Medicare Claims Processing Manual

Chapter 24 - EDI Support Requirements

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Table of Contents

10 - Provider Outreach and Marketing

(Rev.)

A3-3602.2, B3-3023.7

All Medicare providers, except for small providers defined in regulation, must bill Medicare electronically. Therefore all the material on outreach that follows applies only to relations with excepted providers.

Electronic transmission of claims and other data significantly reduces Medicare administrative costs. Medicare carriers and intermediaries are required to continuously conduct an active targeted outreach effort to encourage electronic exchange of Medicare data with providers. This includes Medicare claims as well as related records as described in §40. Specifically, carriers and intermediaries are required to:

- Perform continual analysis to identify providers that could exchange transactions electronically, but who continue to submit or receive paper; and
- Develop strategies to increase electronic transactions with these providers.

In addition, carriers or intermediaries are required to analyze capabilities of new providers and assist such providers in determining electronic capability.

10.1 - Carrier or Intermediary Analysis of Internal Information

(Rev.)

B3-3023.7

10.1.1 - Systems Information

(Rev.)

Carriers or intermediaries must develop the following data for each provider from claims processing operations:

- Number of claims; and
- Number and percent of paper claims.

This may be developed independently or in connection with other operations analysis information. Monthly, carriers and intermediaries array the data by volume to identify the providers that create the largest paper transaction workloads. Consistent with the approved budget, they initiate contact beginning with providers showing the highest number of paper transactions.

First, they telephone the provider to discuss the reasons for the paper transactions.

- If the provider has electronic capability but is temporarily submitting paper for reasons such as problems with their automated system or transition to a different system, no further action may be necessary. However, if appropriate, the carrier or intermediary may offer to facilitate the resolution of the situation with the provider, their data processing staff, or their vendor;
- If the provider is not an electronic biller, initiate a discussion of the advantages of electronic data interchange, including all transaction types. This discussion should focus on the individual provider's needs and determining the electronic solution which best meets those needs. Carriers and intermediaries must offer, as appropriate, to mail literature to the provider and/or to schedule a personal, on-site visit to discuss automating the provider's office. (See §10.4 for a discussion of marketing materials to send.) They must inform the provider of any EDI seminars scheduled in the near future at a nearby location.

Carriers and intermediaries must follow through on appropriate fulfillment activities such as mailing literature, conducting on-site visits or demonstrations, and making follow-up phone calls. Marketing efforts should be documented to prevent duplicate contacts, to provide a basis for future discussions, and to substantiate those instances where the provider refuses to participate in EDI.

Recognizing that this process, from initial contact to implementation, may span a varying duration of time, marketing staff must be able to judge, from the provider's cues, when to

intensify activities and when to withdraw for a period of time. Carriers or intermediaries must use professional sales techniques such as:

- Knowing your product;
- Knowing your customer's business;
- Questioning and listening to determine customer needs and interest;
- Using demonstrations;
- Creating interest and overcoming objections;
- Proving the benefits of EDI; and
- Successful resolution.

Systems information may also identify specific markets, e.g., specialties, to target for EDI marketing campaigns.

Also, carriers and intermediaries must identify providers that have previously committed to EDI but have not begun transition within an appropriate period, e.g., 60 to 90 days, for follow up to determine the reason for delay.

10.1.2 - Review of Provider Profiles

(Rev.)

Carriers and intermediaries determine on a continual basis whether any providers use EDI billing but not electronic remittance or other EDI processes. In such a situation they determine whether, and what type of, further discussion with the provider might be helpful. Use of electronic funds transfer (EFT) is not an indicator of electronic capability.

Carriers and intermediaries must be proactive in encouraging providers, physicians, and suppliers to bill electronically through contractor Web sites and newsletters. Carriers and intermediaries should contact the largest paper billers and work with them to resolve any obstacles to electronic billing.

10.2 - Contact With New Providers

(Rev.)

As new providers are approved for billing Medicare, carriers, and intermediaries must conduct an analysis of the providers' EDI capability for Medicare transactions. They propose EDI transactions as the normal mode of business for claims, corrections, remittance, and funds transfer. Where the provider does not have the related capability, they inform the providers of available options for getting started in EDI, e.g., lists of vendors and billing services, availability of Medicare's free software.

Carriers should make marketing materials available to newly enrolled providers. This may also include working with local medical schools where possible to introduce EDI processes to medical students prior to graduation through:

- Seminars conducted specifically for medical students;
- Demonstrations of Medicare's free software;
- Invitations to vendor trade fairs; and
- Distribution of marketing literature.

10.3 - General Outreach and Marketing Activities

(Rev.)

B3-3023.7

Carriers and intermediaries are required to conduct general outreach and EDI marketing activities. When participating in or conducting these activities, carriers and intermediaries will distribute marketing materials. They must:

- Sponsor trade shows or vendor fairs for EDI vendors and trading partners in connection with appropriate provider meetings;
- Sponsor seminars for segments of providers identified in internal analysis described in §10.1. If appropriate, include vendors that target the attending provider audience;
- Participate as a 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 trade groups; and
- Include specific and meaningful EDI messages in routine bulletins to providers, addressing the themes described in §10.4, below, and other issues that may be pertinent to your area. Point out the advantages to the provider of various aspects of EDI.

10.4 - Production and Distribution of Material to Market EDI

(Rev.)

B3-3023.7, AB-01-19

Carriers and intermediaries 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:

- Earlier payment of claims because of different payment floor requirements;
- The benefit of earlier detection of errors via edits;
- The relative ease of EDI and support available;
- Advantages of online correction of errors (intermediaries only);
- Lower administrative, postage, and handling costs;
- Electronic adjustments (intermediaries only);
- Availability of free software;
- Claims status inquiry; and
- 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, carriers and intermediaries 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 carrier or intermediary does not attend as well as those that they do attend.

20 - Provider and Vendor EDI Enrollment

(Rev.)

B3-3021.7, B3-3021.8 partial, B3-3022

State Agency and CMS Regional Office (RO) processes for certifying or otherwise approving providers for furnishing and billing for Medicare services do not address requirements for electronic commerce. Carriers and intermediaries are required to assess the capability of entities that request to submit electronic data, and to establish their qualifications (see test requirements in §50), and enroll and assign submitter identification numbers to those approved (or requesting approval) for electronic submission.

20.1 - EDI Enrollment Form

(Rev.)

A3 3601.4, B3-3021.4

20.1.1 - New Enrollments

(Rev.)

Arrangements for Medicare EMC submission are specified in the CMS standard Electronic Data Interchange (EDI) Enrollment Form. This agreement must be executed by each provider of health care services, physician, or supplier that makes EMC submissions either directly to the Medicare carrier or intermediary or through a trading partner. Each billing provider must sign the CMS standard EDI Enrollment Form and submit it to the carrier or intermediary before the carrier or intermediary will accept production claims from that provider. Carriers or intermediaries may accept a signed EDI Enrollment Form from providers via fax or hard copy. The EDI Enrollment Form is effective as specified in the terms of the agreement.

Providers who have a signed EDI Enrollment Form on file with particular carriers and intermediaries are not required to submit a new signed EDI Enrollment Form to the same carriers and intermediaries each time they change their method of electronic billing, e.g. changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. However, intermediaries and carriers must be notified in advance, and they must inform the provider when the necessary systems changes have been made to accommodate the change. See §20.3 for instructions about such changes.

An organization comprised of multiple components that have been assigned Medicare provider numbers, supplier numbers or UPINS may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which such numbers have been assigned. The organization as a whole is to be held responsible for the performance of its components.

The actual EDI Enrollment Form to be signed is as follows:

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers or intermediaries.

A. The provider agrees:

1. That it will be responsible for all Medicare claims submitted to CMS 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 carriers or

intermediaries, 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 health insurance claim number;
    - 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 carrier or intermediary 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 identifier) of the provider on each claim electronically transmitted to the carrier or intermediary;

10. That the CMS-assigned unique identifier number (submitter identifier) 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 carrier or intermediary, shall not be used by agents, officers, or employees of the billing service except as provided by the carrier or intermediary (in accordance with §1106(a) of Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier or intermediary or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

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

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

2. Affix the intermediary/carrier 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 carrier or intermediary may require the provider to purchase any or all electronic services from the carrier or intermediary or from any subsidiary of the carrier or intermediary or from any company for which the carrier or intermediary has an interest. The carrier or intermediary 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 carriers or intermediaries 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 the carrier or intermediary sells directly, or indirectly, or by arrangement;

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

NOTICE:

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 CMS or the carrier or intermediary. 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.

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name
Title
Address
City/State/Zip
By
Title
Date

NOTE: This is the end of the complete enrollment form.

20.1.2 - Changes in Provider EDI Business Arrangements

(Rev.)

Periodic changes are expected in provider business arrangements, in such areas as agent for transaction submission, EDI format/version used, EDI addresses, etc. A new agreement is not necessary to describe such changes. Instead, an action request form may be submitted by the submitter or provider as appropriate describing the requested change. A standard form is in development by CMS. Until such form is approved, intermediaries and carriers should adapt the following Model Submitter Action Request for local use. The form may be accepted via e-mail if confirmed by a paper copy where signature is required.

SUBMITTER ACTION REQUEST

TO: _____ DATE: _____

Medicare Carrier or Intermediary: _____

FROM: _____ E-mail Address: _____

Phone Number: _____ Fax No: _____

Submitter Name: _____

Submitter Number: _____ Submitter Type: _____

_____ Move from Submitter Number _____ to Submitter Number _____

_____ Add new physician/provider to existing Submitter Number

_____ Delete physician/provider from existing Submitter Number

* _____ Submitter is changing name, address, or contact person

** _____ Physician/provider has changed Clinic Name and / or EIN

** _____ EIN reissued resulting in a Provider Number change

_____ Provider changing computer vendor / system

* If submitter is the provider, must submit current Form CMS-855C before proceeding

** Must submit current Form CMS-855C form before proceeding.

Submitter Address (if changed): _____

Submitter Contact Person/ Phone Number: _____

(if different from requester on this form)

Provider/Group Name: _____

Street Address 1: _____

Street Address 2:_____

City, State, Zip _____

Contact Person/ Phone Number: _____

IMPORTANT: All of the above changes require provider's original signature unless granted blanket approval.

Provider Name	Provider Number	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Attach a list of Provider Names and Numbers if more than 5 providers in group, with signatures if appropriate.

DATA REQUEST:

____ Eligibility: adding ____ terminating ___ format change: _____ to _____

____ ERAS: adding ____ terminating ___ format change: _____ to _____

____ Reports: adding ____ terminating ___ format change: _____ to _____

____ Changing Claim type format from _____ version _____to version _____

____ Changing Communications protocol from _____ to _____

____ Other: _____

DATE EFFECTIVE: _____

Carrier or Intermediary Representative: _____

20.2 - Submitter Number

(Rev.)

A-3604, NSF Specs

Carriers and intermediaries will assign a submitter number to each entity (provider, clearinghouse, billing agent) submitting electronic transactions. If required by the processing system, carriers and intermediaries will also assign numbers to receivers of electronic remittance files. 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). The profile must indicate where response and remittance files are to be returned.

20.3 - Submitter Profile

(Rev.)

B3-3021.7, B3-3021.8 partial, B3-3022

For every qualified EMC submitter, whether submitting directly or through a billing agent or clearinghouse, carriers and intermediaries will establish a profile to include the following information along with any other information required by their system:

- Identifying information (name, address, city, state, ZIP code, contact and phone number);
- If provider, appropriate provider number (PIN, UPIN, NPI, OSCAR);
- Type (provider, vendor, billing agent, clearinghouse, service bureau, trading partner);
- Name, address, city, state, ZIP code, contact name and phone number of billing agent or clearinghouse if applicable;
- E-mail address;
- Fax number;
- Mode of transmission;
- Software used and name, address, city, state, ZIP code, contact name, and phone number of vendor;
- EDI transactions, formats, and version number (claim correction and claim attachment transactions are not currently available for Medicare Part B):
    - Claim - UB92, 1500;

- Format and version - UB92, National Standard Format, ASC X12N 837;
- Method - online, batch;
- Claim correction;
- Claim attachment;
- Claim functional acknowledgment - flat file, ASC X12N 997, claim acceptance report;
- Electronic Remittance - National Standard Format, ASC X12N 835;
- Electronic Funds Transfer;
- Claim status inquiry - ASC X12N 276/277;
- Beneficiary eligibility inquiry - ASC X12N 270/271, NSF batch, online.

NOTE: As of October 16, 2003, of the transactions listed only the 837, 997, 835 and 270/271 transactions will be allowed under HIPAA regulations

Carriers and intermediaries must maintain a free-form comments area to document any information useful in providing EDI support. For instance, documenting the description and resolution of a problem a provider has experienced will be helpful in troubleshooting future problems.

The carrier or intermediary will determine how this profile is structured, including whether it is maintained in a single database or is obtained from multiple databases. The data must be available for processing as needed and for review upon request.

20.4 - Trading Partner Guidelines

(Rev.)

A3-3601.3 partial, 3601.8 partial, B3-3023.2, 3023.4 partial

A trading partner is any entity that does business with Medicare. Carriers or intermediaries shall make trading partners aware of the following guidelines in conducting business.

1. The trading partner will submit claims on behalf of those providers (hospitals, physicians and other health care suppliers) who have given written authorization to do so and will maintain these written authorizations and will furnish true copies to the carrier or intermediary upon request. Acceptance of claims by the carrier or intermediary from the trading partner is conditioned upon the carrier or intermediary's having an executed CMS EDI Enrollment Form for each provider for whom claims are submitted;

2. The trading partner will submit claims to the carrier or intermediary only in the specific format(s) accepted by the carrier or intermediary. The carrier or intermediary must comply with HIPAA (refer to §40) and related CMS guidelines with respect to transaction formats addressed by HIPAA;

3. The carrier or intermediary, the Secretary of Health and Human Services, or his/her designees, have the right to audit and confirm for any purpose information submitted to the trading partner by providers, and any incorrect payments which are discovered as a result of such an audit will be adjusted according to the applicable provisions of the Social Security Act, Regulations, and Medicare Guidelines;

4. If the trading partner is a clinic or group practice, it will give the carrier or advance notice of any changes made in the status, including names and other appropriate identifiers, of physicians or suppliers for whom it is authorized to bill. The carrier must approve the physicians or suppliers for whom the trading partner intends to submit bills;

5. The CMS or the carrier or intermediary may refuse to accept electronic media claims from any provider(s). In such cases, the carrier or intermediary will notify the provider, and submitter if different, but will provide a complete reason only to the provider. The submitter will be informed only that the provider is not approved for electronic billing because such reporting breaches confidentiality between CMS, the carrier or intermediary and the provider;

6. The trading partner will comply with the contractual and licensing requirements and laws and regulations of the state in which it is doing business;

7. The trading partner is obligated to research and correct any and all claim discrepancies caused by it;

8. The trading partner will retain all original source documents submitted to it by the provider. The trading partner will ensure that every electronic entry can be readily associated and identified with the source document received by the trading partner. All such source documents excluding medical records, which will be retained pursuant to State law, will be retained for a period of six years and three months following the date of payment by carrier or intermediary;

9. The confidentiality of beneficiary information and other individually identifiable information is of utmost importance. The trading partner will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from the Department of Health and Human Services, or its agents, shall not be used by it, its agents, officers, or employees except as provided in §1106 of the Social Security Act, the Freedom of Information Act, and the Privacy Act as amended, and the Regulations prescribed thereunder. The trading partner will not disclose any information concerning a Medicare beneficiary to any person or organization other than the carrier or

intermediary or its agents without the express written permission of the beneficiary or his/her lawful representative, except as ordered under jurisdictional court authority;

10. Beneficiary eligibility data can be used only for the purpose of preparing and filing an accurate Medicare claim. The trading partner will not use patient data for any other purpose. Disclosure of these data is restricted under §1106(a) of the Act and State laws. The trading partner will ensure that Medicare patient eligibility data will be made available only to the provider. Retention and indexing of eligibility data is prohibited;

11. The trading partner will submit no claims to the carrier or intermediary which the trading partner knows or has reason to know conflict with the Social Security Act, Federal regulations, or Medicare guidelines;

12. The trading partner will affix the Medicare-assigned number of the provider on each claim electronically transmitted to the carrier or intermediary. This number constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed;

13. The trading partner will provide and maintain the equipment, software, services, and testing necessary to effectively and reliably transmit claims;

14. The trading partner will use security procedures to ensure that all transmissions of documents are authorized and protect all patient-specific data from improper access;

15. The trading partner acknowledges that the data to which it is being provided access are the property of the contracting provider, the carrier or intermediary, or CMS. The trading partner shall not, except to correct errors, modify any data to which it is granted access. Under no circumstances shall it possess any ownership interest in the data, including but not limited to, the right to sell, lease, or otherwise transfer such data to any party other than the provider. The trading partner will, upon request, promptly return originals and copies of any and all documents and data to the owner;

16. The trading partner understands that the submission of an electronic media claim is a claim for Medicare payment and that anyone who misrepresents or falsifies any record or other information essential to that claim may, upon conviction, be subject to fine and imprisonment under federal law;

17. The trading partner will appropriately route acknowledgment files and electronic remittance notices to the provider or, in the case of billing services, to the appropriate staff.

Carriers and intermediaries will conduct at least one meeting annually with their trading partners in order to brief them on planned Medicare eligibility, coverage, payment, and

billing changes. As an alternative to this meeting, carriers or intermediaries may allow trading partners to attend provider education seminars.

20.5 - Release of Medicare Eligibility Data

(Rev.)

A3-3601.5, A3-3601.6, A3-3601.7, B3-3021.5

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

The CMS is limiting the way eligibility data is being accessed by network service vendors. For information regarding network service vendors, review §80.3. Carriers and intermediaries must give access to any network service vendor that requests access to eligibility data on behalf of providers as long as they adhere to the following rules:

- Each network service vendor must sign the new Network Service Agreement below;
- Each provider must be an electronic biller and must sign a valid Electronic Data Interchange (EDI) Enrollment Form;
- The provider must explain the type of service furnished by its network service vendor in a signed statement authorizing the vendor's access to eligibility data; and
- The network service vendor must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a network service vendor, that vendor must be able to identify the correct provider making the request for each beneficiary's information.

A. All providers and network service vendors must negotiate with an intermediary/carrier for access to eligibility data.

B. All providers and network service vendors are routed through the intermediary's/carrier’s front-end software (which in some cases is operated at a data center location).

C. Vendors and providers must use the carrier or intermediary regular noncustomized online process. No special arrangements may be made for providers or network service vendors.

D. Carriers or intermediaries may not allow vendors and providers to go to one fiscal intermediary (FI) to access all eligibility information. Vendors and providers may receive access to eligibility data only from the intermediary that the provider has elected. Vendors must submit eligibility requests on behalf of a given provider only to that provider's own FI.

E. When an inquiry enters into the carrier or intermediary system, the intermediary or carrier must be able to ensure that:

- An EDI agreement has been signed by the provider;
- A network service agreement has been signed by the vendor; and
- Each inquiry can be identified by provider.

F. Carriers or intermediaries will use either the Health Insurance Query A - Part A Inquiry Screen Display (ELGA) or Health Insurance Query A - Part A Inquiry Data (HUQA) data set as it is received from the Common Working File (CWF), or the ANSI X12N 270/271. Note: with the implementation of HIPAA, carriers and intermediaries are required to use the ANSI X12N 270/271. No other data, e.g., local history, etc., shall be substituted for CWF data. Part A information that is accessed by Part A providers may only come from CWF.

G. Providers may use eligibility data only for the approved use of preparing accurate claims. Access to eligibility data is limited to individuals who support this function.

Carriers or intermediaries must contact all providers and network service vendors to advise them of these procedures. Carriers and intermediaries must remind providers that they must let them know when they change from one network service vendor to another, cease arrangements with a network service vendor, or leave the Medicare program. Carriers or intermediaries must delete each provider from their system when it moves to another bill processor or leaves the Medicare program.

20.6 - Network Services Agreement

(Rev.)

A3-3601.8, B3-3021.8

All current and new network service vendors must sign the following Network Service Agreement. No network service vendor will be able to continue to service providers for eligibility access if this agreement is not signed. The following agreement must be added to existing contracts:

The network service agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974, which requires Federal information systems to

establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims, remittance advice, online claims correction, and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically;

2. It is has no ownership rights and is not a user of the data, but merely a means of transmitting data between users that have a need for the data and are already identified as legitimate users under a "routine use" of the system; that is, disclosure for purposes that are compatible with the purpose for which Medicare collects the information;

3. The data submitted to the network service by the carrier or intermediary are owned by Medicare;

4. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than (a) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider's patient, (b) CMS, or (c) CMS' carriers or intermediaries;

5. It will promptly notify the carrier or intermediary of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure;

6. The data will not be stored for any duration longer than that required to assure that they have reached their destination, and no more than 30 days for any purpose;

7. It has identified to the carrier or intermediary in writing any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks;

8. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. Reports may be written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date;

9. It will guarantee that an authorized user may be deleted within 24 hours. Other standards of performance, including, but not limited to, how quickly a user may be added to the network, must be specified in writing;

10. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing and signed by the provider, and each provider has a valid EDI enrollment form on file;

11. It has the ability to associate each inquiry with the provider making the inquiry;

12. It will furnish, upon request, documentation that assures the above privacy concerns are being met;

13. It understands that final regulations on security and privacy standards for health information under the Health Insurance Portability and Accountability Act of 1996 will be forthcoming. It will adhere to those regulations when they become effective;

14. It will require its subcontractors, agents, and business associates to:

    Comply with all applicable current requirements of the Network Service Agreement as well as any future requirements or changes to the Network Service Agreement.

    Require their subcontractors, agents, and business associates to comply with all applicable current requirements of the Network Service Agreement as well as any future requirements or changes to the Network Service Agreement.

15. The CMS does permit the transmission of protected health data between providers and other parties who are not Medicare contractors over the Internet if it is authenticated and encrypted. The CMS policy requires written notification of intent from organizations anticipating use of the Internet. The CMS reserves the right to require the submission of documentation to demonstrate compliance with requirements, or to conduct on-site audits to ascertain compliance.

NOTICE:

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 network service. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with CMS or the carrier or intermediary. Either party may terminate this arrangement by giving the other party (30) days notice of its intent to terminate.

SIGNATURE:

I am authorized to sign this document on behalf of the indicated party, and I have read and agree to the forgoing provisions and acknowledge same by signing below.

Network Service Company Name:

Address:

City/State/ZIP code:

Signed By:

Title:

Date:

Carrier or intermediary:

20.7- EDI User Guidelines

(Rev.)

A3-3602.2, B3-3023.5

Intermediaries and carriers must make available to new electronic billers literature that describes the various steps in the testing process (see §30) and discloses:

- The names and telephone numbers of appropriate staff to contact when:
    - Getting started with electronic billing;
    - Needing on-going support for electronic transactions; and
    - Needing support for general billing issues;
- Testing requirements and the submitter's and carrier or intermediary's level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
    - National Standard Format (NSF);
    - Uniform Bill (UB92 electronic flat file);
    - The American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) X12N transactions, and instructions for accessing and downloading these specifications via the CMS Internet EDI Home Page http://www.cms.hhs.gov/providers/edi/edi3.asp
- The availability of free Medicare EMC software upon request;
- Logon requirements;
- Telecommunications options and requirements; and
- Frequently asked questions about EDI, and the answers.

30 - Technical Requirements - Data, Media, and Telecommunications

(Rev.)

Carriers and intermediaries may not differentiate between a subsidiary of a parent organization and direct submitters in providing EDI support, but must provide the same level of support and quality of service to both.

30.1 - System Availability

(Rev.)

A3-3600.1 partial

Access to 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.

Carriers and intermediaries will inform users of system availability schedules including any planned downtime for system maintenance.

30.2 - Media

(Rev.)

A3-3600.1, A3-3602.1, B3-3023

An electronic claim is defined by its initial manner of receipt including telecommunications and in some cases magnetic tape. An "electronic claim" is one that is submitted via central processing unit (CPU) to CPU transmission, tape, diskette, direct-data entry, direct wire, dial-in telephone, digital fax, or personal computer upload or download. The term "digital fax" refers to a claim that arrives via fax but is never printed on paper. Rather, the fax is encoded while still in electronic form (generally by an optical code reader [OCR]), and electronically entered into the claims processing system, eliminating manual data entry.

When counting electronic claims for workload reporting, the contractor includes data on all bills received for initial processing from providers (including all RHCs) directly or indirectly through a RO, another intermediary, etc. It also includes data on demand bills and no-pay bills submitted by providers with no charges and/or covered days/visits. A contractor does not include:

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

- Misdirected bills transferred to a carrier or another intermediary;
- HHA bills where no utilization is chargeable and no payment has been made, but which you have requested only to facilitate recordkeeping processes (There is no CMS requirement for HHAs to submit no payment non-utilization chargeable bills.); and
- Bills paid by an HMO and processed by the contractor.

Effective October 1, 1998, carriers and intermediaries report claims received via touch-tone phone, fax imaging, and magnetic disk as paper for workload purposes. Refer to Chapter 1, §80,of the Medicare Claims Processing Manual for further information on workload requirements.

However, if it is cost effective, carriers and intermediaries may continue to accept claims received via fax-imaging and magnetic disk.

Billers should be assisted with transition from these media to more efficient electronic media such as the carrier or intermediary's free Medicare personal computer software. Carriers and intermediaries will not prohibit claims submitters from using other cost-efficient telecommunications means by offering these options.

30.3 - Telecommunications/Protocols

(Rev.)

A3-3602.1, B3-3023

Carriers and intermediaries must support transfers for Medicare using v.34 28.8kb or faster modems on the majority or at least half of their asynchronous communications lines. For asynchronous communications, carriers and intermediaries must support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP), 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 Electronic Data Interchange (EDI) transfers over TCP/IP connections, carriers and intermediaries must support File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication (and therefore billing support) through user id/ password mechanisms. The carrier or intermediary must submit any security mechanism in addition to this to CMS for approval prior to implementation. Carriers or intermediaries should not retire any current protocols unless the customer no longer uses them. Any user should be able to use TCP/IP for asynchronous communication at any Medicare site. The Internet may not be used for beneficiary or provider sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project. See §40.6 for CMS policy on Internet use.

Carriers and intermediaries must provide asynchronous telecommunications to any requesting electronic biller and electronic remittance receiver. Carriers and intermediaries must offer data compression, either through the use of the v.34 28.8kb

modem or through PKZIP version 2.04g, whichever the biller requests. While PKZIP is the standard, carriers or intermediaries may, but are not required to, accommodate other compression software which the biller requests. Carriers and intermediaries must enable hardware compression support in their v.34 modems (the actual use is negotiated between the carrier or intermediary modem and the provider modem at startup). In addition, when hardware compression is used, it is possible for the effective data rate to the host system to be as much as four times the line rate (e.g., 4 times 28.8). Therefore, carriers and intermediaries should have adequate processing capacity to handle this amount of data for each connection.

Note: Contractors need not support file compression for X12N transactions. Compression is permitted between the contractor and its data center, if applicable. However, the Medicare Part A Claim/COB flat file must not be compressed when presented to the standard system.

For asynchronous traffic, carriers and intermediaries may not limit the number of claims or the number of providers in a single transmission, although they may limit a single transmission to 5,000 claims if that is necessary for efficient operations. Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

For asynchronous communications, carriers and intermediaries must accept and send all ASC X12N transactions as a continuous byte stream or as a variable length record. The data should not be required to be broken down into 80 byte segments nor should any other deviation from the variable length format or the continuous byte stream format be required. For example, submitters may not be forced to create each segment as its own record by inserting carriage returns or line feeds. For all X12N transactions, only standard X12N envelopes are to be used.

For asynchronous communications, carriers must accept and send the NSF (claim and remittance respectively) in 320 byte records, and intermediaries must accept the UB92 in 190 byte records. The data should not be required to be broken down into 80 byte segments nor should any other deviation from the 190 or 320 byte formats be required. For asynchronous communications, Medicare flat files are self-enveloped, and the envelope provided shall be the only one used.

The X12N 837 standard claim transaction is a variable-length record designed for wire transmission. The CMS recommends the X12N 837 be accepted over a wire connection. However, intermediaries may support tape or diskettes for those trading partners that do not want to send/receive transmissions via wire. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

30.4 - Carrier Toll-Free Service

(Rev.)

B3-3023.1

Carriers make toll free lines available for inquiries, but previously CMS removed funding for toll free dial up for participating physicians, suppliers, and facilities. Telecommunication methods that are cost effective and in common use should be supported. Carriers should follow "Prudent Buyer" principles to decide whether to support a given method. At the carrier's discretion, companies may be changed to improve the efficiency and/or cost effectiveness of long distance service.

30.5 - Initial Editing

(Rev.)

B3-3023.4

Carriers and intermediaries will establish a system for controlling incoming and outgoing data so that the submitter can ascertain that bills submitted have been received.

Carriers and intermediaries will provide initial (pre-control) editing of electronically submitted claims to ensure the completeness and correctness of claims taken into the claims processing system. Initial editing will include format and data editing:

- Format edits validate the programming of the incoming file and include file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, and relational edits; and

- Data editing validates claim-specific data required for claims processing, e.g., procedure/diagnosis codes, modifiers.

Carriers and intermediaries must establish a technique to detect duplicate transmissions.

Carriers and intermediaries should have the capability to reject, or return as unprocessable, at a file, batch or claim level, based upon the edit(s) failed.

Carriers and intermediaries are not required to control claims until all initial edits have been passed.

30.6 - Translators

Refer to the 837 IG download site (http://www.wpc-edi.com/) for a more detailed explanation of control structure/loop references made in this section.

Intermediaries, carriers, and DMERCs must be able to accept a HIPAA compliant X12N 837 transaction into their front-end system and write the X12N-based flat file to the

standard system. A HIPAA compliant X12N 837 transaction may include Medicare data (data sent to the core standard system) and non-Medicare data (data not sent to the core standard system). Translators will validate the syntax compliance of the inbound X12N 837 standard.

Contractors must use the X12N 997 Functional Acknowledgment to report standard level errors detected by translators. They must create the X12N 997 Functional Acknowledgment, as detailed in the X12N implementation guide, to all EDI submitters who submit claims in the X12N 837 format. Contractors must return a X12N 997 within one business day. Contractors may use the X12N 837 standard syntax editing only. Intermediaries are required to use X12N 997 loops AK2, AK3, and AK4. Intermediaries may purge the X12N 997 after five business days in the event the X12N 997 transaction is not received by the submitting entity.

Contractors must accept at least the basic character set on an inbound X12N 837, plus lower case and the @ sign which are part of the extended character set. Read Appendix A, page A, of the Implementation Guide for a description of the basic character set. All other character sets will be rejected at the translation level. If contractors can not accept more than 9,999 loops or segments due to the limitations of the translator, they may reject the transaction at the translator level and use the X12N 997, AK3 segment with a value of "4" in data element "04".

Translators are to edit the envelope segments (ISA, GS, ST, SE, GE, and IEA) and may include the BHT, in order that 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 X12N-based flat file. The BHT is included as part of the envelope because data element BHT01, which indicates the hierarchical structure for the transaction set, may contain a code value other than indicated in the implementation guide and this could cause programming logic to process erroneously. It is contractor choice to edit the BHT at the translator level. Contractors are not required to accept multiple functional groups (GS/GE) within one transmission. Translators must also:

- Convert lower case to upper case;
- Pass all spaces to the X12N-based flat file for fields that are not present in the inbound X12N 837 version 4010A1;
- Map "Not Used" data elements based upon that segment's definition, 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;
- Remove the hyphen from all range of dates with a qualifier of "RD8" when mapping to the X12N-based flat file; and
- Accept multiple interchange envelopes within a single transmission.

40 - Required Electronic Data Exchange Formats With Providers and Submitters

(Rev.)

B3-3023.6, EDI Web site, A-00-89, PM A-01-57, PM B-01-13

A. CMS General Requirements for Data Exchange

The following data record types are available for Medicare providers and submitters. Carriers and intermediaries must accept and provide these formats, where applicable to the transaction. Specifications for each of these records can be found on the Internet on the CMS Home page at http://www.cms.hhs.gov/. Providers with no Internet access who request information to evaluate starting a specific electronic application (e.g., billing, acknowledgment, or remittance) will be furnished a single copy of the related specifications at no charge upon request to the intermediary or carrier. The carrier or intermediary will determine the media. Otherwise, providers are expected to obtain formats and coding requirements from CMS' Web site. The CMS Central Office updates this information as needed.

Although the effective date for changes is also included on the Internet, specific instructions will be issued to providers via CMS manuals and carrier or intermediary bulletins about effective dates and specific changes. These instructions will be limited to an explanation of changes and a description of effective dates. The full record formats will be issued only on the Internet except for providers beginning the use of specific applications as described above.

Providers can use the current version of the format or any other version approved by CMS.

Maintenance of file and record formats used for Medicare claims and remittance advice transactions is the responsibility of CMS' Division of Data Interchange Standards (DDIS). DDIS consults with the ANSI ASC X12N, the National Uniform Claims Committee (NUCC), the National Uniform Billing Committee, and other industry groups to maintain these file and record formats. Medicare implementation guide requirements may not be modified for these file and record formats in any way without express permission from DDIS.

B. HIPAA

The HIPAA administrative provisions direct the Secretary of Health and Human Services to adopt standards for administrative transactions, code sets, and identifiers, as well as standards for protecting the security and privacy of health data. On October 16, 2000, a final rule designated ANSI standards for eight administrative transactions and HCPCS and National Drug codes used in these transactions. This begins the 2-year implementation period, after which all other formats and code sets cannot be used.

Note: ASCA subsequently allowed providers who submitted an extension form an extra year to implement the HIPAA formats and codesets.

Refer to the Washington Publishing Company Web site address at http://www.wpc-edi.com for access to HIPAA transaction set documentation. Standard documents required for HIPAA compliance for Medicare are also available on the CMS Web site at http://www.cms.hhs.gov/hipaa/hipaa2/links/default.asp. Further information on the HIPAA standards requirements in general may be obtained at http://aspe.hhs.gov/admnsimp.

40.1 - Electronic Claims and Claims Support Attachments

(Rev.)

A3-3602.6, B3-3023.6

The provider may elect to use the current version or any format, which CMS currently approves. Currently acceptable versions are listed on the CMS Internet EDI Home Page. The address is http://www.cms.hhs.gov/providers/edi/edi3.asp.

- ASC X12N 837 Institutional and Professional Claim data sets - Intermediaries must accept the institutional format/data set. It is used for Part A claims and Part B claims processed by the intermediary. This format includes UB-92 data. Carriers accept only the professional format/data set. The professional format includes Form CMS-1500 data.

  X12N formats are acceptable only via telecommunications.

- UB-92 electronic data set (intermediaries only) - This is an electronic version of the UB-92. It also includes specific record formats for reporting medical data related to ESRD, home health plan of treatment, and outpatient therapy. Note that the Form CMS 700-701 attachment format is incorporated into the UB-92 format.

- National Standard Format (NSF) (carriers only) - This is an electronic version of the Form CMS-1500. Record formats are included for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies), chiropractic, and ambulance claims.

The records must be accepted in the published national formats, with no local changes. (Use of state or locally defined fields for non-Medicare purposes in accordance with the national specifications record definitions is not considered a local change.)

Wire communication is the preferred media for claim records, as related processes require fewer intermediary and/or carrier resources. Upon request of the provider, the intermediary or carrier may consider other means of electronic communication if cost effective. New communication methods must be approved by the Regional Office.

Neither the carrier nor the intermediary may reject a record for Medicare processing because it contains data not required for Medicare if the data is included in the format definition. The carrier or intermediary system must be able to transfer such non-Medicare data to another payer according to a Coordination of Benefits agreement. However, such data is not edited for processing Medicare claims. Medicare-required data elements are edited for conformity with formats and content requirements, and for consistency with internal carrier/intermediary and/or CMS files.

NOTE: The processes described in above in this section and in §§40.1.1 and 40.1.2 below will sunset October 16, 2003, when the flat files are no longer used under HIPAA. At that time, any changes to code sets associated with the UB-92 or NSF should be made to NUBC/NUCC as appropriate.

NOTE: Some medical review/attachment data currently defined in many of the electronic UB-92 70-series records are not included in the IG. The CMS is looking at alternative ways of processing this data electronically.

40.1.1 - Submitting Change Requests for the UB-92

(Rev.)

A3-3602.6

Change requests must be submitted on the electronic UB-92 Change Request Form. The form must be completed properly and any necessary documentation attached. Intermediaries may also submit change requests for non-Medicare commercial operations. Complete the form as follows:

Line 1 - Enter the Region Number (e.g., Regions I-X) and the date of the request.

Line 2 - Enter your name/organization.

Line 3 - Enter the name of a contact person in your organization that can answer questions concerning the request.

Line 4 - Enter the contact person's telephone number.

Line 5 - Enter the record type (record identifier) and field that you are requesting to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field.

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation.

Indicate whether this change is the result of a CMS mandate.

ELECTRONIC UB-92 CHANGE REQUEST FORM

1. Region: _____ Date:_____

2. Name/Organization: _____

3. Contact Person: _____

4. Phone #: _____

5. Record Type & Field:
_____ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:

_____

Reason for Change:

_____

Impact Statement: (Volume, lines of business involved, field attributes/values, definition, validation, etc.)

_____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a CMS Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: _____

Final Disposition: [___] Approved for Electronic UB-92 Release Date:

_____

[___] Denied

Remarks:

_____

_____

_____

_____

_____

_____

NOTE: Send this form to your RO EDI Coordinator.

40.1.2 - Submitting Change Requests for the NSF

(Rev.)

B3-3025

Central Office (CO) maintains the National Standard Format (NSF) for electronic media claims (EMC) and for electronic remittance advice (ERA) transactions.

Change requests must be submitted to the RO EDI Coordinator on the NSF Change Request Form. The form must be completed properly and any necessary documentation attached. Carriers may also use this form to submit change requests for non-Medicare commercial carriers.

The form is completed as follows:

Line 1 - Enter the region number (e.g., Regions I-X) and the date of the request;

Line 2 - Enter your name/organization;

Line 3 - Enter the name of a contact person in your organization that can answer questions concerning the request;

Line 4 - Enter the contact person's telephone number;

Line 5 - Enter the record type (record identifier) and field that you are requesting to be revised, deleted, or added. Check the appropriate box to indicate whether this is a request to add a new field, delete a field, or revise an existing field;

Line 6 - Check the box to indicate at which level the field is/should be located.

Use the remainder of the form to describe the change request and the reason(s) for the change. Also, include a discussion of the impact of the change, and attach any supporting documentation. Indicate whether this change is the result of a CMS mandate.

NATIONAL STANDARD FORMAT CHANGE REQUEST FORM

1. Region: _____

   Date: _____

2. Name/Organization: _____

3. Contact Person: _____

4. Phone #: _____

5. Record Type & Field:

_____ [___] New [___] Delete [___] Revised

6. Level: [___] File [___] Batch [___] Claim [___] Line Item

Description of Change Being Requested:
_____

Reason for Change:
_____

Impact Statement: (Volume, lines of business involved, field attributes/values,

definition, validation, etc.)

_____

_____

_____

ATTACH ANY DOCUMENTATION WHICH CLARIFIES THIS REQUEST

Is change request a result of a **CMS** Mandate? [___] No [___] Yes

DO NOT COMPLETE THE FOLLOWING SECTION

Control Number: _____

Final Disposition: [___] Approved for NSF Release

Date: _____

[___] Denied

Remarks:

_____

_____

_____

_____

NOTE: Send this form to your RO EMC Coordinator. Non-Medicare commercial carriers may send this form to a Medicare carrier or CMS CO.

40.1.3 - Attachments

(Rev.)

B-02-053

Under the terms of HIPAA, the Secretary of Health and Human Services has established the Accredited Standards Committee (ASC) X12N (Insurance Standards Subcommittee) 278 (Health Care Services Review - Request for Review and Response) version 4010A1 implementation guide (IG) as the national standard for electronic transmission of Referral Certification requests and Authorization responses. This standard must be used by all health care plans, including Medicare's durable medical equipment regional carriers (DMERCs) that conduct Referral Certification and Authorization. DMERCs and their standard system maintainer must complete implementation of the X12N 278 version 4010A1 by October 16, 2003, to meet the requirements of the administrative simplification provisions of HIPAA.

At this time, the DMERC standard system maintainer is analyzing the flat file requirements development for implementation of the X12N 278 version 4010A1 IG.

Additional information, when it is available, will be published in Chapter 25, "Completing and Processing UB-92 Data Set," of the Medicare Claims Processing Manual.

The version 4010A1 implementation guide for the 278 standard may be found at the following Web site: www.wpc-edi.com/HIPAA.

40.2 - Electronic Claims Functional Acknowledgment

(Rev.)

B3-3023.6

Upon provider request, carriers and intermediaries must provide a functional acknowledgment record in response to claims records. If the claims are received in the NSF or UB92 format, the flat file acknowledgment format must be used. See the CMS Internet EDI Home page for the format. For claims received in the X12N 837 format, the X12N 997 format must be used. The acknowledgment must be provided within one business day after the day the claim is received.

The X12N 997 functional acknowledgment and the flat file functional acknowledgment are the only acceptable functional acknowledgment formats.

40.3 - Remittance Records

(Rev.)

40.3.1 - Electronic Remittance Advice

(Rev.)

B3-3023.6, B3-3024.5, A3-3750, PM A-01-57, PM B-01-35

Remittance records must be provided to describe the claims for which payment is made.

- Intermediaries must provide the ASC X12N 835 Transaction Set.

- Carriers must provide the ASC X12N 835 Transaction Set and the NSF. The provider may select which to accept for the period prior to the implementation of HIPAA. Under HIPAA, only the 835 transaction set may be used.

Acceptable versions are published on the CMS Internet EDI Home page. X12N formats are used only via telecommunications. Version 4010A1 implementation guides may be downloaded without charge from http://www.wpc-edi.com/HIPAA, or users may phone 1-800-972-4334 to purchase hard copies.

40.3.2 - Standard Paper Remittance (SPR) Notices

(Rev.)

PM A-01-57, PM B-01-35

By October 2002, standard systems must use the version 4010 flat file, rather than any earlier flat file, to generate SPRs to avoid data variations between SPRs and ERAs in fields shared by both formats. Standard systems may change to use of the 4010 flat file for SPRs at any point after October 1, 2001, as long as completed by October 2002. Standard systems must furnish their intermediaries at least 90 days advance notice of their SPR changeover date. Intermediaries must in turn furnish their SPR users with advance notice of the effective date of the change and any differences they can expect to see in their SPRs as result of the flat file changeover.

Additionally, carriers must support the Medicare Part B Standard Paper Remittance Notice. A copy of the specifications may be requested from the RO. Intermediaries and carriers must distribute the specifications to all requesting providers. Only one change is being made to the SPR format as a result of HIPPA. Standard systems, carriers and DMERCs must complete system changes by following CMS' normal October quarterly release process to enable reporting of a 20-character patient account number in an X12N 835 version 4010A1 when a number that large is submitted on a version 4010A1 claim. The Medicare core system will continue to record a maximum of 17 characters for patient account numbers. Patient account numbers in excess of 17 characters will be populated from the repository established for coordination of benefits for both SPRs and ERAs. If a

provider requests a SPR or ERA after a 20-character patient account number has been purged from the repository, the SPR/ERA will report the first 17-characters only. A similar limitation applies to reporting of provider line item control numbers in ERAs.

All other data elements included in SPRs and ERAs will be populated from the Medicare core system. By as early as October 1, 2001, but no later than October 2002 standard systems must assure that all data elements that appear in both the SPR and the ERA for the same claim contain identical data. Fields shared by both formats for the same claim may not contain different data. As in the past, data not available in an ERA may not be reported in a SPR. SPRs will also be limited to reporting of one secondary payer, even when payment information for a claim is shared with more than one secondary payer under COB trading partners agreements.

40.3.3 - Remark Codes

(Rev.)

PM A-01-57, PM B-01-35

As the initial user of 835 remark codes, CMS became the defacto maintainer of this code set with ASC X12N approval. Since HIPAA applies to virtually all U.S. health care payers, and will result in much more extensive use of the 835 format, many payers other than Medicare will also begin to use remark codes. Remark code wording must be generic. Language referring to Medicare as the source of decisions in many remark code messages has been replaced by references to "we". Since the remittance advice identifies the issuer (Medicare for a claim processed by an intermediary, a carrier, or a DMERC), the meaning is the same. Existing message numbers have also stayed the same.

Carriers and intermediaries must refer to http://www.wpc-edi.com for the currently approved, generically worded remark code messages. These messages may be used in both pre-HIPAA and HIPAA format ERAs and standard paper remittances as soon as programming changes are complete. None of these messages should be new, but if carriers and intermediaries do begin to use any of these messages for the first time, they must furnish providers advance notice of the new messages and their meanings prior to initial use.

The use of "M" and "MA" codes was formerly restricted to line or claim levels. Any remark code may now be reported at either the claim or the line level, i.e., an "MA" code may now be reported in the LQ segment of the 835, and an "M" code in an MOA segment - if the wording of the message fits the situation being described at that level. "N" codes could always be reported at either the claim or the service level. All new remark codes will now begin with "N." Refer to the 835 Implementation Guide (IG) download site (wpc-edi.com) for an explanation of the all references.

Neither a Medicare carrier, DMERC, nor a non-Medicare payer may use a remark code in a version 4010A1 835 transaction that does not appear on http://www.wpc-edi.com or a subsequent CMS-produced update to this list. This listing will be updated as needed, and

is nationally accessible at http://www.wpc-edi.com by selecting the Guides, Health Care Code Lists, and Remittance Advice Remark Codes menu listings. Carriers and intermediaries must download the remark code message set from this Web site every quarter to keep abreast of the full list of messages approved for use. Also included on the Web site are instructions to request modifications or additional remark codes. New remark codes introduced to meet Medicare-specific needs will continue to be included in the implementation instruction for the Medicare change that necessitated the new message. Remark codes will not otherwise be published in Medicare manuals nor will they be maintained on a CMS Web site.

40.4 - Electronic Funds Transfer

(Rev.)

B3-3023.6, B3-4430, A3-3750, A1-1430

Electronic funds transfer (EFT) is the preferred method of payment. Carriers and intermediaries must obtain and retain a signed copy of Form CMS-588, Authorization Agreement for Electronic Funds Transfer, from each provider. If the provider refuses to accept electronic deposit to his bank account, determine the reason, and attempt to convince the provider to accept direct deposit via EFT. Note that provider pick-up of checks, next day delivery, express mail, and courier services are no longer allowed except in special situations authorized by the CMS RO; and that EFT is as quick or quicker than any other method of payment.

The intermediary or carrier must use a transmission format that is both economical and compatible with the servicing bank. Normally this will be either the National Automated Clearinghouse Association Format (NACHA) or the ASC X12N 835 EFT format.

40.4.1 - Payment Floor Requirement

(Rev.)

A3-3600.1 - partial, A1-1430, B3-4430

Carriers and intermediaries 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.

40.4.2 - Alternative to EFT

(Rev.)

A3-3600.1 - partial, A1-1430, B3-4430

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

40.4.3 - Tri-Partite Bank Agreement

(Rev.)

A3-3600.1 - partial, 1430, B3-4430

Intermediaries and carriers 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 Manual, Pub. 100-6, Chapter 5, "Financial Reporting," §160, "EFT."

40.5 - Electronic Beneficiary Eligibility Inquiry

(Rev.)

B-02-051 - partial, A-02-065

The 270/271 is a "paired" transaction (the 270 is an in-bound eligibility inquiry and the 271 is an out-bound eligibility response).

In order to implement the HIPAA administrative simplification provisions, the 270/271 has been named under 45 CFR 162 as the electronic data interchange (EDI) standard for Health Care Eligibility Benefit Inquiry/Response. All other real time and batch formats for health care eligibility inquiry and response, other than DDE, become obsolete October 16, 2003.

Additionally, fiscal intermediaries (FIs) and the common working file (CWF) must implement the TCP/IP connection for the Health Care Eligibility Benefit Inquiry and Response (270/271) transaction by January 1, 2003.

See Chapter 25, "Completing and Processing UB-92 Data Set" of the Medicare Claims Processing Manual.

The version 4010A1 implementation guide for the 270/271 standard may be found at the following Web site: www.wpc-edi.com/HIPAA.

40.6 - Electronic Communication of Other Information

(Rev.)

The CMS will publish updates to the following on the CMS Web page.

- National physician fee schedule, lab fee schedule, DME fee schedules;

- HCPCS updates;
- ASC price groupings;
- ICD-9-CM codes and descriptions; and
- DRG and PPS Pricer information.

Intermediaries and carriers must establish their own Web pages to publish local bulletins, announcements and instructions. Carrier and intermediary Web pages must be linked to the appropriate CMS Web pages instead of independently publishing duplicate tables and formats that CMS publishes. This requires less expense than incurring independent, duplicate development costs and promotes a single national standard.

The CMS standards for publishing documents on the Internet are to provide downloadable files in Hypertext Markup Language (HTML). Where necessary carriers and intermediaries may provide selected files in Adobe PDF format or in word processor formats.

The CMS does not provide Internet browsers or PDF viewers. It is assumed that an Internet user already has a browser, which will read HTML. Adobe Corporation provides free software that will read Adobe PDF files to increase the use of its software. It can be downloaded from the Adobe Corporation Home Page (http://adobe.com). A number of other sources also furnish free Adobe PDF Readers.

50 - Testing

(Rev.)

50.1 - Requirements for Initial Implementation for Submitters

(Rev.)

A3-3602.2, B3-3023.4

All submitters must electronically produce accurate claims. All new submitters must send the carrier or intermediary a test file containing at least 25 claims, which are representative of their practice or service. Carriers or intermediaries may, based on individual consideration, increase or decrease the number of claims required to adequately test any given submitter.

Carriers or intermediaries will subject test claims to format and data edits and will provide documentation of all edits.

- Format testing validates the programming of the incoming file and includes file layout, record sequencing, balancing, alpha-numeric/numeric/date file conventions, field values, relational edits. Test files must pass 100 percent of format edits before production is approved. A carrier or intermediary may

temporarily waive the 100 percent requirement where, in its judgement, the vendor/submitter will make the necessary correction(s) prior to submitting a production file.

- Data testing validates claim-specific 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. A carrier or intermediary may temporarily waive accuracy requirements for a submitter and allow claims to be submitted to production. However, the carrier or intermediary will work with the submitter to increase claim accuracy to at least 95 percent.

Carriers and intermediaries will provide test results to the submitter within three business days.

Carriers and intermediaries may require potential submitters to have an approved Medicare provider as a client prior to providing testing support.

50.2 - Testing New Providers for Existing Submitters

(Rev.)

A3-3602.2, B3-3023.4

Testing for submitter addition of new providers is not required where all of the following apply.

- For claims, the provider is in the same specialty group (carrier) or provider type (intermediary) as other providers for which the submitter has successfully tested. See §50.3 for a description of same specialty groups and provider types. This criterion is not required for non-claims transactions, e.g. eligibility queries. Prior approval for any provider type is acceptable for eligibility queries.

- The submitter currently submits transactions of the same type (UB-92, NSF, or X12N format) and version for at least five active providers

- The usual error rate for front-end edits for the submitter does not exceed five percent of the transactions. In this context front-end edits means format and data testing as described in §50.1, and telecommunications protocols; and not patient eligibility status, or Medicare policy or adjudication issues. In determining the error rate for this purpose, a single claim counts as one regardless of the number of errors on it, e.g., a batch of 100 claims may contain no more than five claims with errors, but the number of errors on each claim is not considered.

Where a submitter's error rate rises above five percent in a month the carrier or intermediary must notify the submitter in writing. The carrier or intermediary should provide the submitter a 30-day period to correct the problems before requiring testing for

new providers. Also, the carrier or intermediary may excuse testing for new providers if the cause for the error rate is outside the control of the carrier or intermediary and submitter (e.g., implementation of new systems changes required by legislation without adequate time for preparation).

This provision for excusing formal testing for new providers for submitters does not change standard provider enrollment procedures where the submitter's new provider is also a new provider for the Medicare program.

50.3 - Similar Provider Groups for Testing

(Rev.)

A3-3602.2, B3-3023.4

All provider specialties (carrier) or provider types (intermediaries) that fall within each of the following categories are considered the same provider type as other provider types that fall within the same category, for administration of test requirements described in §50.2.

A Intermediaries

Hospital and SNF inpatient A (includes Swing Beds)

Hospital and SNF inpatient B and outpatient

HHAs

CORFs

ESRD (hospital based and independent)

Hospices

All other

B Carriers

Surgery

Medical

Diagnostic/Therapeutic (excluding independent lab)

Independent Lab

Chiropractic

Podiatry

Physical Therapy

Ambulance

Anesthesiology

Portable X-Ray Supplier

Durable Medical Equipment

Psychiatry/Psychology

Ambulatory Surgical Center

Physiological Lab

50.4 - Changes Initiated by CMS or Carrier or Intermediary

(Rev.)

A3-3602.2, B3-3023.4

The carrier or intermediary will determine whether changes initiated by CMS or the carrier or intermediary will require retesting, e.g., changes to the NSF, or telecommunication changes. Upon determining the need for testing, carriers or intermediaries will notify submitters of impending changes and testing requirements and will make available the documentation needed to implement the change. Intermediaries must provide 90 days notice prior to the implementation date. Carriers must provide 60 days notice. Once a submitter has demonstrated that change is successfully implemented, all existing clients may migrated to the new release without testing.

50.5 - Changes in Provider's System or Vendor's Software

(Rev.)

A3-3602.2, B3-3023.4

Changes in the provider's system that could affect the accuracy of their claims (e.g., software changes, status change from individual to group) may require retesting. Vendors, billing agents, clearinghouses, and Value Added Networks (VANs) should also notify carriers or intermediaries when planning changes to their systems and discuss the need for testing. Upon such notification, carriers and intermediaries will work with the submitter and if necessary with the provider, vendor, clearinghouse, or VAN to determine the appropriate level of testing.

60 - Provider Support and Training

(Rev.)

60.1 - User Guidelines

(Rev.)

B3-3023.6, A3-3600.7

Carriers and intermediaries will make available to potential submitters a user guide with detailed information on:

- The telephone numbers of appropriate staff to contact when:
    - Getting started with electronic billing;
    - Needing on-going support for electronic transactions; and
    - Needing support for general billing issues;
- Testing requirements and the submitter's and carrier or intermediary's level of responsibility throughout each step of the testing process (see §30);
- The availability of the appropriate specifications for this provider and instructions for accessing these via the Internet and/or bulletin board system;
- The availability of the carrier or intermediary's provider bulletins via the Internet and/or bulletin board system;
- The availability of the carrier or intermediary's EDI instructions or procedures via the Internet and/or bulletin board system;
- The availability of the carrier or intermediary's free Medicare EMC software upon request (Note that the requirement to provide free software will go away in 2004);
- Logon requirements;
- Hours of operation, system and support;
- Telecommunication options and requirements;
- Procedures for updating submitters with any billing changes;
- Formats required for input to the carrier or intermediary's system. These specifications must be in sufficient detail for the submitter's use, and must include information regarding code, tape density (when applicable), record length(s), field

positioning within record(s), labeling and any other conventions necessary for compatibility with the carrier or intermediary's system;

- All acceptance and rejection formats for output from the carrier or intermediary's system that will be returned to the submitter;

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

- Documentation related to all carrier or intermediary edits, with the exception of those edits which are prohibited from publication due to medical review or fraud and abuse policy, along with indication of which edits are prior to control (front-end processing) and which are post control;

- Description of other EDI functions (claim status, eligibility inquiry, claim acknowledgment and attachments, ERA, EFT, electronic mail, bulletin boards) and the availability of specifications and instructions for each (**NOTE:** Availability of all transactions may not be available with Medicare Part B carriers. Claims correction is not available for any Part B carriers.)

- The availability of online claim entry, claim correction (intermediaries only), claim status check, eligibility verification, claim development, and the procedure for accessing these transactions;

- Specifications of the carrier or intermediary's front-end editing process with complete list of error codes and resolution, including those conditions that will result in the rejection of EDI transmissions/batches;

- Conventions for acknowledging claims received, for recovering data known to be lost and for required biller backup procedures;

- Instructions for notifying carrier or intermediary of changes to the submitter profile;

- Carrier and Intermediary listings of trading partners who are approved for production and have testing requirements waived;

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

- Frequently asked questions about EDI, and the answers.

60.2 - Technical Assistance to EDI Trading Partners

(Rev.)

B3-3023.7 A3-3600.7

Carrier and intermediaries will provide help desk support to assist submitters 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.

Help desk activities may 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, operator.
- Track activities related to the call to the final resolution of the call: identification of routing, callbacks, issues, and resolution.
- Workload distribution of open items.
- Classification of call types for resource planning, provider education, management reporting.
- Storage of caller-specific audit trails.

In addition to an automated call system, intermediaries and carriers must provide for receipt of e-mail, voice mail, or fax 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 days. This plan should include one or more of the following:

- An indication that the carrier or intermediary looked into the issue and did not identify a problem;
- The submission of a new corrected file;
- 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 carrier or intermediary action, and a description of the plan for resolution and estimated completion date.

Where the problem affects multiple submitters the carrier or intermediary must notify all submitters that are affected by the issue.

60.3 - Training Content and Frequency

(Rev.)

B3-3023.7, A3-3600.7

The carrier or intermediary will provide training for medical office and hospital staff in EDI procedures, use of Medicare carrier or intermediary issued software, accessing EDI transactions, and any other EDI-related functions available. The following are some examples of training methods.

- Instructor-led training may be conducted at the carrier or intermediary site or at the provider's location as required;

- Video-taped instruction;

- Training may be accomplished through training manuals and online help with minimal telephone support; and

- Area professional association meetings may provide a willing venue for cost-effective training.

Carriers or intermediaries will determine the most appropriate yet cost-effective way in which to conduct training. Where appropriate, carriers or intermediaries should develop user groups for general EDI users and free software users. Medicare carriers or intermediaries are not required to support or train providers on the use of software provided by commercial vendors/trading partners. Training should be available for any new electronic biller. On an ongoing basis, carriers or intermediaries should assess the need for additional training based on:

- Periodic identification and evaluation of common billing errors;

- New software release; or

- The introduction of new EDI functions or changes to existing functions.

60.4 - Prohibition from Requiring Proprietary Software

(Rev.)

B3-3024.1, B3-3024.3

Carriers or intermediaries will accept and process transactions created from any software as long as the transaction format adheres to HIPAA (refer to §40) and CMS requirements. Carriers or intermediaries are prohibited from the exclusive acceptance of proprietary billing or telecommunication software.

If carriers or intermediaries offer an interactive terminal option, they must offer it to all EDI trading partners at a reasonable cost. They may not limit the use of interactive terminals only to those who submit bills through a carrier or intermediary subsidiary.

60.5 - Free Claim Submission Software

(Rev.)

B3-3024.2, 3023

NOTE: The free-billing software distributed by intermediaries is maintained through the standard system maintainer. Software functionality is controlled through an arrangement with the standard system maintainer and the software developer and not by the intermediaries. Currently, intermediaries are only responsible for testing and distribution of the software.

Carriers and intermediaries will make available to submitters who bill, or wish to bill, via electronic means, basic software free of charge. A fee up to $25.00 per release may be charged to cover postage and handling for the free PC software. The software must create records in either UB92 or the ASC X12N 837 for institutional providers or in the NSF or the ASC X12N 837 for professional providers. Billing software must be able to create an IG compliant Medicare claim.

Carriers and intermediaries will not provide general-purpose translators from provider systems to the 837 format. Prior to distributing the initial or updated versions, carriers and intermediaries will scan the software with a current anti-virus program. Carriers and intermediaries should be able to provide demonstration diskettes of their free claim submission software.

This basic software must, at a minimum, contain the following:

- Front-end 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;

- The ability to prepare and send CMS-approved EDI forms of paper attachments (as they are developed and approved); and

- The ability to retrieve and print the ASC X12N 997 functional acknowledgment or the flat file functional acknowledgment.

60.6 - PC-Print Software

(Rev.)

PC-Print software will not be available for ANSI X12N 837, versions 4010 and forward.

60.6.1 - Medicare Standard PC-Print Carrier Software (PC-Print-B)

(Rev.)

B3-3024.4, PM B-01-35

The requirement for Carriers to support PC- Print has been rescinded due to the fact that PC Print will not support the 835 version 4010 or 4010A.

60.6.2 - Medicare Standard Intermediary PC-Print Software (PC-Print-A)

(Rev.)

A3-3751, PM A-01-57

Intermediaries must periodically notify providers that free PC-Print software is available. They must supply providers with PC-Print software within three weeks of request. The PC-Print software will allow them to print remittance data transmitted in any 835 format version supported by Medicare. The standard system maintainer will distribute the PC-Print software and user's guide through the processing center. The software and instructions are to be designed to be self-explanatory to providers; it should not be necessary to furnish providers training for use of PC-Print software. Providers are responsible for any telecommunication costs associated with receipt of the 835.

The PC-Print software enables providers to:

- Receive over a wire connection an 835 electronic remittance advice transmission on a personal computer (PC) and write the 835 file in American National Standard Code for Information Interchange (ASCII) to the provider's A (floppy disk) drive;

- Print 835 claims and a provider payment summary information;

- View and print a single claim; and

- View and print a sub-total by bill type.

The receiving PC always writes an 835 file in ASCII. The providers may choose one or more print options, i.e., the entire transmission, a single claim, a summary by bill type, or a provider payment summary. All file and print formats must follow the Medicare national standards described in the specifications. Since the software performs limited functions, malfunctions should rarely occur. If software malfunctions are detected, they are to be corrected by the fiscal intermediary standard system maintainer. Individual intermediaries or processing centers may not modify the PC-Print software.

In compliance with HIPPA requirements, the Fiscal Intermediary Standard System (FISS) maintainer must upgrade PC-Print for version 4010, and share the upgrade with both the FISS Data Centers and the Arkansas Part A Standard System Data Centers for distribution to their intermediaries, and through them, to provider users or providers that request the software. Individual intermediaries must not be funded to develop or procure alternate PC-Print software. The PC-Print software must operate on Windows-95, 98, 2000/Me, and NT platforms, and include self-explanatory loading and use information for providers.

60.7 - Newsletters/Bulletin Board/Internet

(Rev.)

B3-3023.7, A3-3600.7

To educate providers and encourage the use of EDI functions, carriers and intermediaries must publish EDI newsletters. These newsletters should:

- Announce any upcoming changes;

- Point out common billing errors and provide guidelines to eliminate errors; and

- Promote non-claim related EDI functions.

As an alternative to an EDI newsletter, carriers and intermediaries may publish articles in an EDI section in their regular provider bulletin. Carriers and intermediaries will provide access to newsletters via bulletin boards and/or the Internet.

Carriers and intermediaries must maintain an Internet site that links to CMS' Web site, which provides record formats and related claim information. If the identical information is available on the CMS Home page, carriers and intermediaries should provide the link to it rather than duplicating development and maintenance. Further instructions on Internet use are in §40.6.

60.8 - Provider Guidelines for Choosing a Vendor

(Rev.)

B3-3022

Providers may request assistance in choosing a vendor. Carriers and intermediaries must furnish the guidelines below in §§60.8.1 - 60.8.4 to providers that make such requests. Upon request, the carrier or intermediary may also provide a list of vendors that are billing for the same provider type, and may provide factual information such as claims volumes, and types of providers serviced. However, care must be taken to avoid making a specific recommendation and to avoid showing favoritism.

Providers may select any vendor that provides the necessary services. However, vendors must enroll and achieve satisfactory test performance as required by other sections of the Medicare Manual before submitting production claims to the carrier or intermediary for provider services rendered.

60.8.1 - Determining Goals/Requirements

(Rev.)

EDI Support Manual

Before selecting a vendor, the provider must examine its business needs to identify the services needed from a vendor. The provider should consider what services it wants to provide from internal operations and what services it wishes provided by a vendor. To receive better vendor proposals, the provider should create a written description of the components of its practice that need vendor support and a description of support needed. 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.

60.8.2 - Vendor Selection

(Rev.)

B3-3022 partial, EDI Support Manual

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:

- Talk to the Medicare carrier or intermediary;
- 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?
- 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?

6. 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.

60.8.3 - Evaluating Proposals

(Rev.)

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 (diskettes, tapes, paper, ribbons);
    - 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.

60.8.4 - Negotiating with Vendors

(Rev.)

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.

70 - Crossover Claims Requirements

A3-3602.3

(Rev.)

Prior to HIPAA, each supplemental insurer specified criteria related to the claims it wanted the carrier or intermediary to transfer. Examples of claims most frequently excluded from the crossover process are:

- Totally denied claims;
- Claims denied as duplicates or for missing information;
- Adjustment claims;
- Claims reimbursed at 100 percent; and
- Claims for dates of services outside the supplemental's policy effective and end dates.

The supplemental insurer will provide an eligibility file no less frequently than monthly, preferably weekly.

The carrier or intermediary will provide the claim payment information in either the UB-92 or NSF COB flat file or X12N COB format. This information will be transferred no less frequently than weekly.

Under HIPAA the carrier or intermediary will provide only the X12N COB format.

A - Standard System Claim/COB flat file

If the standard 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 (intermediary or data center) by the standard system with an appropriate error message. If a syntax error occurs at the standard level, intermediaries must return the entire transmission (ISA to IEA) to the submitter via the X12N 997.

The date of receipt is to be generated upon receipt of a claim, prior to transmission of the data to the data center. The intermediary has the responsibility to ensure the correct date of receipt is populated onto the Medicare Part A Claim/Coordination of Benefit (COB) flat file (flat file) **before** the file gets to the standard system. The standard system will process the date of receipt reported in the flat file. If the flat file contains an incorrect date of receipt (e.g., all zeros), the flat file will be rejected back to the flat file's submitter (intermediary or data center) by the standard system with an appropriate error message.

70.1 - Intermediary Requirements

(Rev.)

A-01-20, A-02-069, A-02-077, A-02-078, AB-02-20

A - Standards

External Keyshop or Imaging Processing

Intermediaries only support the UB-92 version 6.0 as the output format for paper claims received from their external keyshop or imaging processes. However, since CMS will cease to support the UB-92 version 6.0, eventual migration to the Medicare Part A Claim/COB flat file as the output format for these claims will need to occur by October 1, 2003. If intermediaries decide to use the Medicare Part A Claim/COB flat file as output for these claims, intermediaries may bypass the IG edits since these claims will not contain all of the data on the inbound X12N 837 transaction.

Provider Direct Data Entry (DDE)

DDE systems are not subject to the syntax (format) requirements of the standards, but must contain "applicable data content" for the claim. Intermediaries 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 CMS recognizes that DDE is currently the only viable means of EDI available to some providers, particularly small providers. The widespread use of the standard HIPAA transactions will 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. Implementing the data content portion of the standards now means that a provider's change from DDE

to their own EDI software (or to use of a clearinghouse) would be simplified, and plans would be able to accommodate DDE-generated data and HIPAA standard transaction-generated data in the same databases.

In this context, "applicable data content" means the standard system's DDE systems must:

- Collect all fields 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 IG 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 standard system's internal claim records); and

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

Additionally, the following HIPAA DDE updates are effective January 6, 2003. DDE systems must:

- 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.

There is no need to collect non-Medicare data. 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 standard system files, an IG compliant COB transaction can be written.

NOTE: Additional edits may be needed based on further analysis and issues that may be encountered during implementation.

B - Edits Performed by the Intermediary

Intermediaries are to perform standard and IG edits as explained in the IG. IG edits should be standard among all intermediaries. If a syntax error occurs at the IG level, the intermediary may reject the entire transmission, the functional group, batch, or claim. At

a minimum, it must return the claim to the provider (RTP) if it is not HIPAA compliant. Amounts, percentages, integers, and other fields designated in the IG as numeric will be right-justified and zero-filled if the incoming data is smaller than the Medicare Part A Claim/COB flat file field size. Fields designated in the IG as alpha-numeric will be left-justified and space filled if the incoming data is smaller than the Medicare Part A Claim/COB flat file field size. All non-Medicare data field lengths will correspond to the maximum IG length. Incoming alpha-numeric non-Medicare data will be left-justified and space filled if the data is smaller than the Medicare Part A Claim/COB flat file field size. Incoming numeric non-Medicare data will be right-justified and zero-filled if the data is smaller than the Medicare Part A Claim/COB flat file field size. Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) will be mapped to the Medicare Part A Claim/COB flat file (and later written to the store-and-forward repository (SFR) by the standard system). The following programmatic edits override the IG:

- Claims where the ZIP code exceeds nine positions will be left adjusted and the claim will be processed.

- Data where there is an IG note, internal code list, external code list, or qualifier will be limited by the reference. Claims where data exceeds referenced sizes are to be flagged so the standard system can RTP with an appropriate error message.

- The submitter Employer Identification Number (EIN) will not exceed 10 positions. Claims where the EIN exceeds 10 positions are to be rejected with an appropriate error message.

- Incoming data mapping to data elements marked "NOT USED" in the IG will be disregarded.

- All date data will not exceed eight digits (CCYYMMDD), except for date ranges. Claims where the date data exceeds eight positions (and not a valid date range) are to be rejected with an appropriate error message.

- Claims where the attending, referring, or operating physician numbers exceed 16 positions are to be flagged so the standard systems can RTP with an appropriate error message.

- Units of service will not exceed seven positions. Claims where the Units of service exceed seven positions are to be flagged so the standard system can RTP with an appropriate error message.

- Number of days (covered, lifetime reserve, etc.) will not exceed four positions. Claims where the number of days exceeds four positions are to be flagged so the standard systems can RTP with an appropriate error message.

- Credit card and foreign currency data will be disregarded per note in the IG stating that this information must never be sent to the payer and therefore would not be included on the COB transaction.

- IG edit process will map amounts to the Medicare Part A Claim/COB flat file using the COBOL picture of S9(8)V99 (10 positions). Other numeric data elements will be mapped to the data size described within the Medicare Part A Claim/COB flat file document. Numeric data fields larger than the data size described within the Medicare Part A Claim/COB flat file document will be populated with "HIGH-VALUES". HIGH-VALUES has the hexadecimal value X"FF" (a character code of all binary ones).

- As of April 2003, the CMS changed the service line limit to 449. For claims exceeding 449 service lines, write the first 449 lines to the Medicare Part A Claim/COB flat file (the claim will later be RTP'd by the standard system with an appropriate error message based on the missing 0001 line).

- All spaces will be passed to the Medicare Part A Claim/COB flat file for fields that are not present in the inbound X12N 837 version 4010A1.

- The IG allows for the units of service segment to contain a decimal. However, Medicare does not process units of service that contain any decimals. Intermediaries must round units of service that contain decimals so the standard system can process the resulting numeric unit of service (i.e., if the number to the right of the decimal is four or less, round down. If the number to the right of the decimal is five or greater, round up).

- The IG allows for diagnosis codes to contain a decimal. However, the intermediary systems do not process diagnosis codes containing decimals. If an incoming claim contains a diagnosis code with a decimal in the correct position based on the external code source, the intermediary must reformat the diagnosis code into a 6-position alphanumeric field as defined in the Medicare Part A/COB flat file (flat file) where the digits are left justified and space filled when translating the data into the flat file format. The decimal will be assumed between the third and fourth digit (i.e., 999V9bb - "V" represents the assumed decimal and "b" represents a space). If an incoming claim contains a diagnosis code with a decimal in an incorrect position based on the external code source populate (flag) the field with ampersands.

- Intermediaries must suppress the one HCPCS code per Revenue Code edit in their translators to avoid rejecting outpatient claims with line level revenue codes but no HCPCS code.

- Intermediaries must also suppress their translator edit for the absence of a date of service where there are no HCPCS codes.

C - Edits Performed by the Standard Systems

- Claims containing a diagnosis code flagged with ampersands will be returned to the provider/submitter, via the intermediary, with an appropriate error message

- Claims with numeric data elements containing HIGH-VALUES are to be returned by the standard system to the provider via the intermediary with an appropriate error message.

- Claims with S9(8)V99 numeric data elements containing an amount greater than corresponding fields set in the core system at 9 digits (S9(7)V99) are to be returned by the standard system to the provider via the intermediary with an appropriate error message.

- Data residing on the Medicare Part A Claim/COB flat file as a result of data received in loop 2010BD RESPONSIBLE PARTY NAME of the X12N 837 will be RTP'd with an appropriate error message because Medicare policy requires a signature on file for payment.

- Standard systems are not to return non-Medicare data to the provider.

For more information on edits, refer to the Medicare Edits Document available at http://www.cms.hhs.gov/providers/edi/hipaadoc.asp.

D - Outbound COB

The outbound COB transaction is a post-adjudicative transaction. This transaction includes the incoming claim data as well as COB data. Intermediaries are required to receive all possible data on the incoming 837 although they do not have to process non-Medicare data. However, the standard system must store that data in a SFR. This repository file will be designed and maintained by the standard system. This data must be reassociated with Medicare claim and payment data in order to create an IG compliant outbound COB transaction using the Medicare Part A Claim/COB flat file as input. The standard system is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. The standard system must retain the data in the SFR for a minimum of 6 months.

The Medicare Part A Claim/COB flat file is the format to be used to reassociate all data required to map to the COB transaction. The translator will build the outbound COB transaction from the Medicare Part A Claim/COB flat file.

Intermediaries are not required to process an incoming X12N 997. They may create and use their own proprietary report(s) for feedback purposes.

The standard system maintainer must accommodate the COB transaction.

E - Transmission Mode

The CMS recommends that the outbound COB transaction be sent over a wire connection. However, tape or diskettes may be sent to those trading partners that do not wish to receive transmissions via wire. COB trading partners will need to reach agreement on telecommunication protocols. It is the intermediary choice as to whether it wishes to process the X12N 997 Functional Acknowledgment from COB trading partners.

F - External Keyshop or Imaging Processing

Data on claims received from the keyshop or image processing systems may not be included on the SFR, depending on standard system design. Intermediaries must create their Medicare Part A Claim/COB flat file using data available from claim history and reference files. Since some data will not be available on these "paper" claims, the outbound COB transaction will be built as a "minimum" data set. It will contain all "required" COB transaction segments and post-adjudicated Medicare data.

G - Summary of Process

The following summarizes all intermediary steps from receipt of the incoming claim to creation of the outbound COB:

- Intermediary's translator performs syntax edits, IG edits, and Medicare edits and maps incoming claim data to the Medicare Part A Claim/COB flat file;
- Medicare data on the Medicare Part A Claim/COB flat file is mapped to the core system by the standard system.

  NOTE: No changes are being made to core system data fields or field sizes;
- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the SFR by the intermediary's standard system; and
- Adjudicated data is combined with SFR data to create the outbound COB transaction.

70.2 - Carrier/DMERC Requirements

(Rev.)

B-01-32, B-01-06, OCR/ICR definition created through outside IS text

A - Decimal Data Elements

Refer to the 837 IG download site (http://www.wpc-edi.com/) for a more detailed explanation of control structure/loop references made in this section.

All decimal data elements are defined as "R" based on X12N protocol. The translator should write these data elements to the X12N-based flat file at their maximum field size, which will be initialized to spaces. The COBOL picture found under the X12N 837 element name will be used to limit the size of the amounts. These positions are right justified and zero-filled. Translators are to convert signed values using the conversion table shown below. This value is to be placed in the last position of the COBOL-defined field length. The last position of maximum defined field length of the X12N-based flat file data element will be used as a placeholder to report an error code if an "R" defined data element exceeds the limitation that the Medicare system is authorized to process. The error code values are: "X" = value exceeds maximum amount based on the COBOL picture, "Y" = value exceeds maximum decimal places based on the COBOL picture, "Z" = value exceeds x-number of precision places, and "b" blank will represent no error. For example, a dollar amount with the implementation guide maximum of 18-digits would look like 12345678.90. The translator will map this amount to the X12N-based flat file using the COBOL picture of S9(7)V99. The flat file amount will look like 23456789{bbbbbbbbX. The "{" is the converted sign value for positive "0". The error switch value is "X" since this value exceeded the COBOL picture of S9(7)V99.

Conversion Table

Positive Values	Negative Values
1 = A	-1 = J
2 = B	-2 = K
3 = C	-3 = L
4 = D	-4 = M
5 = E	-5 = N
6 = F	-6 = O
7 = G	-7 = P
8 = H	-8 = Q
9 = I	-9 = R
0 = {	-0 = }

B - Keyshop and Optical Character Recognition (OCR)/Image Character Recognition (ICR)

OCR/ICR are data input technologies based on the recognition of numbers or text through special input devices.

Carriers may continue to use the National Standard Format (NSF) as the output format for paper claims received from keyshop and OCR/ICR. However, since CMS will cease to support the NSF, eventual migration to the X12N-based flat file as the output format for these claims will need to occur. If carriers decide to use the X12N-based flat file as output for these claims, they may bypass the implementation guide edits since these claims will not contain all of the data on the inbound X12N 837 transaction.

C - Provider Direct Data Entry (DDE)

Since there is little provider use of DDE, it is not cost effective to redesign any existing DDE screens. Carriers are to eliminate support of DDE in conjunction with the elimination of the NSF for claim submission. Carriers may continue to use existing DDE screens for claim corrections since this function is not subject to HIPAA.

D - Implementation Guide Edits

The standard system will program edits per Medicare instructions and edits should be standard between all shared systems.

E - Outbound Coordination of Benefits (COB)

The outbound COB transaction is a post-adjudicative transaction. This transaction includes incoming claim data as well as COB data. Carriers are required to receive all possible data on the incoming X12N 837 although they do not have to process non-Medicare data. However, they must store that data in a store-and-forward repository (SFR). This repository will be designed by the standard system. This data must be reassociated with Medicare claim and payment data in order to create an outbound X12N 837 COB transaction. The standard systems maintainer is to use post-adjudicated Medicare data (data used from history and reference files to adjudicate the claim) instead of data received when building the outbound COB transaction. Carriers must retain the data in the SFR for a minimum of six months.

The X12N-based flat file is the format to be used to reassociate all data required to map to the outbound X12N 837 (4010A1). The translator will build the outbound X12N 837 COB from the X12N-based flat file.

The standard system maintainer must create the outbound X12N 837.

F - Transmission Mode

The CMS recommends that carriers send the outbound X12N 837 COB transaction over a wire connection. However, they may send tape or diskettes to those trading partners that

do not wish to receive transmissions via wire. COB trading partners will need to reach agreement on telecommunication protocols. It is the carrier choice as to whether it wishes to process the X12N 997 Functional Acknowledgment from COB trading partners.

G - Keyshop and OCR/ICR

Data on claims received from the carrier keyshop or OCR/ICR may not be included on the SFR, depending on the standard system design. Carriers must create the X12N-based flat file using data available from claim history and reference files. Since some data will not be available on these "paper" claims, the outbound X12N 837 COB will be built as a "minimum" data set. It will contain all "required" X12N 837 COB segments and post-adjudicated Medicare data.

H - Summary of Process

The following summarizes all the steps from receipt of the incoming claim to creation of the outbound COB:

- Carrier's translator performs syntax edits and maps incoming claim data to the X12N flat file;
- Standard system creates implementation guide and Medicare edits for the flat file data;
- Medicare data on X12N flat file is mapped to the core system;

  NOTE: No changes are being made to core system data fields or field sizes.

- Non-Medicare data (and Medicare data elements where field sizes are in excess of the core system) are written to the store-and-forward repository; and
- Adjudicated data is combined with repository data to create the outbound COB.

I - Additional DMERC Requirements

If the DMERC or the standard system maintainer encounters an error when editing non-Medicare data, DMERCS must include language on reports that not only is the data in error, but the data is not required by Medicare.

80 - Security

(Rev.)

80.1 - Carrier or Intermediary Data Security and Confidentiality Requirements

(Rev.)

A3-3601.1, B3-3021.1

All Medicare beneficiary-specific information is confidential and subject to the requirements of §1106(a) of the Act and implementing regulations at 42 CFR Part 401, Subpart B. 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 45 CFR Part 5b. Such information is included in claims, remittance advice, eligibility information, online claims corrections, and any other transactions where medical information applicable to an individual is processed or transported. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed. Carriers and intermediaries must ensure the security of all EDI transactions and data. They must include the following system security capabilities:

- Make sure that all data are password protected and that passwords are modified at periodic but irregular intervals, 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.

80.2 - Carrier and Intermediary EDI Audit Trails

(Rev.)

A3-3601.2, B3-3021.2

Carriers and intermediaries must maintain an automated transaction tracking and retrieval capability and retain an audit trail of online and batch transaction experience(s) affecting the complete processing of a claim from date of receipt to date of payment or denial and any subsequent adjustments.

Carriers and intermediaries must be able to retrieve:

- The claim as received from the provider of health care services, physician, supplier, or billing service;
- The claim as paid to the provider of health care services, physician, or supplier;
- All adjustments made on the claim;
- The check or the electronic funds transfer (EFT) record sent to the provider of health care services, physician, or supplier; and
- The remittance advice as sent to the provider of health care services, physician, or supplier.

Carriers and intermediaries must maintain the ability to cross-refer all needed transactions to each claim being processed. The records may be kept on electronic, computer-output-microfilm, or optical disk 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. 100-1, 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.

80.3 - Security-Related Requirements for Subcarrier or Intermediary Arrangements with Network Services

(Rev.)

A3-3601.3, B3-3021.3

A **network service** is any entity other than a billing service, engaged in EDI with a carrier or intermediary, on behalf of Medicare providers. Network services may not view privacy-protected Medicare data. For EDI, that would be any transaction in which either a beneficiary or a provider may be identified.

Some health care providers retain more than one billing service or network. Carriers and intermediaries may choose to support more than one service, but only if their system is adequate to protect Medicare data from being viewed by unauthorized users. Each service may access **only** its own information. As an example, let us say that a hospital would like to have one service for eligibility inquiry, another for initial claims, and yet another for denied claims. The hospital reserves claim status and remittance advice for its own staff. The billing service may access any claims it submitted on the hospital's behalf, and it may perform all of the functions that the provider may perform, if the provider designates that. The eligibility service is a network service. It may send inquiries from the provider, and return responses, but it may not view the data, store it, or use it for any reports. The service that works only on denied claims may have no access as it is neither a wire service nor are they a billing service (e.g., it does not submit initial claims), but rather it must work directly with the hospital. As long as the system is capable of ascertaining that no service gets access to any information it is not authorized to see, then carriers and intermediaries may support the multiple services.

Authorization for access to Medicare claims data must be in writing and signed by the provider. Each provider must be an electronic biller and must sign a valid EDI enrollment form. A separate password is to be used for each provider's access**.**

A **vendor** provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual insurance companies. Vendors have no need to access Medicare data from a carrier or intermediary. Rather it supplies to the provider the means for such access.

An **eligibility verification** vendor is to be treated as a network service.

A **billing service** offers claims billing service to providers. The billing service collects the providers' claim information electronically then bills the appropriate insurance companies, including Medicare. It may do claims billing only, or provide full financial accounting and/or other services. Billing services may view beneficiary or provider data if they must to perform their obligations to the provider, and if the provider designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider's behalf.

A **clearinghouse** transfers or moves EDI transactions for a provider. A clearinghouse accepts multiple types of claims and sends them to various payers, including Medicare. Clearinghouses perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgements and remittance advices. Clearinghouses ordinarily submit initial claims, and ordinarily qualify as billing services.

A **value added network (VAN)** transfers or moves EDI transactions for a provider. A VAN may not read the contents of files containing beneficiary- or provider- specific information. VANs are treated as networks.

A **collection agency** is a service that bills after the original biller. Do not service collection agencies.

NOTE: The carrier or intermediary is responsible for maintenance of necessary carrier or intermediary files and processing procedures to prevent unauthorized access to Medicare information. Arrangements for Medicare electronic claim submission are specified in the CMS standard Electronic Data Interchange (EDI) Enrollment Form. This agreement must be executed by each provider of health care services, physician, or supplier that makes electronic submissions. See §20.3.