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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*

### Key Words

MM4119, CR4119, Transmittal R802CP, HIPAA, Claim, Contingency, Self-Assessable, OTAF, ASCA

### Provider Types Affected

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

### Key Points

- The effective date of the instruction is April 1, 2006.
- The implementation date is April 3, 2006.

### 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.
- 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 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 which can be found at: <http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf> on the CMS website.
- These include 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.
  - Specifications for each of these transactions can be found on the Washington Publishing Company website at <http://www.wpc-edi.com/HIPAA> for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA.

## NCPDP Claims

- NCPDP claims submitted to DMERCs may contain modifiers for compound drugs in the narrative portion in the prior authorization segment of the NCPDP standard since it does not currently support reporting modifiers in the compound segment.
  - For further instructions and a list of the modifiers, affected providers should refer to the *Medicare Claims Processing Manual*, Chapter 24, Section 40.2 – B which can be found at: <http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf> on the CMS website.
- Currently COB trading partners are not able to accept NCPDP format transmissions for **secondary payment**.
  - Until CMS develops a “workaround,” 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 either 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; whichever comes first.

## 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.
- The free billing software (from Medicare contractors) should be able to **identify when Medicare is a secondary payer** as well as when providers should collect standard claim adjustment reason codes and adjustment amounts made by a primary payer when Medicare is the secondary payer. If it is not the case, 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 **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 CR513, CR514, and/or CR515 do not apply to the self-assessable Unusual Circumstance list in which paper claim submission is permitted.
  - Completion of these data elements as required in the 837-P version 4010A1 implementation guide is an assertion that the required condition for inclusion of these data elements is met.
  - However, non-completion of these data elements cannot be interpreted as a statement that the required condition for inclusion of these data elements is not met.
  - 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.
- Affected providers can find modified examples of ASCA exhibit letters A, B, and C in the *Medicare Claims Processing Manual*, Chapter 24, Exhibits of Form Letters at <http://www.cms.hhs.gov/manuals/downloads/clm104c24.pdf> on the CMS website.
  - 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
- Medicare contractors will send these revised letters, as appropriate.

## Important Links

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM4119.pdf>

The official instruction, CR4119, issued to FIs/RHHs, or carriers/ DMERCs, regarding this change may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R802CP.pdf> on the CMS website. Attached to CR4119, are the revised portions of the *Medicare Claims Processing Manual* referenced in this article.