

Chapter 4: Electronic Data Interchange

Electronic Billing

NOTE: ELECTRONIC CLAIM SUBMISSION IS REQUIRED UNDER SECTION 3 OF THE ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA), PUBL. 107-105, AND THE IMPLEMENTING REGULATION AT 42 CFR 424.32.

Medicare claims submitted electronically, via Electronic Data Interchange (EDI), have the benefits of being filed faster, more efficiently, and more cost-effectively than paper claims. Suppliers who do not bill claims electronically should consider the following advantages of EDI:

- 14-day payment floor versus 29-day payment floor for paper claims
- Increased accuracy and minimized rejections - direct processing (processors do not re-key claims)
- Availability of Electronic Remittance Advice (ERA) for faster posting
- Online claim status verification/eligibility
- Electronic Certificates of Medical Necessity (CMNs)
- Ability to submit claims seven days a week, including holidays (excluding system maintenance)
- A department dedicated solely for EDI support for faster problem resolution
- Electronic Funds Transfer (EFT)

EDI is available to both participating and non-participating suppliers; also, assigned and non-assigned claims are accepted.

Suppliers have several options available to them for electronic billing. If suppliers wish to bill directly to the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC A), they can request DME MAC As free Health Insurance Portability and Accountability Act (HIPAA)-compliant software, they may purchase a vendor's software package, or they can have an in-house programmer create software for them. Alternatively, suppliers can use a third party, such as a billing service or clearinghouse, to bill electronically to DME MAC A. Suppliers using a vendor or in-house software are required to pass format testing with EDI before billing.

Note: For information on testing, visit the "EDI - Testing Information" section of the DME MAC A Web site at www.medicarenhic.com/dme/editesting.shtml

ViPs Provider Inquiry System

One benefit of electronic billing is online claim status. Online claim status inquiries allow an electronic biller to check on a claim-by-claim basis the status of their assigned claims. To access the ViPs Provider Inquiry System (VPIQ), suppliers must fill out the VPIQ Enrollment form packet. To

obtain this packet of forms, or for more information, visit the DME MAC A Web site at www.medicarenhic.com/dme/vpiq.shtml

Electronic Eligibility

The following are the rules and regulations for using electronic eligibility, per Pub. 100-4, *Medicare Claims Processing Manual*, Chapter 2, Section 30.6 (crosswalked from Section 6100 of the *Medicare Carriers Manual* (MCM)) and Chapter 24, Section 20.3 6 (crosswalked from Sections 3021.5 and 3021.8 of the MCM):

- The claims-to-inquiry ratio must be at least 80 percent (%).
- **If the claims-to-inquiry ratio does not exceed 80 percent from a given provider, that provider will receive an educational contact from DME MAC A. If there is a problem, or the behavior continues, then the provider loses inquiry access.**
- The eligibility information that the provider receives is only for their use. It is not to be shared with any healthcare providers that are not certified and doing business electronically with the Medicare intermediary or carrier.
- Please note that penalties for illegal disclosure of this information are as follows: being found guilty of a misdemeanor and being fined not more than \$5,000.
- Disclosure of Common Working File (CWF) eligibility data is restricted under the provisions of the Privacy Act of 1974, 5 U.S.C. 552A. Under limited circumstances, the Privacy Act permits DME MAC A to disclose information without the consent of the individual; one of these is for “routine uses,” that is, disclosure for purposes that are compatible with the purpose for which DME MAC A collects information. In the case of this provider access, a routine use exists which permits release of data to providers or their authorized billing agents for the purpose of verifying a patient’s eligibility for benefits under the Medicare program. The use of the data by a provider in preparing bills for hospital-based physicians would be an example of unauthorized use, because the physicians are not Medicare providers as defined in the act.
- Access of eligibility data is used only for submitting a complete and accurate claim and is not to be disclosed to anyone that is not responsible for submitting a claim.
- The eligibility data is only good for the time the provider is receiving it. This information could change at any time. If the beneficiary is not on file, the provider must use the usual billing procedures in effect independent of this data access.

Electronic Transactions

Another benefit of electronic billing is the Electronic Remittance Advice (ERA). An ERA is available to the supplier several days sooner than the paper remittances, which arrive in the mail. (Refer to Chapter 7 of this manual for samples of remittance advices.) More importantly, when using vendor-billing software, the remittance information can be interpreted by the supplier's computer system and automatically posted to the patient's account. Several clerical posting steps can be abbreviated or eliminated. To sign up for ERAs, suppliers will need to sign and return an "ERA Enrollment Form" to DME MAC A. The form is available via our Web site at

www.medicarenhic.com/dme/dme_edi.shtml

For further information on remittance advice refer to the "Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers" on the Centers for Medicare & Medicaid Services (CMS) Web site at

www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

DME MAC A also offers the option of receiving payments electronically. Electronically deposited funds are available in the supplier's account within three days after DME MAC A transmits an Electronic Funds Transfer (EFT) to the bank. This means the DME MAC EFT funds will usually be available to the supplier one week sooner than the DME MAC paper funds. To sign up for EFT, suppliers will need to follow the enrollment procedure on the DME MAC A Web site at

www.medicarenhic.com/dme/eft.shtml

Once suppliers are setup on EFT, they can eliminate receiving standard paper remittance (SPR) notices. If suppliers are receiving ERAs, they will still continue to do so. If suppliers want to receive an ERA, but do not have the software to do so, visit the DME MAC A Web site at *www.medicarenhic.com/dme/dmedi_mrep.shtml* for information about obtaining free Medicare Remit Easy Print (MREP) software.

ERA/EFT Process

- **Payment Floor:** DME MAC A has a mandated payment floor. This means DME MAC A must wait a specific number of days after a claim is received before a payment can be created. Currently, the payment floor for electronically submitted HIPAA-compliant claims is 14 days. The payment floor for paper claims and non-HIPAA compliant electronic claims is 29 days.
- **Packaging and Delivery:** DME MAC A will create two electronic packages, one containing the ERA and one containing the EFT. ERAs may be retrieved via the Jurisdiction A Bulletin Board System (see next page for information on the bulletin board system). DME MAC A will send the

EFT to our originating bank. The originating bank will send the EFT to the supplier's receiving bank, where it will be immediately deposited into the supplier's account.

- **ERA Format:** DME MAC A provides the CMS-specified format for electronic remittance notices. At present, it is the American National Standards Institute (ANSI) 835 X12N version 4010A1 standard, as mandated by HIPAA.
- **EFT Format:** DME MAC A will send the supplier's EFT payment in the Automated Clearing House (ACH) CCD+ format. Most banks belong to the National Automated Clearing House Association (NACHA) and accept this format. The supplier's bank must accept the CCD+ format.
- **Fund Availability:** Generally, DME MAC A will transmit the supplier's EFT payment on the fourteenth day after date of receipt. The supplier's bank will receive the payment the next day, and in most cases, the funds should be available for use on the following business day.

Bulletin Board System

A Bulletin Board System (BBS) is available. The BBS:

- Allows submitters to submit claims in an electronic format.
- To maintain security, each supplier will receive a submitter number and password to log onto the BBS.
- Submitters receive electronic file rejection reports, 24 to 48 hours after transmitting a file, via the BBS.

For more information on the reports, refer to "Electronic Claims Transmission Reports - What They Are and How to Use Them" at www.medicarenhic.com/dme/ECTReports.pdf on the DME MAC A Web site.

EDI ListServes

There are two ListServes available via the "EDI" section of the DME MAC A Web site:

- The EDI ListServe is used to notify subscribers of important announcements and messages pertaining to EDI. If suppliers submit claims electronically, it is strongly recommended that they sign up for the EDI ListServe.

- The MREP software is available for viewing and printing HIPAA-compliant ERAs. In order to effectively utilize this software, sign up for the “MREP ListServe” to receive important information and updates.

To join any of the DME MAC A ListServes, visit www.medicarehbc.com/dme/index.shtml and click on “Join the DME MAC A ListServe”.

EDI Help Desk

Contact the EDI Help Desk toll-free at 866-563-0049 to obtain additional information on electronic data interchange submission and/or its features. Or, visit the “EDI” section on the DME MAC A Web site at www.medicarehbc.com/dme/dme_edi.shtml