CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 736	**Date: July 30, 2010**
	Change Request 7028

SUBJECT: 5010: Workgroup for Pub. 100-04, Medicare Claims Processing Manual, Chapter 24 Revisions

I. SUMMARY OF CHANGES: This CR establishes a workgroup composed of Medicare Contractors to assist in the documentation of EDI processes and contractor responsibilities implemented through 5010 CRs. Pub. 100-04, Medicare Claims Processing Manual, Chapter 24 will be revised to reflect current and forth coming Medicare FFS EDI business practices.

EFFECTIVE DATE: August 30, 2010
IMPLEMENTATION DATE: August 30, 2010

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

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

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

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
Funding for implementation activities will be provided to contractors through the regular budget process.

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

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 736	Date: July 30, 2010	Change Request: 7028

SUBJECT: 5010: Workgroup for Pub. 100-04, Medicare Claims Processing Manual, Chapter 24 Revisions

Effective Date: August 30, 2010
Implementation Date: August 30, 2010

I. GENERAL INFORMATION Pub 100-04, Medicare Claims Processing Manual, Chapter 24, "General EDI and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims" will be revised to reflect current and forthcoming Medicare FFS EDI business practices. The chapter serves as a base document for Medicare Fee-For-Service (FFS) Electronic Data Interchange (EDI) practices, processes, policies, and Medicare contractor responsibilities; this includes Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs) and carriers, until which time as the transition to MACs from FIs and carriers is complete. Several other chapters document specific EDI transactions utilized by Medicare FFS, which are referenced, not duplicated, in chapter 24, they are:

- Chapter 22 – Remittance Advice
- Chapter 25 - Completing and Processing the Form CMS-1450 Data Set
- Chapter 26 - Completing and Processing Form CMS-1500 Data Set
- Chapter 31 - ANSI X12N Formats Other than Claims or Remittance

In order to adequately describe the changes implemented by the 5010 program, chapter 24 will be completely revised. The work involves reorganizing the entire chapter to clearly communicate how Medicare FFS has operationalized EDI per the CMS 5010/D.0 Program inclusive of HIPAA version 5010 updates as well as new EDI process enhancements. Once reorganized, outdated or irrelevant content will be eliminated, and new content will be inserted, to create a chapter that is comprehensive of Medicare FFS' EDI scope and content.

A. Background: Medicare Administrative Contractors shall participate on a workgroup to assist in the recasting of Pub 100-04, chapter 24. The workgroup will complete its work over eight (8) one and one half-(1.5) hour meetings. Workgroup members shall complete minor assignments between workgroup meetings.

CMS will utilize MACs as subject matter experts to:

1. Assist in reviewing the content of the existing chapter 24 and inform CMS regarding the reorganization and content of the chapter based on EDI process changes implemented by the 5010 Program;

2. Conduct a review of EDI operations activities to ensure the chapter is comprehensive; and

3. Document 5010 and enhanced EDI processes, through:

    - Compilation of existing documents; and
    - Assisting with the drafting of new language where it doesn't already exist

The primary product of the workgroup will be a re-drafted chapter 24. CMS anticipates that the product of the workgroup will be issued in an informational CR to MACs for the January 2011 release.

B. Policy: The Administrative Simplification provisions of HIPAA Regulations require the Secretary of DHHS to adopt standard electronic transactions and code sets. The Secretary may also modify these standards periodically. ASC X12 005010 and NCPDP D.0 have been adopted by the Secretary as the next HIPAA standards. CMS shall be fully compliant and be ready on January 1, 2012, when all covered entities must be fully compliant.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7028.1	MACs and CEDI shall dedicate 1 primary and one secondary representative to participate in 8 workgroup sessions – each approximately 1.5 hours in duration.	X	X	X	X						CEDI
7028.2	MACs and CEDI shall dedicate up to 2 hours per session for workgroup assignments.	X	X	X	X						CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
None											

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

Section B: For all other recommendations and supporting information, use this space: NA

V. CONTACTS

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VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

Funding for implementation activities will be provided to contractors through the regular budget process.

Section B: *For Medicare Administrative Contractors (MACs),* include the following statement:

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