CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3346	**Date: September 4, 2015**
	Change Request 9280

SUBJECT: Removing References to Network Service Vendors from Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to remove references to network service vendors from Chapter 24 of the Medicare Claims Processing Manual, Pub. 100-04.

EFFECTIVE DATE: October 6, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 6, 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	Table of Contents
R	24/10.4/Acronyms and Definitions
R	24/30.1/EDI Enrollment
R	24/30.4/ Electronic Remittance Advice (ERA) Enrollment Form
D	24/30.5/Electronic Remittance Advice (ERA) Enrollment Form
R	24/40.2.2.3/Security-Related Requirements for A/B MACs, and CEDI Arrangements With Clearinghouses and Billing Services
R	24/50.1/Telecommunications, Internet and Dial-up
R	24/50.1.3/Telecommunications and Transmission Protocols

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: 3346	Date: September 4, 2015	Change Request: 9280

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I. GENERAL INFORMATION

A. Background: CMS will no longer be providing information about network service vendors in its Medicare Claims Processing Manual, Pub. 100-04, Chapter 24.

B. Policy: CMS has determined that it will not be providing instructions regarding network service vendors in its Medicare Claims Processing Manual, Pub. 100-04, Chapter 24.

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	
9280.1	Contractors shall note the removal of network service vendor information from Chapter 24 in the Medicare Claims Processing Manual, Pub. 100-04.	X	X	X	X					CEDI, RRB
9280.2	Contractors shall consult their Contracting Officer's Representatives for questions they may have related to network service vendors.	X	X	X	X					CEDI, RRB

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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): Claudette Sikora, 410-786-5618 or claudette.sikora@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

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

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(Rev.3346, Issued: 09-04-15)

10.4 - Acronyms and Definitions

(Rev.3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

The following is a list of terms and acronyms if assistance is needed to understand the terminology used in this chapter.

- EDI – Electronic Data Interchange - the process of using nationally established standards to exchange electronic information between business entities.

- HIPAA – Health Insurance Portability and Accountability Act of 1996 – legislation that mandated that the healthcare industry use standard formats for electronic claims and claims related transactions.

- MAC – Medicare Administrative Contractor – Section 911 of the Medicare Modernization Act of 2003 mandated that the Secretary for Health & Human Services replaced the contractors administering the Medicare Part A or Part B fee-for-service programs with Medicare Administrative Contractors (MACs). Part A/Part B Medicare Administrative Contractors (MACs) replaced the fiscal intermediaries and carriers and handle administration of both the Medicare Part A and Part B programs in specified geographic regions. For more information, please see the CMS overview of Medicare Contracting Reform.

- A/B MAC – Medicare Administrative Contractor servicing both Part A and Part B lines of business.

- DME MAC – Durable Medical Equipment Medicare Administrative Contractor

- CEDI - Common Electronic Data Interchange – Common front end for DME MACs

- Trading Partner – one of two or more participants in an ongoing business relationship (e.g., provider, billing service, software vendor, employer group, financial institution, etc.).

- Submitter – an entity that owns the healthcare data being submitted. It is most likely the provider, hospital, clinic, etc. A submitter is directly linked to each billing NPI.

- EDI Enrollment – establishes documentation specifying type of transactions and transmission methods to be used in the exchange of electronic administrative transactions.

- EDI Registration – designates the Medicare contractor as the entity they agree to engage with for EDI and ensures agreement between parties to implement standard policies and practices to ensure the security and integrity of information exchanged.

- Trading Partner Agreement – ensure the integrity of the electronic transaction process. The Trading Partner Agreement is related to the electronic exchange of information, whether the agreement is an entity or a part of a larger agreement, between each party to the agreement.

- Third Party Agreement- ensures the confidentiality, security, and integrity of Medicare data being shared by third party agents that represent providers, certain value-added networks, clearinghouses, and billing agents.

30.1 - EDI Enrollment

(Rev.3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

A/B MACs and CEDI are required to furnish new providers that request Medicare claim privileges information on EDI. A/B MACs and CEDI 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. All providers are required to submit their claims electronically, per ASCA, unless they qualify for a waiver (see section 90 below).

The EDI enrollment process for the Medicare beneficiary inquiry system (HETS 270/271) is currently a separate process. Information on the EDI enrollment process for HETS can be found on the CMS HETSHelp website (http://www.cms.gov/HETSHelp/).

A provider must obtain an NPI and furnish that NPI to their A/B MAC and CEDI prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. The A/B MACs and CEDI are required to verify that NPI is on the NPI Crosswalk. If the NPI is not verified on the NPI Crosswalk, the EDI Enrollment Agreement is denied and the provider is encouraged to contact the A/B MAC provider enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for DME suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

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**.** When leaving the Medicare Program, a provider must notify their MAC to deactivate the EDI number.

If providers elect to submit/receive transactions electronically using a third party such as a billing agent ***or*** a clearinghouse, the A/B MACs or CEDI must notify those providers that they are required to have an agreement signed by that third party. The third party must agree 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 ***or*** clearinghouse~~.~~ Providers must also not share their personal EDI access number 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. 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 A/B MACs or CEDI to whom they will send or receive EDI transactions. For a complete reference to security requirements see section 40.1.2.2 below and refer to the Appendix A CMSR High Impact Level Data document (sections IA-2 and SA-9) located on the CMS website (http://www.cms.gov/informationsecurity/downloads/ARS_App_A_CMSR_HIGH.pdf.)

30.4 - Electronic Remittance Advice (ERA) Enrollment Form

(Rev.3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15) 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. Electronic signatures are only

acceptable for the Medicare Fee-For-Service ERA Enrollment Form. The ERA Enrollment Form is effective as specified in the terms of the agreement.

Providers who have a signed ERA Enrollment Form on file with a particular A/B MAC, or CEDI are not 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 are not 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.

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 ERA.

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.

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.

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

40.2.2.3 - Security-Related Requirements for A/B MACs, and CEDI Arrangements With Clearinghouses and Billing Services

(Rev.3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

A billing service is an entity that markets claim preparation services to providers and should also be able to perform related transactions for providers, such as eligibility and claim status inquiries. The billing service collects a provider's claim information and then bills the appropriate insurance companies, including Medicare. A billing service may submit claims only, or provide full financial accounting and/or other services. Billing services are considered to be provider business associates. As such, HIPAA requires that they comply with each of the privacy and security requirements that apply directly to providers. They are also required to ensure that they require that any clearinghouses, subcontractors or other business associates of their own that may be involved with handling of Medicare beneficiary data also meet those same security and privacy requirements. A billing service may view beneficiary or provider data to carry out their billing obligations for a provider, when a provider authorizes them to have that access. To qualify as a billing service, an entity must at a minimum submit initial claims on the provider's behalf.

A clearinghouse transfers or moves EDI transactions for a provider or billing service, and generally translates the EDI transactions from or into a proprietary format. (HIPAA defines a clearinghouse as a business associate of a provider or a health care plan that translates data from a non-standard format into a standard format or vice versa as preferred by their clients.) A clearinghouse generally accepts multiple types of incoming transactions and sends them to various payers, including Medicare. Clearinghouses often perform general and payer-specific edits on claims, and may handle multiple types of EDI transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgments, remittance advice transactions, and claim status and eligibility queries.

Some entities that refer to themselves as clearinghouses, however, do not edit or translate data, but simply serve as a "telecommunication switch," moving transactions from point A to Point B or wherever directed under the terms of the agreement with a provider. A clearinghouse may also be called a value added network (VAN). A clearinghouse/VAN may not view privacy-protected Medicare data unless a signed authorization has been filed by the provider for whom the clearinghouse/VAN will submit or received Medicare EDI transactions. For EDI, a transaction that contains individually identifiable information about a Medicare beneficiary is considered to be privacy protected data.

That provider may not authorize submission or receipt of data by a third party for a Medicare beneficiary unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider. The provider authorization must be filed with the Medicare contractor to whom EDI transactions will be sent or from whom they will be received. In the case of a DME claim, this authorization need only be submitted to CEDI. If multiple A/B MACs are involved, an authorization must be submitted to each.

Each clearinghouse/VAN that will submit or receive Medicare EDI transactions is prohibited from using the EDI number or password issued to any of the providers they serve. Each clearinghouse/VAN must obtain its

own EDI number and password from each A/B MAC with which it will interact. For, DME, each Clearinghouse/VAN must obtain its own EDI number and password from CEDI.

Some health care providers use or may want to use more than one billing service or clearinghouse/VAN. An A/B MAC and CEDI ability to handle more than one agent varies. Some A/B MACs and CEDIs are able to accommodate one or more clearinghouses/VAN for submission of a provider's claims to Medicare, another agent to receive the provider's remittance advice transactions, and a third clearinghouse/VAN to verify beneficiary Medicare eligibility for a provider. Others may not be able to accommodate more than one agent for a provider. A/B MACs and CEDIs are encouraged to support more than one agent for a provider, when permitted by their front end configuration.

A/B MACs and DME MACs, or other contractors if designated by CMS must notify each provider that applies for permission to obtain eligibility data electronically that:

- They are permitted to view Medicare eligibility data only for patients currently being treated by or who have requested treatment or supplies from that provider;

- A provider cannot authorize a billing agent or clearinghouse to submit or obtain data from a A/B MACs and DME MACs that the provider is not entitled to personally submit or obtain;

- A request for personally identifiable information for any other Medicare beneficiaries would be a violation of Medicare and HIPAA privacy requirements, and subject to the applicable penalties for such violations.

A/B MACs, and DME MACs must notify each billing service and clearinghouse/VAN at the time of their application for access to Medicare eligibility data and by also posting information on their web site that:

- Their access is limited to submission of transactions and receipt of transactions for those providers that are their clients, but only if those providers authorized the billing agent and/or clearinghouse/VAN to submit or receive each transaction.

- A billing agent or clearinghouse/VAN that has provider authorization to submit claim data for a provider cannot obtain eligibility data for that provider unless that was specifically authorized by the provider.

- Likewise, the billing agent or clearinghouse/VAN cannot be sent remittance advice transactions for a provider unless specifically authorized to do so by that provider.

Providers must submit these authorizations to their A/B MACs, DME MACs, CEDI or other contractors if designated by CMS in writing; an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS is not permitted to accept a statement signed by a billing agent or clearinghouse/VAN alleging that they have such provider authorization on file. An original provider signature is required on these authorizations (but an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS is allowed to accept an authorization signed by a provider by fax or mail). The A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS is responsible for maintenance of files to establish system access for individual providers, identify those billing agents and clearinghouses/VAN***s*** authorized to access systems as the agent of a specific provider, and to record those transactions for which a billing agent or clearinghouse/VAN is authorized access as the representative of a specific provider.

With authorization, a clearinghouse/VAN may send inquiries for a provider, and receive responses, but it may not view personally identifiable beneficiary data contained in those queries or responses, store it for longer than necessary to assure delivery to the provider (no longer than 30 days maximum), or use personally identifiable data in any reports. The EDI data sent or received belongs ultimately to the beneficiary, not to the clearinghouse/VAN that may translate and transport the data for a provider acting on the beneficiary's behalf.

Collection agents that contract with providers to collect “bad debts” and third party entities that may analyze data but do not have a specific initial claim submission role or are not responsible for posting of information in a remittance advice to patient accounts may not be sent beneficiary data by a A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS. If a collection agent or such a third party has provided adequate privacy and security assurances to protect beneficiary data, the provider may share Medicare payment information with a collection agent, data analysis firm, or similar third party, but the provider would need to furnish that data to that entity agent in this situation, however. The Medicare program may not incur costs to furnish such data to collection agencies or to other entities that perform services that do not directly support Medicare activities. Delinquent collection, analysis of data related to a provider’s operations, and expenses related to other activities not directly related to Medicare claims or payments are considered provider business expenses. Such activities do not directly benefit Medicare and Medicare may not incur costs to supply data intended only for such uses.

A provider must sign a valid EDI Enrollment Form (see Section 30.1 this chapter) prior to authorizing a billing agent or clearinghouse/VAN to submit/receive any EDI transactions on their behalf. A separate password and User ID is to be used for system access by each authorized provider, billing agent or clearinghouse. A vendor provides hardware, software and/or ongoing support for total office automation or submission of electronic EDI transactions directly to individual providers, billing agent or clearinghouses/VANs. Vendors supply the means for Medicare system access but have no right to direct access to the system of a A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS.

Vendor software is normally tested when it first begins to be used by providers, billing agents or clearinghouses/VANs. At the request of a vendor or a clearinghouse/VAN, an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS may, but is not required to, test new software before a provider has agreed to begin using that software to exchange Medicare eligibility transactions with the contractor. When testing software prior to use by a provider, an A/B MAC, DME MAC, CEDI or other contractor if designated by CMS may not furnish a software vendor who does not currently submit or receive Medicare transactions with an EDI access number or password which would permit the vendor to access to actual Medicare beneficiary data. That software is to be tested using a test database or by other means that would not disclose actual beneficiary data to the vendor. This EDI access limitation for testing of new software does not apply to a clearinghouse/VAN with a history of submission/receipt of EDI transactions with the contractor, or when a software vendor is also a clearinghouse/VAN or a provider billing agent (in which case, testing should only involve data for beneficiaries for which the entity already submit/receives transactions).

50.1 - Telecommunications, Internet and Dial-up

(Rev.3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

A/B MACs, DME MACs and CEDI will support connectivity for EDI functions. These functions include the exchange of EDI transactions at the A/B MACs and CEDI Front End.

Online systems include the Medicare Part A Direct Data Entry (DDE) used for claim entry, claim correction, claim status checks, and beneficiary eligibility. Medicare Part B offers the Provider Professional Telecommunications Network (PPTN) and DME MAC offers Claim Status Inquiry to check the status of claims.

50.1.3 - Telecommunications and Transmission Protocols

(Rev.3346, Issued: 09-04-15, Effective: 10-06-15, Implementation: 10-06-15)

Providers must access A/B MACs and DME MACs online applications, Medicare Part A Direct Data Entry (DDE), Medicare Part B Professional Provider Telecommunications Network (PPTN) and DME MAC Claim Status Inquiry (CSI) ***as directed*** by the A/B MAC or DME MAC. A/B MACs and DME MACs are to permit access to DDE, PPTN and DMCS by using the most cost-effective transmission solution, among the CMS-sanctioned options, that meets the needs of their trading partners.

A/B MACs and CEDI may, but are not required to**,** support electronic transfers for Medicare using 56 K connections for their asynchronous communications lines. For asynchronous communications, A/B MACs and CEDI may, but are not required to, support provider access through Transmission Control Protocol/Internet Protocol (TCP/IP). If A/B MACs and CEDI do support TCP/IP, it must be 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, A/B MACs and CEDI must support using File Transfer Protocol (FTP) in a secure manner which is supported within the FTP protocol in a consistent manner and which takes advantage of existing security infrastructure and technology, compliant with RFC 2228. FTP servers provide for user authentication through user ID/password mechanisms. A/B MACs and CEDI must submit any other security mechanism in addition to this to CMS for approval prior to implementation. A/B MACs and CEDI may but are not required to support file compression for ASC X12 or NCPDP (CEDI only) transactions. Compression is permitted between the contractor and its data center.

A/B MACs and CEDI may not limit the number of ASC X12 837 claim 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. For NCPDP, CEDI may not limit the number of transactions per batch except as noted within the batch standard. However, they may limit a single physical file to having only one batch. Server capacity must be adequate to support simultaneous sustained file transfers from all configured communications lines.

A/B MACs and CEDI must accept and send all ASC X12 837 claim transactions as a continuous byte stream or as a variable length record. A/B MACs and CEDI 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 ASC X12 envelopes may be used with ASC X12 transactions. Only standard NCPDP envelopes may be used with NCPDP transactions (applies to CEDI only).

The ASC 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 otherwise approved, A/B MACs, DME MACs and CEDI are only permitted to accept EDI transactions via the Internet when explicitly directed by CMS. This ability includes compliance with the operating rules for Section 1104 of the Affordable Care Act.