Medicare Claims Processing Manual

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims

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(Rev. 13954; Issued: 09-29-26)

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10 - Introduction to Electronic Data Interchange (EDI) for Medicare Fee For Services (FFS)

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

EDI for Medicare FFS is not limited to the submission and processing of claim related transactions, but includes processes such as provider EDI enrollment, beneficiary eligibility, coordination of benefits, as well as security and privacy concerns. So as not to be duplicative, where EDI is a relevant part of a Medicare business process, it will be indicated here, however, the specifics of the business process will be maintained in its respective IOM chapter or comparable communication venue.

10.1 - Requirement for EDI

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

For a provider, business associate, or other trading partner to engage in EDI with Medicare FFS, it must first establish an EDI agreement with Medicare. There are two ways to do this: 1) complete and submit paper CMS Form 855, or 2) submit an Internet based application via the Provider Enrollment, Chain and Ownership System (PECOS) system. More information on enrolling in the Medicare Program can be found at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/index.html?redirect=/medicareprovidersupenroll

10.2 - Audience for this Chapter

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

The information contained in this chapter will be of interest to Medicare providers, business associates or other trading partners, as well as others interested in how Medicare has structured its EDI policies. Other Medicare FFS and CMS partners as well as general audiences may use this as a source of information to determine Medicare FFS' EDI practices. Primarily however, this chapter, and related chapters, are used by Medicare contractors for descriptive guidance to contractual responsibilities they have to CMS. *The instructions within this chapter are primarily directed to Medicare Administrative Contractors (MACs) and centralized Medicare FFS EDI gateway operations, including Technical Consolidation of the Electronic Data Interchange (TCEDI) where designated by CMS. The* instructions within this chapter are *also* directed to Durable Medical Equipment Medicare Administrative Contractors (DME MACs), the Common Electronic Data Interchange (CEDI) contractor for DME MACs, and their shared systems, and are in reference to Medicare requirements for their implementation of the current HIPAA compliant version of the Accredited Standards Committee (ASC) X12 Technical Report Type 3 (TR3) also known as an ASC X12 Implementation Guide (IG) and NCPDP Telecommunication Implementation Guide, as well as all Medicare and contractor EDI activities related to these transactions. In order to implement the HIPAA administrative simplification provisions, specific ASC X12 and NCPDP transactions have been named under part 162 of title 45 of the Code of Federal Regulations as electronic data interchange (EDI) standards for Health Care. All other EDI formats for health care

became obsolete on October 16, 2003. The Final Rule for Health Insurance Reform: Modifications to the Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards published in the https://www.federalregister.gov/articles/2009/01/16/E9740/health-insurance-reform-modifications-to-the-health-insurance-portability-andaccountability-act, adopted updated versions of HIPAA mandated electronic transactions. Furthermore, the Final Rule conveys inclusion of errata documents to the transaction standard(s). Medicare FFS therefore incorporates by reference any errata documents by the original mandated regulation compliance date through the Federal Register notice(s). Moving forward, all newly adopted errata documents are to be accepted and integrated as part of the EDI transaction(s). Medicare FFS further adopts the Accredited Standards Committee (ASC) X12 and National Council for Prescription Drug Programs (NCPDP) transaction standards as part of its EDI Acknowledgment Model.

10.3 - Scope of this Chapter

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

This chapter will provide an overall description of EDI operations, requirements, roles and responsibilities for Medicare FFS.

Medicare FFS is utilizing the following EDI transactions:

Transactions (Required Under HIPAA Unless Otherwise Noted)	Current Version	Short Reference
ASC X12 Health Care Eligibility Benefit Inquiry and Response (270/271)	005010X279A1	ASC X12 270/271 eligibility transaction
ASC X12 Health Care Claim: Professional (837)	005010X222A1	ASC X12 837 professional claim
ASC X12 Health Care Claim: Institutional (837)	005010X223A2	ASC X12 837 institutional claim
ASC X12 Health Care Claim: Dental (837)	005010X224A2	ASC X12 837 dental claim
ASC X12 Interchange Acknowledgment, TA1(not required under HIPAA)	005010X231A1	ASC X12 TA1 interchange acknowledgment
ASC X12-Implementation Acknowledgment For Health Care Insurance (999) (not required under HIPAA)	005010X231A1	ASC X12 999 implementation acknowledgment
ASC X12 Health Care Claim Payment/Advice (835)	005010X221A1	ASC X12 835 remittance advice

Transactions (Required Under HIPAA Unless Otherwise Noted)	Current Version	Short Reference
ASC X12 Health Care Claim Status Request and Response (276/277)	005010X212	ASC X12 276/277 claim status; ASC X12 276/277 claim status request and response; ASC X12 276 claim status request; ASC X12 277 claim status response
ASC X12 Health Care Claim Acknowledgment (277) (not required under HIPAA)	005010X214	ASC X12 277CA claim acknowledgment
Telecommunication Standard, National Council for Prescription Drug Programs	D.0	Depending upon context: NCPDP claim; NCPDP transaction; other functional NCPDP designation
Batch Standard, National Council for Prescription Drug Programs	1.2	Depending upon context: NCPDP claim; NCPDP batch transaction; NCPDP transaction; other functional NCPDP designation

These administrative transactions require detailed instructions and specifications. General instructions for the institutional and professional claim transactions, the NCPDP transaction, as well as the error handling/acknowledgment transactions are provided within this chapter. All other transactions have separate chapters dedicated to them.

The following IOM Publication 100-04, chapters provide more specific information on the remaining electronic transactions. References to these chapters are provided below. They can be accessed by going to http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html and selecting Publication # 100-04.

1. Chapter 22 - ASC X12 835 remittance advice (includes information for paper remittance advices)

2. Chapter 31 -ASC X12 270/271 eligibility benefit inquiry and response and ASC X12 276/277 claim status request and response

Two other related IOM chapters include:

Chapter 25 -Completing and Processing the Form CMS-1450 Data Set (includes information related to ASC X12 837 institutional claims)

Chapter 26 -Completing and Processing the Form CMS-1500 Data Set (related to ASC X12 837 professional claims)

Other sources of detailed information for each of these transactions are the Medicare FFS Companion Guide documents and Medicare FFS edits documentation which can be found at http://www.cms.gov/ElectronicBillingEDITrans/.

10.4 - Acronyms and Definitions

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

The following is a list of terms and acronyms if assistance is needed to understand the terminology used in this chapter.

- EDI – Electronic Data Interchange - the process of using nationally established standards to exchange electronic information between business entities.

- HIPAA – Health Insurance Portability and Accountability Act of 1996 – legislation that mandated that the healthcare industry use standard formats for electronic claims and claims related transactions.

- MAC – Medicare Administrative Contractor – Section 911 of the Medicare Modernization Act of 2003 mandated that the Secretary for Health & Human Services replaced the contractors administering the Medicare Part A or Part B fee-for-service programs with Medicare Administrative Contractors (MACs). Part A/Part B Medicare Administrative Contractors (MACs) replaced the fiscal intermediaries and carriers and handle administration of both the Medicare Part A and Part B programs in specified geographic regions. For more information, please see the CMS overview of Medicare Contracting Reform.

- A/B MAC – Medicare Administrative Contractor servicing both Part A and Part B lines of business.

- DME MAC – Durable Medical Equipment Medicare Administrative Contractor

- CEDI - Common Electronic Data Interchange – Common front end for DME MACs

- *TCEDI – Technical Consolidation of the Electronic Data Interchange*

- Trading Partner – one of two or more participants in an ongoing business relationship (e.g., provider, billing service, software vendor, employer group, financial institution, etc.).

- Submitter – an entity that owns the healthcare data being submitted. It is most likely the provider, hospital, clinic, etc. A submitter is directly linked to each billing NPI.

- EDI Enrollment – establishes documentation specifying type of transactions and transmission methods to be used in the exchange of electronic administrative transactions.

- EDI Registration – designates the Medicare contractor as the entity they agree to engage with for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.

- Trading Partner Agreement – ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

- Third Party Agreement- ensures the confidentiality, security, and integrity of Medicare data being shared by third party agents that represent providers, certain value-added networks, clearinghouses, and billing agents.

20 - General EDI

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

EDI is the process of using nationally established standards to exchange electronic information between business entities. These national standards are developed and maintained by a group of standards development organizations (SDOs), such as the Accredited Standards Committee (ASC) X12 and the National Council of Prescription Drug Programs (NCPDP). The Department of Health and Human Services (HHS) adopted certain electronic standards for use in health care under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Medicare FFS is required, as are all payers in the US, to adopt the standards specified under HIPAA. However, as part of Medicare FFS' EDI Acknowledgement Model, three additional ASC X12 standards will be adopted for error handling (277CA claim acknowledgment, 999 implementation acknowledgment, and TA1 interchange acknowledgment) that are not mandated under HIPAA. In addition, there will be one additional standard adopted for NCPDP error handling (transmission response) that is not mandated under HIPAA.

20.1 - Legislative Background

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

EDI practices for healthcare business were embraced more than 20 years ago to standardize electronic formats throughout the healthcare industry. Usage of EDI in Health care claim processing was initiated by the Health Insurance Portability and Accountability Act of 1996(HIPAA), Public Law 104,191. Subtitle F of Title II of

HIPAA, added to Title XI of the Social Security Act (the Act) a new part called section C, entitled "Administrative Simplification" and consists of sections 1171 through 1180. This Federal legislation adopted standards for electronic transactions under an Administrative Simplification subtitle. HIPAA mandated the adoption of standards for electronically transmitting certain health care administrative transactions between all covered entities.

Sections 1171 through 1179 are described below:

- Section 1171 of the Act, established definitions for the following: code sets, health care clearinghouses, health care provider, health information, health plan, individually identifiable health information, standard, and standard setting organizations (SSO) such as the American National Standards Institute (ANSI).

- Section 1172 made any standard adopted applicable to covered entities that transmit health information in electronic formats. Covered entities include the following:

    1) health plans
    2) health care clearinghouses
    3) health care providers

- Section 1173 required the adoption of standards for transactions, code sets, and unique health identifiers for each individual, employer, health plan, and health care provider.

- Section 1174 required the adoption of standards for designated transactions, except electronic attachments.

- Section 1175 prohibited health plans from refusing to conduct a transaction as a standard transaction, and delaying the processing and or adversely affecting its processing.

- Section 1176 established civil monetary penalties for violation of the provisions of Part C of Title XI.

- Section 1177 established penalties for any person that knowingly misuses a unique health identifier, or obtains or discloses individually identifiable health information.

- Section 1178 indicated provisions of Part C of Title XI of the Act, as well as any standards or implementation specifications adopted under them generally supersede contrary provisions of State law.

- Section 1179 makes these provisions of the Act inapplicable to financial institutions or anyone acting on behalf of a financial institution when "authorizing, processing, clearing, selling, billing, transferring, reconciling, or collecting payments for financial institutions.

HIPAA mandates all covered entities to comply with the use and maintenance of certain standards. More recently the passing of The America Reinvestment and Recovery Act (ARRA) has further enhanced the definitions and requirements mandated under HIPAA.

20.2 - The America Reinvestment and Recovery Act (ARRA)

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The purposes of this Act is to provide guidance with the development of nationwide health information technology infrastructure that allows for the electronic use and exchange of information that:

(1) ensures that each patient's health information is secure and protected, in accordance with applicable law;

(2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient centered medical care;

(3) reduces health care costs resulting from inefficiency, medical errors, inappropriate care, duplicative care, and incomplete information;

(4) provides appropriate information to help guide medical decisions at the time and place of care;

(5) ensures the inclusion of meaningful public input in such development of such infrastructure;

(6) improves the coordination of care and information among hospitals, laboratories, physician offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information;

(7) improves public health activities and facilitates the early identification and rapid response to public health threats and emergencies, including bio terror events and infectious disease outbreaks;

(8) facilitates health and clinical research and health care quality;

(9) promotes early detection, prevention, and management of chronic diseases;

(10) promotes a more effective marketplace, greater competition, greater systems analysis, increased consumer choice, and improved outcomes in health care services; and

(11) improves efforts to reduce health disparities

The term ‘‘covered entity’’ has the meaning of a health care provider that conducts certain transactions in electronic form, a health care clearinghouse, and a health plan. ARRA extends all requirements applicable to covered entities to their business associates.

A business associate as defined by CFR 45, Part 160.103 is, with respect to a covered entity, a person who:

- performs, or assists in performing a function or activity involving the disclosure of individually identifiable health information, except as a member of the covered entity's workforce. Relevant activities include:
    - claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and re-pricing; or
    - provision of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services.

A covered entity may be a business associate of another covered entity.

Therefore, in compliance with ARRA, a business associate of a covered entity must comply with the same requirements as a covered entity.

20.3 - HIPAA and ARRA on Security and Privacy
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Two aspects of the HIPAA and ARRA legislation are pertinent to this chapter:

1. Ensuring the security of electronic data transmitted between covered entities, and
2. Ensuring the privacy of individuals who are the subject of electronic information being transmitted between covered entities.

The ARRA legislation states the following in reference to actions to be taken by a covered entity or their business associate in case of a breach of protected health information:

H.R. 1-146, Subtitle D, Part 1, Section 13402 states that "a [covered entity or a] business associate of a covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify the covered entity of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during such breach." See section 40.1.2.2 for a description of Medicare security and privacy requirements.

20.4 - Administrative Simplification and Compliance Act (ASCA)
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The Administrative Simplification Compliance Act (ASCA) prohibits payment of services or supplies that a provider did not bill to Medicare electronically. "Providers" is used in a generic sense here and refers equally to physicians, suppliers, and other health care providers. Providers are required to self-assess to determine whether they meet certain permitted exceptions to this electronic billing requirement.

ASCA self-assessable situations are described in the ASCA self assessment page in this section of the CMS web site. In some cases, providers are required to submit a written request to their Medicare contractor to receive permission to submit some or all of their claims on paper.

A/B MACs and DME MACs are required to contact providers that appear to be submitting high numbers of paper claims to verify that those providers meet one or more of the exception criteria for continued submission of their claims on paper.

See Section 90 below for further details regarding ASCA requirements, or access www.cms.gov/ElectronicBillingEDITrans for further information on ASCA enforcement reviews, the self assessment, and the waiver application.

30 - EDI Enrollment and Registration (AKA Trading Partner Agreements)
(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

Medicare FFS' Trading Partner Agreement is comprised of two forms: 1) EDI Registration and 2) EDI Enrollment. The forms are identified under CMS form 10164 and can be accessed at:
EDI Registration - https://www.cms.gov/files/document/cms-10164a.pdf and EDI Enrollment - https://www.cms.gov/files/document/cms-10164b.pdf

CMS 10164A EDI Registration and 10164B EDI Enrollment forms have been watermarked as 'SAMPLE' forms with the Office of Management & Budget (OMB) approval of the 2024 EDI Paperwork Reduction Act (PRA) Package. The A/B MACs and CEDI are currently using their own organization specific forms that are comparable in terms of content to the CMS Sample forms 10164A and 10164B, to transmit data files electronically between themselves and their trading partners.

The A/B MACs and CEDI Organization specific EDI Registration and EDI Enrollment forms must include the OMB number at the bottom of the forms: OMB No. 0938-0983 approved by CMS.

The A/B MACs and CEDI Organization specific EDI Enrollment form must include the following notice:

NOTICE: Federal law and applicable regulation and guidance, including IOM Pub. 100-04, Chapter 24, Section 30.2, 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/Section 1011 claims or any other EDI transactions are submitted to CMS or the CMS contractor. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate, except as noted in applicable regulation and guidance, including IOM Pub. 100-04, Chapter 24 , Section 30.2. 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.

EDI registration and enrollment shall be instituted by the A/B MACs and CEDI and shall accomplish the following:

1. Document the specific type of transactions and transmission methods to be utilized and secure authorizations from the provider or other trading partner requesting to exchange electronic administrative transactions, and

2. Designate the A/B MACs and CEDI with whom the provider or other trading partner agrees to engage in EDI and implements standard policies and practices to ensure the security and integrity of the information to be exchanged.

Under HIPAA, EDI applies to all covered entities transmitting the following administrative transactions: ASC X12 837 institutional claim and ASC X12 837 professional claim, ASC X12 837 dental claim, ASC X12 835 remittance advice, ASC X12 270/271 eligibility, ASC X12 276/277 claim status and NCPDP claim (and others that are not used by Medicare at this time). Beginning on January 1, 2012, A/B MACs and CEDI will also use the ASC X12 TA1 interchange acknowledgment, ASC X12 999 implementation acknowledgment and ASC X12 277CA claim acknowledgment error handling transactions. In addition, CEDI and DME MACs will also use the NCPDP standard transmission response transaction. Entities who prepare and submit the CMS 1500, CMS 1450 or CMS 10883 ADA Dental paper claim forms do not need to complete an EDI registration.

30.1 - EDI Enrollment

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A/B MACs and CEDI are required to furnish new providers that request Medicare claim privileges information on EDI. A/B MACs and CEDI are required to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in §50), and enroll and assign submitter EDI identification numbers to those approved to use EDI. All providers are required to submit their claims electronically, per ASCA, unless they qualify for a waiver (see section 90 below).

The EDI enrollment process for the Medicare beneficiary inquiry system HETS (HIPAA Eligibility Transaction System (HETS 270/271)) is currently a separate process. Information on the EDI enrollment process for HETS can be found on the CMS HETSHelp website (http://www.cms.gov/HETSHelp/).

A provider must obtain an NPI and furnish that NPI to their A/B MAC and CEDI prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. The A/B MACs and CEDI are required to verify that NPI is active in the Provider Enrollment, Chain and Ownership System (PECOS). If the A/B MAC or CEDI is not able to verify the NPI as active in PECOS, the EDI Enrollment Agreement is denied and the provider is encouraged to contact the A/B MAC provider enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for DME suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password. When leaving the Medicare Program, a provider must notify their MAC to deactivate the EDI number.

If providers elect to submit/receive transactions electronically using a third party such as a billing agent **or** a clearinghouse, the A/B MACs or CEDI must notify those providers that they are required to have an agreement signed by that third party. The third party must agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare, but are to be retained by the providers.) The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent **or** clearinghouse. Providers must also not share their personal EDI access number to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim. No other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from those A/B MACs or CEDI to whom they will send or receive EDI transactions. For a complete reference to security requirements see section 40.1.2.2 below and refer to the Appendix A CMSR High Impact Level Data document (sections IA-2 and SA-9) located on the CMS website https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/CIO-Directives-and-Policies/CIO-IT-Policy-Library-Items/STANDARD-ARS-Acceptable-Risk-Safeguards.html.

30.2 - New Enrollments and Maintenance of Existing Enrollments

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The Medicare EDI Enrollment process provides for collection of the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners and also establishes the expectations for both parties in the exchange. This agreement must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form and submit it to the A/B MAC or CEDI with which EDI transactions will be exchanged before the A/B MAC, or CEDI will accept claims or other incoming EDI transactions from that provider, or a third party for that provider, or send outbound EDI transactions. A/B MACs and CEDI may accept a signed EDI Enrollment Form from providers via fax, email, internet portal, or hard copy and may accept electronic signature formats, "wet", or a combination of the two. The EDI Enrollment Form is effective as specified in the terms of the agreement.

Providers who will be accessing the A/B MACs Direct Data Entry (DDE) system will have access to enter and correct claims directly at the A/B MAC and must submit an EDI Enrollment Form to A/B MAC with their request for this access.

NOTES:

1. Although a type of electronic transaction, electronic funds transfers (EFTs) between an A/B MAC or DME MAC and a bank are not considered EDI for EDI Enrollment Form purposes. A provider that uses EFT but no EDI transactions should not complete an EDI Enrollment Form.

2. Medicaid state agencies are not required to complete an EDI Enrollment Form as a condition for receipt of COB claims.

In accord with a particular MAC's business processes, providers who have a signed EDI Enrollment Form on file with a particular A/B MAC or CEDI may or may not be required to submit a new signed EDI Enrollment Form to the same A/B MAC or CEDI each time they change their method of electronic billing or begin to use another type of EDI transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. Additionally, providers may or may not be required to notify their A/B MAC (HHH), A/B MAC or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

A/B MACs and CEDI must inform providers that providers are obligated to notify their A/B MAC or CEDI in writing in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of EDI.

When an A/B MAC or CEDI receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third party, the A/B MAC or CEDI must verify that an EDI Enrollment Form is already on file for that provider or supplier, and that the third party has already been issued an EDI number and password to permit submission/receipt of EDI transactions. The request cannot be processed until both are submitted/issued.

The binding information in an EDI Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that A/B MAC or CEDI is no longer associated with the Medicare program. Medicare responsibility for EDI oversight and administration is simply transferred in that case to that entity that CMS chooses to replace that A/B MAC or CEDI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

An organization comprised of multiple components that have been assigned more than one Medicare provider number, supplier number, or National Provider Identifier (NPI) may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which such numbers have been assigned. The organization is responsible for the performance of its components.

The note at the end of the enrollment agreement language indicates that either party can terminate that agreement by providing 30 days advance notice. There is an exception to that requirement. In the event A/B MAC, DME MAC or CEDI detects abuse of use of an EDI system ID or password, or discovers potential fraud or abuse involving claims submitted electronically, electronic requests for beneficiary eligibility data, or other EDI transactions, that A/B MAC, DME MAC or CEDI is to immediately terminate system access for submission or receipt of EDI transactions by that individual or entity. A decision by A/B MAC, DME MAC or CEDI to terminate or suspend EDI access in such a situation is not subject to appeal by the individual or entity that loses EDI access.

Electronic Data Interchange (EDI) Enrollment Information Required for Inclusion at a Minimum in Each A/B MAC, and CEDI EDI Enrollment Form.

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MACs or CEDI:

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor 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 A/B MACs, DME MACs or CEDI 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 Medicare beneficiary identifier;
    - 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 A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS 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 6 years, 3 months after the bill is paid;

9. That it will affix the CMS-assigned unique identifier number (submitter ID) of the provider on each claim electronically transmitted to the A/B MAC, CEDI, or other contractor if designated by CMS;

10. That the CMS-assigned unique identifier number (submitter identifier) or NPI 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 A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the A/B MAC, DME MAC or CEDI (in accordance with §1106(a) of Social Security Act (the Act) (See section 40.1.2.2 below for a complete reference to Medicare's security requirements);

14. That it will research and correct claim discrepancies;

15. That it will notify the A/B MAC, CEDI, or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form (See section 40.1.2.2 below for a complete reference to Medicare's security requirements).

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

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

2. Affix the A/B MAC, DME MAC, CEDI or other contractor if designated by CMS 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any subsidiary of the A/B MAC, CEDI, other

contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, or other contractor if designated by CMS 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 A/B MACs, CEDI, or other contractors if designated by CMS 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 sold directly, indirectly, or by arrangement by the A/B MAC, CEDI, or other contractor if designated by CMS;

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTE: Federal law and applicable regulation and guidance 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 the A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate, except as noted in applicable regulation and guidance. 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 certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.

Provider’s Name

Title

Address

City/State/Zip

By _____ _____
(signature) (printed name)

Date

30.3 - Submitter Number
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, or CEDI will assign an EDI submitter/receiver number and a periodically renewable password to each entity (provider, clearinghouse, billing agent) submitting or receiving electronic transactions. 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, but not both). If electronic remittance advice transactions will be issued, the profile must indicate where the A/B MAC, or CEDI is to send the remittance advice transactions.

30.4 - Electronic Remittance Advice (ERA) Enrollment Form
(Rev. 3404, Issued: 11-13-15, Effective: 12-14-15, Implementation: 12-14-15)

The Medicare Electronic Remittance Advice (ERA) Enrollment process provides for collection of the information needed to successfully receive ERA transactions from Medicare and EDI trading partners. This agreement must be executed by each provider that receives ERA either directly to or from Medicare or through a third party. Each provider that will use ERA either directly or through a billing agent or clearinghouse with Medicare must sign the ERA Enrollment Form and submit it to the A/B MAC or CEDI with which ERA transactions will be received before the A/B MAC or CEDI will transmit ERA. A/B MACs or CEDI may accept a signed ERA Enrollment Form for providers via fax, email, internet portal, or hard copy and may accept electronic signature formats, “wet”, or a combination of the two. The ERA Enrollment Form is effective as specified in the terms of the agreement.

In accord with a particular MAC’s business processes, providers who have a signed ERA Enrollment Form on file with a particular A/B MAC, or CEDI may or may not be required to submit a new signed ERA Enrollment Form to the same A/B MAC, or CEDI each time they change their method of electronic billing or begin to use another type of EDI transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. Additionally, providers may or may not be required to notify their A/B MAC, or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

A/B MACs and CEDI must inform providers that providers are obligated to notify their A/B MAC or CEDI in writing in advance of a change that involves a change in the billing

agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of ERA.

A/B MAC, or CEDI receives a signed request from a provider or supplier to accept ERA transactions from or send ERA transactions to a third party, the A/B MAC, or CEDI must verify that an ERA Enrollment Form is already on file for that provider or supplier.

The binding information in an ERA Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that A/B MAC, or CEDI is no longer associated with the Medicare program. Medicare responsibility for ERA oversight and administration is simply transferred in that case to that entity that CMS chooses to replace that A/B MAC, or CEDI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

The note at the end of the enrollment agreement language indicates that either party can terminate that agreement by providing 30 days advance notice. There is an exception to that requirement. In the event an A/B MAC, DME MAC or CEDI detects abuse of use of an ERA system, or discovers potential fraud or abuse, that A/B MAC, DME MAC or CEDI is to immediately terminate system access for receipt of ERA transactions by that individual or entity. A decision by an A/B MAC, DME MAC or CEDI to terminate or suspend ERA access in such a situation is not subject to appeal by the individual or entity that loses ERA access.

NOTE: 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 the A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS. 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.

Signature

I certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and

the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.

Provider's Name

Title

Address

City/State/Zip

By _____ _____
(Signature) (Printed Name)

Date

40 - Medicare FFS EDI Users Roles and Responsibilities in an EDI Environment

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Medicare FFS supports EDI as exchanged between all covered entities and Medicare FFS contractors. This chapter provides guidance on how these relationships and the transactions generated by them shall be established, maintained and managed.

40.1 - Centers for Medicare and Medicaid Services - Medicare Fee-For-Service

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

A/B MACs, along with TCEDI where designated by CMS, must support the exchange, routing, validation, acknowledgment, and processing of HIPAA-compliant EDI transactions. A/B MACs, DME MACs along with the Common *Electronic* Data Interchange (CEDI) contractor must transact versions of the institutional and professional claim (ASC X12 837 claim, institutional, professional and dental), the remittance advice (ASC X12 835 remittance advice), the claim status request and response (ASC X12 276/277 claim status request and response), the eligibility inquiry and response (ASC X12 270/271 eligibility), and the newly adopted error handling transactions (the ASC X12 277 CA claim acknowledgment, the ASC X12 999 implementation acknowledgment and the ASC X12 TA1 interchange acknowledgment) within national standards developed by ASC X12. CEDI must transact versions of the National Council for Prescription Drug Programs (NCPDP) claims transactions.

Medicare FFS supports EDI as exchanged between all covered entities and Medicare FFS contractors. This chapter provides guidance on how these relationships and the transactions generated by them shall be established, maintained and managed.

40.1.1 - HIPAA Transaction Standards as Designated by CMS

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

HIPAA transaction standards shall be supported by the A/B MACs, DME MACs, CEDI or other contractors if designated by CMS for the electronic data with Medicare providers/submitters/receivers/COB trading partners. ASC X12 Technical Report 3s (TR3s) for mandated HIPAA transactions may be purchased from the official Washington Publishing Company website. The HIPAA-standard implementation specifications for claims, remittance advices, and claim status requests follow:

- ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim: Professional (837)

    - ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim: Institutional (837).

    - ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claims: Dental (837).

    - ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim Payment/Advice (835).

    - ASC X12 Standards for Electronic Data Interchange Technical Report Type 3- Health Care Claim Status Request and Response (276/277). See chapter 31 for additional details.

- Telecommunication Standard Implementation Guide and equivalent Batch Standard Implementation Guide, National Council for Prescription Drug Programs.

Section 10.3 shows the current versions of these standards adopted under HIPAA.

40.1.2 - Transactions Used in the Acknowledgment of Receipt of Inbound Claims

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

With the CMS implementation of the 5010 transactions, the following two transactions shall be used in the acknowledgment of the receipt of claims.

- ASC X12 Health Care Claim Acknowledgment (277) (short reference: ASC X12 277CA claim acknowledgment); and

- ASC X12-Implementation Acknowledgment For Health Care Insurance (999) (short reference: ASC X12 999 implementation acknowledgment).

Section 10.3 shows the current versions of these standards required by CMS**.**

40.1.3 - Change Request (CR) to Communicate Policy

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

CMS shall issue Change Request (CR) to communicate CMS policy to the A/B MACs, DME MACs, CEDI or other contractors if designated by CMS. Additionally Technical Direction Letters may be issued by CMS with additional information related to published CRs or guidance to A/B MACs, DME MACs, CEDI or other contractors if designated by CMS in the administration of Medicare policy.

40.2 - Medicare FFS Contractors (A/B MAC, DME MAC, CEDI)

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

A/B MACs and TCEDI, where designated by CMS, are responsible for supporting CMS-approved electronic transaction exchange, routing, intake processing, and operational monitoring. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS are responsible to support the exchange of CMS approved electronic transactions. This support includes testing, certifying, and retention of an audit trail for the electronic data interchange platforms. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS must maintain environments according to CMS security policy and guidelines. See Section 40.2.1 and 40.2.2 for specific references to this information.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide outreach and education to encourage the use of electronic transactions. A/B MACs, CEDI or other contractors if designated by CMS are responsible for managing the EDI enrollment of entities who will be exchanging electronic transactions and providing support to these entities. A/B MACs, DME MACs, or other contractors if designated by CMS are responsible to support contact with new providers, make available User Guidelines for EDI transactions and EDI provider training, to include information on EDI transactions in newsletters, bulletin boards, and Internet publications. See Section 40.2.2 and 40.2.3 for specific references to this information.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide limited support to providers in choosing a vendor, determining goals and requirements for the provider in selecting a vendor and assist in evaluating vendor proposals. See Section 40.2.4 for specific references to choosing a vendor.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will provide support to EDI trading partners through technical assistance and training. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will make free claim submission software available to providers and support the software. A/B MACs, DME MACs, CEDI or other contractors if designated by CMS will also support the software to convert the ASC X12 835 remittance advice into a print document. See Section 40.2.5 and 40.2.6 for specific references to this information.

40.2.1 - Certification Test Program and Annual Recertification Activities

(Rev. 2771, Issued: 08-16-13, Effective: 09-17-13, Implementation: 09-17-13)

CMS has initiated a Certification Test Program (CTP) comprised of the following: use cases, test cases, and associated test data files to verify that each A/B MACs, DME MACs, or other contractors if designated by CMS is ready to receive and process current transactions as well as other CMS required EDI enhancements.

A/B MACs, CEDI or other contractors if designated by CMS will perform certification testing using the CTP and produce reports based on the test results. For each use/test case the actual result must be the same as the expected results and must match the associated transactions. Certification results, reports, and files will be retained by the A/B MACs, CEDI or other contractors if designated by CMS for audit ability in the future. As changes are made in to the ASC X12 Version 5010 and D.0 transactions, the CTP will be updated and utilized during recertification.

The CMS will provide detailed instructions to the A/B MACs, CEDI or other contractors if designated by CMS to be used to perform the certification testing. These instructions will be revised as needed and communicated to the A/B MACs, CEDI, or other contractors if designated by CMS. Further information on these instructions can be found at http://www.cms.gov/ElectronicBillingEDITrans/.

In developing the CTP the use case represents the type of response expected by each of the test cases within the use case. Following the ASC X12 Version 5010 and D.0 Edit Spreadsheets as a guide, a use case for each loop transaction was developed. There are multiple test cases for each use case.

In most cases, each loop has at least one "accept" (in process/flat file mapping) use case and at least one "reject" use case. The "reject loop" use case contains only one test case for the rejection or first negative test of the entire loop.

Depending on the edit type, additional use cases were necessary. For example, each loop will have one ASC X12 999 implementation acknowledgement use case with multiple test cases, one accepted ("A") use case for "good clean" claims in process, flat file mapping, and may have one ASC X12 277CA claim acknowledgement use case with multiple test cases. It may be necessary to have more than one data file per use case if there are elements which will result in a structural error by the translator. In those cases, there are multiple data files per use case.

For NCPDP, each segment has one "accept (in process/flat file mapping)" use case, one "reject" use case, and one flat file mapping use case.

A test case describes each task that will insure ASC X12 data elements, qualifiers, and data values conform to the TR3 and the transactions edit spreadsheet. Each valid value, invalid value, and edit as listed in the ASC X12edits spreadsheet has an associated test case.

Each test case includes the purpose of the test case, steps (and prerequisites) required to execute the test case, what the expected results are, and any necessary comments to clarify the test case.

The modifications and enhancements resulting from changes to the Edit Spreadsheets and deviations resulting from the CTP will be used as part of the annual recertification. The contractors will utilize the Recertification Test Package (RTP) that is updated annually to perform self certification annually. The CMS will provide detailed instructions to the A/B MACs, CEDI or other contractors if designated by CMS to be used to perform the re-certification testing. These instructions will be revised as needed and communicated to the A/B MACs, CEDI, or other contractors if designated by CMS. The CMS/MAC Re-Certification Instruction Guide will be used as guidance to set up the execution of the Front End system to certify compliance with the standards. As part of recertification, contractors will use template supplied by the STC for reporting of Re-Certification status, re-certification Checklists Reports, and Deviation Reports. In addition, weekly meetings with the contractors will be established by CMS during the recertification process for gathering status and other reporting activities.

The CMS, utilizing existing processes and guidelines, will continue to provide ongoing administrative support for the ASC X12 5010 certification/recertification including building the master RTP, review of certification/recertification deviations to ensure the chosen recertification use cases and test cases are in sync with the current edit spreadsheets and complete the final sync (occurring immediately prior to the distribution of the Recertification test package) of the recertification Test Package with the most recent edit spreadsheet.

40.2.2 - Security Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, DME MACs, CEDI, and other entities contracting directly with CMS are considered service providers to CMS. As such, these entities are part of CMS' system security boundary and must be in compliance with the Federal Information Security Management Act (FISMA) and are subject to CMS security policies. Covered entities, trading partners and business associates not contracting as service providers to CMS are outside of the CMS system security boundary and are not considered as FISMA entities. These entities must comply with the mandates of the HIPAA Privacy and Security Rules as well as the mandates defined in ARRA/ Health Information Technology for Economic and Clinical Health (HITECH).

A trading partner submitting an EDI Enrollment Agreement attests that it has executed Business Associate Agreements (contracts), as mandated by HIPAA and ARRA/HITECH, with each of its business associates. Moreover, the trading partner attests that it has full responsibility, as mandated by HIPAA and ARRA/HITECH, for notification of breaches of protected health information caused by the trading partner or its business associates.

40.2.2.1 - A/B MACs, DME MACs, and CEDI Data Security and Confidentiality Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

All Medicare beneficiary-specific information is confidential and subject to the requirements of §1106(a) of the Act and implementing regulations at http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR. 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 http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR. Such information is included in claims, remittance advice, eligibility information, online claims corrections, and any other transactions where personal information applicable to a beneficiary is processed or transported. Such information may not be disclosed to anyone other than the provider or supplier that submitted a claim or to the beneficiary for whom a claim was filed. A/B, MACs, DME MACs and CEDI must ensure the security of all EDI transactions and data. See the CMS Business Partners System Security Manual and its Core Security Requirements attachment for more detailed information on system security requirements.

A/B, MACs, DME MACs and CEDI systems must include the following system security capabilities:

- All data must be password protected and passwords modified at periodic but irregular intervals, as well as 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.

40.2.2.2 - A/B MAC, DME MACs and CEDI Audit Trails

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and DME MACs must maintain an automated transaction tracking and retrieval capability and retain an audit trail that notes each change made to each claim from date of receipt to date of payment or denial and any subsequent adjustments. A/B MACs, and DME MACs must be able to retrieve or recreate:

- The claim as received (pre-translation) from the provider, billing service, or clearinghouse (A/B MACs only);
- The claim as received (post-translation) from CEDI (DME MACs only);
- The claim as paid to the provider;
- All adjustments made on the claim;
- The check or the electronic funds transfer (EFT) record sent to the provider; and
- The remittance advice as sent to the provider (A/B MACs only);
- The remittance advice as sent to CEDI (DME MACs only).

A/B MACs and DME MACs must maintain the ability to cross-refer all associated transactions, e.g., EFT or check, claim adjustment, remittance advice, to each related claim being processed. The records may be kept on electronic, computer-output-microfilm, optical disk media, or other reliable and industry accepted types of storage and retrieval 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. 100-01, 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.

CEDI must maintain an automated transaction tracking and retrieval capability and retain an audit trail that notes each change made to each claim from date of receipt to date of transfer to the appropriate DME MAC; and the receipt of remittance advice from the DME MAC and delivery to the provider. CEDI must be able to retrieve or recreate:

- The claim as received (pre-translation) from the provider, billing service, or clearinghouse;
- The remittance advice as sent to the provider.

The records may be kept on electronic, computer-output-microfilm, optical disk media, or other reliable and industry accepted types of storage and retrieval 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.100-01, 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.

40.2.2.3 - Security-Related Requirements for A/B MACs, and CEDI Arrangements With Clearinghouses and Billing Services

(Rev. 3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

A billing service is an entity that markets claim preparation services to providers and should also be able to perform related transactions for providers, such as eligibility and claim status inquiries. The billing service collects a provider's claim information and then bills the appropriate insurance companies, including Medicare. A billing service may submit claims only, or provide full financial accounting and/or other services. Billing services are considered to be provider business associates. As such, HIPAA requires that they comply with each of the privacy and security requirements that apply directly to providers. They are also required to ensure that they require that any clearinghouses, subcontractors or other business associates of their own that may be involved with handling of Medicare beneficiary data also meet those same security and privacy requirements. A billing service may view beneficiary or provider data to carry out their billing obligations for a provider, when a provider authorizes them to have that access. To qualify as a billing service, an entity must at a minimum submit initial claims on the provider's behalf.

A clearinghouse transfers or moves EDI transactions for a provider or billing service, and generally translates the EDI transactions from or into a proprietary format. (HIPAA defines a clearinghouse as a business associate of a provider or a health care plan that translates data from a non-standard format into a standard format or vice versa as preferred by their clients.) A clearinghouse generally accepts multiple types of incoming transactions and sends them to various payers, including Medicare. Clearinghouses often perform general and payer-specific edits on claims, and may handle multiple types of EDI transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgments, remittance advice transactions, and claim status and eligibility queries.

Some entities that refer to themselves as clearinghouses, however, do not edit or translate data, but simply serve as a "telecommunication switch," moving transactions from point A to Point B or wherever directed under the terms of the agreement with a provider. A clearinghouse may also be called a value added network (VAN). A clearinghouse/VAN may not view privacy-protected Medicare data unless a signed authorization has been filed by the provider for whom the clearinghouse/VAN will submit or received Medicare EDI transactions. For EDI, a transaction that contains individually identifiable information about a Medicare beneficiary is considered to be privacy protected data.

That provider may not authorize submission or receipt of data by a third party for a Medicare beneficiary unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider. The provider authorization must be filed with the Medicare contractor to

whom EDI transactions will be sent or from whom they will be received. In the case of a DME claim, this authorization need only be submitted to CEDI. If multiple A/B MACs are involved, an authorization must be submitted to each.

Each clearinghouse/VAN that will submit or receive Medicare EDI transactions is prohibited from using the EDI number or password issued to any of the providers they serve. Each clearinghouse/VAN must obtain its own EDI number and password from each A/B MAC with which it will interact. For, DME, each Clearinghouse/VAN must obtain its own EDI number and password from CEDI.

Some health care providers use or may want to use more than one billing service or clearinghouse/VAN. An A/B MAC and CEDI ability to handle more than one agent varies. Some A/B MACs and CEDIs are able to accommodate one or more clearinghouses/VAN for submission of a provider's claims to Medicare, another agent to receive the provider's remittance advice transactions, and a third clearinghouse/VAN to verify beneficiary Medicare eligibility for a provider. Others may not be able to accommodate more than one agent for a provider. A/B MACs and CEDIs are encouraged to support more than one agent for a provider, when permitted by their front end configuration.

A/B MACs and DME MACs, or other contractors if designated by CMS must notify each provider that applies for permission to obtain eligibility data electronically that:

- They are permitted to view Medicare eligibility data only for patients currently being treated by or who have requested treatment or supplies from that provider;

- A provider cannot authorize a billing agent or clearinghouse to submit or obtain data from an A/B MACs and DME MACs that the provider is not entitled to personally submit or obtain;

- A request for personally identifiable information for any other Medicare beneficiaries would be a violation of Medicare and HIPAA privacy requirements, and subject to the applicable penalties for such violations.

A/B MACs, and DME MACs must notify each billing service and clearinghouse/VAN at the time of their application for access to Medicare eligibility data and by also posting information on their web site that:

- Their access is limited to submission of transactions and receipt of transactions for those providers that are their clients, but only if those providers authorized the billing agent and/or clearinghouse/VAN to submit or receive each transaction.

- A billing agent or clearinghouse/VAN that has provider authorization to submit claim data for a provider cannot obtain eligibility data for that provider unless that was specifically authorized by the provider.

- Likewise, the billing agent or clearinghouse/VAN cannot be sent remittance advice transactions for a provider unless specifically authorized to do so by that provider.

Providers must submit these authorizations to their A/B MACs, DME MACs, CEDI or other contractors if designated by CMS in writing; an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS is not permitted to accept a statement signed by a billing agent or clearinghouse/VAN alleging that they have such provider authorization on file. An original provider signature is required on these authorizations (but an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS is allowed to accept an authorization signed by a provider by fax or mail). The A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS is responsible for maintenance of files to establish system access for individual providers, identify those billing agents and clearinghouses/VAN**s** authorized to access systems as the agent of a specific provider, and to record those transactions for which a billing agent or clearinghouse/VAN is authorized access as the representative of a specific provider.

With authorization, a clearinghouse/VAN may send inquiries for a provider, and receive responses, but it may not view personally identifiable beneficiary data contained in those queries or responses, store it for longer than necessary to assure delivery to the provider (no longer than 30 days maximum), or use personally identifiable data in any reports. The EDI data sent or received belongs ultimately to the beneficiary, not to the clearinghouse/VAN that may translate and transport the data for a provider acting on the beneficiary's behalf.

Collection agents that contract with providers to collect "bad debts" and third party entities that may analyze data but do not have a specific initial claim submission role or are not responsible for posting of information in a remittance advice to patient accounts may not be sent beneficiary data by an A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS. If a collection agent or such a third party has provided adequate privacy and security assurances to protect beneficiary data, the provider may share Medicare payment information with a collection agent, data analysis firm, or similar third party, but the provider would need to furnish that data to that entity agent in this situation, however. The Medicare program may not incur costs to furnish such data to collection agencies or to other entities that perform services that do not directly support Medicare activities. Delinquent collection, analysis of data related to a provider's operations, and expenses related to other activities not directly related to Medicare claims or payments are considered provider business expenses. Such activities do not directly benefit Medicare and Medicare may not incur costs to supply data intended only for such uses.

A provider must sign a valid EDI Enrollment Form (see Section 30.1 this chapter) prior to authorizing a billing agent or clearinghouse/VAN to submit/receive any EDI transactions on their behalf. A separate password and User ID is to be used for system access by each authorized provider, billing agent or clearinghouse. A vendor provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual providers, billing agent or

clearinghouses/VANs. Vendors supply the means for Medicare system access but have no right to direct access to the system of an A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS.

Vendor software is normally tested when it first begins to be used by providers, billing agents or clearinghouses/VANs. At the request of a vendor or a clearinghouse/VAN, an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS may, but is not required to, test new software before a provider has agreed to begin using that software to exchange Medicare eligibility transactions with the contractor. When testing software prior to use by a provider, an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS may not furnish a software vendor who does not currently submit or receive Medicare transactions with an EDI access number or password which would permit the vendor to access to actual Medicare beneficiary data. That software is to be tested using a test database or by other means that would not disclose actual beneficiary data to the vendor. This EDI access limitation for testing of new software does not apply to a clearinghouse/VAN with a history of submission/receipt of EDI transactions with the contractor, or when a software vendor is also a clearinghouse/VAN or a provider billing agent (in which case, testing should only involve data for beneficiaries for which the entity already submit/receives transactions).

40.2.2.4 - Release of Medicare Data

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The CMS is required by law to protect all Medicare beneficiary-specific information from unauthorized use or disclosure. Disclosure of Medicare beneficiary data is restricted under the provisions of the Privacy Act of 1974 and HIPAA. CMS instructions allow release of 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.

A/B MACs, DME MACs or other contractors if designated by CMS must give access to any clearinghouse that requests access to data on behalf of providers as long as they adhere to the following rules:

- Each clearinghouse requesting access to eligibility data must sign a Trading Partner Agreement (TPA) and agree to adhere to CMS rules of behavior (Refer to www.cms.gov/HETSHelp);

- Each provider that contracts with a clearinghouse must sign a valid EDI Enrollment Form before data can be sent to the third party (see Section 30.1);

- The provider must explain the type of EDI services to be furnished by its clearinghouse in a signed statement authorizing the clearinghouse's access to data;

- The clearinghouse must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a clearinghouse, the clearinghouse must be able to identify the correct provider making the request for each beneficiary's information and be able to assure that responses are routed only to the provider that originated each request; and

- There is no record of prior violation of a TPA by this clearinghouse with the A/B MAC, DME MAC or other contractor if designated by CMS to whom a request for access to the data is submitted that would indicate that beneficiary data could be at risk of improper disclosure if access was approved for this clearinghouse.

A. All providers and clearinghouses that wish to obtain Medicare beneficiary data must apply to A/B MACs, DME MACs or other contractor if designated by CMS for access to the records.

B. Providers and clearinghouses must submit each query to the A/B MACs, DME MACs or other contractor if designated by CMS with which they are registered. CMS supports multiple EDI and non-EDI methods for obtaining eligibility data, including ASC X12 270/271 eligibility (see IOM Pub. 100-04 Chapter 31 for more information on the ASC X12 270/271 eligibility transaction).

C. When an inquiry is submitted, the A/B MAC, DME MAC, HETS 270/271, or other contractor if designated by CMS must be able to ensure that:

- An EDI agreement has been signed by the provider;
- A TPA has been signed by the clearinghouse; and
- Each inquiry identifies the provider that initiated the query and to which the response will be routed.

D. Providers must be notified that:

- they may obtain eligibility data only for the approved use of preparing accurate Medicare claims;

- access to eligibility data is limited to individuals within a provider's organization who are involved in claim preparation and submission; and

- they and their authorized third party agents must agree not to request eligibility data for a beneficiary unless the provider has been contacted by the beneficiary, a personal representative of a beneficiary such as a relative or friend, or a health care provider currently treating the beneficiary concerning provision of health care services or supplies to the beneficiary.

E. Medicare contractors, as designated by CMS, must:

- Provide notification of these requirements to all providers requesting electronic receipt of eligibility data;

- remind providers to notify them when there is a change in clearinghouse, arrangements cease with a clearinghouse, or the provider leaves the Medicare program;

- delete each provider from their EDI eligibility security file if there is no longer a business relationship between the Medicare contractor and provider, or if the Medicare contractor or the provider is no longer serving the Medicare program; and

- remind providers, clearinghouses and other third parties that access rights to beneficiary eligibility data may be revoked if they fail to adhere to the requirements for access.

40.2.2.5 - EDI Enrollment and EDI Claim Record Retention
(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

In order for an entity to become an EDI trading partner, an EDI enrollment form must be completed, approved, and on file with an A/B MAC or CEDI. A/B MAC or CEDI are required to retain all EDI enrollment forms according to the same CMS Records Schedule retention requirements that apply to the CMS-855 Medicare Enrollment Application.

The paper claim retention schedule can be found at Pub 100-01, Chapter 7, Section 30: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c07.pdf

Once a trading partner has been tested and approved for electronic submission of claims, they can begin submitting electronic claims to Medicare. A/B MAC, DME MACs or CEDI are required to retain electronically filed claims under the same CMS Records Retention Schedule retention requirements that apply to hardcopy claim.

40.2.3 - General EDI Outreach Activities
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, DME MACs and CEDI are to actively encourage providers to increase their use of EDI transactions. Also see § 60 of this Chapter for EDI Edit Requirements. Specific outreach requirements are included in the CMS requirements for implementation of new or revised EDI standards. A/B MACs, DME MACs and CEDI are also required to notify providers about the need to file most claims with Medicare electronically. See § 90 for specific referenced to Mandatory Submission of Medicare Claims. In general, A/B MACs, DME MACs and CEDI must:

1. Feature information on EDI during trade shows, vendor fairs, educational forums, and vendor association meetings that they sponsor or in which they participate;

2. Provide educational information on EDI to providers identified in internal analysis described in Section 40.2.3.1 as well as to the software vendors and clearinghouses that serve or market services to Medicare providers;

3. Make themselves available whenever possible, and invited to participate as an EDI 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 and related vendor trade groups. DME MACs shall participate in regional meetings that entail supplier use of EDI; and

    - Include specific and meaningful EDI messages in provider newsletters, addressing the themes described in Section 40.2.3.4 below, other issues that may be pertinent to the A/B MAC (B), DME MACs, or A/B MACs (A) geographic area, and as directed in individual EDI instructions issued by CMS. A/B MACs, DME MACs and CEDI are expected to point out the advantages to providers in the use of EDI transactions.

See the Medicare Beneficiary and Providers Communication Manual (100-09) for definitive guidance on Medicare's provider outreach requirements. Provider outreach activities, including those that involve EDI are funded through the Provider Education and Training budget issued to Medicare contractors.

40.2.3.1 - A/B MAC and DME MAC Analysis of Internal Information

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and DME MACs must contact providers with the highest number of paper claim transactions to have them begin submission of claims electronically as required under §90 of this chapter for ASCA enforcement Reviews. A/B MACs, DME MACs, and CEDI are also to strongly encourage providers to conduct their claims status, beneficiary eligibility, payment and remittance advice transactions electronically.

40.2.3.2 - Contact With New Providers

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs must conduct an analysis of the capability of each provider (including physicians and suppliers) that contact a Medicare contractor to begin submission of Medicare claims, or for DME MACs, when notified by the National Supplier Clearinghouse that new supplier identification numbers have been issued. A/B MACs shall use provider education to ensure that all providers/submitters are aware that EDI transactions are to be presented as the normal mode of business for Medicare claims, claim status, and remittance. A/B MACs shall also use provider education to ensure that all providers/submitters are aware that EFT is the normal mode for funds transfer. See

Chapter 31 for HETS information on eligibility verification ASC X12 270/271 eligibility transaction queries. Where the provider does not have the related capability, A/B MACs, DME MACs and CEDI are to inform the providers of available options to begin use of EDI, e.g., list of vendors and clearinghouses and billing services, availability of Medicare's free software.

40.2.3.3 - Production and Distribution of Information to Increase Use of EDI

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, DME MACs, and CEDI are required to post information on their provider web page to educate and influence providers in all aspects of EDI. They must include the following information at a minimum:

- Earlier payment of electronic claims that comply with HIPAA standards requirements;
- The benefit of earlier detection of errors via edits conducted upon submission of electronic transactions;
- The relative ease of use of EDI and the support available from the contractor to assist them in beginning use of EDI transactions;
- Advantages of online correction of errors (A/B MAC (A) only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (A/B MAC (A) only);
- Availability of free software:
    - PCACE Pro32 - Part A/B and DME;
    - Medicare Remit Easy Print Software (MREP) - Part B and DME; and
    - Medicare Standard Electronic PC Print Software (PC Print) - Part A/B.
    - Availability of batch claims status inquiries. The information must be updated on a regular basis.

Availability of batch claims status inquiries. The information must be updated on a regular basis. A/B MACs, DME MACs, and CEDI are encouraged to issue these materials via the Internet or E-Mail when possible, but paper copies may be distributed where most cost effective or when a provider may not have Internet or E-Mail access.

40.2.3.4 - Production and Distribution of Material to Market EDI

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, DME MACs, and CEDI 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:

1. Earlier payment of claims because of different payment floor requirements;
2. The benefit of earlier detection of errors via edits;
3. The relative ease of EDI and support available;
4. Advantages of online correction of errors (A/B MAC (A) only);
5. Lower administrative, postage, and handling costs;
6. Electronic adjustments (A/B MAC (A) only);
7. Availability of free software;
8. Claims status inquiry; and
9. 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, A/B MACs, DME MACs, and CEDI 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 A/B MACs, DME MACs, and CEDI do not attend as well as those that they do attend.

40.2.4 - Trading Partner Management

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

Medicare FFS' Trading Partner Agreement is comprised of two forms: 1) EDI Registration and 2) EDI Enrollment. The forms are identified under CMS form 10164 and can be accessed at:
EDI Registration - https://www.cms.gov/files/document/cms-10164a.pdf
and EDI Enrollment - https://www.cms.gov/files/document/cms-10164b.pdf

40.2.4.1 - User Guidelines

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, and CEDI must make information available to potential users (preferably via their Web page or the Internet) of each EDI transaction supported by Medicare with detailed information on:

- The telephone numbers of appropriate staff to contact to:

    - Get started with electronic billing and other EDI transactions; and
    - Obtain on-going support for electronic transactions.

- Testing requirements and the submitter's and A/B MACs, and CEDI level of responsibility throughout each step of the testing process. See Section 40.1.2.1. for further testing details;

- The availability of the appropriate specifications for providers and instructions for accessing these via the Internet or other cost effective means;

- The availability of the A/B MACs to provide providers bulletins via the Internet and/or bulletin board system;

- The availability of the A/B MACs, and CEDI to provide EDI instructions or procedures via the Internet and/or bulletin board system;

- The availability of the A/B MACs, and CEDI to provide free Medicare EMC software;

- The availability of the A/B MACs free PC-Print software and the A/B MACs, and CEDIs free Medicare Remit East Print (MREP) software for the printing of the Electronic Remittance Advice.

- Login requirements;

- Hours of operation, system and support;

- Telecommunication options and requirements;

- Procedures for updating submitters with any billing changes;

- EDI formats required for input to the A/B MACs and CEDI system. These specifications must be in sufficient detail for the submitter's use, and must include information regarding code, record length(s), field positioning within record(s), labeling and any other conventions necessary for compatibility with the A/B MACs or CEDI system;

- All acceptance and rejection formats and content for output from the A/B MACs, or CEDI;

- Availability of online claim entry, claim correction (A/B MAC (A) only), claim status check, eligibility verification, claim development via DDE or otherwise, and the procedure for accessing these transactions;

- Availability of claim status check and eligibility verification and the procedure for accessing these transactions (A/B MACs only);

- Specifications of the A/B MACs, and CEDIs front-end editing process (except in those cases when disclosure of specific edits is related to medical Review or another sensitive area for which disclosure is not advisable) with complete list of error codes and resolution, including those conditions that will result in the rejection of entire EDI transmissions/batches;

- Conventions for acknowledging claims received and for recovering data known to be lost;

- Instructions for submitters to notify their A/B MACs and CEDIs changes to the submitter profile in regard to use of clearinghouses, billing agents, EDI transactions and software for submission/receipt of those transactions;

- A/B MACs and CEDI listings of vendors and clearinghouses that are approved for production;

- Data requirements for reporting third party Medigap payers,

- Frequently asked questions and answers about EDI.

DME MACs must make information available to potential users (preferably via their web page or the Internet) of each EDI transaction supported by Medicare with detailed information on:

- How to contact CEDI to:

    - Get started with electronic billing and other EDI transactions; and
    - Obtain on-going support for electronic transactions.

- The availability of DME MACs provider bulletins via the Internet and/or bulletin board system;

- The availability of CEDI's free Medicare EMC software

- The availability of the CEDI free Medicare Remit East Print (MREP) software for the printing of the Electronic Remittance Advice.

- Special instructions related to specific diagnosis or procedure codes, i.e., the necessity for attachments or modifiers and appropriate placement within the electronic record and;

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

40.2.4.2 - Technical Assistance to EDI Trading Partners

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and CEDI will provide help desk support to assist submitters and receivers 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 if possible. Help desk activities are to 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;
- Track activities related to the call to the final resolution of the call: identification of routing, callbacks, issues(reason for call), resolution, date and time;
- Workload distribution of open items;
- Classification of call types for resource planning, provider education, management reporting; and
- Storage of caller-specific audit trails.

In addition to an automated call system, A/B MACs and CEDI must provide for receipt of e-mail or voice mail 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 (3) business days. This plan should include one or more of the following:

- An indication that the A/B MACs or CEDI looked into the issue and did not identify a problem;
- The submission of a new corrected file (A/B MAC or CEDI only);
- 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 A/B MACs or CEDI action, and a description of the plan for resolution and estimated completion date.

Where the problem affects multiple submitters the A/B MAC or CEDI makes information on the issue available to all affected submitters.

40.2.4.3 - Training Content and Frequency

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

See the CMS Provider Education and Training (PET) manual for the definitive provider outreach and training requirements. Provider training is included in the CMS contractor PET budget and although EDI information must be included in those training efforts as appropriate, the PET requirements contain specific activities that must be completed by A/B MACs, DME MACs and CEDI. When possible, EDI training should be conducted in conjunction with non-EDI training to share training room and trainers' expenses. This EDI-related training information is included in Chapter 24 for reference purposes only. When appropriate, A/B MACs, DME MACs and CEDI may develop user groups for general EDI users and free software users. A/B MACs, DME MACs and CEDI are not required to support or train providers on the use of software provided by commercial vendors/trading partners, on ASC X12 format structure or coding, the use of PCs, or other subjects non-specific to Medicare EDI. On an ongoing basis, A/B MACs, DME MACs and CEDI should assess the need for additional training based on:

- Periodic identification and evaluation of common electronic billing errors;
- New software release; or
- The introduction of new EDI functions or changes to existing functions.

40.2.4.4 - Prohibition Against Requiring Use of Proprietary Software or DDE

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, DME MACs and CEDI will accept and process HIPAA EDI transactions created from any software as long as the transactions comply with the TR3 requirements standards adopted under HIPAA and CMS business requirements. A/B MACs, DME MACs and CEDI are prohibited from requiring that submitters of HIPAA EDI transactions use proprietary billing software or specific hardware. A/B MACs, DME MACs and CEDI may not charge providers that use their own software, hardware, modems, and telecommunication lines to submit and/or receive EDI electronic transactions in a HIPAA-compliant format.

DDE screens generally involve the use of dumb terminals programmed for specific uses, or of PCs that use software issued by a payer to emulate a dumb terminal to permit providers to individually enter claim data and correct claims errors (applies to Medicare institutional claims only), verify beneficiary eligibility (A/B MACs (A) and some A/B MACs (B)), obtain claims status (A/B MACs (A) and some A/B MACs (B)), or possibly perform another function. A/B MACs and DME MACs incur additional costs to maintain DDE functionality and support, they are allowed to recoup those costs from users and are permitted to charge a reasonable amount for its use A/B MACs, and DME

MACs may not require use of DDE, or refuse to accept or discourage submissions of HIPAA EDI transactions.

40.2.4.5 - Free Claim Submission Software

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, and CEDI will provide free/at cost software for their providers to use on a Windows-based PC for electronic submission of HIPAA-compliant claims to Medicare. At a minimum, this basic software must contain the following:

- 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.

This software must also be able to identify when Medicare is a secondary payer and to collect data elements concerning a primary payer's payment, standard claim adjustment reason codes and adjustment amounts made by a primary payer prior to submission of a claim to Medicare for secondary payment.

A/B MACs and CEDI are not funded to issue free/at cost software for other than submissions of ASC X12 837 claim inbound transaction. NCPDP has indicated software for billing NCPDP formatted claims was already in widespread use by retail pharmacies and there was not a need for Medicare to fund development of free billing software for retail pharmacies.

The software is free/at cost but A/B MACs and CEDI may charge a fee up to $25.00 per request to recoup their postage, reproduction, and handling expenses when a provider requests the software be sent via diskette, CD, or other medium, rather than downloaded by a provider from the Medicare contractor's web page (if not precluded by a software copyright or licensing agreement). A/B MACs and CEDI are to complete upgrades to their free/at cost billing software to correspond to the requirements of the current X12 version of the transactions. Prior to distributing the initial or updated versions, A/B MACs and CEDI will scan the free/at cost billing software with a current anti-virus program. Whenever A/B MACs and CEDI issue a new version of their free/at cost billing software, they shall notify providers to terminate use of the earlier version of the Medicare free/at cost billing software within 90-days of release of the updated software.

NOTE: The free-billing software distributed by A/B MACs (A) is maintained by the shared system maintainer. A/B MACs (A) are responsible for testing and distribution of that software only. There is not a similar common source of free billing software or maintenance for the A/B MACs (A) or A/B MACs (B). A/B MACS or A/B MACs (B) are encouraged to obtain and license for distribution Medicare Part B billing software. This software is available to A/B MACS and A/B MACs (B) for purchase and licensing from software companies.

40.2.4.6 - Newsletters/Bulletin Board/Internet Publication of EDI Information

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

To educate providers and encourage the use of EDI A/B MACs, DME MACs, and CEDI must periodically include information about use of EDI in their newsletters and on their Web site. Their newsletter and Web site shall:

1. Announce upcoming EDI changes;
2. Point out common EDI billing errors and provide guidelines to eliminate errors; and
3. Promote use of each of the Medicare-supported HIPAA EDI transactions.

A/B MACs, DME MACs, and CEDI will provide access to newsletters via bulletin boards and/or the Internet. A/B MACs, DME MACs, and CEDI Web pages must include a link to the CMS Web site, which provides record formats and transactions information. If the information is available on the CMS Home page, A/B MACs, DME MACs, and CEDI should link to it rather than duplicating development and maintenance.

40.2.4.7 - Provider Guidelines for Choosing a Vendor

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Providers may request assistance in choosing a vendor. A/B MACs, and CEDI must maintain a list of software vendors and clearinghouses that are currently successfully submitting transactions in HIPAA-compliant formats on their Web page, and are encouraged to also provide factual information such as claims volumes, types of providers serviced by those vendors and clearinghouses, and whether the software may permit automatic posting or printing of ASC X12 835 remittance advice data. However, A/B MACs, and CEDI must take care to avoid making a specific recommendation and to avoid showing favoritism. Providers may select any vendor that provides the necessary services.

40.2.4.7.1 - Determining Goals/Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Before selecting a vendor, the provider must examine its business needs to identify the EDI, practice management, or other services that the provider is interested in obtaining from a vendor. The provider should consider what services could be easily performed by

their in-house staff and which might be more cost effective to obtain through a vendor. The provider should create a written description of the components of its practice that need vendor support and a description of support needed so prospective vendors can design their proposals to best meet the provider's needs. 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.

40.2.4.7.2 - Vendor Selection

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

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:

- Ask the Medicare A/B MACs and CEDI for a list of approved vendors;

- 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?

6. Check with providers served by the vendor and ask specific questions such as:

- 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?

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.

40.2.4.7.3 - Evaluating Proposals
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

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
- 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.

40.2.4.7.4 - Negotiating With Vendors
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

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. Providers should add a clause to their agreements that will permit them to obtain a refund in the event the vendor's software does not begin to operate successfully by a specific target date following installation. Providers should also add a clause to their agreements allowing them to delay final payment pending successful operation of the new software for a specified period after successful installation.

40.2.5 - Provision of EDI User Guidelines
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs, HIPAA Eligibility Transaction System (HETS) ASC X12 270/271 eligibility and CEDI must make EDI information available to new users that describe the various steps in the testing process (see §30 and §60) and discloses: (This refers to HETS as well.)

- The Help Desk contact information, including telephone number, email address , and website to help with:
    - Getting started with EDI;
    - Needing on-going support for electronic transactions; and
    - Needing support for general transaction issues;
- Testing requirements and the submitter's and A/B MACs, HETS 270/271 and CEDI level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
    - ASC X12 transactions adopted under HIPAA; and
    - NCPDP adopted under HIPAA.

- Instructions for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp

- Login requirements;

- Telecommunications options and requirements; and frequently asked questions and answers about EDI.

40.2.6 - Provision and Maintenance of a Directory of Billing Software Vendors and Clearinghouses

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and CEDI must maintain a directory of electronic billing software vendors and clearinghouses that have successfully completed software and/or submission testing for the current ASC X12 837 claim, NCPDP claim (applies to CEDI only) Telecommunication standard and Batch standard claim transactions adopted as national claim standards for HIPAA. A/B MACs and CEDI must make this directory available to their providers via a Web page or electronic bulletin board. A/B MACs and CEDI must update the directory whenever product offerings from additional software vendors and/or additional clearinghouses are made available for providers to utilize when submitting transactions for production. At a minimum, the directory must include the vendor/clearinghouse name, phone number, email address and product offerings. A/B MACs and CEDI should also note any additional transactions for which the tested software can be used for submission or receipt of HIPAA standard transactions other than the claim.

40.2.7 - Operating Rules for Electronic Transactions

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The Secretary of Health and Human Services (HHS) adopted HIPAA transaction Operating Rules under section 1104(b) (2) of the Administrative Simplification provision of the ACA, requiring covered entities to comply with new administrative transaction standards. The purpose of the Administrative Simplification provision is to establish national standards for the electronic transfer of healthcare information. The Operating Rules are targeted at simplifying administrative processes, and reducing administrative burden and costs for both providers and payers.

The Operating Rules were designed to be added to existing electronic transmission standards for the processing of health information and administrative transactions. The Council for Affordable Quality Healthcare's (CAQH) Committee on Operating Rules for Information Exchange (CORE) was chosen as the operating rules authoring entity for eligibility and healthcare claim status standard transactions. CORE released three phases of operating rules.

A/B MACs, DME MACs, CEDI or other contractors if designated by CMS are responsible for supporting the implementation and adherence to the CAQH CORE Operating Rules for electronic transactions, including but not limited to all future operating rules. This support includes implementing necessary changes via Technical Direction Letters as well as Change requests (CRs) and participating in development meetings with CMS to ensure compliance for the Operating Rules.

40.3 - Trading Partners

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Trading Partners must have signed Trading Partner Agreements in place with their Medicare FFS Contractor prior to engaging in EDI.

50 - Technical Requirements

(Rev. 11427; Issued: 05-20-22; Effective: 01-01-23; Implementation: 01-03-23)

NOTE: CMS seeks to reduce burden and modernize processes to ensure a reduction in improper payments and an increase in customer satisfaction. The Certificate of Medical Necessity (CMN) form and DME Information Form (DIF) were originally required to help document the medical necessity and other coverage criteria for selected Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items. In the past, a supplier received a signed CMN from the treating physician or created and signed a DIF to submit with the claim. Due to improvements in claims processing and medical records management, the information found on CMNs or DIFs is available either on the claim or in the medical record and is redundant. Therefore, to reduce burden and increase customer satisfaction, providers and suppliers no longer need to submit these forms for services rendered after January 1, 2023.

- **For claims with dates of service on or after January 1, 2023** – providers and suppliers no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned to the provider or supplier.
- **For claims with dates of service prior to January 1, 2023** – processes will not change and if the CMN or DIF is required, it will still need to be submitted with the claim, or be on file with a previous claim.

This statement applies throughout the Program Integrity Manual wherever CMNs and DIFs are mentioned.

50.1 - Telecommunications, Internet and Dial-up

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI and A/B MACs shall support connectivity for EDI functions in accordance with CMS-approved centralized gateway architecture and routing requirements. DME MACs and CEDI will support connectivity for EDI functions. These functions include the exchange of EDI transactions at the CEDI Front End.

Online systems include the Medicare Part A Direct Data Entry (DDE) used for claim entry, claim correction, claim status checks, and beneficiary eligibility. Medicare Part B offers the Provider Professional Telecommunications Network (PPTN) and DME MAC offers Claim Status Inquiry to check the status of claims.

50.1.1 - System Availability

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Access to A/B MACs, DME MACs and CEDI to exchange electronic transactions and/or 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. A/B MACs, DME MACs and CEDI shall inform users of system availability schedules including any planned downtime for system maintenance.

50.1.2 - Media

(Rev. 10319, Issued: 08-28-2020, Effective: 09-29-2020 Implementation: 09-29-2020)

An EDI transaction is defined by its initial manner of receipt. Depending upon the capability of the A/B MAC, DME MAC and CEDI and the details negotiated with electronic claim submitters, an electronic claim could be submitted via central processing unit (CPU) to CPU transmission, dial up frame relay, direct wire (T-1 line or similar), or personal computer modem upload or download (also see Section 50.1.3).

When counting electronic claims for workload reporting, the A/B MAC, DME MAC and CEDI include data on all bills received for initial processing from providers directly or indirectly through another A/B MAC (A), etc. They also include data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. See § 90 of this chapter for information about application of the claims payment floor when a claim is submitted electronically in a non-HIPAA-compliant format.

A/B MACs and DME MACs are not permitted to classify the following as electronic claims for Electronic Data Interchange (EDI) reporting, for payment floor or Administrative Simplification Compliance Act (ASCA, see section 90) mandatory electronic claim submission purposes:

- Bills received from providers if they are incomplete, incorrect, or inconsistent, and consequently returned for clarification. Individual controls are not required for these bills;

- Adjustment bills (A/B MAC (A) only);

- Home Health Agency (HHA) bills where no utilization is chargeable and no payment has been made, but which have been requested only to facilitate record keeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.);

- Bills paid by an HMO and processed by the contractor; and

A/B MACs, DME MACs and CEDI are not permitted to accept claims via fax-imaging, tape/diskette or similar storage media. A/B MACs, DME MACs and CEDI are to assist billers using such media to transition to more efficient electronic media.

50.1.3 - Telecommunications and Transmission Protocols
(Rev. 3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

Providers must access A/B MACs and DME MACs online applications, Medicare Part A Direct Data Entry (DDE), Medicare Part B Professional Provider Telecommunications Network (PPTN) and DME MAC Claim Status Inquiry (CSI) **as directed** by the A/B MAC or DME MAC. A/B MACs and DME MACs are to permit access to DDE, PPTN and DMCS by using the most cost-effective transmission solution, among the CMS-sanctioned options, that meets the needs of their trading partners.

A/B MACs and CEDI may, but are not required to**,** support electronic transfers for Medicare using 56 K connections for their asynchronous communications lines. For asynchronous communications, A/B MACs and CEDI may, but are not required to, support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP). If A/B MACs and CEDI do support TCP/IP, it must be 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 EDI transfers over TCP/IP connections, A/B MACs and CEDI must support using File Transfer Protocol (FTP) in a secure manner which is supported within the FTP protocol in a consistent manner and which takes advantage of existing security infrastructure and technology, compliant with RFC 2228. FTP servers provide for user authentication through user ID/password mechanisms. A/B MACs and CEDI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. A/B MACs and CEDI may but are not required to support file compression for ASC X12 or NCPDP (CEDI only) transactions. Compression is permitted between the contractor and its data center.

A/B MACs and CEDI may not limit the number of ASC X12 837 claim transactions or the number of providers with transactions included in a single transmission, but they may limit a single transmission to 5,000 claims if that is necessary for efficient operations.

For NCPDP, CEDI may not limit the number of transactions per batch except as noted within the batch standard. However, they may limit a single physical file to having only one batch. Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

A/B MACs and CEDI must accept and send all ASC X12 837 claim transactions as a continuous byte stream or as a variable length record. A/B MACs and CEDI are not permitted to require that provider EDI transaction data be broken down into 80 byte segments and may not require any other deviation from the variable length format or the continuous byte stream format. For example, submitters may not be forced to create each segment as its own record by inserting carriage returns or line feeds. Only standard ASC X12 envelopes may be used with ASC X12 transactions. Only standard NCPDP envelopes may be used with NCPDP transactions (applies to CEDI only).

The ASC X12 and NCPDP transactions are variable-length records designed for wire transmission. Medicare contractors must be able to accept them over a wire connection. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

Unless otherwise approved, A/B MACs, DME MACs and CEDI are only permitted to accept EDI transactions via the Internet when explicitly directed by CMS. This ability includes compliance with the operating rules for Section 1104 of the Affordable Care Act.

50.1.4 - Toll-Free Service

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Toll free lines are not available for submission or receipt of EDI transactions. Providers and their agents are responsible for all costs they incur for communication and connectivity as described in Section 50.1.

50.2 - Translators

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may perform centralized translation, validation, and flat-file transformation functions for HIPAA-compliant transactions prior to routing transactions to shared systems and A/B MAC processing environments. CEDI must accept HIPAA compliant transactions into their front-end system and translate that data into the appropriate flat file format for the transaction type to enable processing by their shared system. HIPAA compliant transactions may include Medicare data (data sent to the core shared system) and non-Medicare data (data not sent to the core shared system). Translators are required to validate the syntax compliance of each inbound transaction against the transaction standards adopted under HIPAA and upon which the implementation guides (also adopted under HIPAA) are based. Syntax edits must be limited to those syntax requirements specified in those implementation guides (IGs) adopted under HIPAA.

A/B MACs and CEDI must use the ASC X12 999 implementation acknowledgment to report transaction level errors detected by translators and to acknowledge receipt of claims that did not contain syntax errors, unless the submitter has indicated a preference not to receive acknowledgments for claims without errors. A/B MACs or CEDI may purge ASC X12 999 implementation acknowledgment transactions from submitter mailboxes after five (5) business days in the event not downloaded by the submitting entity, but are encouraged to retain these as long as 30 days if system capacity permits. Once purged, an A/B MACs or CEDI is not required to be able to recreate that ASC X12 999 implementation acknowledgment transactions. A provider or clearinghouse that failed to download the ASC X12 999 implementation acknowledgment in a timely manner may submit a claim status query to obtain comparable information for accepted claims. If that response indicates no record of the claim(s), suggesting front end rejection due to a syntax error, the provider/clearinghouse can resubmit the claim and have a new ASC X12 999 implementation acknowledgment issued. The ASC X12 999 implementation acknowledgment TR3 can be downloaded from the official Washington Publishing Company website. A/B MACs and CEDI are required to meet the ASC X12 999 implementation acknowledgment TR3 requirements when issuing the 999.

When receiving claims in the HIPAA adopted NCPDP formats, CEDI must produce a response file in the NCPDP format containing one Transaction Header and one Transaction Trailer with the appropriate syntax error noted in the message field.

TCEDI and CEDI must accept the entire extended character set. Refer to the ASC X12 TR3 for specifics on the character set. If *TCEDI* and CEDI cannot accept more than 9,999 loops or segments per loop in an ASC X12 transaction due to the limitations of their translator, they may reject the transaction at the translator level and use the ASC X12 999 implementation acknowledgment with the IK304 with a value of "4". Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) that surround individual transactions 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. *TCEDI* and CEDI are not required to accept multiple functional groups (GS/GE) with multiple transaction types within one transmission for ASC X12 transactions.

For ASC X12 transactions *TCEDI* and CEDI translators must also:

- Convert lower case to upper case;
- Pass all spaces to the flat file for fields that are not present in an inbound transaction but which are included in the flat file;
- Map "Not Used" data elements for *TCEDI* and CEDI based upon that segment's definition only, 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; "Not Used" data elements are not to be mapped to the flat file; and

- Accept multiple interchange envelopes within a single transmission. This is only applicable to ASC X12 transactions as NCPDP only processes a single batch per transmission.

- Translate data for outgoing transactions supplied by the shared system in the flat file format into the appropriate, compliant IG standard as adopted under HIPAA. Translation of outgoing transactions is to follow the same character set and case requirements noted for incoming translation. *TCEDI* and CEDI are not required to accept or process ASC X12 999 implementation acknowledgment transactions from trading partners for any outgoing ASC X12 transactions.

See Section 60 for additional *TCEDI* and CEDI translator edit requirements that may be specific to individual standards.

50.3 - Combined Common Edits/Enhancements Module (CCEM) - General Description Across All Versions

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

The CCEM establishes consistent editing, acknowledgments, and error handling of the electronic data interchange (EDI) transactions across Medicare Administrative Contractor (MAC) jurisdictions. *The CCEM may interface with centralized CMS-designated gateway infrastructure, including TCEDI, for intake processing, routing, validation, balancing, and acknowledgment workflows.* The CCEM is implemented by each A/B MAC in their local data center (LDC). The Part A and Part B CCEMs were developed by their corresponding Medicare Shared System Maintainers (SSMs). The Durable Medical Equipment (DME) MACs editing, acknowledgment, and error handling of EDI transactions is processed by the Common Electronic Data Interchange (CEDI) contractor. Each A/B MAC has integrated the CCEM into its Front-End Systems for both inbound and outbound EDI transaction processing. The CCEM, in conjunction with the TCEDI translator and any additional Front End Solution, is responsible for editing current ASC X12 standard transactions established under HIPAA via Technical Report Type 3 (TR3s).

The CCEM provides submitters with quicker acknowledgments for the claim transaction(s) ASC X12 version(s) 005010 and beyond inclusive of any adopted errata under HIPAA. This allows submitters to correct any errors and resubmit their transactions without having to wait for a batch cycle.

The CCEM includes the following capabilities:

- Code set editing

- Medicare-specific editing

- Duplicate submission checking
- Claim Control Number assignment of Internal Control Number (ICN) or Document Control Number (DCN)
- Creation of the ASC X12 277CA claim acknowledgment (flat file)
- Creation of a CCEM-edited transaction flat file
- Receipt/Control/Balancing between the local data centers (LDCs) and EDCs for claims, claim status request and responses, and remittance advice
- Reporting Capabilities based on the Control Record database

50.3.1 - Claim Numbering

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI may perform centralized intake and validation processing prior to CCEM assignment of claim control numbers for accepted Part A/B claims. An accepted claim is a unit of work, 2300 loop followed by a 2400 loop, as described in the ASC X12 837 claim TR3 that has passed all translator syntax/semantic and CCEM Medicare business edits and has been assigned a claim control number. The assigned claim control number will be reported back to the submitter via the ASC X12 277CA claim acknowledgment. This will provide the submitter with the claim control number earlier in the adjudication process, thus enabling the submitter to perform more specific claim status inquiries on individual claims instead of entire submissions via standard HIPAA adopted transactions or via traditional IVR/ARU (Interactive Voice Response/Automated Response Unit methods.

50.3.2 - Receipt Control and Balancing

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

Upon receiving an ASC X12 276 claim status request or ASC X12 837 claim (institutional or professional) current standard transaction adopted under HIPAA. *TCEDI, where designated by CMS, may perform centralized receipt, control, balancing, routing, and intake processing functions prior to delivery of CMS-defined flat files to shared systems.* The CMS defined flat file will include a skeleton Control Record, either a Detail Record (CTRD) or a Resubmission Record (CTRR), for each Interchange Control Header/Interchange Control Trailer (ISA/IEA) present, and the A/B MAC then loads/places this file into the designated folder for the CCEM to pick up and process.

The CTRD/CTRR record is placed in the designated transaction outbound folder for the A/B MAC LDC to move via Network Data Mover (NDM) to the EDC. The EDC will run a receipt/control/balancing process upon receipt of a file to ensure that what was sent by the LDC is what the EDC received. Once the EDCs have checked the files, the "Received" portion of the Control Records will be populated, and a copy of the Control

Record shall be sent back to the LDC and logged in the Control Record database. If the file balances, the Control Records will be stripped off and the file will be queued up to be pulled into the next processing cycle. If file does not balance, "Received" portion of the Control Records will be populated, and a copy of the Control Record shall be sent back to the LDC and logged in the Control Record database. An alert will be sent to the LDC to indicate there is a problem with a file, and the bad ISA/IEA will be stripped out of the file. Once the LDC has identified and fixed the issues, they resubmit the bad ISA/IEA.

The Receipt/Control/Balancing process will also be in place for the outbound ASC X12 835 remittance advice and the ASC X12 277 claim status response. The shared system maintainers (SSMs) will create the appropriate CMS defined flat file, based on transaction type. The CMS defined flat file will include the Control Records. The transactions will be sent to the MAC/CEDI local data center, where they will be passed through the receipt/control/balancing process to ensure if the CMS defined flat file is balanced. During the outbound translation process the A/B MACs shall remove the control records prior to translating the CMS defined flat files to ASC X12 EDI format.

50.3.3 - Acknowledgements

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may generate or coordinate ASC X12 acknowledgment transactions, intake validation responses, and operational balancing acknowledgments prior to downstream shared system processing to determine whether an edit failure necessitates the rejection of the entire transaction set via the ASC X12 TA1 interchange acknowledgment or ASC X12 999 implementation acknowledgment edit, back to the submitter or whether those errors are accepted and passed onto the CCEM for claim level rejection via the ASC X12 277CA claim acknowledgment. Errors that the translator passes to the CCEM are referred to as ASC X12 999 implementation acknowledgment "Accepted, but Errors Noted" (ASC X12 999E implementation acknowledgment) edits.

The CCEM will receive CMS defined 837 and 276 flat files from the *TCEDI* translator. The CCEM will flag any 837 flat file data in error and will report that data back to the submitter via the ASC X12 277CA claim acknowledgment. Any 276 flat file data in error will be reported back to the submitter via an ASC X12 277 claim status request response transaction. All accepted data will be sent to the SSM for processing.

1. If the translator sets an edit that does not necessitate rejection of the entire ST-SE transaction set (ASC X12 999E implementation acknowledgment edit), the contractor front end:
    a. Creates an 'STC' segment to document the error and inserts it into the ASC X12 837 claim CMS defined flat file following the segment containing the error.

    b. Returns the ASC X12 999 implementation acknowledgment to the submitter indicating the affected ST-SE transaction was accepted with errors noted.

c. Inserts a receipt date segment (+RC DTP segment) into the ASC X12 837 claim CMS defined flat file.

d. Creates a skeleton (350 character space filled) Control Record (CTR segment) and, if desired, populates CTR17. The CTR is placed in front of each ISA segment.

e. Submits the ASC X12 837 claim CMS defined flat file containing STC error segments to the CCEM.

2. If the translator does not set any edits, the contractor front end:

a. Returns the ASC X12 999 implementation acknowledgment to the submitter indicating the affected ST-SE transaction was accepted.

b. Inserts a receipt date segment (+RC DTP segment) into the ASC X12 837 claim CMS defined flat file.

c. Creates a skeleton CTR segment and if desired, populates CTR17. The CTR is placed in front of each ISA segment.

d. Submits the ASC X12 837 claim CMS defined flat file to the CCEM.

50.3.3.1 - Outbound File Compliance Check

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may perform outbound compliance validation, balancing, and integrity checks for ASC X12 999 implementation acknowledgment and ASC X12 835 remittance advice transactions. The ASC X12 276/277 claim status response and the ASC X12 277CA claim acknowledgment outbound files shall be compliance checked for the following:

- Basic syntactical integrity and specific syntax requirements on all outbound files;
- Balanced field totals, financial balancing of claims or remittance advices, and balancing of summary fields, if appropriate for all outbound file;
- Specific inter-segment situations described in the HIPAA Implementation Guides for all outbound files; and
- Valid TR3 specific code set values and other code sets adopted as HIPAA standards for all outbound files.

50.3.4 - Combined Common Edits/Enhancement Module (CCEM) Code Sets Requirements

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

The functionality of the CCEM is dependent on the standard system maintainers (SSM) providing current code sets for inbound claims and claim status inquiries to be edited against. This requires the CCEM maintainer to update the following code sets on a quarterly release basis in order to align with industry:

- Country Codes (ISO 3166-1)
- Country Subdivision Codes (ISO 3166-2)
- State Codes (United States, Canada, Mexico)
- Not Otherwise Classified (NOC) Procedure Codes (as defined by CMS)
- National Uniform Billing Committee (NUBC) Condition Codes (that are valid for use on the 837 Professional claim per the National Uniform Claim Committee (NUCC))
- Ambulance Modifiers
- Health Insurance Prospective Payment System (HIPPS) (as updated and maintained by CMS)

A/B MACs are required to validate the incoming codes listed above against the most recent codes sets provided by the SSM. CMS will notify the shared system maintainers (via Recurring Update Notification) to load the most recent code sets into the CCEM environment for download to the A/B MAC local data center (LDC) in conjunction with the quarterly release.

The CCEM maintainer also updates the following code sets on a frequency basis other than quarterly in order to align with industry:

- ZIP codes
- Claim Adjustment Reason Codes (CARC)
- Anesthesia Modifiers
- Diagnosis Related Groups (DRG) codes
- Healthcare Common Procedure Coding System (HCPCS) codes
- Health Insurance Premium Payment System (HIPPS) codes
- International Classification of Diseases, (ICD) codes
- National Drug Codes (NDC) (as published by the Federal Drug Administration (FDA))
- National Provider Identifier (NPI)
- Remittance Advice Remark Codes (RARC)
- Taxonomy Codes
- Procedure Code Modifier Codes
- Admission Source Codes
- Admission Type Codes
- Patient Status Codes
- Condition Codes
- Occurrence Codes

- Occurrence Span Codes
- Value Codes
- Revenue Codes
- Uniform Bill Type codes
- Provider Control File (PCF) - Part B only

A/B MACs are required to validate the incoming codes listed above against the most recent codes sets provided by the SSM. When the above listed reference code sets are updated, they are sent to the A/B MAC (LDC) as part of nightly code updates.

50.3.5 - Handling of Poorly Formed/Invalid Flat Files for a 277CA

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

When a poorly formed/corrupted invalid flat file for an ASC X12 277CA claim acknowledgment outbound transaction is received, the contractor may manually correct the flat file acknowledgment data necessary to produce a valid ASC X12 277CA claim acknowledgment. The manually corrected information is then to be submitted to the translator. This process shall be executed on an exception basis to ensure that an ASC X12 277CA claim acknowledgment can be produced for an accepted transaction.

50.4 - CEDI - Unique Specifications for DME

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The Common Electronic Data Interchange (CEDI) contractor is the single front end solution for Durable Medical Equipment (DME) electronic transactions including ASC X12 837 claims, NCPDP claims, ASC X12 835 remittance advice (ERA), ASC X12 276 claims status requests, ASC X12 277 claim status responses, and electronic front end reports.

CEDI receives inbound claims (ASC X12 837 professional claim and NCPDP claim), performs all front end editing on the claims, and returns the reports showing accepted and rejected claims to the Trading Partner's CEDI mailbox.

The following front end reports will be returned by CEDI:

- ASC X12 837 professional claim and 276 claim status request transactions; NCPDP transactions

- ASC X12 999 implementation acknowledgment for ASC X12 837 claim and ASC X12 276 claim status request transactions

- ASC X12 TA1 interchange acknowledgment for ASC X12 837 claim and ASC X12 276 claim status request transactions (when requested)

- ASC X12 277CA claim acknowledgment for ASC X12 837 professional claim transactions

- ASC X12 277 claim status response for ASC X12 transactions

- NCPDP transmission response NCPDP transactions

- DME MAC Front End Report with accepted claims received and CMN rejections based on ASC X12 claim submissions

Claims accepted by CEDI are assigned the Claim Control Number (CCN) to be used by the DME MACs in processing the claim. CEDI translates the claims into the Medicare flat file format and delivers the claims to the appropriate DME MAC based on the beneficiary state code submitted on the claim.

CEDI receives inbound claim status requests (ASC X12 276 claim status request), performs all front end editing on the transactions, and returns the ASC X12 277 claim status response showing accepted and rejected transactions. ASC X12 276 claim status request transactions accepted by CEDI are translated to the Medicare flat file format and delivered to the DME MAC based on the contractor code submitted on the ASC X12 276 claim status request file.

CEDI receives the DME MAC front end report showing claims received by the DME MACs as well as any CMN rejections and returns this report to the Trading Partner's CEDI mailbox.

CEDI receives the ASC X12 835 remittance advice and ASC X12 277 claim acknowledgment flat file formatted transactions from the DME MACs, translates these to the ASC X12 format and delivers them to the Trading Partner's CEDI mailbox.

50.4.1 - CEDI Claim Numbering

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

CEDI will assign the CCN to accepted ASC X12 and NCPDP claims utilizing the DME MACs defined range of CCNs. The CCNs are reported back to the Trading Partner on the front end reports and response files. On the 837 flat file, the CCN will be populated in the 2300 loop REF segment for that claim where REF01 = +CN. For NCPDP, the CCN will be populated in the Transaction Header Segment in positions 117-130.

If the number of accepted claims for a given DME MAC exceeds their defined threshold, CEDI will hold the claims in excess of the threshold to be delivered the next business day using the next business day’s range of CCNs. Claims held will have the date of receipt when the CEDI received the claim.

50.4.2 - CEDI Receipt Control and Balancing

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

CEDI, upon receiving a submitted ASC X12 837 professional claim and/or NCPDP D.0 file from a Trading Partner, will run the file through their Commercial Off The Shelf (COTS) translator. The COTS translator creates an ASC X12 837 professional claim or NCPDP flat file, includes a CTRD record for each ISA/IEA and each Batch Header/Trailer present, forwards the flat file to the EDC, and stores the CTRD record to a database.

The EDC updates the Receipt, Control and Balancing Detail Record (CTRD) creating a CTRD Response. This file is sent back to CEDI who in turn triggers an alert when an out of balance condition has been reported, matches the response to the original CTRD record and stores the updated record to a database. This process will check to be sure what was sent to the EDC is what the EDC received and to update the CTRD record. If it balances, the file continues along through the DME MACs VMS cycle. If it does not balance, the file will not continue. The CTRD record contained in the database is updated with the counts (which identifies which pat of the file is out of balance). CEDI will review the CTRD response file for the out of balance reason and resolve the issue. If necessary, a CTRR resubmission will be sent.

50.4.3 - CEDI Acknowledgments for ASC X12 Version 5010 and NCPDP D.0. Transactions

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Trading Partners transmit their ASC X12 5010 transactions and CEDI performs the following functions.

1. CEDI front end performs Standard and Implementation Guide edits on the ASC X12 837 claims. These edits include, but are not limited to, edits on the ASC X12 837 professional claim edit spreadsheet tagged for ASC X12 TA1 interchange acknowledgment and ASC X12 999R and 999E implementation acknowledgment responses. Please refer to the CMS website for a copy of the ASC X12 837 professional claim edit spreadsheet.

2. CEDI uses the ASC X12 837 professional claim edit spreadsheet to determine whether an edit failure necessitates the rejection of the entire ASC X12 837 transaction set (ASC X12 999R implementation acknowledgment edit) or whether those files should be passed on for further business validation editing, resulting in a claim level rejection via the ASC X12 277CA claim acknowledgment. Errors that the translator identifies at the 999 level and passes on for further business validation and ASC X12 277CA claim acknowledgment issuance are referred to as ASC X12 999E implementation acknowledgment edits on the ASC X12 837 professional claim edit spreadsheet.

3. If the ASC X12 837 professional claim edit necessitates rejection of the entire ST-SE transaction set (ASC X12 999R implementation acknowledgment edit), CEDI returns the ASC X12 999 implementation acknowledgment to the Trading

Partner indicating the affected ST-SE was rejected. The transaction set is not passed for further processing.

4. If the ASC X12 837 professional claim edit sets an edit that does not necessitate rejection of the entire ST-SE transaction set (ASC X12 999E implementation acknowledgment edit), CEDI will:

    a. Return the ASC X12 999 implementation acknowledgment to the Trading Partner indicating the affected ST-SE transaction was accepted with errors.

    b. Continue with performing the ASC X12 837 professional claim edit at the Business Validation level.

    c. Read the beneficiary state code submitted on the accepted claims for use in performing appropriate Business Validation editing (ASC X12 277CA claim acknowledgment) at the DME MAC level.

    d. If an ASC X12 999E implementation acknowledgment error is listed with a coordinating ASC X12 277CA claim acknowledgment, any claims falling subordinate to the level at which the ASC X12 999E implementation acknowledgment error occurred will be rejected.

5. If CEDI does not set any ASC X12 999E implementation acknowledgment edits, CEDI will:

    a. Return ASC X12 999 implementation acknowledgment to the Trading Partner indicating the affected ST-SE transaction was accepted.

    b. Continue performing the ASC X12 837 professional claim edit at the Business Validation level.

6. After all ASC X12 837 professional claim edits have been performed, and claims have successfully passed any ASC X12 999R implementation acknowledgment, ASC X12 999E implementation acknowledgment, or ASC X12 277CA claim acknowledgment level editing, CEDI will:

    a. Assign the CCN to the accepted ASC X12 837 claims.

    b. Insert a receipt date segment (+RC DTP segment) into the ASC X12 837 flat file.

    c. Create a control record (CTR segment) containing the appropriate counts. The CTR is placed in front of each ISA segment on the ASC X12 837 flat file.

7. CEDI will create the ASC X12 277CA claim acknowledgment transactions to be returned to the Trading Partner, containing all ASC X12 277CA claim

acknowledgment errors that may have occurred at the ASC X12 999E implementation acknowledgment or Business Validation level.

8. CEDI will deliver the ASC X12 837 flat files to the EDC for the appropriate DME MAC.

Trading Partners transmit their NCPDP D.0 transactions to and CEDI performs the following functions.

1. CEDI front end performs Standard and Implementation Guide edits on the NCPDP claims. These edits include, but are not limited to, edits on the NCPDP edit spreadsheet tagged for NCPDP transmission response.

2. CEDI uses the NCPDP edit spreadsheet to determine whether an edit failure necessitates the rejection of the entire NCPDP batch or an individual claim.

3. CEDI will read the beneficiary state code submitted on the accepted claims for use in performing appropriate Business Validation editing at the DME MAC level.

4. After all NCPDP edits have been performed, CEDI will assign the CCN to the accepted NCPDP claims.

5. CEDI will return the NCPDP transmission response showing accepted and rejected batches and individual claims as well as the CCN for all accepted claims.

6. Create the NCPDP flat file for each DME MAC with claims for their Jurisdiction.

7. CEDI will deliver the NCPDP flat files to the EDC for the appropriate DME MAC.

50.5 - EDI Testing Accuracy

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

All claim submitters must produce accurate electronic test claims before allowed to submit HIPAA format claim transactions in production. All submitters must send the A/B MAC or CEDI a test file containing at least 25 claims, which are representative of their practice or services. A/B MACs and CEDI may, based on individual consideration, increase or decrease the number of claims required to adequately test any given submitter. A/B MACs and CEDI will subject test claims to standard syntax and IG semantic data edits and will provide documentation when edits detect errors.

- Standard syntax testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits. Test files must pass 100 percent of the standard syntax edits before production is approved. An ASC X12

999 implementation acknowledgment will be used to validate compliance with syntax data.

- IG Semantic Data testing validates 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 where, in the judgment of the A/B MAC or CEDI, the vendor/submitter will make the necessary correction(s) prior to submitting a production file. An ASC X12 277CA claim acknowledgment will be used to validate compliance with semantic data.

50.5.1 - Limitation on Testing of Multiple Providers that Use the Same Clearinghouse, Billing Service, or Vendor Software

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Many claim submitters use the same vendor's software product, or the same clearinghouse to submit their electronic claims to Medicare. In those cases, A/B MACs and CEDI are not required to test each submitter that uses the same software, or each provider or billing agent that uses the same clearinghouse. A/B MACs and CEDI may require potential third party submitters to have an approved Medicare provider as a client prior to testing with such third parties. It is sufficient to test with a small number of users of the same software to establish that the software is compliant, or to simply test with a single provider using a clearinghouse to establish the compliancy of the clearinghouse's software and connectivity for transmission of claims data. Likewise, once A/B MACs and CEDI have tested the validity of the free/at cost billing software they distribute on request, the A/B MACs and CEDI are not expected to test providers that have elected to use that billing software.

Providers who submit transactions directly to more than one A/B MAC and/or CEDI, and billing services and clearinghouses that submit transactions to more than one A/B MAC and/or CEDI, must contact each A/B MAC and/or CEDI with whom they exchange EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional EDI transaction, different or significantly modified software for submission of a previously used EDI transaction, or before a billing agent or clearinghouse begins to submit transactions on behalf of an additional provider. A/B MAC and/or CEDI may need to retest at that time to re-establish compatibility and accuracy, particularly if there will also be a change in the telecommunication connection to be used.

Billing services and clearinghouses are not permitted to begin to submit or receive EDI transactions on behalf of a provider prior to submission of written authorization by the provider that the billing agent or clearinghouse has been authorized to handle those transactions on the provider's behalf. See Section 30 of this Chapter for further information on EDI Enrollment.

50.5.2 - EDI Receiver Testing by A/B MACs, and CEDI

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and CEDI are not required to test individuals who request use of outbound electronic remittance advice (ERA) or claim status transactions unless parties that request receipt of those transactions request pre-testing prior to production use of one or more of those outbound transactions. A/B MACs and CEDI may, at their discretion, require pre-production testing of outbound transactions if there is concern that specific receivers could otherwise experience significant problems.

Even if testing is not normally required, parties that want to begin receipt of an outgoing transaction supported by Medicare must notify their A/B MACs DME MACs or CEDI when to begin transmission of the HIPAA version of a specific outgoing transaction.

50.6 - Changes in Provider's System or Vendor's Software and Use of Additional EDI Formats

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Providers who receive or send transactions directly from/to more than one A/B MAC and/or CEDI, and billing services and clearinghouses that receive or send transactions from/to more than one A/B MAC and/or CEDI, must contact each A/B MAC and/or CEDI with which they receive/send EDI transactions to inquire about the need for supplemental testing whenever they plan to begin to use an additional type of EDI transaction. A provider must also notify their A/B MAC and/or CEDI in writing (see EDI enrollment in Section 30 of this chapter) if they will begin to use a billing agent or clearinghouse for the first time, change a billing agent or clearinghouse, discontinue use of any billing agent or clearinghouse, or authorize a billing agent or clearinghouse currently used for some transactions to begin receiving additional transactions. A billing agent or clearinghouse representative is prohibited from signing an authorization on behalf of a provider to allow them to act as the sender or receiver of specific EDI transactions on behalf of a provider, even if a provider has signed a contract with the billing agent or clearinghouse for such services.

50.7 - Delimiters

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Delimiters - Inbound Transactions

As detailed in the HIPAA adopted ASC X12 implementation guides, delimiters are determined by the characters sent in specified, set positions of the ISA header. For transmissions to Medicare (inbound transmissions), these charters are determined by the submitter and can be any characters which are not contained within any data elements within the ISA/IEA Interchange Envelope. Please note, that the delimiters for NCPDP files are dictated by the transaction standard.

Delimiters - Outbound Transactions

Medicare will use the following delimiters in all outbound ASC X12 transactions. Note that these characters will not be used in data elements within an ISA/IEA Interchange Envelope.

Delimiter	Character Used	Dec Value	Hex Value
Data Element Separator	*	62	3E
Repetition Separator	^	94	5E
Component Element Separator	:	43	2B
Segment Terminator	~	126	7E

50.8 - Nulls

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

The null scrubbing of outbound data exiting the Enterprise Data Center (EDC), prior to its delivery to the Local Data Center (LDC) was initiated with Transmittal 702 Change Request 6946, Combined Common Edits/Enhancements Module (CCEM) October Release Update for Test/Production Indicator Activity and Outbound Data Scrubbing. The scrubbing process will apply to ASC X12 outbound file structures to the EDC (e.g., ASC X12 835 and 277 flat files). It will not apply to outbound ASC X12 837 COBC files.

The Shared System maintainer shall implement a scrubbing process that occurs after the creating of the outbound file structures at the EDC (e.g., ASC X12 835 and 277 flat files). Once the flat files have been processed through the EDC's receipt, control and balancing jobs they are viewed as ready for transmission to the LDC. At this point in the process null values are to be replaced with spaces.

50.9 - Direct Data Entry (DDE) Screens

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

HIPAA does not require, but does permit payers to maintain DDE screens for claim submission, correction, claim status determination, and eligibility verification. A/B MACs (A) are required to maintain claim submission, claim correction and claim status screens, but not A/B MACs (B) or DME MACs. This section is applicable to claim entry and claims correction (see chapter 31 for DDE requirements for formats other than claims).

Medicare considers transactions conducted via DDE screens to meet HIPAA-compliancy requirements. DDE claims are considered HIPAA-compliant EDI transactions for application of the 14-day payment floor.

Data entered via DDE screens are not subject to the syntax (format) requirements of the standards, but must meet "applicable data content" requirements for comparable HIPAA transactions. A/B MACs (A) may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA. DDE systems are proprietary by definition. They are a direct link between a particular health plan (Medicare) and its providers, and the software (and sometimes hardware) is unique to and maintained by the plan. The widespread use of the standard HIPAA transactions should make it economically feasible for more providers to procure or develop their own EDI products that can be used with all plans. The use of DDE should decrease over time as a result. The requirement for "applicable data content" is meant to facilitate that eventual conversion. Adopting the data content requirements of HIPAA in DDE screens will facilitate eventual migration of providers from DDE to use of EDI transaction software (or to use of a clearinghouse). This will also permit maintenance of DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, "applicable data content" means shared system-maintained DDE screens must:

- Collect all data elements that are required in the IG as well as those situational elements that are needed for Medicare processing (unless the data is already available to the payer's system);

- Use only the internal and external code sets designated in the HIPAA standard TR3 with no additions or substitutions;

- Provide for at least the field size minimums noted in the IG, but no more than the maximum sizes (Do not expand the size of a shared system's internal claim records);

- Permit at least the minimum number of field repeats noted in the IG, but no more than the maximum number;

- Allow for only one investigational device exemption number (IDE) per claim (at the claim level);

- Remove employment status code, employer name, and employer address information;

- Allow Other Subscriber Demographic Information (date of birth and gender) if the other subscriber is a person;

- Allow for discharge hour and minute information in the numeric form of HHMM; and

- Allow for correct processing of the unique physicians identifier number in the 2310A (Attending Physician) loop.

Data elements not used by-Medicare are not currently collected in Medicare DDE screens. Claims correction via DDE should be limited to Medicare data (non-Medicare data in error should be purged with an appropriate error message to the DDE user). With Medicare data plus some information from shared system files, an IG compliant COB transaction can be written.

NOTE: See section 60.2.3 for additional DDE edit requirements.

50.10 - Additional Documentation Submitted Via Paperwork (PWK) Segment

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

50.10.1 - PWK Background

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

In the current CMS claims processing environment, providers have to wait to receive requests for additional information, called automated development request letters, in order to provide additional documentation necessary for the adjudication of their claims. This "solicited" method of requesting documentation adds unnecessary extra days to claims processing. Beginning with the 5010 version of the ASC X12 837 institutional, professional and dental (electronic healthcare claim transaction), electronic billers can utilize a new methodology for providing CMS with their additional documentation which is required for claims adjudication. This new methodology involves submission of the PWK segment (paperwork) in the ASC X12 837 claim to indicate "unsolicited" claim-related documentation is forthcoming.

50.10.2 - PWK Workflow

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The PWK segment is the "electronic staple" which connects paper documentation to an electronic claim. Claims are submitted electronically with the PWK segment populated. The additional documentation is then submitted to the A/B MACs, DME MACs or CEDI at the same time or within close proximity of the electronic claim. If needed, the A/B MACs, DME MACs or CEDI will use the additional documentation in their adjudication of the claim. If the claim does not require additional documentation, the claim will be adjudicated without reviewing the additional documentation. If the additional documentation is not received or provides no value, the claim will be handled as it normally would have if the PWK data not been submitted.

50.10.2.1 - Provider Responsibility

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Providers that wish to utilize the PWK process to submit their additional documentation will be required to use a specially designed cover sheet which will be provided to them by their servicing A/B MACs, or DME MACs. Contact your servicing A/B MACs or DME MACs for details on how/where to obtain the cover sheet. These cover sheets will be required to be completely and accurately filled out or they will be manually returned. It is important to note that the A/B MACs or DME MACs is not required to return your additional documentation along with the cover sheet. In the instance where the coversheet is returned due to inaccurate or incomplete information, the claim will be adjudicated according to the normal CMS business policies and procedures without regard for the additional documentation received.

When submitting an electronic claim, the submitter must indicate in the body of the electronic claim their intention to submit additional documentation (at the claim level, line level, or both) along with their claim. This is done by indicating the following in the electronic claim: the PWK elements PWK01 (attachment type), PWK02 (transmission method), PWK05 (the value AC), and PWK06 (a 1-50 byte attachment control number [ACN] of the provider/claim submitter's choosing). PWK data submitted at the claim level will apply to the whole claim, unless overridden at the detail line level. Line level PWK data will only apply to that particular detail line of the claim. Electronic claims submitted with an improperly formatted PWK segment will be rejected back to the submitter via either an ASC X12 277CA claim acknowledgment or an ASC X12 999 implementation acknowledgment depending on the nature and location of the error. Although the ASC X12 837 claim transaction allows for up to 10 iterations of the PWK at both the claim and line level, only the first iteration of the PWK segment will be utilized for claim adjudication. Additional iterations of the PWK segment beyond one will be stored by the claims processing contractor to which the claim was submitted.

Once the electronic claim has been submitted with the PWK, provider/claim submitters are expected to submit their additional documentation as soon as possible. Providers will be required to either fax or mail their additional documentation to the A/B MACs or DME MACs. The only exception will be for those A/B MACs or DME MACs which are part of an approved CMS electronic attachment pilot. In that case, your A/B MACs or DME MACs will notify you of other acceptable methods for submitting your additional documentation. As a rule, the provider/claim submitter is required to provide the additional documentation within 7 calendar days, if utilizing fax, or within 10 calendar days, if utilizing mail. After the 7/10 day waiting period expires, the claim will be adjudicated according to the normal CMS business procedures and policies in place at the time. Documentation submitted late will not be considered for adjudication but will be imaged and sent off for storage as per normal CMS correspondence retention requirements.

50.10.2.2 - Contractor Responsibility

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and DME MACs will be required to establish dedicated fax lines and Post Office boxes for provider/claim submitters to utilize for providing the additional documentation. A/B MACs and DME MACs will provide the education and outreach support to provider/claim submitters on how to utilize the PWK process.

The A/B MACs and DME MACs shall provide the coversheet to the provider/claim submitter in whatever manner they feel provides the most effective and efficient method for providing the cover sheet. If the coversheet is not completely and accurately filled out, the A/B MACs and DME MACs shall return the coversheet to its originator. A/B MACs and DME MACs shall indicate that the cover sheet is being returned for incomplete/inaccurate completion and the documentation is not being taken into consideration for the purpose of claims adjudication. The A/B MACs and DME MACs are free to choose the method of returning the cover sheet which they feel best suits their business operation. It is important to note that the A/B MACs and DME MACs are not required to return the additional documentation along with the cover sheet. The A/B MACs and DME MACs are to follow their current correspondence retention requirements and processes regarding the controlling and storage of the additional documentation (whether the documentation is utilized for claims processing assessment or not). If the provider/claim submitter cannot be identified by the A/B MACs and DME MACs thus making it impossible to return the cover sheet, the documentation will be imaged and sent off for storage as per normal CMS correspondence retention requirements. Documentation submitted late will not be considered for adjudication but will be imaged and sent off for storage as per normal CMS correspondence retention requirements.

Additional documentation received by A/B MACs and DME MACs via the PWK process will be imaged and made available for view and/or retrieval by claims examiners/medical review staff. A/B MACs and DME MACs staff adjudicating claims will only review PWK data when the claim encounters an edit/audit requiring additional documentation. The presence of the PWK indicator within the shared system will alert contractor staff that there is additional documentation which potentially may be used to adjudicate the claim. It is important to note that the simple presence of the PWK on a claim will not cause the claim to suspend.

When A/B MACs and DME MACs staff encounters an edit or an audit within the shared system that could be affected by additional documentation, they will first look to see if a PWK was submitted on the claim. If there is a PWK present, they will retrieve the appropriate additional documentation from their imaging system and review it. If the additional documentation contains the needed information, the A/B MACs and DME MACs will adjudicate the claim accordingly and flag the claim as dirty. If the additional documentation does not contain the needed information, the claim will then be handled according to the normal CMS business procedures and policies in place at the time. Regardless of whether or not the PWK additional documentation is utilized in adjudicating the claim, the waiting days will not count against the contractor's claims processing timeliness (CPT).

60 - EDI Edit Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

60.1 - A/B MACs, and CEDI Edit Requirements

(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

TCEDI, where designated by CMS, may perform centralized front-end editing, validation, rejection processing, and transaction intake services prior to shared system processing.
CEDI *is* required to edit submitted transactions at the front end to determine whether they are sufficiently complete to enable processing. Transactions that are not legible, or do not include adequate data to be considered an acceptable EDI transaction, must be rejected or returned as unprocessable. "Rejected" or "returned" transactions are not classified as "received" by Medicare.

A/B MACs and CEDI are not required to assign a control number or a receipt date to those transactions rejected or returned as unprocessable. Nor are they required to retain any record of those transactions pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

CEDI is required to assign a control number and a receipt date to those claims transactions accepted by CEDI. They are required to retain any record of those originally submitted transaction pending correction and resubmission by the original sender. See § 50 and § 70 of this chapter for further editing and testing requirements.

A. Translation and Date of Receipt Editing

If a 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 (A/B MACs and CEDI) by the shared system with an appropriate error message.

The date of receipt of a claim is the date a claim is received by the A/B MACs and CEDI and not a subsequent date on which the claim may have been received by the shared system. The date of receipt must be an actual calendar date and may not be all zeroes or a future date. See § 80.2.1 of Chapter 1 of this manual for additional information on establishing the date of receipt of a claim.

B. Implementation Guide (IG) Edits: ASC X12 Version 5010 and NCPDP Version D.0

In conjunction with front-end translation, A/B MACs (A)are to also conduct IG edits to identify submitted data elements that do not comply with data element requirements added by the IG developers, using either software available from FISS or other software which is able to edit at this level. A/B MAC (B) shared systems conduct IG edits for

transactions sent to the A/B MACs (B). CEDI conducts IG edits for transactions sent to the DME MACs.

In many cases, IG edits are more restrictive than those established by the ASC X12 standard that served as the platform for development of the TR3. For instance, the ASC X12 standard might allow a maximum of 30-digits in a data element, but an IG note could limit the maximum size to 20-digits. Or the number of valid digits that may be entered in a data element as identified by the qualifiers that apply to the data element, might not permit reporting of more than 15-digits even though the standard permits up to 30-digits.

No national standards have been adopted under HIPAA for acknowledgment or error reporting for any of the HIPAA format transactions. However, Medicare has adopted the ASC X12 999 implementation acknowledgment and ASC X12 277CA claim acknowledgment for this purpose effective with the implementation of version 5010. For Version 5010 DME MACs will continue the use of proprietary error reporting for CMN rejection reports, which are returned to DME submitters through CEDI. IG and Medicare program error reports related to electronic transactions must be sent to the submitters of those transactions electronically. IG level edits typically affect a small number of the transactions in a batch. Whenever not precluded by the standard, A/B MACs and CEDI are expected to reject individual transactions that are identified via IG edits and not reject the entire batch of transactions in which those transactions were submitted.

A/B MACs (A) share IG editing responsibilities with FISS (shared system documentation indicates which IG edits are conducted by the shared system). A/B MACs (B) shared systems are responsible for IG editing of Part B professional transactions. CEDI is responsible for IG editing of DME transactions. When editing for IG compliance, the responsible party must verify that:

- Amounts, percentages, integers, and other fields designated in the IG as numeric are right-justified and zero-filled if the incoming data are smaller than the Medicare flat file field size;

- Fields designated in the IG as alphanumeric are left justified and space filled if the incoming data are smaller than the Medicare flat file field size;

- All non-Medicare data field lengths correspond to the maximum IG length.

- Incoming alphanumeric non-Medicare data are left justified and space filled if the data are smaller than the Medicare flat file field size;

- Incoming numeric non-Medicare data are right justified and zero-filled if the data contain fewer integers than the Medicare flat file field size; and

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are mapped to the Medicare flat file (and later written to the store-and-forward repository (SFR) by the shared system).

60.2 - Key Shop and Optical Character Recognition
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

60.2.1 - Claim Key Shop and Optical Character Recognition (OCR)/Image Character Recognition (ICR) Mapping to ASC X12 Based Flat File
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MAC and DME MAC key shop operations, that do not output directly in the ASC X12 837 claim or ASC X12-based flat file as output, must convert the initial output from paper claims to the ASC X12-based flat file format or the ASC X12 837 claim prior to transmission to their data center. When the ASC X12-based flat file is the output the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (key shop) or "O" (OCR/ICR).

A/B MACs (B) and DME MACs who support telephone claim submission shall convert the output to the ASC X12-based flat file. The value in REF02 shall contain a "T" (teleclaim).

The DME MAC shared system shall apply implementation guide edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

60.2.2 - Key Shop and Image Processing
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Key shop, imaging, and contractor in-house data entry operations that do not output directly in the ASC X12 837 claim or ASC X12-based flat file format, must convert their initial output format into the ASC X12-based flat file or the ASC X12 837 claim format prior to transmission to their data center. When the ASC X12-based flat file is the output, the REF01 segment/element (found prior to the ST segment) shall contain a value of "+PR" and REF02 shall contain a value of "K" (external key shop or in-house data entry) or "O" (OCR/ICR).

Shared systems shall apply IG edits only to those requirements that are applicable to both the HIPAA and the corresponding fields on the paper claim. Implementation guide edits that are inappropriate for paper claims shall be by-passed.

An outbound ASC X12 837 claim COB transaction built from a paper claim will be produced as a "skinny" COB. Gap filling must occur as needed to enable the file sent to the trading partner to meet minimum data set requirements for a compliant ASC X12 837

claim COB transaction. "Skinny" COBs shall contain all required ASC X12 837 claim segments and include post-adjudicated data.

60.3 - COB Trading Partner and Contractor Crossover Claim Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Through the Coordination of Benefits Contractor (COBC), Medicare transmits outbound ASC X12 837 claim Coordination of Benefit (COB) and Medigap claims to COB trading partners and Medigap plans, collectively termed "trading partners," on a post-adjudicative basis. This type of transaction, originating at individual Medicare contractors following their claims adjudication activities, includes incoming claim data, as modified during adjudication if applicable, as well as payment data. All Medicare contractors are required to accept all ASC X12 837 claim segments and data elements permitted by the in- force applicable guides on an initial ASC X12 837 claim professional or institutional claim from a provider, but they are not required to use every segment or data element for Medicare adjudication. Segments and data elements determined to be extraneous for Medicare claims adjudication shall, however, be retained by the Medicare contractor within its store-and-forward repository (SFR). Incoming claims data shall be subjected to standard syntax and applicable TR3 edits prior to being deposited in the SFR to assure non-compliant data will not be forwarded on to another payer as part of the Medicare crossover process. SFR data shall be re-associated with those data elements used in Medicare claim adjudication, as well as with payment data, to create an ASC X12 837 claim IG-compliant outbound COB/Medigap transaction. The shared systems shall always retain the data in the SFR for a minimum of 6 months.

(See IOM Pub 100-04, Chapter 28 Sections §70.6 and 70.6.5 for ASC X12 COB requirements and §70.6.6 for NCPDP D.0 COB requirements.)

60.4 - Remittance Advice and Standard Paper Remittances

(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Remittance advice records shall be provided to explain claim adjudication decisions, including for NCPDP format claims. A/B MACs and CEDI shall send the Electronic Remittance Advice (ERA) in the ASC X12 835 remittance advice format. Or the A/B MACs and DME MACs shall send the remittance as a Standard Paper Remittance (SPR) Advice. HIPAA version implementation guides are available from the official Washington Publishing Company website. See Chapter 22 of this manual for further remittance advice information.

60.5 - Payments

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

60.5.1 - Payment Floor Requirement

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and DME MACs 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.

60.5.2 - Alternative to EFT

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

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

60.5.3 - Electronic Funds Transfer (EFT)

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

EFT is the required method of Medicare payment for all providers entering the Medicare program for the first time and for existing providers that are submitting a change to their existing enrollment data but are not currently receiving payments via EFT.

Once a provider begins to receive Medicare payments via EFT, the A/B MAC or DME MAC shall not issue any routine, ongoing payments to the provider via check. (For purposes of this instruction, the term "routine, ongoing payments" means those payments that are not considered to be "special payments," as that latter term is used in section 4 of the CMS-855 application.) This means, therefore, that - with the exception of special payments - a provider that receives payments via EFT must continue to receive payments via EFT and cannot switch back to receiving paper checks, even in cases of a MAC transition or other CMS-initiated action. A/B MACs and DME MACs shall not approve any requests to change the provider's payment method from EFT to check.

Note that the A/B MAC or DME MAC shall abide by the instructions in Pub. 100-08, chapter 10, sections 4.4 and 8 on all provider enrollment issues relating to EFT. This includes the requirement that A/B MACs and DME MACs compare the information and signature on the provider's Form-CMS-588 (Electronic Funds Transfer Authorization Agreement), to that on the provider's CMS-855 form on file. For changes of information, DME MACs shall verify the authorized official on the CMS 855.

An A/B MAC or DME MAC shall use a transmission format that is both economical and compatible with the servicing bank. If the money is traveling separately from an ASC X12 835 remittance advice transaction, then A/B MACs and DME MACs shall use National Automated Clearinghouse Association (NACHA) format CCP (Cash Concentration/Disbursement plus Addenda -CCD+) to make sure that the addenda record is sent with the EFT. Providers need the addenda record to re-associate dollars with data. A/B MACs and DME MACs shall transmit the EFT authorization to the originating bank upon the expiration of the payment floor applicable to the claim. They shall 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.

For more information on EFT see IOM Pub 100-08 Chapter 10.

60.5.4 - Tri-Partite Bank Agreement
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A/B MACs and DME MACs 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. 100-06, Chapter 5.

60.6 - Health Care Provider Taxonomy Code (HPTC) Requirements
(Rev. 10236, Issued: 07-31-2020, Effective: 08-31-2020, Implementation: 08-31-2020)

Health Care Provider Taxonomy Codes (HPTC) are also called Specialty Codes. HPTCs are 9-digit identifiers assigned by the National Uniform Claim Committee (NUCC) to be used in HIPAA transactions.

Contractors are required to validate the incoming HPTC against the most recent taxonomy code list. CMS will notify A/B MACs, their shared system maintainers, and CEDI (via Recurring Update Notification) to load the most recent HPTC code list into a contractor-controlled table. HPTCs may not be hard coded by the shared system maintainers. Contractor-controlled tables minimize the impact of future system updates.

HPTCs are updated twice a year (tentatively October and April) by the NUCC and the updates are available for download in a portable document format (PDF) from the official Washington Publishing Company (WPC) website 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. Contractors are to use the most cost effective means to obtain the list for validation programming and updating purposes.

70 - CMS Defined File Formats
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

70.1 - General HIPAA EDI Requirements
(Rev. 13954; Issued: 09-29-26; Effective: 10-30-26; Implementation: 10-30-26)

As described in section 40.1.1, the A/B MACs, DME MACs and CEDI shall support the current versions adopted under HIPAA of the following transactions and their implementation guides for the electronic exchange of data with Medicare providers/submitters/receivers/COB trading partners. *TCEDI, where designated by CMS, shall support CMS-approved HIPAA-compliant EDI transaction processing, routing, validation, acknowledgment, and flat-file transformation services.* Electronic

transactions that do not fully comply with the implementation guide requirements for these formats will be rejected.

- ASC X12 837 claim, institutional, professional and dental
- NCPDP telecommunication and equivalent batch standard for retail prescription drug claims (applicable for CEDI and DME MACs only) and COB (see § 40.1 of this chapter for additional information);
- ASC X12 835 remittance advice (see chapter 22 for additional information); and
- ASC X12 276/277 claim status request and response (see chapter 31 for additional information).

Links to sources of implementation guides for these standards are available at

- www.cms.hhs.gov/ElectronicBillingEDITrans

Although not mandated by HIPAA, as noted in § 40.1.2, CMS also requires that A/B MACs and CEDI issue an ASC X12 999 implementation acknowledgment transaction to electronic claim submitters to acknowledge receipt of claims (except where waived by a submitter) and to report syntax errors related to any ASC X12 transactions submitted to Medicare.
See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing Medicare claim remittance advice print software updates information to providers via the Internet and alternate methods to be used to furnish information to those providers that lack Internet access.
An overview of any changes to existing specifications, including effective dates will be issued to providers via A/B MACs and CEDI bulletins, on contractor Web pages, and will also be available via the Internet as Manual transmittals which can be viewed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp to the separate page for each EDI transaction format supported by Medicare fee-for-service plans.

70.2 - National Council for Prescription Drug Program (NCPDP) Claim Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

A. NCPDP Batch Transaction

The NCPDP batch transaction format is intended to provide a file transmission standard for submission in a non-real-time mode of the telecommunications standard transaction for drug claims from retail pharmacies. CEDI will not accept retail pharmacy drug claims that are not submitted as batch transactions.

NCPDP users are required to transmit National Drug Codes (NDCs) in the NCPDP standard for identification of prescription drugs dispensed through a retail pharmacy.

NDCs replace the drug HCPCS codes for retail pharmacy drug transactions submitted to CEDI and delivered to the DME MACs via the NCPDP standard. The DME MAC shared system (VMS) will convert NDCs to HCPCS codes for internal claim processing. The CMS will provide the HCPCS codes for these drugs and an NDC to HCPCS crosswalk for use by VMS and the DME MACs.

B. Generating a Batch NCPDP Response

CEDI will return the NCPDP batch response for all NCPDP transmissions received. The NCPDP term "transaction" is equivalent to a Medicare service or line item and the NCPDP term "transmission" is equivalent to a Medicare claim. The NCPDP implementation guide allows for up to 4 transactions (line items) per transmission (claim). This means that each claim can have up to 4 line items. Therefore, if one transaction (line item) rejects, the entire transmission (claim) will be returned. All transactions (up to 4) in the transmission will be treated as one claim, and each transmission in a batch will be treated as a separate claim. For a transmission (claim) where one or more claim transactions (lines) have errors, the following will occur:

1. CEDI will reject all claim transactions (line items) in the transmission (claim) if any one claim (transmission) has detail errors.

2. The response status for all transactions will equal R (rejected).

3. CEDI will send up to 5 reject codes for claim transactions (line items) that have detail errors.

4. No transaction level reject code will be reflected for the line item with no error. Instead, the 504-F4 response message field at the header level is being used to denote acceptance or rejection of the entire claim.

C. NCPDP Implementation Guide (IG) Edits

CEDI shall allow segments to be submitted in any order including AM07, AM03 and AM11 as permitted by the NCPDP standard. CEDI must create the NCPDP flat file segments in numeric order for receipt by the DME MACs shared system maintainer.

D. Misdirected Claims

With the implementation of CEDI, there are no longer "mis-directed" claims. CEDI receives all DME ASC X12 and NCPDP claims, performs all front end editing and translation. Claims accepted by CEDI are assigned the Claim Control Number and delivered to the appropriate DME MAC based on the beneficiary state code submitted on the claim.

80 - Electronic Data Interchange (EDI) Reporting Requirements

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Contractors are required to participate in the following EDI reporting efforts as appropriate for their line of business. Each reporting effort has its own defined content and reporting frequency.

80.1 – Contractor Monthly Status Reporting

(Rev. 10319, Issued: 08-28-2020, Effective: 09-29-2020, Implementation: 09-29-2020)

The CMS Data Exchange (MDX) portal is a system that provides CMS automated capabilities for monitoring and analyzing data relating to the Medicare contractors' on-going operational activities. A/B MACs are required to input their Electronic Data Interchange (EDI) workload statistics into MDX using the Monthly Status Report in Excel (MSRE) format. Contractors must prepare and submit to CMS the Medicare MSRE showing their EDI and manual transactions workload under the health insurance program. A separate report is required for each office assigned a separate contractor number.

The MSRE EDI claims processing data for PART A, Part B, and Home Health/Hospice (HHH) includes:

- ACCEPTED CLAIM STATUS REQUESTS (276 -Electronic)
- RESPONSES TO CLAIMS STATUS INQUIRIES (277- Electronic)
- REMITTANCE ADVICES - NUMBER SENT (5010) - 835/ERA
- REMITTANCE ADVICES - NUMBER SENT (5010) - SPR
- REMITTANCE ADVICES - NUMBER SENT (5010) - Internet/Portal
- NUMBER OF PAYMENTS TO PROVIDERS OR SUPPLIERS - EFT
- NUMBER OF PAYMENTS TO PROVIDERS OR SUPPLIERS - Paper Checks
- DOLLAR AMOUNTS ASSOCIATED W/PAYMENTS (5010) - EFT
- DOLLAR AMOUNTS ASSOCIATED W/PAYMENTS (5010) - Paper Checks
- ELECTRONIC CLAIMS PROCESSED (5010)- Electronic
- ELECTRONIC CLAIMS PROCESSED (5010)- DDE
- DDE CLAIM ADJUSTMENTS REC'D - DDE
- DDE CLAIM STATUS RESPONSES - DDE
- PAPER CLAIMS PROCESSED
- NCPDP RETAIL PHARMACY DRUG CLAIMS

Contractors shall reference Change Request (CR)10870 (Transmittal R21390TN, 9/17/18) for details on MDX reporting.

80.2 - Combined Common Edits/Enhancement Module (CCEM) Reporting

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

A/B MACs are required to support a vigorous reporting system which will provide a full range of routine and ad hoc workload reports and operational reports regarding Electronic

Data Interchange (EDI) activities. The types of reports which are required include but are not limited to daily EDI workload statistics, edit exceptions, receipt-control-balancing, provider and submitter transaction version utilization data, transmission and receipt problems, etc.

A/B MACs will utilize the reporting functionality in the CCEM to provide CMS with their EDI operational reports.

80.3 - Common Electronic Data Interchange (CEDI) Reporting
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

CEDI is required to support a vigorous reporting system which will provide a full range of routine and ad hoc workload reports and operational reports regarding Electronic Data Interchange (EDI) activities. The types of reports which are required include but are not limited to daily EDI workload statistics, edit exceptions, receipt-control-balancing, provider and submitter transaction version utilization data, transmission and receipt problems, etc.

DME MACs will utilize the reporting functionality in the CEDI to provide CMS with their EDI operational reports.

80.4 - HIPAA Transition Reporting
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

As new HIPAA versions are named, contractors are required to report their implementation progress to CMS via transition reporting. Data collection will be achieved via an external, secure web-based reporting tool designed to support long term, short term, and ad-hoc data gathering efforts, such as Electronic Data Interchange statistics and performance metrics.

The contractor shall obtain access to the web-based reporting tool via self enrollment contingent on CMS approval. Current reports vary in frequency from weekly to monthly; however, any future efforts will reflect the most appropriate time period. Contractors will always be notified via Technical Direction Letter (TDL) on the required starting date of any transition reporting, the content of the transition data, and the frequency of the reporting effort.

Contractors will utilize the reporting functionality in their front end systems, in CEM, in the Shared System Maintainer, and/or in CEDI to provide CMS with their EDI HIPAA transition reports.

80.5 - Administrative Simplification and Compliance Act (ASCA) Reporting
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Contractors are required to report the status of their ASCA enforcement activities on a monthly basis. ASCA enforcement data will be submitted via an external, secure web-based reporting tool.

The contractor shall obtain access to the web-based reporting tool via self enrollment contingent on CMS approval. Contractors will always be notified via Technical Direction Letter (TDL) of any changes in the reporting requirements of the ASCA enforcement reporting, the content of the ASCA enforcement data, and the frequency of the ASCA enforcement reporting effort.

Contractors shall reference Pub 100-04, Chapter 24, Section 90 for the complete details and requirements on ASCA enforcement.

90 - Mandatory Electronic Submission of Medicare Claims

(Rev. 3491, Issued: 04-05-16, Effective: 07-01-16, Implementation: 07-05-16)

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105, 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 A/B MAC or DME MAC for the first time, including resubmitted previously rejected claims, claims with paper attachments, demand bills, claims where Medicare is the secondary payer, and non-payment claims. Initial claims do not include adjustments or claim corrections submitted A/B MAC or DME MAC on previously submitted claims or appeal requests.

Medicare is prohibited from payment of claims submitted in a non-electronic manner that do not meet the limited exception criteria. 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 (see section 70 of this chapter). The mandatory electronic claim submission requirement does not apply to claims submitted by beneficiaries or by providers that only furnish services outside of the United States, claims submitted to Medicare managed care plans, to health plans other than Medicare, or for purchased only Expatriate beneficiary Durable Medical Equipment Prosthetics Orthotics Supplies (DMEPOS) claims.

90.1 - Small Providers and Full-Time Equivalent Employee Self-Assessments

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

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 considers all providers that have fewer than 25 FTEs and that are required to bill a Medicare A/B MAC (A)to be small; and

considers all physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a A/B MAC (B) or DME MAC 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 who 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 (National Provider Identifier (NPI)) 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 may bill A/B MACs or DME MACs. 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. For FTE calculation purposes, it is acceptable to include only those staff members 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.

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.

In the event that a provider uses a clearinghouse or a billing agent to submit claims, it is the number of FTEs on the provider's staff, not those on the staff of the billing agent or the clearinghouse, that determine whether the provider may be considered small for Medicare paper claim submission purposes.

90.2 - Exceptions

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

It has been determined that due to limitations in the claims transaction formats adopted for national use under HIPAA, it would not be possible in some cases 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 for self-assessment purposes:

1. Roster billing of inoculations 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, some suppliers have been permitted to submit a single claim on paper with the basic provider and service data and to attach a list of the Medicare beneficiaries to whom the vaccine was administered and related identification information for those beneficiaries. This is referred to as roster billing. The claim IGs adopted under HIPAA provide for submission of single claims to a payer for single individuals, but cannot be used to submit a roster bill for multiple individuals.

   Flu and pneumonia inoculations 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, particularly when a single individual is responsible for collection of the data and administration of the inoculations. 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 inoculation 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 except in the case of multi-state companies that signed an agreement with a single Medicare contractor for submission of all flu shots to that single contractor for those states, and who agreed to submit those claims electronically as a condition for centralized billing of those inoculations. 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 inoculations.

   This inoculation waiver applies only to injections such as flu shots frequently furnished in non-traditional medical situations, and does not apply to injections including flu shots when furnished in a traditional medical setting such as a doctor's office or an outpatient clinic as a component of other medical care or an

examination. In traditional medical situations where the provider is required to bill the other services furnished to the patient electronically, a flu shot or other inoculation 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) 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 must continue to be submitted electronically, unless another exception or waiver condition applies to the provider.

3. "Obligated to Accept as Payment in Full" (OTAF) Medicare Secondary Payer (MSP) Claims when There is More than One Primary Payer- An OTAF adjustment (also see the Medicare Secondary Payment Manual) is made when a provider, physician or supplier agrees as result of negotiation or otherwise to receive a payment rate that is higher or lower than a payer's normal allowed amount as payment in full for particular services or supplies. By regulation, if a primary payer's OTAF amount is lower than the charge for the related service that appears on the claim, Medicare must include the OTAF adjustment when calculating the amount of Medicare's secondary payment.

The OTAF is identified in the CAS Segment with the Group Code of "CO". The CO is used both on the ASC X12 835 remittance and the ASC X12 837 claim.

4. MSP Claims When There is More than One Primary Payer and More Than One Allowed Amount-In an MSP situation, Medicare needs to use a primary payer's allowed and paid amounts to calculate the supplemental amount that can be paid by Medicare. In some cases, a beneficiary is covered by more than one other primary payer. Each of those other payers must complete adjudication before Medicare can process those claims. The ASC X12 837 current HIPAA version IGs permit reporting of payment information from more than one other payer, but not for reporting of separate allowed amounts at the line or claim level for more than one payer. As result of this limitation, when there is more than one primary payer, and the allowed amounts differ, a provider is permitted to submit the claim to Medicare on paper, with the RA/EOB from each of the primary payers attached.

Except for OTAF claims when there is also more than one primary payer, or if a provider is small or meets one of the temporary exception criteria, such as disruption of electricity or communications, no other types of MSP claims, such as MSP claims when there is only one primary payer, may be submitted to Medicare on paper. Claims submitted by Medicare beneficiaries.

90.3 - "Unusual Circumstance" Waivers

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Congress granted the Secretary considerable discretion to decide what other circumstances should qualify as "unusual circumstances" for which a partial (applies to certain claim types or for a defined period of time) or full 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 A/B MACs or DME MACs 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 A/B MACs or DME MACs to whom they submit their claims. The A/B MACs or DME MACs 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 apply, that provider is again subject to the Medicare electronic claim submission requirement. Likewise, some exception and waiver criteria apply to only a specific type of claim, such as an OTAF secondary claim when there is more than one primary payer for only the current HIPAA version. 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 exception or unusual circumstance criteria.

90.3.1 - Unusual Circumstance Waivers Subject to Provider Self-Assessment

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

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 for either the indicated claim type or the period when an "unusual situation" exists. A provider is to self-assess when one of these circumstances applies, rather than apply for contractor or CMS waiver approval. A provider may submit claims to Medicare on paper or via other non-electronic means when one of these circumstances applies. A provider is not expected to pre-notify their A/B MACs or DME MACs that one of the circumstances applies as a condition of submission of non-electronic claims.

- Dental claims- Effective January 1, 2023, CMS clarified that Medicare may cover certain dental services under its medical benefits (see § 411.15(i)(2) and (3)). For example, Medicare pays for services furnished by dentists to treat certain injuries of the mouth, but those services furnished to treat the injury are covered as medical benefits. The ASC X12 837 professional claim TR3 standard for submission of medical claims requires submission of certain data not traditionally reported in a dental claim but which is needed by payers to adjudicate medical claims. As a result, Medicare contractors have implemented the ASC X12 837 dental claim standard adopted for national use under HIPAA effective July 1, 2024. However, due to the small number of claims that dentists would send to Medicare, dentists will not be required to submit claims to Medicare electronically.

- 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.

- 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 process able by the MSPPay module and must be manually adjudicated by Medicare contractors.

90.3.2 - Unusual Circumstance Waivers Subject to a Contractor Evaluation for CMS Decision

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

A provider may submit a waiver request to their A/B or Durable Medical Equipment Medicare Administrative Contractors (A/B or DME MACs) claiming other types of "unusual circumstances" outside of their control prevent submission of electronic claims. It is the responsibility of the provider to submit appropriate documentation including request application with Provider name, address, email, and phone number to establish the validity of a waiver request in this situation. Requests received without documentation and as above stated information 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 A/B MAC or, DME MAC agrees that the waiver request has merit, the request must be forwarded Centers for Medicare and Medicaid Services, Office of Information Technology, Applications Management Group, to the Division of Shared Systems Management (CMS/OIT/AMG/DSSM) Email box (ASCAwaiverRequest@cms.hhs.gov) for Review and issuance of the CMS decision. The contractor must forward an explanation letter as to why the contractor (MAC) recommends CMS approval to DSSM with the waiver request. The contractor will be copied on the decision notice DSSM issues to the requestor.

If the contractor does not consider an "unusual circumstance" to be met, and does not recommend DSSM 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 (whether 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.

"Unusual Circumstances" that Require CMS Review:

1. Provider alleges that the claim transaction implementation guides adopted under HIPAA do not support electronic submission of all data required for claim adjudication. (If a waiver is approved in this case, it will apply only to the specific claim type(s) affected by the IG deficiency.)

    NOTE: A Medicare contractor is not permitted to prohibit submission of an electronic claim because there is a paper attachment. The ASC X12 837 claim Technical Review 3 (TR3) contains information for provider use of the PWK segment to alert a Medicare contractor that attachment information is being separately submitted. Some Medicare contractors had issued instructions regarding use of the ASC X12 837-claim NTE segment to report attachment information in lieu of PWK. Submitters of claims for which there are attachments essential for adjudication must comply with the ASC X12 attachment reporting direction issued by their Medicare contractor for the

immediate future. System changes will be made for contractor use of PWK in conjunction with implementation of the attachment standard, which is scheduled for future adoption as a HIPAA standard. NCPDP claims should not have attachments.

MACs are required to accept claims electronically for reassociation with attachments submitted separately on paper or via other means such as fax when supported by individual contractors. MACs must include the process for submission of claims when there are attachments in a newsletter article and on their Web site with other applicable information concerning the ASCA requirement that Medicare claims be submitted electronically.

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. In this case, the documentation that establishes the disability of those staff members would need to be issued by providers other than the provider requesting the waiver and would need to be submitted for review.

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. The provider must submit a waiver request with appropriate documentation to their A/B MAC or DME MAC for evaluation by that contractor, and if approved at that level, for subsequent review by CMS. In the event other situations are identified and approved by CMS for which a requirement for electronic filing would always be considered against equity and good conscience, those situations will be added to the self-assessment list.

90.4 - Electronic and Paper Claims Implications of Mandatory Electronic Submission

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Claims providers submit via a DDE screen maintained by a Medicare shared system or transmitted to an A/B MAC or DME MAC 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 may have been temporarily unable to accommodate submission of a secondary or other particular type of claim.

A/B MACs and DME MACs are prohibited from requiring submission of paper claims in any situations on or after October 16, 2003, except as specifically permitted by CMS.

A/B MACs and DME MACs 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.

90.5 - Enforcement
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

See §§90.7-90.7.6 for additional requirements specific to the Railroad Retirement Board Specialty MAC (SMAC).

90.5.1 - FISS Role in ASCA Enforcement
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Enforcement will be conducted on a post-payment basis during those periods when directed by CMS. FISS will prepare quarterly reports for the A/B MACs (A) and (HHH) for those periods as directed by CMS that list each provider's name, provider number, address, number of paper claims received under each provider number, percentage of paper claims to total claims for each provider, and the period being reported, e.g., claims processed July 1, 2005 - September 30, 2005. The data in the reports must be arrayed in descending order with those providers receiving the highest number of paper claims at the beginning of the report. These reports must be available by the end of the month following completion of a calendar quarter, e.g., on October 31 for July 1-September 30.

90.5.2 - MCS & VMS Roles in ASCA Enforcement
(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

As result of the substantially higher number of paper claims sent to DME MACs and A/B MACs (B) than to A/B MACs (A) or (HHH), somewhat different ASCA quarterly report requirements are being applied for the A/B MACs (B) and DME MACs quarterly reports. MCS and VMS will prepare an online (printable at the contractor's discretion) report each calendar quarter (October-December, January-March, April-June and July-September) for each A/B MAC (B) and DME MAC as applicable. Each report must identify the months and year for which the data is being reported. The report must be available for contractor use by the end of the month that follows completion of a calendar quarter, e.g., by October 31 for July 1-September 30.

The following fields are in the provider file to assist with preparation of these reports, A/B MACs (B) and DME MACs tracking of report history, and selection of providers for ASCA Enforcement Reviews:

1. Date (CCYYMMDD) most recent ASCA enforcement review began (shared system will populate with the trigger date of the most recent initial review letter, Exhibit letter C or H; see §90.7 for information on RRB SMAC population of this field for letter G);

2. Date (CCYYMMDD) denial of paper claims began or is to begin as provider not eligible to submit paper claims (shared system shall populate with the 91st day

after letter C, G or H is triggered and an ASCA result has not been entered , or a contractor shall reset that date to the date after an approved extension period expires; see §90.5.3.B);

3. Effective date (CCYYMMDD) of provider eligibility to submit paper claims if effective after the date the provider was initially determined to be not eligible to submit paper claims (see §90.5.3.C; contractor must populate using a shared system field established for reporting of this date);

4. Result of the most recently completed ASCA enforcement review. The ASCA review result field is used for contractor entry of a 2-character code to identify the result of an ASCA review. NE-Provider not eligible to submit paper claims (shared system will populate when paper claim denials begin; see §90.7 for exception when this will be populated by the RRB SMAC);

5. When one of the following applies, the later of 1) the date the most recent ASCA enforcement review began or 2) the date this decision was effective if after the date a provider was initially determined not to be eligible to submit paper claims will be considered the effective date of the decision:

   SM--Provider determined to be small based on provider's FTEs (contractors shall populate);

   WA--Provider determined to meet another ASCA exception or waiver condition, including submission of fewer than 10 claims a month on average to Medicare (does not include a § 90.3.3, chapter 24 unusual circumstance; see §90.7.1 for RRB SMAC application of the fewer than 10 claims per month waiver; contractors shall populate); or

   UC--Provider determined eligible for an "unusual circumstance" waiver per §90.3.3 of chapter 24 (contractors shall populate). When UC applies, a 60-byte field must be supplied by the shared system for contractor entry of the specific "unusual circumstance." The shared system must reject a UC entry unless an entry of at least 6 alphanumeric characters is entered in the 60-byte unusual circumstance field.

A. Quarterly MCS and VMS Provider Online ASCA Report

The quarterly ASCA report prepared by MCS or VMS must be in four parts:

Part 1-This Part must contain information on those providers that submitted some claims electronically and others on paper that quarter. Part 1 must indicate the: name; taxpayer identification number (TIN); legacy provider identifier (PIN or NSC number used for payment); the number of paper claims submitted that quarter under that identifier); the number of electronic claims submitted that quarter under that PIN or NSC number; the percentage of those claims that were

on paper; date the provider's most recent ASCA enforcement review began; effective date of the provider's most recent ASCA enforcement review decision; and the result code from that most recent review. The report sent to the RMC must include the ZIP Code of the provider, extended if available. This part must be organized in descending order according to the number of paper claims submitted for each provider that quarter.

If a provider has more than one PIN or NSC number, but claims under all of those identifiers are covered by the same TIN, the listing for the all PINs or NSC numbers issued that provider are to be reported in successive entries in Part 1. MCS and VMS shall report the first entry for that provider in accordance with the descending order rule based on either the total number of paper claims submitted under all of the PINs or NSC numbers or the number of paper claims submitted under the PIN or NSC number with the highest number of paper claims, followed immediately by the separate entries for each of the other PINs/NSC numbers associated with that same TIN. The listings for the other PINs/NSC numbers associated with that TIN are also to be in descending order according to the number of paper claims submitted under each identifier.

Part 2-This Part must contain information on those providers that submit all of their claims on paper and submitted 100 or more claims that quarter. Part 2 must indicate the name; TIN; legacy provider identifier (PIN or NSC number); the number of paper claims submitted for each listed provider that quarter under that identifier; date the provider's most recent ASCA enforcement review began; effective date of the provider's most recent ASCA enforcement review decision; if for the RMC, the ZIP Code (extended if available); and ASCA review result code from that most recent review. This part must be organized in descending order according to the number of paper claims submitted for each provider that quarter.

In the case of a provider that has more than one PIN or NSC number used to bill that quarter which are covered by the same TIN, apply the reporting directions located at the end of Part 1.

Part 3-This Part must contain information on those providers that submitted only paper claims and who submitted fewer than 100 paper claims during that quarter. Part 3 must indicate the name; TIN; legacy provider identifier (PIN or NSC number); the number of claims submitted for each listed provider that quarter; date the provider's most recent ASCA enforcement review began; effective date of the provider's most recent ASCA enforcement review decision; if for the RMC, the ZIP Code (extended if available); and ASCA review result code from that most recent review. This part must be organized in descending order according to the number of paper claims submitted for each provider during that quarter.

In the case of a provider that has more than one PIN or NSC number used to bill that quarter which are covered by the same TIN, apply the reporting directions located at the end of Part 1.

Part 4-The total number of providers for which one or more paper claims were submitted during the quarter. The number in Part 4 is intended to represent the unduplicated total of all providers that could potentially be considered for ASCA Enforcement Review selection.

NOTE: Shared systems have the option to use adjudicated or processed claims, rather than submitted claims, for preparation of the report if that would take less time or resources to prepare. If using adjudicated or processed claims instead of submitted claims, this must be noted in the report.

B. Identification of Providers to Be Reviewed, Letters to be Issued and Determinations Made

A check block or field that can be used to identify those providers being selected for review must appear at the beginning of the data line for each listed provider. The report produced for the RRB SMAC must permit the RRB SMAC to designate whether letter C or H is to be issued. The block or field will be completed by the contractors to identify those providers chosen for ASCA review. When an A/B MAC (B) and DME MAC completes that block/field, the shared system will notify the A/B MAC (B) and DME MACs correspondence system by the next business day to release Exhibit letter C (or H in the case of the RRB SMAC) to that provider and will furnish the start and end date of the quarter on which the review is based (for contractor entry in the paragraph that follows "e" in Exhibit letter C.) The shared system will automatically begin counting days since letter C, G (manually triggered by the RRB SMAC) or H was triggered and will trigger release of letter D 45-days after letter C, G or H (or the first business day after the 45th day when the 45th day is on a weekend or holiday), and will count elapsed days to begin denying paper claims from that provider effective with the 91st day after letter C, G or H was triggered.

The shared system must permit an A/B MAC (B), and DME MAC to cancel the block/field for issuance of letter C or H in the event completed in error, as long as the correction is made on the same business day as the erroneous entry.

90.5.3 - Contractor Roles in ASCA Reviews

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

A. Identification of Those Providers to be Reviewed

Separate funding will no longer be issued for these reviews annually. Each A/B MACs (B) and DME MAC shall conduct an ASCA review annually of 20% of those providers still submitting paper bills.

The following providers will be included in the quarterly report, but contractors are not to select a provider for review that quarter if:

- A prior quarter review is underway and has not yet been completed for that provider (start date of prior review is listed in the report but not yet an enforcement decision effective date);

- The provider has been reviewed within the past two years, determined to be a "small" provider, and there is no reason to expect the provider's "small" status will change for at least two years (provider file past ASCA review result was "SM" and completion date of that review is less than 24 months in the past); or

- Fewer than 30 paper claims were submitted by the provider for the quarter.

When calculating 20% of providers still submitting paper claims, exclude those providers mentioned above who will not be considered for an ASCA review. For example, the A/B MAC (B) or DME MAC receives claims for 3,200 providers but only 2,000 of those submit any paper claims, and 1,800 submit more than 30 paper claims per quarter. 600 of that 1,800 have been reviewed within 2 years of the quarter in which a Medicare contractor is now determining which providers should be reviewed during that quarter and determined to be small. 75 of the paper billers in the quarterly report had reviews begin the prior quarter which are still open. That leaves a balance of 1,125 providers who could be subject to an ASCA review during the current quarter. 1,125 is the total of the universe of providers that are candidates for review during the current quarter and the number of the universe to be reported to CMS in the A/B MACs (B) or DME MACs monthly ASCA report. 20% of 1,125 is 225 and ¼ of 225 is 56 ¼. That contractor is expected to begin at least 56 new ASCA reviews during the current quarter. By the end of the fiscal year (FY), that A/B MAC (B) or DME MAC is expected to have begun ASCA reviews of the average of the provider universe totals for the quarters multiplied by 20%. In this example, if 1,125 providers was the average number of providers considered for ASCA review for the 4 quarters of the FY and the contractor began ASCA reviews of 225 of those providers by the end of the FY, that A/B MAC (B) or DME MAC will have met the 20% target for that FY.

1. A/B MAC (B) and DME MAC **- Specific Selection Requirements**-A/B MACs (B) and DME MACs will determine the best candidates for review from the quarterly report and will complete the block/field to identify the selected providers in the quarterly report and trigger release of Exhibit letter C to those providers. (The A/B MACs (B) and DME MACs must furnish the appropriate URLs for the last paragraph of the letter.) Select candidates as follows:

    a. Two-thirds from Part 1 providers beginning with those that have the largest number of paper claims and issuing letters in descending order; and

b. One third from Part 2 providers also beginning with those that have the largest number of paper claims and issuing letters in descending order.

NOTE: In the case of a provider that submits claims under more than one PIN or NSC number, all of which are under the same TIN, and for which there are multiple entry lines in the quarterly report, the A/B MAC (B) and DME MAC shall combine the number of paper claims submitted under each of those PINs/NSCs when determining which providers to be selected for review. For ASCA evaluation purposes, consider all of those paper claims as submitted by the same provider even though under different PINs or NSCs. Complete the block/field for each of the provider's lines in that case, but apply the same review result for each of the affected PINs/NSCs recorded for that provider. In terms of number of reviews conducted, a review that involves multiple PINs or NSCs for the same provider is to be treated individually and multiple copies of letter C are to be issued.

If an A/B MAC (B) and DME MAC exhausts the Part 1 list and still has additional reviews to conduct in the quarter, the contractor is to increase the number of initial review letters sent to Part 2 providers. If the Part 2 list is also exhausted for the quarter, and the contractor still has additional reviews to initiate, the contractor will begin to send initial review letters to those providers in Part 3 of the shared system quarterly report, again having letters issued in descending order beginning with those providers with the largest numbers of paper claims.

A/B MACs (B) and DME MACs are to complete selection of providers to be reviewed by the end of the second month of each quarter.

B. Conducting the Reviews

If a provider responds to letter C or D (whether triggered by an A/B MAC or DME MAC selection of the provider for review in the quarterly report or direct issuance of the letters by an A/B MAC (A)), but does not establish eligibility to submit paper claims, the A/B MAC (A) shall notify the shared system to begin denying paper claims submitted by that provider beginning on the 91st day after release of letter C and shall issue letter E. The A/B MAC or DME MAC shall enter ASCA review result code NE in the shared system ASCA review result field (see §90.5.2). This will trigger the shared system to have Exhibit letter E released by the contractor's correspondence system.

If a provider's response to letter C or D establishes that the provider is eligible to submit paper claims to Medicare, the A/B MAC (A) shall issue provider letter F, and the A/B MAC or DME MAC shall enter ASCA review result code SM, WA or UC (see §90.5.2 as appropriate in the ASCA review result field). This will trigger MCS or VMS to have letter F released.

A/B MACs or DME MACs have authority to delay imposition of denial of paper claims for up to 30-days if the provider responds to letter C or D and indicates all changes needed to submit their claims electronically cannot be completed by the 90th day after

letter C, but will be completed within 30 additional days. An A/B MAC or DME MAC should approve an extension request of up to 30 days, if the A/B MAC or DME MAC has no reason to suspect the provider may not complete the changes by the specified date.

When an extension is approved, an A/B MAC (A) must reset the effective date of paper claim denials as needed so FISS does not begin to deny paper claims from that provider prior to expiration of the extension period. An A/B MAC or DME MAC must enter the new effective date (CCYYMMDD) when MCS or VMS is to begin denying paper claims in the paper claim denial date field (see §90.5.2) and also enter NE in the ASCA review result screen/field. MCS or VMS will begin to deny the provider's paper claims on the date entered.

If based on prior experience with the provider or knowledge of the extent of the changes the provider must make, the A/B MAC or DME MAC has reason to doubt the ability of the provider to complete the necessary changes by the 120th day, the MAC is to deny a provider's extension request. The A/B MAC (A) shall immediately notify FISS to begin denying paper claims from that provider beginning on the 91st day after issuance of letter C. The A/B MAC or DME MAC shall enter NE in the ASCA review result screen/field; MCS or VMS shall begin to deny that provider's paper claims on the 91st day after letter C was triggered.

The A/B MAC or DME MAC does not have authority to approve more than one 30-day extension during the same review. A/B MACs or DME MACs must contact CMS/OIT/AMG/Division of Shared Systems Management (DSSM) if a contractor representative thinks a provider's request for an extension beyond the 120th day should be approved. If a c A/B MAC or DME MAC does not endorse an extension request beyond the 120th day, the contractor should deny the request. The A/B MAC or DME MAC shall enter NE in the ASCA review result screen/field. If DSSM approval is requested by a contractor and DSSM does approve an extension, A/B MACs or DME MACs are to follow the requirements in the prior paragraph concerning resetting of the effective date for denial of that provider's paper claims.

When A/B MACs or DME MACs finish each provider's ASCA review, the A/B MAC or DME MAC must enter the outcome to the provider file (see §90.5.2), except where identified as shared system responsibility, as well as enter the specific unusual circumstance when result code UC applies.

The group code CO (provider financial liability) is to be used with reason code 96 (non-covered charges), remark code M117 (Not covered unless submitted by electronic claim), and remark code MA44 (No appeal rights). Adjudicative decision based on law for the entire billed amount in the remittance advice sent to the provider for claims when denied as submitted on paper.

If a provider is a candidate for an ASCA enforcement review and the provider is also undergoing a fraud or abuse investigation, the A/B MAC or DME MAC has discretion to exclude that provider from the ASCA enforcement review that quarter if it could interfere

with the fraud/abuse investigation, or alternately, may combine the ASCA review with the fraud/abuse investigation. If an ASCA enforcement review is not conducted due to possible interference, and the provider is subsequently cleared of fraud or abuse, the ASCA enforcement review is to be conducted when that fraud/abuse investigation is completed.

Most types of ASCA exceptions/waivers apply to individual claim types only, or to submission of paper claims for temporary periods. If a provider is selected for ASCA review, and the contractor determines that most of the paper claims submitted for that provider for that period:

1. Were for MSP claims when there is more than one primary payer, or for mass inoculations, or similar types of claims allowed to be submitted on paper; or

2. Were submitted on a temporary basis as result of power and communication disruption resulting from a natural disaster or similar problem outside the control of the provider; **AND**

3. The number of paper claims submitted for the provider during that quarter that did not meet such criteria would not have been high enough to have resulted in selection of that provider for ASCA review in the absence of the excepted/waived claims, the contractor is to terminate that review. **THEN,**

The A/B MAC or DME MAC must enter provider ASCA review result WA (see §90.5.2) to trigger Exhibit letter F, and an A/B MAC (A) must issue letter F.

NOTE: WA or issuance of letter F to a provider that is being waived for a reason other than the number of FTEs employed does not preclude the provider from A/B MAC, or DME MAC selection for review during subsequent quarters.

A/B MACs and DME MACs are not to maintain a provider FTE database, or establish a separate database of waived providers, unless an "unusual situation" waiver decision is made as result of a provider's request for approval of a waiver (see 90.3.2), or as result of an ASCA review and either A/B MACs or DME MACs provider ASCA determination WA or UC (see §90.5.1) applies, or an A/B MACs (A) has issued letter F for other than the small provider exception.

Each A/B MAC or DME MAC will maintain a local Excel spreadsheet of "unusual situation" waivers and requests with column headings for the name, address, legacy and NPI provider number, whether a requested "unusual circumstance" waiver was approved or denied, the effective and termination dates for an approval (if applicable), and the unusual circumstance identified in the request.

A/B MACs and DME MACs must be able to submit this spreadsheet to CMS when requested or could be asked to submit data from the spreadsheet in a report to CMS.

Provider entries in this spreadsheet shall be retained for the same period that A/B MACs and DME MACs are required to retain claims.

C. Post-Review Actions

If following the start of paper claim denials, a provider subsequently submits documentation to establish that they actually had met criteria for submission of paper claims by that 91st day, the A/B MAC or DME MAC must enter SM, WA or UC as appropriate in the shared system ASCA review result field. This will trigger the shared system to have Exhibit letter F issued and will eliminate further paper claim denials for the provider. An A/B MAC (A) must notify FISS to terminate denial of that provider's paper claims. The shared system is not to reprocess any paper claims previously denied as on paper for that provider unless the provider resubmits those claims.

If a provider submits documentation to establish eligibility to submit paper claims but that eligibility is effective after the 91st day, the A/B MAC or DME MAC shall enter the date when the provider actually became eligible to submit paper claims in the appropriate field in the shared system ASCA review result screen (see §90.5.2). There is no corresponding A/B MAC (A) process for this, but it is considered unlikely that this situation would occur with an institutional provider. If a provider resubmits denied claims, services furnished on or after the date of eligibility to submit paper claims may be paid but services furnished after the 90th day through the day before the provider became eligible to submit paper claims may not be paid. They must be denied as furnished during a period for which the provider was required to bill Medicare electronically.

90.5.4 - Submission of Claims that May Always be Submitted on Paper by Providers Not Otherwise Eligible to Submit Paper Claims

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

If a provider determined to be ineligible to submit most types of claims on paper contacts any MAC to complain because a claim that contained services permitted to be submitted on paper (see §90.2) was denied, the MAC is to manually process and pay that claim. These claims will only be paid at the provider's request, assuming all other requirements are met for coverage and payment of that claim or certain services included in that claim. Medicare systems are incapable of identifying and paying certain types of paper claims, or only certain services included in paper claims, when a provider has been determined to be otherwise ineligible for payment of all other paper claims.

90.6 - Provider Education

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Medicare contractors were required to include information on their provider Web site and in a newsletter by April 2004 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 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 criterion applies at the time of submission;

10. Repercussions of submitting paper claims when ineligible for submission of paper claims;

11. Post-payment monitoring to detect providers that submit unusually high numbers of paper claims for further investigation; and

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.

90.7 - Application of Electronic Data Interchange Enrollment Information and ASCA Enforcement Review Decisions from Other Medicare Contractors to the Same Providers When They Bill the Railroad Retirement Board Specialty MAC (RRB SMAC)

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

ASCA did not differentiate among Medicare contractors or between Railroad (RR) and non-RR Medicare for application of the electronic billing requirement. Section 90.3.1 of this chapter indicates that a provider that submits fewer than 10 claims to Medicare per month on average (fewer than 120 claims per year) is permitted to continue to submit

paper claims. As result of the distribution of RR retirees though, it is not unusual for a single provider to only treat a small number of RR Medicare patients and to submit fewer than 10 claims to the RRB SMAC per month. The same providers that treat RR Medicare patients also treat non-RR Medicare beneficiaries however, and in most cases do submit more than 10 claims per month in total to one or more non-RR Medicare contractors. As result, when selecting providers for an ASCA Enforcement Review, the RRB SMAC shall not exclude a provider from consideration for review simply because the quarterly ASCA report indicates the provider submitted fewer than 10 claims to the RRB SMAC. In a departure from the rule as it applies to non-RRB SMAC Medicare contractors, submission of fewer than 10 claims per month to the RRB SMAC does not automatically qualify a provider for waiver of the electronic claims submission requirement.

Providers that submit paper claims to multiple Medicare MACs, including both RR and non-RR MACs, could have an ASCA Enforcement Review conducted by each of those contractors. If a non-RR Medicare MAC determines that a provider does not meet any criteria which would permit that provider to continue to submit Medicare claims on paper and notifies a provider (letter E is triggered) that all paper claims submitted on or after a specific date will be denied, that same decision is to be applied to that provider if submitting paper claims to the RRB SMAC regardless of whether that provider would submit 10 or more paper claims to the RRB SMAC monthly.

Provider enrollment information from non-RR MACs is sent to the RRB SMAC weekly by the MCS maintainer in a Provider Enrollment System file called SuperPES. As a condition for submission of claims to the RRB SMAC, a provider must first enroll for submission of claims to non-RR Medicare. The RRB SMAC uses SuperPES to determine whether any provider that sends them a claim, but that does not have a record in the RR provider enrollment system (PES), is already enrolled in non-RR Medicare. If so, the RRB SMAC then uses the SuperPES information to establish a record for that provider in the RR PES file, or if not, rejects those claims as there is no indication that provider has enrolled in Medicare.

SuperPES is manually searched by RRB SMAC representatives. It would be difficult and possibly impossible to automatically update PES due to the differences in RR and non-RR legacy provider numbers. Addition of NPIs may not appreciably improve the ability to make one to one matches since providers can obtain more than one NPI or fewer NPIs than legacy identifiers. Although supplemental information is submitted on claims that can often be used to match between an NPI and a single legacy identifier, there is not as much supplemental information in the SuperPES and PES files that could be used to help make a match between the files in the absence of a claim.

SuperPES includes fields (see the date and ASCA decision fields in §90.5.2) for the reporting of an ASCA review result, the date of that ASCA decision and the NPI associated with the provider's non-Railroad PIN. "Multi" is entered in that field if more than one NPI is associated with a PIN.

The RRB SMAC shall check SuperPES for the availability of ASCA Enforcement Review information when selecting providers on PES for ASCA Enforcement Reviews, as well as when first establishing a PES record for a provider. If an ASCA review decision (NE, SM, WA or UC) is in SuperPES, that decision and the effective date of that decision in SuperPES must be entered into that provider's record in PES. In lieu of "NE" however, the RRB SMAC shall enter "NR" in PES to indicate that the "not eligible" determination was made by a contractor other than the RRB SMAC. If either "SM," "WA" or" UC" applies, the effective date of the decision is the later of the date in SuperPES when that contractor began the most recent ASCA review or the date the provider became eligible to submit paper claims when that is later than the date that the denial of claims began as result of a prior NE/NR decision. A future date may not be entered in PES for a NE/NR decision. A future NE effective date in SuperPES signifies that the contractor has not yet completed the ASCA review and that the decision is still tentative. See §90.7.1 for further use of the ASCA decision codes to determine when to issue ASCA review letters.

If there is more than one entry in SuperPES for the same provider, perhaps as result of the provider's submission of claims to more than one Medicare contractor, the RRB SMAC shall compare each of those entries that contains an ASCA decision and enter that decision and that effective date in PES that is the most "negative" in terms of the number of paper claims that would be submitted to the RMC as result of entry of that decision and date. The RRB SMAC has discretion to determine which set of ASCA information is the most negative overall.

90.7.1 - RRB SMAC Entry of ASCA Enforcement Review Decisions and EDI Enrollment Information from Other Medicare Contractors into PES

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

To take advantage of the information being added to SuperPES, the RRB SMAC shall do the following:

- **When using SuperPES to establish an initial record in PES for a provider--**If available in SuperPES, the RRB SMAC shall copy any ASCA review result information and the provider's ZIP Code, (extended if available), as well as those data elements that would have been copied in the past, and include that information in PES. If there is an NE entry in the ASCA review decision field, the RRB SMAC shall manually issue letter G to the provider to notify the provider that paper claims submitted to the RRB SMAC beginning on the 91st day after the date of the letter will be denied unless the provider can establish eligibility for one of the ASCA exceptions. See information later in this section on use of ASCA decision codes in selection of providers to be sent an ASCA Enforcement review letter. If no evidence has been received by the 45th day after the date of that letter, MCS shall trigger release of letter D. MCS shall trigger release of letter E and begin denying paper claims on the 91st day after the

date of letter G as if a normal ASCA review was being conducted, unless the provider submits documentation that results in cancellation of the denial by the RRB SMAC.

- **When a provider for whom a PES record was previously established is selected from the shared system's quarterly paper claim submitters report to initiate a new ASCA Enforcement Review--** The RRB SMAC shall look up each selected provider that has been tentatively selected for an ASCA review in the most recent SuperPES file to see if a record can be located based upon the information the RRB SMAC has available for that provider. When able to locate a record, the RRB SMAC shall add any ASCA review results from another Medicare contractor for that provider and the ZIP Code (extended if available) for that provider to PES. An "NE" decision shall be converted to "NR." See information later in this section on use of ASCA decision codes in selection of providers to be sent an ASCA Enforcement Review letter. The RRB SMAC will use the shared system's quarterly report to trigger release of letter H to notify the provider that paper claims they submit beginning on the 91st day after the date of the letter will be denied. If no response is received after 45 days, MCS shall trigger release of letter D. If no response is received to letter D, or there is a response but it will not result in a decision to allow the provider to continue to submit paper claims, MCS shall trigger release of letter E and begin denying paper claims submitted following the regular procedures for an ASCA Enforcement Review.

- **If the RRB SMAC learns that a provider that sends paper claims to the** RRB SMAC and **sends electronic claims to one or more other Medicare contractors**-When this information comes to the attention of the RRB SMAC as result of an action other than establishment of an initial record in PES or selection of a provider for review from the quarterly ASCA report, the RRB SMAC shall check the provider's record in SuperPES and in the last quarterly paper claim submitters report received from MCS. If there are no ASCA Enforcement Review results in SuperPES that would preclude initiation of an ASCA Enforcement Review (see §90.7.2), the RRB SMAC shall use the quarterly report to trigger release of letter H. MCS shall trigger letters D and E as appropriate in a regular ASCA Enforcement Review unless the RRB SMAC cancels denial of the paper claims because the provider responded and was able to establish grounds for continued submission of paper claims to the RRB SMAC. If the RRB SMAC has already initiated all reviews targeted for that quarter, the RRB SMAC may initiate this review as part of the next quarter's reviews.

If the ASCA information in SuperPES for a provider indicate that the provider was determined to be eligible for continued submission of paper claims as result of an ASCA review, the RRB SMAC shall enter that ASCA exception/waiver decision in PES for

future reference. If a provider alleges that contrary to a NE ASCA review determination in SuperPES, they do not submit Medicare claims to any MAC electronically and that provider furnishes a letter from another MAC that indicates an ASCA exception/waiver determination that is not yet reflected in SuperPES, the RRB SMAC is to enter the appropriate ASCA decision code in PES for the provider and shall not deny the provider's paper claims for ASCA purposes.

In the absence of such a letter however, the RRB SMAC is to assume that providers that have an NE entry in SuperPES do submit electronic claims to at least one other MAC, do submit 10 or more claims electronically to Medicare overall and can also submit claims to the RRB SMAC electronically. The RRB SMAC is to use the most recent MCS quarterly paper claim submitters report, or if all reviews targeted for that quarter have already been initiated, the next quarterly paper claim submitters report received to trigger release of letter H in that situation. MCS shall trigger letters D and E and begin denial of that provider's paper claims on the 91st day unless the RMC delays or cancels the denial action.

90.7.2 - Selection of Providers to be Sent Initial Letters for the RRB SMAC to Begin an ASCA Enforcement Review

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

If a provider is being considered for an ASCA review, the RRB SMAC shall check the latest SuperPES file to determine if another MAC has conducted an ASCA Enforcement Review. If there is an ASCA decision in SuperPES that was made later than any ASCA decision already posted in PES, the RRB SMAC shall update the information in PES and determine based upon the new information whether appropriate for them to initiate a new ASCA review of that provider.

The RRB SMAC shall not send a letter to a provider to begin an ASCA Enforcement Review if:

- SuperPES contains a "SM" decision for the provider that is less than two years old;

- SuperPES contains the date an enforcement review began but does not contain a decision and at least 121 days have not elapsed since the date the review began (this signifies another contractor has an ASCA review underway for that provider); or

- SuperPES contains a "UC" decision and fewer than 6 months have elapsed since the date of that decision.

When there is an NE decision in SuperPES with a past date, the RRB SMAC shall use a MCS quarterly paper claim submitters report to trigger release of letter H to that provider to notify them that their paper claims will begin to be denied on the 91st day after the date of that letter.

The RRB SMAC shall use a MCS quarterly paper claim submitters report to trigger release of letter C to a provider to initiate an ASCA Enforcement Review if:

a. There are no SuperPES ASCA field entries for a provider;

b. There is a "UC" decision in SuperPES and more than 6 months have elapsed since the date of that decision;

c. SuperPES contains the date an enforcement review began but does not contain a decision and more than 121 days have elapsed since the date the review began;

d. There is a "SM" decision in SuperPES, more than two years have elapsed since the date of that decision, and the number of paper claims that provider submitted to the RRB SMAC as indicated in the most recent ASCA quarterly report is high enough to have resulted in this provider being selected for initiation of an ASCA review in the event that there had not been any ASCA field entries in SuperPES for this provider; or

e. There is a "WA" decision in SuperPES and enough paper claims were submitted to the RMC as indicated by the MCS quarterly paper claim submitters report to have resulted in this provider being selected for initiation of an ASCA review in the event that there had not been any ASCA field entries in SuperPES for this provider.

Use of ASCA review information from SuperPES may result in denial of paper claims submitted by some providers who had been previously told by the RRB SMAC that they could submit their claims on paper as they submit fewer than 10 to the RRB SMAC per month. This situation is addressed in letter H. Although it would have been preferable to share ASCA paper claim denial decisions with the RRB SMAC when ASCA Enforcement Reviews first began, that was not possible at the time. Addition of information about ASCA Enforcement Review results to SuperPES files now makes application of these decisions by the RRB SMAC possible.

90.7.3 - Subsequent Reversal of Decision that a Provider is Not Eligible to Submit Paper Claims by an A/B MAC (B)

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

MACs often begin to deny paper claims because a provider failed to respond to the initial and second request ASCA Enforcement Review letters (see exhibit letters D, G, H and E at the end of this chapter). Providers sometimes furnish that evidence after denial of their paper claims begins. If the evidence shows that the provider actually qualified for one or more exception criteria retroactively to the date when denial of their paper claims was effective, the Medicare contractor shall replace the paper claim denial decision (NE) in the provider's file with a new decision based upon the submitted evidence. If the provider then resubmits the claims to that contractor that were denied as submitted on

paper following receipt of letter F from that contractor, they will be reprocessed and paid if they otherwise meet Medicare requirements.

In this situation, a paper claim denial decision transmitted to the RRB SMAC one week may be replaced by a different decision in a subsequent week's SuperPES file. It is not possible to automatically post the revised decision in the RR PES file based on this change in SuperPES however, and A/B MACS (B) do not have access to records that indicate whether particular providers bill the RRB SMAC and which might allow them to notify the RRB SMAC directly of such a reversal. In this situation, a provider who also bills the RRB SMAC and who has been notified that the paper claims sent to the RRB SMAC will be or have started to be denied based on the ASCA electronic claim submission requirement would be expected to contact the RRB SMAC to report the reversal of the decision made by the non-RR Medicare contractor.

When contacted, the RRB SMAC shall:

a. Ask the provider which MAC made and reversed that ASCA denial decision and furnish the provider with information to mail a copy of that letter to the appropriate person at the RRB SMAC;

b. Tell the provider not to begin to submit new paper claims, or resubmit those already denied as submitted on paper, until the provider receives a reversal letter (F) from the RRB SMAC; and

c. Update PES accordingly upon receipt of the copy of the reversal letter and trigger release of a new letter F so that the newly submitted and resubmitted RR paper claims from that provider can be processed.

90.7.4 - Number of ASCA Enforcement Reviews to be Conducted by the RRB SMAC

(Rev. 13105; Issued- 04-10-25; Effective: 05-12-25; Implementation: 05-12-25)

Due to the impact of ASCA review decisions made by A/B MACs (B), it would not be reasonable to require that the RRB SMAC issue new ASCA review letters for 20 percent of the providers who send them paper bills annually without giving the RRB SMAC some credit for the additional effort expended as result of the PES-SuperPES-quarterly paper claim submitters reports reviews the RMC is required to conduct. It takes the RRB SMAC longer to identify providers that should be sent letters to initiate a new ASCA review and in some cases, the cross checks performed by the RRB SMAC result in disqualification of a provider for selection for a new ASCA Enforcement Review. To adjust for this, the RRB SMAC annual ASCA review target is to review the records of 20 percent of those providers who submit paper claims as indicated in the MCS quarterly paper claim submitters reports, and not to necessarily initiate a new ASCA review of 20 percent of the providers that send them paper claims annually.

To compute this 20 percent, the total number of providers for whom reviews are to be conducted shall be computed as directed in §90.5.3. To gauge the number to be reviewed during a single quarter in the same FY prior to production of the fourth quarterly report for that FY, the RRB SMAC shall multiply the total of providers who submitted paper bills in the most recent quarterly report by 0.2 (20 percent), and then multiply again by .25. The number of reviews to be initiated during the fourth quarter shall be computed by subtracting the total reviews identified as conducted for the first three quarters of the FY from the total number of reviews targeted for the FY as a whole; the difference in the totals is the number of reviews to be started during the fourth quarter.

For purposes of the monthly ASCA review report submitted to DSSMdata.info prior to the fourth quarter of a FY, the total number of providers in the MCS most recent quarterly paper claim submitters report shall be entered in the "eligible providers" field. The total number of providers in that quarterly report for whom ASCA review letters are actually issued to begin reviews plus those for whom a decision is made that a new review is not warranted at that time due to an ASCA review action taken by another Medicare contractor shall be entered in the "Initial Review Letters Issued for Report Period" field of the monthly DSSMdata.info report. CMS realizes that an initial review letter will not actually have been issued by the RRB SMAC to each provider in this second situation, but the RRB SMAC review of ASCA data in SuperPES for those providers selected from the MCS quarterly paper claim submitters report which result in decisions not to initiate new reviews will be considered as equivalent to initiation of a new review by CMS for comparison purposes with A/B MACs (B) and to determine if the annual 20 percent target has been reached by the RRB SMAC . The number of ASCA reviews completed total to be entered in the monthly report shall equal the number of ASCA reviews completed during the reporting period that were initiated with an ASCA review letter plus the number of new ASCA reviews that were determined not to be warranted that month as result of review of ASCA information in SuperPES that same month.

For the fourth quarter of the FY, the total number of providers as computed for the FY who are eligible for review, i.e., the total who submitted paper claims in each of the quarterly ASCA reports for the FY divided by four, shall be entered in the DSSMdata.info monthly report as the number of "Eligible Providers." The RRB SMAC shall follow the direction in the prior paragraph to calculate the number of 'Initial Review Letters Issued for Report Period" and the "Reviews Completed" totals to be entered in those fields of the DSSMdata.info reports for the months in that final quarter. The remaining fields of the monthly ASCA reports are to be completed by the RRB SMAC according to the existing completion instructions for that report which were previously issued to the Medicare contractors.

90.7.5 - RRB SMAC Information in ASCA Enforcement Review Letters

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

The letters that apply to ASCA Enforcement Reviews at the end of this chapter did not originally refer to application of decisions made by an A/B MAC (B) to a provider when

billing the RRB SMAC. These letters have now been modified to note that an ASCA Enforcement Review made by one Medicare MAC that a provider does not qualify to submit claims on paper also applies to that same provider when billing other Medicare MACs, including the RRB SMAC. Two letters (G and H) have been added specifically for RRB SMAC use. Letters G and H may not be sent by and do not apply to any contractor other than the RRB SMAC.

The ASCA regulation indicated that denial of claims because they were not submitted to Medicare electronically would be applied on a prospective basis. Ninety days is being allowed prior to denial in letters G and H to allow time for those providers that do not have software for submission of electronic claims to the RRB SMAC to obtain that software from their vendor. Addition of a RRB SMAC module to some commercial electronic claim submission software can reportedly be expensive. As result, wording has also been included in the letters concerning the Medicare free billing software.

The cost charged by a commercial software vendor for a module to enable claims to be submitted to the RRB SMAC electronically is not a valid basis for waiver of the requirement that a provider submit their claims to the RMC electronically. The RRB SMAC shall encourage a provider who may mention cost to use the RMC's free billing software if this would be a more cost effective method of electronic submission of their claims to the RRB SMAC. The provider shall use either the commercial software of their choice or the Medicare free billing software and shall begin to submit their claims to the RRB SMAC electronically if they wish to continue to be paid for services furnished to RR Medicare beneficiaries.

The ASCA Enforcement Review letters now refer to an ASCA electronic claim submission requirement made by one MAC as applying to all MACs because that is actually how ASCA decisions are to be applied. CMS has not enforced this across the board due to the lack of a vehicle for sharing decisions across contractor lines, other than in the case of the RRB SMAC. If a vehicle becomes available to do this in the future for contractors other than the RRB SMAC, CMS will begin to require that this be done. Sharing of these decisions across the board would require coordination to eliminate the possibility that more than one contractor could conduct reviews of the same provider at the same time so this issue would also need to be addressed in any subsequent change request issued for this purpose.

90.7.6 - RRB SMAC Costs Related to Use of ASCA Review Information in SuperPES Files

(Rev. 2803, Issued: 10-28-13, Effective: 09-17-13, Implementation: 09-17-13)

Costs for FY 2009 and later for ASCA review expenses as delineated are to be included in the annual operations budget request submitted by the RRB SMAC.

Exhibits of Form Letters

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Exhibit A - Response to a non- "unusual circumstance" waiver request
(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

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 to be considered for Medicare payment. 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 b, c or d below applies. Medicare will not issue a written waiver determination unless b, c or d applies.

ASCA prohibits payment of service and supply claims submitted to Medicare on paper, except in limited situations that apply either to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers-To qualify, a provider required to use a CMS-1450 form when submitting claims on paper shall have fewer than 25 full time equivalent employees (FTEs).A physician, practitioner, or supplier required to use a CMS-1500 form in a current version when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all

Medicare Administrative Contractors (MACs) including the RRB Specialty Medicare Administrative Contractor**.**);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

10. Providers that can establish that some other "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. Periods when a MAC's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual MACs notify their providers of these situations if they apply);

b. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. 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 b, c or d applies. You are expected to self-assess to determine if one of the other exceptions or unusual circumstances applies. 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. Your MAC will monitor your compliance with this ASCA requirement on a post-payment basis.

If your self-assessment does not indicate that exception or waiver criteria apply as listed above, you shall submit your claims to Medicare electronically. This applies to every MAC to which you submit claims, including the contractor responsible for processing of Railroad Medicare claims. The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.

Sincerely,

Contractor Name

Exhibit B - Denial of an "unusual circumstance" waiver request
(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

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. Claims submitted by small providers-To qualify, a provider required to use a CMS 1450 form when submitting paper claims shall have fewer than 25 full-time equivalent employees (FTEs), and a physician, practitioner, or supplier required to use the CMS-1500 form in a current version when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental Claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project, when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all MACs including the RRB Specialty Medicare Administrative Contractor);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

10. Providers that can establish that some other "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. Periods when a MAC's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual MACs notify their providers of these situations if they apply);

b. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. 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.

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. This decision applies to paper claims you may submit to any MAC in the United States, including the RRB Specialty Medicare Administrative Contractor. As you do not qualify for a waiver of the ASCA electronic claim submission requirement, Medicare will begin to deny paper claims you may submit beginning on the 91st day after the date of this letter.

Waiver applications are only to be submitted to request a waiver if an "unusual circumstance" applies under b, c or d above. The information submitted with your waiver request did not indicate that circumstance b, c or d any other exception or waiver criteria apply in your case. If your self-assessment indicates that an exception condition, other than b, c or d is met, you are automatically waived from the electronic claim submission

requirement and no request should be submitted to a MAC. MACs will monitor compliance with the ASCA electronic billing requirements 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 payment. The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.

Sincerely,

Contractor Name

Exhibit C - Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

A large number of paper claims were submitted under your provider number(s) during the last calendar quarter. Section 3 of the Administrative Simplification Compliance Act, P.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. This also applies to payments made for beneficiaries who qualify for Medicare based upon their employment in the railroad industry.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers-- To qualify, a provider required to use the Form CMS 1450 when submitting claims on paper shall have fewer than 25 full-time

equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 form in a current version when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the RRB Specialty Medicare Administrative Contractor ;

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

10. Providers that can establish that some other "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. Periods when a MAC's claim system might temporarily reject a particular type of electronically submitted claim, pending system modifications (individual MACs notify their providers of these situations if they apply);

b. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. 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.

If you intend to continue to submit paper claims, please respond within 30 calendar days of the date of this letter to indicate which of the above situations is your basis for continuing submission of paper claims to Medicare. Include with your response, evidence to establish that you qualify for waiver of the electronic filing requirement under that situation. For instance, if you are a small provider, evidence might consist of copies of payroll records for all of your employees for (specify the start and end dates of the calendar quarter for which the review is being conducted) that list the number of hours each worked during that quarter. If you are a dentist, evidence might be a copy of your license.

If you are in a Medicare demonstration project, evidence might be a copy of your notification of acceptance into that demonstration. If you are a mass immunizer, evidence might be a schedule of immunization locations that indicates the types of immunizations furnished. If you experienced an extended disruption in communication or electrical services, evidence might consist of a copy of a newspaper clipping addressing the outage. If the paper claims were submitted because this office notified you of a system problem preventing submission of these claims electronically, please note that in your response.

If your continuing submission of paper claims is the result of medical restrictions that prevent your staff from submitting electronic claims, evidence would consist of documentation from providers other than yourself to substantiate the medical conditions. If you obtained an unusual circumstance waiver, evidence would be a copy of your notification to that effect from this office or the Centers for Medicare & Medicaid Services.

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they otherwise qualify for a waiver under a situation that applies to all of their claims.

If you cannot provide acceptable evidence to substantiate that you are eligible under the law to continue to submit paper claims to Medicare, we will begin to deny all paper claims you submit to us effective with the 91st calendar day after the date of this notice. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes. This decision applies to paper claims you may submit to any MAC in the United States, including the Railroad Retirement Board Specialty Medicare Administrative Contractor.

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.

Sincerely,

Contractor

Exhibit D - Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of non-response to that letter

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L. 107-105 and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting evidence to establish that you qualify for submission of paper claims to Medicare. Nor do we have information available to us that would substantiate that you meet any of the limited exceptions that would permit you to legally submit paper claims to Medicare.

Consequently, as noted in the initial letter as well as in information issued providers when this ASCA requirement was put into effect, any Medicare paper claims you submit more than 90 calendar days from the date of the initial letter requesting evidence to substantiate your right to submit paper claims will be denied by Medicare. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes. This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the RRB Specialty Medicare Administrative Contractor.

If you did not respond because you realized that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.

Sincerely,

Contractor Name

Exhibit E - Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of determination that the provider is not eligible to submit paper claims.

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claims Submission Practices

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 from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Social Security Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

We have reviewed your response to our letter requesting that you submit evidence to substantiate that you qualify for submission of paper claims under one of the exception criteria listed in that letter. Upon review, we determined that you do not meet the paper claims waiver/exception criteria as stated in our prior letter. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if such a change in your situation occurs. This decision applies to paper claims you may submit to any Medicare contractor in the United States, including the RRB Specialty Medicare Administrative Contractor.

Consequently, any Medicare paper claims you submit on or after the 91st calendar day from the date of the letter requesting evidence of your eligibility to continue to submit paper claims will be denied by Medicare.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.

Sincerely,

Contractor Name

Exhibit F - Notice that determination reached that the provider is eligible to submit paper claims.

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claim Submission Practices

Thank you for your response to our previous letter regarding the prohibition against the submission of paper claims to Medicare. Based on the information you supplied, we agree that you meet one or more exception criteria to the requirements in §3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, that require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions.

If your situation changes to the point where you no longer meet at least one of the criteria, you will be required to begin submission of your claims electronically by the 91st calendar day after that change in your status.

Although you are not required to submit claims electronically at the present time, you are encouraged to do so. The Common Electronic Data Interchange (CEDI) contractor can supply you with free billing software for submission of Medicare DME claims. Visit the CEDI Web site at www.ngscedi.com for further information on enrollment for use of EDI, use of free billing software, and other DME EDI information. There are also commercial billing software, and billing agent and clearinghouse services available on the open market that can be used to bill Medicare as well as other payers and may better meet your needs. Please visit the CEDI Website (www.ngscedi.com) to see a list of HIPAA-compliant vendor services available to you.

Sincerely,

Contractor Name

Exhibit G - Notice from the Railroad Retirement Board Specialty Medicare Administrative Contractor (RRB SMAC) to a Provider that Has Just Begun to Submit Claims that Paper Claims Submitted by that Provider Will be Denied

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Denial of Paper Claim Submission Practices

You recently began to treat one or more Railroad Medicare beneficiaries and began to submit claims to us for the first time. In the process of establishing a record in our files to indicate that you are eligible to submit Medicare claims, we obtained a copy of your non-RR Medicare enrollment information. That record indicates that you are required to submit your Medicare claims electronically to at least one other Medicare Administrative Contractor and does not indicate that you were issued a waiver to permit submission of paper Medicare claims. Section 3 of the Administrative Simplification Compliance Act

(ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

ASCA did not differentiate among Medicare contractors or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement. As result, we will begin to deny any paper claims you submit to us for Railroad Medicare beneficiaries unless you are able to establish that you meet one or more of the following exceptions to this ASCA requirement:

1. Claims submitted by small providers-- To qualify, a physician, practitioner, or supplier required to use a CMS-1500 form in a current version when submitting claims on paper shall have fewer than 10 full-time equivalent employees (FTEs). A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the RRB Specialty Medicare Administrative Contractor);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

10. Providers that can establish that some other "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. Periods when a Medicare contractor's claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. 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.

If you intend to continue to submit paper claims, please respond within 30 calendar days of the date of this letter to indicate which of the above situations is your basis for continuing submission of paper claims to us. Include with your response, evidence to establish that you qualify for waiver of the electronic filing requirement under that situation. For instance, if you are a small provider, evidence might consist of copies of payroll records for all of your employees for (specify the start and end dates of the calendar quarter for which the review is being conducted) that list the number of hours each worked during that quarter. If you are a dentist, evidence might be a copy of your license.

If you are in a Medicare demonstration project, evidence might be a copy of your notification of acceptance into that demonstration. If you are a mass immunizer, evidence might be a schedule of immunization locations that indicates the types of immunizations furnished. If you experienced an extended disruption in communication or electrical services, evidence might consist of a copy of a newspaper clipping addressing the outage. If the paper claims were submitted because this office notified you of a system problem preventing submission of these claims electronically, please note that in your response.

If your continuing submission of paper claims is the result of medical restrictions that prevent your staff from submitting electronic claims, evidence would consist of documentation from providers other than yourself to substantiate the medical conditions. If you obtained an unusual circumstance waiver, evidence would be a copy of your notification to that effect from this office or the Centers for Medicare & Medicaid Services.

Providers that received waivers for a specific claim type are still required to submit other claims electronically unless they meet another criterion, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, claims are for dental services, or if they otherwise qualify for a waiver under a situation that applies to all of their claims.

If you cannot provide acceptable evidence to substantiate that you are eligible under the law to continue to submit paper claims to us, we will begin to deny all paper claims you submit to us effective with the 91st calendar day after the date of this notice. ASCA did not establish an appeal process for denial of paper claims in this situation, but you may qualify for a waiver at a later date if your situation changes. Please contact this office if your situation changes.

You have a number of alternatives to consider for electronic submission of your claims to Medicare. Commercial software, and billing agent and clearinghouse services are available on the open market that can be used to bill us as well as other payers. Please visit (contractor shall insert the URL for vendor information) to see a list of HIPAA-compliant vendor services available in your state. Some providers have reported that their software vendor or clearinghouse charges a substantial additional amount to allow a provider to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. This office can supply you with free billing software for submission of Medicare claims. See (contractor shall insert the URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed for further information on enrollment for use of EDI, use of free billing software or other EDI information.

Sincerely,
Contractor Name

Exhibit H - Notice from the Railroad Retirement Board Specialty MAC to a Provider with a Pre-Established Record in PES that Paper Claims Will Be Denied as Result of the Requirement that a Provider Submit Claims to One or More Other Medicare Contractors Electronically

(Rev. 2965, Issued: 05-23-14, Effective: 07-25-14, Implementation: 07-25-14)

Date:

From: MAC (Name and address may appear on masthead)

To: Organizational Name of Provider and Mailing Address

Subject: Review of Paper Claim Submission Practices

Section 3 of the Administrative Simplification Compliance Act (ASCA), Pub.L.107-105, and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement from Medicare be submitted electronically, with limited exceptions. The ASCA amendment to § 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Paper claims will be denied if submitted by entities determined to be in violation of the statute or this rule. ASCA did not differentiate among Medicare Administrative Contractors (MACs) or between Railroad and non-Railroad Medicare for application of the electronic claim submission requirement or exceptions to that requirement.

We recently discovered that you have been submitting more than 10 Medicare claims per month on average to one or more other MACs and/or submitting claims to another MAC electronically. Unless you have been issued a letter by one or more MACs granting you a waiver of more than 90 days from the ASCA requirement for electronic submission of your claims, or are now able to establish that you do meet one or more of the criteria for waiver of this ASCA requirement, you are also required to submit your claims to us for Railroad beneficiaries electronically. If you have such a letter, or evidence that you do now qualify for a waiver of this ASCA requirement, please forward a copy of that letter or evidence to this office to enable us to update our records and permit you to continue to submit claims to us on paper if you choose.

ASCA prohibits submission of paper claims except in limited situations that may apply to all of a provider's claims, only to specified types of claims or for a limited period as indicated below:

1. Claims submitted by small providers--To qualify, a provider required to use the Form CMS-1450 when submitting claims on paper shall have fewer than 25 full-time equivalent employees (FTEs). A physician, practitioner, or supplier required to use a CMS-1500 form in a current version when submitting claims on paper shall have fewer than 10 FTEs. A small provider can elect to submit all, some or none of their claims electronically;

2. Dental claims;

3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;

4. Roster claims for mass immunizations, such as flu or pneumonia injections--Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a MAC that commits them to electronic submission of mass immunization claims;

5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;

6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all MACS including the Railroad Board Specialty Administrative Contractor);

7. Claims submitted by beneficiaries;

8. Claims from providers that only furnish services outside of the United States;

9. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and

10. Providers that can establish that some other "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. Periods when a MAC's claim system might temporarily 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. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;

c. Entities that can demonstrate that information necessary for adjudication of a type of Medicare claim that does not involve a medical record or other claim attachment cannot be submitted electronically using the claim formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and

d. 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.

It is possible that you may previously have contacted this office or had an ASCA Enforcement Review conducted by this office and were informed that you are eligible to continue submitting paper claims to this office since you submit fewer than 10 Medicare claims to us per month. Until recently, we did not have access to ASCA review information from other MACs that could be used to determine whether you should be submitting your claims to us electronically. As we do now have access to this type of information from other MACs, we are required to apply that information to you and to other providers that submit paper claims to this office.

As you may not have been notified that an ASCA electronic claim submission requirement that applies to another MAC also affects your submission of paper claims for Railroad Medicare beneficiaries, we will not begin to deny your paper claims until the 91st day after the date of this letter. This will allow you time to make changes as needed so you can begin to submit your claims to us electronically by the 91st day.

In the event your situation changes and you feel that you do meet one or more of the criteria for an exception from the ASCA electronic claim submission requirement, you should recontact us and any other MAC that made a determination that you do not currently qualify for an exception. If determined that you do in fact qualify for an exception at that point, you would have the option to again begin to submit some or all of your Medicare claims on paper. The type of exception criteria you meet will determine if the exception applies to only certain types of your claims, all of your claims or applies only for a temporary period. That would be addressed in the decision notice you would be sent.

Some providers have reported that their software vendor or clearinghouse charges a substantial amount to submit Railroad Medicare claims electronically. Please contact this office if this situation also applies in your case. This office can supply you with free billing software for submission of Medicare claims. See (contractor shall insert the URL where information is located on their free billing software, the amount of any handling charge for issuance, how to obtain further information, and the EDI Enrollment Agreement which will need to be completed for further information on enrollment for use of EDI, use of free billing software or other EDI information.

Sincerely,

Contractor Name

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R13954CP	09/29/2026	Internet Only Manual (IOM) Update, Publication (Pub.) 100-04, Chapter 24 General Electronic Data Interchange (EDI) and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims	10/30/2026	14590
R13105CP	04/10/2025	Internet Only Manual (IOM) Update, Pub. 100-04, Chapter 24 General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims	05/12/2025	13921
R11427CP	05/20/2022	Claims Processing Manual Update - Pub. 100.04 for Elimination of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Forms (DIFs)	01/03/2023	12734
R11414CP	05/12/2022	Claims Processing Manual Update - Pub. 100.04 for Elimination of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Forms (DIFs) - Rescinded and replaced by Transmittal 11427	06/13/2022	12734
R10319CP	08/28/2020	Removal of Contractor Requirement to Submit Electronic Data Interchange (EDI) Data into the Contractor Reporting of Operational and Workload Data (CROWD) System (Form 5)	09/29/2020	11909
R10236CP	07/31/2020	Update to the IOM Publication (Pub) 100-04, Medicare Claims Processing Manual, Chapters 1, 6, 8, 17, 20, 22, 24, and 31 Referencing the Active Universal Resource Locators (URLs) for the Washington Publishing Company (WPC) and the ASC X12 Organizations, and Updates to the HIPAA Eligibility Transaction System (HETS)	08/31/2020	11857

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R4388CP	09/06/2019	Manual Updates to Chapters 1, 22, 24, 26, and 31 in Publication (Pub.) 100-04	10/07/2019	11331
R4202CP	01/18/2019	Update to Pub. 100-04 Chapters 8, 20, and 24 to Provide Language-Only Changes for the New Medicare Card Project	02/19/2019	10964
R4096CP	08/03/2018	Update to the Medicare Claims Processing Manual, Chapter 24, Section 90	11/05/2018	10559
R3491CP	04/05/2016	Payment for Purchased Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Furnished to Medicare Beneficiaries Residing Outside the U.S. - Expatriate Beneficiaries	07/05/2016	9468
R3444CP	01/29/2016	Payment for Purchased Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Furnished to Medicare Beneficiaries Residing Outside the U.S. - Expatriate Beneficiaries - Rescinded and replaced by Transmittal 3491	07/05/2016	9468
R3404CP	11/13/2015	Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04 - Enrollment Form Update	12/14/2015	9430
R3346CP	09/04/2015	Removing References to Network Service Vendors from Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04	10/06/2015	9280
R2965CP	05/23/2014	Medicare Claims Processing Pub. 100-04 Chapter 24 Update	07/25/2014	8756
R2803CP	10/28/2013	Medicare Claims Processing Pub. 100-04 Chapter 24 Update	09/17/2013	8405
R2771CP	08/16/2013	Medicare Claims Processing Pub. 100-04 Chapter 24 Update – Rescinded and replaced by Transmittal 2803	09/17/2013	8405

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R2535CP	08/31/2012	Chapter 24 Update to Remove Outdated Information	10/01/2012	8018
R2517CP	08/10/2012	Medicare Claims Processing Pub. 100-04, Chapter 24 Update for Security Requirements	09/10/2012	8004
R2346CP	11/18/2011	Medicare Claims Processing Pub. 100-04 Chapter 24 Update for HIPAA 5010 and EDI Enhancements	12/19/2011	7598
R2181CP	03/25/2011	Medicare Claims Processing Pub. 100-04 Chapter 24 Update for HIPAA 5010 and EDI Enhancements	04/25/2011	7269
R2164CP	02/25/2011	Healthcare Provider Taxonomy Codes (HPTC) Update April 2011	07/05/2011	7318
R1768CP	07/10/2009	Update to Pub. 100-04, Chapter 24, Section 40.7 of the Claims Processing Manual	08/10/2009	6531
R1736CP	05/15/2009	Chapter 24 Update to Restore Inadvertently Deleted Information and to Remove Outdated Information	08/17/2009	6201
R1720CP	04/24/2009	Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) 837 5010 Coordination of Benefits (COB) Requirements--Part II	07/06/2009	6374
R1614CP	10/03/2008	Healthcare Provider Taxonomy Codes (HPTC) Update October 2008	10/06/2008	6190
R1601CP	09/19/2008	Update to Chapter24 of the Claims Processing Manual	10/20/2008	5974
R1420CP	01/25/2008	Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process	02/01/2008	5837

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R1353CP	10/15/2007	Application of ASCA Enforcement Review Decisions Made by Other Medicare Contractors to the Same Providers When Selected for ASCA Review by the Railroad Medicare Carrier, Elimination of References to Claim Status and COB Medicare HIPAA Contingency Plans and Changes to Reflect Transfer of Responsibility for Medigap Claims to the COBC Contactor	01/07/2008	5606
R1284CP	07/09/2007	Chapter 24 Update and EFT Format Standardization	10/01/2007	5586
R1283CP	07/06/2007	National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), Update of Telecommunication and Transmission Protocols for EDI and Deletion of Obsolete Reference to Medicaid Subrogation Claims	10/01/2007	5637
R1214CP	03/30/2007	Discontinuance of ASCA Excel Spreadsheet Maintenance	07/02/2007	5509
R1213CP	03/30/2007	EDI Enrollment and Electronic Claim Record Retention	07/02/2007	5491
R1194CP	03/09/2007	Temporary Addition to the Administrative Simplification Act (ASCA) Exception List for Medicare Secondary Payer (MSP) Claims	04/09/2007	5488
R1081CP	10/20/2006	Electronic Data Interchange (EDI) Media Changes	04/02/2007	5225
R1077CP	10/13/2006	Electronic Data Interchange (EDI) Media Changes	01/16/2007	5225
R1063CP	09/22/2006	Ending the Contingency Plan for Remittance Advice and Charging for PC Print, Medicare Remit Easy Print, and Duplicate Remittance Advice	10/23/2006	5308

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R1033CP	08/18/2006	Revise Chapters 22 and 24 to delete references to free downloads of X12 implementation guides adopted as HIPAA standards from Washington Publishing Company (WPC)	11/20/2006	5247
R958CP	05/26/2006	Chapter 24 Update to the National Council for Prescription Drug Program (NCPDP) Narrative Portion of Prior Authorization Segment	08/26/2006	5092
R952CP	05/19/2006	Administrative Simplification Compliance Act (ASCA) Review Revisions	10/02/2006	5068
R900CP	04/07/2006	Update to Chapter 24 CMS Website URL References	07/07/2006	4398
R885CP	03/10/2006	Suppression of Standard Paper Remittance Advice to Providers and Suppliers Also Receiving Electronic Remittance Advice for 45 Days or More	06/1/2006	4376
R831CP	02/02/2006	Shared Systems Medicare Secondary Payer (MSP) Balancing Edit, and Administrative Simplification Compliance Act (ASCA) Enforcement Update	07/03/2006	4261
R802CP	12/30/2005	Termination of the Medicare HIPAA Incoming Claim Contingency Plan, Addition of a Self-Assessable Unusual Circumstance, Modification of the OTAF Exception, and Modification of ASCA Exhibit Letters A, B and C	04/03/2006	4119
R615CP	07/22/2005	Complete Revision of Chapter 24, EDI Support Requirements	10/03/2005	3875
R541CP	04/29/2005	Correction to the use of Group Codes for the Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3815

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R450CP	01/27/2005	Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3440
R448CP	01/21/2005	Timeframe for Continued Execution of Crossover Agreements and Update on the Transition to the National Coordination of Benefits Agreement (COBA) Program	02/22/2005	3658
R435CP	01/14/2005	Enforcement of Mandatory Electronic Submission of Medicare Claims	07/05/2005	3440
R238CP	07/23/2004	Intermediary Shared System Changes for Processing HIPAA X12N 837 Transaction	01/03/2005	3321
R199CP	06/10/2004	Rejection of any outpatient claim containing a range of dates in the line item date of service (LIDOS) field	10/04/2004	3337
R175CP	05/14/2004	Instructions for Intermediary Shared Systems Maintainers for Implementation of HIPAA X12N institutional 837 transaction	10/04/2004	3264
R162CP	04/30/2004	Cessation of Support for NSF	10/04/2004	3180
R138CP	04/09/2004	Beta Testing COB Implementation	07/06/2004	3218
R107CP	02/24/2004	Intermediaries and Intermediary Shared System Maintainers must make necessary changes to implement the HIPAA X12N 837 Institutional 837 transaction	07/06/2004	3031
R099CP	02/09/2004	Contractors and shared systems maintainers must make necessary changes to implement the HIPAA X12N 837 coordination of benefits transaction	07/06/2004	3100
R098CP	02/06/2004	Implementation of National COB Process for Crossover Claims	07/06/2004	3109
R086CP	02/06/2004	Required pre-pass editing processes to prevent certain claim errors from being	07/06/2004	3050

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		accepted into the Part B and DMERC shared systems		
R084CP	02/06/2004	Allowing segments to be transmitted in any order	07/06/2004	3095
R057CP	01/02/2004	Accommodating 15 Positions of ISA08 Data on Outbound X12N HIPAA Transactions	04/05/2004	3001
R049CP	12/19/2003	Intermediary Rejection of HIPAA X12N 837 Health Care Claim Transaction When Certain Levels of Errors Are Detected	04/05/2004	2879
R044CP	12/19/2003	Mandatory Electronic Submission of Medicare Claims Based on the Administrative Simplification Compliance Act and Waiver Conditions	01/20/2004	2966
R015CP	10/31/2003	Accommodating 15 Positions of ISA08 Data on Outbound X12N HIPAA Transactions	04/05/2004	2819
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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