CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3441	**Date: January 15 , 2016**
	Change Request 9457

SUBJECT: Update to Pub. 100-04, Chapter 02 Admission and Registration Requirements, for Provider Verification of Beneficiary Eligibility and Entitlement,

I. SUMMARY OF CHANGES: This Change Request contains language-only updates for MAC implementation and ASC X12 language in Pub 100-04, Chapter 02. 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. In addition, several outdated sections have been removed.

EFFECTIVE DATE: MAC Implementation: December 31, 2013; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: MAC Implementation: February 16, 2016; ASC X12: February 16, 2016 from issuance

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
R	2/01/ Purpose of Chapter
R	2/05/ Definition of Provider and Supplier
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R	2/10.1.1/ Changes to HICNs
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R	2/10.2/ Prohibition Against Waiver of Health Insurance Benefits as a Condition of Admission
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R	2/30.6.2/ Reserved
R	2/30.6.3/ Reserved
R	2/30.6.4/ Reserved
R	2/30.6.5/ Reserved
R	2/30.6.6/ Reserved
R	2/30.8/ Reserved
R	2/30.10/ Reserved
R	2/30.11/ Reserved
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	2/30.14/ Reserved
R	2/30.15/ Reserved
R	2/30.16/ Reserved
R	2/30.17/ Reserved
R	2/30.18/ Reserved
R	2/30.19/ Reserved
R	2/30.19.1/Reserved
R	2/30.19.2/ Reserved
R	2/30.19.3/ Reserved
R	2/30.19.4/ Reserved
R	2/30.20/ Reserved
R	2/30.21.1/ HMO-Related Master File Corrections
R	2/30.22/ Provider Problems Obtaining Entitlement Information
R	2/60/ Reserved
R	2/60.1/ Reserved
R	2/60.2/ Reserved
R	2/70/ SSO Assistance in Resolving Entitlement Status Problems
R	2/100/ Reserved
R	2/100.1/ Reserved
R	2/110/ Reserved
R	2/110.1/ Reserved
R	2/120/ Reserved

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. 100-04	Transmittal: 3441	Date: January 15, 2016	Change Request: 9457

SUBJECT: Update to Pub. 100-04, Chapter 02 Admission and Registration Requirements, for Provider Verification of Beneficiary Eligibility and Entitlement,

EFFECTIVE DATE: MAC Implementation: December 31, 2013; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: MAC Implementation: February 16, 2016; ASC X12: February 16, 2016 from issuance

I. GENERAL INFORMATION

A. Background: This Change Request contains language-only changes for updating ASC X12 and MAC implementation language in Pub 100-04, Chapter 02.

B. Policy: This Change Request (CR) contains language-only updates for MAC implementation and ASC X12 language in Pub 100-04, Chapter 02. 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	
9457.1	A/B MACs, DME MACs, and CEDI shall be aware of the updated language for ASC X12 and MAC implementation in Pub. 100 - 04, Chapter 02.	X	X	X	X					CEDI

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:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Cindy Murphy, 410-241-5074 or cindy.murphy@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 Claims Processing Manual
Chapter 2 - Admission and Registration Requirements

Table of Contents
(Rev.3441, Issued: 01-15-16)

01 - Purpose of Chapter

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

This chapter describes general requirements with respect to verifying an individual's Medicare eligibility and entitlement status for providers, suppliers, *A/B MACs (A), (B), and (HHH), and DME MACs*. It also includes general requirements for hospitals for determining the source admission for use later in the claims process.

05 - Definition of Provider and Supplier

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

This chapter uses the definition of provider and supplier found in 42 CFR 400.202. These are:

> **Provider** means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
>
> **Supplier** means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare.

Note that while rural health clinics, Federally qualified health centers, and renal dialysis facilities are suppliers under the regulation, they submit most claims to *A/B MACs (A)*.

10 - General Admission and Registration Rules

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

The following is a general description of requirements and prohibited activities that apply to admission for inpatient services or registration for other healthcare services.

Upon admission, Prospective Payment System (PPS) hospitals and acute care hospitals in areas with waivers from PPS are required to give the notice, "An Important Message from Medicare," to beneficiaries (available at www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads/RevisedImportantMessageFromMedicare05_2007.pdf). The facility inserts its Quality Improvement Organization's (QIO) name, address, and phone number. It provides this notice to each Medicare patient or the patient's representative. The CMS does not supply copies of the notice.

Upon admission of a Medicare beneficiary to an institution that bills Medicare, or as soon thereafter as practical, the provider must verify a patient's eligibility in order to process the bill. The provider may obtain this eligibility information directly from the patient or through the provider's *A/B MAC (A)'s* limited Medicare eligibility data. See §30.6. The provider contacts its *A/B MAC (A)* to obtain technical instructions regarding how this access may be implemented along with hardware/software compatibility details.

This information does not represent a definitive eligibility status. If the individual is not on file, the provider uses the usual admission and billing procedure in effect, independent of this data access.

Disclosure of CMS eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and may be used only for verifying a patient's eligibility to benefits under the

Medicare program. Penalties for misuse by anyone may result in being found guilty of a misdemeanor and paying a fine not more than $5,000.

10.1.1 - Changes to HICNs

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

Changes in an individual's entitlement to Medicare benefits may result in an individual being assigned a completely different HICN. For example, an individual not entitled to monthly benefits (000-00-0000T) marries and becomes entitled to wife's benefits on her husband's account (111-11-1111B). If a claim is submitted under the old HICN, the Common Working File (CWF) disposition code 51 will notify the *A/B MAC (A), (B), (HHH), or DME MAC* (whom we will refer to as the *MAC* when *all* are meant) of the new HICN. The *MAC* will annotate its records and use the new HICN when submitting future bills or claims.

10.1.2 - Contractor Procedures for Obtaining Missing or Incorrect Claim Numbers

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

Upon receipt of a claim or other paper on which the health insurance claim number is omitted, incomplete, inconsistent, or obviously incorrect, the *MAC* submits the claim to CWF with the best information it has available. Depending on the CWF reply, the *MAC* follows the instructions in Chapter 27 for handling various disposition codes, trailers, and error codes.

10.2 - Prohibition Against Waiver of Health Insurance Benefits as a Condition of Admission

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

Providers may not require, as a condition of admission or treatment, that a patient agree to waive the right to have services paid for under Medicare. Requiring such a "waiver" is inconsistent with the agreement with CMS, and the "waiver" is not binding upon the patient. Providers have agreed not to charge an individual (except for specified deductible and coinsurance amounts) for services for which such individual is entitled to have payment made or for which he/she would be entitled if the provider complied with the procedural and other requirements of the program. Further, under this provision, the provider must refund any amounts incorrectly collected.

Where a patient who has signed such a waiver, nevertheless, requests payment under the program, the provider must bill the *A/B MAC (A)* and refund any payments made by the patient, or on the patient's behalf, in excess of permissible charges.

10.5 - Hospital and Skilled Nursing Facility (SNF) Verification of Prior Hospital Stay Information for Determining Deductible and Benefit Period Status

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

If it has been determined that Medicare is the primary payer, the hospital or SNF must determine if the patient has been an inpatient in any hospital or SNF, including swing bed stays, during the prior 60 days. If so, the hospital or SNF must determine the admission and discharge dates and the number of days of hospitalization or skilled nursing (as applicable) the patient used in the current benefit period. The admission and discharge dates must be reported on the claim, and the number of days of hospitalization or skilled nursing (as applicable) must be used to calculate the hospital insurance copayment and the number of days remaining in the benefit period.

If the patient indicates he/she was not an inpatient within the last 60 days, the hospital applies the inpatient deductible to the current stay if it is a covered hospital admission. The *A/B MAC (A)* determines the accuracy of the claim data after receipt of the claim. The remittance advice received from the *A/B MAC (A)* reflects the amount of deductible (hospital claims) and coinsurance (hospital and SNF claims) applied. If this amount is different from what was billed, the hospital/SNF must correct the records accordingly.

10.9 - *A/B MAC (A), (B), or (HHH), or DME MAC* Requests to Verify Patient's HICN

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

Where the name and claim number information on a claim does not match the CMS central record, the *A/B MAC (A), (B), or (HHH), or DME MAC* will return the claim to the provider and request the provider to verify the information.

The provider will compare the name and number on the claim with that on provider records. If the information submitted was incorrect, the provider will return the claim to the *MAC* with the corrected information.

If, however, the information in the provider's records identifying the patient is the same as the information submitted on the claim, the provider will contact the SSO for assistance.

10.10 - *A/B MAC (A), (B), or (HHH) or DME MAC* Learns Beneficiary is an HMO Enrollee

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

If the *A/B MAC (A), (B), or (HHH), or DME MAC* determines from its records or its query to CMS that a patient is an HMO enrollee, the *MAC* will return the claim to the provider with instructions to request payment from the HMO for payment, if appropriate.

10.11 - Retroactive Entitlement

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

When an application for social security benefits is filed by a person 65 years of age or older, the person may inform the SSO that he/she received hospital services in the retroactive period of up to six months for which he/she may be entitled to benefits. In these cases, the provider may bill for covered retroactive services but must verify the patient's eligibility through the *A/B MAC (A), (B), or (HHH), or DME MAC* before billing. If the patient paid, the provider must refund the appropriate amount to the patient.

30 - Provider/Supplier Obtaining/Verifying the HICN and Entitlement Status

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

It is important that the patient's HICN be obtained and accurately recorded because the claim cannot be processed if the HICN is missing or incorrect. A social security number is not sufficient.

When a patient 65 years of age or over, or a younger patient who possibly has entitlement to Medicare as a disability beneficiary or under the provisions for coverage of persons needing a kidney transplantation or dialysis, is admitted or registered for services, the provider asks for the health insurance card, Temporary Notice of Medicare Eligibility, or other notice the patient has received from CMS or *an A/B MAC (A), (B), (HHH), or DME MAC* which shows the claim number. If a patient or prospective patient is within three months of age 65, or is disabled or has ESRD, and has not applied for HI entitlement, the provider advises

the patient to contact the SSO, or to have someone do so on the patient's behalf. The provider may arrange with the SSO to routinely bring such cases to the SSO's attention.

This requirement also applies to inpatient services for which no payment is due because providers are required to submit inpatient claims even when benefits are exhausted or are not payable for some reason. The CMS requires this data to record necessary benefit information on CMS records. Where the patient refuses to request payment and refuses to furnish information about his/her HICN, the provider documents the records accordingly and attempts to get the HICN from the SSO.

30.1 - Cross-Reference of HICN

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

If a beneficiary's entitlement to Medicare has been transferred from one HICN to another, the CWF will cross-reference the old number to the new number. If there has been utilization of benefits under each number, all data will be combined under the new number.

A. Disposition Code 51

1. If, after submitting the admission notice or Part B claim to CMS, the *MAC* receives a disposition code of 51 with trailer code 01 containing a possible HICN, the *MAC* investigates the new HICN, and if it believes the new HICN is correct, the *MAC* resubmits the claim under the new HICN. CWF responds with an appropriate disposition code and any associated trailers for processing the claim.

2. If the *MAC* receives a disposition code of 51 without trailer code 01, or after investigation determines the HICN in the 01 trailer is incorrect, it denies the claim using the following message:

> Payment cannot be made for the services you received from (name of provider) because we have no record of your Medicare number. Please write your correct number on the claim and resubmit the claim to (name of provider). If you think the number is right, check with your local Social Security Office.

B. Disposition Code 55

If CWF returns disposition code 55 and trailer code 08 containing an error code of 5052, indicating a mismatch in the beneficiary's personal characteristics, CWF will also return to the *MAC* what it believes to be the proper information on trailer code 10. The header portion of the response also contains the corrected sex and birth date, if applicable, of the beneficiary.

The *MAC* investigates the information provided, corrects the information on the claim, and resubmits it to CWF. If the *MAC* continues to receive a code 55, it contacts the Host through locally established procedures. See Chapter 27.

30.2 - Health Insurance (HI) Card

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

As part of health insurance electronic data processing, HI cards are issued by CMS (or by the RRB where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. (See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual.) The health insurance card is used to identify the individual as being entitled and serves as a source of information required to process Medicare claims or bills. The health insurance card displays the beneficiary's name, sex, HICN, and effective date of entitlement to hospital insurance and/or medical insurance.

If *any MAC* receives an inquiry about replacing a lost or destroyed HI card, it informs the inquirer to get in touch with the SSO nearest the inquirer's address for assistance. SSO addresses are generally listed in local telephone directories under "Social Security Administration."

A health insurance card is acceptable without a signature, but the provider will ask the patient to sign it.

30.3 - Temporary Eligibility Notice

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

The SSO may issue a temporary health insurance eligibility notice, pending the issuance of a health insurance card, when the beneficiary is in need of immediate medical services. The provider may obtain the patient's name and claim number from the temporary eligibility notice. See Chapter 2 of the Medicare General Information, Eligibility, and Entitlement Manual for an example of the temporary notice.

For claims processed by the *A/B MAC (B) or DME MAC*, the individual, the individual's physician, or other supplier must show the health insurance claim number on the request for Medicare payment and on other related bills and documents. Because Health Insurance records are maintained by the individual's claim number, the claim number must be used on all communications.

30.6 - Provider Access to CMS and *A/B MAC (A) or (HHH)* Eligibility Data

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

The *A/B MAC (A) or (HHH)* will allow only Medicare certified providers as defined in §§1861 and 1866(e) of the Social Security Act (the Act) and their billing agents automated access to beneficiary eligibility data. Disclosure of CWF eligibility data is restricted under provisions of the Privacy Act of 1974, 5 U.S.C §552a. Under limited circumstances, the Privacy Act permits CMS to disclose information without consent of the individual. One circumstance is for "routine uses," that is, disclosure for purposes that are compatible with the purpose for which CMS collects the information. In the case of this provider access, a routine use exists which permits release of data to providers or their authorized billing agents for the purpose of verifying a patient's eligibility for benefits under the Medicare program. The use of the data by a provider in preparing claims for hospital-based physicians would be an example of unauthorized use because the physicians are not Medicare providers as defined in the Act.

A/B MACs (A) or (HHH) will adjust their systems to accept the revised standard HIQA/HUQA records from the CMS CWF. The standard data elements to be made available to providers are listed below:

- HICN;
- Beneficiary:
  - Last name (first six positions)/first initial;
  - Date of birth;
  - Sex;
  - Date of death;
  - Lifetime reserve days remaining;
  - Lifetime psychiatric days remaining (requesting hospital must use a psychiatric provider number to obtain this data);

- Cross reference HICN;
- Current and prior A and B entitlements, with start and stop dates for Part A, Part B, ESRD, HMO, and hospice; and
- Spell of illness (applicable spell based on the date entered by the provider and the next most recent spell):
    - Hospital full days remaining;
    - Hospital coinsurance days remaining;
    - SNF full days remaining;
    - SNF coinsurance days remaining;
    - Part A cash deductible remaining to be met;
    - Date of earliest billing action for indicated spell-of-illness;
    - Date of latest billing action for indicated spell-of-illness;
    - Blood deductible (combined annual Part A and B remaining to be met for applicable year entered by provider);
    - Part B trailer year (applicable year based on date entered by provider);
    - Part B cash deductible;
    - Physical therapy/speech-language pathology limit (physical therapy and speech-language pathology are applicable to physical therapy limit);
    - Occupational therapy limit;
    - Hospice data (applicable periods based on the date entered by the provider and the next most recent period);
    - ESRD indicator (shows beneficiary is currently entitled);
    - REP payee indicator;
    - MSP indicator;
    - Home Health Benefit Period:
        - Part A visits remaining;
        - Part B visits applied;
        - Date of earliest billing action for home health benefit period;
        - Date of latest billing action for home health benefit period.
    - HMO information (applicable periods based on date entered by the provider):

- Name;
- Identification number;
- Zip Code;
- Option code;
- Start date;
- Termination date;
- Pap smear screening risk indicator, professional date, and technical date;
- Mammography screening risk indicator (applicable to screening services prior to January 1, 1998), professional date, and technical date;
- Colorectal screening (no risk indicator); procedure code, professional date, and technical date;
- Pelvic screening risk indicator and professional date;
- Pneumococcal pneumonia vaccine (PPV) date;
- Influenza virus vaccine date; and
- Hepatitis B vaccine date.

See Chapter 10 of this manual for a complete discussion of the HIQH (Health Insurance Query for Home Health Agencies).

The *A/B MAC (A)* will make sure that psychiatric information is not being made available to all hospitals. This information is to be made available **only** to psychiatric hospitals or hospitals that furnish inpatient psychiatric hospital services.

Providers may use direct entry terminals or dial-up terminals to inquire about beneficiary eligibility utilization and deductible status. The *A/B MAC (A)* must use either the HIQA screen display (see §30.6.1.1) or create its own Customer Information Control System (CICS) screens from the HUQA data records (see §§30.6.1.2 and 30.6.1.3). Providers may not have access to any other CWF records, e.g., the health insurance master record (HIMR). The data must be from CWF. The *A/B MAC (A)* will not substitute local history.

30.6.1 – *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.6.1.1 - Part A Inquiry (HIQA) Screen Display

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

All the data elements are explained in full for proper use. *A/B MACs (A) or (HHH)* should access this screen to transmit data to their providers and suppliers when supplying data for §30.6.1.2.

30.6.1.4 - Part A Inquiry Reply (HUQAR) Data

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

This response can be used to create the *A/B MAC (A)'s or (HHH)'s* own screens to return beneficiary eligibility and utilization data to providers.

30.6.1.5 - Health Insurance Query for Home Health Agencies (HIQH)

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

This transaction, which is available through *A/B MAC (HHH)* remote access, is used by HHAs to ascertain whether an episode has been opened for a given beneficiary by another provider (who is the primary HHA) and to track episodes for beneficiaries for whom the inquiring HHA is the primary HHA.

30.6.2 – *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.6.3 – *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.6.4 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.6.5 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.6.6 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.8 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.10 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.11 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.12 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.13 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.14 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.15 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.16 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.17 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.18 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.19 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.19.1 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.19.2 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.19.3 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.19.4 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.20 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.21 - *Reserved*
(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

30.21.1 - HMO-Related Master File Corrections

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

The *A/B MAC (A), (B), or (HHH), or DME MAC* will fully document and send to the HMO inquiries concerning problems with HMO data on the HI Master. The HMO will resolve the problem and advise the contractor of the results.

30.22 - Provider Problems Obtaining Entitlement Information

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

If after application of the above procedures, the provider encounters significant problems in obtaining information regarding Medicare entitlement or benefits in order to accurately prepare bills, the provider should contact the *A/B MAC (A), (B), or (HHH), or DME MAC* for assistance. However, these requests should be on a non-routine basis. The *MAC* will assist providers in obtaining entitlement information. The *MAC* may temporarily refuse assistance if a pattern of abuse is discovered. Situations that may require *MAC* assistance are:

- When the patient dies following admission. It may be necessary to file timely with an estate;
- When the patient is not in a physical or mental condition to discuss his/her entitlement, and no other person with knowledge of the patient's affairs is available;
- When the provider has reason to believe the beneficiary may need lifetime reserve days, and his/her signature must be obtained if the available lifetime reserve days are not to be used for this admission and other financial arrangements must be made;
- When it is suspected that the beneficiary may have exhausted his/her Medicare benefits, and timely confirmation is needed in order to file for possible supplemental benefits; and
- When the patient has experienced repeated admissions during the same spell of illness, and determining available benefits for the beneficiary is difficult.

60 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

60.1 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

60.2 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

70 - SSO Assistance in Resolving Entitlement Status Problems

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

A. Social Security Office (SSO) Assistance

The *A/B MAC (A), (B), or (HHH), or DME MAC* directs initial requests for assistance to the SSO if the problem is caused by difficulties in determining the beneficiary's correct entitlement status. Examples of situations that may require SSO assistance are:

- Problems involving Railroad Retirement Board (RRB) jurisdiction;
- Evidence that a beneficiary has utilization under more than one HICN but there is no awareness of any cross-reference action taken by CMS; or
- The beneficiary's name, address, sex code, date of birth, or date of death is incorrect on the HI master record.

In the event the SSO is unable to resolve the entitlement problem (e.g., cross referencing of HI records), the *MAC* requests assistance from the RO.

B. RRB Assistance

If the problem concerns an entitlement issue involving a claims number with an alpha prefix (A123456, WA12456789), the contractor sends requests for assistance via Form CMS-1980 to:

Railroad Retirement Board
Health Insurance Operations
844 Rush Street
Chicago, IL 60611

The RRB will investigate, initiate corrective action, and provide notification in the same manner as the SSO.

100 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

100.1 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

110 - Reserved

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

110.1 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)

120 - *Reserved*

(Rev. 3441, Issued: 01-15-16, Effective; 12- 31- 13; ASC X12: 01- 01-12, MAC Implementation: 02-16-16; ASC X12: 02- 16- 16)