Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 1673 **Date: AUGUST 3, 2000**

CHANGE REQUEST 1231

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter III	3-1 - 3-1.1a (3 pp.)	3-1 - 3-1.1a (3 pp.)
3021.5 - 3022	3-17.6 - 3-17.9 (4 pp.)	3-17.6 (1 p.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: August 3, 2000*
IMPLEMENTATION DATE: No Later Than January 31, 2001

This transmittal lifts the freeze on eligibility network service vendor connections to contractor systems covered in Program Memorandum, AB-00-19, dated March 2000. Subject to the revised instructions, network service vendors are to be afforded the same treatment and eligibility access, when acting on behalf of providers, as the provider would receive if requesting access directly. The implementation period is intended to allow contractors to complete any necessary contracts, establish communication links, and perform testing to support access to eligibility information by eligible providers and their vendors, along with other scheduled tasks.

Section 3021.5, Information Regarding the Release of Medicare Eligibility Data, explains new safeguards to be added to existing guidelines for network service vendors.

Section 3021.6, New Policy on Releasing Eligibility Data, explains requirements for releasing eligibility data to eligibility verification vendors.

Section 3021.7, Advise Your Providers and Network Service Vendors, requires contractors to explain the new procedures to providers and network service vendors.

Section 3021.8, Network Service Agreement, requires contractors to get the new agreement signed by all network service vendors.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

HCFA-Pub. 14-3

CHAPTER III
CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

Section

Filing the Request for Payment

Electronic Data Interchange

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

Section

Electronic Media Claims

CHAPTER III
CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

Section

3021.5 Information Regarding the Release of Medicare Eligibility Data.--HCFA is required by law to protect all Medicare beneficiary-specific information from unauthorized use or disclosure. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974. HCFA's instructions allow release of eligibility data to providers or their authorized billing agents for the purpose of preparing an accurate claim. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed. In order to strengthen the security of this data and to protect the privacy of our Medicare beneficiaries, we have added some additional safeguards to the existing guidelines.

We are limiting the way eligibility data is being accessed by network service vendors. For information regarding network service vendors, review §3021.3. You must give access to any network service vendor that requests access to eligibility data on behalf of providers as long as they adhere to the following rules:

- Each network service vendor must sign the new Network Service Agreement below;

- Each provider must be an electronic biller and must sign a valid Electronic Data Interchange (EDI) Enrollment Form;

- The provider must explain the type of service furnished by its network service vendor in a signed statement authorizing the vendor's access to eligibility data; and

- The network service vendor must be able to associate each inquiry with the provider making the inquiry. That is, for each inquiry made by a provider through a network service vendor, that vendor must be able to identify the correct provider making the request for each beneficiary's information.

3021.6 New Policy on Releasing Eligibility Data.--Beginning July 1, you must make the following changes. All work must be completed by January 31, 2001.

A. All providers and network service vendors must negotiate with a carrier for access to eligibility data. All contracts or business arrangement to access Medicare information made by providers and vendors with data centers must be terminated and renegotiated with the carrier.

B. All providers and network service vendors who are directly connected to data centers for eligibility access must be disconnected and rerouted through the carrier's front end software (which in some cases is operated at a data center location).

C. If you have made special arrangements for network service vendors to enhance their services such as installing their own special software, creating special code, or modifying CWF eligibility data, etc., then all existing special arrangements or codes must be discontinued. You must migrate all vendors and providers to the regular non-customized online process. You must not make any more special arrangements for providers or network service vendors.

D. You will discontinue allowing vendors and providers to go to one carrier to access all eligibility information. Vendors and providers may receive access to eligibility data only from the carrier to which the provider is assigned.

E. When an inquiry enters into your system, you must be able to ensure that:

- An EDI agreement has been signed by the provider;
- A network service agreement has been signed by the vendor; and
- Each inquiry can be identified by provider.

F. The eligibility data that providers receive from carriers must be either the HCFA standard Part B flat file or the ANSI ASC X12 270/271 transaction sets. No other data, e.g., local history, Part A CWF eligibility data, etc, shall be substituted for eligibility information . You must terminate any eligibility data that is not either the standard Part B flat file or the ANSI ASC X12 270/271.

G. Providers may use eligibility data only for the approved use of preparing accurate claims. Access to eligibility data must be limited to individuals who support this function.

3021.7 Advise Your Providers and Network Service Vendors.--You must contact all providers and network service vendors to advise them of these new procedures and their effective dates.

You must remind providers that they must let you know when they change from one network service vendor to another, cease arrangements with a network service vendor, or leave the Medicare program. Adjustments must be made to your system to reflect these changes. Delete each provider from your system when it moves to another carrier or leave the Medicare program.

3021.8 Network Service Agreement.--All current and new network service vendors must sign the following Network Service Agreement. No network service vendor will be able to continue to service providers for eligibility access if this agreement is not signed. Please add the following agreement to your existing contract.

The network service agrees that:

1. All beneficiary-specific information is confidential and subject to the provisions of the Privacy Act of 1974 which requires federal information systems to establish appropriate safeguards to ensure the security and confidentiality of individually identifiable records. This includes eligibility information, claims, remittance advice, online claims correction and any other transaction where any individually identifiable information applicable to a Medicare beneficiary is processed or submitted electronically.

2. It has no ownership rights and is not a user of the data, but merely a means of transmitting data between users that have a need for the data and are already identified as legitimate users under a "routine use" of the system; that is, disclosure for purposes that are compatible with the purpose for which Medicare collects the information.

3. The data submitted to the network service by the contractor are owned by Medicare.

4. It will not disclose any information concerning a Medicare beneficiary to any person or organization other than a.) an authorized Medicare provider making an inquiry concerning a Medicare beneficiary who is the provider's patient, b.) HCFA or c.)HCFA's contractors.

5. It will promptly notify the contractor of any unauthorized disclosure of information about a Medicare beneficiary and will cooperate to prevent further unauthorized disclosure.

6. The data will be stored for any duration longer than that required to assure that they have reached their destination, and no more than 30 days for any purpose.

7. It has identified to the contractor in writing any instances where it would need to view Medicare data in order to perform its intended tasks under the agreement. It will not view the data unless it is absolutely necessary to perform its intended tasks.

8. It will not prepare any reports, summary or otherwise, based on any individual aspect of the data content. Reports may be written, however, on data externals or summaries such as the number of records transmitted to a given receiver on a given date.

9. It will guarantee that an authorized user may be deleted within 24 hours. Other standards of performance, including, but not limited to, how quickly a user may be added to the network, must be specified in writing.

10. No incoming or outgoing electronic data interchange (EDI) will be conducted unless authorization for access is in writing and signed by the provider, and each provider has a valid EDI enrollment form on file.

11. It has the ability to associate each inquiry with the provider making the inquiry.

12. It will furnish, upon request, documentation that assures the above privacy concerns are being met.

13. It understands that final regulations on security and privacy standards for health information under the Health Insurance Portability and Accountability Act of 1996 will be forthcoming. It will adhere to those regulations when they become effective.

NOTICE:

Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by HCFA under this document.

This document shall become effective when signed by the network service. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with HCFA or the contractor. Either party may terminate this arrangement by giving the other party (30) days notice of its intent to terminate.

SIGNATURE:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the forgoing provisions and acknowledge same by signing below.

Network Service Company Name

_____

Address

_____

City/State/Zip

_____

Signed By

_____

Title

_____

Date

3022. MAINTAINING A DIRECTORY OF ELECTRONIC BILLING VENDORS

Publish and maintain a directory of your electronic billing vendors. Update the directory at least once annually and make it available to your providers (depending on their automation) either through your WEB page, electronic bulletin board, diskette, or hardcopy. Your provider bulletin can be used as hardcopy, when feasible. Use a disclaimer statement in the directory stating that the information is subject to change after the date of publication. Information should minimally include company name, phone number and mailing address. You may provide additional detail.

Conduct at least two meetings annually with all of your electronic billing vendors in order to brief them on planned Medicare eligibility, coverage, payment, and billing changes.