Medicare
Intermediary Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 1231

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter VI	5-1 - 5-2 (2 pp.)	5-1 - 5-2 (2 pp.)
3510 - 3511	5-37 - 5-38 (2 pp.)	5-37 - 5-38.1 (3 pp.)
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NEW/REVISED MATERIAL--*EFFECTIVE DATE:* (Release Date)
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 3508.2, Part A Eligibility Data Security Requirements, is **deleted**. Contractors were instructed not to implement these requirements due to Y2K priorities, and additional analysis is now needed.

Section 3601.5, Information Regarding the Release of Medicare Eligibility Data, explains new safeguards to be added to existing guidelines for network service vendors.

Section 3601.6, New Policy on Releasing Eligibility Data, explains new requirements for releasing eligibility data to eligibility verification vendors.

Section 3601.7, Advise Your Providers and Network Service Vendors , requires contractors to explain the new procedures to their providers and network service vendors.

Section 3601.8, 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 previous published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

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Section

Identifying the Patient's Health Insurance Record

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CHAPTER VI

o That data may not be perused, i.e., no data will be released except on a beneficiary - specific basis. Browsing is prohibited;

o The eligibility data is only good for the time the provider is receiving it. This information could change at any time, and does not guarantee Medicare coverage or payment;

o That data does not represent definitive eligibility status. If the individual is not in file, the provider must use the usual admission and billing procedures in effect independent of this data access; and

o That Medicare eligibility information is confidential and the penalties available under the Privacy Act for illegal disclosure are being found guilty of a misdemeanor and being fined not more than $5,000.

3508.3 Part A Inquiry Screen Display - HIQA.--This screen is described in the CWF Documentation, Chapter VII, Section H, pages 1 through 7. All the data elements are explained in full for proper use. Access this screen to transmit data to your providers when supplying data for §3508.4.

3508.4 Part A Inquiry Reply Screen Display - HIQAR.--This screen format can be used to pass beneficiary entitlement and utilization data to the provider. It is described in the CWF

Documentation, Chapter VII, Section H, pages 1 through 24. Refer to the CWF Documentation when providing utilization data to your provider.

3508.5 Part A Inquiry Data - HUQA.--This transaction may be used to obtain the HUQA dataset. (See §3508.6.) Also, refer to Chapter II.C.2 of the CWF Documentation.

3508.6 Part A Inquiry Reply Data - HUQAR.--This response can be used to create your own screens to return beneficiary eligibility and utilization data to your providers. See Chapter II.C.2 of the CWF Documentation.

3509. CWF RECORD MAINTENANCE

Each host is responsible for a group of beneficiaries and maintains entitlement data for all group members. This information stipulates whether the individual is enrolled in an HMO and the benefits available. If the response indicates the individual is not in file, follow the procedures outlined in §3800. Respond to all other responses as shown in §3800.

3510. HEALTH INSURANCE MASTER RECORD (HIMR) INQUIRY

Access the host site beneficiary database by means of HIMR transaction. The database contains information on the beneficiary's current entitlement and utilization status. This database is updated via claim submission through the Host sites for utilization and via information provided by the Master Beneficiary Record (from SSA) for entitlement.

The HIMR response will include all entitlement and utilization information on a beneficiary as well as history records. The response returns to the screen the following records:

BENA--I/P SPELL + CATASTROPHIC
BENA--PT B DEDUCTIBLE + LIMITS
MSPA--MSP SUMMARY DISPLAY
MSPD--MSP DETAIL DISPLAY
GHO --GHO ENROLLMENT
GPRO--GHO PRORATED DATA

HOSP--HOSPICE ENROLLMENT
SURG--SURGERY INFORMATION
ESRD--END STAGE RENAL DISEASE
XREF--BENEFICIARY CROSS REFERENCE
CMNA--DMEPOS CMN DISPLAY
TNIF--NOT IN FILE STATUS

All screens are explained in the HIMR Inquiry System Screen Guide. Reference should be directed to each section for valid alpha codes.
Access any of these records as follows:

- Type in the user IDs and passwords for the host sites;
- Type in the HIMR transaction;
- Type in BENA, BENB, MSPA, etc., from main menu of the HIMR Inquiry Systems Screen Guide. This includes using the History Inquiry alpha codes, i.e., INPL, INPA, INPH, etc. (See §II.C.1-4 of the HIMR Inquiry System Screen Guide.); and
- Type in beneficiary HICN host site (if needed) and enter.

3511. HIMR MAIN MENU

The Health Insurance Master Record (HIMR) Main Menu is displayed upon initial entry into the CWF (Common Working File) HIMR Inquiry System. Each screen on the HIMR Inquiry System can be accessed from this menu. Entry at each Host and satellite is available through the normal access to the CWF system. See §II.C.1-2 of the HIMR Inquiry System Screen Guide. It is also possible to obtain claim history inquiries for beneficiaries. (See §II.C.1-4 of the HIMR Inquiry System Screen Guide.)

3512. BENEFICIARY MASTER INFORMATION

The Beneficiary Master Information contains Part A and Part B data. Part A data is related to the processing of Medicare Part A inpatient hospital and skilled nursing facility (SNF) claims. Part B data is related to the processing of Medicare Part B or Medicare Part A outpatient and home health agency (HHA) claims. (See §II.C.1-3 of the HIMR Inquiry System Screen Guide.)

3513. MEDICARE SECONDARY PAYER INFORMATION (MSP)

MSP summary display information allows you to identify entitlement periods and related coverage information where one or more insurers is primary to Medicare coverage for a beneficiary. (See §II.C.1-8 of the HIMR Inquiry System Screen Guide.)

3514. GROUP HEALTH ORGANIZATION (GHO)

GHO display contains entitlement data relevant to the beneficiaries using a group health organization plan. (See §II.C.1-9 of the HIMR Inquiry System Screen Guide.)

3515. HOSPICE ENROLLMENT

The Hospice Record Display (HOSP) represents information for the terminally ill beneficiaries who elect hospice care vs. standard Medicare benefits. (See §II.C.1-11 of the HIMR Inquiry System Screen Guide.)

CHAPTER VII
BILL REVIEW

Electronic Data Interchange (EDI)

HCFA-1450

CHAPTER VII
BILL REVIEW

3601.5 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 new 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 §3601.3. 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.

3601.6 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 an intermediary for access to eligibility data. All contracts or business arrangements to access Medicare information made by providers and vendors with data centers must be terminated and renegotiated with the intermediary.

B. All providers and network service vendors who are directly connected to data centers for eligibility access must be disconnected and rerouted through the intermediary'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 the HIQA or HUQA transaction data set, 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 fiscal intermediary (FI) to access all eligibility information. Vendors and providers may receive access to eligibility data only from the intermediary that the provider has elected. Vendors must submit eligibility requests on behalf of a given provider only to that provider's own FI.

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. You will use either the HIQA or HUQA data set as it is received from the common working file (CWF), or the ANSI X12 270/271 when it becomes available. No other data, e.g., local history, etc., shall be substituted for CWF data. Any Part A information that is accessed by Part A providers that is not coming directly from CWF must be terminated.

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.

3601.7 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 FI or leaves the Medicare program.

3601.8 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 is 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 not 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

_____

Contractor

_____