CMS Manual System

Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 2 **Date: NOVEMBER 28, 2003**

CHANGE REQUEST 2566

I. SUMMARY OF CHANGES: This manualizes transmittal number AB-03-077 dated May 23, 2003, Disclosure Desk Reference for Call Centers – Provider Portion.

CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Table of Contents
N	3.60.1 - Disclosure Desk Reference for Call Centers – Provider Portion

III. FUNDING:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 3 - Provider Customer Services

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(Rev. 2, 11-28-03)

60.1 – Disclosure Desk Reference for Call Centers – Provider Portion

(Rev. 2, 11-28-03)

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***	***REFERENCE***
22. A Provider/Physician *Part A or B*	*Provider/physician inquires about claims information on a pre-claim basis*		*No claims information may be released on a pre-claim basis without the beneficiary's authorization.*	*100-1, Ch. 6, §80* *100-9, Ch. 3, §40.2*
23. A Provider/Physician *Part A or B*	*Provider/physician inquires about claims information on a post-claim basis.*	*Validate the provider/physician's name and identification number.* *Verify the beneficiary's:* ● *Date of Service* ● *Last name and first initial* ● *HIC number* *Items must match exactly.*	***Assigned Claims*** *Participating and Non-Participating: Discuss any information on that provider/physician's claim or any other related claim from that provider/physician for that beneficiary.* ***Non-Assigned Claims*** *Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.*	*100-1, Ch. 6, §80* *100-9, Ch. 3, §40.2*

			General Note: *You may speak with the provider/physician about his/her own claims. You may also disclose information about another provider/physician, as long as both providers/ physicians have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the provider/physician that receives the information.*	

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***	***REFERENCE***
24. A Provider/physician *Part A*	*Provider/physician inquires about beneficiary eligibility information, which would be available via EDI.* *This information may only be used in order to submit an accurate claim.*	*Validate the provider/physician's name and identification number.* *Verify the beneficiary's:* ● *Last name & first initial* ● *Date of birth* ● *HIC number* ● *Gender* *Items must match exactly.*	*Release the following eligibility information on a pre-claim or post-claim basis:* *– Date of death* *– Lifetime reserve days remaining* *– Lifetime psychiatric days remaining (if the requesting caller has a psychiatric identification number)* *– Cross reference HICN* *– Current and prior A and B entitlements* *– Spell of illness: hospital full and coinsurance days remaining, SNF full days and coinsurance days remaining, Part A cash deductible remaining to be met, date of earliest billing action for*	*100-1, Ch. 6, §40 & 60.1*

			indicated spell of illness *– Blood deductible (combined Part A and B) remaining to be met for applicable year entered by provider* *– Part B trailer year (applicable year based on date entered by provider)* *– Part B cash deductible* *– Physical/speech and occupational therapy amount* *– Hospice data (applicable periods based on the date entered by the provider and the next most recent period)* *– ESRD indicator* *– Rep payee indicator* *– MSP indicator* *– HMO information: identification code, option code, start & termination date* *– Pap smear screening: risk indicator,*	

			professional and technical date *– Mammography screening: risk indicator, professional and technical date* *– Colorectal screening: procedure code, professional and technical date* *– Pelvic screening: risk indicator and professional date* *– Pneumococcal pneumonia vaccine (PPV) date* *– Influenza virus vaccine date* *– Hepatitis B vaccine date* *– Home health start and end dates and servicing agency's name.*	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
25. A Provider/Physician *Part B*	*Provider inquires about beneficiary eligibility information, which would be available via EDI.* *This information may only be used in order to submit an accurate claim.*	*Validate the provider's name and provider number.* *Verify the beneficiary's:* ● *Last name and first initial* ● *Date of birth* ● *HIC number* ● *Gender* *Items must match exactly.*	*Release the following eligibility information on a pre-claim or post-claim basis:* *– Part A and B entitlement and termination dates* *– Deductible met (yes or no) for current and prior years* *– HMO information: "cost" or "risk" plan, effective and termination dates* *– MSP activity (yes or no)* *– Home health start and end dates and servicing agency's name.* *-- Physical/speech and occupational therapy amount*	*100-1, Ch. 6, §40 & 60.1*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***	***REFERENCE***
26. Supplier *DMERC*	*Supplier inquires about claims information on a pre-claim basis.*		*No claims related information may be released on a pre-claim basis without the beneficiary's authorization.*	*100-1, Ch. 6, §80* *100-9, Ch. 3, §40.2*
27. Supplier *DMERC*	*Supplier inquires about claims information on a post-claim basis.*	*Validate the supplier's name and NSC identification number* *Verify the beneficiary's:* ● *Date of service* ● *Last name and first initial* ● *HIC number* *Items must match exactly.*	***Assigned Claims*** *Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary.* ***Non-Assigned Claims*** *Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.*	*100-1, Ch. 6, §80* *100-9, Ch. 3, §40.2*

			General Note: *You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.*	

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*	*REFERENCE*
28. Supplier *DMERC*	*Supplier inquires about a Certificate of Medical Necessity (CMN)* *NO claim has been submitted.*		*You may not release answers to the question sets on the CMN on file without the beneficiary's authorization.*	
29. Supplier *DMERC*	*Supplier inquires about a Certificate of Medical Necessity (CMN)* *Supplier receives a claim denial due to the CMN.* *This information may only be used in order to submit an accurate claim.*	*Validate the supplier's name and NSC identification number.* *Verify the beneficiary's:* ● *Date of service* ● *Last name and first initial* ● *HIC number* ● *HCPCs code or name of item* *Items must match exactly.*	*You may confirm whether or not the answers to the question sets on the CMN on file matches what the supplier has in his/her records.*	
30. Supplier	*Supplier inquires about beneficiary eligibility*	*Validate the supplier's name and NSC*	*Release the following eligibility information on*	*100-1, Ch. 6, §40 & 60.1*

DMERC	*information, which would be available via EDI.* *This information may only be used in order to submit an accurate claim.*	*identification number.* *Verify the beneficiary's:* ● *Last name and first initial* ● *Date of birth* ● *HIC number* ● *Gender* *Items must match exactly.*	*a pre-claim or post-claim basis:* *– Part A and B entitlement and termination dates* *– Deductible met (yes or no) for current and prior years* *– HMO information: "cost" or "risk" plan, effective and termination dates* *– MSP activity (yes or no)* *– Home health start and end dates and servicing agency 's name.* *-- Physical/speech and occupational therapy limit*	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
31. Ambulance Supplier	*Supplier inquires about claims information on a pre-claim basis.*		*No claims related information may be released on a pre-claim basis without the beneficiary's authorization.*	*100-1, Ch. 6, §80* *100-9, Ch. 3, §40.2*
32. Ambulance Supplier	*Supplier inquires about claims information on a post-claim basis.*	*Validate the supplier's name and identification number* *Verify the beneficiary's:* ● *Date of service* ● *Last name and first initial* ● *HIC number* *Items must match exactly.*	***Assigned Claims*** *Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary.* ***Non-Assigned Claims*** *Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.*	*100-1, Ch. 6, §80* *100-9, Ch. 3, §40.2*

			General Note: *You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.*	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:	REFERENCE
33. Ambulance Supplier	*Supplier inquires about beneficiary eligibility information, which would be available via EDI.* *This information may only be used in order to submit an accurate claim.*	*Validate the supplier's name and identification number.* *Verify the beneficiary's:* ● *Last name and first initial* ● *Date of birth* ● *HIC number* ● *Gender* *Items must match exactly.*	*Release the following eligibility information on a pre-claim or post-claim basis:* *– Part A and B entitlement and termination dates* *– Deductible met (yes or no) for current and prior years* *– HMO information: "cost" or "risk" plan, effective and termination dates* *– MSP activity (yes or no)* *– Home health start and end dates and servicing agency's name.* *-- Physical/speech and occupational therapy limit*	*100-1, Ch. 6, §40 & 60.1*

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*	*REFERENCE*
34. Billing Service/ Clearinghouse	*Billing Service/ Clearinghouse inquires about claims information on a pre-claim basis.*		*No claims related information may be released on a pre-claim basis without the beneficiary's authorization.*	
35. Billing Service/ Clearinghouse	*Billing Service/ Clearinghouse inquires about claims information on a post-claim basis.*	*Validate the employing provider/physician/ supplier's name and identification number.* *Verify beneficiary's:* ● *Date of service* ● *Last name and first initial* ● *HIC number* *Items must match exactly.*	*You may speak with the billing service/clearinghouse about the employing provider/physician/ supplier's claims.*	
36. Billing Service/ Clearinghouse	*Billing Service/ Clearinghouse inquires about beneficiary eligibility information,*	*Validate the employing provider/physician/supplier's name and identification number.*	*Release the following eligibility information on a pre-claim or post-claim basis:*	

	which would be available via EDI. *This information may only be used in order to submit an accurate claim.*	*identification number.* *Verify the beneficiary's:* ● *Last name and first initial* ● *Date of birth* ● *HIC number* ● *Gender* *Items must match exactly.*	*claim basis:* *– Part A and B entitlement and termination dates* *– Deductible met (yes or no) for current and prior years* *– HMO information: "cost" or "risk" plan, effective and termination dates* *– MSP activity (yes or no)* *– Home health start and end dates and servicing agency's name.* *-- Physical/speech and occupational therapy limit*	

General Notes and Definitions

ASSIGNMENT	*When a provider agrees to accept Medicare approved charges as payment in full and the beneficiary agrees to have Medicare's share of the cost of service paid directly to the provider.*
BILLING SERVICE	*Collects provider/physician/supplier claim information and bills the appropriate insurance companies, including Medicare. It may provide claims billing service only, or provide full financial accounting*
CLEARINGHOUSE	*Transfers or moves EDI transactions for a provider/physician/supplier and translates the data into the format required by a health care trading partner, such as a payer. A clearinghouse accepts multiple types of claims and generally other EDI transactions and sends them to various payers, including Medicare. They also accept EDI transactions from payers for routing to and/or reformatting for providers/physicians/suppliers. They perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider/physician/supplier. Clearinghouses frequently reformat data for various payers and manage acknowledgements and remittance advice. Clearinghouses ordinarily submit initial claims and may qualify as a billing service.*
DATE OF SERVICE	*The date on which the beneficiary received health services from a provider, physician or supplier.*
	and/or other services. Billing services may view beneficiary or provider data to perform their obligations to the provider/physician/supplier, and if the provider/physician/supplier designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider/physician/supplier's behalf.
DISCLOSURE	*Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of minor. The individual to whom the information pertains must authorize (either verbally or in writing) the disclosure of his/her personal information to the third party.*

NONASSIGNMENT	*When a provider has not agreed to accept Medicare approved charges as payment in full and the claim potentially is payable directly to the Medicare beneficiary.*
NONPARTICIPATING PHYSICIAN	*A physician who has not signed a participation agreement and is not obligated to accept assignment on Medicare claims; may accept assignment of Medicare claims on a case-by-case basis.*
PARTICIPATING PHYSICIAN	*A physician who has signed a participation agreement to accept assignment on all claims submitted to Medicare.*
PHYSICIAN	*Doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.2), doctor of podiatric medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.3), or doctor of optometry (within the limitations of Pub. 100-1, Chapter 5, subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function.* ***NOTE:*** *The term physician does not include such practitioners as a Christian Science practitioner or naturopath.*
POST-CLAIM	*After a provider, physician or supplier services a beneficiary and a claim has been submitted for that beneficiary.*
PRE-CLAIM	*Before the provider, physician or supplier services a beneficiary and before a claim has been submitted for that beneficiary.*
PROVIDER	*Section 1866(e) of the Social Security Act defines the term "provider of services" (or provider) as:* *(1) A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the*

	requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and *(2) A community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)). Definitions of providers, physicians, practitioners, and suppliers, and a description of the requirements that each must meet in order for their services to be considered covered are described in the following sections.*
RELATIONSHIP	*When a provider/physician/supplier has rendered, or is rendering, health services to a beneficiary.*
REPRESENTATIVE PAYEE	*This is a person or organization appointed by the Social Security Administration when it is determined that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use a representative payee. However, if a beneficiary is judged legally incompetent, they must have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.*
SUPPLIER	*An entity that is qualified to furnish health services covered by Medicare, other than providers, physicians, and practitioners.* *The following suppliers must meet the conditions in order to receive Medicare payment: ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities,*

rural health clinics, and Federally-qualified health centers.
A DME supplier is an entity that furnishes DME and has a number assigned by the National Supplier Clearinghouse.

GENERAL NOTES:

Blended call centers (those that answer both beneficiary and provider calls at the same place) may choose to answer provider calls regarding eligibility inquiries and claims issues on the beneficiary line if they have the ability to track the calls appropriately. Otherwise, they should refer the contact to the appropriate provider inquiry number.

An individual who makes a request by telephone must verify his/her identity by providing identifying particulars, which parallel the record to which notification or access is being sought. If the CSR determines that the particulars provided by telephone are insufficient, the requestor will be required to submit the request in writing or in person. Telephone requests will not be accepted where an individual is requesting notification of, or access to, sensitive records such as medical records.

Always remember that access and disclosure involve looking at a Medicare record and giving out information. If you do not have to look at a record (for example, in explaining a letter), access and disclosure rules are not involved. General (that is, non beneficiary-specific) information may be discussed at any time with any caller.

Medicare Customer Service Center (MCSC) employees must follow the MCSC rules governing disclosure, which require CSRs to obtain at least four items of information to identify the beneficiary for claims information and six items when accessing the MBR or EDB. For consistency among contractors, we recommend that three of those items are the beneficiary's name, HIC number, and date of birth.

On all Medicare Customer Service Center (MCSC) calls dealing with Managed Care issues other than enrollment/disenrollment issues and dates, refer the contact to the Managed Care organization. You may not release any Managed Care claims information.
NOTE: *Representative payees are not authorized to enroll or disenroll beneficiaries in Managed Care Organizations, unless the representative payee has that authority under State law.*

The written authorization must:

- *Include the beneficiary's name, and HIC;*
- *Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;*
- *Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;*
- *Specify the records, information, or types of information that may be disclosed;*
- *A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as "at the request of the individual");*
- *Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary's enrollment in the health plan);*
- *Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative's authority to act for the individual must also be provided; and*
- *A statement describing the individual's right to revoke the authorization along with a description of the process to revoke the authorization;*
- *A statement describing the inability to condition treatment, payment, enrollment or eligibility for benefits on whether or not the beneficiary signs the authorization;*
- *A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.*

For non-English speaking beneficiaries, you must obtain the beneficiary's identifying information and verbal consent (via the AT&T language line or similar service, or other interpreter) prior to speaking with the friend, relative, etc.

If the Automated Voice Response (ARU) or Interactive Voice Response (IVR) system obtains the beneficiary's name, HIC number and DOB and one additional piece of information (such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage) prior to the CSR answering, and this is evident to the CSR, it is not necessary to obtain that information again. The CSR should ask to whom they are speaking just to ascertain if it is the beneficiary or someone acting on the beneficiary's behalf.

If the ARU or IVR system is not currently programmed to obtain all of the disclosure elements, and it is necessary for the CSR to answer the call, the CSR should obtain the required data elements before disclosing any identifiable information.

These instructions do not change any requirements for contractors regarding the use of ARU/IVR systems. You are not authorized to reprogram the ARU or IVR at this time.

For situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. Refer situations in which the CSR is unsure of whether or not to release information to his/her supervisor or to the organization's privacy official.