CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-09 Medicare Contract Beneficiary and Provider Communications	Centers for Medicare & Medicaid Services (CMS)
Transmittal 16	**Date: JULY 21, 2006**
	Change Request 5089

Subject: Disclosure Desk Reference for Provider Contact Centers

I. SUMMARY OF CHANGES: CR is a complete revision of section 30 in Chapter 3 and section 80 in Chapter 6 (IOM 100-9.) The sections contain guidance for provider contact centers to properly authenticate providers/staff who call or write the provider contact center for disclosure of protected health information. Clarification is also provided concerning information that may be disclosed. While new subsections have been added to each chapter/section, this reflects reformatting and revision of existing information rather than new requirements.

New / Revised Material
Effective Date: October 1, 2006
Implementation Date: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	3/30/Disclosure of Information
N	3/30.1/Inquiry Types
N	3/30.1.1/Telephone Inquiries
N	3/30.1.2/Written Inquiries
N	3/30.2/Special Inquiry Topics
N	3/30.2.1/Overlapping Claims
N	3/30.2.2/Pending Claims
N	3/30.3/Deceased Beneficiaries
N	3/30.4/Disclosure Desk Reference

N	3/30.4.1/Authentication of Provider Elements for CSR Inquiries
N	3/30.4.2/Authentication of Provider Elements for IVR Inquiries
N	3/30.4.3/Authentication of Provider Elements for Written Inquiries
N	3/30.4.4/Authentication of Beneficiary Elements
N	3/30.5/NPI Implementation
R	6/80/Disclosure of Information
D	6/80.1/General Notes
N	6/80.1/Inquiry Types
N	6/80.1.1/Telephone Inquiries
N	6/80.1.2/Written Inquiries
N	6/80.2/Special Inquiry Topics
N	6/80.2.1/Overlapping Claims
N	6/80.2.2/Pending Claims
N	6/80.3/Deceased Beneficiaries
N	6/80.4/Disclosure Desk Reference
N	6/80.4.1/Authentication of Provider Elements for CSR Inquiries
N	6/80.4.2/Authentication of Provider Elements for IVR Inquiries
N	6/80.4.3/Authentication of Provider Elements for Written Inquiries
N	6/80.4.4/Authentication of Beneficiary Elements
N	6/80.5/NPI Implementation

III. FUNDING:
Funding for implementation activities will be provided to contractors through the regular budget process.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-09	Transmittal: 16	Date: July 21, 2006	Change Request 5089

SUBJECT: Disclosure Desk Reference for Provider Contact Centers

I. GENERAL INFORMATION

A. Background: The Disclosure Desk Reference for Provider Contact Centers is being updated to include guidance for authenticating providers who send written inquiries to Medicare fee for service provider contact centers and to update authentication requirements of providers calling provider contact centers. The revisions also clarify the information that may be disclosed after authentication of writers and callers. Additionally, the desk reference is being updated to reflect the implementation of the National Provider Identifier.

B. Policy: In order to comply with the requirements of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act, customer service staff at Medicare fee for service provider contact centers shall properly authenticate callers and writers before disclosing protected health information.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5089.1	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section 30, concerning disclosure of protected health information.	x	x		x					RRB carrier
5089.2	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, sections 30.1.1, 30.4.1, 30.4.2 and 30.4.4, to properly authenticate providers who call the provider contact centers before disclosing protected health information.	x	x		x					RRB carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5089.3	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, sections 30.1.2, 30.4.3 and 30.4.4, to properly authenticate providers who write the provider contact centers before disclosing protected health information.	x	x		x					RRB carrier
5089.4	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section 30.2.1, to resolve overlapping claims with another contractor(s), while properly authenticating inquirers before disclosing protected health information.	x	x		x					RRB carrier
5089.5	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section 30.2.2, to provide information about pending claims to inquirers to the provider contact center.	x	x		x					RRB carrier
5089.6	Contractors shall properly authenticate callers to the provider contact center before disclosing protected health information about deceased beneficiaries as required by IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section 30.3.	x	x		x					RRB carrier
5089.7	Contractors shall properly authenticate writers to the provider contact center before disclosing protected health information about deceased beneficiaries as required by IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section 30.3.	x	x		x					RRB carrier
5089.8	Contractors shall follow the NPI implementation dates outlined in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section	x	x		x					RRB carrier

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	30.5, to authenticate providers using the NPI.									
5089.9	Contractors shall implement the Provider Transaction Account Number (PTAN) for use as an authentication element for providers after NPI implementation as required by IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3, section sections 30.1.1, 30.1.2, 30.4.2, and 30.4.3. **NOTE:** For providers enrolled in Medicare before May 23, 2007, the legacy provider number will become the provider's PTAN, post NPI implementation. New providers enrolling in Medicare on or after May 23, 2007, will be assigned a PTAN as part of the enrollment process.	x	x		x					RRB carrier
5089.10	Contractors not funded for the requirements in CR 3376 shall be in compliance with the instructions in the sections noted above in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 3.	x	x		x					RRB carrier
5089.11	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, section 80, concerning disclosure of protected health information.	x	x	x						DME MACs
5089.12	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, sections 80.1.1, 80.4.1, 80.4.2 and 80.4.4, to properly authenticate providers who call the provider contact centers before disclosing protected health information.	x	x	x						DME MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5089.13	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, sections 80.1.2, 80.4.3 and 80.4.4, to properly authenticate providers who write the provider contact centers before disclosing protected health information.	x	x	x						DME MACs
5089.14	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, section 80.2.1, to resolve overlapping claims with another contractor(s), while properly authenticating inquirers before disclosing protected health information.	x	x	x						DME MACs
5089.15	Contractors shall implement the requirements in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, section 80.2.2, to provide information about pending claims to inquirers to the provider contact center.	x	x	x						DME MACs
5089.16	Contractors shall properly authenticate callers to the provider contact center before disclosing protected health information about deceased beneficiaries as required by IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, section 80.3.	x	x	x						DME MACs
5089.17	Contractors shall properly authenticate writers to the provider contact center before disclosing protected health information about deceased beneficiaries as required by IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, section 80.3.	x	x	x						DME MACs
5089.18	Contractors shall follow the NPI implementation dates outlined in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, section	x	x	x						DME MACs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	80.5, to authenticate providers using the NPI.									
5089.19	Contractors shall implement the Provider Transaction Account Number (PTAN) for use as an authentication element for providers after NPI implementation as required by IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, sections 80.1.1, 80.1.2, 80.4.2, and 80.4.3. **NOTE:** For providers enrolled in Medicare before May 23, 2007, the legacy provider number will become the provider's PTAN, post NPI implementation. New providers enrolling in Medicare on or after May 23, 2007, will be assigned a PTAN as part of the enrollment process.	x	x	x						DME MACs
5089.20	Contractors funded for the requirements in CR 3376 shall be in compliance with the instructions in the sections noted above in IOM 100-9, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6.	x	x	x						DME MACs

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5089.21	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. .	x	x	x	x					DME MACs; RRB carrier

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
5089.22	See CR 5061 for information about programming IVRs for NPI.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 1, 2006 **Implementation Date:** October 2, 2006 **Pre-Implementation Contact(s):** Lynne Lockard, 410-786-2174 **Post-Implementation Contact(s):** Appropriate Regional Office contact.	**Funding for implementation activities will be provided to contractors through the regular budget process.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

Table of Contents

(Rev.16, 07-21-06)

80 - Disclosure of Information

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

The main purpose of this Disclosure Desk Reference chart is to protect the privacy of Medicare beneficiaries by ensuring that contractors disclose protected health information to providers only when appropriate. Contractors shall protect an individual's privacy to the extent possible by using authenticating elements that must be given by the inquirer prior to the release of any beneficiary-specific information. Contractors shall authenticate providers in addition to authenticating four beneficiary data elements before disclosure of beneficiary information. The specific authentication elements are contained within the chart. Contractors shall authenticate each telephone and written inquiry with the elements shown.

Contractors should always remember that access and disclosure involve looking at Medicare data, such as claims or eligibility data, and releasing information. Access and disclosure rules do not apply in situations where contractors do not have to look at beneficiary specific information (for example, explaining a Remittance Advice). Contractors shall discuss general (non-beneficiary-specific) information without obtaining authentication of the caller/writer. Contractors shall continue to respond to policy/non-protected health information related questions without having to authenticate the inquirer.

Contractors are reminded that the authentication and disclosure guidelines contained in this section do not supersede any requirements for the operation of the contractor's Provider Customer Service Program, including requirements for handling telephone and written inquiries.

Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (i.e., another Medicare contractor) that may be able to address the inquiry. If the contractor needs to refer the inquiry to another entity for response, the contractors shall inform the caller or writer of the referral and close out the inquiry.

Where the Disclosure Desk Reference is silent, contractors should use discretion to determine release of the information. Contractors shall keep in mind the following key question: Does this provider need this information in order to properly bill Medicare? If, after internal discussion by supervisors and/or the contractor's privacy official, questions remain, contractors shall send an email requesting clarification to ProviderServices@cms.hhs.gov.

Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans: *These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from*

these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.

80.1 –Inquiry Types
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

80.1.1 Telephone Inquiries
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

The Disclosure Desk Reference chart contains the information contractors shall use to authenticate the identity of a caller, so that the information can then be released by CSRs or inquiries answered via Interactive Voice Response (IVR.) Contractors are reminded that the guidance contained in this section does not supersede requirements in section 30.3 concerning operation of the Provider Contact Center and handling of telephone inquiries.

A. ***CSR Telephone Inquiries*** *- CSRs shall authenticate providers with two data elements. For CSR inquiries, through May 22, 2007, CSRs shall authenticate providers using provider number and provider name. On or after May 23, 2007, CSRs shall authenticate providers using the National Provider Identifier (NPI) and provider name.*

B. ***IVR Telephone Inquiries*** *– For inquiries handled by the IVR, the authentication requirements are broken down by time frames related to the implementation of the NPI. For IVR inquiries through May 22, 2007, contractors' IVRs shall authenticate providers with one data element, provider number. On or after May 23, 2007, contractors' IVRs shall authenticate providers with two data elements, NPI and Provider Transaction Access Number (PTAN.)*

C. ***Authentication of Providers with No NPI –*** *In limited circumstances, there will be situations where providers will never be assigned an NPI. These situations may include retired/terminated providers. After NPI implementation, telephone inquiries from these providers shall be handled by CSRs because the IVR shall require two elements (i.e., an NPI and PTAN) for authentication.*

   For those providers never assigned an NPI only*, CSRs shall authenticate these providers with two data elements. Contractors have discretion as to the data elements chosen, but suggestions include name, provider number, provider master address, and remittance address.*

D. ***Beneficiary Authentication*** *- Contractors shall authenticate four beneficiary data elements before disclosure of beneficiary information no matter the type of telephone inquiry (CSR or IVR) or the date of the call (pre- or post-NPI implementation.) The data elements are (1) last name, (2) first name or initial, (3) Health Insurance Claim Number (HICN) and (4) either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable*

*Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) **or** date of service (claim status, CMN/DIF (post-claim.)) Specific guidance related to these data elements, along with any exceptions, is contained in the disclosure chart.*

If the CSR or IVR determines that the authentication elements provided are insufficient or inaccurate, the inquirer will be required to provide accurate information before the information being sought is released. The CSR and, if feasible, the IVR, should relay to the inquirer which element does not match (i.e., date of birth rather than day or month or year) and instruct them to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.

As mentioned above, for situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. CSRs shall refer situations in which he/she is unsure of whether or not to release information to his/her supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at the email address provided above.

In situations where a caller is transferred from the IVR to a CSR, if the provider data elements were authenticated in the IVR and that information is passed to the CSR, the CSR should not re-authenticate the provider before information is released. If a contractor's desktop system displays caller authentication elements when the CSR picks up the call, then only the beneficiary elements need to be authenticated. The main point is that the CSR shall have all information relating to authentication and need only request from the caller those data elements not being populated on the CSR's screen by the desktop system.

80.1.1.1 Contractor Discretion Concerning IVR Information
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall have discretion about whether to offer some types of information through their IVR. If contractors decide to offer this information, the Disclosure Desk Reference offers guidelines on how to authenticate providers prior to releasing information. Contractors should review the chart in 80.4.4 for more information.

Contractors shall use, among other data, analysis and provider feedback to determine what to offer via the IVR. Additionally, contractors shall determine the information relevant to their providers that can be automated and that which, if automated, would direct the most calls to the IVR and away from the CSRs. However, contractors shall note that the information contained in the disclosure chart does not supersede any requirements for IVR operation elsewhere in this chapter (50.1.)

80.1.2 Written Inquiries
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Authentication elements for providers are determined by the date of the written inquiry as well as how the inquiry is received, although CMS allows exceptions for inquiries received on provider letterhead. Contractors shall use the guidelines in the chart to authenticate providers for written inquiries as well as the information below. Contractors are reminded that the guidance contained in this section does not supersede requirements in section 30.4 concerning handling of written inquiries.

A. ***Date of Written Inquiry - Provider Authentication*** *- Contractors shall authenticate providers on written inquiries with two data elements. The elements differ depending upon the date of the inquiry.*

   For written inquiries dated May 22, 2007, or before, contractors shall authenticate providers using provider number and provider name.

   For written inquiries dated May 23, 2007, or after, contractors shall authenticate providers using provider name and one of the following two: (1) NPI or (2) PTAN.

   Contractors shall authenticate providers for all written inquiries using the elements mentioned above, with the exceptions noted in B.

B. ***Exception: Method of Receipt – Hardcopy on Letterhead or Email with Attachment on Letterhead -*** *For written inquiries received on the provider's official letterhead, including emails with an attachment on letterhead, authentication of the provider will be met if the provider's name and address are included in the letterhead and clearly establish the identity of the provider. No provider identification number as detailed in A. above (i.e., current provider number, NPI or PTAN) is required. If all authentication elements are met, contractors shall respond with the information requested in writing via regular mail. (Contractors shall see the information about responding to inquiries received via email and fax below.)*

   In the case of multiple addresses on the letterhead, as long as one of the addresses match, authentication is considered met. Providers should be educated to send in written inquiries on letterhead that contain all practice locations or to use letterhead that has the address that Medicare has on record for that provider.

   Contractors shall treat requests submitted via fax on provider letterhead as written inquiries and subject to the same authentication requirements as those received in regular mail. Contractors shall not fax responses containing protected health information, but shall instead send the information via regular mail.

C. ***Method of Receipt – Hardcopy/No Letterhead, Email/No Attachment on Letterhead or Pre-formatted Inquiry Forms*** *– For inquiries received without letterhead, including hardcopy, fax, email, pre-formatted inquiry forms or*

inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), contractors shall authenticate providers as detailed in A. above using provider name and the appropriate provider identification number depending upon the date of the inquiry (current provider number or NPI or PTAN.)

D. *Special Note about Inquiries Received Via Email and Fax* - *For requests received via email and fax, assuming all authentication elements are present as detailed in A. or B. above, whichever is applicable, contractors shall respond as directed in section 30.4.3.2 in writing via regular mail with the requested information if there is protected health information in the response. In the written response on contractor letterhead, contractors shall inform the provider that beneficiary-specific information cannot be disclosed electronically via email or fax and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information. Additionally, contractors shall have discretion to respond to these requests by telephone as specified in 30.4.3.1.*

For email requests only, contractors shall not notify the provider by email that they will be responding via paper or telephone. However, contractors have discretion to send an automated email reply to an email request as long as no protected health information is in the automated reply. Contractors shall ensure that the automated reply conveys the message that no beneficiary-specific information may be disclosed via email and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

Contractors are reminded that they may respond via email to email requests not involving protected health information or beneficiary-specific information (i.e., policy questions.)

E. *Beneficiary Authentication* - *Assuming provider authentication requirements are met as detailed in A. or B. above, whichever is applicable, contractors shall always authenticate beneficiary data elements before disclosure of information without regard to the date of the written inquiry or method of receipt. See the chart in 80.4.4 for more information about authentication of beneficiary elements.*

F. *Requests Received Without Authentication Elements* - *For any written requests received without one or more authentication elements, without regard to date of inquiry or method of receipt, contractors shall return the request in its entirety to the provider stating that the requested information will be supplied upon submission of all authentication elements. Contractors shall indicate which overall elements are missing or do not match for authentication (i.e., date of birth rather than day or month or year.) Contractors shall return the inquiry to the provider via regular mail, although if sent via email without any protected health information, the inquiry may be returned via email.*

Contractors have discretion to follow up with a telephone call to obtain the rest of the authentication elements instead of returning the inquiry or to close out the written inquiry with a telephone call (see 30.4.3.1 in this chapter.) Contractors shall not leave a message containing protected health information on an answering machine. Contractors shall remind the provider to check its copy of the beneficiary's Medicare card and/or follow up with the beneficiary for the correct information.

For situations not specifically addressed here, the contractor should use discretion, taking care to protect the beneficiary's privacy and confidentiality. Contractors shall refer situations in which they are unsure of whether or not to release information to a supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at CMS ProviderServices@cms.hhs.gov.

80.2 – Special Inquiry Topics

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

80.2.1. Overlapping Claims

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors sometimes receive multiple claims with the same or similar dates of service or billing periods. Overlap occurs when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

In cases where a contractor receives an inquiry from a provider or another Medicare contractor requesting provider information to resolve an overlapping claim, contractors shall work with each other. Resolution can occur through various ways. One way is for one contractor to call the other contractor with or without the provider on the line. This will allow the contractor calling to assure the other contractor that the provider has given all necessary authentication elements. The contractor shall then release the needed information.

Contractors shall have discretion to develop other avenues to work out overlapping claims with one another. Contractors are encouraged to share ideas with one another. However, if a contractor resolves an overlapping claim in a way other than directly calling the other contractor, the CSR shall make it clear to the inquiring provider that the information is not disseminated by CMS and CMS is not responsible for the accuracy of the information. All contractors shall work together to facilitate correct payment of all parties. In general, the servicing contractor of the inquirer should take the lead in resolving an overlapping situation.

In situations where the provider is seeking to avoid a claim being rejected, the contractor should, at their discretion, release information prior to claim submission. An example of this is a situation where some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated. This allows the ESRD facility to code the claim appropriately and bill around

the inpatient hospital stay/stays. This situation falls into the category of disclosing information needed to bill Medicare properly and release is appropriate as long as all authentication elements are met. Other situations may arise that fall into this category as well, for example, skilled nursing facility and inpatient hospital stays. Contractors shall, in these situations, ensure that the request is legitimate and necessary for proper billing.

80.2.2 Pending Claims

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall disclose information about pending claims to providers, preferably via the IVR, if feasible. A pending claim is one that is being processed or has been processed and is on the payment floor. As long as all authentication requirements are met, the IVR or the CSR shall provide information about pending claims, including receipt (yes/no) and the fact that the claim is still pending. Contractors shall have discretion to provide more information about pending claims, including Internal Control Number (ICN), pay date/amount or denial. If contractors choose to provide this additional information, the IVR or the CSR shall state that until payment is made or the RA issued, any information given on the call or in the written response may change. If a contractor chooses to provide this information via the IVR, providers should be educated to request this information via the IVR rather than calling the CSR.

80.3 – Deceased Beneficiaries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, contractors shall comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

80.4 – Disclosure Desk Reference for Provider Contact Centers

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

NOTE – Contractors shall apply the guidance in 80.4.1, 80.4.2, 80.4.3 and 80.4.4 to providers/suppliers, billing services and clearinghouses unless otherwise specified. The use of provider/supplier in these charts refers to all institutional and non-institutional entities and individuals that bill the Medicare program. Because of the upcoming transition to the NPI, (see 80.5 for information concerning NPI implementation dates), the guidance below is broken down into several components: (1) authentication of provider elements for CSR inquiries, (2) authentication of provider elements for IVR inquiries, (3) authentication of provider elements for written inquiries and (4) authentication of beneficiary elements.

80.4.1 – Authentication of Provider Elements for CSR Inquiries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

EFFECTIVE DATES:	***INQUIRY TYPE:***	***THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):***	***THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:***
Present – May 22, 2007	*CSR*	• *Provider number* ***and*** • *Provider name*	*Contractors shall refer to chart below.*
On or after May 23, 2007	*CSR*	• *Provider NPI* ***and*** • *Provider name*	*Contractors shall refer to chart below.*

80.4.2 – Authentication of Provider Elements for IVR Inquiries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

EFFECTIVE DATES:	***INQUIRY TYPE:***	***THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):***	***THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:***
Present – May 22, 2007	*IVR*	• *Provider number*	*Contractors shall refer to chart below.*

On or after May 23, 2007	*IVR*	• *Provider NPI* ***and*** • *Provider Transaction Access Number*	*Contractors shall refer to chart below.*

80.4.3 – Authentication of Provider Elements for Written Inquiries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Present – May 22, 2007	*Written inquiries, including fax and email*	• *Provider number* ***and*** • *Provider name* *NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, provider number is not required for provider authentication (see 80.1.2.B.).* *See 80.1.2.C for information about requests on pre-formatted inquiry forms.*	*Contractors shall refer to chart below.*
On or after May 23, 2007	*Written inquiries, including*	• *Provider name* ***and one of the following two:***	*Contractors shall refer to chart below.*

	fax and email	*Provider NPI* ***OR*** *Provider Transaction Access Number* *NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, NPI is not required for provider authentication (see 80.1.2.B.)* *See 80.1.2.C for information about requests on pre-formatted inquiry forms.*	

80.4.4 – Authentication of Beneficiary Elements

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

IF THE PROVIDER CONTACT INQUIRES ABOUT:	***AND INQUIRES VIA:***	***AFTER THE PROVIDER ELEMENTS HAVE BEEN AUTHENTICATED, THE FOLLOWING BENEFICIARY ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):***	***THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED:***
1. Routine Eligibility Elements[1]	*Call to CSR or written inquiry*	• *Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* • *Beneficiary first name or first initial* • *Current or previously assigned HICN, including both alpha and numerical*	*Contractors have the discretion to routinely release all elements or only release when requested. Contractors shall use inquiry and rejected/denied claims analysis results to decide what elements to routinely release.* • *Part A current and previous entitlement and termination dates* • *Part B current and previous entitlement and termination dates* • *Deductible Met – Yes / No* • *Managed Care – Yes / No* • *MSP – Yes / No* • *Crossover established – Yes / No* • *Home Health – Yes / No*

[1] ***Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:*** *These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.*

		characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number) *• Date of birth* *NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Hospice – Yes / No* *• SNF – Yes / No* *• Pneumoccocal Vaccine – Yes / No* *----------* *When prompted by the inquirer:* *• Deductible amount remaining (Part A) or applied (Part B)* *• Managed Care – plan #, name, address, type, enrollment and termination dates* *• MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, CSRs shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file.* *• Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and termination dates, and deletion dates. For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the CSRs shall direct the provider to the*

			beneficiary's supplemental insurer. (NOTE: Customer service contact information may be referenced at http://www.cms.hhs.gov/medicare/COBAgreement.) • *Home Health – applicable earliest and latest dates* • *Hospice - applicable earliest and latest dates* • *SNF – applicable earliest and latest dates* • *Pneumoccocal Vaccine – administration date* • *Influenza Vaccine – Yes / No, administration date* • *Hepatitis B Vaccine – Yes / No, administration date* • *Blood Deductible* • *Date of Death*
2. Routine Eligibility Elements[2]	*IVR (involves touchtone or speech recognition technology)*	• *Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and*	*Contractors shall frequently analyze IVR usage and inquiry and rejected/denied claims analysis results to determine which elements should be routinely offered. Elements in other categories below may be offered routinely, if providers are frequently requesting this information and to include it here would improve provider service and satisfaction and decrease CSR-handled calls.*

[2] ***Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:*** *These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.*

		suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Part A current and previous entitlement and termination dates* *• Part B current and previous entitlement and termination dates* *• Deductible Met – Yes / No* *• Managed Care – Yes / No* *• MSP – Yes / No* *• Crossover established – Yes / No* *• Home Health – Yes / No* *• Hospice – Yes / No* *• SNF – Yes / No* *• Pneumoccocal Vaccine – Yes / No* *----------* *NOTE: For the elements below, contractors have discretion on whether to offer these elements and if so, how to program the IVR to offer these additional elements.* *When prompted by the inquirer:* *• Deductible amount remaining (Part A) or applied (Part B)* *• Managed Care – plan #, name, address, type, enrollment and termination dates* *• MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For*

			inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, the IVR shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file. *• Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and termination dates, and deletion dates. For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the IVR shall direct the provider to the beneficiary's supplemental insurer.* *• Home Health – applicable earliest and latest dates* *• Hospice - applicable earliest and latest dates* *• SNF – applicable earliest and latest dates* *• Pneumoccocal Vaccine – administration date or next eligible date* *• Influenza Vaccine – Yes / No, administration date or next eligible date* *• Hepatitis B Vaccine – Yes / No, administration date or next eligible date* *• Blood Deductible* *• Date of Death*
3. Optional Eligibility Elements	*Call to CSR or written*	*• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.)*	*NOTE – Contractors should not routinely make this information available to all*

Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining the type of information to be released to an inquirer; the contractor shall only release this information to assist the provider in billing Medicare properly. Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (i.e., another Medicare contractor) that may be able to address the inquiry. In	*inquiry*	*and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* *• Beneficiary first name or first initial* *• Current or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number)* *• Date of birth* *NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*providers/suppliers. Contractors should make this information available on a need to know basis and should disclose it only to enable a provider to bill Medicare properly. For example, a SNF may need information about hospital stays in order to bill properly.* ***• ESRD:*** *• Renal Supplies:* *• ESRD effective dates* *• Transplant discharge date* *• Alternate Method Dialysis:* *• Method 1* *• Method 2* *• ESRD effective date* *• Transplant discharge date* ***• Home Health:*** *• Provider name* *• Servicing contractor* *• Applicable dates* ***• Hospice:*** *• Provider name* *• Servicing contractor* *• Applicable dates* ***• Hospital:***

instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)			• *Days remaining* • *Deductible amount* • *Co-insurance days remaining* • *Lifetime reserve days* • *Benefits Exhaust Date* • *Date of earliest billing action/date of last billing action* ● ***Long Term Care:*** • *Hospital days remaining* • *Deductible amount* • *Co-insurance days remaining* • *Lifetime reserve days* ● ***Rehabilitation Room & Board:*** • *Hospital days remaining* • *Co-insurance hospital days remaining* • *Lifetime reserve days* ● ***Psychiatric Limitation:*** • *Days remaining (full benefit, lifetime)* • *Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance)* • *Benefits Exhaust Date* ● ***SNF:*** • *Days remaining* • *Co-insurance days remaining* • *Date of earliest billing action/date of last*

			billing action ● ***Therapy Cap information, including remaining limitation dollar amount and/or amount applied:*** ● *Speech therapy* ● *Occupational therapy* ● *Physical therapy*
4. Optional Eligibility Elements Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining whether to release this information and, if so, the type of information to be released to an inquirer; the contractor shall only release this information to assist the provider in billing Medicare properly.	*IVR (involves touchtone or speech recognition technology)*	*• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating*	*NOTE: For the elements below, contractors have discretion about whether to release this information and, if so, how to program the IVR to offer these elements.* ● ***ESRD:*** ● *Renal Supplies:* • *ESRD effective dates* • *Transplant discharge date* ● *Alternate Method Dialysis:* ● *Method 1* ● *Method 2* ● *ESRD effective date* ● *Transplant discharge date* ● ***Home Health****:* ● *Provider name* ● *Servicing contractor* ● *Applicable dates*

Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. In instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)		*guide on how to input spaces or blanks so that 6 digits are input.* *• Beneficiary first name or first initial* *• HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	● ***Hospice:*** ● *Provider name* ● *Servicing contractor* ● *Applicable dates* ● ***Hospital:*** ● *Days remaining* ● *Deductible amount* ● *Co-insurance days remaining* ● *Lifetime reserve days* ● *Benefits Exhaust Date* ● *Date of earliest billing action/date of last billing action* ● ***Long Term Care:*** ● *Hospital days remaining* ● *Deductible amount* ● *Co-insurance days remaining* ● *Lifetime reserve days* ● ***Rehabilitation Room & Board:*** ● *Hospital days remaining* ● *Co-insurance hospital days remaining* ● *Lifetime reserve days* ● ***Psychiatric Limitation:*** ● *Days remaining (full benefit, lifetime)*

			• *Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance)* • *Benefits Exhaust Date* • ***SNF:*** • *Days remaining* • *Co-insurance days remaining* • *Date of earliest billing action/date of last billing action* • ***Therapy Cap information, including remaining limitation dollar amount and/or amount applied:*** • *Speech therapy* • *Occupational therapy* • *Physical therapy*
5. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in	*Call to CSR or written inquiry*	• *Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* • *Beneficiary first name or first initial*	***Next eligible dates for professional / technical components based on HCPCS or service description provided by the inquirer:*** • *Cardiovascular (80061, 82465, 83718, 84478)* • *Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328)* • *Diabetes (82947, 82950, 82951)* • *Glaucoma (G0117, G0118)* • *Initial preventive physical exam (G0344, G0366, G0367, G0368)* • *Mammography (76092, G0202)* • *Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148)*

determining a beneficiary's eligibility for these services or billing Medicare properly.		*• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number)* *• Date of birth* *NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Pelvic and clinical breast exam (G0101)* *• Prostate (G0102, G0103)* *• Bone density (G0130)* *• Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period* ***NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information.*** ***NOTE: If a description of the service is used instead of a HCPCS code, the CSR shall confirm the exact service being referenced to ensure that the information being disclosed is what is being requested. For example, there are several codes for colorectal screening. Depending upon the services the beneficiary has already received, the next eligible date will be specific to a particular service.***
6. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining whether	*IVR (involves touchtone or speech recognition technology)*	*• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)*	***Next eligible dates for professional / technical components based on HCPCS provided by the inquirer:*** *• Cardiovascular (80061, 82465, 83718, 84478)* *• Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328)*

to release this information in the IVR and, if so, the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.		*NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.* *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Diabetes (82947, 82950, 82951)* *• Glaucoma (G0117, G0118)* *• Initial preventive physical exam (G0344, G0366, G0367, G0368)* *• Mammography (76092, G0202)* *• Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148)* *• Pelvic and clinical breast exam (G0101)* *• Prostate (G0102, G0103)* *• Bone density (G0130)* *• Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period* ***NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information.***

7. Processed claims information *NOTE – Contractors should release information prior to claim submission only with the beneficiary's authorization or if, in the contractor's discretion, the provider needs information in order to bill Medicare properly and avoid an overlapping rejected claim.*	*CSR (also applies to written inquiries)*	*• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number)* *• Date of service* *NOTE: If there is an error, the CSR should tell the inquirer which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*Contractors shall use discretion in determining what information to release.* ***Assigned Claims*** *Participating and non-participating - any information on that provider/supplier's claim or any other related claim from that provider/supplier for that beneficiary, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable.* ***Non-assigned Claims*** *Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable. However, see note below.* *The following paragraphs apply to both assigned and unassigned claims.* *General Note – Contractors should speak with the provider/supplier about his/her own claims. Contractors should also disclose information about another provider/supplier as long as both providers/ suppliers have a relationship with the beneficiary and the purpose of the disclosure is to facilitate the payment of the provider/supplier that receives the information.*

			*** If a provider inquires about a claim that was denied due to the beneficiary being incarcerated, the contractor shall tell the provider that Social Security Records indicate that this patient was a prisoner when the service was rendered and that Medicare does not cover items and services furnished to an individual while they are in State or local custody under a penal authority. The contractor shall direct the inquirer to follow up with the State Department of Corrections.* ***If a provider inquires about a claim that was denied due to the beneficiary being deported, the contractor shall tell the provider that Social Security records indicate that the individual has been deported and that Medicare does not cover items and services furnished to individuals who have been deported.*
8. Processed claims information *Contractors shall not release any processed claims information about incarcerated beneficiaries or deported beneficiaries via the*	*IVR (involves touchtone or speech recognition technology)*	*• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not*	*Contractors shall use discretion in determining what information to release.* ***Assigned Claims*** *Participating and non-participating - any information on that provider / supplier's claim or any other related claim from that provider / supplier for that beneficiary, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable.*

IVR.		*required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.* *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of service* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	***Non-assigned Claims*** *Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable.*
9. Certificate of Medical Necessity (CMN)) or DME	*Call to CSR or written inquiry*	***Before a claim is submitted:*** *• Beneficiary full last name (including*	*Contractors shall use discretion in determining what information to release. Contractors should release information about CMNs or DIFs that*

MAC Information Form (DIF) – DMERC / DME MAC ONLY		*hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* *• Beneficiary first name or first initial* *• Current or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the supplier gives the HICN, then the CSR may disclose the new number)* *• Date of birth* ***After a claim is processed:*** *• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the*	*will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code or item description in order for the CSR to provide the correct information about the CMN or DIF.* • *Initial date* • *Recertification date* • *Length of need* • *Other elements necessary to properly bill Medicare* *Contractors shall confirm whether or not the answers to the question sets on the CMN or DIF on file match what the supplier has in his/her records.*

		provider is a match to the name on the beneficiary record being displayed. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the supplier gives the HICN, then the CSR may disclose the new number)* *• Date of service* *NOTE: If there is an error, the CSR should tell the inquirer which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	
10. Certificate of Medical Necessity (CMN) or DME MAC Information Form (DIF) – DMERC / DME MAC ONLY	*IVR (involves touchtone or speech recognition technology)*	***Before a claim is submitted:*** *• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister);* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not*	*Contractors shall use discretion in determining what information to release. Contractors should release information about CMNs or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code in order for the IVR to return the correct information about the CMN or DIF.* • *Initial date*

		required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* ***After a claim is processed:*** *• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall*	• *Recertification date* • *Length of need* • *Other elements necessary to properly bill Medicare*

		program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of service* *NOTE: The IVR response, if feasible, should relay which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	

80.5 NPI Implementation

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors are reminded about Medicare's implementation involving acceptance and processing of transactions with the NPI:

May 23, 2005 - January 2, 2006: Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

January 3, 2006 - October 1, 2006: Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and the legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

October 2, 2006 - May 22, 2007: CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the existing Medicare legacy identifier as a secondary identifier. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

May 23, 2007 – Forward: CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

NOTE: To use the IVR, providers will need to use the NPI as well as the IVR account number.

Medicare Contractor Beneficiary and Provider Communications Manual
Chapter 3 - Provider Inquiries

Table of Contents
(Rev.16, 07-21-06)

30 - Disclosure of Information

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

The main purpose of this Disclosure Desk Reference chart is to protect the privacy of Medicare beneficiaries by ensuring that contractors disclose protected health information to providers only when appropriate. Contractors shall protect an individual's privacy to the extent possible by using authenticating elements that must be given by the inquirer prior to the release of any beneficiary-specific information. Contractors shall authenticate providers in addition to authenticating four beneficiary data elements before disclosure of beneficiary information. The specific authentication elements are contained within the chart. Contractors shall authenticate each telephone and written inquiry with the elements shown.

Contractors should always remember that access and disclosure involve looking at Medicare data, such as claims or eligibility data, and releasing information. Access and disclosure rules do not apply in situations where contractors do not have to look at beneficiary specific information (for example, explaining a Remittance Advice). Contractors shall discuss general (non-beneficiary-specific) information without obtaining authentication of the caller/writer. Contractors shall continue to respond to policy/non-protected health information related questions without having to authenticate the inquirer.

Contractors are reminded that the authentication and disclosure guidelines contained in this section do not supersede any requirements for the operation of the contractor's Provider Customer Service Program, including requirements for handling telephone and written inquiries.

Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (i.e., another Medicare contractor) that may be able to address the inquiry. If the contractor needs to refer the inquiry to another entity for response, the contractors shall inform the caller or writer of the referral and close out the inquiry.

Where the Disclosure Desk Reference is silent, contractors should use discretion to determine release of the information. Contractors shall keep in mind the following key question: Does this provider need this information in order to properly bill Medicare? If, after internal discussion by supervisors and/or the contractor's privacy official, questions remain, contractors shall send an email requesting clarification to ProviderServices@cms.hhs.gov.

Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans: *These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from*

these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.

30.1 –Inquiry Types
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

30.1.1 Telephone Inquiries
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

The Disclosure Desk Reference chart contains the information contractors shall use to authenticate the identity of a caller, so that the information can then be released by CSRs or inquiries answered via Interactive Voice Response (IVR.) Contractors are reminded that the guidance contained in this section does not supersede requirements in section 20.1.3 concerning operation of the Provider Contact Center and handling of telephone inquiries.

A. ***CSR Telephone Inquiries*** *- CSRs shall authenticate providers with two data elements. For CSR inquiries, through May 22, 2007, CSRs shall authenticate providers using provider number and provider name. On or after May 23, 2007, CSRs shall authenticate providers using the National Provider Identifier (NPI) and provider name.*

B. ***IVR Telephone Inquiries*** *– For inquiries handled by the IVR, the authentication requirements are broken down by time frames related to the implementation of the NPI. For IVR inquiries through May 22, 2007, contractors' IVRs shall authenticate providers with one data element, provider number. On or after May 23, 2007, contractors' IVRs shall authenticate providers with two data elements, NPI and Provider Transaction Access Number (PTAN.)*

C. ***Authentication of Providers with No NPI –*** *In limited circumstances, there will be situations where providers will never be assigned an NPI. These situations may include retired/terminated providers. After NPI implementation, telephone inquiries from these providers shall be handled by CSRs because the IVR shall require two elements (i.e., an NPI and PTAN) for authentication.*

   For those providers never assigned an NPI only*, CSRs shall authenticate these providers with two data elements. Contractors have discretion as to the data elements chosen, but suggestions include name, provider number, provider master address, and remittance address.*

D. ***Beneficiary Authentication*** *- Contractors shall authenticate four beneficiary data elements before disclosure of beneficiary information no matter the type of telephone inquiry (CSR or IVR) or the date of the call (pre- or post-NPI implementation.) The data elements are (1) last name, (2) first name or initial, (3) Health Insurance Claim Number (HICN) and (4) either date of birth (eligibility, next eligible date, Certificate of Medical Necessity (CMN)/Durable*

*Medical Equipment Medicare Administrative Contractor Information Form (DIF) (pre-claim) **or** date of service (claim status, CMN/DIF (post-claim.)) Specific guidance related to these data elements, along with any exceptions, is contained in the disclosure chart.*

If the CSR or IVR determines that the authentication elements provided are insufficient or inaccurate, the inquirer will be required to provide accurate information before the information being sought is released. The CSR and, if feasible, the IVR, should relay to the inquirer which element does not match (i.e., date of birth rather than day or month or year) and instruct them to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.

As mentioned above, for situations not specifically addressed here, the CSR should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. CSRs shall refer situations in which he/she is unsure of whether or not to release information to his/her supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at the email address provided above.

In situations where a caller is transferred from the IVR to a CSR, if the provider data elements were authenticated in the IVR and that information is passed to the CSR, the CSR should not re-authenticate the provider before information is released. If a contractor's desktop system displays caller authentication elements when the CSR picks up the call, then only the beneficiary elements need to be authenticated. The main point is that the CSR shall have all information relating to authentication and need only request from the caller those data elements not being populated on the CSR's screen by the desktop system.

30.1.1.1 Contractor Discretion Concerning IVR Information
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall have discretion about whether to offer some types of information through their IVR. If contractors decide to offer this information, the Disclosure Desk Reference offers guidelines on how to authenticate providers prior to releasing information. Contractors should review the chart in 30.4.4 for more information.

Contractors shall use, among other data, analysis and provider feedback to determine what to offer via the IVR. Additionally, contractors shall determine the information relevant to their providers that can be automated and that which, if automated, would direct the most calls to the IVR and away from the CSRs. However, contractors shall note that the information contained in the disclosure chart does not supersede any requirements for IVR operation elsewhere in this chapter (20.1.B.)

30.1.2 Written Inquiries
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Authentication elements for providers are determined by the date of the written inquiry as well as how the inquiry is received, although CMS allows exceptions for inquiries received on provider letterhead. Contractors shall use the guidelines in the chart to authenticate providers for written inquiries as well as the information below. Contractors are reminded that the guidance contained in this section does not supersede requirements in section 20.2 concerning handling of written inquiries.

A. ***Date of Written Inquiry - Provider Authentication*** *- Contractors shall authenticate providers on written inquiries with two data elements. The elements differ depending upon the date of the inquiry.*

   For written inquiries dated May 22, 2007, or before, contractors shall authenticate providers using provider number and provider name.

   For written inquiries dated May 23, 2007, or after, contractors shall authenticate providers using provider name and one of the following two: (1) NPI or (2) PTAN.

   Contractors shall authenticate providers for all written inquiries using the elements mentioned above, with the exceptions noted in B.

B. ***Exception: Method of Receipt – Hardcopy on Letterhead or Email with Attachment on Letterhead -*** *For written inquiries received on the provider's official letterhead, including emails with an attachment on letterhead, authentication of the provider will be met if the provider's name and address are included in the letterhead and clearly establish the identity of the provider. No provider identification number as detailed in A. above (i.e., current provider number, NPI or PTAN) is required. If all authentication elements are met, contractors shall respond with the information requested in writing via regular mail. (Contractors shall see the information about responding to inquiries received via email and fax below.)*

   In the case of multiple addresses on the letterhead, as long as one of the addresses match, authentication is considered met. Providers should be educated to send in written inquiries on letterhead that contain all practice locations or to use letterhead that has the address that Medicare has on record for that provider.

   Contractors shall treat requests submitted via fax on provider letterhead as written inquiries and subject to the same authentication requirements as those received in regular mail. Contractors shall not fax responses containing protected health information, but shall instead send the information via regular mail.

C. ***Method of Receipt – Hardcopy/No Letterhead, Email/No Attachment on Letterhead or Pre-formatted Inquiry Forms*** *– For inquiries received without letterhead, including hardcopy, fax, email, pre-formatted inquiry forms or*

inquiries written on Remittance Advice (RAs) or Medicare Summary Notices (MSNs), contractors shall authenticate providers as detailed in A. above using provider name and the appropriate provider identification number depending upon the date of the inquiry (current provider number or NPI or PTAN.)

D. *Special Note about Inquiries Received Via Email and Fax* - *For requests received via email and fax, assuming all authentication elements are present as detailed in A. or B. above, whichever is applicable, contractors shall respond as directed in section 20.2.1.E in writing via regular mail with the requested information if there is protected health information in the response. In the written response on contractor letterhead, contractors shall inform the provider that beneficiary-specific information cannot be disclosed electronically via email or fax and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information. Additionally, contractors shall have discretion to respond to these requests by telephone as specified in 20.2.1.D.*

For email requests only, contractors shall not notify the provider by email that they will be responding via paper or telephone. However, contractors have discretion to send an automated email reply to an email request as long as no protected health information is in the automated reply. Contractors shall ensure that the automated reply conveys the message that no beneficiary-specific information may be disclosed via email and that, in the future, the provider must send a written inquiry through regular mail or use the IVR for beneficiary-specific information.

Contractors are reminded that they may respond via email to email requests not involving protected health information or beneficiary-specific information (i.e., policy questions.)

E. *Beneficiary Authentication* - *Assuming provider authentication requirements are met as detailed in A. or B. above, whichever is applicable, contractors shall always authenticate beneficiary data elements before disclosure of information without regard to the date of the written inquiry or method of receipt. See the chart in 30.4.4 for more information about authentication of beneficiary elements.*

F. *Requests Received Without Authentication Elements* - *For any written requests received without one or more authentication elements, without regard to date of inquiry or method of receipt, contractors shall return the request in its entirety to the provider stating that the requested information will be supplied upon submission of all authentication elements. Contractors shall indicate which overall elements are missing or do not match for authentication (i.e., date of birth rather than day or month or year.) Contractors shall return the inquiry to the provider via regular mail, although if sent via email without any protected health information, the inquiry may be returned via email.*

Contractors have discretion to follow up with a telephone call to obtain the rest of the authentication elements instead of returning the inquiry or to close out the written inquiry with a telephone call (see 20.2.1.D in this chapter.) Contractors shall not leave a message containing protected health information on an answering machine. Contractors shall remind the provider to check its copy of the beneficiary's Medicare card and/or follow up with the beneficiary for the correct information.

For situations not specifically addressed here, the contractor should use discretion, taking care to protect the beneficiary's privacy and confidentiality. Contractors shall refer situations in which they are unsure of whether or not to release information to a supervisor or to the contractor's privacy official. Contractors shall forward further questions to CMS at CMS ProviderServices@cms.hhs.gov.

30.2 – Special Inquiry Topics

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

30.2.1. Overlapping Claims

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors sometimes receive multiple claims with the same or similar dates of service or billing periods. Overlap occurs when a date of service or billing period conflicts with another, indicating that one or the other may be incorrect.

In cases where a contractor receives an inquiry from a provider or another Medicare contractor requesting provider information to resolve an overlapping claim, contractors shall work with each other. Resolution can occur through various ways. One way is for one contractor to call the other contractor with or without the provider on the line. This will allow the contractor calling to assure the other contractor that the provider has given all necessary authentication elements. The contractor shall then release the needed information.

Contractors shall have discretion to develop other avenues to work out overlapping claims with one another. Contractors are encouraged to share ideas with one another. However, if a contractor resolves an overlapping claim in a way other than directly calling the other contractor, the CSR shall make it clear to the inquiring provider that the information is not disseminated by CMS and CMS is not responsible for the accuracy of the information. All contractors shall work together to facilitate correct payment of all parties. In general, the servicing contractor of the inquirer should take the lead in resolving an overlapping situation.

In situations where the provider is seeking to avoid a claim being rejected, the contractor should, at their discretion, release information prior to claim submission. An example of this is a situation where some End State Renal Disease (ESRD) facilities prefer to obtain the inpatient hospital benefit days for the month, prior to the ESRD monthly bill being generated. This allows the ESRD facility to code the claim appropriately and bill around

the inpatient hospital stay/stays. This situation falls into the category of disclosing information needed to bill Medicare properly and release is appropriate as long as all authentication elements are met. Other situations may arise that fall into this category as well, for example, skilled nursing facility and inpatient hospital stays. Contractors shall, in these situations, ensure that the request is legitimate and necessary for proper billing.

30.2.2 Pending Claims
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors shall disclose information about pending claims to providers, preferably via the IVR, if feasible. A pending claim is one that is being processed or has been processed and is on the payment floor. As long as all authentication requirements are met, the IVR or the CSR shall provide information about pending claims, including receipt (yes/no) and the fact that the claim is still pending. Contractors shall have discretion to provide more information about pending claims, including Internal Control Number (ICN), pay date/amount or denial. If contractors choose to provide this additional information, the IVR or the CSR shall state that until payment is made or the RA issued, any information given on the call or in the written response may change. If a contractor chooses to provide this information via the IVR, providers should be educated to request this information via the IVR rather than calling the CSR.

30.3 – Deceased Beneficiaries
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Although the Privacy Act of 1974 does not apply to deceased individuals, the HIPAA Privacy Rule concerning protected health information applies to individuals, both living and deceased. Therefore, contractors shall comply with authentication requirements when responding to requests for information related to deceased beneficiaries.

30.4 – Disclosure Desk Reference for Provider Contact Centers
(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

NOTE – Contractors shall apply the guidance in 30.4.1, 30.4.2, 30.4.3 and 30.4.4 to providers/suppliers, billing services and clearinghouses unless otherwise specified. The use of provider/supplier in these charts refers to all institutional and non-institutional entities and individuals that bill the Medicare program. Because of the upcoming transition to the NPI, (see 30.5 for information concerning NPI implementation dates), the guidance below is broken down into several components: (1) authentication of provider elements for CSR inquiries, (2) authentication of provider elements for IVR inquiries, (3) authentication of provider elements for written inquiries and (4) authentication of beneficiary elements.

30.4.1 – Authentication of Provider Elements for CSR Inquiries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

EFFECTIVE DATES:	***INQUIRY TYPE:***	***THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):***	***THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:***
Present – May 22, 2007	*CSR*	• *Provider number* ***and*** • *Provider name*	*Contractors shall refer to chart below.*
On or after May 23, 2007	*CSR*	• *Provider NPI* ***and*** • *Provider name*	*Contractors shall refer to chart below.*

30.4.2 – Authentication of Provider Elements for IVR Inquiries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

EFFECTIVE DATES:	***INQUIRY TYPE:***	***THE FOLLOWING PROVIDER ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):***	***THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED AFTER BENEFICIARY ELEMENTS HAVE BEEN AUTHENTICATED:***
Present – May 22, 2007	*IVR*	• *Provider number*	*Contractors shall refer to chart below.*

On or after May 23, 2007	*IVR*	• *Provider NPI* ***and*** • *Provider Transaction Access Number*	*Contractors shall refer to chart below.*

30.4.3 – Authentication of Provider Elements for Written Inquiries

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Present – May 22, 2007	*Written inquiries, including fax and email*	• *Provider number* ***and*** • *Provider name* *NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, provider number is not required for provider authentication (see 30.1.2.B.).* *See 30.1.2.C for information about requests on pre-formatted inquiry forms.*	*Contractors shall refer to chart below.*
On or after May 23, 2007	*Written inquiries, including*	• *Provider name* ***and one of the following two:***	*Contractors shall refer to chart below.*

	fax and email	*Provider NPI* ***OR*** *Provider Transaction Access Number* *NOTE: If the inquiry is sent on provider letterhead with the provider's name and address, clearly establishing the identity of the provider, NPI is not required for provider authentication (see 30.1.2.B.)* *See 30.1.2.C for information about requests on pre-formatted inquiry forms.*	

30.4.4 – Authentication of Beneficiary Elements

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

IF THE PROVIDER CONTACT INQUIRES ABOUT:	***AND INQUIRES VIA:***	***AFTER THE PROVIDER ELEMENTS HAVE BEEN AUTHENTICATED, THE FOLLOWING BENEFICIARY ELEMENTS SHALL BE AUTHENTICATED (all elements must match unless otherwise specified):***	***THEN THE FOLLOWING ELEMENTS SHOULD BE RELEASED:***
1. Routine Eligibility Elements[1]	*Call to CSR or written inquiry*	• *Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* • *Beneficiary first name or first initial* • *Current or previously assigned HICN, including both alpha and numerical*	*Contractors have the discretion to routinely release all elements or only release when requested. Contractors shall use inquiry and rejected/denied claims analysis results to decide what elements to routinely release.* • *Part A current and previous entitlement and termination dates* • *Part B current and previous entitlement and termination dates* • *Deductible Met – Yes / No* • *Managed Care – Yes / No* • *MSP – Yes / No* • *Crossover established – Yes / No* • *Home Health – Yes / No*

[1] ***Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:*** *These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.*

		characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number) *• Date of birth* *NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Hospice – Yes / No* *• SNF – Yes / No* *• Pneumoccocal Vaccine – Yes / No* *----------* *When prompted by the inquirer:* *• Deductible amount remaining (Part A) or applied (Part B)* *• Managed Care – plan #, name, address, type, enrollment and termination dates* *• MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, CSRs shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file.* *• Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and termination dates, and deletion dates. For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the CSRs shall direct the provider to the*

			beneficiary's supplemental insurer. (NOTE: Customer service contact information may be referenced at http://www.cms.hhs.gov/medicare/COBAgreement.) • *Home Health – applicable earliest and latest dates* • *Hospice - applicable earliest and latest dates* • *SNF – applicable earliest and latest dates* • *Pneumoccocal Vaccine – administration date* • *Influenza Vaccine – Yes / No, administration date* • *Hepatitis B Vaccine – Yes / No, administration date* • *Blood Deductible* • *Date of Death*
2. Routine Eligibility Elements[2]	*IVR (involves touchtone or speech recognition technology)*	• *Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and*	*Contractors shall frequently analyze IVR usage and inquiry and rejected/denied claims analysis results to determine which elements should be routinely offered. Elements in other categories below may be offered routinely, if providers are frequently requesting this information and to include it here would improve provider service and satisfaction and decrease CSR-handled calls.*

[2] ***Note about Medicare Advantage Plans, Medicare Advantage Prescription Drug Plans and Medicare Prescription Drug Plans:*** *These Plans have access to eligibility information to enroll Medicare beneficiaries in Part C or Part D. Once enrolled, Plans have access to Medicare information about their enrollees. Provider contact centers should not be receiving inquiries from these Plans. Contractors receiving inquiries from these Plans shall tell the Plans that they do not handle these inquiries and to check their guidance from CMS about how to access beneficiary information.*

		suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Part A current and previous entitlement and termination dates* *• Part B current and previous entitlement and termination dates* *• Deductible Met – Yes / No* *• Managed Care – Yes / No* *• MSP – Yes / No* *• Crossover established – Yes / No* *• Home Health – Yes / No* *• Hospice – Yes / No* *• SNF – Yes / No* *• Pneumoccocal Vaccine – Yes / No* *----------* *NOTE: For the elements below, contractors have discretion on whether to offer these elements and if so, how to program the IVR to offer these additional elements.* *When prompted by the inquirer:* *• Deductible amount remaining (Part A) or applied (Part B)* *• Managed Care – plan #, name, address, type, enrollment and termination dates* *• MSP – insurer name, policy #, effective and termination dates, type of primary insurance, and insurer address. Contractors shall release this information with a caveat that this information may not be correct and that the beneficiary is the best source for insurance information. For*

			inquiries about the accuracy of the MSP information on the beneficiary's auxiliary record, the IVR shall refer the caller to the Coordination of Benefits Contractor at 1-800-999-1118. The COBC is responsible for the accuracy of the MSP information in Medicare's file. *• Claims Crossover Status – insurer or supplemental payer names(s), Coordination of Benefits Agreement (COBA) ID(s), effective and termination dates, and deletion dates. For inquiries concerning why the supplemental payer insurer did or did not include the beneficiary on its eligibility files so that claims can be crossed over, the IVR shall direct the provider to the beneficiary's supplemental insurer.* *• Home Health – applicable earliest and latest dates* *• Hospice - applicable earliest and latest dates* *• SNF – applicable earliest and latest dates* *• Pneumoccocal Vaccine – administration date or next eligible date* *• Influenza Vaccine – Yes / No, administration date or next eligible date* *• Hepatitis B Vaccine – Yes / No, administration date or next eligible date* *• Blood Deductible* *• Date of Death*
3. Optional Eligibility Elements	*Call to CSR or written*	*• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.)*	*NOTE – Contractors should not routinely make this information available to all*

Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining the type of information to be released to an inquirer; the contractor shall only release this information to assist the provider in billing Medicare properly. Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. If possible, the contractor should refer the inquirer to the entity (i.e., another Medicare contractor) that may be able to address the inquiry. In	*inquiry*	*and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* *• Beneficiary first name or first initial* *• Current or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the provider supplies the HICN, then the CSR may disclose the new number)* *• Date of birth* *NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*providers/suppliers. Contractors should make this information available on a need to know basis and should disclose it only to enable a provider to bill Medicare properly. For example, a SNF may need information about hospital stays in order to bill properly.* ***• ESRD:*** *• Renal Supplies:* *• ESRD effective dates* *• Transplant discharge date* *• Alternate Method Dialysis:* *• Method 1* *• Method 2* *• ESRD effective date* *• Transplant discharge date* ***• Home Health:*** *• Provider name* *• Servicing contractor* *• Applicable dates* ***• Hospice:*** *• Provider name* *• Servicing contractor* *• Applicable dates* ***• Hospital:***

instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)			• *Days remaining* • *Deductible amount* • *Co-insurance days remaining* • *Lifetime reserve days* • *Benefits Exhaust Date* • *Date of earliest billing action/date of last billing action* ● ***Long Term Care:*** • *Hospital days remaining* • *Deductible amount* • *Co-insurance days remaining* • *Lifetime reserve days* ● ***Rehabilitation Room & Board:*** • *Hospital days remaining* • *Co-insurance hospital days remaining* • *Lifetime reserve days* ● ***Psychiatric Limitation:*** • *Days remaining (full benefit, lifetime)* • *Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance)* • *Benefits Exhaust Date* ● ***SNF:*** • *Days remaining* • *Co-insurance days remaining* • *Date of earliest billing action/date of last*

			billing action ● ***Therapy Cap information, including remaining limitation dollar amount and/or amount applied:*** ● *Speech therapy* ● *Occupational therapy* ● *Physical therapy*
4. Optional Eligibility Elements Based on Type of Provider and Type of Service Provided (Contractors shall use discretion in determining whether to release this information and, if so, the type of information to be released to an inquirer; the contractor shall only release this information to assist the provider in billing Medicare properly.	*IVR (involves touchtone or speech recognition technology)*	*• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating*	*NOTE: For the elements below, contractors have discretion about whether to release this information and, if so, how to program the IVR to offer these elements.* ● ***ESRD:*** ● *Renal Supplies:* • *ESRD effective dates* • *Transplant discharge date* ● *Alternate Method Dialysis:* ● *Method 1* ● *Method 2* ● *ESRD effective date* ● *Transplant discharge date* ● ***Home Health****:* ● *Provider name* ● *Servicing contractor* ● *Applicable dates*

Contractors are not required to respond to inquiries if the contractor does not have access to the information necessary to answer the inquiry. In instances where the provider is part of a multiple physician practice, but the specialty is not identified, contractors have discretion as to whether data should be released.)		*guide on how to input spaces or blanks so that 6 digits are input.* *• Beneficiary first name or first initial* *• HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	● ***Hospice:*** ● *Provider name* ● *Servicing contractor* ● *Applicable dates* ● ***Hospital:*** ● *Days remaining* ● *Deductible amount* ● *Co-insurance days remaining* ● *Lifetime reserve days* ● *Benefits Exhaust Date* ● *Date of earliest billing action/date of last billing action* ● ***Long Term Care:*** ● *Hospital days remaining* ● *Deductible amount* ● *Co-insurance days remaining* ● *Lifetime reserve days* ● ***Rehabilitation Room & Board:*** ● *Hospital days remaining* ● *Co-insurance hospital days remaining* ● *Lifetime reserve days* ● ***Psychiatric Limitation:*** ● *Days remaining (full benefit, lifetime)*

			• *Co-insurance days remaining (regular coinsurance, lifetime reserve coinsurance)* • *Benefits Exhaust Date* • ***SNF:*** • *Days remaining* • *Co-insurance days remaining* • *Date of earliest billing action/date of last billing action* • ***Therapy Cap information, including remaining limitation dollar amount and/or amount applied:*** • *Speech therapy* • *Occupational therapy* • *Physical therapy*
5. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in	*Call to CSR or written inquiry*	• *Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* • *Beneficiary first name or first initial*	***Next eligible dates for professional / technical components based on HCPCS or service description provided by the inquirer:*** • *Cardiovascular (80061, 82465, 83718, 84478)* • *Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328)* • *Diabetes (82947, 82950, 82951)* • *Glaucoma (G0117, G0118)* • *Initial preventive physical exam (G0344, G0366, G0367, G0368)* • *Mammography (76092, G0202)* • *Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148)*

determining a beneficiary's eligibility for these services or billing Medicare properly.		*• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number)* *• Date of birth* *NOTE: If there is an error, the CSR should tell the inquirer which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Pelvic and clinical breast exam (G0101)* *• Prostate (G0102, G0103)* *• Bone density (G0130)* *• Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period* ***NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information.*** ***NOTE: If a description of the service is used instead of a HCPCS code, the CSR shall confirm the exact service being referenced to ensure that the information being disclosed is what is being requested. For example, there are several codes for colorectal screening. Depending upon the services the beneficiary has already received, the next eligible date will be specific to a particular service.***
6. Preventive Services -Next Eligible Date - Contractors shall use discretion in determining whether	*IVR (involves touchtone or speech recognition technology)*	*• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)*	***Next eligible dates for professional / technical components based on HCPCS provided by the inquirer:*** *• Cardiovascular (80061, 82465, 83718, 84478)* *• Colorectal (G0104, G0105, G0106, G0120, G0121, G0107, G0328)*

to release this information in the IVR and, if so, the type of provider to whom to release this information; the contractor shall only release this information to assist the provider in determining a beneficiary's eligibility for these services or billing Medicare properly.		*NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.* *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*• Diabetes (82947, 82950, 82951)* *• Glaucoma (G0117, G0118)* *• Initial preventive physical exam (G0344, G0366, G0367, G0368)* *• Mammography (76092, G0202)* *• Pap test (Q0091, P3000, G0123, G0143, G0144, G0145, G0147, G0148)* *• Pelvic and clinical breast exam (G0101)* *• Prostate (G0102, G0103)* *• Bone density (G0130)* *• Smoking and tobacco-use cessation counseling (G0375, G0376)—remaining sessions for coverage period* ***NOTE: HCPCS codes are accurate as of the publication date of this document and provided for informational purposes only. If codes change before the desk reference is updated, contractors shall use the most updated codes. See http://www.cms.hhs.gov/MedHCPCSGenInfo/ for HCPCS information.***

7. Processed claims information *NOTE – Contractors should release information prior to claim submission only with the beneficiary's authorization or if, in the contractor's discretion, the provider needs information in order to bill Medicare properly and avoid an overlapping rejected claim.*	*CSR (also applies to written inquiries)*	*• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the provider supplies the HICN, then the CSR may disclose the new number)* *• Date of service* *NOTE: If there is an error, the CSR should tell the inquirer which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	*Contractors shall use discretion in determining what information to release.* ***Assigned Claims*** *Participating and non-participating - any information on that provider/supplier's claim or any other related claim from that provider/supplier for that beneficiary, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable.* ***Non-assigned Claims*** *Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable. However, see note below.* *The following paragraphs apply to both assigned and unassigned claims.* *General Note – Contractors should speak with the provider/supplier about his/her own claims. Contractors should also disclose information about another provider/supplier as long as both providers/ suppliers have a relationship with the beneficiary and the purpose of the disclosure is to facilitate the payment of the provider/supplier that receives the information.*

			*** If a provider inquires about a claim that was denied due to the beneficiary being incarcerated, the contractor shall tell the provider that Social Security Records indicate that this patient was a prisoner when the service was rendered and that Medicare does not cover items and services furnished to an individual while they are in State or local custody under a penal authority. The contractor shall direct the inquirer to follow up with the State Department of Corrections.* ***If a provider inquires about a claim that was denied due to the beneficiary being deported, the contractor shall tell the provider that Social Security records indicate that the individual has been deported and that Medicare does not cover items and services furnished to individuals who have been deported.*
8. Processed claims information *Contractors shall not release any processed claims information about incarcerated beneficiaries or deported beneficiaries via the*	*IVR (involves touchtone or speech recognition technology)*	*• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not*	*Contractors shall use discretion in determining what information to release.* ***Assigned Claims*** *Participating and non-participating - any information on that provider / supplier's claim or any other related claim from that provider / supplier for that beneficiary, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable.*

IVR.		*required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input.* *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of service* *NOTE: The IVR response, if feasible, should relay which overall element (for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	***Non-assigned Claims*** *Information regarding only the claim in question; information is restricted to claim received (yes / no), date processed and why it was denied or reduced, including whether the claim was crossed over and the reason the claim was not crossed over, as applicable.*
9. Certificate of Medical Necessity (CMN)) or DME	*Call to CSR or written inquiry*	***Before a claim is submitted:*** *• Beneficiary full last name (including*	*Contractors shall use discretion in determining what information to release. Contractors should release information about CMNs or DIFs that*

MAC Information Form (DIF) – DMERC / DME MAC ONLY		*hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the provider is a match to the name on the beneficiary record being displayed.* *• Beneficiary first name or first initial* *• Current or previously assigned HICN, including both alpha and numerical characters (if a new HICH displays when the supplier gives the HICN, then the CSR may disclose the new number)* *• Date of birth* ***After a claim is processed:*** *• Beneficiary full last name (including hyphenated names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister)* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the CSR shall be certain that the beneficiary surname given by the*	*will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code or item description in order for the CSR to provide the correct information about the CMN or DIF.* • *Initial date* • *Recertification date* • *Length of need* • *Other elements necessary to properly bill Medicare* *Contractors shall confirm whether or not the answers to the question sets on the CMN or DIF on file match what the supplier has in his/her records.*

		provider is a match to the name on the beneficiary record being displayed. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (if a new HICN displays when the supplier gives the HICN, then the CSR may disclose the new number)* *• Date of service* *NOTE: If there is an error, the CSR should tell the inquirer which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	
10. Certificate of Medical Necessity (CMN) or DME MAC Information Form (DIF) – DMERC / DME MAC ONLY	*IVR (involves touchtone or speech recognition technology)*	***Before a claim is submitted:*** *• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use first 6 letters or entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister);* *NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not*	*Contractors shall use discretion in determining what information to release. Contractors should release information about CMNs or DIFs that will facilitate providers / suppliers billing Medicare properly. Although not an authentication element, the caller will need to provide the HCPCS Code in order for the IVR to return the correct information about the CMN or DIF.* • *Initial date*

		required; however, the contractor shall program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of birth* ***After a claim is processed:*** *• Beneficiary last name – first 6 letters (no special characters); if using speech recognition technology, may use entire last name, including hyphenated last names, suffixes (i.e., Jr., Sr.) and abbreviation of titles (i.e., Fr. for Father, Sr. for Sister) NOTE: Because systems limitations sometimes prevent full last names and suffixes from showing on contractor records, an exact name match is not required; however, the contractor shall*	• *Recertification date* • *Length of need* • *Other elements necessary to properly bill Medicare*

		program the IVR to ensure that the beneficiary surname given by the provider is a good match to the name on the beneficiary record being accessed. For surnames of less than 6 letters, contractors should program their IVRs to match names of less than 6 letters or should include instructions for callers in the IVR operating guide on how to input spaces or blanks so that 6 digits are input. *• Beneficiary first name or first initial* *• Currently or previously assigned HICN, including both alpha and numerical characters (the IVR may disclose the current HICN when a previously assigned HICN is input)* *• Date of service* *NOTE: The IVR response, if feasible, should relay which overall element(for example, date of birth instead of day, month and year) does not match and to check the beneficiary's record, which should include a copy of the Medicare card, and/or follow up with the beneficiary, for the correct information.*	

30.5 NPI Implementation

(Rev. 16, Issued: 07-21-06, Effective: 10-01-06, Implementation: 10-02-06)

Contractors are reminded about Medicare's implementation involving acceptance and processing of transactions with the NPI:

May 23, 2005 - January 2, 2006: Providers should submit Medicare claims using only their existing Medicare numbers. They should not use their NPI numbers during this time period. CMS claims processing systems will reject, as unprocessable, any claim that includes an NPI during this phase.

January 3, 2006 - October 1, 2006: Medicare systems will accept claims with an NPI, but an existing legacy Medicare number must also be on the claim. Note that CMS claims processing systems will reject, as unprocessable, any claim that includes only an NPI. Medicare will be capable of sending the NPI as primary provider identifier and the legacy identifier as a secondary identifier in outbound claims, claim status response, and eligibility benefit response electronic transactions.

October 2, 2006 - May 22, 2007: CMS systems will accept an existing legacy Medicare billing number and/or an NPI on claims. If there is any issue with the provider's NPI and no Medicare legacy identifier is submitted, the provider may not be paid for the claim. Therefore, Medicare strongly recommends that providers, clearinghouses, and billing services continue to submit the existing Medicare legacy identifier as a secondary identifier. Medicare will be capable of sending the NPI as primary provider identifier and legacy identifier as a secondary identifier in outbound claim, claim status response, remittance advice (electronic but not paper), and eligibility response electronic transactions.

May 23, 2007 – Forward: CMS systems will only accept NPI numbers. Small health plans have an additional year to be NPI compliant.

NOTE: To use the IVR, providers will need to use the NPI as well as the IVR account number.