CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-09 Medicare Contractor Beneficiary and Provider Communications	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 41	**Date: February 8, 2019**
	Change Request 11059

SUBJECT: Update to Publication (Pub.) 100-09 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This change request updates the New Medicare Card Project-related language in Pub 100-09. 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: March 12, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 12, 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	2/20.2.4/Telephone Responses to Complex Beneficiary Inquiries
R	6/30.7/Fraud and Abuse

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

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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number 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 100-09.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number-based Health Insurance Claim Number 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.

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	
11059.1	The Medicare Administrative Contractors shall be aware of the updated language for the New Medicare Card Project in Pub. 100-09.	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): Kimberly Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov , Tracey Mackey, 410-786-5736 or Tracey.Mackey@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 Contractor Beneficiary and Provider Communications Manual
Chapter 2 - Beneficiary Customer Services

20.2.4 - Telephone Responses to Complex Beneficiary Inquiries
(Rev.41, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12-19)

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.

MACs may respond to complex written beneficiary inquiries by telephone if, in their discretion, MACs determine that a telephone response is appropriate.

For tracking and evaluation purposes, MACs shall develop a report of contact for each telephone response to a complex written beneficiary inquiry. The report of contact shall be retained in the same manner and time frame as written responses to complex written beneficiary inquiries. All reports of contact shall contain the following information:

- Beneficiary name;
- Telephone number;
- *Medicare beneficiary identifier*;
- Date of contact;
- Internal inquiry control number;
- Subject/nature of inquiry
- Summary of discussion;
- Status - closed/pending research/ open
- Follow - up action required (if any); and
- Name of the PRRS correspondent who handled the inquiry

If the beneficiary requests a copy of the report of contact, a response letter containing all the information in the "Summary of Discussion" shall be sent. MACs may send the information via e-mail or fax if requested by the beneficiary and if the response does not contain any financial or PHI. It is not acceptable to send the report of contact itself. All timeliness and quality guidelines for a written response apply to the response containing the "Summary of Discussion."

If the MAC cannot reach the beneficiary by telephone, the MAC shall develop a written response. It is not acceptable to leave a message/response on the beneficiary's voicemail containing financial, PII, or PHI.

Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

30.7 - Fraud and Abuse

(Rev.41, Issued: 02-08-19, Effective: 03-12-19, Implementation: 03-12-19)

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.

MACs shall ensure that when a provider inquiry or complaint of potential fraud and abuse is received, it is immediately sent, along with a referral package, to the Program Safeguard Contractor (PSC) or Zone Program Integrity Contractor (ZPIC). The referral package shall consist of the following information:

1. Provider name and address.
2. Type of provider involved in the allegation and the perpetrator, if an employee of a provider.
3. Type of service involved in the allegation.
4. Relationship to the provider (for example, employee or another provider).
5. Place of service.
6. Nature of the allegation(s).
7. Timeframe of the allegation(s).
8. Date of service, procedure code(s).
9. Name and telephone number of the MAC employee who received the complaint.
10. Beneficiary name who received the service, if known.
11. *Medicare beneficiary identifier* of the beneficiary receiving the service, if known.
12. Date the referral is forwarded to the PSC or ZPIC.