CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1283	**Date: JULY 6, 2007**
	Change Request 5637

Subject: National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), Update of Telecommunication and Transmission Protocols for EDI and Deletion of Obsolete Reference to Medicaid Subrogation Claims

I. SUMMARY OF CHANGES: A provider must now obtain an NPI prior to enrolling for use of EDI. Obsolete information on EDI connectivity has been updated. An obsolete reference to Medicaid subrogation claims has been deleted.

New / Revised Material
Effective Date: October 1, 2007
Implementation Date: October 1, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	24/20/EDI Enrollment
R	24/20.1.1/New Enrollments and Maintenance of Existing Enrollments
R	24/30/30.3/Telecommunication and Transmission Protocols

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 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: 1283	Date: July 6, 2007	Change Request: 5637

SUBJECT: National Provider Identifier (NPI) Required to Enroll in Electronic Data Interchange (EDI), Update of Telecommunication and Transmission Protocols for EDI and Deletion of Obsolete Reference to Medicaid Subrogation Claims

Effective Date: **October 1, 2007**

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: As indicated in CR 5595, Transmittal 1227, Medicare is monitoring claims to determine the level of NPI reporting. This is being done to determine when it will be reasonable for Medicare to begin rejecting claims that lack an NPI for billing, pay-to or rendering providers. Providers have been required to obtain an NPI prior to initial Medicare enrollment or updating of their enrollment records since May 2006 but were not required to have an NPI as a condition for enrollment for use of electronic data interchange (EDI) transactions. This is now being changed as part of a joint CMS initiative to have all providers enrolled in Medicare obtain and begin to use their NPIs in transactions as soon as possible.

CR 5284, Transmittal 182, issued January 12, 2007, revoked all existing billing privileges that had already been issued to a Medicaid State Agency or their designee, directed contractors to deny any pending applications for Medicaid State Agency billing privileges and not to accept future applications from Medicaid State Agencies for Medicare billing privileges. This was effective in March 2007, as result, a reference to those privileges contained in Pub. 100-04 section 20.1.1 of chapter 24 is being deleted in this CR. There is not a need to add a business requirement to this CR however as that business requirement was contained in CR5284, Transmittal 182.

EDI connectivity information in the Medicare Claims Processing Manual has not been updated in some time. Due to technology changes some of the information in the manual concerning data compression is obsolete and is being updated. Although the subsection where EDI connectivity requirements are located contains a requirement for use of the standard X12 electronic envelope with X12 transactions, it failed to note a corresponding requirement for NCPDP transactions and that is being added as part of this CR.

B. Policy: To further support the CMS efforts to have all providers obtain NPIs as soon as possible, providers shall not be permitted to enroll for use of EDI unless they can first furnish at least one NPI. EDI connectivity requirements need to reflect current technology and are being updated in this transmittal to do so. As part of the agency efforts to fully comply with the requirements of the HIPAA standards, DME MACs are to reject NCPDP transactions if the standard NCPDP electronic envelope is not used in transmission.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CMS	
5637.1	Medicare contractors shall not accept an initial EDI Enrollment Agreement form from or issue an EDI access number and password to any provider that cannot supply their NPI.	X	X	X	X		X						
5637.2	Medicare contractors shall use V.90 56K modems for EDI transactions submitted via dial-in connections.	X	X	X	X		X						
5637.3	Medicare carriers and MACs (B portions of A/B MACs) that still support a proprietary, fixed record format for eligibility queries and responses, pending termination of the Medicare Eligibility HIPAA Contingency Plan, and that supported data compression for that format prior to the effective date of this CR shall continue to offer data compression using the V.90 56 K modem, PK ZIP version 2.04x or higher, WinZIP or V.42 bis data compression until they terminate support of that proprietary eligibility format.	X	X		X								
5637.4	Medicare carriers and MACs that still support a proprietary eligibility format may, but are not required to, accommodate other types of data compression requested by an EDI submitter/receiver.	X	X		X								
5637.5	DME MACs shall reject NCPDP transactions that do not use the standard NCPDP electronic envelope.		X										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CMS	
5637.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/	X	X	X	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)											
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	EDC	Shared-System Maintainers				OTHER
									FISS	MCS	VMS	CMS	
	shortly after the CR is released. You will receive notification of the article release via the established "MLN 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 one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.												

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen.Simmons@cms.hhs.gov

Post-Implementation Contact(s): Kathleen.Simmons@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

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

20 - EDI Enrollment

(Rev. 1283, Issued: 07-06-07; Effective/Implementation Dates: 10-01-07)

Carriers, *MAC*s, and FIs are required to furnish new providers that request Medicare claim privileges information on EDI. DME *MAC*s are to furnish such information to new providers when contacted by providers, or by the National Supplier Clearinghouse to identify new suppliers that have been issued new identifiers. Carriers, *A/B MACs* and FIs are required to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in §50), and enroll and assign submitter EDI identification numbers to those approved to use EDI.

When providers contact a contractor to submit/receive transactions electronically using a billing agent or a clearinghouse/network services vendor, carriers, *MACs or* FIs must notify those providers that they are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare, but are to be retained by the providers.) The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor; to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim; and that no other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from those Medicare contractors to whom they will send or from whom they will receive EDI transactions.

A provider must obtain an NPI and furnish that NPI to their Medicare contractor prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. The Medicare contractor is not required to verify that NPI in the NPI Crosswalk or another location with the understanding that if the provider attempts to use an incorrect NPI, the provider's claims will reject. It would be counterproductive for a provider to furnish an incorrect NPI at the time of EDI enrollment. A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password.

20.1.1 - New Enrollments and Maintenance of Existing Enrollments

(Rev. 1283, Issued: 07-06-07; Effective/Implementation Dates: 10-01-07)

The Medicare EDI Enrollment process provides for collection of the information needed to successfully exchange EDI transactions between Medicare and EDI trading partners and also establishes the expectations for both parties in the exchange. This agreement must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form and submit it to the carrier, *MAC*, or FI with which EDI transactions will be exchanged before the carrier, *MAC*, or FI will accept production claims or other incoming EDI transactions from that provider, or a third party for that provider, or send outbound EDI transactions. Carriers, *MAC*s, and FIs 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.

NOTES:

1. Although a type of electronic transaction, electronic funds transfers (EFTs) between a carrier, *MAC*, or FI and a bank are not considered EDI for EDI Enrollment Form purposes. A provider that uses EFT but no EDI transactions should not complete an EDI Enrollment Form.

2. Medicaid state agencies are not required to complete an EDI Enrollment Form as a condition for *receipt of COB claims.*

3. Due to the unique beneficiary Zip Code rule that applies to processing of supplier claims, a supplier is sometimes required to submit claims to DME *MAC*s that do not have a copy of their EDI Enrollment Form. Suppliers are also more likely to become confused and submit a beneficiary claim to their local *MAC* even though the claim falls under the jurisdiction of a different DME *MAC*. Unlike carriers or FIs, DME *MAC*s are not permitted to reject claims when received from out of area suppliers, but must transfer those misdirected claims to the proper DME *MAC*.

Providers who have a signed EDI Enrollment Form on file with a particular carrier, *MAC* or FI are not required to submit a new signed EDI Enrollment Form to the same carrier, *MAC*, or FI each time they change their method of electronic billing or *begin to* use another type of EDI transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. However, contractors must inform providers that providers are obligated to notify their contractor(s) by fax or hardcopy in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of EDI. Providers are not required to notify their Medicare contractor if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible

for notification in that instance. When a contractor receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third party, the contractor must verify that an EDI Enrollment Form is already on file for that provider or supplier, and that the third party has already been issued an EDI number and password to permit submission/receipt of EDI transactions. The request cannot be processed until both are submitted/issued.

The binding information in an EDI Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that carrier, *MAC* or FI is no longer associated with the Medicare program. Medicare responsibility for EDI oversight and administration is simply transferred in that case to that entity that CMS chooses to replace that carrier, *MAC* or FI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.

An organization comprised of multiple components that have been assigned more than one Medicare provider number, supplier number, or *NPI* may elect to execute a single EDI Enrollment Form on behalf of the organizational components to which such numbers have been assigned. The organization is responsible for the performance of its components.

The note at the end of the enrollment agreement language indicates that either party can terminate that agreement by providing 30 days advance notice. There is an exception to that requirement. In the event a Medicare carrier, *MAC* or FI detects abuse of use of an EDI system ID or password, or discovers potential fraud or abuse involving claims submitted electronically, electronic requests for beneficiary eligibility data, or other EDI transactions, that Medicare contractor is to immediately terminate system access for submission or receipt of EDI transactions by that individual or entity. A decision by a Medicare contractor to terminate or suspend EDI access in such a situation is not subject to appeal by the individual or entity that loses EDI access.

Electronic Data Interchange (EDI) Enrollment Information Required for Inclusion at a Minimum in Each Carrier, *MAC* and FI EDI Enrollment Form

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, *MACs*, or FIs:

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor 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, *MAC* s, FIs, or another contractor if so designated by CMS 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, *MAC* FI, or other contractor if designated by CMS 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, *MAC*, FI, or other contractor if designated by CMS;

10. That the CMS-assigned unique identifier number (submitter identifier) *or NPI* 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, *MAC*, FI, or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, *MAC*, or FI (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, *MAC*, FI, or other contractor if designated by 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 FI/carrier/ *MAC* or other contractor if designated by CMS 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, *MAC*, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, *MAC*, or FI or from any subsidiary of the carrier, *MAC*, FI, other contractor if designated by CMS, or from any company for which the carrier, *MAC*, or FI has an interest. The carrier, *MAC*, FI, or other contractor if designated by CMS 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, *MACs*, FIs, or other contractors if designated by CMS 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, *MAC*, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTE: 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 the carrier, *MAC*, FI, or other contractor if designated by CMS. 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 _____ _____

(signature) (printed name)

Title

Date

30.3 - Telecommunications and Transmission Protocols

(Rev. 1283, Issued: 07-06-07; Effective/Implementation Dates: 10-01-07)

Carriers, *MACs*, and FIs must support transfers for Medicare using 56 K connections *for* their asynchronous communications lines. For asynchronous communications, carriers, *MAC*s, and FIs 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 EDI transfers over TCP/IP connections, carriers, *MACs*, and FIs must support a File Transfer Protocol (FTP) compliant with RFC 959. FTP servers provide for user authentication through user ID/password mechanisms. The carrier, *MAC* or FI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. Any user should be able to use TCP/IP for asynchronous communication at any Medicare site. The Internet may not be used for beneficiary sensitive data at this time, except as expressly approved by CMS as a part of a demonstration project. Carriers, *MACs* and FIs must provide asynchronous telecommunications to any requesting EDI user.

*Any c*arriers or *MACs (B portion of A/B MACs) that continue to support a proprietary fixed length format for submission and response to eligibility queries pending termination of the Medicare Eligibility HIPAA Contingency Plan, that were asked prior to October 1, 2007 to permit data compression by a provider, clearinghouse or billing agent for exchange of those proprietary format transactions, is required to continue to* offer data compression, either through the use of *a* v.*90* 56 K modem, PKZIP version *2.04x or higher, WinZip or V.42 bis data compression until support of that proprietary format(s) is terminated*. While *these are* the *most frequently used means of data compression*, carriers *and MACs* may, but are not required to, accommodate other compression software which an *eligibility proprietary transaction* submitter may *have requested in the past*. Carriers *and MACs that supported compression in the past for exchange of still supported proprietary format(s) for eligibility queries and responses* must enable hardware compression support in their v.*90* modems (the actual use is negotiated between the carrier *and MACs* modem and the provider*/billing agent's* 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 56 *K*). Therefore, carriers *and MACs to which this may apply must* have adequate processing capacity to handle this amount of data for each connection.

NOTE: Contractors need not support file compression for X12N *or NCPDP (DME MACs only)* transactions. Compression is permitted between the contractor and its data center, if applicable. *Since FIs and the A portion of A/B MACs are not permitted to support proprietary formats for eligibility queries, they are not required to offer data compression.*

For asynchronous traffic, carriers, *MACs* and FIs may not limit the number of 837 transactions or the number of providers with transactions included in a single transmission, but 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, *MACs* and FIs must accept and send all X12 transactions as a continuous byte stream or as a variable length record. Carriers, *MACs* and FIs are not permitted to require that provider EDI transaction data be broken down into 80 byte segments and may not require any other deviation from the variable length format or the continuous byte stream format. For example, submitters may not be forced

to create each segment as its own record by inserting carriage returns or line feeds. Only standard X12 envelopes may be used with X12 transactions. *Only standard National Council for Prescription Drug Programs (NCPDP) envelopes may be used with NCPDP transactions (applies to DME MACs only).*

The X12 *and NCPDP* transactions are variable-length records designed for wire transmission. Medicare contractors must be able to accept them over a wire connection. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

Unless approved for participation in a limited demonstration program, carriers, *MACs* and FIs are not permitted to accept EDI transactions via the Internet at this time.