CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 900

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: APRIL 7, 2006

Change Request 4398

NOTE: This Transmittal is being reissued because the URLs in the manual instruction were broken. The URLs have been corrected and this instruction will maintain the same transmittal number. All other information remains the same.

SUBJECT: Update to Chapter 24 CMS Website URL References

I. SUMMARY OF CHANGES: The www.cms.hhs.gov website has been completely redesigned. The new website employs a user-friendly design to get visitors the information they need with the least amount of clicks. Currently, Chapter 24 does not contain the new URL's that link to the new www.cms.hhs.gov website. This CR updates the URL's that are currently in Chapter 24 and replaces them with the new URL's or removes them if they no longer apply.

NEW/REVISED MATERIAL
EFFECTIVE DATE: May 8, 2006
IMPLEMENTATION DATE: July 7, 2006

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

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

R/N/D	**Chapter / Section / SubSection / Title**
R	24/20/20.5/EDI User Guidelines
R	24/40/40.1/General HIPAA EDI Requirements
R	24/40/40.2/Continued Support of Pre-HIPAA EDI Formats
R	24/40/40.3.3/Remark Codes
R	24/90/90.6/Exhibit C

R	24/90/90.6/Exhibit E

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 900	Date: April 7, 2006	Change Request 4398

NOTE: This Transmittal is being reissued because the URLs in the manual instruction were broken. The URLs have been corrected and this instruction will maintain the same transmittal number. All other information remains the same.

SUBJECT: Update to Chapter 24 CMS Website URL References

I. GENERAL INFORMATION

A. Background: The www.cms.hhs.gov website has been completely redesigned. The new website employs a user-friendly design to get visitors the information they need with the least amount of clicks.

B. Summary of Changes: Currently, Chapter 24 contains URL's that no longer direct the user to our new website. If used, the following message will appear. We're sorry. The page you requested can not be found. CMS has recently launched a website redesign and many addresses have changed. This CR updates the URL's that are currently in Chapter 24 and replaces them with the new URL's and has removed the URL’s that no longer apply.

II. BUSINESS REQUIREMENTS

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4398.1	Contractors shall be aware of the additions/deletions/changes to the URLs on the CMS website.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4398.2	A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 8, 2006 **Implementation Date:** July 7, 2006 **Pre-Implementation Contact(s):** Tom Latella, thomas.latella@cms.hhs.gov (410) 786-1310 **Post-Implementation Contact(s):** Tom Latella, thomas.latella@cms.hhs.gov (410) 786-1310	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

20.5- EDI User Guidelines

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

FIs, carriers, and DMERCs must make EDI information available to new users that describe the various steps in the testing process (see §30 and §60) and discloses:

- The names and telephone numbers of appropriate staff to contact when:
  - Getting started with EDI;
  - Needing on-going support for electronic transactions; and
  - Needing support for general billing issues;
- Testing requirements and the submitter's and carrier, DMERC, or FI's level of responsibility throughout each step of the testing phase;
- The availability of the appropriate specifications for this provider:
  - American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) X12N transactions adopted under HIPAA; and
  - National Council for Prescription Drug Programs Format (NCPDP) adopted under HIPAA.
- The availability of free Medicare electronic claim submission software upon request;
- *Instructions for accessing and downloading CMS EDI instructions via the CMS Internet EDI Home Page http://www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp*
- Login requirements;
- Telecommunications options and requirements; and
- Frequently asked questions and answers about EDI.

40.1 General HIPAA EDI Requirements

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

The following HIPAA transaction standards must be supported by the Medicare FIs, carriers, and DMERCs for the electronic exchange of data with Medicare providers/submitters/COB trading partners. Electronic transactions that do not fully comply with the implementation guide requirements for these formats will be rejected:

- *X12N 837 implementation guide (IG) version 4010A1 for Institutional(I) and Professional (P) claims can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp and coordination of benefits (COB) with other payers can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/12_COB.asp ;*
- *NCPDP Telecommunication Standard Specifications and IG version 5.1 and Batch Standard 1.1 for retail prescription drug claims (billed to DMERCs only) and COB (see § 40.1 of this chapter for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp ;*

- *X12 835 IG version 4010A1 for Remittance Advice (see Chapter 22 for additional information) and can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/11_Remittance.asp ; and*
- *X12 276/277 IG version 4010A1 for Claim Status Inquiry & Response (see Chapter 31 for additional information) can be accessed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/10_ClaimStatus.asp*

Medicare FIs, carriers, and DMERCs will not be involved in Medicare acceptance and processing of the X12 270/271 IG version 4010A1 transactions for Beneficiary Eligibility Inquiry & Response but information on that transaction is available at www.cms.hhs.gov/ElectronicBillingEDITrans/09_Eligibility.asp . The 270 transaction will be accepted and processed, and a 271 returned by CMS directly. See Chapter 31 for further information.

Although not mandated by HIPAA, as noted in § 30.6, CMS also requires that carriers, DMERCs, and FIs issue an X12 997 transaction to electronic claim submitters to acknowledge receipt of claims (except where waived by a submitter) and to report syntax errors related to any X12N transactions submitted to Medicare.

The initial HIPAA transactions regulation required that covered entities eliminate use of electronic formats and versions not adopted as national standards under HIPAA by October 16, 2002 (applies only to the transaction types addressed by HIPAA). Subsequent legislation in the Administrative Simplification Compliance Act (ASCA) permitted covered entities to apply for a 1-year extension to October 16, 2003, to enable them to complete implementation of the standards mandated by HIPAA. Most covered entities, including Medicare, did request that extension. As a significant portion of the covered entities had still not completed implementation by October 16, 2003, to avoid disruption in health care payments and services, the Secretary of Health and Human Services (HHS) allowed payers to implement contingency plans effective October 16, 2003 to temporarily continue to support pre-HIPAA transaction standards. The contingency plans were permitted to allow additional implementation time for those providers and clearinghouses making a good faith effort to become compliant with the HIPAA transaction requirements to complete work in progress.

CMS announced on August 4, 2005 that the Medicare HIPAA inbound claims contingency plan will end on October 1, 2005. That means that all electronic claims sent to Medicare on or after October 1, 2005, that do not comply with the 837 version 4010A1 IG or the NCPDP requirements will be rejected. The Medicare contingency plan for the X12 835, 276/277 (version 4010 support will need to be terminated), 837 claims that Medicare sends to another payer as provided for in a trading partner agreement, and the 270/271 version 4010A1 transactions remain in effect pending further notice. CMS will issue advance notice to the health care industry when a decision is reached to terminate the remaining Medicare contingency plans.

See Pub.100-09, the Medicare Contractor Beneficiary and Provider Communications Manual, regarding contractor requirements for furnishing information to providers via the Internet and alternate methods to be used to furnish information to those providers that lack Internet access. Contractors are permitted to charge providers up to $25 to recoup their costs for manual distribution of free billing or PC-Print software via diskette, CD, or other hard media which providers are normally expected to download via the Internet. Contractors are to notify new users of EDI that they should make arrangements to enable them to download later format, and most related coding updates, via the Internet.

An overview of any changes to existing specifications, including effective dates will be issued to providers via carrier, DMERC, or FI bulletins, on their Web page, and will also be available via the Internet as Manual transmittals which can be viewed via a link from www.cms.hhs.gov/ElectronicBillingEDITrans/01_Overview.asp.to the page for each type of transaction. These overviews will identify the Web site address and record title where the specifications for the changes will be recorded.

40.2 Continued Support of Pre-HIPAA EDI Formats

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Pending termination of the Medicare contingency plan for the HIPAA mandated transactions types other than claims sent to Medicare, carriers, DMERCs, and FIs are required to temporarily continue to support use of the following pre-HIPAA electronic transaction formats until the earlier of the effective date for CMS elimination of the HIPAA contingency plan that applies to each noted format, or the date when no further providers, billing agents, or clearinghouses are using those formats:

- X12 837 institutional (FIs only) and professional(carriers and DMERCs only) version 4010 and 3051, National Standard Format (NSF) version 3.01 (carriers and DMERCs only) and the UB-92 version 6.0 flat file claims for coordination of benefits sent to other payers under trading partner agreements;
- X12 835 versions 3030Ma, 3051.3A, and 3051.4A for remittance advice (FIs only);
- X12 835 IG versions 3030Mb, 3051.3B, and 3051.4B for remittance advice (carriers and DMERCs) and NSF versions 1.04, 2.01 and 3.01 (carriers and DMERCs);
- X12 270/271 IG version 3051 for eligibility query and response (carriers only);
- Proprietary format for eligibility data responses using the CMS standard eligibility data set; and
- X12 276/277 version 4010.

Carriers, DMERCs, and FIs must accept and provide these formats, where applicable for the noted transactions. See Chapters 22 (remittance advice), 25 (UB-92), 26 (CMS-1500), and 31(claim status and eligibility data) for additional information. *Specifications for each of these transactions can be found on the Washington Publishing Company web site at http://www.wpc-edi.com/HIPAA for those X12 IGs (other than the NCPDP) adopted as national standards under HIPAA. CMS also publishes all HIPAA IG "companion documents". To access a companion document for a specific transaction, go to www.cms.hhs.gov/ElectronicBillingEDITrans and select the specific transaction on the left side of that screen. There will be a link to the companion document at the bottom of the page for that transaction.* "Companion documents" contain supplemental Medicare requirements and information for providers, vendors, clearinghouses, COB trading partners and/or Medicare carriers, DMERCs, and FIs on application of certain situational requirements, code usage, and Medicare interpretations of certain information in the IGs. Companion documents supplement but may not contradict the IGs. Companion documents are designed to clarify Medicare's expectations about use of

situational loops, segments and data elements, and other Medicare-specific information that may impact reporting of data in the HIPAA transactions. Carriers, DMERCs, and FIs are required to adhere to the requirements of the Medicare companion documents as well as the HIPAA standard transaction IGs.

X12 version 4010 IGs were initially adopted as first set of X12 national transaction standards under HIPAA, but were subsequently supplanted by an amended version, 4010A1. Medicare shared system maintainers were required to complete programming changes for implementation of the X12 version 4010A1 IGs that apply to Medicare (837 claim/COB, 835, 276/277) by April 1, 2003. In some cases, individual extensions were approved as result of contractor transitions between shared systems, or due to local issues.

40.3.3 - Remark Codes

((Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

AB-02-067, AB-02-142, AB-03-012

Carriers and FIs can download the currently approved remark code list from http://www.wpc-edi.com/codes/remittanceadvice 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. If carriers and FIs begin to use any of these codes for the first time, they must furnish advance notice to providers, including the code, the text, and under what situations the code will be used. Carriers, DMERCs, and FIs must use only currently valid codes available at the two Web sites mentioned above. CMS issues code update instruction every four months, informing of the changes made in the previous four months. In addition, contractors will be notified of new/modified codes that Medicare initiated in conjunction with a policy change, in the form of a PM or manual instruction implementing the policy change.
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.”

90.6 - Provider Education

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Medicare contractors were required to include information on their provider Web site and in a newsletter by April 2004 to notify providers of/that:

1. Providers that do not qualify for a waiver as small and that do not meet any of the remaining exception or waiver criteria must submit their claims to Medicare electronically;

2. Small provider criteria and that small providers are encouraged to submit as many of their claims electronically as possible;
3. FTE definition and calculation methodology;
4. Exception criteria;
5. Unusual circumstance criteria;
6. Self-assessment requirements;
7. Process for submission of an unusual circumstance waiver;
8. Additional claims, such as certain claim types not supported by free billing software, that must continue to be submitted on paper pending any contractor or shared system modifications to enable those claims to be submitted electronically;
9. Submission of paper claims constitutes an attestation by a provider that at least one of the paper claim exception or waiver criterion applies at the time of submission;
10. Repercussions of submitting paper claims when ineligible for submission of paper claims;
11. Post-payment monitoring to detect providers that submit unusually high numbers of paper claims for further investigation; and
12. Waiver request submitted by providers should include the providers' name, address, contact person, the reason for the waiver, why the provider considers enforcement of the electronic billing requirement to be against equity and good conscience, and any other information the contractor deems appropriate for evaluation of the waiver request.

Exhibit C—Request for Documentation from Provider Selected for Review to Establish Entitlement to Submit Claims on Paper
(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Date:

From: Contractor (May be preprinted on a contractor's masthead)

TO: Organizational Name of Provider

Subject: Review of Paper Claims Submission Practices

A large number of paper claims were submitted under your provider number during the last calendar quarter. Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of

the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

ASCA prohibits submission of paper claims unless providers are classified as:

1. FI small providers - To qualify, a provider required to submit claims to Medicare must have fewer than 25 full-time equivalent employees (FTEs).
   Carrier small providers - To qualify, a physician, practitioner, or supplier that bills Medicare must have fewer than 10 FTEs;
2. Dentists;
3. Participants in a Medicare demonstration project when paper claim filing is required by that demonstration project due to the inability of the applicable implementation guide adopted under HIPAA to report data essential for the demonstration;
4. Providers that conduct mass immunizations, such as flu injections, that prefer to submit single paper roster bills that cover multiple beneficiaries and who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of flu shot claims;
5. Providers that submit a claim for Medicare payment after the claim was processed by more than one other payer;
6. Providers of home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply , e.g., oxygen saturation is not greater than 88%, arterial PO_2 is more than 60 mmHg;
7. Those few claims that may be submitted by beneficiaries;
8. Providers that only furnish services outside of the United States;
9. Providers experiencing a disruption in their electricity or communication connection that is outside of their control; and
10. Providers that can establish that an "unusual circumstance" exists that precludes submission of claims electronically.

The Centers for Medicare & Medicaid Services (CMS) interprets an "unusual circumstance" to be a temporary or long-term situation outside of a provider's control that precludes submission of claims electronically and therefore, it would be against equity and good conscience for CMS to require claims affected by the circumstance to be submitted electronically. Examples of "unusual circumstances" include:

a. Limited temporary situations when a Medicare contractor's claim system would reject a particular type of electronically submitted claim, pending system modifications (individual Medicare claims processing contractors notify their providers of these situations if they apply);
b. Providers that submit fewer than 10 claims per month to a Medicare contractor on average;

c. Documented disability of each employee of a provider prevents use of a computer to enable electronic submission of claims;
d. Entities that can demonstrate the information necessary for adjudication of a Medicare claim, other than a medical record or other claim attachment, cannot be submitted electronically using the claims formats adopted under the Health Insurance Portability and Accountability Act (HIPAA); and
e. Other circumstances documented by a provider, generally in rare cases, where a provider can establish that due to conditions outside the provider's control it would be against equity and good conscience for CMS to enforce the electronic claim submission requirement.

If you intend to continue to submit paper claims, please respond within 30 calendar days of the date of this letter to indicate which of the above situations is your basis for continuing submission of paper claims to Medicare. Include with your response, evidence to establish that you qualify for waiver of the electronic filing requirement under that situation. For instance, if you are a small provider, evidence might consist of copies of payroll records for all of your employees for (specify the start and end dates of the calendar quarter for which the review is being conducted) that list the number of hours each worked during that quarter. If you are a dentist, evidence might be a copy of your license.

If you are in a Medicare demonstration project, evidence might be a copy of your notification of acceptance into that demonstration. If you are a mass immunizer, evidence might be a schedule of immunization locations that indicates the types of immunizations furnished. If you experienced an extended disruption in communication or electrical services, evidence might consist of a copy of a newspaper clipping addressing the outage. If the paper claims were submitted because this office notified you of a system problem preventing submission of these claims electronically, please note that in your response.

If your continuing submission of paper claims is the result of medical restrictions that prevent your staff from submitting electronic claims, evidence would consist of documentation from providers other than yourself to substantiate the medical conditions. If you obtained an unusual circumstance waiver, evidence would be a copy of your notification to that effect from this office or the Centers for Medicare & Medicaid Services.

In some of these situations, permission to submit paper claims applies only to a specific claim type, e.g., flu shots, for a temporary period. In those cases, only those claims can be submitted on paper. Providers that received waivers for a specific claim type or for a specific period are still required to submit other claims electronically unless they meet another criterium, e.g., small provider, all staff have a disabling condition that prevents any electronic filing, dentist, or otherwise qualify for a waiver under a situation that applies to all of their claims.

If you cannot provide acceptable evidence to substantiate that you are eligible under the law to continue to submit paper claims to Medicare, we will begin to deny all paper

claims you submit to us effective with the 91st calendar day after the date of this notice. This decision cannot be appealed.

If in retrospect, you realize that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. *See (Contractor is to enter the URL) for further information on enrollment for use of EDI, use of free billing software and other EDI information).* There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs.

Sincerely,

Contractor Name

Exhibit D—Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of non-response to that letter

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Date:

From:	Contractor (may be preprinted on a contractor's masthead)
To:	Organizational Name of Provider
Subject:	(Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form.

Our records indicate that you are submitting paper claims to Medicare and did not respond to our initial letter requesting justification to establish that you qualify for submission of paper claims to Medicare. Nor do we have information available to us that would substantiate that you meet any of the limited exceptions that would permit you to legally submit paper claims to Medicare.

Consequently, as noted in the initial letter as well as in information issued providers when this requirement was put into effect, any Medicare paper claims you submit more than 90 calendar days from the date of the initial letter requesting evidence to substantiate

your right to submit paper claims will be denied by Medicare. You may not appeal this decision.

If you did not respond because you realized that you do not qualify for continued submission of paper claims, you have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. *See (Contractor is to enter the URL) for further information on enrollment for use of EDI, use of free billing software and other EDI information).* There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs.

Sincerely,

Contractor Name

Exhibit E—Notice that paper claims will be denied effective with the 91st calendar day after the original letter as result of determination that the provider is not eligible to submit paper claims.

(Rev. 900, Issued: 04-07-06; Effective: 05-08-06; Implementation: 07-07-06)

Date:

From:	Contractor (may be preprinted on a contractor's masthead)
To:	Organizational Name of Provider
Subject:	(Review of Paper Claims Submission Practices

Section 3 of the Administrative Simplification Compliance Act, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, require that all initial claims for reimbursement under Medicare be submitted electronically as of October 16, 2003, with limited exceptions. The ASCA amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Entities determined to be in violation of the statute or this rule may be subject to claim rejections, overpayment recoveries, and applicable interest on overpayments.

We have (Reviewed your response to our initial letter requesting you to submit evidence to substantiate that you qualify for submission of paper claims under one of the exception criteria listed in that letter. Upon (Review, we have determined that you do not meet the paper claims waiver/exception criteria because (contractor must insert the reason). This determination is not subject to appeal.

Consequently, any Medicare paper claims you submit on or after the 91st calendar day from the date of the initial letter requesting that evidence will be denied by Medicare. You have a number of alternatives to consider for electronic submission of your claims to Medicare. This office can supply you with HIPAA-compliant free billing software for submission of Medicare claims. *See (Contractor is to enter the URL) for further information on enrollment for use of EDI, use of free billing software and other EDI information).* There is also commercial billing software, billing agent, and clearinghouse services available on the open market that often include services other than Medicare billing and may better meet your needs.

Sincerely,

Contractor Name