CMS Manual System

Pub. 100-01 Medicare General Information, Eligibility, and Entitlement

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

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CHANGE REQUEST 2484

I. SUMMARY OF CHANGES: Application of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to the Original Medicare Plan

MANUALIZATION - EFFECTIVE DATE: Non-applicable
***IMPLEMENTATION DATE: Non-applicable**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	6\190\The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule
N	Exhibit D - Disclosure Desk Reference Guide for Call Centers

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

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

***Medicare contractors only**

Medicare General Information, Eligibility, and Entitlement

Chapter 6 - Disclosure of Information

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(Rev. 7, 06-25-04)

190 - The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

(Rev. 7, 06-25-04)

A. General Information

To improve the efficiency and effectiveness of the health care system, HIPAA included provisions that required national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.

The Department of Health and Human Services issued the regulation "Standards for Privacy of Individually Identifiable Health Information", 45 CFR Parts 160 and 164, (the HIPAA Privacy Rule) to implement section 264 of HIPAA. The HIPAA Privacy Rule establishes a set of basic national privacy standards and fair information practices. It sets a floor of ground rules for health care providers, health plans, and health care clearinghouses to follow to protect the privacy of an individual's personal health information.

The HIPAA Privacy Rule is based on the same fair information principles that are found in the Privacy Act of 1974 and are now generally extended to the public and private sectors of the health care delivery system. The HIPAA Privacy Rule applies to protected health information (PHI) held by covered entities, as defined by the Rule, while the Privacy Act protects records with individually identifiable information held by Federal agencies. The Privacy Act continues to apply to Medicare and Medicare fee-for-service (FFS) contractors in their day-to-day operations.

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is responsible for providing outreach and technical assistance to covered entities (health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically) and for enforcing the HIPAA Privacy Rule. OCR maintains information on the HIPAA Privacy Rule at http://www.hhs.gov/ocr/hipaa/

B. How CMS Applies Laws Affecting the use and Disclosure of Personal Information

1. General rules

Since Medicare operates under both the Privacy Act and the HIPAA Privacy Rule, CMS has determined how the provisions interact with each other as it uses personally identifiable information in its day-to-day operations. For example, a use or disclosure that is permitted under the HIPAA Privacy Rule (e.g., to

facilitate cadaveric organ donation and transplants), but not published in a ***Federal Register*** *notice as a routine use in a CMS system of records would not be permitted for Medicare. Similarly, if the disclosure is a "routine use" under the Privacy Act, but the HIPAA Privacy Rule prohibits the disclosure, CMS will not make the disclosure.*

Exemption 6 of the Freedom of Information Act (FOIA) permits Federal agencies to withhold personnel and medical files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy. When a FOIA request asks for documents that include personal information, CMS must apply Exemption 6 to preclude the release of, or must otherwise redact, identifying details before disclosing the remaining information.

2. Information About Deceased Individuals

The application of Exemption 6 of the FOIA to information about deceased individuals requires a different analysis than that applicable to living individuals because under the Privacy Act of 1974, privacy rights are extinguished at death. However, under FOIA, it is entirely appropriate to consider the privacy interest of a decedent's survivors under Exemption 6. Under the HIPAA Privacy Rule, the personal health information of deceased as well as living persons is protected.

3. Requests for Access to Records

FOIA and Privacy Act requests will continue to be handled according to current procedures and timeliness standards. A FOIA request for access to public records requires CMS, as a Federal agency, to provide the fullest possible disclosure of its records to the public, subject to certain exceptions (e.g., proprietary information, national defense risks). The Privacy Act requires CMS to provide individuals access to their personal information maintained in a System of Records. Note that an individual's request under the Privacy Act to access his or her records must specify a Privacy Act System of Records and must be addressed to the system manager identified in the ***Federal Register*** *notice.*

A HIPAA Privacy Rule request for access is separate from both FOIA and the Privacy Act and has it own timeliness standards associated with it. Requests for access under the HIPAA Privacy Rule will be handled by CMS' Central Office (see section G below).

4. State Law Preemption Under HIPAA

Medicare is a national program that is administered under Federal statute and regulation. CMS administers Medicare through Medicare FFS contractors that are required to operate in accordance with statutory and regulatory requirements and CMS administrative direction.

When considering the provisions of HIPAA, Congress expressly intended to defer to more stringent state laws if those laws conflict with provisions in the HIPAA Privacy Rule. The HIPAA Privacy Rule therefore explicitly preempts conflicting state law provisions, unless they are more stringent or more protective of the individual's rights. Since the Federal law expressly preserves more stringent state laws, and because of the complexity of this issue, contractors should ask CMS for guidance as issues arise.

C. CMS Programs that are Covered Entities Under HIPAA

The Federal health programs that CMS administers are health plans as defined in HIPAA and are covered entities subject to the HIPAA Privacy Rule. These health plans are:

- *Part A or Part B of the Medicare program under Title XVIII;*
- *TheMedicaid program under Title XIX;*
- *The State Children's Health Insurance Program (SCHIP); and*
- *The Medicare Advantage (formerly Medicare+Choice (M+C)) program and other Medicare health plans.*

CMS is directly responsible for ensuring that the Medicare Fee-For-Service (FFS) program, also known as the Original Medicare Plan, complies with the HIPAA Privacy Rule. For the Medicaid and SCHIP programs, the appropriate State Agency is responsible for ensuring compliance with privacy requirements. Medicare Advantage (formerly M+C) plans are covered entities subject to the HIPAA Privacy Rule in their own right and responsible for their own compliance.

D. Business Associates

Most health care providers and health plans do not carry out all of their health care activities and functions by themselves; they require assistance from a variety of contractors and other businesses. By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity.

Medicare FFS contractors that perform health care activities involving the use of PHI on behalf of the Medicare FFS health plan (i.e., claims processing functions) are business associates of the Medicare FFS health plan (the covered entity). The HIPAA Privacy Rule allows providers and plans to give PHI to their business associates as long as they have satisfactory assurances and document those assurances, typically by contract, that business associates will safeguard the information.

Medicare contracts have been modified to include the business associate provisions. These provisions also address the contractor's responsibility to ensure that

subcontractors or agents to whom they disclose Medicare data agree, by contract, to safeguard any PHI as well. Contracts continue to include language that applies to contractors who maintain or operate a Privacy Act protected systems of records on Medicare's behalf.

Medicare contractors that perform health care activities involving the use of PHI on behalf of the Medicare FFS health plan are not business associates of providers, physicians, suppliers, clearinghouses, or other health plans. Likewise, providers, physicians, suppliers, clearinghouses, or other health plans are not business associates of the Medicare contractor unless the provider, physician, supplier, clearinghouse, or other health plan is doing work on behalf of the Medicare contractor. For these reasons, Medicare FFS contractors should not sign business associate agreements with any provider, physician, supplier, clearinghouse, or other plan unless the provider, physician, supplier, clearinghouse, or other health plan is doing work on the contractor's behalf.

E. Trading Partner Agreements

Currently, Medicare contractors execute trading partner agreements (TPAs) with a number of payers, including Medigap insurers, Medicare supplemental/employee retiree health plans, multiple employer welfare trusts, TRICARE for Life, as well as State Medicaid Agencies, for the purpose of exchanging adjudicated Medicare claims for secondary liability determination by those partners. This exchange of data is commonly referred to as the "claims crossover process." For coordination of benefits (COB) purposes, Medicare contractors and trading partners are not business associates of each other since neither entity is doing work on the other's behalf; therefore, intermediaries and carriers should not sign business associate agreements with COB trading partners that receive claims crossover data from them.

F. Notice of Privacy Practices

The HIPAA Privacy Rule requires each covered entity to develop and provide a plain language notice that describes its legal duties, the uses and disclosures of protected health information that it may make, and individual privacy rights and how to exercise them. The individual rights include the right to inspect and copy protected health information, to amend protected health information, to request restrictions, confidential communications, an accounting of disclosures, a paper copy of the privacy notice, and how to file complaints.

Medicare's privacy notice was provided to beneficiaries for the first time in the 2003 Medicare & You handbook and is provided in the handbook every year. New enrollees receive the privacy notice in the handbook that is mailed to them within 30 days of Medicare entitlement. Medicare's privacy notice is also posted on Medicare's Web site at www.medicare.gov.

Medicare's Notice of Privacy Practices informs beneficiaries who are interested in exercising individual rights to go to www.medicare.gov or call 1-800-MEDICARE.

Customer Service Representatives (CSR) at 1-800-MEDICARE use scripts to answer questions regarding exercising individual rights and filing complaints.

Since Medicare's privacy notice describes the uses and disclosures of PHI in the day-to-day operations of Medicare (including Medicare FFS contractors), FFS contractors are not required to develop a separate privacy notice for Medicare beneficiaries.

G. Individual Rights and Complaints

NOTE: For Individual Rights Under the Privacy Act of 1974, see §10 above.

The HIPAA Privacy Rule gives individuals rights with respect to their PHI. These rights are listed in covered entities' privacy notices. The Notice of Privacy Practices for the Original Medicare Plan includes the right to:

1. *See and get a copy of personal health information held by Medicare.*

   CMS Central Office is responsible for responding to beneficiary requests for access to records under the HIPAA Privacy Rule. Medicare FFS contractors should only respond to those requests for information related to payment of a claim, for which they are already responsible under the contract under existing customer service procedures. Simple telephone inquiries, such as asking about the status of a claim or requesting a duplicate Medicare Summary Notice, are not considered a HIPAA request for access and should be handled under existing customer service procedures.

2. *Have personal health information amended if it is wrong or missing, and Medicare agrees. If Medicare disagrees, a statement of disagreement may be added to the personal health information.*

   CMS Central Office is responsible for handling beneficiary requests to amend the record under the HIPAA Privacy Rule. Contractors will not be responding to requests to amend records.

   Requests for changes to claims or payment records, such as an appeal or change of address request, are not considered HIPAA Privacy Rule requests for amendments, and should be handled according to current procedures.

   Please note, however, that if the request for amendment involves medical records, contractors should explain that, except in rare circumstances, only the source of the medical record (i.e., the provider) may make changes to the record.

3. *Get a listing of those receiving personal medical information from Medicare.*

CMS Central Office is responsible for responding to beneficiary requests for an accounting of disclosures under the HIPAA Privacy Rule. Contractors will not be responding to requests for an accounting of disclosures.

The listing does not cover personal health information that was given to the individual or his or her personal representative, that was given out to pay for health care or Medicare operations, or that was given out for law enforcement purposes.

4. *Ask Medicare to communicate in a different manner or at a different place, for example, by sending materials to a P.O. box instead of the address on file. Current regulations and existing agreements with the Social Security Administration are extremely prescriptive, often governing precisely how CMS can respond to requests for confidential communications.*

   Operationally, CMS can only maintain one address at a time. Because of this, routine change of address requests should be handled according to current change of address procedures.

5. *Ask Medicare to limit how personal health information is used and given out to pay claims and run the Medicare program.*

   CMS Central Office is responsible for responding to beneficiary requests to restrict disclosure of PHI. Contractors will not be responding to requests to restrict disclosure of PHI.

6. *Get a separate paper copy of the privacy notice.*

   Contractors who receive requests for a paper copy of the Notice of Privacy Practices for the Original Medicare Plan should refer requestors to their Medicare & You handbook.

7. *File a complaint.*

   Medicare's Notice of Privacy Practices informs individuals of the right to file complaints about Medicare's privacy practices with either Medicare or the Secretary of Health and Human Services. The privacy notice refers individuals to www.medicare.gov or 1-800-MEDICARE for further information on filing a complaint.

   CMS is required to document in written or electronic form the complaints received and their disposition. There is no requirement to respond in a particular manner or time frame.

For the privacy rights listed above where CMS Central Office is responsible for responding to the request, contractors should advise beneficiaries to address their requests to:

HIPAA Privacy
P.O. Box 8050
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

H. Privacy Authorizations

An authorization is a document that an individual uses to give a covered entity permission to disclose his or her PHI for a particular purpose (e.g., for marketing) or to a third party specified by the individual. A covered entity is generally not required to obtain an authorization for the use or disclosure of PHI for treatment, payment, or health care operations, as well as for certain public priority activities under specified conditions (e.g., health care oversight, law enforcement). Contractors should inform providers that contractors are unable to make payment for Medicare claims if the provider fails to provide the information needed to process them.

The HIPAA Privacy Rule specifies certain core elements and required statements for a valid authorization. Contractors may add more elements to their authorizations as long as the core elements and required statements remain and no provisions are added that conflict with these core elements and statements.

Contractors must also accept an authorization from another entity, provided it includes all of the core elements and required statements, and no provisions are added that conflict with these core elements and statements.

I. Core Elements and Required Statements for an Authorization

The core elements of a valid authorization are:

1. *A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;*

2. *The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;*

3. *The name or other specific identification of the person(s) or class of persons, to whom the covered entity may make the requested use or disclosure;*

4. *A description of each purpose of the requested use or disclosure. The statement, "at the request of the individual" is a sufficient description of the*

purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose;

5. *An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and*

6. *The signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided. Although the HIPAA Privacy Rule requires only a description of the representative's authority to act for the individual, CMS is requiring that documentation showing the representative's authority be attached to the authorization (e.g., a Power of Attorney).*

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

1. *The individual's right to revoke the authorization in writing, how the individual may revoke the authorization, and the exceptions to the right to revoke, e.g.,"You have the right to take back ("revoke") your authorization at any time in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to: [Each Medicare contractor or CMS: Please insert Name, Address, and Telephone number of your organization here]";*

2. *The inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, e.g., "I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive";*

3. *The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected, e.g.: "Your personal medical information that you authorize Medicare to disclose may be subject to redisclosure and no longer protected by law."*

In addition, the authorization must be written in plain language and a signed copy must be provided to the individual (or the individual should be advised to retain a copy).

CMS is developing a standard authorization for beneficiaries or their personal representatives to request disclosure of PHI to third parties. The standard will contain the elements for compliance with both the HIPAA Privacy Rule and Privacy Act requirements. Contractors will be notified when the standard authorization is available.

J. Personal Representatives and Third Party Authorizations

The HIPAA Privacy Rule requires covered entities to treat an individual's personal representative as the individual with respect to uses and disclosures of the individual's PHI, as well as exercising the individual's privacy rights listed in the covered entity's Notice of Privacy Practices. A personal representative may also authorize disclosures of an individual's PHI (see §190H above).

In addition to these formal designations of a personal representative, the HIPAA Privacy Rule permits a covered entity to disclose to any person identified by the individual the protected health information directly relevant to such person's involvement with the individual's care or payment related to the individual's care. Therefore, a verbal authorization is allowed under the HIPAA Privacy Rule for those individuals involved in the care of an individual.

Contractors should continue to handle routine inquiries, such as telephone requests for the status of claims, under existing customer service procedures that include verification of the individual's identity. Therefore, with the beneficiary's verbal or written permission, contractors may continue to speak to third parties on behalf of the individual. See Exhibit D – Disclosure Desk Reference Guide for Call Centers for detailed instructions on disclosing PHI over the telephone.

Contractors may also continue to handle Congressional inquiries under existing customer service procedures (see §10J above).

K. Administrative Requirements

As Medicare's business associate, contractors are not subject to the administrative requirements of the HIPAA Privacy Rule. However, under the Privacy Act, contractors must comply with the privacy provisions specified in their contracts. Contractors are not required to designate a privacy official. However, contractors are required to have in place a senior official or other responsible party to address the privacy concerns of the organization and to establish an internal control system to monitor compliance with privacy requirements.

Similarly, as Medicare's business associate, contractors are not subject to the HIPAA Privacy Rule's requirement to train staff specifically on the HIPAA Privacy Rule. However, under the Privacy Act, contractors are required to ensure that employees understand their responsibility to protect the privacy and confidentiality of CMS's records.

It is CMS policy that any data collected on behalf of CMS in the administration of a Medicare contract belongs to CMS. Any disclosure of individually identifiable information without prior consent from the individual to whom the information pertains, or without statutory or contract authorization, requires prior approval by CMS.

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
1. The beneficiary		*Verify it is the beneficiary by asking for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.*	*Release any entitlement and claim information and answer any questions pertaining to the beneficiary's Medicare coverage.*
2. The beneficiary	*The beneficiary makes a mistake on the information (name, date of birth, HIC number or additional piece of information) used to verify his/her identity.* *NOTE: There is a two-year tolerance for the year of birth. (For example, for a beneficiary born on 3/12/31, you may accept the year of birth as 1929, 1930, 1931, 1932, or 1933 – two years prior and two years after the correct year of birth. The month and date, however, must match exactly.)*	*Explain to the beneficiary that the information does not match the information in your records. Ask him/her to repeat the information, and if still incorrect, suggest that the beneficiary look at his/her Medicare paperwork to find the correct information or ask someone (family or friend) to help him/her with this information.* *The CSR may advise the beneficiary to contact SSA to discuss the DOB SSA established.*	*If the beneficiary is able to provide the correct information, release per the instructions above.* *If the beneficiary is unable to provide the correct information, YOU MAY NOT release any entitlement or claim information or answer any questions pertaining to the beneficiary.* *Advise the beneficiary that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.*

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*
3. Parent of a minor child	*Generally, a parent may have access to the child's information as his/her personal representative when such access in not inconsistent with State or other law.* *The parent would no longer be the personal representative of the child when the child reaches the age of majority or becomes emancipated, unless the child elects to have the parent continue as a personal representative.*	*Verify the identity of the minor child by asking for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Verify that there is nothing listed in your files that would preclude sharing information with the parent calling, (e.g., a copy of a court order).*	*Release any entitlement and claim information and answer any questions pertaining to the issue in question.*
4. SSA-Appointed Representative Payee *Or* *A legal guardian of any individual who has been declared incompetent by the court*	*To answer any questions via the telephone, you must have proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR), Health Insurance Master Record (HIMR) or Inquiry Response Numident Identification screen (QRID)).*	*Verify that the caller's name matches the representative payee or legal guardian's name in your files.* *Have the representative payee or legal guardian provide the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.*	*Release any entitlement and claim information and answer any questions pertaining to the issue in question.*

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*
5. Legal representative as defined by the State.	*Initially, these types of requests must come in as written requests in order to verify the relationship.* *To answer any questions via the telephone, you must have proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR) or Inquiry Response Numident Identification screen (QRID)).* *The representative's name must match the name of the representative that is on file.*	*Verify the identity of the beneficiary by asking for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Verify that the caller's name matches the representative's name in your files.*	*Release information to legal representatives (such as an attorney) pertaining to the matter for which they have been appointed as representative. You may assume the legal representative can receive any entitlement and claim information on behalf of the beneficiary unless it is evident by the documentation that they represent the beneficiary for limited services (i.e., financial representative only).*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
6. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)	*The beneficiary gives verbal authorization for you to speak with the caller.* *(The beneficiary does not have to remain on the line during the conversation, or even be at the same place as the caller – you may obtain the beneficiary's authorization to speak with the caller via another line or three way calling.)*	*Verify the identity of the beneficiary by asking the beneficiary for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *A verbal authorization on file is good for 14 days. The CSR may advise the beneficiary and the caller that if the beneficiary wants the caller to receive information for more than 14 days, the beneficiary should send in a written authorization.*	*Release any entitlement and claim information and answer any questions pertaining to the issue in question.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
7. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)	*The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file.*	*Advise the caller that you may not give out any information without the beneficiary's authorization.* *The caller may call back at a later time when the beneficiary is available to give authorization.* *-Or-* *The beneficiary could provide written authorization to allow the caller to obtain information about his or her record.*	*YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.* *Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.*
8. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)	*You have written authorization on file that allows you to give beneficiary-specific information to the caller.* *See Notes at end of chart for information regarding written authorization.*	*The caller must provide the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Ensure that the caller is the authorized individual, and within the authorized time period (if specified).*	*Only discuss information authorized by the written authorization.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
9. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)	*Previous written authorization has expired.*	*In order to access the beneficiary's record, the caller must provide the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Advise the caller that the written authorization has expired.* *Obtain the beneficiary's verbal authorization and/or develop for a new written authorization.*	*Unless you receive a verbal authorization, YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.* *Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.* *However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
10. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) requesting information on a specific claim *(No MSN/EOMB)*	*The beneficiary is not available to verbally authorize you to speak with the caller, there is no written authorization on file, and the caller does not have a copy of the MSN/EOMB, however the caller has the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *Information on a specific claim (e.g., date of service, physician name, procedure).*	*The CSR may suggest that the caller have the beneficiary forward written authorization to the call center if he/she anticipates any need for future telephone contacts.*	*Release information only:* • *On whether or not the claim has been received or processed, and* • *The date the beneficiary can expect to receive the EOMB or MSN.*
11. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) requesting information on a specific claim *(Has MSN/EOMB)*	*The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file, however the caller has the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *Copy of the MSN or EOMB.*	*The CSR may suggest that the caller have the beneficiary forward written authorization to the call center if he/she anticipates any need for future telephone contacts.*	*Only release information for the service(s) that appear on the MSN or EOMB.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
12. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers)	*The caller states that the beneficiary is deceased.*	*In order to access the beneficiary's record, the caller must provide the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *If you DO NOT have proof of death (i.e., date of death shown on Common Working File (CWF), Master Beneficiary Record (MBR), advise the caller to notify SSA at 1-800-772-1213 that beneficiary is deceased.*	*YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary* *Advise the contact that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information. Advise the caller that the request should be in writing, include the authority under which the caller is making the request (e.g., executor, next of kin) and must state why the information is sought.* *However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
13. A State Health Insurance Assistance Program (SHIP) employee or volunteer	*One of the following applies:* • *You have a verbal or written authorization allowing you to speak with the SHIP employee or volunteer; or* • *The SHIP employee or volunteer is listed on the SHIP roster as an approved contact.*	*In order to access the beneficiary's record, the caller must provide the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.*	*Release any entitlement and claim information and answer any questions pertaining to the issue in question.*
14. A State Health Insurance Assistance Program (SHIP) employee or volunteer	*The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file and the caller is NOT listed on the SHIP roster as an approved contact.*	*Advise the caller that you may not give out any information without the beneficiary's authorization.* *The caller may call back at a later time with the beneficiary present to give authorization* *-Or-* *The beneficiary could provide written authorization to allow the caller to obtain information about his or her record.*	*YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.* *Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
15. Congressional Office	*The Congressional staff member states that he/she is calling at the request of the beneficiary (and not on behalf of someone else about the beneficiary).*	*In order to access the beneficiary's record, the caller must provide the beneficiary's:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Document the name and title of the caller.*	*Release any entitlement and claim information and answer any questions pertaining to the issue in question.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
16. A CMS employee	*The CMS employee provides the following information in order to identify the beneficiary in question:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.*	*There are three ways that a CSR may verify that he/she is speaking with a CMS employee.* • *Both parties on the call look at the CWF or MBR record (or other beneficiary record to which they both have access). The CSR or CMS employee can name a field on the CWF or MBR and ask that the other party identify what is in that particular field.* *OR*	*If the CSR is reasonably certain that he/she is speaking to a CMS employee, the CSR may release any claim information and answer any questions pertaining to the issue in question.*
		• *The CSR should ask for the CMS employee's phone number and call him/her back, making sure that the area code and exchange is correct for the CO or RO location;* ***NOTE:*** *Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.* *OR* • *The CSR should take the name and number of the agency employee, the name and number of*	

		his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen.	

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
17. An employee of another Federal agency (e.g., SSA, RRB, VA, DoD) who needs the information to perform duties on behalf of that agency	*The employee of the other agency provides the following information in order to identify the beneficiary in question:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Ensure that the reason for the inquiry is related to the administration of that agency's program.*	*There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.* • *Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on the MBR and ask that the other agency's employee identify what is in that particular field.* *OR* • *The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; NOTE: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.* *OR* • *The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and*	*If the CSR is reasonably certain that he/she is speaking to the other agency's employee, the CSR may release any claim information and answer any questions related to the administration of that agency's program.*

		post this information to the "NOTES" screen.	

IF THE CONTACT IS:	AND:	YOU MUST:	THEN YOU CAN:
18. State Agencies administering Medicaid *Inform the caller that State Agencies must get this information through the channels formerly referred to as BEST/CASF.* *Advise the caller that instructions on the process can be found at http://www.cms.hhs.gov/states/letters/*	*If the caller has an issue that cannot be resolved using the instructions found at http://www.cms.hhs.gov/states/letters/, the CSR may resolve the issue after verifying that the caller is an employee of the State Medicaid Agency.* *The employee of the State Medicaid Agency provides the following information in order to identify the beneficiary in question:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Ensure that the reason for the inquiry is related to the administration of that agency's program.*	*There are three ways that a CSR may verify that he/she is speaking with an employee of State Medicaid Agency.* • *Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field.* *OR* • *The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; NOTE: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.* *OR* • *The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and*	*The CSR may release any claim information and answer any questions related to the administration of State Medicaid Agency's program.*

		post this information to the "NOTES" screen.	

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
19. Complementary health insurance (Medigap, complementary crossover, supplemental)	*The beneficiary has signed an agreement with the complementary health insurer granting that company the authorization to receive Medicare claim information.*	*Verify the complementary health insurer is identified on the beneficiary's file.* *Verify the identity of the beneficiary in question by asking for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.*	*Answer any question pertaining to the beneficiary's claims that should have crossed over to the complementary insurer.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
20. Medicare Contractor (Fiscal Intermediary/Carrier/ DMERC/RHHI)	*The Medicare Contractor being contacted processed the claim in question.* *Verify the identity of the beneficiary in question by asking for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.*	*There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.* • *Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field.* *OR* • *The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; NOTE: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.* *OR* • *The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and*	*If the CSR is reasonably certain that he/she is speaking to the other contractor's employee, the CSR may release any claim information and answer any questions pertaining to the beneficiary's claims that were processed by the Medicare Contractor being contacted.*

		post this information to the "NOTES" screen.	

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
21. Other Health Insurer (MSP involved)		*Verify the identity of the beneficiary in question by asking for his/her:* • *Full name;* • *Date of birth;* • *HIC number; and* • *One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.* *Refer the caller to the Coordination of Benefits (COB) Contractor for all Medicare Secondary Payer (MSP) inquiries (except claims-related questions and termination of MSP situations related to an accident, illness or injury) including:* • *The reporting of potential MSP situations;* • *Changes in a beneficiary's insurance coverage;* • *Changes in employment;* • *End Stage Renal Disease (ESRD) entitlement issues; and* • *All other general MSP questions.* *Please note that questions about*	*You may answer any questions pertaining to the beneficiary's file that are necessary to coordinate benefits.*

		eligibility to the Medicare program are NOT to be referred to the COB Contractor, whose main task is to ensure that the Medicare program has current, accurate data about other insurance that Medicare beneficiaries have that may be primary to Medicare. The COB Contractor does not make Medicare eligibility determinations. *COB Contractor Number* *1-800-999-1118* *TTY/TDD* *1-800-318-8782* *CSRs are available 8 am to* *8 pm (Eastern Time)*	

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
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.*
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; and* ● *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.* *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:*
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; and* ● *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 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 limit* *– 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 provider's name.*

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*
25. A Provider *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; and* ● *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 provider's name.*

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*
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.*
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; and* ● *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.* *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:*
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.*
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; and* *● 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 *DMERC*	*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 NSC identification number.* *Verify the beneficiary's:* *● Last name and first initial;* *● Date of birth;* *● HIC number; and* *● 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 provider's name.*

IF THE CONTACT IS:	*AND:*	*YOU MUST:*	*THEN YOU CAN:*
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.*
32. Ambulance Supplier	*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; and* *● 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.* *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:***
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 NSC identification number.* *Verify the beneficiary's:* ● *Last name and first initial;* ● *Date of birth;* ● *HIC number; and* ● *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 provider's name.*

IF THE CONTACT IS:	***AND:***	***YOU MUST:***	***THEN YOU CAN:***
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; and* *● 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, which would be available via EDI.* *This information may only be used in order to submit an accurate claim.*	*Validate the employing provider/physician/supplier's name and identification number.* *Verify the beneficiary's:* *● Last name and first initial;* *● Date of birth;* *● HIC number; and* *● 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 provider's name.*

DEFINITIONS:

ACCESS *– Releasing information in a Medicare record directly to the beneficiary to whom it pertains. A natural or adoptive parent of a minor child or a legal guardian can also have access when acting on behalf of the individual. A minor child may access his/her own record. Any person may have access to information maintained in his/her own record after identifying his/herself.*

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.*

A ***REPRESENTATIVE PAYEE*** *- 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.*

A ***LEGAL REPRESENTATIVE*** *- is appointed by the beneficiary to handle specific areas of concern on his/her behalf. The legal representative may only receive information related to the reason he/she was appointed (e.g., health care decisions, financial matters). The beneficiary does not have to be unable to handle his/her affairs.*

Certain individuals are entitled to Medicare, but not entitled to Social Security benefits and are directly billed for the Medicare premium payments. If SSA determines that an individual is not capable of handling his/her premium payments, or at the individual's request, SSA will appoint a PREMIUM PAYER. A premium payer is similar to a representative payee and can be given information related to Medicare claims.

A ***RELATIONSHIP*** *- exists when a provider/physician/supplier has rendered, or is rendering, health services to a beneficiary.*

The ***DATE OF SERVICE*** *- is the date on which the beneficiary received health services from a provider, physician or* ***supplier****.*

A ***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 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.

*A **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.*

***PRE-CLAIM** - means before the provider, physician or supplier services a beneficiary and before a claim has been submitted for that beneficiary.*

***POST-CLAIM** - means after a provider, physician or supplier services a beneficiary and a claim has been submitted for that beneficiary.*

***GENERAL NOTES**:*

Prior versions of this Disclosure Desk Reference for Call Centers specifically excluded the State Health Insurance Assistance Program (SHIP) employees and volunteers. This version includes a new category for SHIP employees and volunteers. Specific disclosure instructions on the process of validating the identity of the SHIP employees and volunteers via the use of rosters will be addressed in separate guidelines to be issued shortly. Continue your current practice until such instructions are published.

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 <u>not</u> 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.

You can discuss diagnosis denials such as medical necessity, MSP and routine diagnosis services in order to explain the reason the claim was denied. Assist the caller if the diagnosis is in dispute.

***EXAMPLE 1**: The patient's claim denied for a routine physical exam (program exclusion). The CSR explains the reason the claim was denied was because of the routine diagnosis submitted on the claim. The patient explains that he/she was seeing the doctor for back pain. The CSR needs to advise the caller to contact the physician to discuss the reported diagnosis.*

***EXAMPLE 2**: After receiving an auto/liability questionnaire, the beneficiary calls to report a service noted was not related to an accident/injury. The CSR should check the claims history to verify the presence of an open MSP auto/liability segment with an unrelated diagnosis. If an open MSP segment and an unrelated diagnosis are present on the claim, the CSR should follow established procedure for overriding the edit and adjusting the claim. This may include contacting the provider office first to confirm whether an erroneous unrelated diagnosis was reported. If an unrelated diagnosis was erroneously reported, the CSR may initiate an adjustment after receiving confirmation of the incorrect reporting from the provider office.*

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.

Frequently Asked Questions on this topic may be found at
http://www.cms.hhs.gov/callcenters/QandA.asp