# Program Memorandum Intermediaries/Carriers

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

**Transmittal AB-03-077** **Date: MAY 23, 2003**

**CHANGE REQUEST 2566**

**SUBJECT: Revised Disclosure Desk Reference for Call Centers**

This Program Memorandum (PM) updates the guidelines for the Medicare contractors' call centers regarding the disclosure of beneficiary-specific information over the telephone. These guidelines apply to requests for information that come in over telephone lines provided for beneficiary and provider inquiries and are consistent with the provisions of the Privacy Act of 1974. This revision includes instructions for disclosing information to providers, general clarifications and is compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

The general clarifications consist of the inclusion of the State Health Insurance Assistance Program (SHIP) employees and volunteers as approved contacts: additional information regarding Congressional inquiries, deceased beneficiaries, parents and minor children: and clarifications regarding when to forward inquiries to the Coordination of Benefits (COB) Contractor. We also made changes to the procedures for disclosing beneficiary-specific information to State Medicaid agencies, and to allow for the discussion of claims-related issues with one provider about another provider's claims when both providers have a relationship with the beneficiary.

In the attachment, we have attempted to address the most likely scenarios in this PM. For situations not specifically addressed here, the customer service representative (CSR) should use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. The CSR should contact his/her supervisor or the organization's privacy official for determinations if he/she is unsure whether or not to disclose beneficiary-specific information.

Frequently Asked Questions on this topic are posted at the following Web site: http://www.cms.hhs.gov/callcenters/qanda.asp.

**The *effective date* for this PM is *July 7, 2003*.**

**The *implementation date* for this PM is *July 7, 2003*.**

**These instructions should be implemented within your current operating budget.**

**This PM may be discarded after *June 30, 2004*.**

**If you have any questions regarding beneficiary inquiries, contact Robin Getzendanner at rgetzendanner@cms.hhs.gov or call 410-786-9621. For questions regarding provider inquiries, contact Emily Norment at enorment@cms.hhs.gov or call 410-786-0495.**

**Attachment**

**ATTACHMENT**

## DISCLOSURE OF BENEFICIARY-SPECIFIC INFORMATION OVER THE TELEPHONE

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 1. The beneficiary | | Verify it is the beneficiary by asking for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. | Release any entitlement and claim information and answer any questions pertaining to the beneficiary's Medicare coverage. | Medicare Carriers Manual (MCM) Part 2 §5104 A. 7-9<br><br>MCM Part 3 §10010<br><br>Medicare Intermediary Manual (MIM)<br>Part 2 §2958 A. 7-9<br><br>MIM Part 3 §3763<br><br>45 CFR 164.524 |
| 2. The beneficiary | The beneficiary makes a mistake on the information (name, date of birth, HIC number or additional piece of information) used to verify his/her identity.<br><br>**NOTE**: There is a two-year tolerance for the year of birth. (For example, for a beneficiary born on 3/12/31, you may accept the year of birth as 1929, 1930, 1931, 1932, or 1933 – two years prior and two years after the correct year of birth. The month and date, however, must match exactly.) | Explain to the beneficiary that the information does not match the information in your records. Ask him/her to repeat the information, and if still incorrect, suggest that the beneficiary look at his/her Medicare paperwork to find the correct information or ask someone (family or friend) to help him/her with this information.<br><br>The CSR may advise the beneficiary to contact SSA to discuss the DOB SSA established. | If the beneficiary is able to provide the correct information, release per the instructions above.<br><br>If the beneficiary is unable to provide the correct information, YOU MAY NOT release any entitlement or claim information or answer any questions pertaining to the beneficiary.<br><br>Advise the beneficiary that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information. | 45 CFR Subtitle A 5b.5(b)(v)<br><br>MCM Part 3 §10010<br><br>MIM Part 3 §3763<br><br>Program Operation Manual System (POMS)<br>GN 03360.005 – Releasing Information by Telephone<br><br>45 CFR 164.524 |

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| 3. Parent of a minor child | Generally, a parent may have access to the child's information as his/her personal representative when such access in not inconsistent with State or other law.<br><br>The parent would no longer be the personal representative of the child when the child reaches the age of majority or becomes emancipated, unless the child elects to have the parent continue as a personal representative. | Verify the identity of the minor child by asking for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Verify that there is nothing listed in your files that would preclude sharing information with the parent calling, (e.g., a copy of a court order). | Release any entitlement and claim information and answer any questions pertaining to the issue in question. | MCM Part 3 §10020 B<br><br>MIM Part 3 §3766 B<br><br>POMS GN 03360.005 – Releasing Information by Telephone<br><br>45 CFR 164.502(g)(2)(3) |
| 4. SSA-Appointed Representative Payee<br><br>Or<br><br>A legal guardian of any individual who has been declared incompetent by the court | To answer any questions via the telephone, you must have proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR), Health Insurance Master Record (HIMR) or Inquiry Response Numident Identification screen (QRID)). | Verify that the caller's name matches the representative payee or legal guardian's name in your files.<br><br>Have the representative payee or legal guardian provide the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. | Release any entitlement and claim information and answer any questions pertaining to the issue in question. | MCM Part 3 §10020 E.1.b<br><br>MIM Part 3 §3766 E.1.b<br><br>SSA training module – Title II Claims Representative Basic Training Course (CR-02) Disclosure/Confidentiality/ Privacy Act/ Freedom of Information<br><br>POMS GN 03360.005 – Releasing Information by Telephone<br><br>45 CFR 164.502(g)(1) |

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| 5. Legal representative as defined by the State. | Initially, these types of requests must come in as written requests in order to verify the relationship.<br><br>To answer any questions via the telephone, you must have proof of the arrangement for services on file or the representative's name must appear on the system (e.g., Master Beneficiary Record (MBR), Supplemental Security Income Record (SSR) or Inquiry Response Numident Identification screen (QRID)).<br><br>The representative's name must match the name of the representative that is on file. | Verify the identity of the beneficiary by asking for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Verify that the caller's name matches the representative's name in your files. | Release information to legal representatives (such as an attorney) pertaining to the matter for which they have been appointed as representative. You may assume the legal representative can receive any entitlement and claim information on behalf of the beneficiary unless it is evident by the documentation that they represent the beneficiary for limited services (i.e., financial representative only). | SSA training module – Title II Claims Representative Basic Training Course (CR-02) Disclosure/Confidentiality/ Privacy Act/ Freedom of Information<br><br>POMS GN 03360.005 – Releasing Information by Telephone<br><br>45 CFR 164.502(g)(1) |

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| 6. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) | The beneficiary gives verbal authorization for you to speak with the caller.<br><br>(The beneficiary does not have to remain on the line during the conversation, or even be at the same place as the caller – you may obtain the beneficiary's authorization to speak with the caller via another line or three way calling.) | Verify the identity of the beneficiary by asking the beneficiary for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>A verbal authorization on file is good for 14 days. The CSR may advise the beneficiary and the caller that if the beneficiary wants the caller to receive information for more than 14 days, the beneficiary should send in a written authorization. | Release any entitlement and claim information and answer any questions pertaining to the issue in question. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2 §2958 A. 7-9<br><br>45 CFR 164.510(b) |

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| 7. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) | The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file. | Advise the caller that you may not give out any information without the beneficiary's authorization.<br><br>The caller may call back at a later time when the beneficiary is available to give authorization.<br>-Or-<br>The beneficiary could provide written authorization to allow the caller to obtain information about his or her record. | YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.<br><br>Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2§2958 A. 7-9<br><br>MCM Part 3 §10010<br><br>MIM Part 3 §3763<br><br>45 CFR 164.510(b) |
| 8. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) | You have written authorization on file that allows you to give beneficiary-specific information to the caller.<br><br>See Notes at end of chart for information regarding written authorization. | The caller must provide the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Ensure that the caller is the authorized individual, and within the authorized time period (if specified). | Only discuss information authorized by the written authorization. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2 §2958 A. 7-9<br><br>45 CFR 164.510(b) |

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| 9. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) | Previous written authorization has expired. | In order to access the beneficiary's record, the caller must provide the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Advise the caller that the written authorization has expired.<br><br>Obtain the beneficiary's verbal authorization and/or develop for a new written authorization. | Unless you receive a verbal authorization, YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.<br><br>Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information.<br><br>However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2 §2958 A. 7-9<br><br>45 CFR 164.510(b) |

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| 10. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) requesting information on a specific claim<br><br>(No MSN/EOMB) | The beneficiary is not available to verbally authorize you to speak with the caller, there is no written authorization on file, and the caller does not have a copy of the MSN/EOMB, however the caller has the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• Information on a specific claim (e.g., date of service, physician name, procedure). | The CSR may suggest that the caller have the beneficiary forward written authorization to the call center if he/she anticipates any need for future telephone contacts. | Release information only:<br>• On whether or not the claim has been received or processed, and<br>• The date the beneficiary can expect to receive the EOMB or MSN. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2 §2958 A. 7-9<br><br>45 CFR 164.510(b) |
| 11. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) requesting information on a specific claim<br><br>(Has MSN/EOMB) | The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file, however the caller has the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• Copy of the MSN or EOMB. | The CSR may suggest that the caller have the beneficiary forward written authorization to the call center if he/she anticipates any need for future telephone contacts. | Only release information for the service(s) that appear on the MSN or EOMB. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2 §2958 A. 7-9<br><br>45 CFR 164.510(b) |

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| 12. A beneficiary's spouse, relative, friend or advocacy group (excluding State Health Insurance Assistance Program (SHIP) employees and volunteers) | The caller states that the beneficiary is deceased. | In order to access the beneficiary's record, the caller must provide the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>If you DO NOT have proof of death (i.e., date of death shown on Common Working File (CWF), Master Beneficiary Record (MBR), advise the caller to notify SSA at 1-800-772-1213 that beneficiary is deceased. | YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary<br><br>Advise the contact that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information. Advise the caller that the request should be in writing, include the authority under which the caller is making the request (e.g., executor, next of kin) and must state why the information is sought.<br><br>However, if the caller has a question about a specific claim, see the instructions regarding release of information on a specific claim. *(See #10 or #11.)* | MCM Part 3 §10022<br><br>MIM Part 3 §3767<br><br>45 CFR 164.502(g)(4) |

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| 13. A State Health Insurance Assistance Program (SHIP) employee or volunteer | One of the following applies:<br>• You have a verbal or written authorization allowing you to speak with the SHIP employee or volunteer; or<br>• The SHIP employee or volunteer is listed on the SHIP roster as an approved contact. | In order to access the beneficiary's record, the caller must provide the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. | Release any entitlement and claim information and answer any questions pertaining to the issue in question. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2 §2958 A. 7-9<br><br>45 CFR 164.510(b) |
| 14. A State Health Insurance Assistance Program (SHIP) employee or volunteer | The beneficiary is not available to verbally authorize you to speak with the caller and there is no written authorization on file and the caller is NOT listed on the SHIP roster as an approved contact. | Advise the caller that you may not give out any information without the beneficiary's authorization.<br><br>The caller may call back at a later time with the beneficiary present to give authorization<br>-Or-<br>The beneficiary could provide written authorization to allow the caller to obtain information about his or her record. | YOU MAY NOT release any claim information or answer any questions pertaining to the beneficiary.<br><br>Advise the caller that the information is protected under the Privacy Act and the HIPAA Privacy Rule and it is for the beneficiary's protection that we will not release the information. | MCM Part 2 §5104 A. 7-9<br><br>MIM Part 2§2958 A. 7-9<br><br>MCM Part 3 §10010<br><br>MIM Part 3 §3763<br><br>45 CFR 164.510(b) |

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| 15. Congressional Office | The Congressional staff member states that he/she is calling at the request of the beneficiary (and not on behalf of someone else about the beneficiary). | In order to access the beneficiary's record, the caller must provide the beneficiary's:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Document the name and title of the caller. | Release any entitlement and claim information and answer any questions pertaining to the issue in question. | MCM Part 3 §10020 E 1a<br><br>MIM Part 3 §3763 E 1a<br><br>45 CFR 164.510(b) |

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| 16. A CMS employee | The CMS employee provides the following information in order to identify the beneficiary in question.<br>• Full name<br>• Date of birth<br>• HIC number<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. | There are three ways that a CSR may verify that he/she is speaking with a CMS employee.<br>• Both parties on the call look at the CWF or MBR record (or other beneficiary record to which they both have access). The CSR or CMS employee can name a field on the CWF or MBR and ask that the other party identify what is in that particular field.<br>OR<br>• The CSR should ask for the CMS employee's phone number and call him/her back, making sure that the area code and exchange is correct for the CO or RO location;<br>**NOTE**: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.<br>OR<br>• The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. | If the CSR is reasonably certain that he/she is speaking to a CMS employee, the CSR may release any claim information and answer any questions pertaining to the issue in question. | 45 CFR Subtitle A 5b.5 (v)<br><br>MCM Part 3 §10020 E 2<br><br>MIM Part 3 §3764 E 2<br><br>POMS GN 03310.005<br><br>45 CFR 164.506 |

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| 17. An employee of another Federal agency (e.g., SSA, RRB, VA, DoD) who needs the information to perform duties on behalf of that agency | The employee of the other agency provides the following information in order to identify the beneficiary in question:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Ensure that the reason for the inquiry is related to the administration of that agency's program. | There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.<br>• Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on the MBR and ask that the other agency's employee identify what is in that particular field.<br>OR<br>• The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; **NOTE**: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.<br>OR<br>• The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. | If the CSR is reasonably certain that he/she is speaking to the other agency's employee, the CSR may release any claim information and answer any questions related to the administration of that agency's program. | MCM Part 3 §10013<br><br>MIM Part 3 §3765<br><br>MCM Part 3 §10020 E 2<br><br>MIM Part 3 §3764 E 2<br><br>MCM Part 3 §10037<br><br>MIM Part 3 §3772<br><br>POMS GN 03310.015<br><br>45 CFR 164.506 |

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| 18. State Agencies administering Medicaid<br><br>Inform the caller that State agencies must get this information through the channels formerly referred to as BEST/CASF.<br><br>Advise the caller that instructions on the process can be found at http://www.cms.hhs.gov/states/letters/ | If the caller has an issue that cannot be resolved using the instructions found at http://www.cms.hhs.gov/states/letters/, the CSR may resolve the issue after verifying that the caller is an employee of the State Medicaid agency.<br><br>The employee of the State Medicaid agency provides the following information in order to identify the beneficiary in question:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Ensure that the reason for the inquiry is related to the administration of that agency's program. | There are three ways that a CSR may verify that he/she is speaking with an employee of State Medicaid agency.<br>• Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field.<br>OR<br>• The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; **NOTE**: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.<br>OR<br>• The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. | The CSR may release any claim information and answer any questions related to the administration of State Medicaid agency's program. | MCM Part 3 §10031 A<br><br>MIM Part 3 §3770<br><br>http://www.cms.hhs.gov/states/letters/<br><br>*45 CFR 164.506* |

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| 19. Complementary health insurance (Medigap, complementary crossover, supplemental) | The beneficiary has signed an agreement with the complementary health insurer granting that company the authorization to receive Medicare claim information. | Verify the complementary health insurer is identified on the beneficiary's file.<br><br>Verify the identity of the beneficiary in question by asking for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. | Answer any question pertaining to the beneficiary's claims that should have crossed over to the complementary insurer. | 45 CFR 164.506 |

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| 20. Medicare Contractor (Fiscal Intermediary/Carrier/ DMERC/RHHI) | The Medicare Contractor being contacted processed the claim in question.<br><br>Verify the identity of the beneficiary in question by asking for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage. | There are three ways that a CSR may verify that he/she is speaking with an employee of another agency.<br>• Both parties on the call look at the MBR record (or other beneficiary record to which they both have access). The CSR can name a field on MBR and ask that the other agency's employee identify what is in that particular field.<br>OR<br>• The CSR should ask for the employee's phone number and call him/her back, making sure that the area code and exchange matches a listed phone number for that agency; **NOTE**: Caller ID or similar service may be used to verify the area code and exchange in lieu of a callback.<br>OR<br>• The CSR should take the name and number of the agency employee, the name and number of his/her supervisor, the date and reason for the inquiry, and post this information to the "NOTES" screen. | If the CSR is reasonably certain that he/she is speaking to the other contractor's employee, the CSR may release any claim information and answer any questions pertaining to the beneficiary's claims that were processed by the Medicare Contractor being contacted. | 45 CFR 164.506 |

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| 21. Other Health Insurer (MSP involved) | *The beneficiary has signed an agreement with the other health insurer granting that company the authorization to receive Medicare claim information.* | Verify the identity of the beneficiary in question by asking for his/her:<br>• Full name;<br>• Date of birth;<br>• HIC number; and<br>• One additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage.<br><br>Refer the caller to the Coordination of Benefits (COB) Contractor for all Medicare Secondary Payer (MSP) inquiries <u>(except claims-related questions and termination of MSP situations related to an accident, illness or injury</u>) including:<br>• The reporting of potential MSP situations<br>• Changes in a beneficiary's insurance coverage<br>• Changes in employment,<br>• End Stage Renal Disease (ESRD) entitlement issues,<br>• All other general MSP questions.<br>Please note that questions about eligibility to the Medicare Program are **NOT** to be referred to the COB Contractor, whose main task is | You may answer any questions pertaining to the beneficiary's file that are necessary to coordinate benefits. | MCM Part 3 10025 C<br><br>MIM Part 3 3768 C<br><br>Program Memorandum Intermediaries/Carriers Transmittal AB-00-129, Change Request 1460, Dated 12/19/00<br><br>45 CFR 164.506 |

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| | | to ensure that the Medicare Program has current, accurate data about other insurance that Medicare beneficiaries have that may be primary to Medicare. The COB Contractor does not make Medicare eligibility determinations.<br><br>COB Contractor Number<br>1-800-999-1118<br><br>TTY/TDD<br>1-800-318-8782<br><br>CSRs are available 8 am to 8 pm (Eastern Time) | | |

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| 22. A Provider/Physician<br><br>Part A or B | Provider/physician inquires about claims information on a pre-claim basis | | No claims information may be released on a pre-claim basis without the beneficiary's authorization. | MCM § 10025<br><br>MIM § 3768<br><br>MCM § 5105<br><br>MIM § 2959 |
| 23. A Provider/Physician<br><br>Part A or B | Provider/physician inquires about claims information on a post-claim basis. | Validate the provider/physician's name and identification number.<br><br>Verify the beneficiary's:<br>● Date of Service<br>● Last name and first initial<br>● HIC number<br><br>Items must match exactly. | Assigned Claims<br>Participating and Non-Participating: Discuss any information on that provider/physician's claim or any other related claim from that provider/physician for that beneficiary.<br><br>**Non-Assigned Claims**<br>Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.<br><br>You may speak with the provider/physician about his/her own claims. You may also disclose information about another provider/physician, as long as both providers/ physicians have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the provider/physician that receives the information. | MCM §10025<br><br>MIM § 3768<br><br>MCM § 5105<br><br>MIM § 2959<br><br>Program Memorandum Intermediaries/Carriers Transmittal AB-03-034, Change Request 2484, Dated 02/28/03 |

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 24. A Provider/physician<br><br>Part A | Provider/physician inquires about beneficiary eligibility information, which would be available via EDI.<br><br>This information may only be used in order to submit an accurate claim. | Validate the provider/physician's name and identification number.<br><br>Verify the beneficiary's:<br>● Last name & first initial<br>● Date of birth<br>● HIC number<br>● Gender<br><br>Items must match exactly. | Release the following eligibility information on a pre-claim or post-claim basis:<br><br>– Date of death<br>– Lifetime reserve days remaining<br>– Lifetime psychiatric days remaining (if the requesting caller has a psychiatric identification number)<br>– Cross reference HICN<br>– Current and prior A and B entitlements<br>– Spell of illness: hospital full and coinsurance days remaining, SNF full days and coinsurance days remaining, Part A cash deductible remaining to be met, date of earliest billing action for indicated spell of illness<br>– Blood deductible (combined Part A and B) remaining to be met for applicable year entered by provider<br>– Part B trailer year (applicable year based on date entered by provider)<br>– Part B cash deductible<br>– Physical/speech and occupational therapy limit<br>– Hospice data (applicable periods based on the date entered by the provider and the next most recent period)<br>– ESRD indicator | MIM § 3508<br><br>Program Memorandum Transmittal AB-01-137, Change Request 1587, Dated 09/26/01 |

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| | | | – Rep payee indicator<br>– MSP indicator<br>– HMO information: identification code, option code, start & termination date<br>– Pap smear screening: risk indicator, professional and technical date<br>– Mammography screening: risk indicator, professional and technical date<br>– Colorectal screening: procedure code, professional and technical date<br>– Pelvic screening: risk indicator and professional date<br>– Pneumococcal pneumonia vaccine (PPV) date<br>– Influenza virus vaccine date<br>– Hepatitis B vaccine date<br>– Home health start and end dates and servicing provider's name. | |

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 25. A Provider<br><br>Part B | Provider inquires about beneficiary eligibility information, which would be available via EDI.<br><br>This information may only be used in order to submit an accurate claim. | Validate the provider's name and provider number.<br><br>Verify the beneficiary's:<br>● Last name and first initial<br>● Date of birth<br>● HIC number<br>● Gender<br><br>Items must match exactly. | Release the following eligibility information on a pre-claim or post-claim basis:<br><br>– Part A and B entitlement and termination dates<br>– Deductible met (yes or no) for current and prior years<br>– HMO information: "cost" or "risk" plan, effective and termination dates<br>– MSP activity (yes or no)<br>– Home health start and end dates and servicing provider's name. | MCM § 6100<br><br>Program Memorandum Transmittal AB-01-137, Change Request 1587, Dated 09/26/01 |

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 26. Supplier<br><br>DMERC | Supplier inquires about claims information on a pre-claim basis. | | No claims related information may be released on a pre-claim basis without the beneficiary's authorization. | MCM §10025<br><br>MIM §3768 |
| 27. Supplier<br><br>DMERC | Supplier inquires about claims information on a post-claim basis. | Validate the supplier's name and NSC identification number<br><br>Verify the beneficiary's:<br>● Date of service<br>● Last name and first initial<br>● HIC number<br><br>Items must match exactly. | **Assigned Claims**<br>Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary.<br><br>**Non-Assigned Claims**<br>Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.<br><br>You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information. | MCM §10025<br><br>MIM §3768<br><br>MCM § 5105<br><br>MIM §2959<br><br>MCM §2125<br><br>Program Memorandum Intermediaries/Carriers Transmittal AB-03-034, Change Request 2484, Dated 02/28/03 |

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 28. Supplier<br><br>DMERC | Supplier inquires about a Certificate of Medical Necessity (CMN)<br><br>NO claim has been submitted. | | You may not release answers to the question sets on the CMN on file. | |
| 29. Supplier<br><br>DMERC | Supplier inquires about a Certificate of Medical Necessity (CMN)<br><br>Supplier receives a claim denial due to the CMN.<br><br>This information may only be used in order to submit an accurate claim. | Validate the supplier's name and NSC identification number.<br><br>Verify the beneficiary's:<br>● Date of service<br>● Last name and first initial<br>● HIC number<br>● HCPCs code or name of item<br><br>Items must match exactly. | You may confirm whether or not the answers to the question sets on the CMN on file matches what the supplier has in his/her records. | |
| 30. Supplier<br><br>DMERC | Supplier inquires about beneficiary eligibility information, which would be available via EDI.<br><br>This information may only be used in order to submit an accurate claim. | Validate the supplier's name and NSC identification number.<br><br>Verify the beneficiary's:<br>● Last name and first initial<br>● Date of birth<br>● HIC number<br>● Gender<br><br>Items must match exactly. | Release the following eligibility information on a pre-claim or post-claim basis:<br><br>– Part A and B entitlement and termination dates<br>– Deductible met (yes or no) for current and prior years<br>– HMO information: "cost" or "risk" plan, effective and termination dates<br>– MSP activity (yes or no)<br>– Home health start and end dates and servicing provider's name. | MCM § 6100<br><br>MIM § 2125<br><br>Program Memorandum Transmittal AB-01-137, Change Request 1587, Dated 09/26/01 |

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 31. Ambulance Supplier | Supplier inquires about claims information on a pre-claim basis. | | No claims related information may be released on a pre-claim basis without the beneficiary's authorization. | |
| 32. Ambulance Supplier | Supplier inquires about claims information on a post-claim basis. | Validate the supplier's name and identification number<br><br>Verify the beneficiary's:<br>● Date of service<br>● Last name and first initial<br>● HIC number<br><br>Items must match exactly. | **Assigned Claims**<br>Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary.<br><br>**Non-Assigned Claims**<br>Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied.<br><br>You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information. | |

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

| IF THE CONTACT IS: | AND: | YOU MUST: | THEN YOU CAN: | REFERENCE |
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| 34. Billing Service/ Clearinghouse | Billing Service/ Clearinghouse inquires about claims information on a pre-claim basis. | | No claims related information may be released on a pre-claim basis without the beneficiary's authorization. | MCM § 3021<br><br>MIM § 3601<br><br>Program Memorandum Intermediaries/Carriers Transmittal AB-03-034, Change Request 2484, Dated 02/28/03 |
| 35. Billing Service/ Clearinghouse | Billing Service/ Clearinghouse inquires about claims information on a post-claim basis. | Validate the employing provider/physician/ supplier's name and identification number.<br><br>Verify beneficiary's:<br>● Date of service<br>● Last name and first initial<br>● HIC number<br><br>Items must match exactly. | You may speak with the billing service/clearinghouse about the employing provider/physician/ supplier's claims. | MCM § 3021<br><br>MIM § 3601<br><br>Program Memorandum Intermediaries/Carriers Transmittal AB-03-034, Change Request 2484, Dated 02/28/03 |
| 36. Billing Service/ Clearinghouse | Billing Service/ Clearinghouse inquires about beneficiary eligibility information, which would be available via EDI.<br><br>This information may only be used in order to submit an accurate claim. | Validate the employing provider/physician/supplier's name and identification number.<br><br>Verify the beneficiary's:<br>● Last name and first initial<br>● Date of birth<br>● HIC number<br>● Gender<br><br>Items must match exactly. | Release the following eligibility information on a pre-claim or post-claim basis:<br><br>– Part A and B entitlement and termination dates<br>– Deductible met (yes or no) for current and prior years<br>– HMO information: "cost" or "risk" plan, effective and termination dates<br>– MSP activity (yes or no)<br>– Home health start and end dates and servicing provider's name. | MCM §3021 |

DEFINITIONS:

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

DISCLOSURE – Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of minor. The individual to whom the information pertains must authorize (either verbally or in writing) the disclosure of his/her personal information to the third party.

A REPRESENTATIVE PAYEE is a person or organization appointed by the Social Security Administration when it is determined that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use a representative payee. However, if a beneficiary is judged legally incompetent, they must have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.

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

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

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

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

A BILLING SERVICE collects provider/physician/supplier claim information and bills the appropriate insurance companies, including Medicare. It may provide claims billing service only, or provide full financial accounting and/or other services. Billing services may view beneficiary or provider data to perform their obligations to the provider/physician/supplier, and if the provider/physician/supplier designates them for that access. To qualify as a billing service, the entity must submit initial claims on the provider/physician/supplier's behalf.

A CLEARINGHOUSE transfers or moves EDI transactions for a provider/physician/supplier and translates the data into the format required by a health care trading partner, such as a payer. A clearinghouse accepts multiple types of claims and generally other EDI transactions and sends them to various payers, including Medicare. They also accept EDI transactions from payers for routing to and/or reformatting for providers/physicians/suppliers. They perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider/physician/supplier. Clearinghouses frequently reformat data for various payers and manage acknowledgements and remittance advice. Clearinghouses ordinarily submit initial claims and may qualify as a billing service.

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

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

GENERAL NOTES:

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

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

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

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

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

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

The written authorization must:

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

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

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

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

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

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

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

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

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

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