Medicare carrier or FI or through a trading partner. Each billing provider must sign the CMS standard EDI Enrollment Form and submit it to the carrier or FI before the carrier or FI will accept production claims from that provider. Carriers or FIs may accept a signed EDI Enrollment Form from providers via fax or hard copy. The EDI Enrollment Form is effective as specified in the terms of the agreement.

Providers who have a signed EDI Enrollment Form on file with particular carriers and FIs are not required to submit a new signed EDI Enrollment Form to the same carriers and FIs each time they change their method of electronic billing, e.g. changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. However, FIs and carriers must be notified in advance, and they must inform the provider when the necessary systems changes have been made to accommodate the change. See §20.2 for instructions about such changes.

An organization comprised of multiple components that have been assigned Medicare provider numbers, supplier numbers or UPINS may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which such numbers

have been assigned. The organization as a whole is to be held responsible for the performance of its components.

The actual EDI Enrollment Form to be signed is as follows:

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers or FIs.

A. The provider agrees:

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

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its carriers or FIs, without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law;

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

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

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

5. That the Secretary of Health and Human Services or his/her designee and/or the carrier or FI has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the

applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines;

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

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

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

9. That it will affix the CMS-assigned unique identifier number (submitter identifier) of the provider on each claim electronically transmitted to the carrier or FI;

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

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

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

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its carrier or FI, shall not be used by agents, officers, or employees of the billing service except as provided by the carrier or FI (in accordance with §1106(a) of Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier or FI or CMS within two business days if any transmitted data are received in an unintelligible or garbled form.

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

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

2. Affix the FI/carrier number, as its electronic signature, on each remittance advice sent to the provider;

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

4. Ensure that no carrier or FI may require the provider to purchase any or all electronic services from the carrier or FI or from any subsidiary of the carrier or FI or from any company for which the carrier or FI has an interest. The carrier or FI will make alternative means available to any electronic biller to obtain such services;

5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare carriers or FIs to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the carrier or FI sells directly, or indirectly, or by arrangement;

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

NOTICE:

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

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

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name
Title
Address
City/State/Zip
By
Title
Date

NOTE: This is the end of the complete enrollment form.

20.2 - Submitter Number

(Rev. 1, 10-01-03)

A-3604, NSF Specs

Carriers and FIs will assign a submitter number to each entity (provider, clearinghouse, billing agent) submitting electronic transactions. If required by the processing system, carriers and FIs will also assign numbers to receivers of electronic remittance files. Provision must be made to return claim remittance files either to the provider or to a designated receiver (which may be the submitter or another entity). The profile must indicate where response and remittance files are to be returned.

20.3 - Release of Medicare Eligibility Data

(Rev. 1, 10-01-03)

A3-3601.5, A3-3601.6, A3-3601.7, B3-3021.5, AB-03-036

The CMS is required by law to protect all Medicare beneficiary-specific information from unauthorized use or disclosure. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and HIPAA. The CMS' instructions allow release of eligibility data to providers or their authorized billing agents for the purpose of preparing an accurate claim. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed.

The CMS is limiting the way eligibility data is being accessed by network service vendors. For information regarding network service vendors, review §80.3. Carriers and FIs must give access to any network service vendor that requests access to eligibility data on behalf of providers as long as they adhere to the following rules:

- Each network service vendor must sign the new Network Service Agreement below;

- Each provider must sign a valid Electronic Data Interchange (EDI) Enrollment Form;

- The provider must explain the type of service furnished by its network service vendor in a signed statement authorizing the vendor's access to eligibility data; and

- The network service vendor must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a network service vendor, that vendor must be able to identify the correct provider making the request for each beneficiary's information.

A. All providers and network service vendors must negotiate with an FI/carrier for access to eligibility data.

B. Carriers or FIs may not allow vendors and providers to go to one fiscal FI (FI) to access all eligibility information. Vendors and providers may receive access to eligibility data only from the FI that the provider has elected. Vendors must submit eligibility requests on behalf of a given provider only to that provider's own FI.

C. When an inquiry enters into the carrier or FI system, the FI or carrier must be able to ensure that:

- An EDI agreement has been signed by the provider;
- A network service agreement has been signed by the vendor; and
- Each inquiry can be identified by provider.

D. Contractors use one of the two CMS national standard flat file formats (one for professional claims, the other for institutional providers) to send and receive eligibility inquiries, or contractor's may use the ANSI X12N, 270 Health Care Eligibility/Benefit Inquiry Format which requires response with an ANSI X12N, 271 Health Care Eligibility/Benefit Information Transaction Set.

E. Providers may use eligibility data only for the approved use of preparing accurate claims. Access to eligibility data is limited to individuals who support this function.

Carriers or FIs must contact all providers and network service vendors to advise them of these procedures. Carriers and FIs must remind providers that they must let them know when they change from one network service vendor to another, cease arrangements with a network service vendor, or leave the Medicare program. Carriers or FIs must delete each provider from their system when it moves to another bill processor or leaves the Medicare program.

20.4 - Network Services Agreement

(Rev. 1, 10-01-03)

A3-3601.8, B3-3021.8

New network service vendors must sign the following Network Service Agreement. The following agreement must be added to existing contracts:

The network service agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974, which requires Federal information systems to establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims,

remittance advice, online claims correction, and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically;

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

3. The data submitted to the network service by the carrier or intermediary are owned by Medicare;

4. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than (a) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider's patient, (b) CMS, or (c) CMS' carriers or FIs;

5. It will promptly notify the carrier or intermediary of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure;

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

7. It has identified to the carrier or intermediary in writing any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks;

8. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. Reports may be written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date;

9. It will guarantee that an authorized user may be deleted within 24 hours. Other standards of performance, including, but not limited to, how quickly a user may be added to the network, must be specified in writing;

10. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing and signed by the provider, and each provider has a valid EDI enrollment form on file;

11. It has the ability to associate each inquiry with the provider making the inquiry;

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

13. It understands that final regulations on security and privacy standards for health information under the Health Insurance Portability and Accountability Act of 1996 will be forthcoming. It will adhere to those regulations when they become effective;

14. It will require its subcontractors, agents, and business associates to:

    Comply with all applicable current requirements of the Network Service Agreement as well as any future requirements or changes to the Network Service Agreement.

    Require their subcontractors, agents, and business associates to comply with all applicable current requirements of the Network Service Agreement as well as any future requirements or changes to the Network Service Agreement.

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

NOTICE:

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

This document shall become effective when signed by the network service. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with CMS or the carrier or intermediary. Either party may terminate this arrangement by giving the other party (30) days notice of its intent to terminate.

SIGNATURE:

I am authorized to sign this document on behalf of the indicated party, and I have read and agree to the forgoing provisions and acknowledge same by signing below.

Network Service Company Name:
Address:
City/State/ZIP code:
Signed By:
Title:
Date:
Carrier or intermediary:

20.5- EDI User Guidelines

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.5

FIs and carriers must make available to new electronic billers literature that describes the various steps in the testing process (see §30) and discloses:

- The names and telephone numbers of appropriate staff to contact when:
    - Getting started with electronic billing;
    - Needing on-going support for electronic transactions; and
    - Needing support for general billing issues;
- Testing requirements and the submitter's and carrier or FI's level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
    - National Standard Format (NSF);
    - Uniform Bill (UB-92 electronic flat file);
    - The American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) X12N transactions; and
    - National Council for Prescription Drug Programs Format (NCPDP).
- The availability of free Medicare EMC software upon request;
- Instructions for accessing and downloading these specifications via the CMS Internet EDI Home Page http://www.cms.hhs.gov/providers/edi/edi3.asp;
- Logon requirements;
- Telecommunications options and requirements; and
- Frequently asked questions about EDI and the answers.

30 - Technical Requirements - Data, Media, and Telecommunications

(Rev. 1, 10-01-03)

Carriers and FIs may not differentiate between a subsidiary of a parent organization and direct submitters in providing EDI support, but must provide the same level of support and quality of service to both.

30.1 - System Availability

(Rev. 1, 10-01-03)

A3-3600.1 partial

Access to lookup files (e.g., HCPCS codes, fee schedules) may be dependent upon hours the core processing system is available. Where EDI functions are dependent upon the operation of the host processing system, the host system's hours of operation determine system availability.

Carriers and FIs will inform users of system availability schedules including any planned downtime for system maintenance.

30.2 - Media

(Rev. 1, 10-01-03)

A3-3600.1, A3-3602.1, B3-3023

An electronic claim is defined by its initial manner of receipt including telecommunications and in some cases magnetic tape. An "electronic claim" is one that is submitted via central processing unit (CPU) to CPU transmission, tape, diskette, direct-data entry, direct wire, dial-in telephone, digital fax, or personal computer upload or download. The term "digital fax" refers to a claim that arrives via fax but is never printed on paper. Rather, the fax is encoded while still in electronic form (generally by an optical code reader [OCR]), and electronically entered into the claims processing system, eliminating manual data entry.

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through a RO, another FI, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. A contractor does not include:

- Bills received from institutional providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for them;
- Adjustment bills;
- Misdirected bills transferred to a carrier or another FI;
- HHA bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate recordkeeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.); and
- Bills paid by an HMO and processed by the contractor.

Effective October 1, 1998, carriers and FIs report claims received via touch-tone phone, fax imaging, and magnetic disk as paper for workload purposes. Refer to Chapter 1 for further information on workload requirements.

However, if it is cost effective, carriers and FIs may continue to accept claims received via fax-imaging and magnetic disk.

Billers should be assisted with transition from these media to more efficient electronic media such as the carrier or FI's free Medicare personal computer software. Carriers and FIs will not prohibit claims submitters from using other cost-efficient telecommunications means by offering these options.

30.3 - Telecommunications/Protocols

(Rev. 1, 10-01-03)

A3-3602.1, B3-3023

Carriers and FIs must support transfers for Medicare using v.34 28.8kb or faster modems on the majority or at least half of their asynchronous communications lines. For asynchronous communications, carriers and FIs must support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP), compliant with Internet Request for Comment (RFC) number 1122 and 1123, using Serial Line Internet Protocol (SLIP) or Point-to-Point Protocol (PPP). For any Electronic Data Interchange (EDI) transfers over TCP/IP connections, carriers and FIs must support File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication (and therefore billing support) through user id/password mechanisms. The carrier or FI must submit any security mechanism in addition to this to CMS for approval prior to implementation. Carriers or FIs should not retire any current protocols unless the customer no longer uses them. Any user should be able to use TCP/IP for asynchronous communication at any Medicare site. The Internet may not be used for beneficiary or provider sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project. See §40.6 for CMS policy on Internet use.

Carriers and FIs must provide asynchronous telecommunications to any requesting electronic biller and electronic remittance receiver. Carriers and FIs must offer data compression, either through the use of the v.34 28.8kb modem or through PKZIP version 2.04g, whichever the biller requests. While PKZIP is the standard, carriers or FIs may, but are not required to, accommodate other compression software which the biller requests. Carriers and FIs must enable hardware compression support in their v.34 modems (the actual use is negotiated between the carrier or FI modem and the provider modem at startup). In addition, when hardware compression is used, it is possible for the effective data rate to the host system to be as much as four times the line rate (e.g., 4 times 28.8). Therefore, carriers and FIs should have adequate processing capacity to handle this amount of data for each connection.

Note: Contractors need not support file compression for ANSI X12N transactions. Compression is permitted between the contractor and its data center, if applicable.

However, the Medicare Part A Claim/COB flat file must not be compressed when presented to the shared system.

For asynchronous traffic, carriers and FIs may not limit the number of claims or the number of providers in a single transmission, although they may limit a single transmission to 5,000 claims if that is necessary for efficient operations. Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

For asynchronous communications, carriers and FIs must accept and send all ANSI X12N transactions as a continuous byte stream or as a variable length record. The data should not be required to be broken down into 80 byte segments nor should any other deviation from the variable length format or the continuous byte stream format be required. For example, submitters may not be forced to create each segment as its own record by inserting carriage returns or line feeds. For all ANSI X12N transactions, only standard ANSI X12N envelopes are to be used.

For asynchronous communications, carriers must accept and send the NSF (claim and remittance respectively) in 320 byte records, and FIs must accept the UB-92 in 192 byte records. The data should not be required to be broken down into 80 byte segments nor should any other deviation from the 192 or 320 byte formats be required. For asynchronous communications, Medicare flat files are self-enveloped, and the envelope provided shall be the only one used.

The ANSI X12N 837 standard claim transaction is a variable-length record designed for wire transmission. The CMS recommends the ANSI X12N 837 be accepted over a wire connection. However, FIs may support tape or diskettes for those trading partners that do not want to send/receive transmissions via wire. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

30.4 - Carrier Toll-Free Service

(Rev. 1, 10-01-03)

B3-3023.1

Carriers make toll free lines available for inquiries, but previously CMS removed funding for toll free dial up for participating physicians, suppliers, and facilities. Telecommunication methods that are cost effective and in common use should be supported. Carriers should follow “Prudent Buyer” principles to decide whether to support a given method. At the carrier’s discretion, companies may be changed to improve the efficiency and/or cost effectiveness of long distance service.

30.5 - Initial Editing

(Rev. 1, 10-01-03)

B3-3023.4

Carriers and FIs will establish a system for controlling incoming and outgoing data so that the submitter can ascertain that bills submitted have been received.

Carriers and FIs will provide initial (pre-control) editing of electronically submitted claims to ensure the completeness and correctness of claims taken into the claims processing system. Initial editing will include format and data editing:

- Format edits validate the programming of the incoming file and include file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits; and

- Data editing validates claim-specific data required for claims processing, e.g., procedure/diagnosis codes, modifiers.

Carriers and FIs must establish a technique to detect duplicate transmissions.

Carriers and FIs should have the capability to reject, or return as unprocessable, at a file, batch or claim level, based upon the edit(s) failed.

Carriers and FIs are not required to control claims until all initial edits have been passed.

30.6 - Translators

(Rev. 1, 10-01-03)

Refer to the 837 IG download site (http://www.wpc-edi.com) for a more detailed explanation of control structure/loop references made in this section.

FIs, carriers, and DMERCs must be able to accept a HIPAA compliant ANSI X12N 837 transaction into their front-end system and write the flat file to the shared system. A HIPAA compliant ANSI X12N 837 transaction may include Medicare data (data sent to the core shared system) and non-Medicare data (data not sent to the core shared system). Translators will validate the syntax compliance of the inbound ANSI X12N 837 standard.

Contractors must use the ANSI X12N 997 Functional Acknowledgment to report standard level errors detected by translators. They must create the ANSI X12N 997 Functional Acknowledgment, as detailed in the ANSI X12N implementation guide, to all EDI submitters who submit claims in the ANSI X12N 837 format. Contractors may use the ANSI X12N 837 standard syntax editing only. FIs are required to use ANSI X12N 997 loops AK2, AK3, and AK4. Contractors may purge the ANSI X12N 997 after five business days in the event the ANSI X12N 997 transaction is not received by the submitting entity.

Contractors must accept the basic character set on an inbound ANSI X12N 837, plus lower case and the "@" sign which are part of the extended character set. Refer to Appendix A, page A2, of the Implementation Guide for a description of the basic character set. All other character sets may be rejected at the translation level. If contractors can not accept more than 9,999 loops or segments per loop due to the limitations of the translator, they may reject the transaction at the translator level and use the ANSI X12N 997, AK3 segment with a value of "4" in data element "04."

Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) so the translation process can immediately reject an interchange, functional group, or transaction set not having met the requirements contained in the specific structure, which could cause software failure when mapping to the flat file. Contractors are not required to accept multiple functional groups (GS/GE) within one transmission. Translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in the inbound ANSI X12N 837 HIPAA version;
- Carrier and DMERCs Translators map "Not Used" data elements only based upon that segment's definition, i.e., if a data element is never used, do not map it. However, if a data element is "required" or "situational" in some segments but not used in others, then it must be mapped;
- FI translators do not map "Not Used" data elements;
- Remove the hyphen from all range of dates with a qualifier of "RD8" when mapping to the flat file; and
- Accept multiple interchange envelopes within a single transmission.

40 - Required Electronic Data Exchange Formats With Providers and Submitters

(Rev. 1, 10-01-03)

B3-3023.6, EDI Web site, A-00-89, PM A-01-57, PM B-01-13

A. CMS General Requirements for Data Exchange

The following data record types are available for Medicare providers and submitters. Carriers and FIs must accept and provide these formats, where applicable to the transaction. Specifications for each of these records can be found on the Internet on the CMS Home page at http://www.cms.hhs.gov and on the Washington Publishing Company web site at http://www.wpc-edi.com. Providers with no Internet access who request information to evaluate starting a specific electronic application (e.g., billing, acknowledgment, or remittance) will be furnished a single copy of the related specifications at no charge upon request to the FI or carrier. The carrier or FI will

determine the media. Otherwise, providers are expected to obtain formats and coding requirements from those Web sites.

Although the effective date for changes is also included on the Internet, specific instructions will be issued to providers via CMS manuals and carrier or FI bulletins about effective dates and specific changes. These instructions will be limited to an explanation of changes and a description of effective dates. The full record formats will be issued only on the Internet except for providers beginning the use of specific applications as described above.

B. HIPAA

The HIPAA administrative simplification provisions direct the Secretary of Health and Human Services to adopt standards for administrative transactions, code sets, and identifiers, as well as standards for protecting the security and privacy of health data. On October 16, 2000, a final rule designated ANSI standards for eight administrative transactions and HCPCS and National Drug codes used in these transactions. This begins the 2-year implementation period, after which all other formats and code sets cannot be used.

NOTE: ASCA subsequently allowed providers who submitted an extension form an extra year to implement the HIPAA formats and codesets.

Refer to the Washington Publishing Company Web site address at http://www.wpc-edi.com/Default_40.asp for access to HIPAA transaction set documentation. Standard documents required for HIPAA compliance for Medicare are also available on the CMS Web site at http://www.cms.hhs.gov/hipaa/hipaa2/links/default.asp Further information on the HIPAA standards requirements in general may be obtained at http://aspe.hhs.gov/admnsimp.

40.1 - Electronic Claims and Claims Support Attachments

(Rev. 1, 10-01-03)

A3-3602.6, B3-3023.6

The provider may elect to use the current version or any format, which CMS currently approves. Currently acceptable versions are listed on the CMS Internet EDI Home Page. The address is http://www.cms.hhs.gov/providers/edi/edi3.asp.

- ANSI X12N 837 Institutional and Professional Claim data sets - FIs must accept the institutional format/data set. It is used for Part A claims and Part B claims processed by the FI. This format includes UB-92 data. Carriers accept only the professional format/data set. The professional format includes Form CMS-1500 data.

- UB-92 electronic data set (FIs only) - This is an electronic version of the UB-92. It also includes specific record formats for reporting medical data related to ESRD, home health plan of treatment, and outpatient therapy. Note that the Form CMS-700-701 attachment format is incorporated into the UB-92 format.

- National Standard Format (NSF) (carriers only) - This is an electronic version of the Form CMS-1500. Record formats are included for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies), chiropractic, and ambulance claims.

- The National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version 5.1 and Batch Standard 1.1. This standard will be used by all DMERCs that process retail pharmacy drug transactions.

The records must be accepted in the published national formats, with no local changes. (Use of state or locally defined fields for non-Medicare purposes in accordance with the national specifications record definitions is not considered a local change.)

Wire communication is the preferred media for claim records, as related processes require fewer FI and/or carrier resources. Upon request of the provider, the FI or carrier may consider other means of electronic communication if cost effective. New communication methods must be approved by the Regional Office.

Neither the carrier nor the FI may reject a record for Medicare processing because it contains data not required for Medicare if the data is included in the format definition. The carrier or FI system must be able to transfer such non-Medicare data to another payer according to a Coordination of Benefits agreement. However, such data is not edited for processing Medicare claims. Medicare-required data elements are edited for conformity with formats and content requirements, and for consistency with internal carrier/FI and/or CMS files.

NOTE: The processes described in above in this section and in §§40.1.1 and 40.1.2 below will sunset October 16, 2003, when the flat files are no longer used under HIPAA. At that time, any changes to code sets associated with the UB-92 or NSF should be made to NUBC/NUCC as appropriate.

NOTE: Some medical review/attachment data currently defined in many of the electronic UB-92 70-series records are not included in the IG. The CMS is looking at alternative ways of processing this data electronically.

40.1.1 - Submitting Change Requests for the UB-92

(Rev. 1, 10-01-03)

A3-3602.6

Change requests must be submitted on the electronic UB-92 Change Request Form. The form must be completed properly and any necessary documentation attached. FIs may

also submit change requests for non-Medicare commercial operations. Complete the form as follows:

Line 1 - Enter the Region Number (e.g., Regions I-X) and the date of the request.

Line 2 - Enter the name/organization.

Line 3 - Enter the name of a contact person in the organization that can answer questions concerning the request.

Line 4 - Enter the contact person's telephone number.

Line 5 - Enter the record type (record identifier) and field that is requested to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field.

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation.

Indicate whether this change is the result of a CMS mandate.

ELECTRONIC UB-92 CHANGE REQUEST FORM

1. Region: _____ Date:_____

2. Name/Organization: _____

3. Contact Person: _____

4. Phone #: _____

5. Record Type & Field:
_____ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:

_____

Reason for Change:

_____

Impact Statement: (Volume, lines of business involved, field attributes/values, definition, validation, etc.)

_____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a CMS Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: _____

Final Disposition: [___] Approved for Electronic UB-92 Release Date:

_____

[___] Denied

Remarks:

_____

_____

_____

_____

_____

_____

NOTE: Send this form to the RO EDI Coordinator.

40.1.2 - Submitting Change Requests for the NSF

(Rev. 1, 10-01-03)

B3-3025

Central Office (CO) maintains the National Standard Format (NSF) for electronic media claims (EMC) and for electronic remittance advice (ERA) transactions.

Change requests must be submitted to the RO EDI Coordinator on the NSF Change Request Form. The form must be completed properly and any necessary documentation attached. Carriers may also use this form to submit change requests for non-Medicare commercial carriers.

The form is completed as follows:

Line 1 - Enter the region number (e.g., Regions I-X) and the date of the request;

Line 2 - Enter the name/organization;

Line 3 - Enter the name of a contact person in the organization that can answer questions concerning the request;

Line 4 - Enter the contact person’s telephone number;

Line 5 - Enter the record type (record identifier) and field that is requested to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field;

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation. Indicate whether this change is the result of a CMS mandate.

NATIONAL STANDARD FORMAT CHANGE REQUEST FORM

1. Region: _____

   Date: _____

2. Name/Organization: _____

3. Contact Person: _____

4. Phone #: _____

5. Record Type & Field:

_____ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:
_____

Reason for Change:
_____

Impact Statement: (Volume, lines of business involved, field attributes/values,

definition, validation, etc.)

_____

_____

_____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a **CMS** Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: _____

Final Disposition: [___] Approved for NSF Release

Date: _____

[___] Denied

Remarks:

_____

_____

_____

_____

NOTE: Send this form to the RO EMC Coordinator. Non-Medicare commercial carriers may send this form to a Medicare carrier or CMS CO.

40.1.3 FI HIPAA Claim Level Edits

(Rev. 49, 12-19-03)

The FIs must reject 837 claims with implementation guide (IG) errors at the claim level. FIs must install the APASS IG edit module in order to reject claims that have implementation guide (IG) errors at the claim level (see example below). If a batch of claims passes the basic syntax edits, the APASS IG edit module will be invoked and only claims that fail the IG edits will be rejected and appropriate reports generated.

ISA (example 1)

GS (example 2)

ST (example 3)

PROV A

SUBSCRIBER A (example 5)

CLAIM A1 (example 6)

CLAIM A2

CLAIM A3

SUBSCRIBER AA

CLAIM AA1

CLAIM AA2

PROV B (example 4)

SUBSCRIBER B

CLAIM B1

CLAIM B2 (example 6)

CLAIM B3

SE

ST

PROV C

SUBSCRIBER C

CLAIM C1

CLAIM C2

CLAIM C3 (example 6)

PROV D

SUBSCRIBER D

CLAIM D1

CLAIM D2

CLAIM D3

SE

GE

IEA

Example 1 (ISA-IEA level IG edit): Any errors found at this level (envelope) will result in all claims within the ISA-IEA being rejected.

Example 2 (GS-GE level IG edit): Any errors found at this level will result in all claims within the GS-GE being rejected. In this example all claims would be rejected. If a second GS-GE loop followed the first and passed all edits, then any claims within the second GS-GE would be entered into the system providing they passed the IG edits.

Example 3 (ST-SE level IG edit): Any errors found at this level will result in all claims within the ST-SE being rejected. In this example assume only the first ST had errors. In this case claims A1, A2, A3, B1, B2, B3 would be rejected. Claims C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits.

Example 4 (Provider level IG edit): Any errors found at this level will result in all claims for this provider being rejected. In this example assume only the Provider B had errors (such as an invalid provider number). In this case, claims A1, A2, A3, C1, C2, C3, D1, D2, D3 would be entered into the system providing they passed IG edits and claims B1, B2, B3 would be rejected.

Example 5 (Subscriber level IG edit): Any errors found at this level will result in all claims for this subscriber being rejected. In this example, claims for Subscriber A (A1, A2, and A3) would be rejected. Claims for Subscriber AA (AA1 and AA2) would be entered into the system providing they passed IG edits.

Example 6 (Claim level IG edit): Any errors found at this level will result in only that claim(s) being rejected. In this example assume only claims A1, B2 and C3 had errors. All of the other claims would be entered into the system providing they passed IG edits.

40.2 - Electronic Claims Functional Acknowledgment

(Rev. 1, 10-01-03)

B3-3023.6

Upon provider request, carriers and FIs must provide a functional acknowledgment record in response to claims records. If the claims are received in the NSF or UB-92 format, the flat file acknowledgment format must be used. See the

CMS Internet EDI Web page for the format. For claims received in the ANSI X12N 837 format, the ANSI X12N 997 format must be used. The acknowledgment must be provided within one business day after the day the claim is received.

The ANSI X12N 997 functional acknowledgment and the flat file functional acknowledgment are the only acceptable functional acknowledgment formats.

40.3 - Remittance Records

(Rev. 1, 10-01-03)

40.3.1 - Electronic Remittance Advice

(Rev. 1, 10-01-03)

B3-3023.6, B3-3024.5, A3-3750, PM A-01-57, PM B-01-35

Remittance records must be provided to describe the claims for which payment is made.

- FIs must provide the ANSI X12N 835 Transaction Set.

- Carriers must provide the ANSI X12N 835 Transaction Set and the NSF. The provider may select which to accept for the period prior to the implementation of HIPAA. Under HIPAA, only the 835 transaction set may be used.

Acceptable versions are published on the CMS Internet EDI Home page. ANSI X12N formats are used only via telecommunications. HIPAA version implementation guides may be downloaded without charge from http://www.wpc-edi.com/HIPAA, or users may phone 1-800-972-4334 to purchase hard copies.

40.3.2 - Standard Paper Remittance (SPR) Notices

(Rev. 1, 10-01-03)

PM A-01-57, PM B-01-76

By October 2003, shared systems must use the HIPAA version flat file, rather than any earlier flat file, to generate SPRs to avoid data variations between SPRs and ERAs in fields shared by both formats. Shared systems may change to use of the HIPAA version flat file for SPRs at any point after October 1, 2001, as long as completed by October 2003. Shared systems must furnish their FIs at least 90 days advance notice of their SPR changeover date. FIs must in turn furnish their SPR users with advance notice of the effective date of the change and any differences they can expect to see in their SPRs as result of the flat file changeover.

The Medicare core system will continue to record a maximum of 17 characters for patient account numbers. Patient account numbers in excess of 17 characters will be populated from the repository established for coordination of benefits for both SPRs and ERAs. If a provider requests a SPR or ERA after a 20-character patient account number has been

purged from the repository, the SPR/ERA will report the first 17-characters only. A similar limitation applies to reporting of provider line item control numbers in ERAs.

All other data elements included in SPRs and ERAs will be populated from the Medicare core system. By as early as October 1, 2001, but no later than October 2003 shared systems must assure that all data elements that appear in both the SPR and the ERA for the same claim contain identical data. Fields shared by both formats for the same claim may not contain different data. As in the past, data not available in an ERA may not be reported in a SPR. SPRs will also be limited to reporting of one secondary payer, even when payment information for a claim is shared with more than one secondary payer under COB trading partners agreements.

40.3.3 - Remark Codes

(Rev. 1, 10-01-03)

AB-02-067, AB-02-142, AB-03-012

Carriers and FIs can download the currently approved remark code list from http://www.cms.hhs.gov/providers/edi/edi3.asp#REMITTANCE or http://www.wpc-edi.com for the currently approved, generically worded remark code messages. These messages may be used in both pre-HIPAA and HIPAA format ERAs and standard paper remittances as soon as programming changes are complete. If carriers and FIs begin to use any of these codes for the first time, they must furnish advance notice to providers, including the code, the text, and under what situations the code will be used.. Carriers, DMERCs, and FIs must use only currently valid codes available at the two Web sites mentioned above. CMS issues code update instruction every four months, informing of the changes made in the previous four months. In addition, contractors will be notified of new/modified codes that Medicare initiated in conjunction with a policy change, in the form of a PM or manual instruction implementing the policy change.

The use of “M” and “MA” codes was formerly restricted to line or claim levels. Any remark code may now be reported at either the claim or the line level, i.e., an “MA” code may now be reported in the LQ segment of the 835, and an “M” code in an MOA segment - if the wording of the message fits the situation being described at that level. “N” codes could always be reported at either the claim or the service level. All new remark codes will now begin with “N.”

40.4 - Electronic Funds Transfer

(Rev. 1, 10-01-03)

B3-3023.6, B3-4430, A3-3750, A1-1430

Electronic funds transfer (EFT) is the preferred method of payment. Carriers and FIs must obtain and retain a signed copy of Form CMS-588, Authorization Agreement for Electronic Funds Transfer, from each provider. If the provider refuses to accept electronic deposit to his bank account, determine the reason, and attempt to convince the

provider to accept direct deposit via EFT. Note that provider pick-up of checks, next day delivery, express mail, and courier services are no longer allowed except in special situations authorized by the CMS RO; and that EFT is as quick or quicker than any other method of payment.

The FI or carrier must use a transmission format that is both economical and compatible with the servicing bank. Normally this will be either the National Automated Clearinghouse Association Format (NACHA) or the ANSI X12N 835 EFT format.

40.4.1 - Payment Floor Requirement

(Rev. 1, 10-01-03)

A3-3600.1 - partial, A1-1430, B3-4430

Carriers and FIs must transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They must designate a payment date (the date on which funds are deposited in the provider's account) of two business days later than the date of transmission.

40.4.2 - Alternative to EFT

(Rev. 1, 10-01-03)

A3-3600.1 - partial, A1-1430, B3-4430

The only acceptable alternative to EFT is paper check mailed by first class mail.

40.4.3 - Tri-Partite Bank Agreement

(Rev. 1, 10-01-03)

A3-3600.1 - partial, 1430, B3-4430

FIs and carriers must ensure that Tri-partite bank agreements (three-party agreements between the contractor, the bank, and the provider) include wording that allows funding of the letter of credit to include EFT as well as paper checks. The agreement must clearly state that all references to checks in the agreement include checks and/or electronic funds transfer.

For more information, refer to the Medicare Financial Management Manual, Pub. 100-6, Chapter 5.

40.5 - Electronic Beneficiary Eligibility Inquiry

(Rev. 1, 10-01-03)

B-02-051 - partial, A-02-065

The 270/271 is a "paired" transaction (the 270 is an in-bound eligibility inquiry and the 271 is an out-bound eligibility response).

In order to implement the HIPAA administrative simplification provisions, the 270/271 has been named under 45 CFR 162 as the electronic data interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response. All other real time and batch formats for health care eligibility inquiry and response, other than DDE, become obsolete October 16, 2003.

See Chapter 25.

The HIPAA version implementation guide for the 270/271 standard may be found at the following Web site: http://www.wpc-edi.com/HIPAA/.

40.6 - Electronic Communication of Other Information

(Rev. 1, 10-01-03)

The CMS will publish updates to the following on the CMS Web page.

- National physician fee schedule, lab fee schedule, DME fee schedules;
- HCPCS updates;
- ASC price groupings;
- ICD-9-CM codes and descriptions; and
- DRG and PPS Pricer information.

FIs and carriers must establish their own Web pages to publish local bulletins, announcements and instructions. Carrier and FI Web pages must be linked to the appropriate CMS Web pages instead of independently publishing duplicate tables and formats that CMS publishes. This requires less expense than incurring independent, duplicate development costs and promotes a single national standard.

The CMS standards for publishing documents on the Internet are to provide downloadable files in Hypertext Markup Language (HTML). Where necessary carriers and FIs may provide selected files in Adobe PDF format or in word processor formats.

The CMS does not provide Internet browsers or PDF viewers. It is assumed that an Internet user already has a browser, which will read HTML. Adobe Corporation provides free software that will read Adobe PDF files to increase the use of its software. It can be

downloaded from the Adobe Corporation Home Page (http://www.adobe.com). A number of other sources also furnish free Adobe PDF Readers.

40.7 – Implementation Guide (IG) Edits

(Rev. 57, 01-02-04)

The HIPAA implementation guides (IGs) state that the ISA08 is an "identification code published by the receiver of the data; when sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them". The ISA08 is a 15-position alphanumeric data element.

FIs, carriers, and DMERCs, and their shared systems must populate 15 positions of ISA08 data (as published by the receiver of the data) on the following outbound X12N HIPAA transaction as requested by your receiving trading partners: The 837 coordination of benefits.

FIs, carriers, and DMERCs must also make the necessary changes to be able to ensure that each trading partner has a unique ISA08. FIs, Carriers, and DMERCs must inform their trading partners that the CMS will not allow two trading partners to have the same ISA08.

40.7.1 – X12N 837 Institutional Implementation Guide (IG) Edits

(Rev. 199, 06-10-04)

The FI shared system will edit *(via an edit module run by the FI) outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims, TOBs* 13X, 14X, 23X, 24X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, and 85X claims to ensure each contains a line item date of service *(LIDOS)* for each revenue code. *Outpatient* claims not containing a *LIDOS* for each revenue code shall be rejected from the flat file with an appropriate error message.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. These claims containing an ICD-9 procedure shall be rejected by the shared system with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all outpatient claims to ensure all Health Insurance Prospective Payment System (HIPPS) Rate Codes used with a "ZZ" qualifier are accepted (not just HIPPS skilled nursing facility rate codes).

The FI shared system will edit all outpatient claims to ensure each does not contain Covered Days (QTY Segment). Outpatient claims containing Covered Days shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all claims to ensure each does not contain a NPP000 UPIN. Claims containing a NPP000 UPIN shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound X12N 837 HIPAA COB transaction, the FI shared system will edit all claims to ensure each containing service line adjudication information also contains an appropriate service line adjudication date (the paid claim date).

The FI shared system will edit all claims to ensure each does not contain an invalid E-code. Claims containing an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid E-code (an E-code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any found shall be subject to on-line edits.

The FI shared system shall edit all claims submitted via DDE to ensure all occurrences of the data element do not contain an invalid diagnosis code (a diagnosis code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid value code (a value code not listed in the external code source referenced by the HIPAA 837 institutional IG), an invalid occurrence code (an occurrence code not listed in the external code source referenced by the HIPAA 837 institutional IG), or an invalid occurrence span code (an occurrence span code not listed in the external code source referenced by the HIPAA 837 institutional IG). Any claims submitted via DDE containing an invalid E-code, value code, diagnosis code, occurrence code, or occurrence span code shall be subject to on-line edits.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) claims received via DDE to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be subject to on-line edits.

The FI shared system shall edit outpatient (as defined in Pub. 100-04 Transmittal 107 – CR 3031) HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an ICD-9 procedure code. Any found shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system shall edit inbound HIPAA X12N 837 claims to ensure all occurrences of the data element do not contain an invalid E-code, value code, occurrence code, or occurrence span code. These shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The healthcare provider taxonomy codes (HPTCs) must be loaded by the FIs and FI shared system, as contractor-controlled table data, rather than hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future updates. The HPTCs are scheduled for update 2 times per year (tentatively October and April). That list may be downloaded in portable document format (PDF) from the Washington

Publishing Company (WPC) for no charge or an electronic representation of the list, which could facilitate loading of the codes, may be purchased from WPC on a subscription basis. Use the most cost effective means to obtain the list for validation programming and updating purposes.

The FIs and FI shared system will edit all claims to ensure that HPTCs that have been submitted comply with both the data attributes for the data element as contained in the HIPAA 837 *institutional* IG, and are contained in the approved list of HPTCs. HPTCs are not required data elements. Claims received with invalid HPTCs shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

The FI shared system will edit all outpatient claims to ensure each containing revenue code 045X, 0516, or 0526 also contain an HI02-1 code of "ZZ", along with a compliant "Patient Reason for Visit" diagnosis code. Outpatient claims containing an invalid "Patient Reason for Visit" code (a "Patient Reason for Visit" code not listed in the external code source referenced by the HIPAA 837 institutional IG) shall be rejected from the flat file with an appropriate error message before the flat file is received by the shared system.

For the outbound HIPAA X12N 837 COB transaction, the FI shared system shall ensure a "ZZ" qualifier in HI02-1 is populated when revenue code 045X, 0516, or 0526 is present on an outpatient claim.

For bill types 12X and 22X, FIs and FI shared system will be responsible for editing to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present on an inbound 837 (contractors should already be editing other inpatient bill types to ensure these are required). Claims not containing this data shall be rejected from the flat file with an appropriate error message before the flat file is accepted by the shared system.

For bill types 12X and 22X, the FI shared system will edit to ensure the admission date, admitting diagnosis, admission type code, patient status code, and admission source code are present when submitted via *DDE* (these are already required for other inpatient bill types). Claims not containing this data shall be subject to an appropriate on-line error message.

40.7.2 – X12N 837 Professional Implementation Guide (IG) Edits

(Rev. 86, 02-06-04)

The Part B Carriers and Durable Medical Equipment Regional Carriers (DMERCs) must reject inbound electronic claims that contain invalid diagnosis codes whether pointed to a specific detail line or not.

The Part B Carriers and Durable Medical Equipment Regional Carriers shall reject inbound electronic claims that contain a space, dash, special character, or 1 byte numeric in any zip code.

The Part B Carriers and Durable Medical Equipment Regional Carriers (DMERCs) must reject inbound electronic claims that contain a space, dash, special character, or parentheses in any telephone number.

40.7.3 – National Council for Prescription Drug Program (NCPDP) Implementation

(Rev 84, 02-06-04)

A. NCPDP Implementation Guide (IG) Edits

DMERCs must allow segments to be submitted in any order including the AM07, AM03 and AM11 according to the NCPDP standard.

B. NCPDP Narrative Portion of Prior Authorization Segment

DMERCs must allow the value "MOD" to be entered in positions 001-003 of the narrative portion of the prior authorization segment indicating that the supporting documentation that follows is Medicare modifier information.

50 - Testing

(Rev. 1, 10-01-03)

50.1 - Requirements for Initial Implementation for Submitters

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.4

All submitters must electronically produce accurate claims. All new submitters must send the carrier or FI a test file containing at least 25 claims, which are representative of their practice or service. Carriers or FIs may, based on individual consideration, increase or decrease the number of claims required to adequately test any given submitter.

Carriers or FIs will subject test claims to format and data edits and will provide documentation of all edits.

- Format testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, relational edits. Test files must pass 100 percent of format edits before production is approved. A carrier or FI may temporarily waive the 100 percent requirement where, in its judgment, the vendor/submitter will make the necessary correction(s) prior to submitting a production file.

- Data testing validates claim-specific 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. A carrier or FI may temporarily waive accuracy requirements for a

submitter and allow claims to be submitted to production. However, the carrier or FI will work with the submitter to increase claim accuracy to at least 95 percent.

Carriers and FIs will provide test results to the submitter within three business days.

Carriers and FIs may require potential submitters to have an approved Medicare provider as a client prior to providing testing support.

50.2 - Testing New Providers for Existing Submitters

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.4

Testing for submitter addition of new providers is not required where all of the following apply.

- For claims, the provider is in the same specialty group (carrier) or provider type (FI) as other providers for which the submitter has successfully tested. See §50.3 for a description of same specialty groups and provider types. This criterion is not required for non-claims transactions, e.g. eligibility queries. Prior approval for any provider type is acceptable for eligibility queries.

- The submitter currently submits transactions of the same type (UB-92, NSF, or ANSI X12N format) and version for at least five active providers

- The usual error rate for front-end edits for the submitter does not exceed five percent of the transactions. In this context front-end edits means format and data testing as described in §50.1, and telecommunications protocols; and not patient eligibility status, or Medicare policy or adjudication issues. In determining the error rate for this purpose, a single claim counts as one regardless of the number of errors on it, e.g., a batch of 100 claims may contain no more than five claims with errors, but the number of errors on each claim is not considered.

Where a submitter's error rate rises above five percent in a month the carrier or FI must notify the submitter in writing. The carrier or FI should provide the submitter a 30-day period to correct the problems before requiring testing for new providers. Also, the carrier or FI may excuse testing for new providers if the cause for the error rate is outside the control of the carrier or FI and submitter (e.g., implementation of new systems changes required by legislation without adequate time for preparation).

This provision for excusing formal testing for new providers for submitters does not change standard provider enrollment procedures where the submitter's new provider is also a new provider for the Medicare program.

50.3 - Similar Provider Groups for Testing

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.4

All provider specialties (carrier) or provider types (FIs) that fall within each of the following categories are considered the same provider type as other provider types that fall within the same category, for administration of test requirements described in §50.2.

A FIs

Hospital and SNF inpatient A (includes Swing Beds)

Hospital and SNF inpatient B and outpatient

HHAs

CORFs

ESRD (hospital based and independent)

Hospices

All other

B Carriers

Surgery

Medical

Diagnostic/Therapeutic (excluding independent lab)

Independent Lab

Chiropractic

Podiatry

Physical Therapy

Ambulance

Anesthesiology

Portable X-Ray Supplier

Durable Medical Equipment

Psychiatry/Psychology

Ambulatory Surgical Center

Physiological Lab

50.4 - Changes Initiated by CMS or Carrier or FI

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.4

The carrier or FI will determine whether changes initiated by CMS or the carrier or FI will require retesting, e.g., changes to the NSF, or telecommunication changes. Upon determining the need for testing, carriers or FIs will notify submitters of impending changes and testing requirements and will make available the documentation needed to implement the change. FIs must provide 90 days notice prior to the implementation date. Carriers must provide 60 days notice. Once a submitter has demonstrated that the change is successfully implemented in their product or service, all existing clients may be migrated to the new release without testing.

50.5 - Changes in Provider's System or Vendor's Software

(Rev. 1, 10-01-03)

A3-3602.2, B3-3023.4

Changes in the provider's system that could affect the accuracy of their claims (e.g., software changes, status change from individual to group) may require retesting. Vendors, billing agents, clearinghouses, and Value Added Networks (VANs) should also notify carriers or FIs when planning changes to their systems and discuss the need for testing. Upon such notification, carriers and FIs will work with the submitter and if necessary with the provider, vendor, clearinghouse, or VAN to determine the appropriate level of testing.

60 - Provider Support and Training

(Rev. 1, 10-01-03)

60.1 - User Guidelines

(Rev. 1, 10-01-03)

B3-3023.6, A3-3600.7

Carriers and FIs will make available to potential submitters a user guide with detailed information on:

- The telephone numbers of appropriate staff to contact when:

- Getting started with electronic billing;
- Needing on-going support for electronic transactions; and
- Needing support for general billing issues;

- Testing requirements and the submitter's and carrier or FI's level of responsibility throughout each step of the testing process (see §30);
- The availability of the appropriate specifications for this provider and instructions for accessing these via the Internet and/or bulletin board system;
- The availability of the carrier or FI's provider bulletins via the Internet and/or bulletin board system;
- The availability of the carrier or FI's EDI instructions or procedures via the Internet and/or bulletin board system;
- The availability of the carrier or FI's free Medicare EMC software upon request (Note that the requirement to provide free software will go away in 2004);
- Logon requirements;
- Hours of operation, system and support;
- Telecommunication options and requirements;
- Procedures for updating submitters with any billing changes;
- Formats required for input to the carrier or FI's system. These specifications must be in sufficient detail for the submitter's use, and must include information regarding code, tape density (when applicable), record length(s), field positioning within record(s), labeling and any other conventions necessary for compatibility with the carrier or FI's system;
- All acceptance and rejection formats for output from the carrier or FI's system that will be returned to the submitter;
- Special instructions related to specific diagnosis or procedure codes, i.e., the necessity for attachments or modifiers and appropriate placement within the electronic record;
- Documentation related to all carrier or FI edits, with the exception of those edits which are prohibited from publication due to medical review or fraud and abuse policy, along with indication of which edits are prior to control (front-end processing) and which are post control;

- Description of other EDI functions (claim status, eligibility inquiry, claim acknowledgment and attachments, ERA, EFT, electronic mail, bulletin boards) and the availability of specifications and instructions for each (**NOTE:** Availability of all transactions may not be available with Medicare Part B carriers. Claims correction is not available for any Part B carriers.)

- The availability of online claim entry, claim correction (FIs only), claim status check, eligibility verification, claim development, and the procedure for accessing these transactions;

- Specifications of the carrier or FI's front-end editing process with complete list of error codes and resolution, including those conditions that will result in the rejection of EDI transmissions/batches;

- Conventions for acknowledging claims received, for recovering data known to be lost and for required biller backup procedures;

- Instructions for notifying carrier or FI of changes to the submitter profile;

- Carrier and FI listings of trading partners who are approved for production and have testing requirements waived;

- Data requirements for reporting third party payers, i.e., Medigap, crossover, Medical Assistance and private insurance; and

- Frequently asked questions about EDI, and the answers.

60.2 - Technical Assistance to EDI Trading Partners

(Rev. 1, 10-01-03)

B3-3023.7 A3-3600.7

Carrier and FIs will provide help desk support to assist submitters with inquiries related to file transmission and acknowledgment, file retrieval, transaction requirements/specifications and the use of free software.

Help desk support will be available during normal business hours at a minimum. Time zone differences at the provider's location should be accommodated.

Help desk activities may be controlled and monitored through an automated call management system that provides the following functions:

- Control (login) of all incoming calls: identification of caller, reason for call, date and time, operator.

- Track activities related to the call to the final resolution of the call: identification of routing, callbacks, issues, and resolution.

- Workload distribution of open items.

- Classification of call types for resource planning, provider education, management reporting.

- Storage of caller-specific audit trails.

In addition to an automated call system, FIs and carriers must provide for receipt of e-mail, voice mail, or fax when the help desk is not available.

Receipt of customer service inquiries must be acknowledged within one business day, or attempts to acknowledge the inquiry within this time must be documented if contact has not been made successfully.

Where transmission, retrieval or file problems are reported, a plan of action to resolve the issue must be provided to the inquirer within three days. This plan should include one or more of the following:

- An indication that the carrier or FI looked into the issue and did not identify a problem;

- The submission of a new corrected file;

- An explanation which either solves the problem or indicates action which the submitter or receiver can take to resolve the problem;

- An indication of the need for further investigation, with an estimated time frame for responding with more information and or a resolution;

- An indication that resolution requires carrier or FI action, and a description of the plan for resolution and estimated completion date.

Where the problem affects multiple submitters the carrier or FI must notify all submitters that are affected by the issue.

60.3 - Training Content and Frequency

(Rev. 1, 10-01-03)

B3-3023.7, A3-3600.7

The carrier or FI will provide training for medical office and hospital staff in EDI procedures, use of Medicare carrier or FI issued software, accessing EDI transactions, and any other EDI-related functions available. The following are some examples of training methods.

- Instructor-led training may be conducted at the carrier or FI site or at the provider's location as required;

- Video-taped instruction;

- Training may be accomplished through training manuals and online help with minimal telephone support; and

- Area professional association meetings may provide a willing venue for cost-effective training.

Carriers or FIs will determine the most appropriate yet cost-effective way in which to conduct training. Where appropriate, carriers or FIs should develop user groups for general EDI users and free software users. Medicare carriers or FIs are not required to support or train providers on the use of software provided by commercial vendors/trading partners. Training should be available for any new electronic biller. On an ongoing basis, carriers or FIs should assess the need for additional training based on:

- Periodic identification and evaluation of common billing errors;

- New software release; or

- The introduction of new EDI functions or changes to existing functions.

60.4 - Prohibition from Requiring Proprietary Software

(Rev. 1, 10-01-03)

B3-3024.1, B3-3024.3

Carriers or FIs will accept and process transactions created from any software as long as the transaction format adheres to HIPAA (refer to §40) and CMS requirements. Carriers or FIs are prohibited from the exclusive acceptance of proprietary billing or telecommunication software.

If carriers or FIs offer an interactive terminal option, they must offer it to all EDI trading partners at a reasonable cost. They may not limit the use of interactive terminals only to those who submit bills through a carrier or FI subsidiary.

60.5 - Free Claim Submission Software

(Rev. 1, 10-01-03)

B3-3024.2, 3023

NOTE: The free-billing software distributed by FIs is maintained through the shared system maintainer. Software functionality is controlled through an arrangement with the shared system maintainer and the software developer and not by the FIs. Currently, FIs are responsible only for testing and distribution of the software.

Carriers and FIs will make available to submitters who bill, or wish to bill, via electronic means, basic software free of charge. A fee up to $25.00 per release may be charged to cover postage and handling for the free PC software. The software must create records in either UB-92 or the ANSI X12N 837 for institutional providers or in the NSF or the ANSI X12N 837 for professional providers. Billing software must be able to create an IG compliant Medicare claim.

Carriers and FIs will not provide general-purpose translators from provider systems to the ANSI X12N 837 format. Prior to distributing the initial or updated versions, carriers and FIs will scan the software with a current anti-virus program. Carriers and FIs should be able to provide demonstration diskettes of their free claim submission software.

This basic software must, at a minimum, contain the following:

- Front-end edits to prevent incomplete and inaccurate claims from entering the system;

- "User friendly" qualities including:

    - A low initial investment, as well as low-cost upgrades, on the part of the submitter;

    - Minimal effort for both the software installation and training for the submitter; and

    - Clear and understandable software documentation, including information about where to receive additional help;

- The ability to prepare and send CMS-approved EDI forms of paper attachments (as they are developed and approved); and

- The ability to retrieve and print the ANSI X12N 997 functional acknowledgment or the flat file functional acknowledgment.

60.6 - PC-Print Software

(Rev. 1, 10-01-03)

60.6.1 - Medicare Standard PC-Print Carrier Software (PC-Print-B)

(Rev. 1, 10-01-03)

B3-3024.4, PM B-01-35

The requirement for Carriers to support PC- Print has been rescinded.

60.6.2 - Medicare Standard FI PC-Print Software (PC-Print- A)

(Rev. 1, 10-01-03)

A3-3751, PM A-01-57

FIs must periodically notify providers that free PC-Print software is available. They must supply providers with PC-Print software within three weeks of request. The PC-Print software will allow them to print remittance data transmitted in any 835 format version supported by Medicare. The shared system maintainer will distribute the PC-Print software and user's guide through the processing center. The software and instructions are to be designed to be self-explanatory to providers; it should not be necessary to furnish providers training for use of PC-Print software. Providers are responsible for any telecommunication costs associated with receipt of the 835.

The PC-Print software enables providers to:

- Receive over a wire connection an 835 electronic remittance advice transmission on a personal computer (PC) and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's A (floppy disk) drive;
- Print 835 claims and a provider payment summary information;
- View and print a single claim; and
- View and print a sub-total by bill type.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, i.e., the entire transmission, a single claim, a summary by bill type, or a provider payment summary. All file and print formats must follow the Medicare national standards described in the specifications. Since the software performs limited functions, malfunctions should rarely occur. If software malfunctions are detected, they are to be corrected by the fiscal FI shared system maintainer. Individual FIs or processing centers may not modify the PC-Print software.

In compliance with HIPAA requirements, the Fiscal FI Shared system (FISS) maintainer must upgrade PC-Print for HIPAA version, and share the upgrade with both the FISS Data Centers and the Arkansas Part A Shared system Data Centers for distribution to their FIs, and through them, to provider users or providers that request the software. Individual FIs must not be funded to develop or procure alternate PC-Print software. The PC-Print software must operate on Windows-95, 98, 2000/Me, and NT platforms, and include self-explanatory loading and use information for providers.

60.7 - Newsletters/Bulletin Board/Internet

(Rev. 1, 10-01-03)

B3-3023.7, A3-3600.7

To educate providers and encourage the use of EDI functions, carriers and FIs must publish EDI newsletters. These newsletters should:

- Announce any upcoming changes;
- Point out common billing errors and provide guidelines to eliminate errors; and
- Promote non-claim related EDI functions.

As an alternative to an EDI newsletter, carriers and FIs may publish articles in an EDI section in their regular provider bulletin. Carriers and FIs will provide access to newsletters via bulletin boards and/or the Internet.

Carriers and FIs must maintain an Internet site that links to CMS' Web site, which provides record formats and related claim information. If the identical information is available on the CMS Home page, carriers and FIs should provide the link to it rather than duplicating development and maintenance. Further instructions on Internet use are in §40.6.

60.8 - Provider Guidelines for Choosing a Vendor

(Rev. 1, 10-01-03)

B3-3022

Providers may request assistance in choosing a vendor. Carriers and FIs must furnish the guidelines below in §§60.8.1 - 60.8.4 to providers that make such requests. Upon request, the carrier or FI may also provide a list of vendors that are billing for the same provider type, and may provide factual information such as claims volumes, and types of providers serviced. However, care must be taken to avoid making a specific recommendation and to avoid showing favoritism.

Providers may select any vendor that provides the necessary services. However, vendors must enroll and achieve satisfactory test performance as required by other sections of the Medicare Manual before submitting production claims to the carrier or FI for provider services rendered.

60.8.1 - Determining Goals/Requirements

(Rev. 1, 10-01-03)

EDI Support Manual

Before selecting a vendor, the provider must examine its business needs to identify the services needed from a vendor. The provider should consider what services it wants to provide from internal operations and what services it wishes provided by a vendor. To receive better vendor proposals, the provider should create a written description of the components of its practice that need vendor support and a description of support needed. Requirements to consider include the following:

- Future Growth of the Practice;
- Workload;
- Payer Analysis;
- Referral Tracking;
- Fee Schedules;
- Appointment Scheduling;
- Medical Records;
- Interconnections with Physicians/Hospitals and other Networks;
- Word Processing Needs;
- Electronic Billing (formats and versions supported);
- Multiple Practices/Locations;
- High Volume/Low Volume Billing;
- Specific Bill Types;
- Management Reporting;
- Hardware/Software Requirements/compatibility with existing equipment; and
- Data Storage needs.

60.8.2 - Vendor Selection

(Rev. 1, 10-01-03)

B3-3022 partial, EDI Support Manual

Once a provider has determined its own goals and requirements, it must begin the vendor selection process. Selecting a vendor must be as objective and quantitative as possible. Areas to be evaluated should include technical functionality, flexibility, and customer service. The following steps may be used as guidelines for providers to start the vendor selection process:

1. Develop a list of potential vendors:

    - Talk to the Medicare carrier or FI;
    - Ask other providers of comparable size/specialties what vendors they use for what services and how satisfied they are;
    - Ask a consultant;
    - Attend standards conferences, follow trade magazines and investigate Web pages.

2. Call or write the vendors selected/recommended to discuss the organization's needs and request a proposal.

3. Tell the vendors how the proposals should be structured so that the various proposals can be more easily compared.

4. Attend demonstrations of at least two to three vendors and pay close attention to:

    - How individual requirements will be met;
    - Ease of understanding;
    - Ease of features - data entry, search features, editing/compliance checking features, help features, error correction features;
    - Security - disaster recovery plans, controls, and audits;
    - Daily Procedures;
    - Reporting/Tracking features.

5. Check vendor references and ask specific questions such as:

    - How long has the business been in operation?

- How long has the system been in place?
- What is the quality of the training and ongoing support?
- Is there a user's group in place?
- What formats are supported?
- Have you experienced any problems with the system?
- Have you experienced any problems with the vendor?
- How long did it take to get up and running?
- Are you happy with the system/vendor and would you recommend it/them today?
- Is there anything else I should know or ask before making my decision?

6. Make site visits to the vendor as well as other clients of similar size and bill mix that have been running the system for some time.

60.8.3 - Evaluating Proposals

(Rev. 1, 10-01-03)

Vendor proposals should be evaluated on several levels including company reputation/history, system functionality, flexibility, overall costs, and support provided. Providers should create a checklist that compares the vendor proposals against their original requirements by assigning a relative weight to each requirement and then rating the vendor's ability to meet each requirement based on their written proposals. Although some aspects of each checklist will be highly individual, the following are some of the elements that should be considered:

1. Overall costs:

    - Software costs;
    - Hardware costs (types as well as quality);
    - Licensing fees;
    - Training costs;
    - Installation costs;
    - Cabling;

- Phone lines (leased line/toll charges);
- Remodeling/Furniture;
- Forms;
- Conversion costs;
- Electricity costs;
- Supply costs (diskettes, tapes, paper, ribbons);
- Annual hardware maintenance;
- Annual software maintenance;
- Cost of custom program changes; and
- Cost of continuous software support.

2. Evaluate hardware differences;
3. Evaluate quality of training and support;
4. Evaluate system documentation;
5. Consider the staff size of the vendor;
6. Determine how well each vendor responded to requirements and questions in the proposals;
7. Determine flexibility (whether the package is proprietary, whether the software can be easily modified, whether the vendor can accommodate changing payer requirements, and if so, at what cost);
8. Determine overall system convenience including hours of customer service, technical support, and connection times;
9. Assess future risks and the vendor mitigation of such risks through system trial periods and source codes placed in escrow.

60.8.4 - Negotiating With Vendors

(Rev. 1, 10-01-03)

Once a vendor has been selected, the provider must negotiate the final costs, services, and implementation dates to be provided by the vendor. All agreements reached between the two parties should be obtained in writing.

70 - Crossover Claims Requirements

A3-3602.3

(Rev. 138, 04-09-04)

Currently, each supplemental insurer specifies *the* criteria related to the claims it *wants* the carrier or FI to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental policy's effective and end dates.

*Until a trading partner has signed a national Coordination of Benefits Agreement (COBA), t*he carrier or FI will *continue to* provide the claim payment information in either the UB-92 or NSF COB flat file or ANSI X12N COB format. This information will be transferred no less frequently than weekly.

Under HIPAA the carrier or FI will provide only the ANSI X12N COB format.

When non-HIPAA inbound claims do not contain data necessary to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (except for MCS) and MCS carriers shall gap fill alphanumeric data elements with Xs and numeric data elements with 9s. For example, a 5-character alphanumeric data element would contain "XXXX" and a 5-character numeric data element would contain "99999".

When non-HIPAA inbound claims do not contain a required telephone number to create a HIPAA compliant outbound X12N 837 HIPAA COB transaction, the shared systems maintainers (except for MCS) and MCS carriers shall gap fill the phone number data element with "8009999999."

Data elements with pre-defined implementation guide values such as qualifiers and data elements that refer to a valid code source shall not be gap filled.

On July 6, 2004, CMS will inaugurate the small-scale implementation of the national Coordination of Benefits Agreement (COBA) claims crossover consolidation initiative. From July 6, 2004, to October 1, 2004, the COBA initiative will proceed as part of a parallel production period. The larger-scale implementation of the COBA eligibility-file based crossover process will commence with the October 2004 systems release. Under

both the parallel production and larger-scale COBA process, intermediaries and carriers will receive confirmation via a Common Working File (CWF) Beneficiary Other Insurance (BOI) auxiliary reply trailer that a trading partner has selected a beneficiary's claim for crossover. Upon receipt of a BOI reply trailer, the intermediary or carrier will transfer the processed claim to the COBC via an 837 COB flat file or National Council for Prescription Drug Programs (NCPDP) file to be crossed over to the trading partner.

Refer to Pub. 100-4, Chapter 28, §70.6 for further details about specific intermediary and carrier responsibilities under the consolidated crossover (or COBA) claims process.

70.1 - FI Requirements

(Rev. 138, 04-09-04)

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20, A-01-63

Shared System Claim/COB flat file

If the shared system detects an improper flat file format/size (incorrect record length, record length exceeding 32,700 bytes, etc.), the flat file will be rejected back to the file's submitter (FI or data center) by the shared system with an appropriate error message. If a syntax error occurs at the standard level, FIs must return the entire transmission (ISA to IEA) to the submitter via the ANSI X12N 997.

The date of receipt is to be generated upon receipt of a claim, prior to transmission of the data to the data center. The FI has the responsibility to ensure the correct date of receipt is populated onto the Medicare Part A Claim/Coordination of Benefit (COB) flat file (flat file) **before** the file gets to the shared system. The shared system will process the date of receipt reported in the flat file. If the flat file contains an incorrect date of receipt (e.g., all zeros), the flat file will be rejected back to the flat file's submitter (FI or data center) by the shared system with an appropriate error message.

Intermediary responsibilities related to the COB flat file will be significantly modified under the COBA process beginning with July 6, 2004. Refer to Pub.100-04, Chapter 28,

§70.6 for details.

Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. FIs are required to receive all possible data on the incoming 837 although they do not have to process non-Medicare data. However, the shared system must store that data in a SFR. This repository file will be designed and maintained by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The shared system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB

transaction. The shared system must retain the data in the SFR for a minimum of 6 months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

FIs are not required to process an incoming ANSI X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The shared system maintainer must accommodate the COB transaction.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by April 30, 2005. Refer to Pub.100-04, Chapter 28, §70.6 for details regarding intermediary versus Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

Summary of Process

The following summarizes all FI steps from receipt of the incoming claim to creation of the outbound COB:

- FI's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;

- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the shared system.

  NOTE: No changes are being made to core system data fields or field sizes;

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the FI's shared system; and

- Adjudicated data is combined with SFR data to create the outbound COB transaction.

For specifics on how the claims crossover process will change as early as July 6, 2004, under the COBA initiative, refer to Pub.100-04, Chapter 28, §70.6.

70.2 - Carrier/DMERC Requirements

(Rev. 138, 04-09-04)

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming ANSI X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the shared system. This data must be reassociated with Medicare claim and payment data in order to create an outbound ANSI X12N 837 COB transaction. The shared systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The ANSI X12N-based flat file is the format to be used to reassociate all data required to map to the outbound ANSI X12N 837 (HIPAA version). The translator will build the outbound ANSI X12N 837 COB from the ANSI X12N-based flat file.

The shared system maintainer must create the outbound ANSI X12N 837.

The flat file creation process and responsibility for sending outbound COB files to crossover trading partners will change appreciably once CMS' COBA process is implemented. The implementation of COBA is scheduled to begin July 6, 2004, and conclude by April 30, 2005. Refer to Pub.100-04, Chapter 28, §70.6 for details regarding intermediary verses Coordination of Benefits Contractor (COBC) responsibilities under the COBA process.

Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the ANSI X12N flat file;

- Shared system creates implementation guide and Medicare edits for the flat file data;

- Medicare data on ANSI X12N flat file is mapped to the core system;

  NOTE: No changes are being made to core system data fields or field sizes.

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and

- Adjudicated data is combined with repository data to create the outbound COB.

For specifics on how the claims crossover process will change as early as July 6, 2004, under the COBA initiative, refer to Pub.100-04, Chapter 28, §70.6.

80 - Security

(Rev. 1, 10-01-03)

80.1 - Carrier or FI Data Security and Confidentiality Requirements

(Rev. 1, 10-01-03)

A3-3601.1, B3-3021.1

All Medicare beneficiary-specific information is confidential and subject to the requirements of §1106(a) of the Act and implementing regulations at 42 CFR Part 401, Subpart B. Those regulations specify that, as a general rule, every proposed disclosure of Medicare information shall be subject to the Freedom of Information Act rules at 45 CFR Part 5. Also all such information, to the extent that it is maintained in a "system of records," is protected under the provisions of the Privacy Act of 1974 (5 USC. 552a) and implementing regulations at 45 CFR Part 5b. Such information is included in claims, remittance advice, eligibility information, online claims corrections, and any other transactions where medical information applicable to an individual is processed or transported. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed. Carriers and FIs must ensure the security of all EDI transactions and data. They must include the following system security capabilities:

- Make sure that all data are password protected and that passwords are modified at periodic but irregular intervals, when an individual having knowledge of the password changes positions, and when a security breach is suspected or identified;

- Provide mechanisms to detect unauthorized users and prohibit access to anyone who does not have an appropriate user ID and password;

- Maintain a record of operator-attempted system access violations;

- Maintain a multi-level system/user authorization to limit access to system functions, files, databases, tables, and parameters from external and internal sources;

- Maintain updates of user controlled files, databases, tables, parameters, and retain a history of update activity; and

- Protect data ownership and integrity from the detailed transaction level to the summary file level.

80.2 - Carrier and FI EDI Audit Trails

(Rev. 1, 10-01-03)

A3-3601.2, B3-3021.2

Carriers and FIs must maintain an automated transaction tracking and retrieval capability and retain an audit trail of online and batch transaction experience(s) affecting the complete processing of a claim from date of receipt to date of payment or denial and any subsequent adjustments.

Carriers and FIs must be able to retrieve:

- The claim as received from the provider of health care services, physician, supplier, or billing service;

- The claim as paid to the provider of health care services, physician, or supplier;

- All adjustments made on the claim;

- The check or the electronic funds transfer (EFT) record sent to the provider of health care services, physician, or supplier; and

- The remittance advice as sent to the provider of health care services, physician, or supplier.

Carriers and FIs must maintain the ability to cross-refer all needed transactions to each claim being processed. The records may be kept on electronic, computer-output-microfilm, or optical disk media. They may never allow anyone to overlay or erase a record. Each record must be kept intact. All records must be archived in accordance with the instructions in the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-1, Chapter 7.

It is important to have a well-defined system for maintaining audit trail data so that data integrity is maintained at all times.

80.3 - Security-Related Requirements for Subcarrier or FI Arrangements With Network Services

(Rev. 1, 10-01-03)

A3-3601.3, B3-3021.3

A **network service** is any entity other than a billing service, engaged in EDI with a carrier or FI, on behalf of Medicare providers. Network services may not view privacy-

protected Medicare data. For EDI, that would be any transaction in which either a beneficiary or a provider may be identified.

Some health care providers retain more than one billing service or network. Carriers and FIs may choose to support more than one service, but only if their system is adequate to protect Medicare data from being viewed by unauthorized users. Each service may access **only** its own information. As an example, let us say that a hospital would like to have one service for eligibility inquiry, another for initial claims, and yet another for denied claims. The hospital reserves claim status and remittance advice for its own staff. The billing service may access any claims it submitted on the hospital's behalf, and it may perform all of the functions that the provider may perform, if the provider designates that. The eligibility service is a network service. It may send inquiries from the provider, and return responses, but it may not view the data, store it, or use it for any reports. The service that works only on denied claims may have no access as it is neither a wire service nor are they a billing service (e.g., it does not submit initial claims), but rather it must work directly with the hospital. As long as the system is capable of ascertaining that no service gets access to any information it is not authorized to see, then carriers and FIs may support the multiple services.

Authorization for access to Medicare claims data must be in writing and signed by the provider. Each provider must be an electronic biller and must sign a valid EDI enrollment form. A separate password is to be used for each provider's access**.**

A **vendor** provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual insurance companies. Vendors have no need to access Medicare data from a carrier or FI. Rather it supplies to the provider the means for such access.

An **eligibility verification** vendor is to be treated as a network service.

A **billing service** offers claims billing service to providers. The billing service collects the providers' claim information electronically then bills the appropriate insurance companies, including Medicare. It may do claims billing only, or provide full financial accounting and/or other services. Billing services may view beneficiary or provider data if they must to perform their obligations to the provider, and if the provider designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider's behalf.

A **clearinghouse** transfers or moves EDI transactions for a provider. A clearinghouse accepts multiple types of claims and sends them to various payers, including Medicare. Clearinghouses perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgements and remittance advices. Clearinghouses ordinarily submit initial claims, and ordinarily qualify as billing services.

A **value added network (VAN)** transfers or moves EDI transactions for a provider. A VAN may not read the contents of files containing beneficiary- or provider- specific information. VANs are treated as networks.

A **collection agency** is a service that bills after the original biller. Do not service collection agencies.

NOTE: The carrier or FI is responsible for maintenance of necessary carrier or FI files and processing procedures to prevent unauthorized access to Medicare information. Arrangements for Medicare electronic claim submission are specified in the CMS standard Electronic Data Interchange (EDI) Enrollment Form. This agreement must be executed by each provider of health care services, physician, or supplier that makes electronic submissions.

90 – Mandatory Electronic Submission of Medicare Claims

See Business Requirements at http://www.cms.hhs.gov/manuals/pm_trans/R44CP.pdf

(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