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Submitting Paper Attachments to Medicare Claims

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This Timely Topic will appeal to those who really enjoy getting into the technological weeds but the information it provides will come in handy when you need to send a paper attachment to an electronic claim.

Most claims are transmitted electronically from physicians to payers through Electronic Data Interface (EDI) transactions. Even physicians who send paper claims often use a clearinghouse to convert those paper claims to EDI transactions. Most commonly utilized transactions in this interchange are considered "Standard Transactions" under the Health Insurance Portability and Accountability Act (HIPAA). On occasion it is necessary to send additional information to payers to support the claim – for example, when you report an "unlisted" CPT® code and need to send documentation that will clarify the exact service performed and support the amount you are charging. However, to date there is no standard transaction by which such attachments can be sent. This means that physicians must be prepared to send attachments in a variety of ways and their staffs must keep track of how each payer wants those attachments sent.

The Centers for Medicare & Medicaid Services (CMS) recently published a Medicare Learning Network Matters article for physicians and other providers that outlines how to submit unsolicited electronic medical documentation (also known as paperwork (PWK)) through Medicare's Electronic Submission of Medical Documentation (esMD) system. Currently physicians can submit unsolicited medical documentation via fax or regular mail. Once this new system is in place, they will be able to do so electronically.

CMS has standardized cover sheets that must be used with any paperwork submission, whether the paperwork is submitted electronically, by fax or through the mail. There are three separate cover sheets, one each for Part A and Part B providers and one for Durable Medical Equipment (DME) suppliers. These cover sheets are available through the Medicare Administrative Contractors (MACs).

Paperwork can be submitted through the esMD system as an electronic submission or as a file transfer, such as a pdf. CMS will update its companion documents for 5010 X12 837 claims to include two new values in the PWK 02 field:

- The value "EL" (electronic) in PWK 02 represents an esMD submission using X12 Standards (6020 X12 275)
- The value "FT" (file transfer) in PWK 02 represents an esMD submission in PDF format using the XDR Specifications

When the PWK 02 field includes either "EL" or "FT", CMS will allow 7 days from the receipt of the 5010 X12 837 claim for the additional information to be submitted.

The MACs will reject paperwork submissions when the cover sheet is incomplete or incorrectly filled out. Specific error codes are being finalized to indicate specific reasons for these rejections, including:

- The date(s) of service on the cover sheet received is missing or invalid.
- The NPI on the cover sheet received is missing or invalid.
- The state where services were provided is missing or invalid on the cover sheet.
- The Medicare ID on the cover sheet received is missing or invalid.
- The billed amount on the cover sheet received is missing or invalid.
- The contact phone number on the cover sheet received is missing or invalid.
- The beneficiary name on the cover sheet received is missing or invalid.
- The claim number on the cover sheet received is missing or invalid.
- The Attachment Control Number (ACN) on the cover sheet is missing or invalid.

While the 5010 X12 837 is a standard transaction under HIPAA, the 6020 X12 275 is not. This means that while Medicare will use the 6020 X12 275 transaction for providers to send paperwork, other payers are not required to do so. Once Medicare fully implements its use of the 6020 X12 275 to receive additional information, others may also accept this transaction, but are not required to do so.

At this time CMS has not determined when the next standard transaction code set will be implemented. When CMS adopts a new standard transaction code set, the proposal to do so will need to go through the rulemaking process – to include a proposed rule with comment period and a final rule. Once that process is complete, there is typically a two-year implementation period, so it is unlikely that a new standard transaction code set will be implemented before 2020 or 2021. It may be several years beyond that. At that time, we will know whether that code set will include a standard transaction for sending and receiving additional medical information. If so, all payers will be required to accept that new standard transaction. This would simplify the transmission of additional medical information since one transaction would be used for all payers.