CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-01 Medicare General Information, Eligibility, and Entitlement	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 124	**Date: May 17, 2019**
	Change Request 11240

SUBJECT: Update to Publication (Pub.) 100-01 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Pub. 100-01 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: June 18, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 18, 2019
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	2/Table of Contents/50/Identifying the Patient's Health Insurance Record Using the Medicare Card
R	2/Table of Contents/50/50.1/Medicare Beneficiary Identifier (Mbi)
R	2/50/Identifying the Patient's Health Insurance Record Using the Medicare Card
R	2/50/50.1/Medicare Beneficiary Identifier (Mbi)
D	2/50/50.2/Health Insurance Claims Numbers (HICNs)
D	2/50/50.3/HICNs Assigned by CMS
D	2/50/50.4/HICNs Assigned by the RRB
R	6/170/Disclosure of Health Insurance Information by Providers
R	6/170/170.4/Disclosure to Third Parties for Other Than program Purposes
R	6/170/170.6/Disclosure of Itemized Statement to an Individual for Any Item or Service Provided
R	7/30/30.20/Implementing a Files Management Program
R	7/30/30.30.2/Description of Records
R	7/30/30.40.1/Segment File Accumulation Period
R	7/30/30.90/Exhibit 1 - Preprinted Container Label
R	7/30/30.90/Exhibit 2 - Minimum Label Data Required for Unlabeled Boxes
R	7/30/30.90/Exhibit 5 - Certificate of Authenticity - START

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-01	Transmittal: 124	Date: May 17, 2019	Change Request: 11240

SUBJECT: Update to Publication (Pub.) 100-01 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: June 18, 2019
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IMPLEMENTATION DATE: June 18, 2019

I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub. 100-01.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11240.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100-01.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare General Information, Eligibility, and Entitlement

Chapter 2 - Hospital Insurance and Supplementary Medical Insurance

Table of Contents

(Rev.124, Issued: 05-17-19)

50 - Identifying the Patient's Health Insurance Record Using the *Medicare* Card

50.1 - *Medicare Beneficiary Identifier (Mbi)*

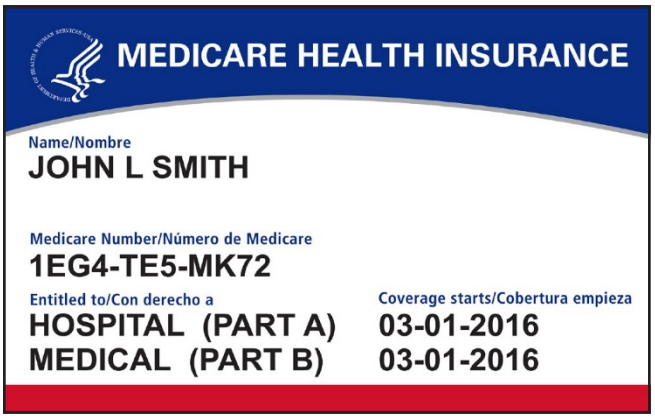
50 - Identifying the Patient's Health Insurance Record Using the *Medicare* Card

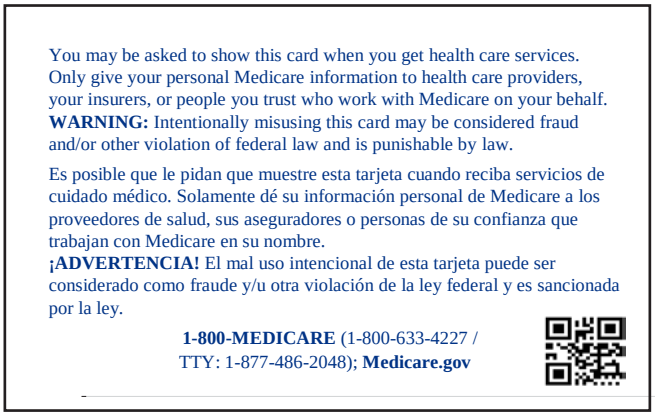
(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

As part of health insurance electronic data processing, *Medicare* cards are issued by CMS to individuals who have established entitlement to health insurance.

Below is an example of the Medicare card.

New Medicare Card





New Medicare Card Front *New Medicare Card Back*

The *Medicare* card is used to identify the individual as being entitled and also serves as a source of information required to process Medicare claims or bills. It displays the beneficiary's name, *Medicare number*, and effective date of entitlement to hospital insurance and/or medical insurance. The Social Security Administration's Social Security Office assists in replacing a lost or destroyed *Medicare* cards.

50.1 - *Medicare Beneficiary Identifier (Mbi)*

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

The MBI has 11 characters, like the Health Insurance Claim Number (HICN), which can have up to 11. Each MBI is randomly generated. This makes MBIs different than HICNs, which are based on the Social Security Numbers (SSNs) of people with Medicare. The MBI's characters are "non-intelligent" so they don't have any hidden or special meaning.
MBIs are numbers and upper-case letters. We'll use numbers 0-9 and all letters from A to Z, except for S, L, O, I, B, and Z. This will help the characters be easier to read. If you use lowercase letters, our system will convert them to uppercase letters.

The MBI will contain letters and numbers. Here's an example: 1EG4-TE5-MK73

- *The MBI's 2nd, 5th, 8th, and 9th characters will always be a letter.*
- *Characters 1, 4, 7, 10, and 11 will always be a number.*
- *The 3rd and 6th characters will be a letter or a number.*
- *The dashes aren't used as part of the MBI. They won't be entered into computer systems or used in file formats.*

Medicare General Information, Eligibility, and Entitlement

Chapter 6 - Disclosure of Information

170 - Disclosure of Health Insurance Information by Providers

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Records and information, acquired in the administration of the Medicare program, may be disclosed only under prescribed rules and regulations or under the authority of the Administrator of CMS. Information furnished specifically for purposes of a claim under the health insurance program is subject to these rules and regulations. These regulations apply to Governmental or private agencies that participate in program administration. These entities include the following:

- Institutions;
- Agencies;
- Person(s) providing services; and
- Providers of services.

The type of information includes, but is not limited to, the following:

- The individual's *Medicare beneficiary identifier*;
- Facts regarding the individual's entitlement to health insurance benefits; and
- Medical and other information obtained from CMS, a MAC (contractor).

Information not subject to these rules and regulations includes information in the provider's own records, such as the following:

- Name;
- Date of Birth;
- Sex;
- Marital status; and
- Address.

A provider's own records are, however, subject to requirements listed in the "Conditions of Participation", that "Patient's records be kept confidential (20 CFR Part 405.126). These records may also be subject to State or local laws governing disclosure.

Providers are also responsible for following conditions for coverage. A provider or supplier that receives a request for disclosure of information about a Medicare beneficiary, Medicare claim, or related information

that it may not disclose, should refer the requestor to the appropriate contractor for further consideration of the request.

170.4 - Disclosure to Third Parties for Other Than program Purposes

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Information obtained from CMS or its contractor is confidential and may be disclosed only under conditions prescribed in rules and regulations or on the express authorization of the Administrator of CMS. However, certain limited information about a beneficiary's Medicare eligibility status and related claims information may be released to third party payers with the beneficiary's express authorization.

The following information may be released subject to necessary authorization:

- *Medicare beneficiary identifier*;
- Coinsurance and deductible status;
- Dates of entitlement to Medicare;
- Copies of Medicare claims forms;
- Medicare report of eligibility; and
- Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN).

Providers should refer requests for other information to the contractor. Contractors refer requests to the CMS regional office.

The provider or supplier will adhere to the following authorization guidelines to ensure that information is not released without the required authorization. Authorization must:

- Be in writing;
- Be signed and dated by the individual or someone authorized to act on the individual's behalf;
- Specify the name of the provider authorized to disclose information;
- Specify what information the individual is authorizing the provider to disclose;
- Specify the names of the third party payers to whom the information is being released;
- Specify the purpose for which the information is being released;
- Specify an expiration date for the authorization that should not exceed 2 years from the date it was signed; and
- Specify that it may be revoked at any time.

170.6 - Disclosure of Itemized Statement to an Individual for Any Item or Service Provided

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. General

Section 4311 of the Balanced Budget Act of 1997 requires that if a Medicare beneficiary submits a written request to a health services provider for an itemized statement for any Medicare item or service provided to that beneficiary, the provider must furnish this statement within 30 days of the request. The law also states that a health services provider not furnishing this itemized statement may be subject to a civil monetary penalty of up to $100 for each unfulfilled request. Since most institutional health practices have established an itemized billing system for internal accounting procedures as well as for billing other payers, the furnishing of an itemized statement should not pose any significant additional burden.

B. 30-Day Period to Furnish Statement

The provider will furnish to the individual described above, or duly authorized representative, no later than 30 days after receipt of the request, an itemized statement describing each item or service provided to the individual requesting the itemized statement.

C. Suggested Contents of Itemized Statement

Although §4311 of the Balanced Budget Act of 1997 does not specify the contents of an itemized statement, suggestions for the types of information that might be helpful for a beneficiary to receive on any statement include: beneficiary name, date(s) of service, description of item or service furnished, number of units furnished, provider charges, and an internal reference or tracking number. If Medicare has adjudicated the claim, additional information the provider can include are: amounts paid by Medicare, beneficiary responsibility for co-insurance, and *Medicare beneficiary identifier*. The statement should also include a name and telephone number for the beneficiary to call if there are further questions.

D. Penalty

A knowing failure to furnish the itemized statement shall be subject to a civil monetary penalty of up to $100 for each such failure.

General Information, Eligibility, and Entitlement Manual

Chapter 7 - Contract Administrative Requirements

30.20 - Implementing a Files Management Program

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Adequate records management controls over the creation of contractor files must insure that important policies and decision are adequately recorded, routine operational paper work is kept to a minimum, and the accumulation of unnecessary files is prevented. Effective techniques in this area include the application of systems for the control of correspondence and forms, the minimizing of duplicate files, and the disposal without filing of transitory material that has no value for record purposes.

CMS expects each contractor to establish an appropriate program for the management of its files. The following actions are generally basic to such a files management program.

A. Standardize classification and filing schemes to:

1. Achieve maximum uniformity and ease in maintaining and using program records;

2. Facilitate disposal of records in accordance with applicable records disposal schedules; and

3. Facilitate possible later consolidation of identical type files presently maintained at different locations.

B. Formally authorize official file locations. Prohibit the maintenance of files at other than authorized locations.

C. Standardize reference service procedures to facilitate the finding, charge-out, and refiling of records.

D. File accumulations of papers received at file locations on a daily basis.

E. Audit periodically a representative sample of the files for duplication, misclassification, or misfiles. In addition to the above, the contractor's program must:

1. Establish and implement standards and procedures issued by CMS. Such CMS standards and procedures relate to:

   a. Classifying, indexing, and filing records;

   b. Providing reference services to filed records;

   c. Locating active files to facilitate use of the records; and

d. Reviewing the program periodically to determine the adequacy of the system and its effectiveness in meeting requests.

2. Ensure that the standards, guides, and instructions developed for the files management program are readily available to all employees concerned with the files operations. In addition, give pertinent information for users of files and references services the widest possible dissemination.

3. File accumulations of papers received at file locations on a daily basis.

4. Audit periodically a representative sample of the files for duplications, misclassification, or misfiles.

The methods used in maintaining, using, and disposing of these files vary with the contractor. Variations depend on the filing and control methods established (e.g., provider number, *Medicare beneficiary identifier*, date, name, or other sequence) to record requests from providers; to furnish replies; to check on overdue cases; to control cases for completion of processing; to control cases requiring some type of investigation or additional documentation; to retain completed cases for history or other reference; to maintain for audits; and to schedule for transfer to other storage areas. Other variances may be due to computer or clerical practices; workload volume; review initiated at time of notice of admission, at time of start of care, at time of request for advance payment or at time of receipt of billing form; and other considerations.

30.30.2 - Description of Records

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

1. Medicare Claims Records:

A. A/B MAC (A) or (HHH) Billing Records (**FROZEN - DO NOT DESTROY)**

These files consist of Inpatient and/or Outpatient Billing forms, and other documents used to bill for services processed by A/B MACs (A) or (HHH) i.e., inpatient hospital, outpatient hospital, SNF, hospice, home health, etc.

DISPOSITION: Once the freeze is lifted, cutoff at the close of the CY in which paid. Destroy 6 years and 3 months after cutoff.

B. A/B MAC (B) or DME MAC Billing Records **(FROZEN - DO NOT DESTROY)**

These files consist of Requests for Payment and similar forms. Also included are itemized bills, correspondence (including correspondence with district offices), and comparable documents used to support payment to beneficiaries, physicians, and other suppliers of services under the Supplemental Medical Insurance (SMI) Program.

DISPOSITION: Once the freeze is lifted, cutoff at the close of the CY in which paid. Destroy 6 years and 3 months after cutoff.

2. Medicare Benefit Check Records (FROZEN - DO NOT DESTROY)

These files consist of paid checks that contractors receive from banks covering amounts paid to providers of service, beneficiaries, physicians, and other suppliers of service under the Hospital Insurance and Supplementary Medical Insurance (SMI) programs. Also included are check vouchers and cancelled or voided checks resulting from nonreceipt, loss, theft, or non-delivery.

Disposition: The contractor cuts off the file at the close of the calendar year in which issued, holds the file for 1 additional year, and then transfers it to inactive storage. Once the freeze is lifted, the file is destroyed after a total of 6 years and 3 months retention.

When fraud or overutilization of services is involved, the contractor retains the hard copy claim until 3 months after the resolution of the investigation OR reverts to normal disposition, whichever is longer.

3. Medicare Summary Notices (MSNs) (FROZEN - DO NOT DESTROY)

These files consist of MSNs used to advise beneficiaries about remaining Part A benefits, Part A and Part B deductible status, and about applying for complementary health benefits.

Disposition: The contractor cuts off the file at the close of the calendar year in which benefit was paid or denied, as applicable, holds for 1 additional year and then transfers to inactive storage. Once the freeze is lifted, remove them from inactive storage for destruction after a total of 6 years and 3 months retention from cut off.

4. Reconsideration and Hearing Case Files - Hospital Insurance Program (FROZEN - DO NOT DESTROY)

Reconsideration records accumulate when a beneficiary or their representative is dissatisfied with the A/B MAC (A) or (HHH)'s determination denying payment, or with the amount of benefits payable on the beneficiary's behalf under the Hospital Insurance Program and files either an expressed or implied request for reconsideration. Hearing case records accumulate when a beneficiary or their representative is dissatisfied with the reconsideration determination and requests a hearing; and if still dissatisfied after the hearing, files for a subsequent court review. Included are Forms CMS-2649, Request for Hearing; CMS-561, Request for Reconsideration; or their equivalents. Also included are evidence furnished by beneficiaries or their representatives, correspondence, CMS determinations, Administrative Law Judge decisions, original bills, Appeals Council decisions and similar material.

Disposition: Once the freeze is lifted, the contractor disposes of these records in accordance with instructions for Medicare claims records.

5. Review and Fair Hearing Case Files - Supplementary Medical Insurance Program (FROZEN - DO NOT DESTROY)

This category includes files accumulated when a beneficiary, physician, provider, or other supplier of service is dissatisfied with the MAC’s determination denying a request for payment, or with the amount of the payment, or with the reasonable promptness of action on a request for payment. Included are copies of claimant's requests for review, relevant written statements or evidence, notices of adverse formal review decisions, requests for hearings to protest the adverse decisions, hearings proceedings, hearing officers' final decisions, and other comparable papers.

Disposition: The contractor places these records in an inactive file upon final action on the case. It cuts off the inactive file at the close of the calendar year in which the final action was taken, and holds it for 2 additional years, then transfers it to off-site storage. Once the freeze is lifted, these records can be destroyed when 5 years old.

6. A/B MACs (A) and (HHH) and A/B MAC (B) or DME MAC Administrative Budget Estimate and Cost Report Form (FROZEN - DO NOT DESTROY)

These files consist of all uses of the Administrative Cost and Budget Report, CMS-1523 for A/B MAC (B) or DME MAC and CMS-1524 for A/B MACs (A) or (HHH). This form is a multi-use document and issued for budget and cost reporting activities.

Specific uses are:

a. Budget request, supplemental budget request, notice of budget approval, interim expenditure report.

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

b. Supplemental Budget Request

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

c. Notice of Budget Approval. The MAC's certified funding authority for the fiscal year. Include all supporting schedules, correspondence and justification.

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

d. Interim Expenditure Report. Cumulative fiscal year to date expenditures incurred by the MAC. Include all supporting schedules, correspondence and justifications.

Disposition: Once the freeze is lifted, destroy after a total retention of 3 years after HHS audit and final settlement.

e. Final Administrative Cost Proposal. The final statement of expenditures for the fiscal year. This form is used as the basis for final settlement of allowable costs. Include all supporting schedules, correspondence, HHS or GAO audit reports on administrative cost and benefits payments.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months after HHS audit and final settlement.

7. MAC Letter of Credit Files (FROZEN - DO NOT DESTROY)

These records are authorizations to a Federal Reserve Bank to disburse funds to designated MACs' banks on behalf of CMS upon presentation of request for funds for collection through the Federal Reserve System. Included are Standard Form 1193, Letter of Credit or its equivalent, and amending letters.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months after the year in which the letters of credit are cancelled.

8. A/B MAC (A) or (HHH) Payment Vouchers and Transmittal Files (FROZEN - DO NOT DESTROY)

These consist of Form TFS-218, Request for Funds, and similar documents prepared by the A/B MAC (A) or (HHH)'s servicing bank to obtain Federal funds for benefits paid in administering medical insurance programs. Also included is Form CMS-1521, Payment Voucher on Letter of Credit, a transmittal that forwards information on request for funds to CMS and shows the purpose for which funds were drawn, i.e.,

hospital insurance benefits, supplementary medical insurance benefits, and total amount of payment vouchers.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months or after HHS audit and final settlement, whichever is later.

9. A/B MAC or DME MAC Payment Vouchers and Transmittal Files (FROZEN - DO NOT DESTROY)

These files consist of form TSF-5805, Request for Funds, and similar documents prepared by the A/B MAC (B) or DME MAC's servicing bank to obtain Federal funds for benefits paid in administering medical insurance benefit programs. Also included is Form CMS-1521, Payment Voucher on Letter of Credit Transmittal, a transmittal that forwards information on request for funds to CMS and shows the purpose for which funds were drawn, i.e., SMI benefits and total amount of payment vouchers.

Disposition: Once the freeze is lifted, destroy after a total retention of 6 years and 3 months or HHS audit and final settlement, whichever is later.

10. A/BMAC (A) or (HHH) Monthly Financial Report Files

These are reports submitted monthly to provide CMS with the basic data to reconcile CMS's accounts with those that contractors maintain. Included are Form CMS-1522, Monthly Intermediary Financial Report and attachments.

Disposition: Destroy after HHS audit and final settlement.

11. A/B MAC (B) or DME MAC Performance Report Files

These consist of Forms CMS-1565, Health Insurance for the Aged Program Carrier Performance Reports, and equivalent documents prepared monthly summarizing each A/B MAC (B) or DME MAC's performance in processing claims. The information provides management information needed for budgeting, financing, work planning, performance evaluation, and identifying operating problems.

Disposition: Destroy after 3 years.

12. Ambulance Supplier Certification Files

These consist of certifications of suppliers of ambulance services.

Disposition: Destroy 1 year from the end of the year when certification requirements are no longer met.

13. Requests for Assistance from District Offices (DOs) (FROZEN - DO NOT DESTROY)

These consist of correspondence and forms submitted to the DO for development of additional information or documents relating to a Medicare claim, e.g., incorrect name or *Medicare beneficiary identifier* and similar errors that prevent the processing of a claim.

Disposition: Once the freeze is lifted, dispose of in accordance with instructions for claims records.

14. A/B MAC (A) or (HHH) Workload Reports Files

These consist of monthly statistical reports on the status of A/B MAC (A) or (HHH) workloads used by CMS to identify basic management data needed for budgeting, financing, work planning, and progress evaluation. Included is Form CMS-1566, Health Insurance for the Aged Program FI Workload Report, or equivalent documents.

Disposition: Destroy after 3 years.

15. Overpayment and Duplicate Charge Detection Activity Report Files - A/B MAC (B) or DME MAC Report

These consist of quarterly reports summarizing overpayment and duplicate charge detection activity. They are used to tabulate data on the number of cases in which overpayments are recovered, the total dollar amount of money overpaid, causes of overpayments, number of duplicated charges detected, and similar information.

Disposition: Destroy after 3 years.

16. Medicare Beneficiary Correspondence Files (FROZEN - DO NOT DESTROY)
These accumulate as a result of inquiries and complaints received by CO, RO, and contractors and **do not** include any correspondence that is related to a claim file.

Disposition: Destroy 3 months after the date of the response to the correspondence. If a response is not required, the contractor destroys the material 3 months after the date of the correspondence.

Where the material documents a specific claim, appeal, or similar case, the contractor follows the instructions for claims records.

17. MAC Contract Files

These consist of agreements entered into with MACs by the Secretary under the provisions of §§1816 and 1842 of the Act by which MACs agree to perform certain functions in administering the Hospital Insurance and Supplementary Medical Insurance programs. As such, they provide basic documentation of the manner in which these programs are implemented. Included are modifications and amendments.

Disposition: Destroy 3 years after supersession or termination, as applicable.

18. MAC Subcontract Files

These consist of copies of MAC agreements with subcontractors regarding performance of an audit of providers' costs A/B MAC (A) or (HHH), leases for building space, equipment, and consulting and other services. Included are CMS approvals, amendments, and similar papers.

Disposition: Destroy 3 years after termination of agreement.

19. Contract Performance Review Visit Files

These consist of documents relating to scheduled or special visits to Medicare contractors to review your Medicare operations, to determine the degree of adherence to established policy and adequacy of service to the public, and to verify the accuracy of reporting. Included are reports of staff visits, follow-up reports, communications concerning improvements in operations, and any other related documents.

Disposition: Destroy 4 years after the close of the calendar year in which action on the review is completed.

20. MAC Computer Printout Records (FROZEN - DO NOT DESTROY)

These consist of computer printouts used in processing, paying, and controlling Medicare claims.

a. Pending and process listing, payment listing, duplicate check control, master file update control, and profiles of physicians and other suppliers of services.

Disposition: Once the freeze is lifted, destroy 4 years after the close of the calendar year in which payment was made.

b. Check listing and bank reconciliation.

Disposition: Once the freeze is lifted, destroy 6 years after the close of the calendar year in which paid or voided.

c. CWF inquiry or response listings, transaction listing, activity listings, posting exceptions, analysis of posting errors, claims inventory control, edit input transactions, and aging of open claims.

Disposition: Once the freeze is lifted, destroy 3 years after processing. (Contractors with the capability of electronically retaining the CWF data may destroy the paper copies after the tapes have been verified.)

21. A/B MAC (A) or (HHH) Cost Report Files (FROZEN - DO NOT DESTROY)

These consist of cost reports submitted by providers to A/B MACs (A) or (HHH) for determining Medicare reimbursable costs in accordance with regulations and the principles of reimbursement. The cost report file includes: (a) a copy of the original cost report form as filed by the provider; (b) copies of all decisions made by field auditors, including those subsequently reversed by senior auditors; (c) a copy of the Audit Adjustment Report; (d) a copy of revised cost report schedules (or a revised cost report); (e) a copy of the notice of program reimbursement; (f) a copy of the audit report when prepared by the A/B MAC (A) or (HHH) staff accountants and the supporting audit working papers.

Disposition: The A/B MAC (A) or (HHH) maintains the cost report on premises for 3 years after the Notice of Amount of Medicare Program Reimbursement has been issued to the provider, and then transfers cost report to inactive storage. Once the freeze is lifted, destroy the cost report files 5 years after receipt.

(Exception: A cost report file that is the subject of an appeal, litigation, or any other administrative proceedings, e.g., collection of outstanding overpayments or bankruptcies is not sent to inactive storage until the case has been settled or closed and all the review and appeal procedures have been exhausted.)

22. MAC Closing Agreements

These files contain the accepted final settlement for all MAC costs of administration and consist of the closing agreement, appendix, and schedules of balances due the MAC or Secretary.

Disposition: The MAC cuts off files at the end of the fiscal year. It holds the file in office 1 year after HHS audit and final settlement then transfers to inactive storage. Destroy these 10 years after HHS audit and final settlement.

23. Medicare Data Match Files (FROZEN - DO NOT DESTROY)

Questionnaires, case files, employer records and data match records.

Disposition: Cutoff files at the end of the calendar month and transfer to an offsite storage facility. Once the freeze is lifted, destroy 6 years and 3 months after cutoff.

24. Initial Enrollment Questionnaire (FROZEN - DO NOT DESTROY)

Questionnaires sent to newly enrolled Medicare beneficiaries to obtain information on whether the individual is covered under a primary insurance plan.

Disposition: Once the freeze is lifted, destroy/delete when 5 years old.

25. Provider Statistical and Reimbursement Reports (PS&RR) - (FROZEN - DO NOT DESTROY)

These files consist of EDP printouts or microforms showing summaries of payments to hospitals, skilled nursing facilities, home health agencies, and other providers of service. They are used to effect cost settlements between the A/B MACs (A) or (HHH) and the providers for program validation purposes and to determine accuracy of cost reports. These reports contain Part A and Part B inpatient and outpatient information, inpatient statistics, total bills, covered costs, and other related data.

Disposition: Once the freeze is lifted, destroy 5 years after completion of audit and/or settlement process for provider cost report for corresponding fiscal year.

26. A/B MAC (B) or DME MAC Claims Processing File

Consists of documents relating to Part B A/B MAC (B) or DME MAC performance. Submitted on a weekly basis electronically to CMS's data center.

Disposition: Destroy after 6 months.

30.40.1 - Segment File Accumulation Period

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

In order to facilitate the transfer of material to an approved offsite storage facility, MACs maintain the permanent claims records files in accumulation period segments, based on the starting date of initial payment or denial. Each contractor may select an accumulation period segment of from 6 months to 2 years in length after such starting date. The contractor may also adopt one period of time on an ongoing basis, but a different period for the initial segment.

Contractors who have been authorized to microfilm/image claims records may be authorized to shorten the segment file accumulation period. (See §30.50.)

After a file segment is closed, the contractor retains the records contained in that segment until time to transfer them to an approved storage facility. (See §§30.40.2 and 30.40.3 for definition of retention periods.)

EXCEPTION: Contractors who maintain total history files by individual *Medicare beneficiary identifier*, name, or other sequence, may wish to operate under some procedure other than by a file segment accumulation period.

Such alternative procedures may be used provided purging techniques to withdraw inactive records are established which meet one of the following requirements:

1. They avoid costly and time consuming manual selection of material to be purged from each folder.

2. Separators are used for each year's (or other period's) material within the history folder to facilitate rapid selection.

3. The capability exists (e.g., computer prepared lists) to identify inactive cases in which no action has been taken for 12 months or more for selection as purged segments to be transferred to an approved storage facility when such a purge becomes necessary.

4. Periods for purging and transfer are carefully selected by studying rates of reference to claims materials in order to select a realistic inactive period to avoid unnecessary recall from the storage facility.

Although contractors who follow a purging procedure need not establish a standard retention period, the establishment of one of these requirements provides them with the potential of transferring inactive files to a storage facility if such a transfer should become desirable. When such a purge is begun, the contractor should make no transfer to the storage facility until the entire purging operation for the period is completed.

Exhibit 1 - Preprinted Container Label

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

ACCESSION NO. CARTON NO. of

AGENCY MAJOR SUBDIVISION

DESCRIPTION OF RECORDS (BRIEF)

Instructions for Completing Label

Accession No. - Control number you assign to each shipment of records.

Carton No. - Show the box number and also the total number of boxes in the same shipment, e.g., 5 of 60.

Agency - Enter CMS

Major Subdivision - Enter the name of the MAC in this block.

Description of Records - Enter “Part A A/B MAC (A) or (HHH) or Part B A/B MAC (B) or DME MAC - Medicare bills and related claims records received, processed and paid (including dates),” or “Part A A/B MAC (A) or (HHH) - Medicare Fiscal Records, canceled checks and related records (including dates).”

Also, for each box, show the inclusive claims numbers, dates, etc., depending on arrangement of records.

Exhibit 2 - Minimum Label Data Required for Unlabeled Boxes

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

For boxes not having a preprinted label (see Exhibit 1 above), enter the label as shown:

CARTON _____ OF _____ CARTONS

CMS

MAC NAME

CITY, STATE

MAC - PAID MEDICARE BILLS

DATE TO DATE

(086-12-8462A--093-14-2362T)

Instructions For Labeling Boxes

Use broad-point felt tip marker to facilitate shelf reference.

Minimum Label Data

Accession Number - Control number assigned to each shipment of records.

Carton No. - Show the box number and also total boxes in the shipment, e.g., 5 of 60.

Agency - Show "CMS."

Office - Show the name of MAC with city and State address.

Description of Records - For Medicare bills and related records, show: "MAC name - Paid Medicare Bills (inclusive dates)." For fiscal records, canceled checks, and related records, show: " MAC - Medicare Fiscal Records (inclusive dates)."

First and Last Entry in Box - Show the inclusive claim number, terminal digit numbers, check numbers, or other designated key numbers.

Exhibit 5 - Certificate of Authenticity - START

(Rev.124, Issued: 05-17-19, Effective: 06-18-19, Implementation: 06-18-19

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

CONTRACTOR NAME AND ADDRESS

CERTIFICATE OF AUTHENTICITY

START

THIS IS TO CERTIFY THAT THE MICROPHOTOGRAPHIC IMAGES APPEARING ON THIS ROLL OF MICROFILM:

STARTING WITH (e.g., control number, *Medicare beneficiary identifier*)

ARE ACCURATE REPRODUCTIONS OF THE RECORDS OF:

AND WERE MICROFILMED IN THE REGULAR COURSE OF BUSINESS PURSUANT TO ESTABLISHED ROUTINE COMPANY POLICY FOR SYSTEMS UTILIZATION AND OR FOR THE MAINTENANCE AND PRESERVATION OF SUCH RECORDS THROUGH THE STORAGE OF SUCH MICROFILMS IN PROTECTED LOCATIONS.

IT IS FURTHER CERTIFIED THAT THE PHOTOGRAPHIC PROCESSES USED FOR MICROFILMING OF THE ABOVE RECORDS WERE ACCOMPLISHED IN A MANNER AND ON

MICROFILM THAT MEETS THE RECOMMENDED REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC REPRODUCTIONS.

Date Microfilmed

Camera Operator

Location

Authorized Signature