



News Flash - News Flash - If you treat a Medicare Advantage enrolled beneficiary and you have questions about their Medicare Advantage Plan, you may wish to contact that plan. A plan directory and MA claims processing contact directory are available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/index.html> / on the CMS website. CMS updates this site on a monthly basis.

MLN Matters Number: MM5586

Related Change Request (CR) #: 5586

Related CR Release Date: July 9, 2007

Effective Date: July 1, 2007

Related CR Transmittal #: R1284CP

Implementation Date: October 1, 2007

Note: This article was updated on September 10, 2012, to reflect current Web addresses. All other information remains the same.

Electronic Funds Transfer Standardizations and Revisions to the Medicare Claims Processing Manual (Chapter 24)

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

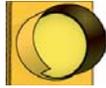


STOP – Impact to You

This article is based on Change Request (CR) 5586 which revises the *Medicare Claims Processing Manual*, Chapter 24 (General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims and Coordination of Benefits Requirements, Mandatory Electronic Filing of Medicare Claims).

Disclaimer

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**CAUTION – What You Need to Know**

Effective July 1, 2007, your Medicare contractor will conduct Administrative Simplification Compliance Act (ASCA) reviews annually of at least 20% of providers submitting CMS 1500 paper claims who were not already reviewed in the past 2 years and found to have fewer than 10 FTEs employed by the practice. In addition, contractors will insure that the addenda record is sent with the Medicare claim payment when an ACH format is used to transmit an EFT payment to a financial institution but the remittance advice is separately transmitted to a provider. This will assist with reconciliation of the payment and the information that explains the payment. The EFT format will be the National Automated Clearinghouse Association (NACHA) format CCP - Cash Concentration/Disbursement plus Addenda (CCD+) (ACH) as mentioned in the X12N 835 version 004010A1 implementation guide.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Change Request (CR) 5586 provides the following revisions to the *Medicare Claims Processing Manual* (Chapter 24, Sections 40.7 and Section 90.5.3) regarding electronic funds transfer (EFT) and the identification of providers to be reviewed.

Contractor Roles in Administrative Simplification Compliance Act (ASCA) Reviews and Identification of Providers to be Reviewed

Each carrier, DME MAC and B MAC (not FIs or RHHs at this time) conducts an ASCA review annually of 20% of those providers still submitting CMS 1500 paper claims. Medicare contractors will not select a provider for a quarterly review if:

- A prior quarter review is underway and has not yet been completed for that provider;
- The provider has been reviewed within the past two years, determined to be a “small” provider as fewer than 10 FTEs are employed in that practice and there is no reason to expect the provider’s “small” status will change within two years of the start of the prior review; or
- Fewer than 30 paper claims were submitted by the provider to Medicare during the prior quarter.

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Electronic Funds Transfer (EFT)

Although EFT is not mandated by the Health Insurance Portability and Accountability Act (HIPAA), EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and any existing providers, not currently receiving payments by EFT, who are submitting a change to their existing enrollment data. Providers must submit a signed copy of Form CMS-588 (Electronic Funds Transfer Authorization Agreement) to their Carriers, DME MACs, A/B MACs, FIs, and/or RHHIs. For changes of information, DME MACs will verify the authorized official on the CMS-855 form. In addition, Medicare contractors will not approve any requests to change the payment method from EFT to check.

Carriers, DME MACs, A/B MACs, FIs and RHHIs must use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an X12 835 transaction, then the NACHA format CCP (Cash Concentration/Disbursement plus Addenda –CCD+) is used to make sure that the addenda record is sent with the EFT, because providers need the addenda record to re-associate dollars with data. Carriers, DME MACs, A/B MACs, FIs, and RHHIs must:

- Transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim, and
- 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.

Note: Medicare contractors will not approve any requests to change payment method from EFT to check.

Additional Information

The official instruction, CR5586, issued to your carrier, intermediary, RHHI, A/B MAC, or DME MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1284CP.pdf> on the CMS website.

If you have any questions, please contact your Medicare carrier, intermediary, RHHI, A/B MAC, or DME MAC at their toll-free number, which may be found on the CMS website at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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