CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3404	**Date: November 13, 2015**
	Change Request 9430

NOTE: This Transmittal is no longer sensitive and is being re-communicated January 21, 2016. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04 - Enrollment Form Update

I. SUMMARY OF CHANGES: The purpose of this change request is to update the Enrollment Form requirements in Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04.

EFFECTIVE DATE: December 14, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 14, 2015

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 / 30.2 / New Enrollments and Maintenance of Existing Enrollments
R	24 / 30.4 / Electronic Remittance Advice (ERA) Enrollment Form

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3404	Date: November 13, 2015	Change Request: 9430

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SUBJECT: Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04 - Enrollment Form Update

EFFECTIVE DATE: December 14, 2015
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IMPLEMENTATION DATE: December 14, 2015

I. GENERAL INFORMATION

A. Background: The EDI Enrollment Form requirements have been modified in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 24.

B. Policy: The EDI Enrollment Form requirements, in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 24, have been modified to allow the Medicare Administrative Contractor greater flexibility in their business processes in the maintenance of EDI enrollment data.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9430.1	Contractors shall adhere to updated requirements as stated in Section 30.2 of Chapter 24 in the Medicare Claims Processing Manual, Pub. 100-04.	X	X	X	X					CEDI, RRB
9430.2	Contractors shall adhere to updated requirements as stated in Section 30.4 of Chapter 24 in the Medicare Claims Processing Manual, Pub. 100-04.	X	X	X	X					CEDI, RRB

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mathew Klischer, matthew.klischer@cms.hhs.gov , Charles Watson, 410-786-8209 or charles.watson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims

30.2 - New Enrollments and Maintenance of Existing Enrollments
(Rev.3404, Issued: 11-13-15, Effective: 12-14-15, Implementation: 12-14-15)

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 A/B MAC or CEDI with which EDI transactions will be exchanged before the A/B MAC, or CEDI will accept claims or other incoming EDI transactions from that provider, or a third party for that provider, or send outbound EDI transactions. *A/B MACs and CEDI may accept a signed EDI Enrollment Form from providers via fax, email, internet portal, or hard copy and may accept electronic signature formats, "wet", or a combination of the two. The EDI Enrollment Form is effective as specified in the terms of the agreement.*

Providers who will be accessing the A/B MACs Direct Data Entry (DDE) system will have access to enter and correct claims directly at the A/B MAC and must submit an EDI Enrollment Form to A/B MAC with their request for this access.

NOTES:

1. Although a type of electronic transaction, electronic funds transfers (EFTs) between an A/B MAC or DME MAC 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.

In accord with a particular MAC's business processes, providers who have a signed EDI Enrollment Form on file with a particular A/B MAC or CEDI may or may not be required to submit a new signed EDI Enrollment Form to the same A/B MAC or CEDI 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. Additionally, providers may or may not be required to notify their RHHI, A/B MAC or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

A/B MACs and CEDI must inform providers that providers are obligated to notify their A/B MAC or CEDI in writing 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.

When an A/B MAC or CEDI receives a signed request from a provider or supplier to accept EDI transactions from or send EDI transactions to a third party, the A/B MAC or CEDI 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 A/B MAC or CEDI 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 A/B MAC or CEDI, 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 National Provider Identifier (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/B MAC, DME MAC or CEDI 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 A/B MAC, DME MAC or CEDI is to immediately terminate system access for submission or receipt of EDI transactions by that individual or entity. A decision by A/B MAC, DME MAC or CEDI 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 A/B MAC, and CEDI EDI Enrollment Form.

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MACs or CEDI:

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 A/B MACs, DME MACs or CEDI 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 A/B MAC, DME MAC, CEDI, 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 ID) of the provider on each claim electronically transmitted to the A/B MAC, CEDI, 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 A/B MAC, DME MAC, CEDI, 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 A/B MAC, DME MAC or CEDI (in accordance with §1106(a) of Social Security Act (the Act) (See section 40.1.2.2 below for a complete reference to Medicare's security requirements);

14. That it will research and correct claim discrepancies;

15. That it will notify the A/B MAC, CEDI, or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form (See section 40.1.2.2 below for a complete reference to Medicare's security requirements).

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

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

2. Affix the A/B MAC, DME MAC, CEDI 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any

subsidiary of the A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, 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 A/B MACs, CEDI, 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 sold directly, indirectly, or by arrangement by the A/B MAC, CEDI, or other contractor if designated by CMS;

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 A/B MAC, DME MAC, CEDI, 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 certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.

Provider’s Name

Title

Address

City/State/Zip

By _____ _____
(signature) (printed name)

Date

30.4 - Electronic Remittance Advice (ERA) Enrollment Form

(Rev.3404, Issued: 11-13-15, Effective: 12-14-15, Implementation: 12-14-15)

The Medicare Electronic Remittance Advice (ERA) Enrollment process provides for collection of the information needed to successfully receive ERA transactions from Medicare and EDI trading partners. This agreement must be executed by each provider that receives ERA either directly to or from Medicare or through a third party. Each provider that will use ERA either directly or through a billing agent or clearinghouse with Medicare must sign the ERA Enrollment Form and submit it to the A/B MAC or CEDI with which ERA transactions will be received before the A/B MAC or CEDI will transmit ERA. *A/B MACs or CEDI may accept a signed ERA Enrollment Form for providers via fax, email, internet portal, or hard copy and may accept electronic signature formats, "wet", or a combination of the two. The ERA Enrollment Form is effective as specified in the terms of the agreement.*

In accord with a particular MAC's business processes, providers who have a signed ERA Enrollment Form on file with a particular A/B MAC, or CEDI may or may not be required to submit a new signed ERA Enrollment Form to the same A/B MAC, or CEDI 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. Additionally, providers may or may not be required to notify their A/B MAC, or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.

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A/B MAC, or CEDI receives a signed request from a provider or supplier to accept ERA transactions from or send ERA transactions to a third party, the A/B MAC, or CEDI must verify that an ERA Enrollment Form is already on file for that provider or supplier.

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

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 an A/B MAC, DME MAC or CEDI detects abuse of use of an ERA system, or discovers potential fraud or abuse, that A/B MAC, DME MAC or CEDI is to immediately terminate system access for receipt of ERA transactions by that individual or entity. A decision by an A/B MAC, DME MAC or CEDI to terminate or suspend ERA access in such a situation is not subject to appeal by the individual or entity that loses ERA access.

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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.

Signature

I certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.

Provider's Name

Title

Address

City/State/Zip

By _____ _____
(Signature) (Printed Name)

Date