CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4260	**Date: March 22, 2019**
	Change Request 11178

SUBJECT: Update to Chapter 31 in Publication (Pub.) 100-04 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 31 in Pub. 100-04 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: April 22, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 22, 2019

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	31/20/20.1.2/Online Direct Data Entry (DDE)

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Chapter 31 of Pub. 100-04.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11178.1	MACs shall be aware of the updated language for the New Medicare Card Project in Chapter 31 of Pub. 100-04.	X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov , Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

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

ATTACHMENTS: 0

20.1.2 - Online Direct Data Entry (DDE)

(Rev.4260; Issued: 03-22-19; Effective: 04-22-19; Implementation: 04-22-19)

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 HIPAA uses the term "direct data entry" generically to refer to a type of functionality operated by many different payers under a variety of titles. Within this instruction, the acronym DDE is being used to refer to any type of direct data entry system maintained by contractors, or shared system maintainers, including A/B MAC (A) or (HHH) DDE or equivalent functionality that may have a different title. Although DDE operates online, DDE does not typically operate on a detailed inquiry and response basis. For claim status purposes, data is maintained within an interactive database that providers may access to view screens containing a wide variety of information on their claims. A provider accesses that data by furnishing certain identifying data for security purposes to establish their right to read the data and to specify those claim records the provider wishes to review.

The information in this database for specific claims or providers is initiated when a provider enters claim data, and is then updated by a contractor to include subsequent actions taken that affect that claim. DDE was specifically permitted to continue in the HIPAA initial transactions final rule (45 CFR 162.923), with the stipulation that direct data entry is subject to "…the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirements of the standard."

Data content conformity means that the same information permitted or required by the ASC X12 277 claim status response implementation guide must be reported in the claims status screens (the DDE outbound). The DDE outbound may not report a data element for claim status purposes that is not included in the ASC X12 277 claim status response, exceeds the maximum length of the data element in the ASC X12 277 claim status response, does not meet the minimum length for the data element in the ASC X12 277 claim status response, or that does not meet the ASC X12 277 claim status response requirement that the data element be numeric, alpha-numeric, an amount, or meet another characteristic as specified in the ASC X12 277 claim status response. On the inbound, the DDE system can require less information than the ASC X12 276 claim status request, but not more. The inquirer is not required to furnish information in the DDE inquiry that is available by other means to the contractor. Any data element keyed in a DDE system must conform to the requirements. The ASC X12 standard TR3 include data element length and characteristics in their definition of data attributes.

Conformity does not mean that a DDE screen that includes claim status information must display each of the data qualifiers or other means of data identification contained in the ASC X12 277 claim status response implementation guide. DDE screens typically identify, explicitly or by context, the type of information being reported in a field, e.g., would identify if a number represents a HCPCS, *Medicare beneficiary identifier*, amount, grams, date of birth, etc. DDE screens would not be expected to use a qualifier contained in the ASC X12 277 *claim status response* to identify data type if that is otherwise evident in the design or content of the DDE screen.

Shared system maintainers must map the DDE claim status data elements to the ASC X12 276/277 claim status request and response implementation guide to determine if the DDE claim status data elements meet the conformity requirements above. If needed, changes must be made to enable contractor DDE claim status data elements to conform.

If a contractor continues to support DDE, it must be offered in addition to batch ASC X12 276/277 claim status request and response, but the contractor must take one of two approaches to assure their claim status data content conforms to the requirements:

1. Eliminate claim status data elements from the DDE screens, unless those data elements are also needed for a purpose other than claim status. For example, if a data element is needed in a DDE screen for claim entry or claim correction, and it is also used to help determine claim status, retain the data element so it can continue to be used for claim entry or correction. If a data element is used solely for claim status, and is not essential for an alternate purpose, eliminate it; or

2. If a contractor elects to continue to display claim status-specific data elements in their DDE screens, those data elements must at a minimum contain/report data that conforms to:

    - All required and applicable conditional data elements for those segments in the ASC X12 277 claim status response; and

    - Data content as specified for those data elements in the ASC X12 277 claim status response, as applicable, including compliance with the data attributes for those data elements as defined in the ASC X12 277 implementation guide.

Preliminary feedback from contractors suggests that existing DDE screens used for Medicare may already conform to the ASC X12 277 claim status response implementation guide requirements, but data element mapping is required to verify. For example, since industry input was used to develop the ASC X12 277 claim status response implementation guide as well as, presumably the data elements for claim status currently furnished via DDE, it is unlikely that DDE screen field sizes would be larger than the ASC X12 277 claim status response maximum length or shorter than the ASC X12 277 claim status response minimum length. It is also unlikely that a DDE screen would contain a data element considered important for claim status that is not included in the ASC X12 277 claim status response, or vice versa.

If a shared system maintainer determines that DDE screen changes are required, the maintainer in conjunction with its users must determine if it would be cost effective to modify the DDE screens to conform to the ASC X12 277 claim status response implementation guide. If not cost effective, the maintainer must eliminate the claim status-only data elements from the DDE screens and require the contractors to use the batch ASC X12 276/277 claim status request and response, an ARU, and/or other non-EDI means to obtain claim status information.

If retention is cost effective, the maintainer must modify these screens as necessary to ensure that providers are able to access all applicable data content available in the ASC X12 277 claim status response. The DDE screens must be able to furnish providers information that conforms to the data that would have been issued to the provider in an ASC X12 277 claim status response. See above for the discussion of conformity.