

## Customer Support Alert May 29, 2008

### Palmetto is new Medicare Payer; You must enroll with Palmetto

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This advisory pertains to all Alteer Office® users in Medicare Jurisdiction 1 (J1) who use Alteer Office® to submit electronic Medicare fee-for-services claims. (J1 includes American Samoa, California, Guam, Hawaii, Nevada, and the Northern Mariana Islands.) In the Fall of 2007, the Centers for Medicare & Medicaid Services (CMS) announced that Palmetto GBA, a leading provider of technical and administrative services for the federal government, had been awarded the contract for the combined administration of Part A and Part B Medicare fee-for-service claims in J1. According to CMS, the contract award to Palmetto is another step toward improved service to providers, physicians, and practitioners and greater administrative efficiency for fee-for-services Medicare.

Medicare fee-for-service claims submitted to the following payer ID's will be serviced by Palmetto as of **August 4, 2008** for NV Medicare and **September 2, 2008** for

#### California Medicare:

- 57011 CA - MEDICARE
- SMCA1 CA - MEDICARE (NHIC)
- SMCA2 CA - MEDICARE (NHIC)
- SMH10 HI - MEDICARE (NORIDIAN ADMINISTRATIVE SERVICES)
- SMNV0 NV - MEDICARE (NORIDIAN ADMINISTRATIVE SERVICES)
- 12M20 NV - MEDICARE

Palmetto GBA requires all customers currently enrolled to submit claims electronically to Medicare CA or NV to complete and submit a *new* EDI enrollment form. This form is called the J1 EDI Enrollment Form (refer to pages 3-6).

#### **CAUTION**

The first page of the J1 EDI Enrollment Form, below the Palmetto GBA address toward the bottom, states that the EDI application form must be returned with the EDI Application Form. HOWEVER, according to Emdeon, *only* the EDI Enrollment Form (agreement) should be completed and sent to Palmetto GBA. For more details, refer to the Customer Service Alert from Emdeon (refer to pages 7-8).

## **IMPORTANT NOTES**

- If your practice is a group, you are required to complete only one form for the group number with which you currently are enrolled.
- If you have multiple individual providers (no group), you are required to complete one enrollment form for each provider.
- ALL forms must be signed by the provider, President, CEO, or practice owner.
- Information completed on the forms must match the information the payer has on file (Provider/Group name, address, NPI, provider/group numbers).
- Payer ID's will not change.

## **ELECTONIC FUNDS TRANSFER (EFT)**

Customers currently enrolled using EFT (deposit instead of a paper check) must complete and submit a new EFT form CMS588 (refer to pages 9-11) with current banking information and a copy of a voided check to:

Palmetto GBA Finance  
J1 EFT  
Post Office Box 100277  
Columbia, SC 29202-327

### ***EFT Agreement Due Dates***

Medicare NV: July 18, 2008

Medicare CA: August 15, 2008

## **ELECTRONIC REMITTANCE ADVICE (ERA)**

Per Emdeon, customers currently enrolled and receiving ERA files from NHIC are NOT required to fill out any enrollment paper work in order to continue with ERA. Palmetto will obtain the required details about current claim submitters and ERA receivers directly from NHIC during the transition.

## **GETTING HELP**

For general questions, please contact Customer Support at 949.790.0400, Mon-Fri, 6:00am-5:00pm, Pacific Time; e-mail: [support@alteer.com](mailto:support@alteer.com).

For specific inquiries, please contact Palmetto GBA at 866.749.4301, or visit their Web site at: [HTTP:WWW.PALMETTOGBA.COM/PALMETTO/J1.NSF/DOCSCAT/HOME](http://www.palmettogba.com/palmetto/j1.nsf/docscat/home).

As we receive additional information, we will keep you informed of any updates or changes, and we will let you know if there are additional actions you must take.

This information also was sent to your Document Routing work area, Attn: Billing Staff.



## EDI Enrollment (Agreement) Form and Instructions

The EDI Enrollment Form (commonly referred to as the EDI Agreement) should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the providers to ensure each provider is knowledgeable of the enrollment request and the associated requirements.

Providers that have contracted with a third party (clearinghouse/network service vendor or a billing agent) 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 the viewing or use of Medicare Beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is responsible for notification in this instance.

Note: The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

### General Instructions:

- Please ensure that you include your **Medicare Provider Number** and **National Provider Identifier [NPI]** where requested on the EDI Enrollment Form.
- If the submitter will be submitting for multiple providers, this form must be completed by **each** provider whose claim data will be submitted.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed **3-page EDI Enrollment Form** must be returned **with** the **EDI Application** form to the following address:

Palmetto GBA  
Jurisdiction 1, AG-420  
PO Box 100145  
Columbia, SC 29202-3145

Note: If the submitter will be an entity other than the provider, the submitter must complete the EDI Application form and the provider(s) must complete the EDI Enrollment Form(s). The EDI Application form must be returned with the EDI Enrollment Form enclosed for each applicable provider.

### IMPORTANT NOTE:

The address shown on the EDI Enrollment Form must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Form does not match, your entire EDI Enrollment Packet will be returned.

The National Provider Identifier (NPI) must be printed in the space provided on the EDI Enrollment Form. If this information is missing, the EDI Enrollment Form will not be processed.

## Medicare Electronic Data Interchange Enrollment Agreement

### **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 contactor 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, MACs, 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 or 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 the Social Security Act (the Act));
14. That it will research and correct claim discrepancies;
15. That it will notify the carrier, MAC or 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's 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: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

By (Print Name): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Medicare Provider Number \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

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Complete ALL fields above and mail entire agreement (three pages) with **original** signature and **with** a copy of the **EDI Application form** to:

Palmetto GBA  
Jurisdiction 1, AG-420  
PO Box 100145  
Columbia SC 29202-3145

## Customer Service Alert



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**Subject:** RE-ENROLLMENT REQUIRED - REMINDER  
**Date:** 05/23/2008  
**LOB:** Institutional/Professional  
**Payer(s):** 57011 - CA - MEDICARE  
SMCA1 - CA - MEDICARE (NHIC)  
SMCA2 - CA - MEDICARE (NHIC)  
SMHI0 - HI - MEDICARE (NORIDIAN ADMINISTRATIVE SERVICES)  
SMNV0 - NV - MEDICARE (NORIDIAN ADMINISTRATIVE SERVICES)  
12M20 - NV - MEDICARE

### **Topic:**

As previously communicated the Centers for Medicare & Medicaid Services (CMS) announced the award of the contract for the combined administration of Part A and Part B Medicare fee-for-service claims in Jurisdiction 1 (J1) to Palmetto GBA. This jurisdiction includes California, Hawaii, Nevada, American Samoa, Guam and the Northern Marianna Islands.

Due to this transition all providers currently using any EDI service must complete and return a new Electronic Data Interchange Enrollment Form to Palmetto GBA.

Emdeon had previously communicated that an EDI application would also be required. Note: Palmetto GBA has advised that an EDI application is not required by providers. ONLY the EDI Enrollment Agreement should be completed and sent to Palmetto GBA at this time.

Palmetto will be working with the outgoing contractors and clearinghouses to ensure that providers EDI setups are transitioned to Palmetto GBA.

### **Action Required by Customer:**

Please complete and send in the J1 EDI Enrollment Form located on the Palmetto GBA J1 website under EDI Section ---> Enrollment at <http://www.palmettogba.com/palmetto/j1.nsf/DocsCat/Home>

### **Action Taken by Emdeon:**

Emdeon is actively working with Palmetto GBA to ensure all J1 MAC requirements are met.

**Resolution Status:**

Please continue to watch for additional updates regarding the J1 MAC transition

Emdeon is proud to be your EDI partner and remains committed to your success.

Thank You for your attention and cooperation,

**Emdeon**

**CSA ID:** 1-3OL8J5

**Disclaimer:** This notice contains CONFIDENTIAL information intended only for the use of Emdeon customers. If you are NOT the intended recipient of this notice or an agent or employee responsible for delivering it to the intended recipient, you are hereby notified that any unauthorized dissemination or copying of the notice or the information contained therein is strictly prohibited.

## ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

### PART I – REASON FOR SUBMISSION

Reason for Submission:  New EFT Authorization  
 Revision to Current Authorization (e.g. account or bank changes)

Chain Home Office:  Check here if EFT payment is being made to the Home Office of Chain  
Organization (Attach letter Authorizing EFT payment to Chain Home Office)

### PART II – PROVIDER OR SUPPLIER INFORMATION

Name \_\_\_\_\_

Provider/Supplier Legal Business Name \_\_\_\_\_

Chain Organization Name \_\_\_\_\_

Home Office Legal Business Name (if different from Chain Organization Name) \_\_\_\_\_

Tax Identification Number: (Designate SSN  or EIN ) \_\_\_\_\_

Medicare Identification Number (if issued) \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

### PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Depository Telephone Number \_\_\_\_\_

Depository Contact Person \_\_\_\_\_

Depository Routing Transit Number (nine digit) \_\_\_\_\_

Depositor Account Number \_\_\_\_\_

Type of Account (check one)  Checking Account  Savings Account

Please include a voided check or deposit slip or confirmation of account information on bank letterhead. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and the bank officer's name signature. This information will be used to verify your account number.

### PART IV – CONTACT PERSON

First Name	Middle Initial	Last Name
Telephone Number		Fax Number (if applicable)

Address Line 1 (Street Name and Number) \_\_\_\_\_

Address Line 2 (Suite, Room, etc.) \_\_\_\_\_

City/Town	State	ZIP Code + 4
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E-mail Address \_\_\_\_\_

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## PART V – AUTHORIZATION

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I hereby authorize the Centers for Medicare & Medicaid Services fee-for-service contractor, \_\_\_\_\_, hereinafter called the CONTRACTOR, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is being made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still considered payment to the Provider, and the Provider authorizes the forwarding of Medicare payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/ Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

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### Signature Line

Authorized/Delegated Official Name (Print) \_\_\_\_\_

Authorized/Delegated Official Title \_\_\_\_\_

Authorized/Delegated Official Signature \_\_\_\_\_ Date \_\_\_\_\_

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### PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Under 31 U.S.C. 3332(f)(1), all Federal payments, including Medicare payments to providers and suppliers, shall be made by electronic funds transfer.

The information collected will be entered into system No. 09-70-0501, titled "Carrier Medicare Claims Records," and No. 09-70-0503, titled "Intermediary Medicare Claims Records" published in the Federal Register Privacy Act Issuances, 1991 Comp. Vol. 1, pages 419 and 424, or as updated and republished. Disclosures of information from this system can be found in this notice.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government, under certain circumstances, to verify the information you provide by way of computer matches.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0626. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**DO NOT MAIL THIS FORM TO THIS ADDRESS.  
MAILING YOUR APPLICATION TO THIS ADDRESS WILL SIGNIFICANTLY DELAY PROCESSING.**

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## INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

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All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicare direct deposits are made.

### PART I – REASON FOR SUBMISSION

Indicate your reason for completing this form by checking the appropriate box: New EFT authorization or change to your account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

### PART II – IDENTIFICATION DATA

**Line 1 –** Enter the name of the physician or individual practitioner, or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account to which must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.

**Line 2 –** Enter the provider's/supplier's legal business name. The account to which EFT payments made must exclusively bear the name of the physician or individual practitioner, or the legal business name of the person or entity enrolled with Medicare.

**Line 3 –** Enter the chain organization's name.

**Line 4 –** Enter the home office legal business name if different from the chain organization name.

**Line 5 –** Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

**Line 6 –** If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

**Line 7 –** Enter the 10 digit NPI number. The NPI is required to process this form.

### PART III – DEPOSITORY INFORMATION (Financial Institution)

**Line 8 –** Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).

**Line 9 –** Enter the depository's street address.

**Line 10 –** Enter the depository's city, state and ZIP code.

**Line 11 –** Enter the bank or financial institutional telephone number.

**Line 12 –** Enter the depository's contact person.

**Line 13 –** Enter the bank or financial institutional nine-digit routing number.

**Line 14 –** Enter the depositor's account number and select the account type.

**If you do not submit this information, your EFT authorization agreement will be returned without further processing.**

### PART IV – CONTACT PERSON

Enter the information for the contact person responsible for this EFT authorization agreement.

### PART V – AUTHORIZATION

Enter the name of the CMS fee-for-service contractor in Part V who has authority to initiate credit entries.

**Line 24 –** By your signature on this form you are certifying that the account is drawn in the Name of the Physician or Individual Practitioner, or the Legal Business Name of the Provider or Supplier. The Provider or Supplier has sole control of the account to which EFT deposits are made in accordance with all applicable Medicare regulations and instructions. All arrangements between the depository and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions with the effective date of the EFT authorization. You must notify the Medicare contractor regarding any changes in the account in sufficient time to allow the contractor and the depository to act on the changes.

The EFT authorization form must be signed and dated by the same Authorized Representative or a Delegated Official named on the CMS-855 Medicare enrollment application which the Medicare contractor has on file.

Mail this form with the original signature (no facsimile signatures can be accepted) to the Medicare contractor that services your geographical area. To locate the mailing address for your fee-for-service contractor, go to: [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll).