Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

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Termination of the Medicare Health Insurance Portability & Accountability Act (HIPAA) Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual Circumstance, Modification of the "Obligated to Accept as Payment in Full"(OTAF) Exception, and Modification of Administrative Simplification Compliance Act (ASCA) Exhibit Letters A, B and C

Note: This article was updated on February 21, 2013, to reflect current Web addresses. All other information remains unchanged.

Provider Types Affected

Physicians, providers, and suppliers who submit claims to the Centers for Medicare & Medicaid Services (CMS) Medicare contractors (carriers, fiscal intermediaries (FIs), durable medical equipment regional carriers (DMERCs), or regional home health intermediaries (RHHIs))

Background

This article, based on CR4119, summarizes some of the key revisions to electronic data interchange (EDI) requirements contained in the *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). Some of these changes have already been reported in earlier MLN Matters articles and are mentioned here only as reminders.

The EDI policy revisions are necessary for:

- HIPAA compliancy, including contingency plan termination, and free claim software changes;
- Administrative Simplification Compliance Act (ASCA) compliancy, including unusual circumstance, "Obligated to Accept as Payment in Full" (OTAF) modification, and modified ASCA letters.

Medicare providers must adhere to these electronic data interchange requirements. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected.

Key Points

Medicare HIPAA Incoming Claim Contingency Plan

The Medicare HIPAA incoming claim contingency plan has been terminated. **All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the** National Council for Prescription Drug Program (NCPDP) **Telecommunication Standard requirements and the Batch Standard 5.1 (DMERCs only) will be rejected.** Please refer to the *Additional Information* section of this article for more information.

Until the Medicare contingency plan for **HIPAA mandated transaction types other than claims sent to Medicare is terminated**, Medicare contractors **will support** the pre-HIPAA electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 (attached to CR 4119). Please refer to the *Additional Information* section of this article for more information.

NCPDP Claims

NCPDP claims submitted to DMERCs may contain modifiers for compound drugs in the **narrative portion** in the prior authorization segment on the NCPDP standard since it does not currently support reporting modifiers in the compound segment. Please refer to the attachment to CR4119, *Medicare Claims Processing Manual,* Chapter 24, Section 40.2 – B, for further instructions and a list of the modifiers.

Currently Coordination of Benefits (COB) trading partners are not able to accept NCPDP format transmissions for **secondary payment**. CMS is working with the NCPDP to develop a "workaround" to resolve this problem, however, until then, NCPDP claims will not be crossed over to other payers. **Retail pharmacies will need to bill secondary payers directly to collect supplemental benefits that may be due for those claims.** Transmission of pre-HIPAA electronic format claims to other payers under a COB agreement will end when (the earliest of the date) a trading partner completes successful testing on the use of the X12 837 version 4010A1 and /or the HIPAA NCPDP format (as appropriate); or the Medicare HIPAA COB contingency plan ends.

Other Issues

Medicare secondary payer claims may be submitted non-electronically when a primary payer has made an "Obligated to Accept as Payment in Full" (OTAF) adjustment, and there is more than one primary payer. Providers have been directed to report OTAF adjustments in a CN1 segment of a claim, but it is not possible to either identify which primary payer owns a reported OTAF adjustment, or to report more than one OTAF adjustment in the event they apply to each primary payer.

The free billing software (from your Medicare contractor) should be able to identify when Medicare is a secondary payer. It should also be able to collect standard claim adjustment reason codes and adjustment amounts made by a primary payer when Medicare is the secondary payer. If it is not collecting this information, the software must be modified to enable this requirement.

Unusual Circumstances

Certain "unusual circumstances" are automatically waived from the electronic claim submission requirement for either the indicated claim type, or for the period when an "unusual situation" exists. CMS has added a circumstance to the self-assessable Unusual Circumstance list in which paper claim submission is permitted. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg but a combination of factors necessitates use of oxygen. The X12 work group responsible for development of the version 4010A1 implementation guide recognizes that there is a deficiency in the guide pertaining to home oxygen therapy claims. This will be corrected in a later version of that implementation guide, but in the interim, covered entities are bound by the existing version 4010A1 requirements. As result, CMS will permit claims that meet this situation to be submitted on paper.

Modified examples of ASCA exhibit letters A, B, and C can be found in the manual attachment to CR4119(*Medicare Claims Processing Manual*, Chapter 24, Exhibits of Form Letters). Your Medicare contractor will send these revised letters, as appropriate.

- Exhibit A—Response to a non- "unusual circumstance" waiver request
- Exhibit B—Denial of an "unusual circumstance" waiver request
- Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper.

Additional Information

Medicare HIPAA Incoming Claim Contingency Plan Termination

All electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

HIPAA Mandated Transaction Types Other Than Claims Sent to Medicare

Until the Medicare contingency plan (mentioned above) is terminated, Medicare contractors will support the pre-HIPAA electronic transaction formats listed in the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2. These include for claims submitted to:

- All Medicare contractors – UB – 92 version 6.0 claims for coordination of benefits (COB) sent to other payers under trading partner agreements; proprietary format for eligibility data responses using the CMS standard eligibility data set; and X12 276/277 version 4010.
- FIs – X12 837 institutional version 4010 and 3051; X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice.
- Carriers and DMERCs – X12 837 professional version 4010 and 3051; National Standard Format (NSF) version 3.01; X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice; and NSF version 3.01.
- Carriers only - X12 270/271 IG version 3051 for eligibility query and response.
- Please note - Specifications for each of these transactions can be found the Washington Publishing Company website at http://www.wpc-edi.com/ for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA.

The official instruction, CR4119, issued to your FI/RHHI, or carrier/ DMERC, regarding this change may be found by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R802CP.pdf on the CMS website.. Attached to CR4119, you will find the revised portions of the *Medicare Claims Processing Manual* referenced in this article.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll-free phone number, go to http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.