Care CEU's
Continuing Education for Nursing Home Administrators

Medicare Eligibility and Entitlement

General Overview

The Health Insurance for the Aged and Disabled Act (title XVIII of the Social Security Act), known as "Medicare," has made available to nearly every American 65 years of age and older a broad program of health insurance designed to assist the nation's elderly to meet hospital, medical, and other health costs. Health insurance coverage has also been extended to persons under age 65 qualifying as disabled and those having end stage renal disease (ESRD) or Lou Gehrig's disease. The program includes two related health insurance programs--hospital insurance (HI) (Part A) and supplementary medical insurance (SMI) (Part B).

Hospital Insurance (Part A) for Inpatient Hospital, Hospice, Home Health and Skilled Nursing Facility (SNF) Services - A Brief Description

Hospital insurance is designed to help patients defray the expenses incurred by hospitalization and related care. In addition to inpatient hospital benefits, hospital insurance covers posthospital extended care in SNFs and posthospital care furnished by a home health agency in the patient's home. Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, are also a Part A benefit for beneficiaries in a covered Part A stay. The purpose of these additional benefits is to provide continued treatment after hospitalization and to encourage the appropriate use of more economical alternatives to inpatient hospital care. Program payments for services rendered to beneficiaries by providers (i.e., hospitals, SNFs, and home health agencies) are generally made to the provider. In each benefit period, payment may be made for up to 90 inpatient hospital days, and 100 days of posthospital extended care services.

Hospices also provide Part A hospital insurance services such as short-term inpatient care. In order to be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

*The various Part A benefit categories (inpatient hospital services, SNF services, home health services, etc.) are subject to separate and mutually exclusive day limits, so that the use of benefit days under one of these benefits does not affect the number of benefit days that remain available under any of the other benefits. For example, the 90 days of inpatient hospital benefits (plus 60 nonrenewable lifetime reserve days-- see Pub. 100-02, Medicare Benefit Policy Manual, chapter 5) that are available to a beneficiary in a hospital **do not** count against the 100 days of posthospital extended care benefits that are available in a SNF, and vice-versa.*

Home Health Services

To qualify for home health benefits under either Part A or Part B of the program, a beneficiary must be confined to his/her home, under the care of a physician, and in need of skilled nursing services on an intermittent basis, physical therapy, or speech-language pathology services. Being "confined to the home" does not mean a beneficiary can never leave the home. See Chapter 7 of the Benefit Policy publication for the definition of homebound. A beneficiary who requires one or more of these services in the treatment of his/her illness or injury and otherwise qualifies for home health benefits is eligible to have payment made on his/her behalf for the skilled nursing,

physical therapy or speech-language pathology services he needs, as well as for any of the other home health services specified in the law. These services include occupational therapy, medical social services, the use of medical supplies and medical appliances, and the part-time or intermittent services of home health aides. Conversely, a patient who does not require intermittent skilled nursing or physical therapy or speech-language pathology services cannot qualify to have payment made under the program for any home health services furnished him. Excluded as home health services are the costs of housekeepers, food service arrangements, and transportation to outpatient facilities.

To be covered, the home health services must be needed for a condition for which the patient required inpatient hospital services or extended care services. See the Chapter 7 of the Benefit Policy publication for a description of services covered. Discharge from the hospital must have occurred in a month in which the patient has attained age 65 or was entitled to health insurance benefits under the disability or chronic renal disease provisions of the law.

Home health services are services provided by a home health agency or by others under arrangements with such an agency. A home health agency is a public agency or private organization which is primarily engaged in providing skilled nursing and other therapeutic services. Where applicable the agency must be licensed under State or local law, or be approved by the State or local licensing agency as meeting the licensing standards. Examples of home health agencies are visiting nurse associations, official health agencies, and hospital-based home care programs. To participate in the health insurance program, a home health agency must meet certain other requirements included in the law as well as health and safety conditions prescribed by the Secretary of the Department of Health and Human Services. It may not qualify under hospital insurance, however, if it is primarily engaged in the treatment of mental diseases; such an agency may qualify only under supplementary medical insurance.

Home health services are usually furnished on a visiting basis in a place of residence used as the individual's home. However, outpatient services in a hospital, SNF, or rehabilitation center are covered home health services, if arranged for by a home health agency, when equipment is required that cannot be made available in the patient's home.

The services of an intern or resident-in-training are covered if the agency has an affiliation with or is under common control of a hospital providing such medical services and the agency bills for such services.

Prior to July 1, 1981, home health services under hospital insurance included up to 100 home health visits, after the beginning of one benefit period and before the beginning of the next. The visits must have been furnished to a patient within 1 year of his/her most recent discharge from a hospital where he was an inpatient for at least 3 consecutive calendar days (counting the day of admission, but not the day of discharge). If, after his/her hospitalization, he had a covered stay in a SNF, the 1 year during which the patient may receive home health services began with the discharge from the SNF. A plan of treatment must have been established within 14 days after the hospital or SNF discharge. Home health services were also provided under supplementary medical insurance where the 100-visit limit under Part A was exceeded.

Effective July 1, 1981, the 100-visit limitation under Parts A and B, and the prior inpatient stay requirement under Part A were eliminated. In addition, a person could qualify for home health services based on his or her need for skilled nursing services on an intermittent basis, physical

therapy, speech-language pathology services, or occupational therapy. Effective December 1, 1981, occupational therapy was eliminated as a basis for entitlement to home health services. However, if a person has otherwise qualified for home health services because of the need for skilled nursing care, physical therapy or speech-language pathology services, the patient's eligibility for home health services may be extended solely on the basis of the continuing need for occupational therapy.

Effective January 1, 1998, the first 100 visits must be paid under Part A if the beneficiary is entitled under Part A, and the remainder of the visits may be paid under Part B.

Supplementary Medical Insurance (Part B) - A Brief Description

To obtain SMI, an eligible individual must enroll during an enrollment period and pay the required premiums. An individual is eligible to enroll if they are entitled to HI or are 65 years of age and a citizen or resident alien who meets certain residence requirements. SMI provides for payment to participating providers for furnishing covered services after a yearly cash deductible is met. The voluntary medical insurance plan is designed to supplement the basic hospital insurance coverage. It provides coverage for home health visits not available under hospital insurance (e.g., no Part A entitlement or visits after the first 100 visits) and for medical and other health services. Payment may not be made under Part B for any service that may be paid under Part A. However, where payment is not possible under Part A (e.g., no Part A entitlement or benefits are exhausted) payment may be made under Part B if the service is covered.

Subject to coverage and limitations described in the Benefit Policy Publication, the following services are covered under Part B.

- Physicians' services;
- Services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;
- Hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;
- Diagnostic services which are-- (i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and (ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;
- Outpatient physical therapy services, occupational therapy services, and speech-language pathology services;
- Rural health clinic services and Federally qualified health center services;
- Home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies;

- Antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1) of the Act, for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician;

- Services furnished pursuant to a contract under section 1876 of the Act to a member of an eligible organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his/her service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service; and, services furnished pursuant to a risk-sharing contract under section 1876(g) of the Act to a member of an eligible organization by a clinical psychologist (as defined by the Secretary) or by a clinical social worker, and such services and supplies furnished as an incident to such clinical psychologist's services or clinical social worker's services to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

- Blood clotting factors, for hemophilia patients competent to use such factors to control bleeding without medical or other supervision, and items related to the administration of such factors, subject to utilization controls deemed necessary by the Secretary for the efficient use of such factors;

- Prescription drugs used in immunosuppressive therapy furnished to an individual who receives an organ transplant for which payment is made under this title;

- Services which would be physicians' services if furnished by a physician and which are performed by a physician assistant under the supervision of a physician and which the physician assistant is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as incident to such services as would be covered if furnished incident to a physician's professional service; and but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

- Services which would be physicians' services if furnished by a physician and which are performed by a nurse practitioner or clinical nurse specialist working in collaboration with a physician which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

- Certified nurse-midwife services;

- Qualified psychologist services;

- Clinical social worker services;

- Erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug;

- Prostate cancer screening tests;

- An oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered if the drug could not be self-administered;

- Colorectal cancer screening tests;

- Diabetes outpatient self-management training services;

- An oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)-- (i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and (ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously;

- Screening for glaucoma (as defined in subsection (uu)) for individuals determined to be at high risk for glaucoma, individuals with a family history of glaucoma and individuals with diabetes;

- Medical nutrition therapy services in the case of a beneficiary with diabetes or a renal disease who-- (i) has not received diabetes outpatient self-management training services within a time period determined by the Secretary; (ii) is not receiving maintenance dialysis for which payment is made under section 1881 of the Act; and (iii) meets such other criteria determined by the Secretary after consideration of protocols established by dietitian or nutrition professional organizations;

- Diagnostic X-ray tests (including tests under the supervision of a physician, furnished in a place of residence used as the patient's home, if the performance of such tests meets such conditions relating to health and safety as the Secretary may find necessary and including diagnostic mammography if conducted by a facility that has a certificate (or provisional certificate) issued under section 354 of the Public Health Service Act), diagnostic laboratory tests, and other diagnostic tests; X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

- Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations; Durable medical equipment;

- Ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

- Prosthetic and orthotic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of such devices, and including one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with insertion of an intraocular lens;

- Leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition;

- Vaccines: (1) pneumococcal vaccine and its administration and, subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987, (2) influenza vaccine and its administration; and (3) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B;

    NOTE: A charge separate from the ESRD composite rate will be recognized and paid for administration of the vaccine to ESRD patients.

    NOTE: For Medicare program purposes, the hepatitis B vaccine may be administered upon the order of a doctor of medicine or osteopathy by home health agencies, SNFs, renal dialysis facilities (RDFs), hospital outpatient departments, persons recognized under the "incident to physicians' services" provision of law, and, of course, doctors of medicine and osteopathy.

- Services of a certified registered nurse anesthetist;

- Subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if-- (1) the physician who is managing the individual's diabetic condition (a) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (b) certifies that the individual needs such shoes under a comprehensive plan of care related to the individual's diabetic condition; (2) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and (3) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in (1) above (unless the Secretary finds that the physician is the only such qualified individual in the area);

- Screening mammography;

- Screening pap smear and screening pelvic exam; and

- Bone mass measurement.

- No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) of the Act shall be included unless such laboratory-

1. Is situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (1) is licensed pursuant to such law, or (2) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing;

2. Meets the certification requirements under section 353 of the Public Health Service Act; and

3. Meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified any item or service which would not be included if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) of the Act shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

Basis for Payment

(See Claims Processing, Pub 100-04 for a description of the basis for payment for the various services.)

Administration of the Medicare Program - Introduction

The conduct of the program has been delegated by the Secretary of the Department of Health and Human Services to the Administrator of the Centers for Medicare & Medicaid Services (CMS). Congress has also provided substantial administrative roles for the States and for voluntary insurance organizations in recognition of their experience in the health care and insurance fields.

The law does not permit the Federal Government to exercise supervision or control over the practice of medicine, the manner in which medical services are provided, and the administration or operation of medical facilities. The patient is free to choose any qualified institution, agency, or person offering him/her services. The responsibility for treatment and the control of care remains with the individual's physician and the hospital or other facility or agency furnishing services. The individual may keep or obtain any other health insurance he/she desires including the choice to enroll in a Medicare+Choice plan. More information about Medicare+Choice plans is in the Medicare Managed Care Manual.

Financing the Program

Part A is financed through separate payroll contributions paid by employees, employers, and self-employed persons. The proceeds are deposited to the account of the Federal Hospital Insurance Trust Fund, which is used only for hospital insurance benefits and administrative

expenses. Federal employees and State and local employees who do not pay the full FICA tax must pay the HI portion; they are not eligible for monthly Social Security or railroad retirement benefits. The cost of providing Part A benefits to other persons who are not Social Security or railroad retirement beneficiaries is met by appropriations to the Federal Hospital Insurance Trust Fund from general revenues or through premium payments.

Part B is financed by monthly premiums of those who voluntarily enroll in the program and by the Federal Government which makes contributions from general revenues. All premiums and Government contributions are deposited in a separate account known as the Federal Supplementary Medical Trust Fund. Money from this fund is used only to pay for Part B benefits and administrative expenses.

Discrimination Prohibited

Participating providers of Part A services under the supplementary medical insurance program (e.g., hospitals, SNFs, HHAs, hospices, outpatient physical therapy, comprehensive outpatient rehabilitation facilities (CORFs), occupational therapy and speech-language pathology providers, and renal dialysis facilities) must comply with the requirements of title VI of the Civil Rights Act of 1964. Under the provisions of that Act, a participating provider is prohibited from making a distinction on the grounds of race, color, or national origin, in the treatment of patients, the use of equipment, other facilities, and the assignment of personnel to provide services.

The DHHS is responsible for investigating complaints of noncompliance.

Fraud and Abuse - General

Providers and suppliers have an obligation, under law, to conform to the requirements of the Medicare program. Fraud and abuse committed against the program may be prosecuted under various provisions of the United States Code and could result in the imposition of restitution, fines, and, in some instances, imprisonment. In addition, there is also a range of administrative sanctions (such as exclusion from participation in the program) and civil monetary penalties that may be imposed when facts and circumstances warrant such action.

Following are definitions and examples of fraud and abuse. These definitions and examples give a better understanding of the types of practices that are forbidden, under law, in the Medicare program.

Definition and Examples of Fraud

Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the Government, it is necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally.

Examples of fraud include, but are not limited to, the following:

- Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep;
- Altering claims forms and/or receipts in order to receive a higher payment amount;
- Duplicating billings that includes billing both the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than allowed;
- Offering, paying, soliciting, or receiving bribes, kickbacks, or rebates, directly or indirectly, in cash or in kind, in order to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program;
- Falsely representing the nature of the services furnished. This encompasses describing a noncovered service in a misleading way that makes it appear as if a covered service was actually furnished;
- Billing a person who has Medicare coverage for services provided to another person not eligible for Medicare coverage; and
- Using another person's Medicare card to obtain medical care.

Definition and Examples of Abuse

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare program. Many times abuse appears quite similar to fraud except that it is not possible to establish that abusive acts were committed knowingly, willfully, and intentionally.

Following are three standards that CMS uses when judging whether abusive acts in billing were committed against the Medicare program:

- Reasonable and necessary;
- Conformance to professionally recognized standards; and
- Provision at a fair price.

Examples of abuse include, but are not limited to, the following:

- Charging in excess for services or supplies;
- Providing medically unnecessary services or services that do not meet professionally recognized standards;
- Billing Medicare based on a higher fee schedule than for non-Medicare patients;
- Submitting bills to Medicare that are the responsibility of other insurers under the Medicare secondary payer (MSP) regulation; and
- Violating the participating physician/supplier agreement.

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud if there is evidence that the subject was knowingly and willfully conducting an abusive practice.

Federal Government Administration of the Health Insurance Program

The DHHS has overall responsibility for administering the hospital insurance and voluntary SMI programs. Two major agencies - CMS and the Public Health Service - are involved in specified administrative functions.

CMS Responsibilities

The CMS is responsible for policy formulation. The central and regional offices are responsible for the general management and operation of the program. In brief, CMS's responsibilities include the following:

- Determining an individual's entitlement to benefits in consultation with the Social Security Administration (SSA);
- Determining the nature and duration of services for which a beneficiary's benefits may be paid;
- Establishing, maintaining, and administering agreements with State agencies, providers of services, and intermediaries;
- Establishing operational policy for contractors;
- Developing operational instructions and official interpretations of policy for contractors;
- Formulating major policies regarding conditions of participation for providers in consultation with the Public Health Service;
- Developing and maintaining statistical research and actuarial programs; and
- Managing general finances of the program; and
- Managing the Medicare Premium Collection Operation.

The regional offices are responsible for assuring that contractors meet applicable Federal requirements under the provisions of their contracts. They also:

- Provide liaison, direction, and technical assistance to contractors in the day-to-day management of their operations;
- Interpret CMS guidelines, policies, and procedures applicable to contractor activities;

- Analyze contractor budgets and spending patterns to assure that funds are economically and appropriately utilized;
- Conduct assessments of contractor operations;
- Review contractor actions; and
- Provide feedback to each contractor.

Public Health Service Responsibilities

The Public Health Service is responsible for administering the professional health aspects of the program. In brief, its responsibilities include the following:

- Consulting and recommending to CMS matters concerning the development of health and safety standards and other guidelines needed for determining whether providers of services meet the conditions of participation under the program;
- Consulting and advising State agencies concerning the application of standards for providers; and
- Coordinating programs and activities necessary in studying the utilization of services under the program.

State Agencies

The States, by agreement with the Secretary, are assigned significant administrative functions to the extent that each is willing and capable of discharging such responsibilities.

Certification by State Agencies

Facilities desiring to participate in either the Medicare or Medicaid programs must meet participation conditions for certification. State agencies certify to DHHS whether providers satisfy, and continue to satisfy, their respective conditions of participation in the Medicare and Medicaid programs. The Secretary, DHHS, certifies facilities requesting participation in the Medicare and Medicaid programs. States certify those facilities that request participation in the Medicaid program only.

The State function of making certifications is intended to be a natural adjunct to ongoing State activities (such as the licensing of health care facilities and the setting of standards).

Consultation by State Agencies

A State consults with providers of services that need and request participation condition assistance. For Medicare participation, the Secretary, DHHS, must approve the consultation service rendered by the State certifying agency.

Coordination by State Agencies

A State coordinates activities with other State programs that involve payment for health care, quality of care, and location of health facilities. Coordinating these activities is essential in assuring effective and economical use of existing State facilities and trained personnel and to prevent duplication of effort.

Role of Part A Intermediaries

The Part A intermediary is a public or private agency or organization that has entered into an agreement with CMS to enroll legitimate providers into the Medicare program and process Medicare claims under both Part A and Part B services under the supplementary medical insurance program (e.g., hospitals, SNFs, HHAs, hospices, CORFs, OPTs, occupational therapy, and speech-language pathology providers, and ESRD facilities).

Intermediaries make payments to providers. The amount of payment to a provider is restricted to the lower of the billed charge, the reasonable cost of covered services or the fee schedule amount. Hospices are paid on a per diem amount that is prospectively set. SNFs and HHAs are paid based on a Prospective Payment System (PPS). (See Provider Reimbursement Manual, Part 1, §§2800ff.)

Hospitals are paid based on the PPS. Under this system, Medicare payment is made at a predetermined, specific rate for each hospital discharge. This statement applies to inpatient for acute care hospitals and to inpatient rehabilitation hospitals. Whereas inpatient acute and rehab PPS payment is based on the discharge date, Outpatient PPS (OPPS) payments are based on Ambulatory Patient Classification payment for the date of service.

The amount of payment to other types of providers is restricted to the lesser of (a) the reasonable cost of covered services and items; or (b) the billed charges with respect to such services; or (c) the fee schedule amount.

In addition, intermediaries assist in applying safeguards against unnecessary use of covered services, furnish consultative services to serve as a center for communicating with providers, conduct audits of provider records, assist in the beneficiary appeals process, and provide information and advice to institutions and organizations that wish to qualify as providers of services.

Election of Intermediary

Except for HHAs, hospices and freestanding CORFs, providers may elect to be served by an intermediary authorized to serve other providers in its area. Elections are reviewed by the RO and approved unless special or temporary limitations have been placed on the elected intermediary's availability, or an addition to the elected intermediary's workload at the time would be undesirable.

The RO sends the official notice to the contractor of changes in the contractor's list of providers.

Intermediary Service to HHAs

Under 42 CFR 421.117, CMS is authorized to designate intermediaries to service HHAs and hospices. This provision was implemented through the designation of regional and alternative regional intermediaries to service all HHAs and hospices within the respective intermediary's jurisdictional boundaries.

In the case of HHAs and hospices based in another Medicare provider (e.g., a hospital or SNF), audit, cost report settlement, and other fiscal functions (such as setting interim payment rates) are performed by the intermediary serving the parent provider.

While RHHIs have been designated to service all HHAs and hospices, CMS has designated an alternative regional intermediary. Where HHAs or hospices can demonstrate that it is in the best interest of the Government for them to not be serviced by the designated RHHI, the provider may request (through the CMS Regional Office) to be serviced by the designated alternative regional intermediary. The following are the designated alternative regional intermediaries and their respective jurisdictions.

Blue Cross and Blue Shield of Alabama.	Alabama, Alaska, Arizona, Arkansas, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, the Virgin Islands, Virginia, Washington, West Virginia, and Wisconsin.
Blue Cross and Blue Shield United of Wisconsin	Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, and Wyoming.

Role of Part B Carriers

The law requires the Secretary, DHHS, to enter into contracts with carriers to serve in the operation and administration of the non-provider Part B program. Carriers enroll physicians, non-physician health care practitioners and other entities that will submit claims to the carrier, and process Medicare claims and make payments for services and supplies covered by Part B. Other major functions include, for example, controlling over-utilization and communicating with beneficiaries and the health community.

Durable medical equipment (DME) regional carriers have been given the responsibility of processing durable medical equipment, prosthetic, orthotic, and supply (DMEPOS) claims. See Claims Processing Manual, chapter 1, for description of jurisdiction.

Background and Responsibilities of the Peer Review Organization (PRO)

Section 1153 of the Social Security Act (the Act) requires the Secretary to enter into contracts with physician-approved or physician-access organizations defined as PROs.

The PROs are organizations who are responsible for monitoring the quality of care provided to Medicare patients by hospitals, SNFs, home health agencies, Medicare+Choice plans, and other types of health care providers.

PRO review is governed by titles XI and XVIII of the Act as amended, and by regulations contained in:

- 42 CFR 411 - Limitation on liability;
- 42 CFR 412 - Outlier review, diagnosis related group (DRG) validation, and hospital notices of non coverage;
- 42 CFR 417.605 - Immediate PRO review of Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP) notices of discharge;
- 42 CFR 422.622 - Immediate review of Medicare+Choice discharge notices;
- 42 CFR 475 - Definition of eligible organizations and area designation;
- 42 CFR 476 - Assumption and conduct of review;
- 42 CFR 478 - PRO reconsideration and appeals;
- 42 CFR 480 - Disclosure of information;
- 42 CFR 482 - Hospital conditions of participation; and
- 42 CFR 1004 - PRO recommendations of sanctions.

Purpose of PRO Review for the Individual Medicare Beneficiaries

The PROs review items or services provided to Medicare beneficiaries to determine:

- Whether services provided or proposed to be provided are reasonable and medically necessary for the diagnosis and treatment of illness or injury, or to improve functioning of a malformed body member, or for prevention of an illness, or for the palliation and management of terminal illness;
- Whether those services furnished or proposed to be furnished on an inpatient basis could be effectively furnished on an outpatient basis, or in an inpatient health care facility of a different type;
- Medical necessity, reasonableness, and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions of PPS;

- Whether a hospital has misrepresented admission or discharge information, or has taken an action that results in the unnecessary admission of an individual entitled to benefits under Part A, unnecessary multiple admissions of an individual, or other inappropriate medical or other practices with respect to beneficiaries, or billing for services furnished to beneficiaries;

- The validity of diagnostic and procedural information supplied by the provider to the fiscal intermediary for payment purposes;

- The completeness and adequacy of hospital care provided; and

- Whether the quality of services meets professionally recognized standards of health care.

These activities enable PROs to determine whether Medicare payment may be made for the services claimed and to identify and initiate corrective action where appropriate. PROs have the authority to deny Medicare payment for medically inappropriate and unnecessary admissions. They also investigate individual beneficiary complaints about the quality of care received.

PRO Responsibility for the Overall Approach to Health Care

In addition to individual case review, PROs also help providers improve the overall approach to health care for Medicare beneficiaries.

This function includes the following activities:

- Using clinical and other data bases to examine patterns of care and outcomes, rather than focusing on isolated cases;

- Identifying systemic variations of concern or interest by monitoring patterns of care and outcomes;

- Working with providers to identify provider-specific root causes of systemic variations; and

- Working cooperatively with the health care community to measurably improve the processes and outcomes of care for Medicare beneficiaries.

Other PRO Responsibilities

A. Responsibilities Prior to Review

The PROs are responsible for:

- Specifying in their plan and instructions to practitioners and providers the type of evidence they require to document the care ordered or furnished to provide medically necessary, appropriate, and quality health care services; and

- Applying professionally developed criteria for providing care, diagnosis, and treatment based upon typical patterns of practice within their geographic area to evaluate the medical necessity, quality, or appropriateness of services ordered or furnished.

B. Ongoing Review Activities

As a part of their ongoing review activities, PROs must:

- Notify the appropriate agency of the State or Federal government when they become aware of situations which appear to be improper, but which do not fall within their review responsibilities (e.g., poor quality care in a renal dialysis center);

- Use their authority or influence to enlist the support of other professional or Government agencies to ensure that all providers and practitioners for which they have review responsibilities comply with their obligations (see §1156 of the Act.); and

- Perform beneficiary and physician outreach activities.

C. Responsibilities as a Result of PRO Review

To act upon information they obtain as a result of their review activities, PROs must:

- Provide information on results of their review (e.g., annual report, periodic meetings with providers/practitioners);

- Identify and seek correction of situations that, if continued, would result in violations under §1156 of the Act;

- Submit reports to the Office of the Inspector General on providers and practitioners found to have substantially violated an obligation in a substantial number of cases, or to have grossly and flagrantly violated an obligation in one or more instances. This includes referring certain cases to State licensing boards.

D. Additional Activities

PROs perform all other activities specified in the Scope of Work, including any modifications, CMS regulations and instructions, and relevant statutory provisions.

E. Payment Error Prevention Program (PEPP)

In order to reduce inpatient PPS payment errors, PROs must initiate a program of Payment Error Prevention Projects (PEPPs). CMS defines the payment error rate as the number of dollars found to be paid in error out of the total of all dollars paid for inpatient PPS services. CMS provides State-specific error rates to PROs to evaluate performance.

Statutory Obligations of Practitioners and Other Persons

It is the obligation of any health care practitioner or other person who furnishes or orders health care items or services that may be reimbursed under Medicare, to ensure that to the extent of his or her authority, those services are:

- Furnished economically and only when and to the extent medically necessary;
- Of a quality that meets professionally recognized standards of health care; and
- Supported by evidence of the medical necessity and quality of the services in the form and fashion that the reviewing PRO may reasonably require (including copies of the necessary documentation) to ensure that the practitioner or other person is meeting the obligations imposed by Section 1156(a) of the Act.

These obligations apply whether payment is made directly to the provider (i.e., assignment) or to the beneficiary, or even if payment is not made.

Responsibilities of Designated Agents Working With PROs; Organizations Subcontracted for Review

The PRO has ultimate responsibility for monitoring the compliance of practitioners and providers with statutory obligations. It is not relieved of any of the responsibility under the sanction regulations in the event of non-performance by an organization with which it has subcontracted for review.

An organization with which the PRO subcontracts to carry out review functions is responsible for:

- Ensuring that practitioners and other persons meet their obligations with respect to the items and services it reviews; and
- Reporting to the PRO (primary contractor) those instances where it appears a violation of an obligation may have occurred or is occurring.

Institutional Planning and Budgeting

The Social Security Act requires each provider, as a condition of participation under Medicare, to have a written overall plan and budget reflecting an annual operating budget and a capital expenditures plan (that covers at least a 3-year period including the year to which the operating budget is applicable). For this requirement, provider means hospital, critical access hospital, SNF, comprehensive outpatient rehabilitation facility, home health agency, or hospice program.

The annual operating budget will include all anticipated income and expenses related to items which would under generally accepted accounting principles be considered income and expense items. The capital expenditure plan would be expected to include and identify in detail the anticipated sources of finance for, the objectives of, each anticipated expenditure in excess of $l00,000 related to acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items.

The overall budget and plan will be prepared under the direction of the provider's governing body by a committee consisting of representatives of the governing body, administrative staff and if any, the medical staff. Further, it will be reviewed and updated at least annually. The purpose of the requirement is to assure that providers carry on budgeting and substance by the Government or any of its agents.

CMS Managed Modules for Software Programs and Pricing/Coding Files

The CMS Managed Modules contains scheduled release dates for software programs and pricing/coding files.

Medicare contractors will be receiving subsequent quarterly updates of the CMS Managed Modules via a Recurring Update Notification.

Hospital Insurance and Supplementary Medical Insurance

10 - Hospital Insurance Entitlement

Hospital insurance (HI), as well as supplementary medical insurance (SMI), is available to three basic groups of "insured individuals"- the aged, the disabled, and those with end stage renal disease. Following is an explanation of how an individual becomes "insured" as well as an explanation of the eligibility requirements for each group.

10.1 - Insured Status

To be eligible for premium-free HI, an individual must be "insured" based on his or her own earnings or those of a spouse, parent, or child. To be insured, the worker must have a specific number of quarters of coverage (QCs); the exact number required is dependent upon whether the person is filing for HI on the basis of age, disability, or end stage renal disease. QCs are earned through payment of payroll taxes under the Federal Insurance Contributions Act (FICA) during the person's working years. QCs earned by an individual who pays the full FICA tax are usable to insure the person for both monthly social security benefits and HI.

Federal employees were exempt from payment of FICA taxes prior to January 1983. However, beginning in January 1983, Federal employees became subject to the HI portion of the FICA tax (those actually employed in January 1983 were also deemed to have earned HI quarters of coverage for their Federal service prior to January 1983). Also, Government employees who pay only the HI portion of the FICA tax are only insured for HI; they are not insured for monthly social security benefits.

State and local Government employees hired after March 31,1986, are eligible for Medicare coverage and must pay the HI portion of the FICA tax. A State may elect to cover employees hired prior to April 1986 for the Medicare portion of the FICA tax by requesting an agreement or modification of its existing agreement under section 218 of the Social Security Act.

10.2 - Hospital Insurance for the Aged

To be eligible for HI on the basis of age, a person must be age 65 or older and either eligible for monthly social security or railroad retirement cash benefits, or would be eligible for such benefits if the worker's Government QCs were regular social security QCs. An individual who is insured for monthly benefits need not actually file for benefits to receive HI benefits. If such a person continues to work beyond age 65, he or she may instead elect to file an application for HI only.

Premium-free HI for the aged begins with the month in which the individual attains age 65, provided he or she files an application for HI or for cash benefits and HI within 6 months of the month in which he or she attains age 65. If the application is filed later than that, HI entitlement can be retroactive for only 6 months. An individual attains age 65 on the day before his or her 65th birthday. For example, if an individual is born on August 1, the attainment date is July 31, and HI begins with July 1. Entitlement generally does not end until death.

10.3 - Hospital Insurance for Disability Beneficiaries

A disabled person who is entitled to social security or railroad retirement benefits on the basis of disability is automatically entitled to HI after 24 months of entitlement to such benefits. Since there is a 5-month disability benefits waiting period, the person actually becomes entitled to HI after being disabled for 29 months.

In addition, disabled persons who are not insured for monthly Social Security disability benefits but would be insured for such benefits if Government QCs were treated as social security QCs, are deemed to be entitled to disability benefits and automatically entitled to HI after being disabled for 29 months.

The months in the Medicare qualifying period need not be consecutive so that months from a previous period of disability benefit entitlement generally may be counted in determining when the qualifying period requirement is met. HI entitlement on the basis of disability is available not only to the worker, but to the widow, widower, or child of a deceased, disabled, or retired worker if any of them become disabled within the meaning of the Social Security or Railroad Retirement Acts.

If an individual recovers from a disability, HI entitlement ends with the month after the month he or she is notified of the disability termination. For example, if notification is November 15, entitlement ends December 31. However, if the individual's disability benefit entitlement ends only because he or she was working, HI entitlement may continue for up to 78 additional months.

10.4 - Hospital Insurance for Persons Needing Kidney Transplant or Dialysis

Individuals of any age with end stage renal disease (ESRD) who receive dialysis on a regular basis or a kidney transplant are eligible for HI (and are deemed enrolled for Supplementary Medical Insurance (SMI) unless such coverage is refused) if they file an

application. They must also meet certain work requirements for insured status under the social security or railroad retirement programs, or be entitled to monthly social security benefits or an annuity under the Railroad Retirement Act, or be the spouse or dependent child of an insured or entitled person.

10.4.1 - Effective Date of Entitlement for Persons on Dialysis

Entitlement usually begins after a 3-month waiting period has been served, i.e., with the first day of the third month after the month in which a course of regular dialysis begins. Entitlement begins before the waiting period has expired if the individual receives a transplant or participates in a self-dialysis training program during the waiting period..

10.4.2 - Entitlement Based on Transplant

Entitlement begins with the month the individual is admitted as an inpatient to a hospital for procedures in preparation for or in anticipation of a kidney transplant, provided the transplant surgery takes place within the following 2 months. If the transplant is delayed more than 2 months after the preparatory hospitalization, entitlement begins with the second month prior to the month of transplant. Under the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, Congress extended immunosuppressive drug benefits to lifetime, as long as the beneficiary is entitled to Medicare and was entitled to Medicare when his/her transplant took place.

10.4.3 - Effect on Self-dialysis Training on Entitlement

Entitlement begins with the first month of the course of dialysis if the individual is expected to complete the self-dialysis training program and self-dialyze thereafter.

10.4.4 - End of Coverage Based on ESRD

HI coverage based on ESRD ends with the earliest of the following dates:

- The day an individual dies,
- The last day of the 12th month after the month the course of dialysis is discontinued, unless the individual receives a kidney transplant during that period or begins another course of dialysis, or
- The last day of the 36th month after the month the person receives a kidney transplant.

10.4.5 - Reentitlement for Beneficiaries with ESRD

If a person whose entitlement based on ESRD has ended begins a new course of regular dialysis or has a kidney transplant, reentitlement begins without a waiting period.

20 - Hospital Insurance Obtained by Premium Payment

20.1 - Eligibility Requirements

Individuals who want hospital insurance coverage but who are not otherwise eligible (i.e., do not qualify under either the regular or deemed insured provisions, in §§10.1, 10.2, 10.3 10.4 above) may obtain such coverage by enrolling timely, paying a monthly premium, and upon meeting the following three requirements:

- Attaining age 65,
- Enrolling or already having enrolled in the SMI program,
- Being a resident of the U.S., and either:
    - A citizen, or
    - An alien lawfully admitted for permanent residence who has resided continuously in the U.S. for the 5 years prior to the month of enrollment.

20.2 - Premiums for Hospital Insurance

Each year, the Secretary of the Department of Health and Human Services announces the amount of the hospital insurance premium payable for each month in the following calendar year. The applicable premium amount is 33/76 (about 43.4 percent) of the hospital insurance deductible for that calendar year. The premium is rounded to the nearest $1. An individual who is not entitled to free Part A and wishes this type of coverage must enroll him/herself during the appropriate enrollment period. A premium is due for each month of entitlement under Premium HI.

20.3 - Beginning of Coverage

20.3.1 - Initial Enrollment Period (IEP)

Persons may enroll for premium hospital insurance by filing a request during the IEP which begins the third month before the month of first eligibility and lasts for 7 months. The individual's IEP for premium hospital insurance is in most cases the same 7-month period as the IEP for SMI.

The individual may enroll for hospital insurance when he or she enrolls for SMI, or later during his or her IEP. The beginning date of an individual's premium hospital insurance coverage period is determined by the rules applicable to SMI coverage based on an SMI enrollment during an IEP. (See chapter 2 §40 below.)

20.3.2 - General Enrollment Period (GEP)

Eligible persons who have not enrolled for premium hospital insurance during their IEP, or whose premium hospital insurance has been terminated, may enroll during a GEP (January 1 - March 31 of each year) if they are enrolling or have enrolled for SMI. As with SMI, an eligible person who enrolls for hospital insurance during a GEP will have hospital insurance coverage beginning the following July.

The same restrictions on enrollment and reenrollment apply as in the SMI program. Individuals who enroll late may pay a 10 percent premium penalty.

30 - End of Coverage for Hospital Insurance

A beneficiary's entitlement under the provision terminates:

- With the month of the individual's death,
- With the last day of the third month following the premium billing month (for nonpayment of premiums),
- With the end of the month following the month in which he or she files a voluntary request for termination,
- With the month SMI coverage is terminated, or
- With the month before the month in which he or she becomes entitled to hospital insurance under the regular or ESRD provisions. (See §2, §10.4 of this chapter.)

40 - Supplementary Medical Insurance (SMI)

Unlike the HI benefits program, which is largely financed by compulsory taxes on employers, employees, and the self-employed, the SMI benefits program is a voluntary program financed from premium payments by enrollees, together with contributions from funds appropriated by the Federal Government, and certain deductible and cost-sharing provisions.

40.1 - Eligibility for Enrollment

To obtain SMI coverage, eligible individuals must enroll in the plan during an enrollment period open to them and pay the required premiums. They are eligible to enroll if they are entitled to premium-free HI, or are age 65 and resident citizens or resident aliens. To qualify as a resident alien, an individual must have been lawfully admitted for permanent residence and have resided continuously in the United States during the 5 years immediately preceding the month of enrollment.

40.2 - Automatic Enrollment in SMI

Beneficiaries (except those residing in foreign countries or Puerto Rico) are deemed to have enrolled in SMI in the month before the month for which they are entitled to HI so

that HI and SMI coverage start in the same month. Thus, monthly beneficiaries other than disability beneficiaries are deemed to enroll in the month before attainment of age 65. Disability beneficiaries are deemed to enroll in the 24th consecutive month of entitlement to disability benefits.

Every potential "deemed" enrollee is given a reasonable opportunity (at least 2 months) to decline SMI enrollment by filing notice to this effect. He or she is deemed not to have enrolled and does not incur any premium liability. A refusal of SMI not timely filed is treated as a request for voluntary termination under existing disenrollment rules once it has been established that the individual does not wish to have SMI.

40.3 - Enrollment Periods

Enrollment is possible only during specified enrollment periods:

- An individual's initial enrollment period is of 7 months duration. It begins 3 full calendar months before and ends 3 full calendar months after the month in which the individual first meets all the requirements for enrollment.
- A general enrollment period occurs each year from January 1 through March 31. Coverage is effective the following July 1. These periods afford enrollment opportunities to those who failed to enroll during their initial enrollment periods and to those whose enrollment has terminated.
- A special enrollment period (SEP) is available, effective November 1984, for individuals age 65 or over who did not enroll in SMI when first eligible (or who terminated SMI enrollment because of coverage under a group health plan (GHP) based on their own or a spouse's current employment status). These individuals may enroll in SMI anytime while covered under the GHP or during the 8-month period immediately following the last month of GHP coverage based on current employment status.
- An SEP also became available, effective January 1987, for disabled beneficiaries under age 65 who did not enroll in SMI when first eligible (or who terminated SMI enrollment because of coverage under a GHP or a large group heath plan (LGHP) based on their own or a family member's current employment status. These individuals may also enroll in SMI anytime while covered under the GHP/LGHP or during the 8-month period immediately following the last month of GHP/LGHP coverage based on current employment status.
- There is no SEP for individuals who have ESRD. This includes individuals who are dually entitled to Medicare based on ESRD and age or disability.

40.3.1 - Enrollment During the Individual's Initial Enrollment Period

Coverage begins on the first day of:

- The month in which the individual first becomes eligible for SMI if enrollment takes place during the first 3 months of the initial enrollment period,
- The month following the month of enrollment if enrollment occurs during the fourth month of the initial enrollment period,
- The second month following the month of enrollment if enrollment occurs during the fifth month of the initial enrollment period, or
- The third month following the month of enrollment if enrollment occurs during the sixth or seventh month of the initial enrollment period.

40.3.2 - Enrollment During General Enrollment Period

Coverage begins the following July 1.

40.3.3 - Enrollment During the Individual's Special Enrollment Period

If an individual enrolls in SMI or premium HI while still covered under a GHP or LGHP or during the first full month when not enrolled in a GHP/LGHP based on current employment status, coverage begins either with:

- The first day of the month of SMI or premium HI enrollment, or
- At the individual's option, with the first day of any of the following 3 months.

If the individual enrolls during any of the 7 remaining months of the special enrollment period, coverage begins with the first day of the month following the month of enrollment;

40.4 - Nature and Purpose of State Buy-in

Under the buy-in program, States may enroll certain groups of needy people in the supplementary medical insurance program and pay their premiums. The purpose of buy-in is to permit the State, as part of its total assistance plan, to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and also meet the eligibility requirements for SMI. It has the effect of transferring some medical costs for this population from the title XIX Medicaid program, which is partially State financed, to the title XVIII program, which is financed by the Federal Government. Federal matching money is available through the Medicaid program to assist the States with the premium payments for certain buy-in enrollees.

40.5 - End of Coverage

An individual may notify CMS in writing, at any time, that he or she no longer wishes to participate in the supplementary medical insurance plan. Termination of coverage takes

effect at the close of the calendar month following the calendar month in which the request for termination was filed.

Enrollment under medical insurance is terminated because of nonpayment of premiums. Termination is effective with the end of the grace period provided for payment of premiums. (See chapter 2, §40.7.4 of this manual.)

For individuals under age 65, enrollment is terminated because HI entitlement ended. SMI terminates at the same time as HI.

If not terminated sooner, coverage ends with the beneficiary's death.

40.6 - Termination and Reenrollment

An individual whose enrollment has terminated may reenroll only in a general enrollment period or a special enrollment period if the requirements are met.

40.7 - Premiums

A premium is due for each month of entitlement under SMI. The SMI premium covers about one-fourth of the cost of the Part B program.

40.7.1 - Amount of Premiums

In the third quarter of each calendar year, the Secretary of the Department of Health and Human Services announces the base premium for SMI coverage that is payable as of the following January 1. The SMI premium is the same for all enrollees even though the cost to the program is greater for ESRD enrollees and the disabled than it is for the aged. The SMI premium is refigured each year and is based on the lower of one-half of SMI program costs per aged enrollee or the general percentage by which social security benefits were increased during the calendar year in which the announcement occurs. (During the 5-year period, January 1984 through December 1988, the formula for computing the SMI premium has been modified to provide that the Part B premium reflects exactly one-fourth of the cost of the Part B program. Beginning with the premium announced for the period beginning January 1989, however, the method of computing the SMI premium reverts back to the pre-January 1984 rules.)

40.7.2 - Increase in Base Premium Amount

The base premium that is announced by the Secretary is paid by most enrollees. However, it is increased for those who enroll late or reenroll after a prior termination of entitlement. The amount of the increase is 10 percent of the base rate for each full 12-month period during which the individual could have been but was not enrolled in the program. However, months in which an individual has GHP coverage based on current employment status are not counted as months in which the individual "could have been,

but was not enrolled." This exception does not apply to individuals who are entitled to Medicare on the basis of ESRD.

40.7.3 - Collection of Premiums

SMI premiums are collected from benefits payable (in order of priority) by the Railroad Retirement Board, SSA, or Office of Personnel Management (Civil Service) unless the individual is covered under a State buy-in agreement. If the individual is entitled to such benefits but the payments are in suspense, e.g., due to work deductions, he or she is billed for the amounts due. Uninsured beneficiaries are also billed directly for the premiums due.

Premium bills are sent every 3 months unless the individual specifically requests a monthly bill or is also entitled to Premium -HI (in which case a monthly combined SMI-Premium-HI bill is sent).

40.7.4 - Grace Period for Payment

A grace period has been provided for payment of premiums by those who are billed directly. The period extends for 90 days after the month in which the bill is mailed. If the premiums are not received in that prescribed time, entitlement terminates at the end of the grace period. This 90-day grace period for paying overdue SMI premiums and continuing SMI coverage may be extended by CMS for good cause for up to an additional 90 days. Good cause, for example, is found if the enrollee was mentally or physically incapable of paying his or her premiums timely, or had some reasonable basis to believe that payment had been made, or the failure to pay was due to administrative error.

40.7.5 - Payment After Grace Period Applies

If an extension to the grace period (additional 90 days; a total not to exceed 180 days) has been granted, an enrollee may retain SMI entitlement by paying all past due premiums if there was a good cause for his/her failure to pay premiums within the initial grace period.

40.7.6 - Premiums Paid by Other Than the Enrollee

The following subsections describe premiums paid by other than the enrollee.

40.7.6.1 - Informal Arrangement

Enrollees who are being billed directly for Medicare premiums may turn over their premium bills to a friend, relative, employer lodge, union or other organization to pay premiums on their behalf. The third party payer forwards the proper amount of payment for each enrollee to CMS's Premium Collection Center. Enrollees participating in this type of informal arrangement continue to receive their premium notice (Form CMS-500),

and remain responsible for assuring that premiums paid on their behalf are paid timely in order to avoid termination of Medicare coverage.

40.7.6.2 - Premium Payer

Individuals may be designated as the premium payer for an enrollee and receive the enrollee's premium bills, if it is judged to be in the enrollee's best interest (e.g., the enrollee is competent, but too physically ill or infirm to be able to handle such matters). The individual receiving the premium bill must be a relative or friend showing personal interest in the welfare of the enrollee.

40.7.6.3 - Formal Group Arrangement

Employers, religious orders, lodges, unions or other organizations may enter into a formal agreement with CMS in order to receive a single bill and pay a lump sum for the premiums due from a group of individuals. Group payments under a formal group agreement may be made only on behalf of individuals who are already enrolled and are being billed for direct remittance. This type of arrangement is referred to as a "Formal Group Payer" arrangement. While included in a formal group payer arrangement, enrollees will no longer receive a premium notice (Form CMS-500). This arrangement is available only where the number of enrollees in the group is large enough to make it practicable to send one bill to the group payer and where the following conditions are also met:

- Enrollees included under the formal group arrangement are directly billed for their premium, and are not having his/her premiums deducted from a Social Security, Railroad Retirement, or Civil Service benefit, or, are not having premiums paid by a State Medicaid agency under a State buy-in agreement;
- The enrollee authorizes the formal group payer to pay premiums on his/her behalf;
- The formal group payer has a minimum of 20 enrollees; and
- The formal group payer agrees to submit premium payments via electronic funds transfer.

If the formal group payer agreement is terminated, or if the group payer alerts CMS to remove an individual from the group payer arrangement, CMS will resume collection of premiums from the individual through the direct billing process.

40.7.6.4 - Premium Surcharge Payment

States or local Governments may pay a lump sum for the total amount of the SMI late enrollment premium surcharge for a group of individuals. In order to pay the premium surcharge, States or local Governmental entities are required to enter into a formal agreement with CMS. An individual is not billed for the premium surcharge portion of

his/her SMI premium while under a premium surcharge agreement, however, he/she is billed for the base premium amount. If the enrollee is receiving a Social Security, Railroad Retirement, or Civil Service annuity, the agencies responsible for these programs will continue to withhold the base premium amount from the annuity. Enrollees who are billed directly for premiums will continue to receive a premium bill for the base premium amount.

The ultimate responsibility for paying premiums rests with the enrollees.

40.7.7 - Premiums Under Buy-In

Although a person who individually enrolls for SMI may be subject to an increase in the premium rate if he or she fails to enroll when first eligible, a State always pays premiums for its enrollees at the base rate. No premium surcharge for late enrollment is imposed.

40.8 - Waiver of Enrollment Period Requirements Due to Administrative Error

CMS and SSA are authorized to take necessary action to correct an erroneous SMI or premium hospital insurance enrollment or nonenrollment which was based upon the action, inaction, or error of a Government officer, employee, or agent. The action may include designating special individual enrollment periods and premium adjustments.

For the purpose of this provision, an individual's enrollment or nonenrollment in SMI is considered to have been prejudiced and due to the "action, inaction, or error" of an officer, employee, or agent of the Government, if there is an official record or other evidence showing that:

- The individual took reasonable appropriate and timely measures to assert his or her rights, and
- Due to administrative fault or other action, which may or may not have been erroneous at the time taken, his or her rights have been or are likely to be impaired unless relief is given.

This authority applies to all Part B cases which have arisen since the Medicare program began on July 1, 1966. It is applied to cases that come to CMS's or SSA's attention; however, intermediaries and carriers should not search their files.

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

As part of health insurance electronic data processing, health insurance cards are issued by CMS (or by the RRB where railroad retirement beneficiaries are involved) to individuals who have established entitlement to health insurance. An example of the Health Insurance card is found at the bottom of:

http://www.medicare.gov/Basics/ymc.asp

The HI 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, sex, Health Insurance Claim Number (HICN), 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 HI card.

50.1 - Temporary Eligibility Notice

A Social Security field office may issue a temporary health insurance eligibility notice if medical services are needed immediately. Sample text for such notices follows:

TEMPORARY NOTICE OF MEDICARE ELIGIBILITY

(If the individual is only eligible for HI or SMI, delete the inapplicable words)

District Office Address:

Date:

Patients HICN

Dear

Based on the information given to the Social Security Administration, you are (Mr./Ms. is) eligible for hospital insurance beginning (mo.) (yr.) and for medical insurance beginning (mo.) (yr.) . This notice will serve as evidence of your (his,her) eligibility for these benefits for 60 days from the date shown at the top of this notice, unless you are notified otherwise during the 60-day period.

To obtain medical services (or payment for medical services) before you receive a health insurance card, show this letter to your hospital or doctor, but keep the letter with you. This temporary notice of eligibility is to be used only by the person to whom it is addressed. Misuse is unlawful and will make the offender liable to a penalty.

This letter should be destroyed as soon as you receive a health insurance card or other notice of eligibility.

Sincerely Yours,

Commissioner of Social Security

IMPORTANT: When services are provided on the basis of this notice, all bills or correspondence with a carrier, intermediary, or the Social Security Administration should show the patient's health insurance claim number.

50.2 - Health Insurance Claims Numbers (HICNs)

All HICNs issued by SSA are 9-digit numbers with at least one letter suffix (called a beneficiary identification code or BIC) in the tenth position. If there is an eleventh position, it may be either a letter or number e.g. 123-45-6789A or 987-65-4321D4. The HICN issued by the RRB, may contain either 6 or 9 digit numbers with up to a 3-position letter prefix e.g., A123456 or MA123-45-6789. If a beneficiary's entitlement changes, it is possible for the 9-digit number, the prefix, the suffix or all three to change. It is also possible to go from an SSA issued HICN to a RRB HICN or vise versa.

The numeric portion of a 9-digit HICN consists of a Social Security Number (SSN). If the BIC is A, T, TA, M, M1, J1, J2, J3, J4 or the RRB prefix is A or H the number is the beneficiary's own SSN. If the BIC or RRB prefix is other than one of the above, the SSN belongs to a number holder and the beneficiary is entitled as an auxiliary or survivor on that SSN.

Currently, the first three digits of the HICN range from 001-772. However this may change as SSA issues more numbers. All numbers except 00 are possible for the fourth and fifth digits and all numbers except 0000 are possible for the last four digits.

The patient's HICN is on his/her HI card, SSA award letter, SSA Benefit Verification letter, an SSA issued Temporary Notice of Eligibility, Explanation of Medicare Benefits (EOMB), Notice of Utilization (NOU), or Medicare Summary Notice (MSN). Where the patient cannot furnish a HICN, it may be an indication that he/she has not filed an application with SSA to establish entitlement to health insurance benefits, or that SSA action on a pending application has not been completed.

50.3 - HICNs Assigned by CMS

(See Section 50.2 for an explanation of the valid 9-digit numbers issued by SSA.)

A
B, Bl, B2, B3, B4, B5, B6, B7, B8, B9, BA, BD, BG, BH, BJ, BK, BL, BN, BP, BQ, BR, BT, BW, BY
Cl, C2, C3, C4, C5, C6, C7, C8, C9, CA, CB, CC, CD, CE, CF, CG, CH, CI, CJ, CK, CL, CM, CN, CO, CP, CQ, CR, CS, CT, CU, CV, CW, CX, CY, CZ
D, Dl, D2, D3, D4, D5, D6, D7, D8, D9, DA, DC, DD, DG, DH, DJ, DK, DL, DM, DN, DP, DQ, DR, DS, DT, DV, DW, DX, DY, DZ
E, El, E2, E3, E4, E5, E6, E7, E8, E9, EA, EB, EC, ED, EF, EG, EH, EJ, EK, EM

Fl, F2, F3, F4, F5, F6, F7, F8
Jl, J2, J3,J4
Kl, K2, K3, K4, K5, K6, K7, K8, K9, KA, KB, KC, KD, KE, KF, KG, KH, KJ, KL, KM
T, TA, TB, TC, TD, TE, TF, TG, TH, TJ, TK, TL, TM, TN, TP, TQ, TR, TS, TT, TU, TV, TW, TX, TY, TZ, and T2
W, Wl, W2, W3, W4, W5, W6, W7, W8, W9, WB, WC, WF, WG, WJ, WR, WT

50.4 - HICNs Assigned by the RRB

The RRB began using the social security number in their numbering system during calendar year l964. The HICNs assigned prior to that time were 6-digit numbers assigned in numerical sequence and had no special characteristics. However, both the 6-digit numbers and the 9-digit social security numbers when used as claim numbers by the RRB always have letter prefixes. In rare cases, a qualified railroad retirement beneficiary may have a claim number with less than 6-digits. In this case, sufficient zeros are added between the prefix and other digits to make a 6-digit number, e.g., WD-00l234. The current range of valid RRB claim numbers is 000001-994999.

50.4.1 - Six-Digit Numbers

The basic RRB claim numbers assigned to each type of prefix are shown in this section. Under the RRB system, it is permissible for two beneficiaries to have identical claim numbers. For example, when a widower remarries, the second wife is assigned the same claim number that was assigned to the first wife. Under the Medicare program, however, every individual has a distinctive claim number. Therefore, for Medicare purposes, pseudo numbers are assigned to railroad retirement beneficiaries who would otherwise have a claim number that was assigned to someone else.

The numbers in the series 995000 through 999999 were assigned to these beneficiaries. But, whenever possible, the Board will use the railroad retirement beneficiary's own 9-digit social security number with the appropriate prefix. They will only use the 6-digit number if the railroad retirement beneficiary does not have their own social security number and cannot obtain one because of Social Security Administration limitations on issuing numbers. An example of an individual who cannot get a number is a beneficiary who lives outside the United States and is not a citizen of the U.S.

50.4.2 - Valid RRB HICNs

A-000000	WD-000000	PD-000000
A-000-00-0000	WD-000-00-0000	PD-000-00-0000
MA-000000	WCD-000000	H-000000

MA-000-00-0000	WCD-000-00-0000	MH-000000
WA-000000	WCA-000000	PH-000000
WA-000-00-0000	WCA-000-00-0000	JA-000000
CA-000000	PA-000000	WH-000000
CA-000-00-0000	PA-000-00-0000	WH-000-00-0000
H-000-00-0000	MH-000-00-0000	WCH-000000
JA-000-00-0000	PH-000-00-0000	WCH-000-00-0000

60 - Medicare Part C, Medicare+Choice

Medicare Part C, which is also known as Medicare+Choice, is a Medicare program that gives beneficiaries more choices among health plans. Everyone who has Medicare Parts A and B is eligible, except those who have end stage renal disease, and were not in a Medicare+Choice plan at the onset of this condition.

Public Law 105-33, the Balanced Budget Act of 1997, establishes a new authority permitting contracts between CMS and a variety of different managed care and fee-for-service entities. The types of entities that may be granted contracts under this new authority include:

- Coordinated care plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Provider-Sponsored Organizations (PSOs). A PSO is defined as a public or private entity established by health care providers, which provide a substantial proportion of health care items and services directly through affiliated providers who share, directly or indirectly, substantial financial risk.
- Religious fraternal benefit society plans which may restrict enrollment to members of the church, convention or group with which the society is affiliated. Payments to such plans may be adjusted, as appropriate to take into account the actuarial characteristics and experience of plan enrollees.
- Private fee-for-service plans which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115 percent of the plan's payment schedule (which may be different from the Medicare fee schedule).

In addition to the Medicare+Choice contractors, beginning in January, 1999, up to 390,000 beneficiaries will have the choice (on a demonstration basis ending January 1, 2003) of enrolling in a Medical Savings Account (MSA) option. Under this option, beneficiaries would obtain high deductible health policies that pay for at least all Medicare-covered items and services after an enrollee meets the annual deductible of up to $6,000. The difference between the premiums for such high deductible policies and the applicable Medicare+Choice premium amount would be placed into an account for the beneficiary to use in meeting his or her deductible expenses.

Past 1876 Contracts - HMO/CMP risk plans that remain in compliance with current contracting standards and comply with new requirements established under this statutory authority automatically transitioned into the Part C Medicare+Choice program. Section 1876 risk-based contractors were paid under a new Medicare+Choice payment methodology rather than the prior method in section 1876(a), and were subject to certain other Medicare+Choice provisions. The Secretary no longer accepts new 1876 risk applications. As of January 1, 1999, existing 1876 risk-based contracts were terminated, and plans in good standing transitioned to the Medicare+Choice program.

Repeal of Cost Option - As of August 5, 1997, the Secretary is prohibited from entering into any new 1876 cost-based contracts, unless the plan is a Health Care Prepayment Plan with an agreement under section 1833 of the Social Security Act. The 1876 cost-based payment authority is repealed and all cost contracts are terminated as of December 31, 2002.

Limited HCPP Option - Beginning January 1, 1999, the Secretary may only contract with those HCPPs that are sponsored by Union or Employer groups, or HCPPs that do not "provide, or arrange for the provision of, any inpatient hospital services ...." This amendment will result in the termination of section 1833 agreements with any organization that does not meet the new definition. CMS will establish transition rules for 1876 risk-based contractors that currently receive reimbursement on a cost basis for enrollees remaining under a previous HCPP agreement.

Deductibles, Coinsurance Amounts, and Payment Limitations

10 - Hospital Insurance (Part A)

10.1 - Inpatient Hospital Deductible

The patient is responsible for a deductible amount for inpatient hospital services in each benefit period. For each year after 1991, the Secretary of the Department of Health and Human Services (DHHS) is required to set the deductible and coinsurance amounts between September 1 and September 15 of the preceding year. The deductible will be set at an amount equal to the deductible for the preceding year, changed by the same percentage as applies to PPS payment rates, and adjusted to reflect changes in real case mix. The deductible and coinsurance amounts are shown in the chart in §10.3 of this chapter.

The coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur. The deductible is satisfied only by charges for covered Part A services. Expenses for covered services count toward the deductible on an incurred, rather than paid, basis. Expenses incurred in one benefit period cannot be applied toward the deductible in a later benefit period. Expenses incurred in meeting the blood deductible do not count toward the inpatient hospital deductible.

A reduction in benefit days resulting from confinement in a psychiatric hospital, on and immediately preceding the date of entitlement, does not affect the amount of the deductible for which the patient is responsible.

If the actual charge is less than the deductible and the customary charge, the customary charge is applied to the deductible.

A beneficiary is not responsible for payment of the deductible for an inpatient stay if the provider has been determined to be liable because the care was not medically necessary or because the care provided was custodial.

10.2 – Coinsurance

The following subsections describe coinsurance.

10.2.1 - Inpatient Services

In each benefit period, the patient is responsible for coinsurance amounts equal to:

- One-fourth of the inpatient hospital deductible for each day of inpatient hospital services from the 61st through the 90th days;

- One-half of the inpatient hospital deductible for each lifetime reserve day (the 91st through the 150th days of inpatient hospital services); and

- One-eighth of the inpatient hospital deductible for each day of extended care services from the 21st through the 100th days. A beneficiary is not responsible for payment of the coinsurance for a stay if the provider has been determined to be liable because the care was not medically necessary or because the care provided was custodial.

Use the chart in §10.3 of this chapter to determine the applicable coinsurance amounts.

Where the actual charge to the patient for the 61st through the 90th days of inpatient hospital services is less than the applicable coinsurance amount, the coinsurance is the actual charge per day. Where the actual charge to the patient for lifetime reserve days is less than the coinsurance amount for those days, the beneficiary may be deemed to have elected not to use the days because he/she would not benefit from their utilization.

10.2.2 - Durable Medical Equipment (DME) Furnished as a Home Health Benefit

The patient is responsible for 20 percent of the payment amount for DME furnished as a home health benefit.

10.3 - Basis for Determining the Part A Coinsurance Amounts

The applicable inpatient deductible is the one in effect during the calendar year in which the patient's benefit period begins (i.e., in most cases, the year in which the first inpatient hospital services are furnished in the benefit period). Except for 1989, the coinsurance amount is based on the deductible applicable for the calendar year in which the coinsurance days occur.

When Deductible and/or Coinsurance Are Applicable for Part A

Inpatient Hospital- First 60 Days	Deductible applicable equal to national average cost per day
Inpatient Hospital- 61st thru 90th Day	Coinsurance per day always equal to 1/4 of inpatient hospital deductible
Inpatient Hospital- 60 Lifetime Reserve Days (nonrenewable) - 91st thru 150th day	Coinsurance always equal to 1/2 of inpatient hospital deductible
Skilled Nursing Facility 21st thru 100th Day	Coinsurance always equal to 1/8 of inpatient hospital deductible

Home Health Agency	No Deductible No Coinsurance (except for 20 percent coinsurance for DME and prosthetics/ orthotics)
Blood	1st 3 pints (or equivalent units of packed red blood cells) in a calendar year - combined Part A and B
Hospice * a. Drugs and Biologicals b. Respite Care	a. 5 percent of the cost determined by the drug copayment schedule (may not exceed $5 per prescription) b. 5 percent of the payment for a respite care day

*Hospices may charge coinsurance for two services only, drugs and biologicals, and respite care. The amount of coinsurance for each prescription may not exceed $5.00. The amount for respite care may not exceed the inpatient deductible for the year in which the hospital coinsurance period began.

Deductible and Coinsurance Amounts

Year	Inpatient Hospital Deductible, 1st 60 Days	Inpatient Hospital Coinsurance, 61st-90th Days	60 Lifetime Reserve Days Coinsurance	SNF Coinsurance
1986	$492	123	246	61.50
1987	520	130	260	65.00
1988	540	135	270	67.50
1989	560	0 (1)	0 (1)	0(2)
1990	592	148	296	74.00
1991	628	157	314	78.50
1992	652	163	326	81.50
1993	676	169	338	84.50
1994	696	174	348	87.00
1995	716	179	358	89.50
1996	736	184	368	92.00
1997	760	190	380	92.00
1998	764	191	382	95.50
1999	768	192	384	96.00
2000	776	194	388	97.00
2001	792	198	396	99.00
2002	812	203	406	101.50
2003	840	210	420	105.00
2004	876	219	438	109.50
2005	912	228	456	114.00
2006	952	238	476	119.00

2007	992	248	496	124.00
2008	1,024	256	512	128.00
2009	1,068	267	534	133.50
2010	1,100	275	550	137.50
2011	1,132	283	566	141.50
2012	1,156	289	578	144.50
2013	1,184	296	592	148.00

1. Coinsurance was not charged for inpatient hospital care in CY 1989 due to Catastrophic Coverage. The deductible was applied.

2. Under Catastrophic Coverage, a coinsurance payment of $25.50 was due for days 1-8 of SNF care. No SNF coinsurance was due after day 8 in 1989.

10.4 - Benefit Period (Spell of Illness)

A benefit period is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which covered services furnished to a patient, up to certain specified maximum amounts, may be paid for by the hospital insurance plan. For example, a patient is eligible for 90 days of hospital care in a benefit period and 100 days of extended care services during the same benefit period. A patient may be eligible for as many as l50 days of hospital care in a benefit period if he/she draws on his/her lifetime reserve. As long as a person continues to be entitled to hospital insurance, there is no limit on the number of benefit periods he/she may have. The term "benefit period" is synonymous with spell of illness. Since the term "spell of illness" could connote a single illness or a particular "spell" of sickness, the term benefit period is used in communications with the public.

10.4.1 - Starting a Benefit Period

A benefit period begins with the first day (not included in a previous benefit period) on which a patient is furnished inpatient hospital or extended care services by a qualified provider in a month for which the patient is entitled to hospital insurance benefits.

A provider qualified to start a benefit period is a hospital (including a psychiatric hospital) or SNF that meets all the requirements of the definition of such an institution. A hospital which meets all requirements in Chapter 5, §20 of this manual is also a qualified hospital for purposes of beginning a benefit period when it furnishes the patient covered inpatient emergency services. Thus, generally, the benefit period begins when covered inpatient services are initially furnished to an entitled individual. However, the noncovered services furnished by a nonparticipating provider can begin a spell of illness only if the provider is a qualified provider. A qualified provider is a hospital (including a psychiatric hospital) or a SNF which meets all requirements in the definition of such an institution even though it may not be participating. A qualified hospital in Canada or

Mexico is also a qualified provider for purposes of beginning a benefit period when it furnishes covered inpatient hospital services. If a person is in a nonqualified institution and is subsequently transferred to a qualified hospital (general or psychiatric), his/her benefit period begins on admission to the qualified hospital.

Admission to a qualified SNF or to the SNF level of care in a swing-bed hospital begins a benefit period even though payment for the services cannot be made because the prior hospitalization or *thirty-day* transfer requirement has not been met. *It is also worth noting that the SNF benefit's "thirty-day" transfer requirement has a medical appropriateness exception (described in Pub. 100-02, Medicare Benefit Policy Manual, chapter 8, section 20.2.2), under which the allowable interval between a beneficiary's discharge from a qualifying prior hospitalization and the initiation of SNF care can exceed the normal 30-day timeframe; moreover, in a situation where the allowable interval under this exception is* ***60 days*** *or longer, the subsequent commencement of extended care services in the SNF would serve to trigger the start of a new benefit period.* Inpatient care in a Religious Non-Medical Health Care Institution (whether as hospital or extended care services) can begin or prolong a benefit period.

10.4.2 - Ending a Benefit Period

The benefit period ends with the close of a period of 60 consecutive days during which the patient was neither an inpatient of a hospital nor of a SNF. To determine the 60 consecutive day period, begin counting with the day the individual was discharged. (See §10.4.3.2 of this chapter for determining the end of a benefit period when an individual remains in a SNF.)

As noted in section 10.4, the term "benefit period" is synonymous with spell of illness. However, the statutory language (at §1861(a) of the Social Security Act) that describes a benefit period as a "spell of illness" is sometimes misunderstood to mean that a benefit period is linked to a particular medical episode or type of condition, so that the onset of a new and entirely unrelated condition could serve to end a benefit period even in the absence of a 60-day break in the beneficiary's "inpatient" status. In fact, the onset of a new condition is not, in itself, relevant to the ending of a benefit period, which can occur ***only*** *through a 60-day break in inpatient status, as described above.*

10.4.3 - Definition of Hospital or SNF for Ending a Benefit Period

It is important to note that a benefit period cannot end while a beneficiary is an inpatient of a hospital, even if the hospital does not meet all of the requirements that are necessary for starting a benefit period. Similarly, a benefit period cannot end while a beneficiary is an inpatient of a SNF, as defined below.

10.4.3.1 - Hospital Stay and End of Benefit Period

In order to end a benefit period, for at least 60 consecutive days, a beneficiary cannot have been in a hospital which meets the initial requirement in the definitions in Chapter 5, §20.1 through §20.7 of this publication. That is, the beneficiary cannot have been in a facility that is primarily engaged in providing, by or under the supervision of a physician(s), to inpatients:

- Diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for injured, disabled, or sick persons; or

- Psychiatric services for the diagnosis and treatment of mentally ill persons. A stay in a hospital outside the United States prolongs a benefit period. It may be assumed, in the absence of evidence to the contrary, that:

- A foreign hospital in which a beneficiary spent one or more days meets the requirement of the definition in Chapter 5, §20 of this manual; and

- The beneficiary's statement about length and place of stay is correct.

10.4.3.2 - SNF Stay and End of Benefit Period

Similarly, to end a benefit period, a beneficiary cannot have been an inpatient (see subsection 10.4.4) of a SNF for at least 60 consecutive days; where SNF is defined as a facility which is primarily engaged in providing skilled nursing care and related services to residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

Examples: An individual may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 consecutive days have not elapsed between discharge and readmission. The stays need not be for related physical or mental conditions.

Example l: X was born 8/9/36. On 7/28/2001, X entered a participating general hospital. After he/she had been in the hospital for 2 weeks, X was discharged on 8/11/2001. On his/her doctor's orders, X entered a participating SNF on 8/15/2001, and remained an inpatient there (see subsection 10.4.4) until his/her discharge on 10/27/2001. He/she had no further inpatient stays in 2001.

X's benefit period began on 8/1/2001, the first day of the month he/she attained age 65 and was entitled to hospital insurance. The benefit period ended 12/25/2001, the end of the 60-day period beginning with the date of his/her last discharge.

Example 2: Y, over age 65, entered a participating general hospital on 8/28/2000 for treatment of a heart condition. He/she was discharged on 9/11/2000. On 10/3/2000, Y

entered a Medicaid-only nursing facility, and remained an inpatient of this facility (see subsection 10.4.4) until his/her discharge on 11/17/2000. On 12/26/2000, Y was again admitted to a participating hospital because of injuries suffered in an accident. He/she was discharged on 1/13/2001 and had no further inpatient stays in 2001.

Y's benefit period began on 8/28/2000. His/her stay in the nursing facility began less than 60 days after his/her hospital stay and the benefit period was continued because he/she remained an inpatient there (see subsection 10.4.4) even though Medicare did not cover the stay. The subsequent hospital stay began less than 60 days after the nursing facility stay and continued the benefit period although the condition treated was unrelated to his/her prior stays. The benefit period ended on 3/14/2001, the end of the 60-day period beginning with the day of last discharge.

Example 3: Z, over age 65 and entitled to hospital insurance benefits, was admitted to General Hospital on 8/l/2000 and discharged on 8/l0/2000, having received nonemergency hospital services. General Hospital met all the requirements in the definition of a hospital except those concerning utilization review and health and safety. While General Hospital met the minimum requirements of an emergency hospital, Z's benefit period did not begin with his/her admission to this hospital because:

1. The hospital did not meet all of the requirements in the definition of a hospital; and

2. Although the hospital satisfied the minimum requirements for coverage of emergency services, Z did not receive emergency inpatient care there.

(As noted previously, a stay in an emergency hospital does not begin a benefit period unless it actually involves the receipt of covered inpatient emergency services; by contrast, even a nonemergency stay in such a hospital can serve as a qualifying hospital stay for purposes of coverage under the posthospital extended care benefit.) Z was admitted to Haven Convalescent Home on 8/20/2000 and remained an inpatient of the home (see subsection 10.4.4) until his/her discharge on 3/l/2001. He/she had no further inpatient stays in 2001. Haven Convalescent Home became a participating SNF on l/l/2001.

Z's benefit period began 1/1/2001, the day Haven Convalescent Home was determined to be a qualified SNF. The services Z received from that date through discharge were extended care services even though they were not covered and, therefore, not charged against Z's Medicare SNF utilization. (The services were not covered posthospital extended care services because Z was not admitted to a participating SNF within 30 days after discharge from the hospital.) Z's benefit period ended 4/29/2001, the end of the 60-day period beginning with the date of his discharge from the convalescent home.

10.4.4 - Definition of Inpatient for Ending a Benefit Period

Generally, a beneficiary is an inpatient of a hospital if the beneficiary is receiving inpatient services in the hospital (i.e., not on an outpatient basis). The type of care actually received is not relevant.

However, a different definition of inpatient applies in determining the end of a benefit period for a beneficiary in a SNF*, under which such a* beneficiary is *considered* an inpatient *in this context* only if the beneficiary's care in the SNF meets certain skilled level of care standards. *Specifically, t*he beneficiary must need and receive a skilled level of care while in the SNF.

This means that in order to have been an *"*inpatient*" for benefit period purposes* while in a SNF, the beneficiary must have required and received skilled services on a daily basis which could, as a practical matter, only have been provided in a SNF on an inpatient basis. *(Under the regulations at 42 CFR 409.60(b)(2), an additional level of care criterion at 42 CFR 409.31(b)(2)--requiring that the SNF care must in some way relate back to a condition that was present during the beneficiary's qualifying hospital stay--does not apply to benefit period determinations.)* If these provisions were not met during the prior SNF stay, the beneficiary was not an inpatient of the SNF for purposes of prolonging the benefit period. *Conversely, a beneficiary would remain an SNF "inpatient" in this context (thus prolonging his or her current benefit period) for as long as the beneficiary continues receiving a skilled level of care in the SNF--even if Part A payment has ended due to the beneficiary's exhaustion of SNF benefits.*

Use the following presumptions for determining whether the skilled level of care standards were met during a prior SNF stay.

Presumption 1: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim was paid for the care, unless such payment was made under limitation on liability rules.

Presumption 2: A beneficiary's care in a SNF met the skilled level of care standards if a SNF claim was paid for the services provided in the SNF under the special Medicare limitation on liability rules pursuant to placement in a non-certified bed.

Presumption 3: A beneficiary's care in a SNF did not meet the skilled level of care standards if a claim was paid for the services provided in the SNF pursuant to the general Medicare limitation on liability rules. (This presumption does not apply to placement in a non-certified bed. For claims paid under these special provisions, see Presumption 2.)

Presumption 4: A beneficiary's care in a Medicaid nursing facility (NF) did not meet the skilled level of care standards if a Medicaid claim for the services provided in the NF was denied on the grounds that the services received were not at the NF level of care (even if paid under applicable Medicaid administratively necessary days provisions which result in payment for care not meeting the NF level of care requirements).

Presumption 5: A beneficiary's care in a SNF met the skilled level of care standards if a Medicare SNF claim for the services provided in the SNF was denied on grounds other than that the services were not at the skilled level of care.

Presumption 6: A beneficiary's care in a SNF did not meet the skilled level of care standards if a Medicare claim for the services provided in the SNF was denied on the grounds that the services were not at the skilled level of care and no limitation of liability payment was made.

Presumption 7: A beneficiary's care in a SNF did not meet the skilled level of care standards if no Medicare or Medicaid claim was submitted by the SNF.

Presumptions 1 through 4 cannot be rebutted. Thus, prior Medicare and Medicaid claim determinations that necessarily required a level of care determination for the time period under consideration are binding for purposes of a later benefit period calculation.

Presumptions 5 through 7 can be rebutted by the beneficiary showing that the level of care needed or received is other than that which the presumption dictates.

Presumption 6 can be rebutted because the Medicare skilled level of care definition for coverage purposes is broader than the skilled level of care definition used here for benefit period determinations. Specifically, the requirement referred to in Chapter 4, §40.2 regarding prior hospital care related to the SNF care is included in the Medicare SNF coverage requirements but is not included in the standard for benefit period determinations. Therefore, Medicare payment could have been denied for a SNF stay on level of care grounds (i.e., not even waiver payment was made) because of noncompliance with that requirement, even though skilled level of care requirements for benefit period determinations were in fact met by the SNF stay. Consequently, when Medicare SNF payment is denied on level of care grounds, the beneficiary must be given the opportunity to demonstrate that he/she still needed and received a skilled level of care for purposes of benefit period determinations.

NOTE: Effective October 1, 1990, the levels of care that were previously covered separately under the Medicaid SNF and intermediate care facility (ICF) benefits are combined in a single Medicaid nursing facility (NF) benefit. Thus, the Medicaid NF benefit includes essentially the same type of skilled care covered by Medicare's SNF benefit, but it includes less intensive care as well. This means that when a person is found not to require at least a Medicaid NF level of care (as under Presumption 4), it can be presumed that he or she also does not meet the Medicare skilled level of care standards. However, since the NF benefit can include care that is less intensive than Medicare SNF care, merely establishing that a person does require NF level care does not necessarily mean that he or she also meets the Medicare skilled level of care standards. Determining whether an individual who requires NF level care also meets the Medicare skilled level of care standards requires an actual examination of the medical evidence and cannot be accomplished through the simple use of a presumption. Therefore, the previous

references to Medicaid claims have been deleted from those presumptions which establish that an individual does meet the Medicare standards.

Medicare no-payment bills submitted by a SNF result in Medicare program payment determinations (i.e., denials). Therefore, such no-payment bills trigger the appropriate presumptions. This also applies in any State where the Medicaid program utilizes no-payment bills which lead to Medicaid program payment determinations. If a SNF erroneously fails to submit a Medicare claim (albeit a no-pay claim) when Medicare rules require such submission, intermediaries request a SNF to submit one. Once the no-pay bill is submitted and denied, the applicable presumption (other than presumption 7) is triggered. If a patient is moving from a SNF level of care to a non-SNF level of care in a facility certified to provide SNF care, occurrence code 22 (date active care ended) is used to signify the beginning of the no-pay period on the bill and trigger the appropriate presumptions.

Where the presumptions are rebuttable (i.e., 5 through 7), rebuttal showings are permitted at both intermediary determination levels under 42 CFR 405, Subpart G (i.e., a rebuttal showing regarding the status of a prior SNF stay is made at the time that an inpatient claim is submitted and/or at the reconsideration level). Intermediaries evaluate rebuttal documentation even if the presumption being rebutted was triggered by a Medicaid denial.

This special rule for determining whether a beneficiary in a SNF is an inpatient for benefit period purposes is applicable in all cases where a prior SNF stay affects benefit period status, not only when a beneficiary is in exhausted or copay status and is seeking to renew a benefit period. The rule has equal application where it results in the beneficiary starting a new benefit period and paying a new deductible without receiving an increase in the amount of Medicare benefits paid.

20 - Supplementary Medical Insurance (SMI) (Part B)

Supplementary Medical Insurance is described in the following subsections.

20.1 - Supplementary Medical Insurance Incurred Expenses

The SMI plan includes coverage for expenses incurred for the services described in Chapter 1, §10.3:

Payment may not be made under Part B for services furnished an individual entitled to have payment made for those services under Part A, e.g., if the expenses incurred were to satisfy a Part A deductible or coinsurance amount, or if payment would be made under Part A except for the lack of request for payment or physician certification.

20.2 - Part B Annual Deductible

In each calendar year, a cash deductible must be satisfied before payment can be made under SMI. (See 20.4 of this chapter for exceptions.)

Calendar Year	Deductible
1966 – 1972	$50
1973 – 1981	$60
1982 – 1990	$75
1991 – 2004	$100
2005	$110
2006	$124
2007	$131
2008	$135
2009	$135
2010	$155
2011	$162
2012	$140
2013	$147

Expenses count toward the deductible on the basis of incurred, rather than paid expenses, and are based on Medicare allowed amounts. Non-covered expenses do not count toward the deductible. Even though an individual is not entitled to Part B benefits for the entire calendar year (i.e., insurance coverage begins after the first month of a year or the individual dies before the last month of the year), he or she is still subject to the full deductible for that year. Medical expenses incurred in the portion of the year preceding entitlement to medical insurance are not credited toward the deductible.

The date of service generally determines when expenses were incurred, but expenses are allocated to the deductible in the order in which the bills are received. Services not subject to the deductible cannot be used to satisfy the deductible.

Pro Rata Amounts

Pro Rata Amounts		
	First Month	Second Month
2012	$100.20	$39.80
2013	$103.95	$43.05

The Part B deductible is split into pro rata amounts. The purpose of the pro rata amount is to provide beneficiaries who are enrolled in managed care plans the benefit of assuming they have paid their deductible as if they were not enrolled in a managed care plan. The pro rata amount does not apply only to just the first two months of the year but rather for the number of months after first enrollment in a managed care plan that is

necessary to cover the Part B deductible. Each year starts the deduction for the pro rata amount over again.

20.3 - Part B Coinsurance

After the deductible has been satisfied, coinsurance of 20 percent is usually applicable.

For providers and suppliers that bill intermediaries, the 20 percent may be based on the allowed amount, billed charges, or a preset rate per service (APC), depending upon the type of service. See Claims Processing instructions for a description of coinsurance calculation for each benefit type.

Physicians and other suppliers will be paid 80 percent of allowed amount under the fee schedule amounts or in some instances reasonable charges incurred during the balance of the calendar year. The patient is responsible for a coinsurance amount equal to 20 percent of the fee schedule amounts or reasonable charges for the items and services. (See §20.4 of this chapter for exceptions.)

20.4 - Exceptions to Annual Deductible and Coinsurance

There is no deductible for screening mammography effective for services January 1, 1998 and later.

Neither the annual deductible nor the 20 percent coinsurance apply with respect to:

- Parts A and B home health services, except that there is a coinsurance of 20 percent of the payment amount for supplies, drugs, DME and prosthetics /orthotics furnished as a home health benefit;
- Clinical diagnostic laboratory tests (including specimen collection fees) performed or supervised by a physician, laboratory, or other entity paid on an assigned basis;
- Pneumococcal vaccine and its administration;
- Influenza vaccine and its administration; and
- Services or items denied as medically unnecessary.

NOTE: Services which are not subject to the deductible cannot be used to satisfy the deductible.

20.4.1 - Applications of Deductible and Coinsurance in Liability and Indemnification Situations

Under 1879 of the Act, a beneficiary is not responsible for payment of the Part B deductible or coinsurance for items or services that are neither reasonable and necessary to diagnose or treat the illness or injury, nor to improve the functioning of a malformed body member. If the provider knew, or should have known, that Medicare considered such services medically unnecessary, but failed to inform the beneficiary before furnishing them, the provider is held liable for their cost. If the beneficiary made payment for such items or services, he/she can be indemnified for them.

In most cases, however, funds can be collected while awaiting the outcome of review of a demand bill for institutional services-- See Publication 100-04, Chapter 1, §60.3, See §60.3.1 in the same chapter for specific information on limitations on collecting funds from beneficiaries in SNF Part A stays. In general, see Chapter 30 of that publication for information on limitation of liability.

20.5 - Blood Deductibles (Part A and Part B)

Program payment may not be made for the first 3 pints of whole blood or equivalent units of packed red cells received under Part A and Part B combined in a calendar year. However, blood processing (e.g., administration, storage) is not subject to the deductible.

The blood deductibles are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible.

The deductible applies only to the first 3 pints of blood furnished in a calendar year, even if more than one provider furnished blood.

20.5.1 - Part A Blood Deductible

Blood must be furnished on a Medicare covered day in a hospital or SNF to be counted under Part A. Blood furnished to an inpatient after benefits exhausted or before entitlement is not counted toward the combined deductible. Blood furnished during a lifetime extension election period is counted toward the combined A/B 3 pint total.

20.5.2 - Part B Blood Deductible

Blood is furnished on an outpatient basis or is subject to the Part B blood deductible and is counted toward the combined limit. It should be noted that payment for blood may be made to the hospital under Part B only for blood furnished in an outpatient setting. Blood is not covered for inpatient Part B services.

20.5.3 - Items Subject to Blood Deductibles

The blood deductibles apply only to whole blood and packed red cells. The term whole blood means human blood from which none of the liquid or cellular components have been removed. Where packed red cells are furnished, a unit of packed red cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biologicals.

Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §231 regarding billing for blood and blood products under the Hospital Outpatient Prospective Payment System (OPPS).

20.5.4 - Obligations of the Beneficiary to Pay for or Replace Deductible Blood

A provider may charge the beneficiary or a third party its customary charge for whole blood or units of packed red cells which are subject to either the Part A or Part B blood deductible, unless the individual, another person, or a blood bank replaces the blood or arranges to have it replaced.

20.5.4.1 - Replacement of Blood

For replacement purposes, a pint of whole blood is considered equivalent to a unit of packed red cells. A deductible pint of whole blood or unit of packed red cells is considered replaced when a medically acceptable pint or unit is given or offered to the provider or, at the provider's request, to its blood supplier. Accordingly, where an individual or a blood bank offers blood as a replacement for a deductible pint or unit furnished a Medicare beneficiary, the provider may not charge the beneficiary for the blood, whether or not the provider or its blood supplier accepts the replacement offer. Thus a provider may not charge a beneficiary merely because it is the policy of the provider or its blood supplier not to accept blood from a particular source which has offered to replace blood on behalf of the beneficiary. However, a provider would not be barred from charging a beneficiary for deductible blood, if there is a reasonable basis for believing that replacement blood offered by or on behalf of the beneficiary would endanger the health of a recipient or that the prospective donor's health would be endangered by making a blood donation. Once a provider accepts a pint of replacement blood from a beneficiary or another individual acting on his/her behalf, the blood is deemed to have been replaced, and, the beneficiary may not be charged for the blood, even though the replacement blood is later found to be unfit and has to be discarded.

When a provider accepts blood donated in advance, in anticipation of need by a specific beneficiary, whether the beneficiary's own blood, that is, an autologous donation, or blood furnished by another individual or blood assurance group, such donations are considered replacement for pints or units subsequently furnished the beneficiary.

20.6 – Part B Premium

The Centers for Medicare and Medicaid Services (CMS) updates the Part B premium each year. These adjustments are made according to formulas set by statute. By law, the monthly Part B premium must be sufficient to cover 25 percent of the program's costs, including the costs of maintaining a reserve against unexpected spending increases. The federal government pays the remaining 75 percent.

Below are the annual Part B premium amounts from Calendar Year (CY) 1996 to 2006. For these years, and years prior to 1996, the Part B premium is a single established rate for all beneficiaries.

Year	Part B Premium
1996	$42.50
1997	$43.80
1998	$43.80
1999	$45.50
2000	$45.50
2001	$50.00
2002	$54.00
2003	$58.70
2004	$66.60
2005	$78.20
2006	$88.50

Beginning on January 1, 2007, the Part B premium is based on the income of the beneficiary.

Attachment A: Income Parameters for Determining Part B Premium

	Income Parameters for Determining Part B Premium		
Premium/ month	**Individual Income**	**Joint Income (Married)**	**Married filing Separate**
$104.90	$85,000 or less	$170,000.00 or less	$85,000.00 or less
$146.90	$85,000.01 - $107,000.00	$170,000.01 - $214,000.00	
$209.80	$107,000.01 - $160,000.00	$214,000.01 - $320,000.00	
$272.70	$160,000.01 - $214,000.00	$320,000.01 - $428,000.00	$85,000.01 - $129,000.00
$335.70	$214,000.01 or more	$428,000.01 or more	$129,000.01 or more

Individual Income = Beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year)
Joint Income (Married) = Beneficiaries who are married and lived with their spouse at any time during the taxable year, and also file a joint tax return.
Married filing Separate = Beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse

30 - Outpatient Mental Health Treatment Limitation

Regardless of the actual expenses a beneficiary incurs in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation). The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2010. However, effective January 1, 2010, through January 1, 2014, the limitation will be phased out as follows:

- January 1, 2010 – December 31, 2011, the limitation percentage is 68.75%. (Medicare pays 55% and the patient pays 45%).

- January 1, 2012 – December 31, 2012, the limitation percentage is 75%. (Medicare pays 60% and the patient pays 40%).

- January 1, 2013 – December 31, 2013, the limitation percentage is 81.25%.

(Medicare pays 65% and the patient pays 35%).

- January 1, 2014 – onward, the limitation percentage is 100%.
  (Medicare pays 80% and the patient pays 20%).

For additional details concerning the outpatient mental health treatment limitation, please see the Medicare Claims Processing Manual, Publication 100-04, chapter 9, section 60 and chapter 12, section 210.

40 - Limitation on Physical Therapy, Occupational Therapy and Speech-Language Pathology Services

Coverage of outpatient physical therapy, occupational therapy, and speech-language pathology services under Part B has been limited in some years. For descriptions of these limitations see Pub 100-04, Chapter 5, §10.2.

Physician Certification and Re-certification of Services

10 - Certification and Recertification by Physicians for Hospital Services – General

Payments may be made for covered hospital services only if a physician certifies and recertifies to the medical necessity for the services at designated intervals of the hospital inpatient stay. Appropriate supporting material may be required. The physician certification or recertification statement must be based on a current evaluation of the patient's condition.

For patients admitted to a general hospital, regardless of whether the patients are under PPS, a physician certification is not required at the time of admission for patient services. For services continued over a period of time or for a day outlier case (i.e., an appropriately admitted case results in an extraordinarily long stay) or for a PPS cost outlier case (i.e., an appropriately admitted case results in the expenditure of extraordinary resources), a physician must certify or recertify the continued need for the services at specified intervals. (See § 80 for timing of physician certification and recertification.) Psychiatric and tuberculosis hospitals (which are excluded from PPS) are required to obtain a physician certification on admission.

Hospitals do not transmit physician certification and recertification statements to the intermediary or to CMS. The hospital must itself certify on the appropriate billing form that the required physician certification and recertification statements have been obtained and are on file. The physician certification and recertification statements are retained in the hospital's file where they are available for verification if needed.

A hospital must also have available in its files a written description of the procedure it adopts on the timing of certifications and recertifications, i.e., the intervals at which the necessary certification statements are required and whether review of long stay cases by the utilization review committee may serve as an alternative to recertification by a physician in the case of the second or subsequent recertification.

10.1 - Failure to Certify or Recertify for Hospital Services

If a hospital fails to obtain the required certification or recertification statements in an individual case, program payments may not be made in that case.

If the hospital's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he/she objects in principle to the concept of certification and recertification), the hospital may not bill the program or the beneficiary for covered items or services. The provider agreement precludes the hospital from charging the patient for covered items and services.

10.2 - Who May Sign Certification or Recertification

A certification or recertification statement must be signed by the attending physician responsible for the case or by another physician who has knowledge of the case and is authorized to do so by the attending physician, or by a member of the hospital's medical staff with knowledge of the case.

Ordinarily for purposes of certification and recertification, a "physician" must meet the definition in Chapter 5, §70 and §70.3.

10.3 - Certification for Hospital Admissions for Dental Services

The attending doctor of dental surgery or of dental medicine is authorized to certify that the patient's underlying medical condition and clinical status or the severity of the dental procedure requires the patient to be admitted to the hospital for the performance of the dental procedure; and to recertify the patient's continuing need for hospitalization when required. This applies even if the dental procedure is not covered.

10.4 - Inpatient Hospital Services Certification and Recertification

A certification or recertification statement must contain the following information:

- An adequate written record of the reason for either;
    - Continued hospitalization of the patient for medical treatment or for medically required inpatient diagnostic study, or
    - Special or unusual services for cost outlier cases for hospitals under the prospective payment system (PPS);
- The estimated period of time the patient will need to remain in the hospital and, for cost outlier cases, the period of time for which the special or unusual services will be required; and
- Any plans for posthospital care.

10.5 - Selection by Hospital of Format and Method for Obtaining Statement

The individual hospital determines the method by which certifications and recertifications are to be obtained and the format of the statement. Thus, the medical and administrative

staffs of each hospital may adopt the form and procedure they find most convenient and appropriate.

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary to determine that the certification and recertification requirements are, in fact, met. The certification or recertification could, therefore, be entered or preprinted on a form the physician already has to sign; or a separate form could be used. If all the required information is included in progress NOTEs, the physician's statement could indicate that the individual's medical record contains the information required and that continued hospitalization is medically necessary.

10.6 - Criteria for Continued Inpatient Hospital Stay

A physician who certifies or recertifies to the need for continued inpatient stay should use the same criteria that apply to the hospital's utilization review committee. These criteria include not only medical necessity, but also the availability of out-of-hospital facilities and services which will assume continuity of care. A physician should certify or recertify need for continued hospitalization if the physician finds that the patient could receive treatment in a SNF but no bed is available in the participating SNF. Where the basis for the certification or recertification is the need for continued inpatient care because of the lack of SNF accommodations, the certification or recertification should so state. The physician is expected to continue efforts to place the patient in a participating SNF as soon as the bed becomes available.

10.7 - Utilization Review (UR) in Lieu of Separate Recertification Statement

For cases not subject to PPS and for PPS day outlier cases, a separate recertification statement is not necessary where the requirements for the second or subsequent recertification are satisfied by review of a stay of extended duration, pursuant to the hospital's UR plan. However, it is necessary to satisfy the certification and recertification content standards. It would be sufficient if records of the UR committee show that consideration was given to the three items required for certifications and recertifications: the reasons for continued hospitalization (e.g., consideration was given to the need for special or unusual care in cost outlier status under PPS), estimated time the patient will need to remain in the hospital (e.g., the time period during which such special or unusual care would be needed), and plans for posthospital care.

10.8 - Timing of Certifications and Recertifications

The timing of certifications and recertifications is described in the following subsections.

10.8.1 - Admissions On or After January 1, 1970 for Non-PPS Hospitals

For services furnished to beneficiaries admitted on or after January 1, 1970, the initial certifications are required no later than as of the 12th day of hospitalization. A hospital may at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories. The first recertification is required no later than as of the 18th day of hospitalization. Subsequent recertifications must be made at intervals established by the UR committee (on a case-by-case basis), but in no event may the interval between recertifications exceed 30 days.

The UR committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed.

A hospital can, if it wishes, coordinate its physician recertifications with the process of review by the UR committee of longstay cases not subject to PPS, and for PPS day-outlier cases. At the option of the hospital, review of a stay of extended duration under the hospital's utilization review plan may take the place of the second and any subsequent physician recertifications. (Such review may be the initial review, or a second or subsequent review of an extended case by the UR committee.)

Where review of an extended stay case by the UR committee is deemed to take the place of a physician recertification, it would be possible for the recertification to be made later than the specified day, because the review of an extended duration case may be made at any time within the 7-day period following the last day of the period of extended duration defined in the utilization review plan. Such a recertification will be treated as a delayed recertification; however, no explanation for the normal delay is required.

10.8.2 - Patients Discharged During Hospital Fiscal Years Beginning On or After October 1, 1983 Under PPS

For cases subject to the prospective payment system (PPS), certification is not required at the time of admission for inpatient services. The admission is reviewed by a hospital review organization upon discharge of the patient. For outlier cases certification is required as follows:

- For day-outlier cases (now discontinued), certification was required no later than 1 day after the hospital reasonably assumes that the case meets the established outlier criteria, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the utilization review committee, on a case-by-case basis if it so chooses, but not less than every 30 days.

- For cost-outlier cases, if possible, certification must be made before the hospital incurs cost for which it will seek cost outlier payment. However, certification is required no later than the date on which the hospital requests cost outlier payment or 20 days into the hospital stay, whichever is earlier. For cost-outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee, on a case-by-case basis if it chooses.

As previously stated the UR committee will be reviewing long-stay cases and may be in the best position to decide when subsequent recertifications are needed. Review by the UR committee used in place of recertification for PPS day outlier cases is considered timely if performed within 7 days after the physician recertification would have been required.

10.9 - Inpatient Psychiatric Facility Services Certification and Recertification

The requirements for physician certification and recertification for inpatient psychiatric facility services are similar to the requirements for certification and recertification for inpatient hospital services. However, there is an additional certification requirement. In accordance with 42 CFR 424.14, all IPFs (distinct part units of acute care hospitals, CAHs, and psychiatric hospitals) are required to meet the following certification and recertification requirements.

At the time of admission or as soon thereafter as is reasonable and practicable, a physician (the admitting physician or a medical staff member with knowledge of the case) must certify the medical necessity for inpatient psychiatric hospital services. The first recertification is required as of the 12th day of hospitalization. Subsequent recertifications will be required at intervals established by the hospital's utilization review committee (on a case-by-case basis), but no less frequently than every 30 days.

There is also a difference in the content of the certification and recertification statements. The required physician's statement should certify that the inpatient psychiatric facility admission was medically necessary for either: (1) treatment which could reasonably be expected to improve the patient's condition, or (2) diagnostic study.

The physician's recertification should state:

1. That inpatient psychiatric hospital services furnished since the previous certification or recertification were, and continue to be, medically necessary for either:

    a. Treatment which could reasonably be expected to improve the patient's condition;

    b. Diagnostic study;

2. The hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services, and

3. Effective July 1, 2006, physicians will also be required to include a statement recertifying that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel.

For convenience, the period covered by the physician's certification and recertification is referred to a period during which the patient was receiving active treatment. If the patient remains in the hospital but the period of "active treatment" ends (e.g., because the treatment cannot reasonably be expected to improve the patient's condition, or because intensive treatment services are not being furnished), program payment can no longer be made even though the patient has not yet exhausted his/her benefits. Where the period of "active treatment" ends, the physician is to indicate the ending date in making his recertification. If "active treatment" thereafter resumes, the physician should indicate, in making his recertification, the date on which it resumed.

20 - Certification for Hospital Services Covered by the Supplementary Medical Insurance Program

A physician must certify that medical and other health services covered by medical insurance which were provided by (or under arrangement made by) the hospital were medically required.

Physician certification is not required for the following outpatient services furnished on or after January 3, 1968:

- Hospital services and supplies incident to physicians' services rendered to outpatients; and

- Diagnostic services furnished by a hospital or which the hospital arranges to have furnished in other facilities operated by or under the supervision of the hospital or its medical staff.

Hospitals must obtain a physician's certification with respect to other services furnished to outpatients.

Primarily, this means that a certification statement is needed for diagnostic services furnished under arrangements by a facility that is not operated by or under the supervision of the hospital or its organized medical staff, e.g., services obtained from an independent laboratory.

This certification requires a brief description of the services and the signature of the physician. It needs to be made only once for a course of treatment. Where services are provided on a continuing basis, such as a course of radium treatments, the physician's certification may be made at the beginning or end of the course of treatment, or at any other time during the period of treatment.

There is no requirement that the certification be entered on any specific form or handled in any specific way, as long as the approach adopted by the hospital permits the intermediary to determine that the certification requirement is in fact met. Therefore, the certification could be entered or pre-printed on a form the physician already has to sign; or a separate certification form could be used.

In addition, physician's certifications are required for the rental and purchase of durable medical equipment (see §70), outpatient therapy, i.e., physical therapy, occupational therapy and speech-language pathology services (see Pub. 100-02, Chapter 15, §220).

The Physician Certification Statement requirements for all ambulance providers (hospital-owned and operated) and suppliers (independently-owned and operated) are located at 42 CFR §410.40 (d) (2) and §410.40 (d) (3).

20.1 - Delayed Certifications and Recertifications

Hospitals are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an oversight or lapse.

In addition to complying with the appropriate content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other evidence which the hospital considers relevant for purposes of explaining the delay. The hospital will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

20.2 - Timing for Certification and Recertification for a Beneficiary Admitted Before Entitlement

If an individual is admitted to a hospital (including a psychiatric hospital) before he/she is entitled to hospital insurance benefits (for example, before attainment of age 65), no certification is required as of the date of admission or entitlement. Certifications and recertifications are required as of the time they would be required if the patient had been admitted to the hospital on the day he/she became entitled. (The time limits for

certification and recertification are computed from the date of entitlement instead of the date of admission.)

30 - Certification and Recertification by Physicians for Home Health Services

30.1 - Content of the Physician's Certification

Under both the hospital insurance and the supplementary medical insurance programs, no payment can be made for covered home health services that a home health agency provides unless a physician certifies that:

- The home health services are because the individual is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech-language pathology services, or continues to need occupational therapy;
- A plan for furnishing such services to the individual has been established and is periodically reviewed by a physician; and
- The services are or were furnished while the individual was under the care of a physician.

Certifications must be obtained at the time the plan of care is established or as soon thereafter as possible.

Effective January 1, 2011, as a requirement for payment, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) working in collaboration with the certifying physician, had a face-to-face encounter with the patient in accordance with Pub. 100-02, the Medicare Benefit Policy Manual, Chapter 7 manual guidance, Section 30.5.1.1.

The attending physician signs and dates the POC/certification prior to the claim being submitted for payment; rubber signature stamps are not acceptable. The form may be signed by another physician who is authorized by the attending physician to care for his/her patients in his/her absence. While the regulations specify that documents must be signed, they do not prohibit the transmission of the POC or oral order via facsimile machine. The Home Health Agency (HHA) is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

The HHAs which maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The

HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records upon request from the intermediary, state surveyor, or other authorized personnel, in the event of a system breakdown.

See §10.1 for the effects of failure to certify or recertify.

30.2 - Method and Disposition of Certifications for Home Health Services

There is no requirement that the certification or recertification be entered on any specific form or handled in any specific way as long as the intermediary can determine, where necessary, that the certification and recertification requirements are met. The CMS Form CMS-485 (the Home Health Certification and Plan of Care) meets regulatory and national survey requirements for the physician's POC, certification and recertification. (See the Program Integrity Manual for Form CMS-485 and instructions for completion.) The certification by the physician must be retained by the home health agency.

The following instructions pertain to required documentation of the certification and recertification period both before and after the implementation of the home health prospective payment system.

For Dates of Service before the effective date of the Home Health Prospective Payment System (HH PPS) (October 1, 2000):

The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the Start of Care (SOC) date. The "To" date can be up to, but never exceed 2 calendar months and, mathematically, never exceed 62 days. The "To" date is repeated on a subsequent re-certification as the next sequential "From" date. Services delivered on the "To" date are covered in the next certification period.

Example: Initial certification "From" date 03012000; Initial certification "To" date 05012000; Re-certification "From" date 05012000; Re-certification "To" date 07012000.

For Dates of Service on or after the effective date of HH PPS (October 1, 2000):

The HHA enters the month, day, year, e.g., MMDDYYYY that identifies the period covered by the physician's POC. The "From" date for the initial certification must match the SOC date. The "To" date is up to and including the last day of the episode which is not the first day of the subsequent episode. The "To" date can be up to, but never exceed a total of 60 days that includes the SOC date plus 59 days.

Example:Initial certification "From" date 10012000; Initial certification "To" date 11292000; Re-certification "From" date 11302000; Re-certification "To" date 01282001.

NOTE: Services delivered on 11292000 are covered in the initial certification episode.

30.3 - Recertifications for Home Health Services

Under both the hospital insurance and supplementary medical insurance programs, when services are continued for a period of time, the physician must recertify at intervals of at least once every 60 days that there is a continuing need for services and should estimate how long services will be needed. The recertification should be obtained at the time the plan of care is reviewed since the same interval (at least once every 60 days) is required for the review of the plan.

The physician must recertify that an individual needs or needed skilled nursing care on an intermittent basis or physical therapy or speech-language pathology services or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, needs or continues to need occupational therapy. Recertifications must be signed by the physician who reviews the plan of treatment. The form of the recertification and the manner of obtaining timely recertifications are up to the individual agency.

40 - Certification and Recertification by Physicians for Extended Care Services

Payment for covered posthospital extended care services may be made only if a physician makes the required certification and, where services are furnished over a period of time, the required recertification regarding the services furnished.

The skilled nursing facility is responsible for obtaining the required physician certification and recertification statements and for retaining them in file for verifications, if needed, by the intermediary. The skilled nursing facility determines the method by which the physician certification and recertification statements are to be obtained. There is no requirement that a specific procedure or specific forms be used, as long as the approach adopted by the facility permits a verification to be made that the certification and recertification requirements are in fact met. Certification and recertification statements may be entered on or included in forms, NOTEs, or other records a physician normally signs in caring for a patient, or a separate form may be used. Except as otherwise specified, each certification and recertification statement is to be separately signed by a physician.

If the facility's failure to obtain a certification or recertification is not due to a question as to the necessity for the services, but rather to the physician's refusal to certify based on other grounds (e.g., he objects in principle to the concept of certification and recertification), the facility may not bill the program or the beneficiary for covered items or services. The provider agreement which the facility files with the Secretary precludes it from charging the patient for covered items and services.

If a physician refuses to certify because, in his/her opinion, the patient does not require skilled care on a continuing basis for a condition for which he/she was receiving inpatient hospital services, the services are not covered and the facility can bill the patient directly. The reason for the physician's refusal to make the certification must be documented in the facility records. For such documentation to be adequate, there must be some statement in the facility's records, signed by a physician or a responsible facility official, indicating that the patient's physician feels that the patient does not require skilled care on a continuing basis for any of the conditions for which he/she was hospitalized.

40.1 - Who May Sign the Certification or Recertification for Extended Care Services

A certification or recertification statement must be signed by the attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case, or by a nurse practitioner or *a* clinical nurse specialist *(or, effective with items and services furnished on or after January 1, 2011, a physician assistant)* who does not have a direct or indirect employment relationship with the facility, but who is working in collaboration with the physician.

Ordinarily, for purposes of certification and recertification, a "physician" must meet the definition contained in Chapter 5, §70 of this manual.

40.2 - Certification for Extended Care Services

The certification must clearly indicate that posthospital extended care services were required to be given on an inpatient basis because of the individual's need for skilled care on a continuing basis for any of the conditions for which he/she was receiving inpatient hospital services, including services of an emergency hospital (see Chapter 5, §20.2 prior to transfer to the SNF. Certifications must be obtained at the time of admission, or as soon thereafter as is reasonable and practicable. The routine admission procedure followed by a physician would not be sufficient certification of the necessity for posthospital extended care services for purposes of the program.

If ambulance service is furnished by a skilled nursing facility, an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

40.3 - Recertifications for Extended Care Services

The recertification statement must contain an adequate written record of the reasons for the continued need for extended care services, the estimated period of time required for the patient to remain in the facility, and any plans, where appropriate, for home care. The recertification statement made by the physician does not have to include this entire statement if, for example, all of the required information is in fact included in progress.

NOTE: In such a case, the physician's statement could indicate that the individual's medical record contains the required information and that continued posthospital extended care services are medically necessary. A statement reciting only that continued extended care services are medically necessary is not, in and of itself, sufficient.

If the circumstances require it, the first recertification and any subsequent recertifications must state that the continued need for extended care services is for a condition requiring such services which arose after the transfer from the hospital and while the patient was still in the facility for treatment of the condition(s) for which he/she had received inpatient hospital services.

40.4 - Timing of Recertifications for Extended Care Services

The first recertification must be made no later than the l4th day of inpatient extended care services. A skilled nursing facility can, at its option, provide for the first recertification to be made earlier, or it can vary the timing of the first recertification within the l4-day period by diagnostic or clinical categories. Subsequent recertifications must be made at intervals not exceeding 30 days. Such recertifications may be made at shorter intervals as established by the utilization review committee and the skilled nursing facility.

At the option of the skilled nursing facility, review of a stay of extended duration, pursuant to the facility's utilization review plan (if a UR review plan is in place), may take the place of the second and any subsequent physician recertifications. The skilled nursing facility should have available in its files a written description of the procedure it adopts with respect to the timing of recertifications. The procedure should specify the intervals at which recertifications are required, and whether review of long-stay cases by the utilization review committee serves as an alternative to recertification by a physician in the case of the second or subsequent recertifications.

40.5 - Delayed Certifications and Recertifications for Extended Care Services

Skilled nursing facilities are expected to obtain timely certification and recertification statements. However, delayed certifications and recertifications will be honored where, for example, there has been an isolated oversight or lapse.

In addition to complying with the content requirements, delayed certifications and recertifications must include an explanation for the delay and any medical or other

evidence which the skilled nursing facility considers relevant for purposes of explaining the delay. The facility will determine the format of delayed certification and recertification statements, and the method by which they are obtained. A delayed certification and recertification may appear in one statement; separate signed statements for each certification and recertification would not be required as they would if timely certification and recertification had been made.

40.6 - Disposition of Certification and Recertifications for Extended Care Services

Skilled nursing facilities do not have to transmit certification and recertification statements to the intermediary; instead, the facility must itself certify, in the admission and billing form that the required physician certification and recertification statements have been obtained and are on file.

50 - Physician's Certification and Recertification for Outpatient Physical Therapy Occupational Therapy and Speech-Language Pathology

For certification and recertification of outpatient physical therapy, occupational therapy and speech-language pathology services see Pub. 100-02, Chapter 15, §220.1.3.

60 - Certification and Recertification by Physicians for Hospice Care

The hospice must obtain written certification of terminal illness for each period of hospice care received by an individual. For the initial 90-day period, the hospice must obtain written certification statements from the medical director of the hospice or the physician member of the hospice interdisciplinary group, and the individual's attending physician (if the individual has one). The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. Recertification for subsequent periods only requires the written certification by the hospice medical director or the physician member of the hospice interdisciplinary group. Certifications and recertifications must be dated and signed by the physician and must include the benefit periods to which they apply. Certifications and recertifications must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less.

If written certification is not obtained within 2 calendar days of the initiation of hospice care, a verbal certification must be obtained within the 2 days. A written certification from the medical director of the hospice or the physician member of the interdisciplinary group must be on file in the beneficiary's record prior to the submission of a claim to the Medicare Contractor. If these requirements are not met, no payment may be made for the

days prior to certification. Instead payment will begin with the day certification is obtained, i.e., the date verbal certification is obtained.

Certifications and recertifications may be completed up to 15 days before the next benefit period begins.

For recertifications on or after January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient prior to the beginning of the patient's third benefit period, and prior to each subsequent benefit period. Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the patient's recertification of terminal illness eligibility requirement. The patient would cease to be eligible for the benefit. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 9, Section 20.1, Timing and Content of Certification.

70 - DME Certification

The DME supplier must retain a copy of the physician's order for DME in its files; and in some cases must furnish a Certificate of Medical Necessity to the Carrier.

80 - Summary Table for Certifications/Recertifications

The following is a table summarizing the certification/recertification signature requirements and timeframes for various provider types. Please review sections above for more detailed information on Certifications/Recertifications and their required content:

	Who Signs Certification	Certification Timeframe	Recertification
Hospital Inpatient	Attending physician or by another physician with knowledge of the case with authorization from attending physician or by a member of hospital's medical staff with knowledge of the case.	No later than the 12th day of hospitalization	Interval between recertifications not to exceed 30 days
SNF	Attending physician or physician on staff at SNF with knowledge of case	Obtain at time of admission or shortly thereafter	First recertification no later than the 14th day of inpatient extended care services. Subsequent at intervals not exceeding 30 days.
HHA	Attending physician	Obtain at time POC is established or shortly thereafter	Physician must recertify at least once every 60 days
Hospice	For initial 90-day period, must obtain written certification statements from medical director of hospice or physician member of the hospice interdisciplinary group and the attending physician.	If written certification is not obtained within 2 calendar days of the initiation of hospice care, a verbal certification must be obtained.	Must be obtained for each period of hospice care; written certification by hospice medical director or physician member of interdisciplinary group.

Defenitions

10 - Part A Provider and Related Definitions

Section 1866(e) of the Social Security Act defines the term "provider of services" (or provider) as:

(1) A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of section 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of section 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and

(2) A community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)). Definitions of providers, physicians, practitioners, and suppliers, and a description of the requirements that each must meet in order for their services to be considered covered are described in the following sections.

10.1 - Provider Agreements

The following provider types must have provider agreements under Medicare:

- Hospitals,
- Skilled nursing facilities (SNFs),
- Home health agencies (HHAs),
- Clinics, rehabilitation agencies, and public health agencies,
- Comprehensive outpatient rehabilitation facilities (CORFs),
- Hospices,
- Critical access hospitals (CAHs), and
- Community mental health centers (CMHCs).

Clinics, rehabilitation agencies, and public health agencies may enter into provider agreements only for furnishing outpatient therapy services as defined in section 10 above. CMHCs may enter into provider agreements only to furnish partial hospitalization services.

The term "provider agreement" is defined in 42 CFR 489.3 as an agreement between CMS and one of these providers specified in this section to provide services and to comply with the requirements of section 1866 of the Act.

A provider which has executed an agreement becomes qualified to participate after the agreement is accepted. When the agreement is made retroactive, the provider must comply with the terms of the agreement and the provisions of title XVIII and regulations issued thereunder as of the retroactive date. For payment to be made to the provider for covered items and services it furnishes on or after the effective date of the agreement, the provider must have a record keeping capability sufficient to determine the costs of services furnished to Medicare beneficiaries.

Provider agreements require the providers to comply with regulations. Therefore, new provider agreements are not made when regulations change.

Providers as defined in this section may also function as suppliers and bill the program for other services provided as suppliers if they meet the applicable requirements for supplying the specific service.

10.1.1 - Basic Commitment in Provider Agreement

Section 1866 of the Act and 42 CFR 489 require the provider to agree to the following:

1. To limit its charges to beneficiaries and to other individuals on their behalf to:

- The deductible and coinsurance amounts (see §10.1.2 for details;
- The blood deductible (see §10.1.4 for details); and
- Services requested by the beneficiary. (See §10.1.5)

2. To return any amounts incorrectly collected from a beneficiary or any other person on the beneficiary's behalf;

3. To notify the intermediary promptly if it hires an individual who at any time during the preceding year was employed in a managerial, accounting, auditing, or similar capacity by an intermediary or carrier;

4. In the case of a hospital or a Critical Access Hospital (CAH), either to furnish directly or to make arrangements (as defined in §10.3 of this chapter) for all Medicare-covered services to inpatients of a hospital or a CAH except the following:

- Physicians' services that meet the criteria of 42 CFR 405.550(b) for payment on a reasonable charge basis;

- Physician assistant services, as defined in section 1861(s)(2)(K)(I) of the Act, that are furnished after December 31, 1990;

- Certified nurse-midwife services, as defined in section 1861(ff) of the Act, that are furnished after December 31, 1990;

- Qualified psychologist services, as defined in section 1861(ii) of the Act, that are furnished after December 31, 1990; and

- Services of an anesthetist, as defined in 42 CFR 410.69.

5. In the case of a hospital or CAH that furnishes inpatient hospital services or inpatient CAH services for which payment may be made under Medicare, to maintain an agreement with a PRO for that organization to review the admissions, quality, appropriateness, and diagnostic information related to those inpatient services. The requirement of this paragraph applies only if, for the area in which the hospital or CAH is located, there is a PRO that has a contract with CMS under Part B of title XI of the Act;

6. To maintain a system that, during the admission process, identifies any primary payers other than Medicare so that incorrect billing and Medicare overpayments can be prevented;

7. To bill other primary payers before billing;

8. If the provider receives payment for the same services from Medicare and another payer that is primary to Medicare, to reimburse Medicare any overpaid amount within 60 days;

9. If the provider receives, from a payer that is primary to Medicare, a payment that is reduced because the provider failed to file a proper claim; to reimburse Medicare any overpaid amount up to the amount that would have been paid had the provider filed a proper claim timely.

10. In the State of Oregon, because of a court decision, and in the absence of a reversal on appeal or a statutory clarification overturning the decision, hospitals may bill liability insurers first. However, if the liability insurer does not pay "promptly," the hospital must withdraw its claim or lien and bill Medicare for covered services;

11. In the case of home health agencies, to offer to furnish catheters, catheter supplies, ostomy bags, and supplies related to ostomy care to any individual who requires them as part of their furnishing of home health services;

12. In the case of hospital emergency department services that provide for medical screening to determine if an emergency medical condition exists, CMS guidelines provided in CFR 42 489.24(d) for transfer of patients to other facilities should be followed;

13. In the case of hospital emergency department services report to CMS or the State Survey Agency any time it has reason to believe it may have received an individual who

has been transferred in an unstable emergency medical condition from another hospital in violation of the requirements of CFR 42 489.24(d);

14. In the case of inpatient hospital services for admissions on and after January 1, 1987, to participate in the Tricare program;

15. In the case of inpatient hospital services for admissions on and after July 1, 1987, to admit veterans whose admission is authorized by the VA and to meet related VA admission and payment requirements;

16. In the case of a hospital, to give each beneficiary a notice about his or her discharge rights at or about the time of the individual's admission;

17. In the case of a hospital with an emergency department:

- To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency departments (that is, entrance, admitting area, waiting room, treatment area), a sign (in a form specified by the Secretary) specifying rights of individuals under Section 1867 of the Act with respect to examination and treatment for emergency medical conditions and women in labor; and

- To post conspicuously information indicating whether or not the hospital or critical access hospital participates in the Medicaid program under a State plan approved under title XIX;

18. In the case of a hospital with an emergency department (including both the transferring and receiving hospitals), to maintain:

- Medical and other records related to individuals transferred to or from the hospital for a period of 5 years from the date of the transfer;

- A list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition; and

- A central log on each individual who comes to the emergency department seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged.

19. Effective December 1, 1991, in the case of a hospital to comply with the advance directive provisions of 4206 of OBRA 1990. Hospitals must, in accordance with written policies and procedures, for all adult individuals:

- Inform them, in writing, of State laws regarding advance directives;

- Inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that State law permits for a hospital or any agent of a hospital that, as a matter of conscience, cannot implement an advance directive);

- Document in the individual's medical record whether the individual has executed an advance directive;

- Not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require the individual to do so); and

- Educate staff and the community on issues concerning advance directives.

20. Effective October 1, 2007, CMS revised the regulations governing provider agreements that require hospitals to disclose physician ownership information to patients when a referring physician (or his or her immediate family member) has an ownership interest in the hospital. Pursuant to 42 CFR 489.20(u), hospitals must: (1) furnish written notice to each patient at the beginning of the patient's hospital stay or outpatient visit that the hospital is a physician-owned hospital, in order to assist the patient in making an informed decision regarding his or her care. The notice must disclose the fact that the hospital meets the Federal definition of a physician-owned hospital and that the list of physician owners or immediate family members of physicians is available upon request and must be provided to the patient at the time of the request; and (2) require each physician who is a member of the hospital's medical staff to agree, as a condition of continued medical staff membership or admitting privileges, to disclose in writing to all patients the physician refers to the hospital any ownership or investment interest in the hospital held by the physician or held by an immediate family member of the physician. Disclosure must be made at the time of the referral.

Effective October 1, 2008, hospitals that do not have any physician owners who refer patients to the hospital are exempt from the disclosure requirements (See 42 CFR 489.20(v)). In addition, CMS may deny a provider agreement to a hospital that does not have procedures in place to notify patients of physician ownership in the hospital (See 42 CFR 489.12).

10.1.2 - Part A Deductible and Coinsurance

The provider may charge the beneficiary or his or her representative:

- The amount of the inpatient hospital deductible or, if less, the actual charges for the services;
- The amount of inpatient hospital coinsurance applicable for each day the individual is furnished inpatient hospital services after the 60th day, during a benefit period;
- The posthospital extended care coinsurance amount; and
- In the case of durable medical equipment (DME) furnished as a home health service, 20 percent of the fee schedule amount.

10.1.3 - Part B Deductible and Coinsurance

The provider may charge the beneficiary or other person on his or her behalf: the $100 deductible and 20 percent of the customary (insofar as reasonable) charges in excess of that deductible.

For hospital outpatient services, the allowable deductible charges depend on whether the hospital can determine the beneficiary's deductible status. If the hospital is unable to determine the deductible status, it may charge the beneficiary its full customary charges up to $100. If the beneficiary provides official information as to deductible status, the hospital may charge only the unmet portion of the deductible.

The hospital is required to indicate on the UB-92 the amounts collected.

In the case of DME furnished as a home health service under Medicare Part B, the coinsurance is 20 percent of the fee schedule amount for the services, with the following exception: If the DME is used, purchased by, or on behalf of the beneficiary at a price at least 25 percent less than the reasonable charge for comparable new equipment, no coinsurance is required.

10.1.4 - Blood

A provider may charge the beneficiary (or other person on his or her behalf) only for the first three pints of blood or units of packed red cells furnished during the calendar year. The charges may not exceed the provider's customary charges.

The provider may not charge for any whole blood or packed red cells in any of the following circumstances:

- The provider obtained the blood or red cells at no charge other than a processing or service charge;

- The blood or packed red cells have been replaced; or

- The provider (or its blood supplier) receives from an individual, or a blood bank, a replacement offer. This offer is applicable if the replacement blood would not endanger the health of a recipient and if the prospective donor's health would not be endangered by making a blood donation. In this case the provider is precluded from charging even if it or its blood supplier rejects the replacement offer.

- Refer to Pub. 100-04, Medicare Claims Processing Manual, chapter 4, §231 regarding billing for blood and blood products under the Hospital Outpatient Prospective Payment System (OPPS).

10.1.5 - Services Requested by Beneficiary

If services furnished at the request of a beneficiary (or his or her representative) are more expensive than, or in excess of, services covered under Medicare, a provider may charge the beneficiary an amount that does not exceed the difference between (1) the provider's customary charges for the services furnished; and (2) the provider's customary charges for the kinds and amounts of services that are covered under Medicare.

A provider may not charge for these services unless they have been requested by the beneficiary (or his or her representative) and may not require a beneficiary to request services as a condition of admission.

To avoid misunderstanding and disputes, a provider must inform any beneficiary who requests a service for which a charge will be made that there will be a specified charge for that service.

10.1.6 - Provider Charges to Beneficiary Where Provider Customarily Furnishes More Expensive Services Not Requested by Beneficiary

A provider that customarily furnishes an individual items or services that are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services, may charge an individual entitled to benefits under Medicare for such more expensive items or services even though not requested by the individual. The charge, however, may not exceed the amount by which the cost of (or, if less, the customary charges for) more expensive items or services furnished by such provider in the second cost reporting period immediately preceding the cost reporting period in

which such charges are imposed, exceeds the applicable limit imposed under the provisions of 42 CFR 413.30.

This charge may be made only if:

- The intermediary determines that the charges have been calculated properly in accordance with the provisions of this regulation section;
- The services are not emergency services as defined in §20.1 or §20.2 of this chapter;
- The admitting physician has no direct or indirect financial interest in such provider;
- CMS has provided notice to the public through notice in a newspaper of general circulation servicing the provider's locality and such other notice as the Secretary may require, of any charges the provider is authorized to impose on individuals entitled to benefits under Medicare on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare; and
- The provider has identified such charges to such individual or person acting on his/her behalf as charges to meet the costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under Medicare.

10.1.7 - Hospitals Participating in State Reimbursement Control Systems or Demonstration Projects

A hospital receiving payment for a covered hospital stay under:

- Either a State reimbursement control system approved under 1886 (c) of the Act; or
- A demonstration project authorized under section 402(a) of Pub. L. 90 - 248 (42 U.S.C. 1395b - 1) or section 222(a) of Pub. L. 92 - 603 (42 U.S.C.1395b - 1 (NOTE)); and
- Would otherwise be subject to the prospective payment system set forth in part 412 of this chapter, may also charge a beneficiary for custodial care and medically unnecessary services described in CFR CUR 412.42(c), after the conditions of 412.42(c)(1) through(c)(4) are met.

10.1.8 - Medicare Secondary Payer Involvement of Failure to File Proper Claims

A provider that has not filed a proper claim and has received a reduced payment because of this from a payer primary to Medicare agrees:

- To bill Medicare for an amount no greater than would have been payable as secondary payment if the primary insurer's payment had been based on a proper claim; and

- To charge the beneficiary only (a) the amount it would have been entitled to charge if it had filed a proper claim and received payment based on such a claim; and (b) an amount equal to any third-party payment reduction attributable to failure to file a proper claim, but only if the provider can show that:

    - It failed to file a proper claim solely because the beneficiary, for any reason other than mental or physical incapacity, failed to give the provider the necessary information; or

  - The beneficiary, who was responsible for filing a proper claim, failed to do so for any reason other than mental or physical incapacity.

10.1.9 - Advance Directive Requirements

Effective December 1, 1991, participating hospitals must comply with the advance directive provisions of §4206 of OBRA 1990. Therefore, an agreement per §1866 of the Act with a hospital includes that the hospital must, in accordance with written policies and procedures, for all adult individuals: inform them, in writing, of state laws regarding advance directives; inform them, in writing, of its policies regarding the implementation of advance directives (including a clear and concise explanation of a conscientious objection, to the extent that state law permits for a hospital or any agent of a hospital that, as a matter of conscience, cannot implement an advance directive); document in the individual's medical record whether the individual has executed an advance directive; not condition the provision of care or otherwise discriminate against an individual based on whether that individual has executed an advance directive (since the law does not require the individual to do so); and educate staff and the community on issues concerning advance directives.

10.1.10 - Posting of Signs in Hospital Emergency Departments

Section 6018(a)(2) of the Omnibus Budget Reconciliation Act of 1989 (OBRA §89), effective July 1, 1990, requires hospitals with emergency departments to post signs which

specify the rights (under section 1867 of the Social Security Act) of women in labor and individuals with emergency medical conditions to examination and treatment.

To comply with these requirements, hospitals must post signs that meet the following criteria:

- At a minimum, the signs must specify the rights of unstable individuals with emergency conditions and women in labor who come to the emergency department for health care services;
- It must indicate whether the facility participates in the Medicaid program;
- The wording of the sign must be clear and in simple terms understandable by the population serviced;
- Print the signs in English and other major languages that are common to the population of the area serviced;
- The letters within the signs must be clearly readable at a distance of at least 20 feet or the expected vantage point of the emergency department patrons; and
- Post signs in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment (e.g., entrance, admitting area, waiting room, treatment area).

The sample below may be adapted, contains sufficient information to satisfy these requirements, and may be adapted to satisfy the visibility requirement.

IT'S THE LAW!

IF YOU HAVE A MEDICAL EMERGENCY OR ARE IN LABOR

YOU HAVE THE RIGHT TO RECEIVE, WITHIN THE CAPABILITIES OF THIS HOSPITAL'S STAFF AND FACILITIES:

An appropriate medical SCREENING EXAMINATION

Necessary STABILIZING TREATMENT (including treatment for an unborn child)

And if necessary

An appropriate TRANSFER to another facility

Even if

YOU CANNOT PAY OR DO NOT HAVE MEDICAL INSURANCE

OR

YOU ARE NOT ENTITLED TO MEDICARE OR MEDICAID

This hospital (does/does not) participate in the Medicaid program

10.2 - Admission of Medicare Patients for Care and Treatment

The participation of a provider of services which voluntarily files an agreement to participate in the health insurance program contemplates that such provider will admit Medicare beneficiaries for care and treatment, and upon admission, will provide them with such services as are ordinarily furnished by the provider to its patients generally.

A provider may have restrictions on the types of services it makes available and/or the types of health conditions it accepts, or may establish other criteria relating to the admission of persons for care and treatment. However, the law does not contemplate that such restrictions or criteria will apply only to Medicare beneficiaries as a class. It does contemplate, however, that if such restrictions or criteria apply to Medicare beneficiaries, they will be applied in the same manner in which they are applied to all other persons seeking care and treatment by the provider. Thus, a provider admission or patient policy or practice which is not consistent with the objective contemplated in the law may be used by CMS as a basis for termination of the agreement for cause.

10.3 - Under Arrangements

A provider may have others furnish certain covered items and services to their patients through arrangements under which receipt of payment by the provider for the services discharges the liability of the beneficiary or any other person to pay for the service. In permitting providers to furnish services under arrangements, it was not intended that the provider merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the provider must exercise professional responsibility over the arranged-for services.

The provider's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The provider must accept the patient for treatment in accordance with its admission policies, and maintain a complete and timely clinical record on the patient, which includes diagnoses, medical history, physician's orders, and progress NOTEs relating to all services received, and must maintain liaison with the attending physician regarding the progress of the patient and the need for revised orders. In the case of home health services and outpatient physical therapy or speech-language pathology services, the provider must ensure that the required plan of treatment is periodically reviewed by the physician and secure from the physician the required certifications and

recertifications. Additionally, the provider (other than a SNF) must ensure that the medical necessity of such services is reviewed on a sample basis by the utilization review (UR) committee if one is in place, the facility's health professional staff, or an outside UR group. (Effective October 1, 1990, a SNF is no longer required to have a plan for UR.) The provider, including a SNF that conducts optional UR services, is responsible for medical necessity decisions made under arrangement by an outside group.

10.4 - Term of Agreements

An agreement with a hospital, HHA, hospice, and (for the purposes of furnishing outpatient physical therapy, occupational therapy, or speech-language pathology services) a clinic, a rehabilitation agency, or public health agency is not time limited and has no fixed expiration date. The agreement remains in effect until such time as there is a voluntary termination, or involuntary termination, or a change of ownership.

10.4.1 - Agreement with a SNF

All agreements with SNFs are required to be for a specified term of up to l2 full calendar months with fixed expiration dates. In appropriate situations, the agreement may also contain a cancellation clause. Therefore, when it is determined that a SNF is eligible and that its agreement for participation in the Medicare program will be accepted for filing, the term of the agreement will be determined in the following manner:

A. No Deficiencies - If a SNF is certified as being in full compliance with all standards contained in the requirements for participation for SNFs, the term of the agreement is, as appropriate to the period of certification for it has been approved, for a term of up to 12 full calendar months.

B. Deficiencies - If a SNF is certified as not being in full compliance, the term of the agreement is, as appropriate to the period of certification or conditional period of certification for which it has been approved:

    1. For a term which expires no later than the close of the 60th day following the last day of the time period specified in the written plan providing for the correction of deficiencies in meeting the requirements for participation, provided that such term does not exceed 12 full calendar months or

    2. Provide a conditional term of up to 12 full calendar months, subject to a cancellation clause that the agreement may be canceled on a predetermined date (no later than the close of the 60th day following the last day of the time period specified in the written plan providing for the correction of deficiencies in meeting the requirements for participation), provided that date will occur within the 12-month term.

If the health and safety of Medicare patients are not jeopardized, the term of an agreement may be extended for 2 full calendar months when necessary to prevent irreparable harm to the facility, to prevent hardship to Medicare beneficiaries furnished care, or if it is impracticable within the term of the agreement to determine whether the SNF is complying with the provisions of the Act and regulations issued thereunder.

10.4.2 - Agreement with Rurhal Health Clinic (RHC)/Federally Qualified Health Clinic (FQHC)

Agreements between RHCs/FQHCs and CMS are generally for a term of 1 year. They may be annually renewed by mutual agreement of the RHC/FQHC and CMS, i.e., a new agreement need not be signed each year. Special circumstances may result in a term of less than 1 year for an initial agreement, e.g., a clinic or center may wish the agreement year to run concurrently with the RHC/FQHC's fiscal year or have some other technical considerations.

10.5 - Responsibilities of Participating Provider

Upon acceptance for participation, a provider becomes responsible for remaining in compliance with the terms of the agreement and the provisions of title XVIII and regulations issued thereunder. Where the agreement is made retroactive, the provider must comply with its responsibilities as of the retroactive date. Payment to the provider for covered items and services it furnishes on or after the effective date of the agreement will require that the provider have a recordkeeping capability sufficient for determining the cost of services furnished Medicare beneficiaries.

The termination of participation (see §10.6 of this chapter) does not immediately abrogate all of the provider's responsibilities and in specific matters a responsibility may extend beyond the effective date of termination. For example, the provider continues to be responsible (as applicable) for those provisions of the law and regulations which provide for program coverage to remain in effect for specified periods of time beyond the effective termination date, for those beneficiaries who were accepted for care and treatment by the provider before such date. The provider also continues to be responsible for filing a final cost report and/or the repayment of any overpayment, as these actions relate to final program cost settlement after termination.

10.6 - Termination of Provider Participation

A provider may voluntarily terminate its participation in the program or have it terminated by the Secretary for cause.

10.6.1 - Voluntary Termination

A provider may terminate its agreement (and in the case of a SNF, it may terminate its agreement prior to the close of the specified term of its agreement) by filing with the Secretary a written notice of its intention to terminate the agreement. The Secretary may accept the termination date stated in the notice (the date must be the first day of a month and, in the case of a SNF, must occur within the specified term of such facility's agreement) or set a different date. However, the termination date set by the Secretary may not be more than 6 months from the date the provider's notice is filed.

10.6.2 - Involuntary Termination, Including SNF Agreement Cancellations

The Secretary may terminate an agreement (and in the case of a SNF, he/she may terminate its agreement prior to the close of the specified term of the agreement) with a provider if it is determined that the provider:

- Is not complying substantially with the provisions of the agreement or with the applicable provisions of title XVIII of the Act and regulations;
- No longer meets the appropriate requirements for participation;
- Has failed to supply information which is necessary to determine whether payments are due or were due and the amounts of such payments; or
- Refuses to permit examinations of fiscal and other records, including medical records.

The cancellation of a SNF agreement at the close of the predetermined date stated in the cancellation clause contained in such agreement (see §10.6.2 of this chapter) is viewed as an involuntary termination of the agreement by the Secretary for cause. Such actions involve a finding that the SNF has not satisfactorily completed its written plan providing for the correction of deficiencies with respect to one or more of the standards in the applicable requirements for participation, or that the facility has not made substantial effort and progress in correcting such deficiencies.

A provider which is dissatisfied with the Secretary's determination terminating its agreement is entitled to request a hearing thereon in accordance with the appeals procedures contained in 42 CFR Part 498. There is no reconsideration step before the opportunity for a hearing.

NOTE: The involuntary termination of a hospital's approval authorizing it to provide extended care services, i.e., to be a swing bed facility, does not automatically result in the

involuntary termination of the hospital's agreement relating to the provision of hospital services.

10.6.3 - Expiration and Renewal - Nonrenewal of SNF Term Agreements

All agreements with skilled nursing facilities are required to be for a specified term of up to 12 full calendar months with fixed expiration dates. The agreement expires at the close of the last day of its specified term and is not automatically renewable from term to term. When the term of an agreement is extended (see §10.6.3 of this chapter), the close of the last day of its specified term is the close of the day of the extension of the agreement. Thus, when the term of an agreement is extended, the provider's participation in the program continues, and the agreement does not expire until the close of the last day to which it has been extended.

Since an agreement with a SNF is not automatically renewable from term to term, each term agreement with a SNF requires that the SNF qualify for participation and that its agreement be accepted for filing. A participating SNF may, however, continue its participation under the agreement form previously accepted for filing, provided the SNF continues to qualify for participation and the agreement form is again accepted for filing and renewed for a term which begins on the date immediately following the close of the last day of the prior term of the agreement. When the requirements for participation continue to be met, there is no limit to the number of times that the SNF's agreement form may again be accepted and renewed for a specified term.

When the time-limited agreement (including an agreement which has had its term extended) is renewed on the day immediately following the close of the last day of its term, the expiration of the agreement is not considered a termination of participation in the program.

However, once an agreement with a SNF is (1) not renewed, or (2) voluntarily terminated by the SNF, or (3) involuntarily terminated (including cancellations) by the Secretary, the previously accepted agreement cannot again be accepted and renewed. In such cases, the SNF is required to execute and file a new agreement if it is again found eligible to participate in the Medicare program. The effective date of the new agreement must be determined in accordance with regulatory provisions (42 CFR 489.13).

The Secretary's determination not to accept and renew a SNF agreement is a determination relating to the qualifications of the SNF in the period immediately following the close of the SNF's existing agreement and the SNF is entitled to request a reconsideration of the determination in accordance with the appeals procedure contained in 42 CFR part 405, subpart 0. Such determinations involve a finding that:

- Based on a State agency resurvey and recertification, the SNF will not be approved for a period of certification because it is out of compliance with one or more requirements for participation;

- Based on a State agency resurvey and recertification, the SNF continues to be out of compliance with the same standard(s) in the requirements for participation as were found out of compliance during the term of the agreement and the facility will not be approved for a new period of certification; or

- The SNF has violated the terms of its agreement or the provisions of title XVIII or regulations promulgated thereunder.

In cases of nonrenewal by the Secretary, the intermediary's role is the same as for involuntary terminations.

10.6.4 - Determining Payment for Services Furnished After Termination of Provider Agreement

Effective with the date a provider agreement (or swing bed approval) terminates no payment is made to the provider under such agreement for the following:

A. Hospital

1. Termination-Hospital Agreement - Inpatient hospital services (including inpatient psychiatric hospital services) and swing bed extended care services furnished on or after the effective date of the hospital's termination, except that payment can continue to be made for up to 30 days of inpatient hospital services and/or swing bed extended care services (total of no more than 30 days) furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

2. Termination-Swing Bed Approval - Swing bed extended care services furnished on or after the effective date of the termination of the hospital's swing bed approval, except that payment can continue for up to 30 days of extended care services furnished on or after the termination date to beneficiaries who were admitted (at either the acute or extended care level) prior to the termination date.

B. Skilled Nursing Facility

1. Termination-SNF - Posthospital extended care services furnished on or after the effective date of termination of the agreement, where such agreement has been voluntarily terminated by the provider (see §10.6.1 of this chapter) or involuntarily terminated by the Secretary for cause (see §10.6.2 of this chapter), except that payment can continue to be made for up to 30 days of posthospital

extended care services furnished on and after the termination date to beneficiaries who were admitted prior to the termination date.

C. HHA and Hospice

Payment may be made for services under a plan of treatment for up to 30 days following the effective termination date of a home health agency or hospice if the plan was established before the termination date.

D. Providers - Termination

See Medicare Claims Processing Manual Chapter 1 for billing instructions concerning other items and services, including outpatient physical therapy or speech-language pathology and diagnostic services, furnished on or after the effective date of termination on or after the day following the close of such agreement.

10.6.5 - Change of Provider Ownership

When an organization having a provider agreement undergoes a change of ownership, the agreement is automatically assigned to the new owner. A participating provider which plans to change ownership should give advance notice of its intention so that necessary action can be taken in the event the newly-owned institution does not wish to participate in the Medicare program.

A participating provider which plans to enter into a lease arrangement (in whole, or in part) should also give advance notice of its intention. A change of ownership would occur for example:

- Where a sole proprietor transfers title to an enterprise to another party;
- Where, in the case of a partnership, the addition, removal, or substitution of a partner effects a termination of such partnership and creates a successor partnership or other entity;
- Where an incorporated provider merges with an incorporated institution which is not participating in the program and the nonparticipating institution is the surviving corporation or where two or more corporate providers consolidate and such consolidation results in the creation of a new corporate entity; or
- Where an unincorporated provider (a sole proprietorship or partnership) becomes incorporated.

Whenever intermediaries learn of an impending change of ownership, or possible change of ownership, they inform the regional office immediately. They refer any questions they may have concerning change of ownership situations to the regional office.

20 - Hospital Defined

A hospital (other than psychiatric) means an institution which is primarily engaged in providing, by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

To be eligible to participate in Medicare, a hospital must also be an institution which:

- Maintains clinical records on all patients;
- Has bylaws in effect with respect to its staff of physicians;
- Has a requirement that every patient must be under the care of a physician;
- Provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;
- Has in effect a hospital utilization review plan;
- Is licensed or is approved by the State or local licensing agency as meeting the standards established for such licensing; and
- Meets other health and safety requirements found necessary by the Secretary of Health, and Human Services. (These additional requirements may not be higher than comparable ones prescribed for accreditation by the Joint Commission on Accreditation of Hospitals with exceptions specified in the law).

Such an institution, if approved to participate as a hospital, may also be approved as a swing bed facility pursuant to demonstration authority or if the hospital is a rural hospital with less than 100 beds. (See §30.3 below.)

20.1 - Definition of Emergency Inpatient and Outpatient Services

Payment may be made for certain Part A inpatient hospital services and Part B outpatient hospital services provided in a nonparticipating U.S. hospital where they are necessary to prevent the death or serious impairment of the health of the individual. Because of the threat to the life or health of the individual, the use of the most accessible hospital equipped to furnish such services is necessary. The determination of emergency services depends upon three separate findings:

- The hospital meets the definition of an emergency hospital (see §20.2 of this chapter);

- The services meet the definition of emergency services (see Claims Processing Manual, Chapter 3, §110), and

- The hospital is substantially more accessible from the site of the emergency than is the nearest participating hospital.

20.2 - Definition of an Emergency Services Hospital

An emergency services hospital is a nonparticipating hospital which meets the requirements of the law's definition of a "hospital" relating to full-time nursing services and licensure under State or applicable local law. (A Federal hospital need not be licensed under State or local licensing laws to meet the definition of emergency hospital.) In addition, the hospital must be primarily engaged in providing, under the supervision of doctors of medicine or osteopathy, services of the type that §20.1 describes in defining the term hospital, and must not be primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care. (See the definition of a SNF in §30 of this chapter.) Psychiatric hospitals that meet these requirements can qualify as emergency hospitals.

Inpatient hospital services and related physician and ambulance services furnished outside the U.S. are covered under the limited conditions in Medicare Claims Processing Manual Chapter 1.

20.3 - Psychiatric Hospital

A psychiatric hospital is an institution which is primarily engaged in providing by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons. To be eligible for participation in the program as a psychiatric hospital, it must meet the Medicare conditions of participation for hospitals or be deemed to meet those conditions based on accreditation by the Joint Commission on Accreditation of Hospitals (JCAH), have a utilization review plan, and comply with additional staffing and medical record requirements necessary to carry out an active program of treatment and intensive care.

20.4 - Certification of Parts of Institutions as Hospital

Under certain conditions a distinct part of a psychiatric institution may be certified as a psychiatric or general hospital.

20.5 - Part of a Psychiatric Institutions as a Psychiatric Hospital

A distinct part of a psychiatric institution can be certified as a psychiatric hospital if it meets the conditions of participation even though the institution of which it is a part does not. If the distinct part meets requirements equivalent to the accreditation requirements of the JCAH, it can qualify under the program even though the institution itself is not accredited.

20.6 - General Hospital Facility of Psychiatric Hospital

A general hospital facility within a psychiatric hospital may be certified as a general hospital independent of the institution as a whole provided the general facility is a self-contained operational entity distinct from the rest of the institution. The general hospital facility would be regarded as a separate institution for this purpose since the law does not provide for certifying a "distinct part' of an institution as a general hospital. Services furnished in a separately certified general hospital facility are not subject to any of the benefit limitations applicable to the other parts of the institution, i.e., the reduction in benefit days in the first spell of illness and the 190-day lifetime maximum on inpatient services in psychiatric hospitals.

20.7 - Part of a General Hospital as a Psychiatric Hospital

There is no provision for a psychiatric wing of a general hospital to be certified as a psychiatric hospital. The distinct part provisions apply only to psychiatric institutions and not to general hospitals. However, this does not prevent the certification of a psychiatric hospital which is a part of a medical center or other large complex, provided the hospital operates as a separate functioning entity, i.e., it is located in a separate building, wing, or part of a building, has its own administration and maintains separate fiscal records.

30 - Skilled Nursing Facility Defined

A SNF is an institution or a distinct part of an institution (see §30.1 of this chapter), such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals (see §30.2 of this chapter for transfer agreements and §10.1 of this chapter, for definition of a participating hospital) and which:

- Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

- Meets the requirements for participation in 1819(a) through 1819 (d) as amended by 4201 of OBRA 1987 of the Social Security Act and in regulations at 42 CFR 483, B.

A qualified SNF is one that meets all the requirements in the preceding definition. For Medicare purposes, the term SNF does not include any institution which is primarily for the care and treatment of mental diseases. (This restriction does not apply to title XIX (Medicaid)). Also, the term "skilled nursing facility" does not include swing bed hospitals authorized to provide and be paid for extended care services. Swing bed hospitals must meet many of the same requirements that apply to SNFs (for more details regarding swing bed hospitals, see §30.3.)

30.1 - Distinct Part of an Institution as a SNF

The term "distinct part" refers to a portion of an institution or institutional complex (e.g., a nursing home or a hospital) that is certified to provide SNF and/or Nursing Facility (NF) services. To qualify for participation in the program as a distinct part SNF of an institution, it must be physically separate from the rest of the institution, i.e., it must represent an entire physically identifiable unit consisting of all the beds within that unit, such as a separate building, floor, wing, or ward. A distinct part must be fiscally separate for cost reporting purposes. Although it is required that the distinct part be identifiable as a separate unit within the institution, it need not necessarily be confined to a single location within the institution's physical plant. The distinct part may, for example, consist of several floors or wards which are scattered throughout several different buildings within the institutional complex. In each case, however, the patients of the distinct part must be located in units which are physically separate from those units housing all other patients of the institution. Various beds scattered throughout the institution do not comprise a distinct part for purposes of being approved by Medicare as a SNF.

An institution or institutional complex can only be certified with one distinct part SNF and/or one distinct part NF. A hospital-based SNF is by definition a distinct part. Multiple certifications within the same institution or institutional complex are strictly prohibited. The distinct part must consist of all beds within the designated area. Where an institution or institutional complex owns and operates a SNF and/or a NF distinct part, that SNF and/or NF distinct part is a single distinct part even if it is operated at various locations throughout the institution or institutional complex. The aggregate of the SNF and/or NF locations represents a single distinct part subprovider, not multiple subproviders, and must be assigned a single provider number.

30.2 - Transfer Agreements

To participate in the program, a SNF must have a written transfer agreement with one or more participating hospitals (see §10.1 of this chapter) providing for the transfer of patients between the hospital and the SNF, and for the interchange of medical and other

information. If an otherwise qualified SNF has attempted in good faith, but without success, to enter into a transfer agreement, this requirement may be waived by the State agency. (See 42 CFR 483.75 (n) for the detailed requirements for transfer agreements.)

30.3 - Hospital Providers of Extended Care Services

In order to address the shortage of rural SNF beds for Medicare patients, rural hospitals with fewer than 100 beds may be reimbursed under Medicare Part A for furnishing post hospital extended care services to Medicare beneficiaries if the hospital has obtained a swing bed approval from the Department of Health and Human Services. Such a hospital, known as a swing bed hospital, can "swing" its beds between hospital and SNF levels of care, on an as needed basis. In accordance with §1883 of the Act, rural hospitals with fewer than 100 beds must make application and request approval to be a swing bed hospital from the regional office. In order to obtain swing bed approval, the hospital must:

- As noted above, be located in a rural area (i.e., located outside of an "urbanized area," as defined by the Census Bureau and based on the most recent census, see 42 CFR 482.66(a)(2)) and have fewer than 100 beds (excluding intensive care-type beds and newborn bassinets)
- Have a Medicare provider agreement, as a hospital;
- Be substantially in compliance with the SNF participation requirements identified in 42 CFR 482.66; (most other SNF participation requirements would be largely met by virtue of the facility's compliance with comparable hospital conditions);
- Not have in effect a 24-hour nursing waiver granted under 42 CFR 488.54(c); and
- Not have had a swing bed approval terminated within the 2 years previous to application for swing bed participation.

However, the Department may grant swing bed approval, on a demonstration basis, with hospitals meeting all of the statutory requirements except bed size and geographic location.

Prior to October 1, 1990, a swing-bed hospital could also furnish intermediate care facility (ICF) type services to non-Medicare patients. Effective with services furnished on or after October 1, 1990, the distinction between SNFs and ICFs for certifying a facility for the Medicaid program was eliminated. Thus, for purposes of the Medicaid program, facilities may no longer be certified as ICFs but instead may be certified only as nursing facilities (NFs) and can provide services as defined in §1919(a)(1) of the Act. Effective October 1, 1990, such services furnished by swing-bed hospitals to Medicaid and to other non-Medicare patients are referred to as NF-type services.

40 - Religious Nonmedical Health Care Institution Defined

In order for a Medicare or Medicaid provider to meet the definition of an RNHCI, it must satisfy the ten qualifying provisions as contained in Section 1861(ss)(1) of the Act. Section 1861(ss)(1) of the Act states that an RNHCI means an institution that:

1. Is described in Subsection (c)(3) of Section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under Subsection (a) of that section. The inability to either gain or retain this status will disqualify an institution from participation as an RNHCI.

2. Is lawfully operated under all applicable Federal, State, and local laws and regulations. Federal law supersedes State and local laws unless the State and local requirements are more stringent than the Federal requirements.

3. Furnishes only nonmedical nursing items and services to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical services would be inconsistent with their religious beliefs. Medicare does not cover the religious component of the healing.

4. Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of these patients. This care frequently involves: assistance in moving, turning, positioning, and ambulation; meeting nutritional needs; and comfort and support measures.

5. Furnishes nonmedical items and services to inpatients on a 24-hour basis.

6. Does not furnish, on the basis of its religious beliefs, through its personnel or otherwise, medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients.

7. Is not owned by, under common ownership with, or has an ownership interest of 5 percent or more in, a provider of medical treatment or services, and is not affiliated with a provider of medical treatment or services, or with an individual who has an ownership interest of 5 percent or more in, a provider of medical treatment or services. For purposes of this requirement, an affiliation does not exist in the circumstances described in Section 1861(ss)(4) of the Act or 42 CFR 403.738(c).

8. Has in effect a utilization review plan that:

- Provides for review of admissions to the institution, of the duration of stays, of cases of continuous extended duration, and of the items and services furnished by the institution;

- Requires that the reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution;

- Provides that records be maintained of the meetings, decisions, and actions of the committee; and

- Meets other requirements as the Secretary finds necessary to establish an effective utilization review plan.

9. Provides information the Secretary may require to implement Section 1821 of the Act, including information relating to quality of care and coverage determinations.

10. Meets other requirements the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution. These requirements include the conditions of participation in 42 CFR 403, Subpart G. An RNHCI must meet or exceed the conditions of participation in order to qualify as a Medicare provider. The RNHCI must also have a valid provider agreement with CMS.

50 - Home Health Agency Defined

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, which meets the following requirements:

- It is primarily engaged in providing skilled nursing services and other therapeutic services, such as physical therapy, occupational therapy, or speech-language pathology, medical social services, and home health aide services. A public or voluntary nonprofit health agency may qualify by:

    - Furnishing both skilled nursing and at least one other therapeutic service directly to patients, or

    - Furnishing directly either skilled nursing services or at least one other therapeutic service and having arrangements with another public or voluntary nonprofit agency to furnish the services which it does not provide directly.

      NOTE: A proprietary agency can qualify only by providing directly both skilled nursing services and at least one other therapeutic service.

- It has policies established by a professional group associated with the agency or organization (including at least one physician and at least one registered

professional nurse) to govern the services, and provides for supervision of such services by a physician or a registered professional nurse;

- It maintains clinical records on all patients;

- It is licensed in accordance with State or local law or is approved by the State or local licensing agency as meeting the licensing standards (where State or local law provides for the licensing of such agencies or organizations); and

- It meets other conditions found by the Secretary of the Department of Health and Human Services to be necessary for health and safety.

A private organization which is not exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (sometimes referred to as a "proprietary" organization) must be licensed pursuant to State law. If the State has no licensing law for such organizations, a proprietary agency cannot participate in the health insurance program.

For services under hospital insurance, the term "home health agency" does not include any agency or organization which is primarily for the care and treatment of mental disease. There is no such restriction under supplementary medical insurance.

50.1 - Subdivisions of Agencies as Home Health Agencies

When the subdivision of an agency, such as the home care department of a hospital or the nursing division of a health department, wishes to participate as a home health agency, the subdivision must meet the conditions of participation and must maintain records in such a way that subdivision activities and expenditures attributable to services provided under the health insurance program are identifiable.

50.2 - Arrangements by Home Health Agencies

A. A home health agency (HHA) may have others furnish covered items or services through arrangements under which receipt of payment by the HHA for the services discharges the liability of the patient or any other person to pay for the services. Whether the items and services are provided by the HHA itself or by another agency under arrangement, both must agree not to charge the patient for covered items and services and must also agree to return money incorrectly collected.

In permitting HHAs to furnish services under arrangements, it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered, the agency must exercise professional responsibility over the arranged-for services and ensure compliance with the home health conditions of participation.

The agency's professional supervision over arranged-for services requires application of many of the same quality controls as are applied to services furnished by salaried employees. The agency must accept the patient for treatment in accordance with its administration policies, maintain a complete and timely clinical record of the patient that includes diagnosis, medical history, physician's orders, and progress notes relating to all services received; maintain liaison with the attending physician with regard to the progress of the patient and to assure that the required plan of treatment is periodically reviewed by the physician; secure from the physician the required certifications and recertifications; and ensure that the medical necessity of such services is reviewed on a sample basis by the agency's staff or an outside review group.

There are three situations in which an HHA may have arrangements with another health organization or person to provide home health services to patients:

- Where an agency or organization, in order to be approved to participate in the program, makes arrangements with another organization or individual to provide the nursing or other therapeutic services that it cannot provide directly;

- Where an agency that is already approved for participation, makes arrangements with others to provide services or items it does not provide directly; and

- Where an agency that is already approved for participation makes arrangements with a hospital, skilled nursing facility, or rehabilitation center for services on an outpatient basis because the services involve the use of equipment that cannot be made available to the patient in his/her place of residence.

B. If an agency's subdivision (acting in its capacity as an HHA) makes an arrangement with its parent agency for the provision of certain items or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the HHA and another provider participating in the health insurance program (hospital, skilled nursing facility, or HHA, and, in the case of physical therapy, occupational therapy, or speech-language pathology services, clinics, rehabilitation agencies, and public health agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

C. If the arrangements are with an agency or organization that is not a qualified provider of services, there must be a written contract that includes all of the following:

    1. A description of the services to be provided.

    2. The duration of the agreement and how frequently it is to be reviewed.

    3. A description of how personnel will be supervised.

4. A statement that the contracting organization will provide services in accordance with the plan of care established by the patient's physician in conjunction with the HHA's staff.

5. A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training.

6. A description of the method of determining reasonable costs and reimbursement by the HHA for the specific services to be provided by the contracting organization.

7. An assurance that the contracting organization will comply with title VI of the Civil Rights Act.

- If an HHA notifies a beneficiary of noncoverage of services that another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is still considered to be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangements with the home health agency, absent evidence to the contrary. Thus, if a beneficiary appeals the noncoverage of any or all of the arranged for services furnished after the notice, and a ruling is made in favor of the beneficiary, those services ruled on favorably would be reimbursable since they would constitute services furnished under arrangements by a certified HHA. If the denial is sustained, however, the other party cannot bill the beneficiary for the denied services since the HHA, not the other party, is responsible for the care rendered.

50.3 - Arrangements with Parent Agency and Other Entities

If an agency's subdivision (acting in its capacity as an HHA) makes an arrangement with its parent agency for the provision of certain items or services, there need not be a contract or formal agreement. If, however, the arrangement is made between the HHA and another provider participating in the health insurance program (hospital, skilled nursing facility, or HHA, and, in the case of physical therapy, occupational therapy, or speech-language pathology services, clinics, rehabilitation agencies, and public health agencies), there must be a written statement regarding the services to be provided and the financial arrangements.

If the arrangements are with an agency or organization that is not a qualified provider of services, there must be a written contract that includes all of the following:

- A description of the services to be provided;

- The duration of the agreement and how frequently it is to be reviewed;
- A description of how personnel will be supervised;
- A statement that the contracting organization will provide services in accordance with the plan of care established by the patient's physician in conjunction with the HHA's staff;
- A description of the contracting organization's standards for personnel, including qualifications, functions, supervision, and inservice training;
- A description of the method of determining reasonable costs and reimbursement by the HHA for the specific services to be provided by the contracting organization; and
- An assurance that the contracting organization will comply with title VI of the Civil Rights Act.

50.4 - Notice of Noncoverage of Services

If an HHA notifies a beneficiary of noncoverage of services that another party has been furnishing under arrangements entered into by the agency, the initial notice, in and of itself, does not negate the contract between the agency and the other party. Unless the evidence shows that the contract has been formally terminated, the beneficiary is still considered to be the agency's patient and the other party to be the representative of the agency. Consequently, if upon initial notice that a service is no longer covered the other party continues to provide services to the patient, the other party is considered to be furnishing the services under arrangement.

50.5 - Rehabilitation Centers

When the services are of such a nature that they cannot be administered at the patient's residence and are administered at a rehabilitation center which is not participating in the program as a hospital, skilled nursing facility, or home health agency, the rehabilitation center must meet certain standards. The physical plant and equipment of such a rehabilitation center must meet all applicable State and local legal requirements for construction, safety, health, and design, including safety, sanitation and fire regulations, building codes, and ordinances. Given the statutory definition, a community mental health center is not considered a rehabilitation center.

60 - Hospice Defined

A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals and meets the conditions of participation for hospices, and has a valid provider agreement.

60.1 - Subdivision of Organizations as Hospices

When a subdivision of an organization, such as the home care department of a hospital, wishes to participate as a hospice, the subdivision must meet the hospice conditions of participation and must maintain records in such a way that activities and expenditures attributable to services provided under the hospice program are identifiable.

60.2 - Arrangements by Hospices

Hospices are required to provide core services directly, that is, nursing services, medical social services, and counseling. Other covered services may be provided under arrangement.

70 - Physician Defined

Physician means doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in subsection §70.2), doctor of podiatric medicine (within the limitations in subsection §70.3), or doctor of optometry (within the limitations of subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations imposed by the State on the scope of practice.

The issuance by a State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards determine whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered.

The issuance by a State of a license to practice medicine constitutes legal authorization. Temporary State licenses also constitute legal authorization to practice medicine. If State law authorizes local political subdivisions to establish higher standards for medical practitioners than those set by the State licensing board, the local standards determine whether a particular physician has legal authorization. If State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within the limitations are covered.

NOTE: The term physician does not include such practitioners as a Christian Science practitioner or naturopath.

70.1 - Doctors of Medicine and Osteopathy

The requirement that a doctor of medicine be legally authorized to practice medicine and surgery by the State in which he/she performs his/her services means a physician is licensed to practice medicine and surgery.

A doctor of osteopathy who is legally authorized to practice medicine and surgery by the State in which he/she performs his/her services qualifies as a physician. In addition, a licensed osteopath or osteopathic practitioner qualifies as a physician to the extent that he/she performs services within the scope of his/her practice as defined by State law.

70.2 – Dentists

A dentist qualifies as a physician if he/she is a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such function and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

70.3 - Doctors of Podiatric Medicine

A doctor of podiatric medicine is a physician, but only with respect to those functions which he/she is legally authorized to perform in the State in which he/she performs them. The professional services furnished by a doctor of podiatric medicine within the scope of his/her applicable State license (except services which are specifically excluded) are physician's services payable on a reasonable charge basis under Part B. Where permissible by State law, these services include ordering laboratory tests that are reasonably related to the legal scope of podiatric practice, that are reasonable and

necessary for the diagnosis or treatment of a patient's condition and are not in connection with excluded services, such as treatment of flat foot and routine foot care.

A doctor of podiatric medicine may hold any of the following professional degrees: Pod. D. or D. P. (Doctor of Podiatry), D.S.C. (Doctor of Surgical Chiropody), D.P.M. (Doctor of Podiatric Medicine), D.S.P. (Doctor of Surgical Podiatry), Graduate in Podiatry, Master Chiropodist, Graduate Chiropodist, or in some instances another podiatry degree. Within a particular State, all individuals holding any of these degrees are licensed to perform the same functions; however, there are variations from State to State as to the authorized scope of podiatric practice.

For purposes of the Medicare program, a doctor of podiatric medicine is considered a physician for any of the following purposes:

- Making the required physician certification and recertification of the medical necessity for services;

- Having a patient in a home health agency under his/her care, and establishing and periodically reviewing a home health plan of treatment; or

- Serving as a member of a Utilization Review (UR) committee, but only if at least two of the physicians on the UR committee are doctors of medicine or osteopathy. The performance of these functions must be consistent with the scope of the professional services provided by a doctor of podiatric medicine as authorized by applicable State law.

A doctor of podiatric medicine is not a physician for the purpose of performing any of the physician activities required to qualify an institution or organization as a SNF.

70.4 - Physicians in Federal Hospitals

There are many physicians performing services in hospitals operated by the Federal Government, e.g., military, Veterans Administration, and Public Health Service hospitals. Normally, the services provided by a physician in a Federal hospital are not payable except when the hospital provides services to the public as a community institution. A physician working in the scope of his/her Federal employment is considered a physician even though he/she may not have a license to practice in the State in which he/she is employed.

70.5 – Optometrists

A. Services Furnished Through March 31, 1987

Prior to April 1, 1987, a doctor of optometry who was legally authorized to practice optometry by the State in which he or she performed such a function was considered a physician under Medicare, but only for the purpose of services related to the condition of aphakia. Aphakia is defined as the absence of the natural crystalline lens of the eye, whether or not an intraocular lens has been implanted. The services performed by optometrists within this definition were subject to limitations set by the State relating to the scope of practice of optometry.

The following are examples of examination services which were covered when furnished by optometrists if related to the condition of aphakia: case history, external examination, ophthalmoscopy, biomicroscopy, tonometry, visual fields, ocular motility, binocular function, and evaluation for contact lenses, if the optometrist furnishing these services is legally authorized to perform them.

B. Services Furnished After March 31, 1987

Effective April 1, 1987, a doctor of optometry is considered a physician with respect to all services the optometrist is authorized to perform under State law or regulation. To be covered under Medicare, the services must be medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements. (See Benefit Policy Manual for information concerning exclusions from coverage that apply to vision care services.)

70.6 – Chiropractors

A. General

A licensed chiropractor who meets uniform minimum standards (see subsection C) is a physician for specified services. Coverage extends only to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated by X-ray, provided such treatment is legal in the State where performed. All other services furnished or ordered by chiropractors are not covered. An X-ray obtained by a chiropractor for his or her own diagnostic purposes before commencing treatment may suffice for claims documentation purposes. This means that if a chiropractor orders, takes, or interprets an X-ray to demonstrate a subluxation of the spine, the X-ray can be used for claims processing purposes. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor.

In addition, in performing manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. While such manual manipulation may be covered, there is no separate payment permitted for use of this device.

B. Licensure and Authorization to Practice

A chiropractor must be licensed or legally authorized to furnish chiropractic services by the State or jurisdiction in which the services are furnished.

C. Uniform Minimum Standards

l. Prior to July 1, 1974, Chiropractors licensed or authorized to practice prior to July 1, 1974, and those individuals who commenced their studies in a chiropractic college before that date must meet all of the following minimum standards to render payable services under the program:

a. Preliminary education equal to the requirements for graduation from an accredited high school or other secondary school;

b. Graduation from a college of chiropractic approved by the State's chiropractic examiners that included the completion of a course of study covering a period of not less than 3 school years of 6 months each year in actual continuous attendance covering adequate course of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and

c. Passage of an examination prescribed by the State's chiropractic examiners covering the subjects listed in subsection b.

2. After June 30, 1974 - Individuals commencing their studies in a chiropractic college after June 30, 1974, must meet all of the following additional requirements:

a. Satisfactory completion of 2 years of pre-chiropractic study at the college level;

b. Satisfactory completion of a 4-year course of 8 months each year (instead of a 3-year course of 6 months each year) at a college or school of chiropractic that includes not less than 4,000 hours in the scientific and chiropractic courses specified in subsection 1.b, plus courses in the use and effect of X-ray and chiropractic analysis; and

c. The practitioner must be over 21 years of age.

70.7 - Interns and Residents

A. General

For Medicare purposes, the terms "interns" and "residents" include physicians participating in approved graduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital setting; e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign

medical schools. Where a senior resident has a staff or faculty appointment or is designated, for example, a "fellow," it does not change the resident's status for the purposes of Medicare coverage and payment. As a general rule, services of interns and residents are paid as provider services by the intermediary.

B. Services Furnished by Interns and Residents Within the Scope of an Approved Training Program

Medical and surgical services furnished by interns and residents within the scope of their training program are covered as provider services. Effective with services furnished on or after July 1, 1987, this includes services furnished in a setting which is not part of the provider where a hospital has agreed to incur all or substantially all of the costs of training in the nonprovider facility. The Medicare intermediary is required to notify the carrier of such agreements. Where the provider does not incur all or substantially all of the training costs and the services are performed by a licensed physician, the services are payable on a fee schedule basis by the carrier. Prior to July 1, 1987, the covered services of interns and residents were paid by the carrier on a reasonable charge basis as physician services if furnished by a licensed physician off the provider premises regardless of who incurred the training costs.

C. Services Furnished by Interns and Residents Outside the Scope of an Approved Training Program-Moonlighting

Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed outside the facility where they have their training program, are covered as physicians' services and paid on a fee schedule or reasonable charge basis where the requirements in the first 2 bullets below are met. Medical and surgical services furnished by interns and residents that are not related to their training program, and are performed in an outpatient department or emergency room of the hospital where they have their training program, are covered as physicians' services and paid on a fee schedule or reasonable charge basis where the following criteria are met:

- The services are identifiable physicians' services, the nature of which requires performance by a physician in person and which contributes to the diagnosis or treatment of the patient's condition;

- The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; and

- The services performed can be separately identified from those services that are required as part of the training program.

When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as physicians and not in their capacity as interns and residents.

80 - Health Maintenance Organizations (HMOs) Defined

An HMO for Medicare purposes is a public or private organization that provides, either directly or through arrangement with others, comprehensive health services to enrolled members. An HMO must service those who live within a specified service area. It must provide services based on a predetermined periodic rate or periodic per capita rate basis without regard to the frequency or extent of covered services it furnishes. An HMO must also meet other statutory requirements.

An HMO's service area is a geographic area in which a full range of its services are offered to its members. This geographic area differs from an HMO's enrollment area since it may include locations outside its service area where it offers less than its full range of services. (For example, an HMO may cover house calls in emergencies in its service area but not for members who live outside the service area.)

Section 1876 of the Act allows a Medicare beneficiary eligible for Part A and Part B, or Part B only, to choose to have covered items and services furnished through a Medicare qualified HMO. An HMO enters into a contract with the Secretary in order to participate under Medicare.

90 - Other Definitions

NOTE: We anticipate adding to this section as we find the need to define other terms.

90.1 - Supplier Defined

The term supplier means an entity that is qualified to furnish health services covered by Medicare, other than providers, physicians, and practitioners.

The following suppliers must meet the conditions in order to receive Medicare payment: ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics, and Federally-qualified health centers.

An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure, or control of a hospital).

A DME supplier is an entity that furnishes DME and has a number assigned by the National Supplier Clearinghouse.

90.2 - Laboratory Defined

Laboratory means a facility for the biological, microbiological, serological, chemical, immuno-hematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

90.3 - Practitioners Defined

Practitioners except for physicians are health professionals who may deliver covered Medicare services if the services are incident to a physician's service or if there is specific authorization in the law. The following practitioners may deliver services without direct physician supervision: nurse practitioners and physician assistants in rural health clinics, designated manpower shortage area or HMOs, qualified clinical psychologists, clinical social workers, certified nurse midwives, and certified registered nurse anesthetists.

90.4 - Group Practice Defined

A group practice is a group of two or more physicians and non-physician practitioners legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association:

- In which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel;

- For which substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group;

- In which the overhead expenses of and the income from the practice are distributed in accordance with methods previously determined by members of the group; and

- Which meets such other standards as the Secretary may impose by regulation to implement §1877(h)(4) of the Social Security Act. The group practice definition also applies to health care practitioners.

Disclosure of Information

10 - The Privacy Act of 1974 - (Rev. 1, 09-11-02)

A. General

The purpose of the Privacy Act of 1974 is to provide safeguards for individuals against an invasion of privacy by Federal agencies. Among other things, Federal agencies are required to permit an individual to:

- Determine what records pertaining to the individual are collected, used, or disseminated by such agencies;
- Prevent records pertaining to the individual obtained by Federal agencies for a specific purpose from being used for another purpose without the individual's consent; and
- Gain access to information pertaining to the individual in Federal agency records, and to correct such records when appropriate.

Contractors considered to be Federal agencies for purposes of administering the Privacy Act must comply with its provisions. Contractors must:

- Inform each individual from whom information is requested of their rights under the Privacy Act;
- Describe the method of accessing an individual's records;
- Prepare a method of accounting for disclosures; and
- Devise a method of reviewing records at the request of individuals and making corrections if appropriate.

Additional information concerning Medicare privacy policies can be accessed on the CMS Web site under the Privacy Policy link at the bottom of the web page.

B. Definition of "Individual"

"Individual" means a living person on whom CMS has any personal (as opposed to business) information. "Individual" does not include so-called persons such as sole proprietorships, partnerships, or corporations. Except for disclosure of and access to medical information about minors, a parent or legal guardian of a minor, or a legal guardian of someone the court has declared incompetent, has the same rights as the individual to the individual's records. No one may act on behalf of an individual who has not been declared incompetent by a court or gain access to his/her records under the Privacy Act without the individual's written consent.

C. Physicians' and Suppliers' Rights to Access Under the Privacy Act

Providers, physicians, and suppliers as business entities do not have access to business information about themselves under the Privacy Act, since the Privacy Act concerns individuals only. However, a physician or other supplier who is also an individual has the same access rights as any other individual to personal information maintained about themselves. Purely business information which is retrievable by the physician's unique identifier is not subject to the Privacy Act, but it may be disclosed to the physician to the extent that we would not deny the physician the information under the Freedom of Information Act (FOIA).

D. Informing Individuals of Rights

The contractor must inform the individual of his/her rights under the Privacy Act when it solicits any information directly from the beneficiary in connection with a Medicare claim. This would usually be a result of the failure of the individual or provider to furnish all the information required on a claims form. When information is collected by telephone, the contractor will give the individual a brief oral explanation. When information is requested by mail a written notice is used.

E. Method of Accessing Individual Records - General

The law requires that an agency must inform an individual, upon request, whether a system of records contains a record pertaining to the individual, permit the individual to review such record and to be accompanied for the purpose of reviewing the record by a person of his or her choice. Further, the individual is permitted to obtain a copy of such record in a comprehensible form at a reasonable cost. There is a charge of 10 cents per page with all fees under $25 waived. There is no charge for searching; nor is there a charge for a copy furnished as a means of permitting an individual access to their records.

Each requester shall be asked for proof of identity as well as such general information as is necessary to determine where and how to look for records about the data subject Within 10 working days of receiving a request, the contractor must decide whether to release the records. The requested information must be furnished within 30 working days unless good cause exists. An example of "good cause" would be an inactive record filed in a records center that cannot be obtained within 30 days. The requester should be told of the delay and given an approximate date to expect the information.

If an individual's request for information concerning themselves is not in the contractor's files, the contractor should advise the individual that it does not have the information and, if available elsewhere, that it is forwarding the request to the office which has it. The contractor should furnish any requested information available if the request cannot be satisfied in full. The contractor should identify requests under the Privacy Act that require referral to CMS for data in central office systems. As required by the Privacy Act, the contractor should send the request for processing, along with a copy of the interim response, to the systems manager listed in the Annual Publication: Systems of Records.

F. Methods of Accessing Individual Medical Records

The official responsible for the records, or their designated medical officer, may disclose medical information directly to the individual if the official determines, based on review of the medical evidence, that such disclosure is not likely to have an adverse effect. In such cases the responsible official will give the requested information to the individual and annotate the record to show that the disclosure was made.

If the responsible official determines that direct disclosure of the medical record would be likely to have an adverse effect on the individual or does not consider themselves qualified to make such a determination, the official will disclose the medical information to the representative designated in writing by the individual. The representative must be a medical professional (licensed medical practitioner or nurse) who would be willing to review the record and discuss it with the individual. The contractor will retain a record showing the reason for its determination and a copy of the correspondence transmitting the information to the individual or to his/her medical representative.

If there is sensitive medical information in the records and the individual refuses to name a medical professional or cannot afford the fee for the service, or if the designated medical professional refuses to serve, the contractor will refer the file to the CMS regional office.

G. Disclosure of Medical Information Relating to Minors

In order to protect the privacy of a minor, a parent or authorized guardian who requests access to the minor's medical record may not be given direct access to the record. Contractors shall ask a parent or guardian who requests access to such a record to designate a physician or other professional (other than a family member) to whom the record may be sent. The physician or health professional to whom the record is sent will be asked by the contractor to consider the effect that the disclosure of the record to the parent or guardian would have on the minor in determining whether the record should be made available to the parent or guardian.

The contractor will prepare a response to the parent or guardian in substantially the following form:

> We have completed processing your request for access to the medical records of (name)_____, a minor
>
> The medical records have been sent to (name and address of designated health professional) in accordance with your instructions

In each case where a minor's medical records are sent to a physician or health professional, reasonable efforts will be made by the contractor to so inform the minor. In the event the parent or guardian refuses to name a medical professional or cannot afford

the fee for the service or the designated medical professional refuses to serve, the contractor will refer the file to the CMS regional office for appropriate action.

H. Disclosure to Third Parties

The Privacy Act permits disclosure to any third party with the written consent of the individual to whom the record pertains. It also permits disclosure in certain instances without the individual's consent. However, the contractor must not disclose information unless the disclosure is specifically authorized in this chapter, or the individual has consented to the disclosure in writing, or the CMS regional office authorizes the disclosure.

I. Disclosures with Consent

Except for those disclosures discussed below in §10L of this chapter, Disclosure Without Consent, information may not be disclosed without the written consent of the subject individual, or their legal guardian, or, in the case of a minor, their parent (a parent or legal guardian of a minor may not consent to the disclosure of medical information about the minor). Other persons, regardless of relationship (except members of Congress and representative payees), may not receive information about the individual without their consent. In addition, a person who receives information about an individual with the individual's consent may not authorize disclosure of that information to someone else. Awkward situations may develop from a refusal, in compliance with the Privacy Act, to divulge information to the child or spouse of an aged or infirm individual. In order to avoid lengthy and unproductive correspondence, the requester should be advised that the Privacy Act precludes our disclosing any information to anyone other than the individual to whom the information pertains without the specific written consent of that individual, but that the requested information will be sent directly to the individual concerned with an explanation of the inquiry received on their behalf.

J. Disclosures to Members of Congress

Information requested by members of Congress and their staffs may be disclosed as follows:

- Where a member of Congress (or a staff member) inquires on behalf of a constituent, the contractor may respond to the member of Congress (MC) without the written consent of the individual, but must make a record of the disclosure.

- Where the MC's inquiry is on behalf of a relative of the subject individual (but the inquirer is not the legal guardian of the individual, or the parent of the individual minor), the contractor should advise the MC that it can respond directly only to the individual unless the individual furnishes written consent to release the information about themselves to the MC (if we respond directly to the individual or with their consent, no accounting record is required). Where the inquirer is the

legal guardian, or the parent of a minor, the contractor may disclose the information to the MC, but must make a record of the disclosure.

- Where the MC's inquiry is in writing and does not indicate whether the request is from the subject individual, the contractor will contact the MC, usually by telephone, to clarify the situation.

A copy of the reply (or a report of telephone call if the response is by telephone) will provide an adequate accounting record. The record should show the date of disclosure, the information disclosed, and to whom the disclosure was made. The contractor should file this record by name or social security claim number so that retrieval may be made expeditiously.

K. Disclosure to Representative Payees

An SSA-appointed representative payee is entitled to receive information on, or act on, behalf of a beneficiary to the extent necessary to protect the beneficiary's rights under title II or XVIII.

L. Disclosure without Consent

Below are listed the situations in which data on identifiable individuals may be released without the individual's consent. The disclosure is permitted if the disclosure would be:

- To DHHS employees and officers who need the records to perform their duties;
- Required by the FOIA;
- To the Bureau of Census;
- For research purposes under certain circumstances;
- To the National Archives;
- For law enforcement activities if the activity is authorized by law and the request is from the head of the agency and specifies the particular record desired and the law enforcement activity for which the record is sought;
- For compelling circumstances affecting the health and safety of any person if notice of the disclosure is sent to the last known address of the individual;
- To either House of Congress or to any congressional committee or subcommittee (see section I above for requests from members of Congress on behalf of constituents);
- To the Comptroller General or an authorized representative to perform the duties of the General Accounting Office;
- Pursuant to the order of a court of competent jurisdiction;
- For a "routine use" - A "routine use" is a disclosure of information which may be made without the individual's written consent because the disclosure is compatible with the purpose for which the information was collected in the first place. An explanation of the purposes and uses of each "routine use" disclosure

must be published in the Federal Register at least 30 days prior to the disclosure and at least annually thereafter. Current routine uses are:

- Part B Payment Records
- Payment Record Reference File
- Tape containing amount, type, and cost of health care services.
- Summary Records
- Group Health Plan Membership Data
- Identification Data
- Group Health Membership Data
- Group Health Membership List
- Quality Assurance Program Releases and Corrections

M. Accounting for Disclosure

The Privacy Act requires that agencies account for disclosures of personal data to organizations outside DHHS or made in response to requests under the FOIA. The purposes of the accounting are:

- To allow individuals to learn to whom records about themselves have been disclosed; and

- To provide a basis for subsequently advising recipients of any amended or disputed records.

The accounting must enable the contractor to tell the individual when and what information about the individual was released and to whom. It is not necessary to maintain a separate record of disclosures if such information can be retrieved from the contractor's operating records.

An individual has the same access rights to an accounting of disclosures as to other information, with no exception. It is not mandatory to tell an individual about disclosures made to an agency for law enforcement purposes. (Refer requests for accountings that include disclosures to law enforcement agencies to the CMS regional office.)

The contractor must maintain accounting records for 5 years, or the life of the basic record, whichever is longer. The lives of various basic records are furnished in Chapter 1 of the Claims Processing Manual.

N. Reviewing and Correcting Records

Individuals are permitted by the Privacy Act to request correction of any record pertaining to themselves. The contractor should have a method of reviewing records at the request of the individual and making corrections where appropriate. In reviewing an individual's request to amend a record, the contractor should, whenever practicable, complete the review and advise the individual of the results within 10 days of the receipt

of the request. Prompt action should be taken wherever possible to reduce the administrative costs involved in issuing both a separate acknowledgment of the receipt of the request and a subsequent notice informing the individual of the action taken. If a contractor denies a request for correction, the individual can appeal to the system manager for the contractor's system of records.

O. Penalties

All employees must be aware of their responsibilities under the Privacy Act and guard against improper disclosure of personal information. Any officer or employee who willfully discloses individually identifiable information, the disclosure of which is prohibited by the Act, shall be guilty of a misdemeanor and fined not more than $5,000.

P. Providers, Physicians, Suppliers, and the Privacy Act:

1. Confidentiality of Provider and Supplier Records

Medicare information may not be accepted from providers, physicians, and other suppliers of services on a confidential basis, expressed or implied, since any medical information obtained by a contractor is subject to disclosure to the individual to whom it pertains. Contractors are to make sure their providers and other suppliers of services are aware that no medical information marked "confidential" will be accepted on that basis and that any medical information received by the contractor may be disclosed to the patient or his/her representative upon request, either directly or through designated professional medical personnel. If a provider, physician, or other supplier of services documents medical findings on medical forms preprinted "confidential" or the provider or other supplier of services routinely stamps all records "confidential," such records, when transmitted to the contractor are to be accompanied by a signed statement to the effect that the provider, physician or supplier understands that the information is subject to disclosure at the request of the patient or his/her representative under the Privacy Act.

2. Release of Eligibility Data to Providers and Suppliers When the Individual is Unable to Sign an Authorization

In situations such as the admission to a hospital of an unconscious person, where the individual has not signed a statement authorizing the provider to pursue a Medicare claim, the disclosure of Medicare information to the provider should be treated as a routine use disclosure. If the individual has authorized the provider or supplier to pursue a Medicare claim, the release of information may be treated as a disclosure made with the beneficiary's consent.

10.1 - Disclosure of Information

The following sections contain instructions concerning the confidentiality and disclosure of information acquired and maintained by CMS, contractors (i.e., Medicare intermediaries and carriers), providers, and State agencies in the administration of the

health insurance program. These instructions comply with the statutes and regulations governing disclosure of information, specifically section 1106 of the Social Security Act, the Freedom of Information Act (5 USC §552) and implementing HHS FOIA regulations at 45 CFR Part 5, and CMS Confidentiality and Disclosure regulations at 42 CFR 401.101, et seq.

10.2 - Procedures for Handling Requests

The Freedom of Information Act (FOIA) requires that within 20 working days of the receipt of a written request for records (or information known to be contained within an agency record), Federal agencies must decide whether the records/information will or will not be disclosed. By HHS regulation, only the CMS Freedom of Information Officer can make this decision, However, the CMS Freedom of Information Officer with the concurrence of the Office of the Assistant Secretary for Public Affairs, HHS, has delegated authority to Medicare contractors to directly release certain categories of frequently requested documents that the CMS Freedom of Information Officer has previously reviewed and decided to always release. These records are called "direct release" records. Some are identified within this manual; others are established by the CMS Freedom of Information Officer in administrative issuances.

Accordingly, within 20 working days of receipt of an FOI request, if the contractor is authorized to release all or at least some of the requested records, it will advise the requester in writing whether the request will be wholly or partially fulfilled.

The CMS does not permit the contractor to issue a written denial of any request for information, except in response to the contractor's direct receipt of a state or local court subpoena duces tecum that seeks records on a beneficiary or individual practitioner that are contained in a Privacy Act System of Records, when such subpoena is not accompanied by a valid authorization to release the records signed by the subject of records. (See §40.1B.) CMS requires the contractor to refer to the RO all requests for which the contractor does not have clear authority to release the records/information.

Therefore, if the contractor receives a written request for records, the contractor must determine within 2 days of the receipt of the request whether it is clearly authorized to disclose the information. When able to furnish the requested materials, the contractor will furnish it whenever possible, within 20 working days. If it is not possible to furnish the materials within 20 working days, the contractor will immediately send the requester a substantive response that states that the records will be released, and explains the reason for the delay.

If the contractor is not clearly authorized to release the information, it notifies the RO immediately and refers the request to the RO for handling. It sends the request, along with one set of the requested records, immediately to the RO by first class mail, and clearly identifies the request as a Freedom of Information Act request.

The contractor acknowledges to the requester any request referred to the RO, using the following language:

> Dear:
>
> We have referred your (date) Freedom of Information Act request for (specify type of information requested) to: (name of the CMS Regional Office FOIA Coordinator, address of CMS RO, and telephone number of the CMS RO Coordinator).
>
> Any questions you may have relative to your request should be directed to that office.
>
> Sincerely yours,

The contractor sends a copy of the acknowledgment letter with the request to the RO. The contractor is not required to create records to comply with requests for information. Contractors may answer requests that require creation of records by stating that the requested records do not exist and that the FOIA does not require agencies to recreate records in order to respond to a request. Include the appeal rights statement set forth below in the response. (Note that deletion of non-releasable information from an existing record is not considered creation of a records, no matter how extensive or time consuming the deletion process might be. Respond to requests that require creation of records using the following language:

> Dear:
>
> This is in response to your request dated ____, seeking access to (specify the subject(s) of requested record). Because you seek access to one or more agency records, or information contained in such records, we have considered your request under the Freedom of Information Act (FOIA) (5USC §552).
>
> We are unable to comply with your request because the agency does not maintain a records that is responsive to your request and because, under FOIA, we are not required to create records or to furnish information in a particular form or format is not readily reproducible employing reasonable efforts.
>
> If you have reason to disagree with this decision, you may appeal. Your appeal should be mailed, within 30 days of the date of this letter, to the
>
> > Deputy Administrator
> > Centers for Medicare & Medicaid Services,
> > Room C5-16-03,
> > 7500 Security Boulevard,
> > Baltimore, Maryland 21244-1850.

Please mark your envelope "Freedom of Information Act Appeal," and enclose a copy of this letter.

10.3 - Processing Freedom of Information Act (FOIA) Requests

Form CMS-632-FOI (Exhibit A) serves as a cover sheet for FOI requests. The form is designed to expedite the handling of requests and to provide the information necessary for reporting purposes. For each FOI request, the contractor will complete a Form CMS-632-FOI. Completion instructions for the form are included on the reverse side. The contractor may furnish estimated costs if actual postage costs are not readily available.

Order Form CMS-632-FOI routinely on an annual basis using the CMS 1961 Forms Order. Direct any interim requests for Form CMS-632-FOI to CMS Forms Distribution Officer, Forms Management and Distribution, Office of Internal Customer Support. Interim requests must be submitted in writing.

10.4 - Reporting Freedom of Information Act Activity

The contractor's authority to directly release certain kinds of records includes the responsibility for complete and accurate reporting on the use of this authority. The following are reporting requirements for Medicare contractors:

- Fill out completely and accurately a Form CMS-632-FOIA for each "direct release."
- Maintain in either hardcopy or electronic form a Freedom of Information Daily Log on a daily basis. This log must include the case control number, date of incoming letter, requester's name, subject of the request, the date received in the FOIA unit, the date the response was mailed and the invoiced fee.
- Prepare, on a monthly basis, the Summary Sheet for the CMS Monthly FOIA Report (Exhibit B). This Summary Sheet aggregates data from the individual Form CMS-632.
- Submit the Daily Log and Summary Sheet for a given month to your RO FOIA Coordinator by the end of the fifth work day of the following month.
- Retain copies of all completed Forms CMS-632-FOI in accordance with record retention requirements for FOIA Administrative Files.

20 - Case Numbering

Since many requesters make multiple FOIA requests, name identification is not adequate to assure proper tracking, or fiscal accounting. Therefore, CMS employs a Case Numbering System which includes unique identifiers for each releasing activity.

- Use the Case Numbering System for all FOIA cases.

- Use the case number in item one of the Form CMS-632-FOI and in the "case number" block at the top left of the Form CMS-633 Invoice of Fees for FOIA Services (Exhibit C). Requesters will be asked to put the case number on checks rendered for payment of FOIA services and on any correspondence relating to that case.

1. All case numbers in this system consist of ten characters. These characters maybe numeric or alphabetical and are determined as follows:

a. Case numbers for requests responded to directly by contractors begin with an arabic number for the Region.

Region	Case Number	Region	Case Number
Boston	1	Dallas	6
New York	2	Kansas City	7
Philadelphia	3	Denver	8
Atlanta	4	San Francisco	9
Chicago	5	Seattle	0

NOTE: Only one space is designated to indicate the responding regional office or contractor within the region. Therefore, Seattle is represented by "0" rather than by "10".

b. For example, a request responded to directly by any carrier within Region 1 would begin with the digit "1":

1---------

c. In all case numbers, the second character is the last digit of the calendar year in which the request is received by the responding activity. Thus, continuing the example above, for a 2001 request in Region 1:

11--------

d. Characters three through six indicate the contractor within the region. A request answered by a contractor would use the last four digits of the contractor number in positions three through six. Thus, a request responded to directly by Blue Cross and Blue Shield of Rhode Island (carrier number 00870) would be:

110870----

e. The last four characters indicate the consecutively assigned case number, beginning with "0001". Thus, the first request responded to by that carrier in calendar year 2002 would be:

1108700002

21 - Fees for Information (Contractors)

Under the provisions of the Freedom of Information Act, certain fees and charges have been established to recover some of the cost of disclosing information to the public. Providers, contractors, and State agencies are required to pay appropriate fees for copies of reports they request pertaining to other providers, contractors, or State agencies. Such fees are not reimbursable administrative costs under the Medicare program for contractors or State agencies. A provider may claim such fees as allowable costs only if it demonstrates that the information is necessary in developing and maintaining the operation of patient care facilities and activities. Members of Congress, when clearly requesting information on behalf of a constituent or other third party, are subject to the same fees and charges that would apply to the person represented. The contractor will not charge the public for inspection of disclosable documents, or for requests which result in charges under the minimum described in §21.3, below.

21.1 - Fees

1. Fees are to be charged differentially, depending on the category of requester/use of the requested material, as follows:

- Commercial Use Request- If the request is for a commercial use, charge the requester for search and review, plus duplication.

- Education and Scientific Institutions and News Media- If the requester is (1) an educational institution or a non-commercial scientific institution operated primarily for scholarly or scientific research, or (2) a representative of the news media, charge only for duplication. However, do not charge for the first 100 pages of duplication.

- Other Requesters- If the request fits into neither of the above categories, charge for search and duplication. However, do not charge for the first 2 hours of search time and the first 100 pages of duplication. In addition, do not charge the requester if the charge to be billed is less than the established billing threshold.

NOTE: The CMS Freedom of Information Officer can rule on requests for waiver or reduction of fees, other than those listed above.

2. Regardless of the actual cost of responding to the requester, the law only permits charges to be levied for certain services and only in accord with a published FOIA fee

schedule. The DHHS schedule at 45 CFR Part 5 is binding on CMS, and results in the following charges:

a. Photocopying - Charge 10 cents per page for copying records. The contractor may charge lower fees for particular documents where:

- The document has already been printed in large numbers,
- The contractor determines that using existing stock to answer this request, and any other anticipated FOI requests will not interfere with program requirements, and
- The contractor determines that the lower fee is adequate to recover the prorated share of the original printing costs.

b. Search and Review - For manual searching and for review (when used, as applicable, in connection with processing records for a commercial use or other request), base the cost on the hourly rate of employees involved. Equate employee hourly wage scales to these three categories:

Level	Hourly Wage Range	GS Grade Range	CMS Bills
Level 1	Up to $20.74	Federal Grades 1 through 8	$16.00
Level 2	$20.75 - $46.69	Federal Grades 9 through 14	$33.00
Level 3	$46.70 or more/hr	Federal Grades 15 and up	$59.00

NOTE: The CMS Freedom of Information Officer updates the above scale based upon changes to the HHS fee schedule, and provides such updates to all CMS/contractor FOIA Coordinators.

The contractor will not charge the requester any fee at all if the costs of routine collection and processing of the fee are likely to equal or exceed the amount of the fee. As of November 2001, CMS's charge threshold is $15.00.

If the contractor determines that the requester is breaking down a single request into a series of requests in order to avoid (or reduce) the fees charged, it may aggregate all these requests for purposes of calculating the fees charged.

Certifying that records are true copies - Charge $10 per certification.

Performing any other special service requested, that the contractor agrees to provide - actual costs of operating any machinery, plus actual cost of any materials used, plus charges for the time of its employees, at the rates given in paragraph 2b of this section.

Special Forwarding Arrangements - Actual cost. This includes special delivery, airmail, registered mail, etc.

21.2 - Billing of Fees and Charges

The contractor is responsible for the billing of costs resulting from providing disclosable information. To invoice, use Form CMS-633 - Invoice of Fees for FOIA Services (Exhibit C). The requester sends payment derived from the release of information to the CMS Division of Accounting.

21.3 - Advance Payment/Requests Fulfilled Without Remittance

Where estimated costs exceed $250.00, or if the requester has failed to pay previous bills in a timely fashion, collect fees and charges before the requested material is copied and furnished. Use the Division of Accounting, CMS's FOIA Bad Debtor Listing to determine delinquency. Notify the requester of the total estimated charges, using language similar to the following:

> The HHS regulations require that a charge be made to recover some of the costs incurred in the disclosure of information. The total (estimated) billable cost for the material you requested is $ _____. The cost consists of the following charges: (list here breakdown of charges; e.g., "Photocopying: $10; Searching: $450). Please send a check or money order for the total amount made out to CMS and mail it to (contractor address).
>
> The material will be mailed to you upon receipt of payment (subject to any adjustment to the estimate). If we do not hear from you within 30 days, we will assume your request has been withdrawn and no further action will be taken.

Be sure to point out to the requester that even though the invoice says to mail the check to the CMS Division of Accounting in Baltimore, in this case the check must be mailed to the contractor so that payment can be verified before the material is mailed. Subsequent to the contractor's receipt of the advance payment, send both the check and the finance copy of the invoice to the Division of Accounting in Baltimore. Because some requesters will neither provide advance payment nor notify the contractor that they no longer desire the requested material, do not send the "Finance" copy of the invoice to Accounting until after the advance payment check is received. For the same reason, do not begin searching for and photocopying the requested material until the advance payment is received. If you do not hear from the requester in 30 days, close the request.

30 - Disclosure of Program Materials (Contractors)

The Freedom of Information Act deals with the right of the public to information about Government rules and methods of operating. It requires that every Federal agency make available for inspection and copying:

"522(a)(2) (B) those statements of policy and interpretations which have been adopted by the agency and are not published in the Federal Register; and (C) administrative staff manual and instructions to staff that affect any member of the public, unless such materials are promptly published and copies offered for sale."

Information contained in Medicare program manuals and Program Memoranda can be obtained via the Internet. Where requests are made to contractors, contractors will photocopy Program Memoranda and individual pages from CMS manuals to respond to minor requests. When inquirers ask to see Social Security Manuals and letters that are not maintained, the contractor will refer them to the SSO. If the request is for Medicare related information, the contractor may disclose the following:

- Written policy used to evaluate and make payment decisions on claims subject to medical review. (Parameters are not components of medical payment policies and should not be disclosed.)

- Fee schedules and profiles of customary and prevailing charges of physicians/suppliers, including backup data, as long as the provider identifiers and the frequencies of procedures per provider have been deleted.

- Relative value units and conversion factors used to develop approved charges for procedures done too rarely to compile customary charges.

- Lists of contractors, physicians/suppliers and provider numbers.

- Documents listing and/or describing acceptable diagnostic or procedure codes, rate schedules or covered services.

The contractor will not engage in interpretive analysis or discussion of the material when responding to requests.

The contractor will not release information on the parameters and computer edits used to identify claims for medical review. These are tools for selection of claims for MR and are not determinants of whether a service is payable.

EXAMPLE: The contractor has a screen which identifies for review all claims for CAT Scans of the head in excess of 3 in 30 days. Written MR policy contains diagnoses and other descriptions of medical conditions that would justify CAT Scans in excess of that amount. The contractor is required to release the policy guidelines but must withhold the "3 in 30 days" parameter used to identify claims for MR.

The contractor must refer requests for information for which denial is recommended, including parameters and computer edits to the RO.

30.1 - Manuals, PMs, and Other CMS Materials

The contractor should provide a facility for the public to view the program manuals and other information available to the public on the Internet.

It will fulfill requests for printouts resulting in 50, or fewer, pages.

Requests to examine manuals or letters usually arise where a beneficiary calls at an office to discuss his/her claim. In such situations, the contractor will abstain from engaging in interpretative analysis or discussion of the material.

30.2 - Internal Guidelines

All interpretive materials, guidelines, and clarification of policies that relate to payment of Medicare benefits must be released.

Upon request, the contractor will release written guidelines used to evaluate and make payment decisions on claims subject to MR. Precise information on the screens, parameters and computer edits used to identify claims for MR may be withheld.

EXAMPLE: A screen identifies for review any SNF claim with more than 30 covered days. Written MR policy contains the documentation standards and guidelines which assist the reviewer in the decision to pay or deny the claim. Release of the policy guidelines is required, but the review screen can be withheld.

Guidelines may be withheld that use specific criteria and tolerances intended to identify claims that raise a strong possibility of fraud or abuse because of a pattern of payment requests for excessive or duplicate services, or services not rendered. If disclosure of such guidelines could be judged to adversely affect the program by allowing violators to go undetected, the contractor should refer the request to the RO with its recommendations. The contractor will acknowledge any requests that should have gone to another contractor and refer them to the appropriate contractor.

40 - Disclosure of Information about Identifiable Beneficiaries (Contractors)

Sections 3764 - 3769 set the guidelines for disclosure of information about a named beneficiary, to whom it may be disclosed, and the purposes for which it may be disclosed. In general, no information may be released except to the beneficiary (or the beneficiary's legal guardian) without the beneficiary's (or legal guardian's) explicit written authorization.

In cases requiring the beneficiary's consent, the authorization may be in any form, but it must:

- Be signed and dated;
- Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;

- Specify the record(s), information, or type(s) of information which may be disclosed; and
- Indicate whether the consent is a one-time or on-going release of records.

A contractor will not honor a blanket consent to disclose all beneficiary records to unspecified individuals or organizational units.

The disclosure of information about beneficiaries is governed by the provisions of § 1106 if the Social Security Act as implemented by Regulation No. 1, the Privacy Act, the FOI Act, and the DHHS Public Information Regulation.

40.1 - Prohibition Against Disclosure

Section 1106 of the Social Security Act prohibits disclosure of any file, record, report, or other paper, or any information obtained at any time by the Secretary or an officer or employee of DHHS in the course of discharging their duties under the Act, except as prescribed by regulations. Where manual instructions permit disclosure, assume that related regulations have been published. The same prohibition applies to information received by any person outside DHHS, from the Secretary, or an officer or employee of DHHS.

The prohibition applies to any agency, organization (e.g., contractors), or institution, or any of its officers or employees, in the fulfillment of a contract or agreement with the Secretary.

A. Disclosure of Provider or Physician Records

The prohibition also relates to any information received from DHHS, a contractor, or any person or entity that furnishes services under arrangements with a provider or accepts an assignment under the program. However, patient records in the possession of a provider or physician are not subject to the prohibition against disclosure or to the Departmental rules and regulations concerning confidentiality merely because the patient is entitled to Medicare benefits. Disclosure of provider or physician records not in the possession of CMS or a contractor may, however, be subject to applicable State or local laws, or to hospital rules governing disclosure.

B. Authority for Refusal to Disclose Information

Denial of all or portions of requested records can only be made by the CMS Freedom of Information Officer. Therefore, when a request for information is received, disclosure of which is prohibited under these guidelines, the contractor will follow §10.2 above.

The CMS FOIA Officer has authorized Medicare contractors to issue a denial on his/her behalf in the following situation: If any officer, employee, agent or subcontractor is served a subpoena or other compulsory process requiring the production of records or information on a beneficiary or individual practitioner that are contained in a Privacy Act

System of records and such a request is not accompanied by a valid authorization to release the records signed by the subject of the records, he/she will decline to produce the records or information. He/she will base the refusal on §1106 of the Social Security Act and on 5 USC §552a, 5 USC §552, 45 CFR Part 2 and 45 CFR Part 5. The contractor will notify the RO immediately.

If the contractor directly receives such a subpoena, it uses the following language to respond:

> Dear Sir or Madam:
>
> This is in response to the subpoena duces tecum, dated _____, initiated by your firm, for certain Medicare records in our possession.
>
> The Department of Health and Human Services regulation at 45 CFR Part 2 states, among other things, that the Department will treat subpoenas duces tecum for records in its possession as requests under the Freedom of Information Act (5 U.S.C. §552).
>
> Because the records the subpoena seeks are in a Privacy Act system of records, the Privacy Act (5 U.S.C. §552a) precludes release of those records except pursuant to a written authorization to release signed by the subject(s) of the records or unless the Freedom of Information Act requires release of the records or a court of competent jurisdiction orders release. Regarding the latter condition of disclosure, for purposes of the Privacy Act, a court of competent jurisdiction is a Federal court only.
>
> Review of this matter indicates that your firm has not presented a written authorization to release records signed by the subject(s) of the records. Moreover, your firm's subpoena is not an order of a court of competent jurisdiction, and 45 CFR Part 2 requires us to treat the subpoena duces tecum as a Freedom of Information Act request. Further the Freedom of Information Officer for the Centers for Medicare & Medicaid Services has determined that the requested records are exempt from mandatory disclosure under the Freedom of Information Act by exemption (b)(6) of that Act. Exemption (b)(6) permits the withholding of information about individuals in personnel and medical files and similar files, when the disclosure of such information would constitute a clearly unwarranted invasion of personal privacy.
>
> Based upon the foregoing, we respectfully decline to produce the Medicare records requested by your firm's subpoena duces tecum.
>
> If you have reason to disagree with this decision, you may appeal. Your appeal should be mailed, within 30 days of the date of this letter, to the Deputy Administrator, Centers for Medicare & Medicaid Services, Room C5-16-03, 7500

Security Boulevard, Baltimore, MD 21244-1850. Please mark your envelope "Freedom of Information Act Appeal," and enclose a copy of this letter.

Sincerely yours,

Signature of Authorized Official

cc: FOI Officer, CMS

Process the State or local court subpoena duces tecum that seeks other kinds of CMS records in accord with §10.2 above.

C. Penalty for Failure to Comply With the Rules Relating to Disclosure of Information Obtained in the Administration of the Act

Section 1106(a) of the Act provides that any person who violates the disclosure provisions shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, by imprisonment not exceeding 1 year, or both.

40.2 - The Authority for Disclosure

Regulation No. 1 of the Act defines the basic authorization for disclosure of information obtained in the administration of the program. The general rule is that information about an individual obtained in the administration of the program may not be disclosed without the authorization of that individual. Medical information relating to an individual will generally be disclosed under more restrictive conditions than other information and, where permitted, usually may be furnished only upon the written authorization of the individual. Specific exceptions to this rule are detailed in the following sections. As far as program operations are concerned, information about an individual may be disclosed without the individual's authorization when the disclosure is necessary in connection with any claim, or other proceeding, under the Social Security Act.

Information will be disclosed for other than program purposes only if the disclosure is authorized by Regulation No. 1 and is consistent with the proper and efficient administration of the program.

50 - Disclosure Necessary for Proper Administration of the Health Insurance Program

A. Information About an Individual

Disclosure of any record, report, or information about an individual may be made without the individual's authorization if it is in connection with any claim, or other proceeding, under the Act when it is necessary for the proper performance of duties of:

- Any officer or employee of the Department; or

- Any officer or employee of a State agency, contractor, provider of services, or other agency or organization participating in the administration of the program by contract or agreement in carrying out such contract or agreement.

The SSOs have a responsibility for public information activities. In its development of a human interest story concerning health insurance, an SSO may, on occasion, request the contractor to provide claims reimbursement information about a specific beneficiary. The contractor will honor such a request when it comes from an SSO employee having authority for liaison with the contractor.

Depending upon the agreements made with the parallel SSO, the employee authorized may be the manager, assistant manager, staff assistant, and/or HI coordinator. The contractor will not honor requests by other employees for beneficiary claims information.

B. Disclosure to Third Parties

In the administration of the program, the contractor may want to avail itself of the services of third parties such as auditors, court reporters, public stenographers, microfilm processors, or companies developing equipment for use in the program.

The arrangement between the contractor and such third parties, even where it is of short duration, is in the nature of an agreement supplementing its contract with the Secretary. Under such an arrangement, disclosure to these parties of necessary information that relates to, and is used in, the administration of title XVIII of the Social Security Act is permitted as provided by §1106 of the Social Security Act and Regulation No. 1.

However, when the contractor enters into an agreement with these parties, it will inform them that §401.1 of Regulation No. 1 precludes the disclosure of any information on identifiable individuals. It will call their attention to the penalty clause of §1106(a). It will call attention to these provisions by letter (see below), and obtain a written agreement to comply with the disclosure provisions before releasing any information.

Sample Letter to Third Party

> Dear
>
> We are prepared to make available to your organization certain social security records so that (state reason).
>
> However, before making these records available, we must point out that by law, all information derived on identifiable individuals in the administration of the Social Security Act is confidential and may be disclosed to others only under very restrictive circumstances. Regulation No. 1 of the Social Security Administration

which governs disclosure of official records and information precludes you from disclosing any information on identifiable individuals.

You should also note that §1106(a) of the Social Security Act imposes criminal penalties for unauthorized disclosure.

Any social security records which do not identify or make identifiable any individuals are not subject to these restrictions, but may be restricted under the provisions of the Freedom of Information Act.

In order to comply with the requirements of the Social Security Act and Freedom of Information Act you must agree to the following conditions before we can make any social security records available to you:

Any information which is turned over to you will be used only for the specific purpose intended.

All employees having access to this material will be instructed as to its confidential nature.

An official of your company will assume the responsibility for ensuring that the information is not revealed to another.

The material must be returned to us as soon as you have finished the job.

We must have a letter from a responsible official in your office agreeing to these conditions and assuming responsibility for carrying them out.

Upon receipt of such letter, the social security records will be made available to you.

Sincerely yours,

60 - Disclosure of Beneficiary Specific Data by Contractors to Medicare Providers and Suppliers in Coordination with Social Security Administration (SSA)

The contractor will use these guidelines to handle requests for beneficiary-specific information from providers, physicians, and suppliers. In general, it will emphasize that the Medicare card is to be used to obtain the necessary information for filing Medicare claims; that it contains the health insurance claim (HIC) number and entitlement dates; and is correct in the majority of cases.

60.1 - Telephone Requests from Institutional Providers, Physicians, Suppliers, and Other Providers

The standard method for sharing eligibility information with providers is through electronic data interchange (EDI). EDI is the most efficient and cost-effective way for intermediaries and carriers to make this eligibility information available to providers and ensures privacy safeguards through EDI agreements that bind providers. Instructions regarding provider EDI access to limited eligibility information and the specific data elements that can be disclosed can be found in the Claims Processing publication, Admission and EDI Support chapters.

Carriers and intermediaries are permitted to release eligibility information over the telephone to providers, subject to ensuring the protection of the beneficiary's privacy rights.

NOTE: Contractors should not automatically assume that a provider who submits claims electronically can verify eligibility electronically. For example, contractors provide free or low-cost software to some providers enabling electronic claims submission. That software, however, does not provide for electronic eligibility queries.

The eligibility information that may be released by telephone is limited to only that information that would be available via EDI.

Before releasing eligibility information to providers via the telephone the intermediary or carrier must validate the provider's name and number, and obtain the following information:

- Beneficiary last name and first initial;
- Beneficiary date of birth;
- Beneficiary Health Insurance Claim (HIC) number; and,
- Beneficiary gender.

These items must match exactly.

Information may be released via the Automated Response Unit (ARU) or Interactive Voice Response (IVR) systems.

60.2 - Written Inquiries from Institutional Providers, Physicians, Suppliers, and Other Providers

If the written inquiry is not accompanied by a written consent statement signed by the beneficiary or representative (and containing all of the elements indicated in §60.1 above), the contractor informs the requestor, in writing, that the information may not be released, and to first contact the beneficiary for the information. It tells the requestor that if that does not work, then the requestor should obtain a written and signed consent statement from the beneficiary containing all of the elements outlined in §60.1 above.

60.3 - Online Access for Medicare Certified Providers

The contractor should remind Medicare certified providers that it is providing online access to certain entitlement data for those certified providers who bill electronically. The contractor should be contacted for further information.

60.4 - Beneficiary Outreach

When making presentations before beneficiary groups, the contractor reminds them to carry their Medicare card with them whenever they are away from home and to always show their Medicare card when they receive services that are covered by Medicare. It refers beneficiaries to SSA for a replacement card if the beneficiary's Medicare card is lost or misplaced. If the beneficiary authorized the provider or supplier to pursue a Medicare claim, the contractor treats the release of information as a disclosure made with the beneficiary's consent.

70 - Disclosure of Information after the Death of a Beneficiary (Contractors)

The contractor may disclose information concerning the fact, date, or circumstances of death when efficient administration permits. The request must be in writing and must state why the information is sought. Additional information may be disclosed to a surviving relative or an authorized representative of that relative, the legal representative of the estate, or to a probate court for the purpose of appointing a legal representative of the decedent's estate. The contractor must exercise care, however, to see that it discloses no information which would appear to be detrimental to the individual or the individual's estate, i.e., unusual place or manner of death or information which could create a liability to the individual's estate.

The contractor may disclose medical information, in form and detail consistent with proper and efficient administration of the program, when such disclosure is reasonably necessary for a title XVIII purpose. (See §50 of this chapter for further information concerning the disclosure of non-medical and medical information when necessary for a program purpose.)

The contractor may disclose medical information obtained in the administration of title XVIII to a surviving relative or legal representative of the estate of the individual or to others for other than a title XVIII purpose, when such information is necessary for a determination as to what supplementary benefits or services such deceased individual was eligible to receive under a private or public hospital or medical insurance program which is consistent with the purposes and objectives of title XVIII. The contractor may disclose such information only if the individual has consented to such disclosure or a surviving relative or the legal representative of the estate consents. (See §80.1 "Release of Title XVIII Claims Information for Complementary Insurance Purposes" in this chapter.)

80 - Disclosure to Third Parties for Other than Program Purposes (Contractors)

A. Non-medical Information

Non-medical information about an individual may be disclosed for other than a program purpose, to persons or organizations designated by the individual, if the individual authorizes disclosure, and if disclosure is consistent with the proper and efficient administration of the Act.

B. Disclosure of Medical Information to a Physician, Institution, or Other Supplier of Services

The contractor may disclose medical information to a supplier of medical services solely for the purpose of the beneficiary's care or treatment. Such supplier will be informed that the information is being furnished in connection with the treatment of the beneficiary and that its use should be restricted to that purpose.

C. Disclosure to the Source of Medical Evidence

Occasionally in the course of reviewing medical evidence submitted to substantiate a claim, contractor medical personnel may discover a medical condition of which the source of the information is unaware. (For purposes of this section, the "source" of the information is the part submitting the evidence.) In cases where a serious or potentially serious condition is found, the contractor may wish to inform the source of the information. If the source of the information indicates that the beneficiary is not institutionalized and the identity of the beneficiary's current physician is not known, the source should recommend that the beneficiary consult a physician or institution of the beneficiary's choice for further treatment.

D. Disclosure to a Source of Medical Services other Than the Source of the Information

Medical information may also be disclosed, upon request, to the beneficiary's physician or to a medial institution at which the beneficiary is or was a patient when such physician or institution is not the source of the information. However, consent for the release must be obtained from the beneficiary.

80.1 - Release for Title XVIII Claims Information for Complementary Insurance Purposes (Contractors)

The contractor may not release or use information obtained in the administration of the Medicare program for non-program activities. However, when the beneficiary has given written authorization the contractor is permitted to release certain information to its complementary insurance program under specific conditions in its capacity as insurance writer or administrator, or to other insurers for complementary health benefits purposes.

Under no circumstances may the contractor use the knowledge of an individual's entitlement or benefit utilization information for purposes of dropping an individual from a group health insurance plan.

A. Information That May be Released

Subject to necessary authorizations, copies, extracts, or summaries of only the following records may be released:

- Provider billing forms (e.g., Form CMS-1450);
- Explanation of benefits for Part B Provider Services, or denial letters; and
- Information on date of entitlement to Part A, or date of enrollment under Part B, or the date Part B coverage began.

Requests for other information desired for complementary insurance purposes should be referred to the RO.

B. Form of Authorization

The contractor must make certain that information is not released without the required authorization. This authorization may be either indicated on the billing and admission form or on a dated statement from the beneficiary. Where the authorization is on a dated statement it must:

- Authorize release of information about his/her title XVIII Medicare claim;
- Designate to whom the release is authorized;
- Show that the release authorized is for complementary insurance purposes (this may be implied by the designation in the second bullet above);
- Indicate whether the authorization is for a one-time or ongoing release of data (i.e., for the duration of the claims and appeals process, but not to exceed 2 years); and
- Bear the signature of the beneficiary, the beneficiary's legal guardian, or the beneficiary's authorized representative.

Where the bill contains a beneficiary signature or indicates that the beneficiary's signature authorizing release of information is contained in the provider's records, the bill must contain the name of the complementary insurer unless a dated statement as outlined above is already on file.

Where the contractor has a dated statement on file, information may not be released for individual claims when the beneficiary indicated that they do not want disclosure on that claim. This may be indicated on certain claims forms by the beneficiary checking an appropriate block, or by attaching a separate statement.

If someone other than the beneficiary, legal guardian, or authorized representative has authorized disclosure to a third party by filling out the appropriate item on the billing form, the contractor may not release the information unless an authorization from the beneficiary is on file. Instead, where feasible, the contractor will inform the beneficiary (or legal guardian or authorized representative) that the signature on the claims form does not constitute a proper authorization for disclosure and that, if the beneficiary desires information to be disclosed to a third party, the beneficiary should send to either the contractor or the third party, a statement authorizing release. (The contractor will indicate the necessary contents of a proper authorization or enclose an appropriate form or statement for use by the proper party in authorizing release.)

If invalid authorizations are a frequent problem, the contractor advises third party payers to obtain appropriate ongoing consent statements from enrollees.

C. Methods of Handling Requests

Where the complementary insurers desire title XVIII information for certain claims only, either the complementary insurer or the beneficiary may request its release.

The complementary insurer must furnish the required authorization(s) for release and must pay any charges. (The Medicare program will absorb charges for supplying duplicate MSN's or billing forms to beneficiaries, their authorized representatives, and to social security offices.) In the absence of a standing arrangement, the mere presence of an "authorization' to release and the identification of a complementary insurer on a title XVIII billing form does not constitute a request for the "release" of information. There must be a specific request for the information.

The contractor may enter into a standing arrangement with a complementary insurer to provide and charge for title XVIII information, such as MSNs or deductible non-met letters, in every case in which the contractor receives a title XVIII claim which contains the necessary authorizations and identifies the complementary insurer.

D. Release of Title XVIII Claims Information for Complementary Insurance Purposes by Providers

Contractors should be aware that, subject to specific written beneficiary authorization, providers are permitted to furnish certain limited information about Medicare eligibility status and related claims information to third part payers for complementary insurance purposes. (See §170.)

90 - Matching Intermediary/Carrier Health Insurance

In using an integrated claims processing system, it is permissible to match a currently updated subscriber file against a run of currently processed Medicare claims to extract information required to pay the complementary claim provided:

- When routinely securing beneficiary authorization for an ongoing release of information safeguards are maintained to ensure that, where a beneficiary revokes the authorization on the billing form or by a separate statement, there will be no release of information;

- When a statement is not routinely secured for the ongoing release of information, controls ensure that there is an authorization per §80.1 of this chapter from each Medicare beneficiary with complementary insurance before information is released; and

- Controls ensure that no information will be released in the matching process for any Medicare beneficiary who does not have complementary insurance.

Contractors must update the subscriber file to incorporate all terminations before each match with the Medicare claims file so that information will not be passed to the private business sector for beneficiaries who are not entitled to the complementary insurance plan.

The contractor may not permit the private business sector to have access to the Medicare claims history file. The private business sector may use only information concerning the current claim from the current run of processed claims.

100 - Disclosure to State Agencies or to Contractors Acting for State Agencies Administering Programs Receiving Grants in Aid (Contractors)

100.1 - Information That May Be Disclosed and Authorization Required

The contractor may disclose information on such matters as entitlement, benefit payment, or benefit utilization relating to an individual who has applied for benefits administered by the State welfare departments. It may make such disclosure without the authorization of the individual or the individual's legal representative (i.e., legal guardian appointed by a court or a parent or a minor) to any duly authorized officer or employee of a State agency administration of grants-in-aid programs under titles IV, V, or XIX or in the case of Puerto Rico, Guam, or the Virgin Islands, titles I, X, or XVI of the Social Security Act with the authorization of the individual or their authorized representative. Medical information beyond that shown on billing forms relating to an individual (and obtained in the administration of the Medicare program) may be disclosed to a State agency administering the grants-in-aid program if the State agency shows a special need for the information, and the file contains a written authorization by the beneficiary specifically consenting to disclosure of medical information.

Title XVIII, billing forms and completion instructions, provide for authorization by the beneficiary for the release of information to State agencies or their agents. Where the

contractor, or a third party organization, is administering the medical payment program under a contract or underwriting arrangement with the State, it may release information to itself or to the third party organization on the same basis as it may release information to a State agency.

100.2 - Procedures for Supplying Title XVIII Information to State Agencies

The type of billing and payment information concerning individual beneficiaries that is needed by State agencies is determined by the nature of the State program and the extent to which it provides for payment of deductibles, coinsurance, and supplementary benefits. Subject to necessary payment of charges by the State in accordance with cost principles set by CMS, the contractor will arrange to release individual payment data such as copies, extracts, or summaries of Part A and Part B billing forms, explanation of benefits, denial letters, or equivalent special forms.

Because of the variations among State programs, contractors should arrange with the State Agency the procedures for release or use of information. Arrangements may include transfer of information on magnetic tape or other electronic means. For example, the contractor could match the updated State buy-in files or a current Medicaid master file or other files prepared by the State. The contractor obtains approval for this procedure with appropriate cost allocation from the RO just as it must obtain RO approval for integrated processing. (See §90.1.)

100.3 - Disclosure to Title V and Title XIX Agencies of Information Indicating Unprofessional or Unethical Practices by Physicians and Other Practitioners

The release of information obtained in the administration of title XVIII indicating a course of unprofessional conduct or unethical practices by a physician or other practitioner will assist in the investigation of such conduct under titles V and XIX. The information to be released must have previously been released by a contractor in the administration of title XVIII to an official of a State licensing board (see §100.4 of this chapter), or to any officer, agency, establishment, or department of the Federal Government charged with the duty of conducting an investigation to determine whether there has been a violation of any provision of a Federal tax law (see §120 of this chapter).

100.4 - Disclosure to Title XIX Agencies of Physician Charge Information

The CMS, which administers title XIX, requires a correlation between payments under that title and the fee schedule or the 75th percentile of the range of customary charges, if applicable, as determined for treatment rendered under Part B of title XVIII. This requirement assumes that title XVIII fee schedule and medical charge experience, where applicable, will be available to title XIX agencies.

Therefore, it is necessary that agencies administering title XIX be furnished with physician, other practitioner, and supplier identification numbers; and fee schedules and/or charges of physicians or other practitioners, or suppliers for services furnished to beneficiaries, to enable them to determine the amount of benefits payable for medical services furnished under Title XVIII and XIX.

As the individual title XIX programs of the several States may differ, some variation in the type of information required can be expected. Therefore, in order to obtain the information it needs, each State agency should consult with the title XVIII contractor(s) serving the various areas in each State concerning the availability and format of the necessary information. (CMS advises the appropriate State agencies of this arrangement.)

Contractor Involvement -

- The contractor will normally receive the request of the State title XIX agency through the RO.
- The contractor will determine the amount of information it can furnish in accordance with the particular request. (See §10ff of this chapter.)
- The contractor will determine the charge and discuss it with the State agency. (See Medicare Carrier Manual, Part 1, §4602.6.)
- If consultation or clarification of the data requested is needed, the contractor should make contact with the State agency through the RO or directly, as advised by the RO.
- When all details are completed, the contractor should submit the requested information in final form to the RO for furnishing to the State agency.

100.5 - Electronic Reporting of Crossover Claims

Contractors provide State agencies with a magnetic tape file of adjudicated claims for which Medicaid has some responsibility. The contractor provides this data in the record format shown on the CMS EDI web page at cms.hhs.gov/medicare/edi/edi3.htm.

If the State agency accepts crossover claims on magnetic tape, but requires additional data, or a different format, the contractor arranges to report these claims to the State agency. The State agency is required to absorb additional costs incurred by the contractor.

110 - Disclosure to Peer Review Organizations (PROs)

The CMS and/or intermediaries may furnish PROs information on claims specified by CMS for PRO review.

120 - Disclosure to the Internal Revenue Service (Contractors)

The contractor may disclose information to the Internal Revenue Service when requested for investigation of a possible violation of the F.I.C.A., S.E.C.A., F.U.T.A., or any Federal income tax law. The contractor will bring to the attention of the RO any problem in complying with the IRS request (e.g., machine capability, cost, etc.).

130 - Disclosure to the Office for the Civilian Health and Medical Program of the Uniformed Services (TriCare) by Contractors

130.1 - General

The CMS may disclose certain information to TriCare for use in administering the TriCare program. The type of information to be made available parallels that made available to non-complementary title V and XIX State agencies and contractors. (See §100 of this chapter.)

130.2 - Type of Information

We expect that most requests from TriCare for information will involve primarily Part B Medicare operations in such areas as identification of physicians and other medical practitioners who may be engaging in providing excess services or fraud. Before we release this information to a requesting TriCare contractor that is not also a Medicare contractor, a Medicare contractor must have previously released the information in the administration of Title XVIII to:

- An official of a medical or other applicable professional society or
- An official of a State licensing board, or
- Any other officer, agency, establishment or department of the Federal Government charged with the duty of conducting an investigation to determine whether there has been a violation of any provision of Federal law (see §120 of this chapter).

We may also disclose to TriCare the types of data covered in §100.2 of this chapter, upon request when authorized by the beneficiary or the beneficiary's legal representative. In addition, we will, upon request, make available to TriCare Economic Index Data (as prescribed by §§405.502(a) and 405.504(a) of Regulations No. 5) that might affect the limits on prevailing charge levels.

130.3 - Procedures for Release

TriCare fiscal agents desiring Medicare information will usually request it either through the TriCare headquarters in Denver or through the parallel RO. The TriCare headquarters

will refer the request to the parallel RO. Should a Medicare contractor receive a request directly from TriCare, it will refer the request to the RO. The RO will meet with the TriCare fiscal agent and the Medicare contractor to determine exactly what is needed, impress upon the TriCare contractor that TriCare may not further disclose the information, and indicate the cost involved, if any. (Also note that payment may be estimated or waived if collection would interfere with efficient administration.) At the RO's discretion, the Medicare contractor and the TriCare fiscal agent may meet to discuss data and cost requirements without regional involvement. Upon agreement about data and cost requirements, the RO will authorize release of the information from the Medicare contractor to the TriCare fiscal agent.

140 - Disclosure of Information About Providers and Suppliers by CMS

In keeping with the spirit of the Freedom of Information Act and growing consumer interest in health care facilities and suppliers, CMS has made available to the public various final reports and other information regarding providers and suppliers. Disclosure to the public by a contractor is limited, but the following guidelines indicate what information is available, to whom it may be released, and the source to which a requestor should be directed for information that the contractor is not authorized to release.

140.1 - Disclosure Necessary for Proper Administration of the Medicare Program (CMS)

A. Disclosure of Survey Information of the Joint Commission on Accreditation for Hospitals (JCAH), American Osteopathic Association (AOA), or any other National Accreditation Organization

The CMS may not disclose any accreditation survey made and released by the JCAH, AOA or other national accreditation organization except as prescribed by regulations. Accreditation letters and accompanying Recommendations and Comments prepared by the JCAH, AOA or other national accreditation organization for the provider's accreditation survey are confidential and exempted from public disclosure.

A copy of the provider's most recent accreditation survey may be disclosed with the provider's authorization to any authorized representative, employee or agent of CMS for official use only in connection with the Medicare sample validation or substantial allegation survey program.

B. Disclosure of Information About Hospitals, Skilled Nursing Facilities, Home Health Agencies, and Independent Laboratories

Information about a hospital, skilled nursing facility, or home health agency, as well as information about independent laboratories, providers of outpatient physical therapy (rehabilitation and public health agencies and clinics) and portable X-ray suppliers, may

be disclosed without the authorization of the institution or organization when such disclosure is required for the proper performance of the duties of:

- An officer or employee of the Department;
- An officer or employee of a contractor; or
- An officer or employee of a State agency when necessary to carry out their duties under State law in the licensing or approving of hospitals, skilled nursing facilities, home health agencies, or independent laboratories, etc.

Information obtained in the provider certification process is not to be disclosed to those not included in the above three categories, except as indicated in §140.3 below.

However, information that a particular institution is participating in the program may be released; and information indicating the specialties for which title XVIII payment may be made for services of a particular independent laboratory may be released. This information is usually available from the Directory of Medical Providers and Suppliers of Services published by the Government Printing Office.

C. Contractors' Disclosure to Third Parties

Disclosure to third parties for program purposes of information about identifiable physicians and other suppliers who are natural persons is governed by the same restrictions and procedures as disclosure about named beneficiaries to third parties for program purposes. (See §50 of this chapter.)

Information about unidentifiable individuals or about providers or corporate entities (e.g., clinics or independent laboratories), is not exempt from disclosure by section 1106 and regulations at 42 CFR, Part 401. However, it is not to be disclosed by third parties to which information is disclosed for program purposes.

If the information the contractor discloses to third parties for program purposes is solely information that does not identify, or make identifiable, individuals (e.g., aggregate statistics or records on providers and other corporate entities) the following sample letter is to be used instead of the letter in §50B of this chapter.

Sample Letter from Contractor to Third Party

> Dear
>
> We are prepared to make available to your organization certain CMS records so that (state reason).
>
> However, before making these records available to you, we must point out that by law all information derived in the administration of the Social Security Act is subject to the provisions of the Freedom of Information Act, which exempts from disclosure certain categories of records. In order to assure that no records held

confidential under the Freedom of Information Act are disclosed, you must agree to meet the following conditions before we make any social security records available to you:

- 1. Any information we supply you will be used only for the specific purpose intended and for no other purpose.
- 2. All employees having access to this material will be instructed as to its confidential nature.
- 3. An official of your company will assume responsibility for ensuring that the information is not revealed to any other party.
- 4. You must return the material to us as soon as you have finished the job, and you may not retain copies.
- 5. We must have a letter from a responsible official in your office agreeing to these conditions and assuming responsibility for carrying them out.

Upon receipt of this letter from your organization, we will make available to you the CMS records you requested.

Sincerely yours,

140.2 - Disclosure of Medicare Reports

A. Provider Survey Report and Related Information

Information concerning survey reports of providers or facilities, as well as statements of deficiencies based on survey reports are available at the local social security office or the public health assistance office in the area where the facility is located. The following data may be released under this provision.

- The official Medicare survey report;
- Statement of deficiencies which have been conveyed to the provider following a survey;
- Plans of correction, and pertinent comments submitted by the provider relating to Medicare deficiencies cited following a survey.

B. Program Validation Review Reports and Other Formal Evaluation (CMS)
Upon written request, CMS makes available to the public official reports and other formal evaluations of the performance of providers. After CMS prepares the survey reports and other formal evaluations, it must provide the evaluated provider an opportunity (not to exceed 30 days) to review the report and submit comments on the accuracy of the findings and conclusions. CMS must incorporate the provider's pertinent comments in the report.

Generally, the RO serving the area in which the provider is located releases Program validation review reports. It will provide a copy of the report and the provider's comments to the contractors servicing the provider.

CMS may also make available to the public, subject to certain possible exemptions, informal reports and other evaluations of the performance of providers prepared by the contractor. The contractor refers requests for these reports to the Medicare regional office with a copy of the information requested.

C. Provider Cost Reports (Intermediaries)

1. Requests for Disclosure

Requests by the public either to inspect or to obtain a copy of a provider cost report must be in writing and must identify the provider or class of providers and specific cost reports requested.

NOTE: Personal salary information cannot be disclosed.

2. Ten Day Notice Requirement

Intermediaries must respond in writing within 10 working days after receipt of the written request, advising the requestor of the date the reports will be available. This date should be no earlier than 10 working days from the date of the contractor's response. (For exceptions, see Exceptions To 10-Day Notice Requirement immediately below.) A copy of this response must be sent simultaneously to the provider, thus putting it on notice that its report has been requested and by whom. (For exception, see §140.3 below.) If the request is for a report submitted by a former owner of a participating facility, copies of the contractor's response should go to both the present and former owners. If the request is for a report submitted by a provider no longer participating in the program, a copy of the contractor's response should be sent to the former provider. (For both former owners and former providers the copy of the response should be sent to the last known address of the party.)

If we cannot make the information available within a reasonable period of time, our response will include a brief explanation for the delay (e.g., because of the extent of searching, photocopying, or delay in securing reports from records retention centers). In addition to the provider's copy, the contractor sends a copy to the CMS regional office servicing the provider.

If a contractor receives a request for information concerning providers that it does not service, it will immediately forward such request to the CMS regional office servicing the provider and will inform the requester of its action. The regional office forwards the request to the servicing contractor.

3. Exceptions to 10 Day Notice Requirement

No 10-day delay in furnishing cost reports is necessary in the case of requests from:

- Federal or State agencies that need cost report information to carry out requirements of the Social Security Act (e.g., a State health planning agency under title XI (§1122), or a Medicaid State agency under title XIX).

The Congress - Requests from Congress are limited to those from the Congress as an official body (e.g., the Speaker of the House or the President of the Senate, or from the chairman of a committee or subcommittee of the House or Senate with jurisdiction related to the information requested). Requests from individual members of the House or Senate are considered requests from the public.

4. Information That Can Be Disclosed

CMS's rules limit disclosure to cost report documents that providers are required by regulations and instructions to submit. In the case of a settled cost report, this includes the contractor's notice of program reimbursement. Cost report documents include the statistical page, the settlement pages, trial balance of expenses, cost finding schedules, balance sheet, statement of income and expenses, and other schedules or documents required as part of the regular cost report process. (Where a provider, after first obtaining program approval, submits equivalent documents in lieu of official program documents, such documents are subject to the same disclosure rules as apply to official forms.)

Information That May Not Be Disclosed

If a provider chooses to submit with its cost report additional information not specifically required by regulations or instructions, the contractor should not disclose such information unless it is contained within an official document or the equivalent thereof. For example, some providers may submit supplementary analyses of certain expenses, details of the professional component adjustment, financial statements (other than the statement of income and expenses and the balance sheet as required in accordance with cost reporting instructions), or income tax returns that are not required by the program. These would not be disclosable by the contractor.

Except where a provider has not submitted an acceptable cost report and supplements are required to complete the report, any additional documents or schedules that the contractor requires the provider to submit in support of its cost representations are also not to be disclosed. In addition, do not disclose audits, schedules, letters, notes, and comments; comments on results of desk reviews (including copies of the actual desk review documents); contractor notes and comments (including transmittal letters); audit adjustment summaries that contractors and auditors are required to prepare; and information pertaining to an individual patient. Contractors acknowledge such requests and refer them to the regional office.

NOTE: Cost report information that the contractor may not disclose may, nevertheless, be disclosed under the Freedom of Information Act by the CMS regional office, central

office or, upon appeal of a denial, by the Administrator, CMS. Upon judicial review, a U. S. District Court may order Disclosure.

When an intermediary discloses a settled report, it may disclose schedules applicable to the settlement that have been reworked. The general rule is that if the contractor has reworked any of the schedules that the provider is required to submit with its original submission, these schedules become an integral part of the report for disclosure purposes. However, the intermediary may not disclose any details containing contractor or auditor comments concerning the settlement, details of specific adjustments, or supporting schedules applicable to the settlement of the provider's operation.

Prior to the release of cost report information to the requestor, the intermediary servicing the provider must screen each cost report and remove non-disclosable documents and information. If the intermediary is uncertain whether a particular document must be disclosed it should consult the regional office in the region in which the provider is located. Further, if the intermediary discovers as a result of review that the cost report reflects information that might result in adverse program publicity, it alerts the RO immediately. However, it does not delay disclosure.

The above instructions do not negate in any manner the requirement that the intermediary submit cost reports to CMS that contain full and complete information, including the details of all contractor and auditor adjustments, comments, and any supporting schedules that may be needed to verify the settlement.

5. Responding to Requests for Inspection of Cost Reports

The intermediary will make cost reports available for inspection by the requestor at the intermediary's office during regular business hours. In addition, arrangements will be made to make copies available upon specific request at any RO, or at central office. The intermediary must provide appropriate space for such inspections. It must establish procedures to ensure that all reports inspected are properly accounted for. Under no circumstances should it permit any requester to remove cost reports from the place of inspection.

If the requester has questions with respect to the interpretation or analysis of cost report information, the intermediary will advise the requester to submit such requests for more than routine explanations in writing to the regional office.

6. Disclosure of Cost Reports

If a request is received to inspect or to obtain a copy of a report that has not been settled; i.e., the final settlement notice of program reimbursement has not been sent, the intermediary will disclose a copy of the report as submitted by the provider. If settlement has been made, it will disclose the settled report. If a requester specifically asks for both the settled and unsettled cost reports of a provider, the intermediary will comply. When a

report is made available for inspection or copying, it should be clearly marked with one of the following captions, as applicable.

Cost report as submitted:

- Settlement subject to audit; and
- Audited settlement.

Requests for reproduction of all or part of a provider's cost report may be subject to photocopy fees. If it is determined that a fee must be charged, the intermediary prepares the written response to the requester in accordance with §20 and §20.4 of this chapter.

7. Responding to Requests for Information

A requester may desire only selected cost report information of a provider or several providers. However, the DHHS Freedom of Information Regulation specifies that agencies are not required to create a record by compiling selected items from the files; such requests will be met by furnishing copies of specific documents which contain the information requested. In addition, when the contractor receives a request that requires selecting documents from various cost reports, the request should be honored. It will follow the written response procedure above even though the entire report is not being disclosed. It will advise the requester that a searching fee will be charged and give an approximate date when the documents will be ready.

D. Medicare Payment and Cost Data

The intermediary may release Medicare payment or Medicare cost data concerning a named provider without giving the provider the ten-day notice required in §10.2 or 30 above. However, it does not give the requester enough information to calculate provider non-Medicare data as well. For example, intermediaries do not tell a requester that Medicare payments to the provider represent 30 percent of its total revenues.

The Medicare payment or Medicare cost data may be extracted from such documents as cost reports or Form CMS-3286, Monthly Actuarial Sample of Hospital Reimbursement. Any extraction of data is subject to the instructions above concerning creation of records.

E. Waiver of Liability Status

The waiver of liability status of a particular provider and the statistics used to determine that status may be disclosed.

140.3 - Disclosure of Information About Named Physicians and Other Suppliers of Service (RO's)

A. General

Generally, the contractor will not honor requests for information about a specific physician or other supplier of services, or for information which would identify such a physician or other supplier of services, except in situations described in §140.1 above. Disclosure to third parties for program purposes of information about individual physicians and other suppliers who are natural persons is governed by the same restrictions and procedures as disclosure about named beneficiaries to third parties for program purposes. (See §50B of this chapter.) The contractor acknowledges such requests and refers them to the RO for response.

If the information the contractor discloses is solely information that does not identify or make identifiable individuals (e.g., aggregate statistics or records on providers and other corporate entities), it uses the following language:

> Dear:
>
> We are prepared to make available to your organization certain social security records so that (state reason).
>
> However, before making these records available to you, we must point out that by law all information derived in the administration of the Social Security Act is subject to the provisions of the Freedom of Information Act, which exempts from disclosure certain categories of records. In order to assure that no records held confidential under the Freedom of Information Act are disclosed, you must agree to meet the following conditions before we make any social security records available to you:
>
> 1. Any information which is turned over to you will be used only for the specific purpose intended and for no other purpose.
>
> 2. All employees having access to this material will be instructed as to its confidential nature.
>
> 3. An official of your company will assume responsibility for ensuring that the information is not revealed to any other party.
>
> 4. The material must be returned to us as soon as you have finished the job.
>
> 5. We must have a letter from a responsible official in your office agreeing to these conditions and assuming responsibility for carrying them out.
>
> Upon receipt of this letter from your organization, the social security records will be made available to you.
>
> Sincerely yours,

If the contractor receives a written request for a physician's or supplier's customary charges or for amounts of program payments made to physicians outside of its jurisdiction, it acknowledges the request and sends it to the appropriate contractor, when known. If not known, it sends the request to the RO.

Disclosure of information about unidentifiable individuals, or about provider or corporate entities (e.g., clinics or independent laboratories) is not to be disclosed by third parties to which information is disclosed for program purposes.

B. Physician Fee and Supplier Charge Information

Customary charges may be disclosed to the public. However, requests from anyone (including a physician or supplier) for actual data used to determine the customary charge(s) should be referred to the RO.

Carriers may voluntarily specify a physician's or supplier's customary charges when explaining reimbursement or when furnishing denial or review notices.

The carrier may furnish a physician or supplier with a copy of their own customary charges free of charge; requests for customary charges from other sources will be subject to FOIA fees. However, anyone may inspect the customary charges free at the office of the carrier serving the locality for which the screens are used. Carriers produce a printout to be made available for inspection and/or photcopying in their office. If past experience with requests for customary charge screens from the public does not warrant the expense of producing a printout of all screens for inspection (i.e., there have been few request and no one has requested to inspect all the screens), printout copies of single screens or small numbers of screens may be furnished instead of photocopies; however, there will be no charge for the computer time for the printout nor shall the requesters be asked to pay more than they would if they were to request a photocopy of the screens. Requests specifically for printouts or tapes shall be furnished at cost to related Federal programs (for example, to TRICARE or Medicaid).

Carriers may release information to the public regarding the method used to determine Medicare allowances, e.g., that the median of the charges made by physician for a service is used as the customary charge, and that the 75th percentile of such customary charges in an area (weighted by frequency of service) is used to establish the prevailing charge. Written requests for lists carriers do not have should be referred to the RO immediately by telephone so that RO can indicate whether the carrier should create a list. Such request might be for all the customary charge screens of internists in a given county or for a list of all physicians who charge a given amount or less for a certain procedure. If requesters orally ask to see a list, which does not exist, the carrier will offer them the opportunity to inspect the screens and create their own list.

C. Disclosure of Related Entrepreneurial Information

Information such as the specialty and business address of a physician or supplier may be disclosed to the public. The carrier will refer to the RO written requests for special lists, such as a list of five orthopedists in a given city. However, if the carrier has processed a list of all orthopedists in that city, it may, upon request, disclose the entire list. It may fulfill oral requests by offering the requester the opportunity to look at whatever disclosable records (e.g., customary charge screens) there are that contain the data (or to purchase photocopies of the data) or by referring the requester to the medical society or licensing board in the requester's area, if appropriate.

140.4 - Disclosure of Names of Providers, Physicians, and Suppliers of Services

140.4.1 - Names of Providers Terminated from Program Participation (Carriers)

Upon request, a carrier may disclose to the public the fact that a provider no longer participates in the program. It will refer to the RO inquiries as to why a provider no longer participates in the program.

140.4.2 - Names of Providers, Suppliers, and Physicians Found Guilty of Fraud (CMS)

CMS publishes the names of providers, physicians, other suppliers of services, or any other persons who have been found guilty by a Federal court of submitting false claims in connection with title XVIII. Carriers will refer requests for such names to the RO for response.

140.4.3 - Names of Physicians on Second Opinion Lists (Contractors)

The DHHS Second Opinion Campaign has led to requests under the Freedom of Information Act for the list of physicians who have volunteered to accept referrals for second opinions. If a contractor has a list, it should disclose it upon request.

140.4.4 - Referral to State Licensing Boards, Medical Review Boards, and Professional Societies

A. Referral of Suspended Practitioners

Section 1862(e)(2)(B) of the Social Security Act requires the Secretary to notify the appropriate State or local licensing authority (e.g., State licensing board or medical review board) whenever a physician or other practitioner has been suspended from participation in the Medicare program. Thus, whenever CMS suspends a practitioner from participation in the Medicare program because the practitioner has been convicted of a criminal offense related to participation in the title XVIII or XIX program, CMS will

promptly notify the appropriate State or local licensing authority(ies) to (1) make appropriate investigations, (2) invoke any sanctions available under State law which the authority(ies) deems appropriate, and (3) keep CMS and the Inspector General fully and currently informed of any action it takes.

B. Referral By Medicare Carriers

In addition to the referrals made by CMS under section 1862, Medicare carriers are authorized to refer title XVIII-related cases of apparent unethical practices or unprofessional conduct to medical or other professional societies, and State or local licensing authorities (licensing boards or medical review boards). (See the routine uses for the Medicare Carrier Claims Records system as described in the system notice published in the Federal Register. The web address for this information is: http://www.usdoj.gov/04foia/1974condis-3.htm.

When considering a case for referral, the carrier should assure itself that substantial basis for referral exists; that more than mere suspicion is involved. It need not compile evidence sufficient to prove misconduct before referral; it should ascertain the probability and severity of misconduct and leave further investigation, review, and disciplinary action to the appropriate society or board. Isolated instances of questionable practices or conduct should not normally be referred.

Further, referral of apparent unethical practices or a course of unprofessional conduct by a practitioner should be made only after proper professional advice has been obtained from the carrier's physician staff members, medical consultants, or other professional advisors.

Since State licensing boards and medical review boards are responsible for the licensing and sanctioning of practitioners, cases should be referred to those boards only where the apparent unethical practices or unprofessional conduct is of a severity to possibly warrant such sanctions; cases involving less severe improprieties should typically be referred only to professional or medical societies for action.

The following are examples of cases that should be referred:

1. Over-utilization - This refers to a pattern of medical care which consists of providing more services than are medically necessary or which is not in accordance with acceptable medical practice (e.g., an inordinate number of office visits over an extended period of time for a chronic illness, a conspicuously high number of injections, excessive hospitalizations). Cases involving suspected over utilization should be reviewed by the carrier's physician staff. In cases where additional peer review is necessary, carriers may refer the case to a PRO. If the PRO servicing the area in question is not available to perform this type of review, the case should be reviewed by the medical society, medical consultants, or other professional advisors.

2. Mis-utilization - This involves the rendering of services that are not medically acceptable according to the standards of the community concerned.

3. Overcharging - This refers to the charging of fees by a physician, or other practitioner, that are not commensurate with the services rendered. Billing for amounts in addition to the deductible and coinsurance when assignment has been accepted also falls into this category.

4. Harmful Services or Pattern of Treatment - This involves the furnishing of services or a pattern of treatment that is harmful to the patient, or of a quality which does not meet professionally-recognized standards of care.

5. Violation of Ethics - These violations involve conduct of a physician or other practitioner that is contrary to the principles of ethics of the professional society to which the physician or other practitioner may belong, or which would make their practice a danger to the health and welfare of their patients or to the public.

6. Violation of the State's Professional Practice Statutes - This involves the committing of acts that, under the applicable State law, would be grounds for suspension or revocation of the physician's or practitioner's license to practice.

These guidelines are not all inclusive; any activities by a physician, or other practitioner, in their treatment of program beneficiaries, which would warrant concern by professional societies or State or local licensing boards or medical review boards may be brought to their attention.

When a carrier refers a case to a professional society or State or local licensing board or medical review board because of apparent unethical practices or unprofessional conduct by practitioners furnishing services to beneficiaries, the PI staff in the regional office should be concurrently notified of the referral. Notification should include copies of all materials referred to the professional society or State or local board, and should be followed by reports of significant case developments. Since such cases may involve program abuse by the practitioner, the RO should be notified as quickly as possible to permit remedial or sanction action if deemed appropriate.

When a case is pending prosecution, or when a decision is pending on whether to proceed with prosecution, the contractor will delay referral to the professional society until: (l) the prosecution action is completed, (2) the decision is made not to prosecute, or (3) CMS authorizes the referral.

C. Requests for Assistance by State or Local Licensing Boards, or State or Local Medical Review Boards

While cooperation on the part of CMS ROs and carriers with State or local licensing/medical review boards is generally encouraged, there seems to be three distinct situations in which these boards might request assistance:

1. When a case has been referred to a State or local licensing/medical review board for investigation and possible sanctions (either by CMS as a result of the conviction and suspension of the subject practitioner, or by a carrier), it would seem appropriate for CMS and carriers to provide assistance to the board in its investigative activity, provided the demands on staff time and resources do not become burdensome or unreasonable. All requests for carrier assistance should, however be channeled through the servicing CMS RO for a determination regarding the reasonableness of the request. Appearance by CMS personnel before board meetings involving a case which has been previously referred would also be permitted.

2. When a State or local licensing board or medical review board requests information or assistance on a case which was self-initiated (i.e., not previously referred to the board by CMS or a Medicare carrier) as a result of a complaint, allegation, inquiry, etc., relative to a specific physician or practitioner's practices, this request should be treated as a Freedom of Information Act request. Therefore, any requested material should be screened for sensitive information, with the decision to release or withhold such information made on a case-by-case basis. Further, the board would be responsible for the costs involved in providing such information (searching costs, duplicating costs, etc.). In such instances, the appearance of CMS personnel at a board hearing would be discouraged.

3. When the State or local licensing board or medical review board's request is for general information pursuant to a study or investigation of physician or practitioner impropriety or abuse, and is not related to a complaint, allegation, etc., against a specific physician or practitioner; or when the request would represent a clearly unwarranted invasion of personal privacy, cooperation by CMS or contractor personnel would be discouraged. In such instances it would be appropriate to release general or statistical information that did not identify specific individuals; however, the request for identifying information would constitute an improper search for information.

140.4.5 - Disclosure of Medicare Statistics

Numerous statistics on individual providers are available to the public. They include, but are not limited to, the following:

1. Waiver of liability statistics;
2. Interim rate payment data;
3. Amount of Medicare reimbursement;
4. Overpayment data;
5. Data from the Provider Monitor Listing;
6. Information from the Directory of Medical Facilities and the Directory of Medicare Providers and Suppliers of Services;
7. Medicare statistics (e.g., total visits, number of starts of care,)
8. Presumptive waiver of liability status;
9. Information as to whether a provider participates in the Medicare program; and

10. Medicare inpatient statistics for inpatient facilities (e.g., total inpatient days, number of admissions, average length of stay).

150 - Disclosure of Reports About Named Contractors

150.1 - Disclosure by ROs of Annual Reports of Contractors Performance (RCP)

RCPs are available to the public at the RO servicing the contractor. The contractor will refer requests for RCPs to the RO for response. It will refer requests for an RCP of a multi-State contractor to the RO servicing the home office of the contractor.

The contractor will refer requests for supporting documentation for the RCP contained in Contractor Performance Evaluation (CPE) reports to the RO.

150.2 - Disclosure of Medicare Audit Reports to the Press and Public (Audit Agency)

DHHS Audit Agency reports issued to Medicare contractors are available if requested, to members of the press and the public. The contractor will refer requests for DHHS Audit Agency reports directly to the Audit Agency, which is responsible for decisions regarding the release of these reports.

160 - Disclosure of Statistics (CMS or Contractors)

CMS and its agents may disclose statistical data and similar information that does not relate to any identifiable person or persons. However, they are not required to create records for requestors by compiling selected items from the files, nor are they required to create records to provide such data as ratios, proportions, percentages, per capitas, frequency distributions, trends, correlations or comparisons.

They may, however, create such records when efficient administration permits. Final authority to determine when "efficient administration permits" rests with CMS. The contractor will refer requests for information, which can be created by hand, to the RO unless the requestor is willing to accept copies of the pages containing the data needed to compile the requested information (i.e., the requester is willing to do the necessary compilation). The contractor will refer requests for information, which must be created by machine (e.g., computer programs to manipulate data and print results), to the RO.

CMS and the contractors have a joint obligation to ensure that the program is clearly and accurately represented and that the public is given a complete picture of program performance.

There are certain problems in accurately representing program performance by means of statistical data alone, since some groupings of statistics are subject to inadvertent inaccuracies or are susceptible to misinterpretation. Careful judgment is, therefore, essential in presenting information on operating and payment activities.

160.1 - Information That the Contractor May Disclose

When considered appropriate, the contractor may release operating, payment, and cost data listed below without prior approval of the RO. The contractor will promptly forward to the RO a copy of information provided under this guideline.

In releasing any data under this guideline, the contractor must insure that the data are related specifically to the geographical area for which the contractor is responsible. For example, if a press inquiry is clearly for the purpose of presenting program operating data for a geographical area beyond the jurisdiction of the contractor, and CMS has not made such data available for public release, the contractor will tell the requestor that it does not have the authority to release information beyond its operational jurisdiction. It will refer the request to the RO. (See §160ff of this chapter.)

In releasing payment data, the contractor must indicate that the information refers only to the area it services and does not include payments to direct dealing providers, group practice prepayment plans, or railroad beneficiaries.

If it is not clear whether information can be released under this guide, the contractor will resolve doubt in favor of obtaining prior clearance from the RO.

The data released under this guideline should be based on the figures furnished to CMS in the monthly financial report and the monthly workload report. The administrative cost information should be the same as in the quarterly Operations Schedule-Cumulative Interim Expenditure Report.

The following data, relating only to the contractor's title XVIII workload, may be released:

- Benefit amounts paid by the contractor, including:

  - Aggregate amounts, or

  - Amounts broken out by category; e.g., inpatient hospital, outpatient hospital, etc., or

  - Amounts broken out by provider, including interim rates, and cost reports. (See also §140.1 of this chapter.)

- Total number of bills or claims paid by the contractor, either as an aggregate or broken out by category.

- Total number of bills processed.

- Admission notices, by category, i.e. inpatient hospital, skilled nursing facility, home health agency. (Extreme caution must be exercised to assure that this statistic is properly related to the items shown above.)

- Claims volume as an aggregate amount, or broken out by category.

- Median claims processing time, by category. Processing time is derived by subtracting date of receipt from date of approval for payment using the dates shown on bills.

- Any data determined from the data in items 1-6 above and related data available to the public (e.g., average payment per paid claims).

- Total administrative cost.

- Average (arithmetic mean) cost per bill or claim processed.

- Number or percentage of claims requiring contact with providers for further development.

- Contractor-completed CMS forms and reports listed chronologically by form number. Refer requests for CMS generated reports to the RO.

  - Form SSA-1522 (Monthly Workload Report)

  - Form SSA-1523 (Estimate of Administrative Costs and Credits)

  - Form SSA-1566 (Intermediary Workload Report)

  - Form SSA-1566 Supplement (1972 Amendment Supplement to Intermediary Workload Report)

  - Form SSA-1615 (Operations Schedule - Final Administrative Cost Proposal)

  - Form SSA-1822 (Monthly Provider Audit Activity Report-Schedule I)

  - Form SSA-1822A (Final Summary of Audits Completed During Quarter-Schedule II)

  - Form SSA-1822B (Costs Accrued During Quarter, Cumulative Costs by Contract and FY, Schedule III)

- Form SSAz-2580 (Cost Classification Report)

- Form CMS-2582 (Plan of Expenditures)

- Form CMS-2598 (Budget Distribution)

- Form CMS-3208 (Provider Audit Cost Report)

- Form CMS-1527 (Operations Schedule - Cumulative Interim Expenditure Report and Budget)

Release of the last form should be accompanied by a qualifying statement such as the following:

"This report is based on preliminary data and is subject to adjustment by subsequent cumulative reports and a final cost proposal."

Absent prior RO clearance, the contractor may release only the data listed above. A request for data not included in the above list may, in the contractor's judgement, require an immediate response. If so, the contractor may furnish general comments but cannot provide statistics. No further action need be taken on these requests unless the requestor asks for additional information. When additional information is requested, the contractor refers the request to the RO.

160.2 - Information That May Be Released Upon Authorization by the Regional Office

The CMS regional office may authorize contractors to release the following information:

- Total man-years (or man-quarters, etc.) employed per report period.
- Man-hours per claim or bill processed.
- Number of weeks' work on hand.
- Denial rates.
- Percent of claims or total payments involving reduction in charges.

Data which contrast one contractor's performance with the performance of any other contractor, or which compare a contractor's performance with any set of national, regional, or other combined contractor performance data, may not be released by the contractor without prior RO approval. The contractor refers requests for such information to the RO. Generally, data of this type will be made available in periodic CMS releases when sufficient to permit valid statistical inferences. When the release of this kind of information is considered valuable for contractor or program public relation, telephone request and approval for contractor release may be appropriate.

This section applies only to data compiled in the administration of the health insurance program. The contractor does not need prior RO approval to release, for example, compilations created by the Blue Cross Administration (BCA) or The National Association of Blue Shield Plans (NABSP).

Data pertaining to more than one contractor or which compare contractor performance may be released only in proper perspective. Essentially, cost information alone is not an accurate indication of a contractor's performance and, therefore, is not to be publicized without other relevant data accompanying it; e.g., information pertaining to workload volume and processing time. Moreover, release should always be accompanied by an interpretive statement indicating the limitations of the data and the known variables; e.g., wage differentials.

Requests which include a provider population beyond the jurisdiction of the contractor may involve data which have not been made available by CMS for public release. Requests for such combined data will be handled by the RO, which, if it approves the release, will furnish the requestor with the appropriate combined data and alert the contractors involved regarding the release.

170 - Disclosure of Health Insurance Information by Providers

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 health insurance claim number (HICN);
- Facts regarding the individual's entitlement to health insurance benefits; and
- Medical and other information obtained from CMS, an intermediary, or a carrier (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.

170.1 - Disclosure of Health Insurance Information to a Beneficiary or in Connection With a Claim

Information such as Medicare entitlement or eligibility data may be disclosed to a beneficiary or their authorized representative (this includes the beneficiary's representative payee).

170.2 - Disclosure to Contractors

Providers and suppliers may not forward medical information to contractors on a confidential basis, expressed, or implied, since, under the Privacy Act, any medical information obtained by a contractor is subject to disclosure to the individual to whom the information pertains or to another person authorized by the individual to have access to it.

Some providers and suppliers document findings on medical forms pre-printed "confidential" or routinely stamp all records "confidential" whether or not such records are ever intended for disclosure to a contractor. The contractor will accept such records only if the provider or supplier accompanies them with a signed statement indicating the following:

- That the provider or supplier understands the information is subject to disclosure to the patient under the Privacy Act, and

- That any words or statements that the transmitted records are confidential may be disregarded if the patient or the patient's representative requests them from the contractor or from CMS.

170.3 - Disclosure to Third parties for Proper Administration of the Health Insurance Program

Disclosure by the provider or supplier to persons other than the individual or the individual's authorized representative of any records, reports, or other information about the individual is authorized without the individual's or their representative's consent under the following circumstances:

The disclosure is required in connection with any claim or other proceeding under the Social Security Act for the proper performance of the duties of:

- Any officer or employee of the Department; or
- Any officer or employee of a State agency, intermediary, provider of services, or other agency or organization participating in the administration of the program, by contract or agreement, in carrying out such contract or agreement.

These limitations apply whether or not the individual to whom the information pertains authorizes further disclosure to third parties (e.g., to a private medical plan).

170.4 - Disclosure to Third Parties for Other Than program Purposes

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:

- Beneficiary HICN;
- 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.

170.5 - Disclosure of Claims Payment Information in Alcohol and Drug Abuse Cases

The law requires providers to observe more stringent rules when disclosing medical information for claims processing purposes from the records of alcohol and drug abuse patients. Since the standard consent statement on the provider billing form is not sufficient authority, under the law, to permit the provider to release information from the records of alcohol or drug abuse patients, more explicit consent statements are required.

Providers that participate in Medicare and alcohol and drug abuse prevention and treatment programs must obtain written consent in each alcohol or drug abuse case from beneficiaries to release medical information. This written consent, which allows the provider to disclose the records of the patient, must include all of the following:

- The name of the organization (e.g., hospital name) that is to make the disclosure;
- The name or title of the person or organization to which disclosure is to be made (e.g., CMS, including the appropriate intermediary or carrier, specified by name);
- The name of the patient;
- The purpose or need for the information to be disclosed (e.g., for processing a claim for Medicare payment and for such evaluation of the treatment program as is legally and administratively required in the overall conduct of the Medicare program);
- The specific extent or nature of information to be disclosed (e.g., all medical records regarding the beneficiary's treatment, hospitalization, and/or outpatient care including treatment for drug abuse or alcoholism);
- A statement that the beneficiary may revoke their consent at any time to prohibit disclosures on or after date or revocation;

- A statement specifying a date (not to exceed 2 years), event, or condition upon which consent expires without revocation;
- The date on which the consent is signed; and
- The signature of the patient or the signature of their authorized or legal representative.

If the beneficiary wishes, the consent statement may be expanded to permit disclosure by the provider to any other person, organization, or program (e.g., PRO), as appropriate. Providers may also give authorization to CMS and its contractors to re-disclose specific information to third party payers for complementary insurance purposes.

The provider keeps the consent statement with the patient's medical and other records.

The duration of the consent statement is not to exceed 2 years after which it must be renewed by the beneficiary if further disclosures are necessary.

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

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 claim number. 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.

180 - Cost to a Provider That Requests Information Available to the Public

Providers are required to pay appropriate fees for information they request pertaining to other providers, Medicare contractors, or State agencies. A provider may claim such fees as allowable costs only if it demonstrates to the contractor the information is necessary in developing and maintaining the operations of patient care facilities and activities.

190 - The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

A. General Information

To improve the efficiency and effectiveness of the health care system, HIPAA included provisions that required national standards for electronic health care transactions. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated the adoption of Federal privacy protections for individually identifiable health information.

The Department of Health and Human Services issued the regulation "Standards for Privacy of Individually Identifiable Health Information", 45 CFR Parts 160 and 164, (the HIPAA Privacy Rule) to implement section 264 of HIPAA. The HIPAA Privacy Rule establishes a set of basic national privacy standards and fair information practices. It sets a floor of ground rules for health care providers, health plans, and health care clearinghouses to follow to protect the privacy of an individual's personal health information.

The HIPAA Privacy Rule is based on the same fair information principles that are found in the Privacy Act of 1974 and are now generally extended to the public and private sectors of the health care delivery system. The HIPAA Privacy Rule applies to protected health information (PHI) held by covered entities, as defined by the Rule, while the Privacy Act protects records with individually identifiable information held by Federal agencies. The Privacy Act continues to apply to Medicare and Medicare fee-for-service (FFS) contractors in their day-to-day operations.

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) is responsible for providing outreach and technical assistance to covered entities (health plans, health care clearinghouses, and health care providers who conduct certain financial and administrative transactions electronically) and for enforcing the HIPAA Privacy Rule. OCR maintains information on the HIPAA Privacy Rule at http://www.hhs.gov/ocr/hipaa/

B. How CMS Applies Laws Affecting the use and Disclosure of Personal Information

1. General rules

Since Medicare operates under both the Privacy Act and the HIPAA Privacy Rule, CMS has determined how the provisions interact with each other as it uses personally identifiable information in its day-to-day operations. For example, a use or disclosure that is permitted under the HIPAA Privacy Rule (e.g., to facilitate cadaveric organ donation and transplants), but not published in a Federal Register notice as a routine use in a CMS system of records would not be permitted for Medicare. Similarly, if the disclosure is a "routine use" under the Privacy Act, but the HIPAA Privacy Rule prohibits the disclosure, CMS will not make the disclosure.

Exemption 6 of the Freedom of Information Act (FOIA) permits Federal agencies to withhold personnel and medical files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy. When a FOIA request asks for documents that include personal information, CMS must apply Exemption 6 to preclude the release of, or must otherwise redact, identifying details before disclosing the remaining information.

2. Information About Deceased Individuals

The application of Exemption 6 of the FOIA to information about deceased individuals requires a different analysis than that applicable to living individuals because under the Privacy Act of 1974, privacy rights are extinguished at death. However, under FOIA, it is entirely appropriate to consider the privacy interest of a decedent's survivors under Exemption 6. Under the HIPAA Privacy Rule, the personal health information of deceased as well as living persons is protected.

3. Requests for Access to Records

The FOIA and Privacy Act requests will continue to be handled according to current procedures and timeliness standards. A FOIA request for access to public records requires CMS, as a Federal agency, to provide the fullest possible disclosure of its records to the public, subject to certain exceptions (e.g., proprietary information, national defense risks). The Privacy Act requires CMS to provide individuals access to their personal information maintained in a System of Records. Note that an individual's request under the Privacy Act to access his or her records must specify a Privacy Act

System of Records and must be addressed to the system manager identified in the Federal Register notice.

A HIPAA Privacy Rule request for access is separate from both FOIA and the Privacy Act and has it own timeliness standards associated with it. Requests for access under the HIPAA Privacy Rule will be handled by CMS' Central Office (see section G below).

4. State Law Preemption Under HIPAA

Medicare is a national program that is administered under Federal statute and regulation. CMS administers Medicare through Medicare FFS contractors that are required to operate in accordance with statutory and regulatory requirements and CMS administrative direction.

When considering the provisions of HIPAA, Congress expressly intended to defer to more stringent state laws if those laws conflict with provisions in the HIPAA Privacy Rule. The HIPAA Privacy Rule therefore explicitly preempts conflicting state law provisions, unless they are more stringent or more protective of the individual's rights. Since the Federal law expressly preserves more stringent state laws, and because of the complexity of this issue, contractors should ask CMS for guidance as issues arise.

C. CMS Programs that are Covered Entities Under HIPAA

The Federal health programs that CMS administers are health plans as defined in HIPAA and are covered entities subject to the HIPAA Privacy Rule. These health plans are:

- *Part A or Part B of the Medicare program under Title XVIII;*
- *The Medicaid program under Title XIX;*
- *The State Children's Health Insurance Program (SCHIP); and*
- *The Medicare Advantage (formerly Medicare+Choice (M+C)) program and other Medicare health plans.*

The CMS is directly responsible for ensuring that the Medicare Fee-For-Service (FFS) program, also known as the Original Medicare Plan, complies with the HIPAA Privacy Rule. For the Medicaid and SCHIP programs, the appropriate State Agency is responsible for ensuring compliance with privacy requirements. Medicare Advantage (formerly M+C) plans are covered entities subject to the HIPAA Privacy Rule in their own right and responsible for their own compliance.

D. Business Associates

Most health care providers and health plans do not carry out all of their health care activities and functions by themselves; they require assistance from a variety of

contractors and other businesses. By definition, a business associate is a person or entity that performs or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information on behalf of a covered entity.

Medicare FFS contractors that perform health care activities involving the use of PHI on behalf of the Medicare FFS health plan (i.e., claims processing functions) are business associates of the Medicare FFS health plan (the covered entity). The HIPAA Privacy Rule allows providers and plans to give PHI to their business associates as long as they have satisfactory assurances and document those assurances, typically by contract, that business associates will safeguard the information.

Medicare contracts have been modified to include the business associate provisions. These provisions also address the contractor's responsibility to ensure that subcontractors or agents to whom they disclose Medicare data agree, by contract, to safeguard any PHI as well. Contracts continue to include language that applies to contractors who maintain or operate a Privacy Act protected systems of records on Medicare's behalf.

Medicare contractors that perform health care activities involving the use of PHI on behalf of the Medicare FFS health plan are not business associates of providers, physicians, suppliers, clearinghouses, or other health plans. Likewise, providers, physicians, suppliers, clearinghouses, or other health plans are not business associates of the Medicare contractor unless the provider, physician, supplier, clearinghouse, or other health plan is doing work on behalf of the Medicare contractor. For these reasons, Medicare FFS contractors should not sign business associate agreements with any provider, physician, supplier, clearinghouse, or other plan unless the provider, physician, supplier, clearinghouse, or other health plan is doing work on the contractor's behalf.

E. Trading Partner Agreements

Currently, Medicare contractors execute trading partner agreements (TPAs) with a number of payers, including Medigap insurers, Medicare supplemental/employee retiree health plans, multiple employer welfare trusts, TRICARE for Life, as well as State Medicaid Agencies, for the purpose of exchanging adjudicated Medicare claims for secondary liability determination by those partners. This exchange of data is commonly referred to as the "claims crossover process." For coordination of benefits (COB) purposes, Medicare contractors and trading partners are not business associates of each other since neither entity is doing work on the other's behalf; therefore, intermediaries and carriers should not sign business associate agreements with COB trading partners that receive claims crossover data from them.

F. Notice of Privacy Practices

The HIPAA Privacy Rule requires each covered entity to develop and provide a plain language notice that describes its legal duties, the uses and disclosures of protected health information that it may make, and individual privacy rights and how to exercise

them. The individual rights include the right to inspect and copy protected health information, to amend protected health information, to request restrictions, confidential communications, an accounting of disclosures, a paper copy of the privacy notice, and how to file complaints.

Medicare's privacy notice was provided to beneficiaries for the first time in the 2003 Medicare & You handbook and is provided in the handbook every year. New enrollees receive the privacy notice in the handbook that is mailed to them within 30 days of Medicare entitlement. Medicare's privacy notice is also posted on Medicare's Web site at www.medicare.gov.

Medicare's Notice of Privacy Practices informs beneficiaries who are interested in exercising individual rights to go to www.medicare.gov or call 1-800-MEDICARE. Customer Service Representatives (CSR) at 1-800-MEDICARE use scripts to answer questions regarding exercising individual rights and filing complaints.

Since Medicare's privacy notice describes the uses and disclosures of PHI in the day-to-day operations of Medicare (including Medicare FFS contractors), FFS contractors are not required to develop a separate privacy notice for Medicare beneficiaries.

G. Individual Rights and Complaints

***NOTE:** For Individual Rights Under the Privacy Act of 1974, see §10 above.*

The HIPAA Privacy Rule gives individuals rights with respect to their PHI. These rights are listed in covered entities' privacy notices. The Notice of Privacy Practices for the Original Medicare Plan includes the right to:

1. *See and get a copy of personal health information held by Medicare.*

   CMS Central Office is responsible for responding to beneficiary requests for access to records under the HIPAA Privacy Rule. Medicare FFS contractors should only respond to those requests for information related to payment of a claim, for which they are already responsible under the contract under existing customer service procedures. Simple telephone inquiries, such as asking about the status of a claim or requesting a duplicate Medicare Summary Notice, are not considered a HIPAA request for access and should be handled under existing customer service procedures.

2. *Have personal health information amended if it is wrong or missing, and Medicare agrees. If Medicare disagrees, a statement of disagreement may be added to the personal health information.*

Central office is responsible for handling beneficiary requests to amend the record under the HIPAA Privacy Rule. Contractors will not be responding to requests to amend records.

Requests for changes to claims or payment records, such as an appeal or change of address request, are not considered HIPAA Privacy Rule requests for amendments, and should be handled according to current procedures.

Note, however, that if the request for amendment involves medical records, contractors should explain that, except in rare circumstances, only the source of the medical record (i.e., the provider) may make changes to the record.

3. Get a listing of those receiving personal medical information from Medicare.

CMS Central Office is responsible for responding to beneficiary requests for an accounting of disclosures under the HIPAA Privacy Rule. Contractors will not be responding to requests for an accounting of disclosures.

The listing does not cover personal health information that was given to the individual or his or her personal representative, that was given out to pay for health care or Medicare operations, or that was given out for law enforcement purposes.

4. Ask Medicare to communicate in a different manner or at a different place, for example, by sending materials to a P.O. box instead of the address on file.

Current regulations and existing agreements with the Social Security Administration are extremely prescriptive, often governing precisely how CMS can respond to requests for confidential communications.

Operationally, CMS can only maintain one address at a time. Because of this, routine change of address requests should be handled according to current change of address procedures.

5. Ask Medicare to limit how personal health information is used and given out to pay claims and run the Medicare program.

CMS Central Office is responsible for responding to beneficiary requests to restrict disclosure of PHI. Contractors will not be responding to requests to restrict disclosure of PHI.

6. Get a separate paper copy of the privacy notice.

Contractors who receive requests for a paper copy of the Notice of Privacy Practices for the Original Medicare Plan should refer requestors to their Medicare & You handbook.

7. *File a complaint.*

Medicare's Notice of Privacy Practices informs individuals of the right to file complaints about Medicare's privacy practices with either Medicare or the Secretary of Health and Human Services. The privacy notice refers individuals to www.medicare.gov or 1-800-MEDICARE for further information on filing a complaint.

CMS is required to document in written or electronic form the complaints received and their disposition. There is no requirement to respond in a particular manner or time frame.

For the privacy rights listed above where CMS Central Office is responsible for responding to the request, contractors should advise beneficiaries to address their requests to:

HIPAA Privacy
P.O. Box 8050
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

H. Privacy Authorizations

An authorization is a document that an individual uses to give a covered entity permission to disclose his or her PHI for a particular purpose (e.g., for marketing) or to a third party specified by the individual. A covered entity is generally not required to obtain an authorization for the use or disclosure of PHI for treatment, payment, or health care operations, as well as for certain public priority activities under specified conditions (e.g., health care oversight, law enforcement). Contractors should inform providers that contractors are unable to make payment for Medicare claims if the provider fails to provide the information needed to process them.

The HIPAA Privacy Rule specifies certain core elements and required statements for a valid authorization. Contractors may add more elements to their authorizations as long as the core elements and required statements remain and no provisions are added that conflict with these core elements and statements.

Contractors must also accept an authorization from another entity, provided it includes all of the core elements and required statements, and no provisions are added that conflict with these core elements and statements.

I. Core Elements and Required Statements for an Authorization

The core elements of a valid authorization are:

1. A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion;

2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;

3. The name or other specific identification of the person(s) or class of persons, to whom the covered entity may make the requested use or disclosure;

4. A description of each purpose of the requested use or disclosure. The statement, "at the request of the individual" is a sufficient description of the purpose when the beneficiary initiates the authorization and does not, or elects not to, provide a statement of the purpose;

5. An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure; and

6. The signature of the individual and date. If a personal representative of the individual signs the authorization, a description of such representative's authority to act for the individual must also be provided. Although the HIPAA Privacy Rule requires only a description of the representative's authority to act for the individual, CMS is requiring that documentation showing the representative's authority be attached to the authorization (e.g., a Power of Attorney).

In addition to the core elements, the authorization must contain statements adequate to place the individual on notice of all of the following:

1. The individual's right to revoke the authorization in writing, how the individual may revoke the authorization, and the exceptions to the right to revoke, e.g., "You have the right to take back ("revoke") your authorization at any time in writing, except to the extent that Medicare has already acted based on your permission. To revoke your authorization, send a written request to: [Each Medicare contractor or CMS: Please insert Name, Address, and Telephone number of your organization here]";

2. The inability to condition treatment, payment, enrollment or eligibility for benefits on the authorization, e.g., "I understand refusal to authorize disclosure of my personal medical information will have no effect on my enrollment, eligibility for benefits, or the amount Medicare pays for the health services I receive";

3. The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer protected, e.g.: "Your personal medical information that you authorize Medicare to disclose may be subject to redisclosure and no longer protected by law."

In addition, the authorization must be written in plain language and a signed copy must be provided to the individual (or the individual should be advised to retain a copy).

The CMS is developing a standard authorization for beneficiaries or their personal representatives to request disclosure of PHI to third parties. The standard will contain the elements for compliance with both the HIPAA Privacy Rule and Privacy Act requirements. Contractors will be notified when the standard authorization is available.

J. Personal Representatives and Third Party Authorizations

The HIPAA Privacy Rule requires covered entities to treat an individual's personal representative as the individual with respect to uses and disclosures of the individual's PHI, as well as exercising the individual's privacy rights listed in the covered entity's Notice of Privacy Practices. A personal representative may also authorize disclosures of an individual's PHI (see §190H above).

In addition to these formal designations of a personal representative, the HIPAA Privacy Rule permits a covered entity to disclose to any person identified by the individual the protected health information directly relevant to such person's involvement with the individual's care or payment related to the individual's care. Therefore, a verbal authorization is allowed under the HIPAA Privacy Rule for those individuals involved in the care of an individual.

Contractors should continue to handle routine inquiries, such as telephone requests for the status of claims, under existing customer service procedures that include verification of the individual's identity. Therefore, with the beneficiary's verbal or written permission, contractors may continue to speak to third parties on behalf of the individual. See Exhibit D – Disclosure Desk Reference Guide for Call Centers for detailed instructions on disclosing PHI over the telephone.

Contractors may also continue to handle Congressional inquiries under existing customer service procedures (see §10J above).

K. Administrative Requirements

As Medicare's business associate, contractors are not subject to the administrative requirements of the HIPAA Privacy Rule. However, under the Privacy Act, contractors must comply with the privacy provisions specified in their contracts. Contractors are not required to designate a privacy official. However, contractors are required to have in place a senior official or other responsible party to address the privacy concerns of the

organization and to establish an internal control system to monitor compliance with privacy requirements.

Similarly, as Medicare's business associate, contractors are not subject to the HIPAA Privacy Rule's requirement to train staff specifically on the HIPAA Privacy Rule. However, under the Privacy Act, contractors are required to ensure that employees understand their responsibility to protect the privacy and confidentiality of CMS's records.

It is CMS policy that any data collected on behalf of CMS in the administration of a Medicare contract belongs to CMS. Any disclosure of individually identifiable information without prior consent from the individual to whom the information pertains, or without statutory or contract authorization, requires prior approval by CM4S.

Exhibit A - Freedom of Information Act Request

Exhibit B - Summary Sheet for the CMS Monthly FOIA Report

INTERMEDIARY/CARRIER/CENTRAL OFFICE COMPONENT SUMMARY SHEET FOR THE CMS MONTHLY FOIA REPORTS

Data on this Summary Sheet is a summation of the data from all Forms CMS-632-FOI completed during the month.

INSTRUCTIONS

1. Enter the month and year that this summary sheet covers.
2. Enter, in the applicable space, appropriate identifying information concerning your unit.
3. Enter the total number of 632s completed during the identified month.
4. Enter the number of times the 632s showed a request was closed by the cited action.
5. Enter the total of all staff hours used during the identified month. Use only whole numbers and fractions or decimals, e.g., 102 1/2 or 102.25, not 102 hours and fifteen minutes.
6. Enter the total of actual cost figures, based on the salaries of the staff involved.
7. Enter the total of copying charges.
8. Enter the mailing/postage costs.
9. Enter the total dollar amount of fees charged. This figure is not the same as actual costs.

10. Enter the total of all fees waived. (Unless the FOI Office, CMS has granted a waiver, this figure is a compilation of all fees which were waived because they were lower than CMS' $15.00 threshold).

11. Enter the name, office and address of the person who completed this summary sheet.

12. Enter the date the summary sheet was completed.

PLEASE FILL OUT COMPLETELY

1. Month: _____ Year: _____

INTERMEDIARY CARRIER:
_____

CENTRAL OFFICE COMPONENT:
_____
Total 632s: _____
Actions:

_____ Direct Reply (Records Sent)
_____ Request Withdrawn
_____ Records Not Reasonably Described
_____ Fee Related Closure
_____ No Records Found
_____ Not FOIA
_____ Subpoena Denial
_____ Other

Staff Hours: _____
Staff Charges: _____
Copy Charges: _____
Postage: _____
Fees Charged: _____
Fees Waived: _____
Name/Phone: _____

Office: _____

Address: _____
Date: _____

Exhibit C - Invoice of Fees for FOIA Services

Contract Administrative Requirements

30 - Files Maintenance

30.10 - Files Maintenance Program - General

Subject to the provisions of the Code of Federal Regulations, Title 41, Part 102 – Creation, Maintenance and Use of Records, http://www.access.gpo.gov/nara/cfr/waisidx_05/41cfr102-193_05.html CMS has the responsibility for the development and implementation of standards and programs for the economical management of records under the health insurance program. Specifically, CMS is required to provide for effective controls over the creation of records, including the making of records containing adequate and proper documentation of the contractor's administration and operations. Each contractor is required to establish and maintain an active, continuing program for the economical and efficient management of the records outlined in §30.20.

The contractor's programs must provide for:

- Effective controls over the creation, the organization, maintenance and use, and disposition of all CMS health insurance claims and non-claims records; and

- Development and application of standards, procedures, and techniques designed to assure the maintenance and security of records of continuing value and facilitate the disposal of all records of temporary value.

The contractor provides for the continued analysis and improvement of record classification and indexing systems, the use of filing equipment and supplies, and the reproduction and transportation of records. The contractor assures that records are maintained economically and efficiently for maximum usefulness.

The files established by the contractor, and all records and procedures documenting its programs for controlling the creation, maintenance, and use of current records, for the selective retention of records of continuing value, and for the disposal of noncurrent records, must be available for periodic review by CMS.

Under no circumstances are any records identified by CMS as relating to a current investigation or litigation/negotiation by the Office of the Inspector General or the Department of Justice, ongoing Workers' Compensation, set aside arrangements, or documents which prompt suspicions of fraud and abuse of overutilization of services to be destroyed. These records must be retained until you receive authorization from CMS.

30.10.1 - Description of Records Maintained

A - Claims Records

These are Government records including Government-issued standard forms and other forms, documents, and statements needed to support claims. Such records are maintained by the

contractor in accordance with instructions regarding retention, transfer, destruction, and other disposition of claims materials. (See §§30.30 and 30.40.)

B - Non-Claims Records

These include materials not needed as supporting documentation of a claim, such as used work sheets, extra copies of documents, retained CMS bill copies where records were submitted on tape, used punched cards, EDP listings, used paper tape, and general correspondence not related to specific pending or processed claims. See §30.30 for the records retention and disposal schedule and §30.70 for the disposition of such material.

C - Fiscal and Administrative Records

These include records that are not included as claims or non-claims records. See §30.70 for the records retention and disposal schedule.

D – Microform Records

This is a term used for any form containing micro-images (e.g., microfilm, microfiche). If records are microfilmed, the original records must still be retained.

E – Scanned/Imaged Records

This is a term used for any information that is recorded in a form that only a computer can process. This is the preferred format when paper records are not retained. The image becomes the "official record/recordkeeping copy" which must be retained in accordance with directives from CMS.

30.10.2 - Definition of a Record

Records are basically files consisting of papers, folders, photographs, photographic copies, magnetic tapes, or other recorded information regardless of physical form or characteristics, accumulated or maintained in filing equipment, boxes, disks, CDs or shelves, and occupying office or storage space. Stocks of publications and blank forms are not included in this definition.

30.20 - Implementing a Files Management Program

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:

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

1. Classifying, indexing, and filing records;

2. Providing reference services to filed records;

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

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

B. 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.

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

D. 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, health insurance claim number, 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 - Record Retention and Disposal Schedule

This schedule identifies those records accumulated by the contractor in administering the Medicare program and outlines the disposal schedule for each type of record.

A freeze has been imposed on the destruction of Medicare records. No paper Medicare records can be destroyed unless they are electronically imaged. If Medicare records are not imaged, the original paper document must be retained. A contractor who images paper Medicare records:

1. Must always be able to demonstrate the imaged version is an exact copy of the paper document,

2. Document the steps taken to image the original document,

3. Establish and implement a certification/quality assurance process to ensure the imaged information is an identical replication of the paper document in every way,

4. Retain the scanned image as the “recordkeeping copy” for the required retention period, and

5. Maintain accessibility and the ability to read the document in accordance with changes in technology.

The methods used in imaging files may vary with the contractor. These variations depend on the type of equipment used and methods used to prepare documents for imaging. All imaged documents shall be tamper proof. Once an image is verified as an exact copy of the original paper document, only then can the original paper document be destroyed and the imaged copy is certified as the “recordkeeping copy”.

Certifying images as an exact copy of the paper document means there is a "quality assurance" process in place that verifies that the images are good. Each contractor is responsible for establishing their own "quality assurance" procedures.

Below is an example of a certification/quality assurance process.

1. The staff member performing the actual scan will:

    a. Observe that all pages successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.

b. Affix a sticker marked “Scanned” to the top page, write the current date on the sticker and place on top of a pile of scanned material.

2. The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 30 days to use and review the images. If any problem is detected, the paper will be retrieved and rescanned. After 30 days, the paper copies are subject to proper disposal.

A contractor is authorized to cut off and transfer Medicare claims records and other records to inactive storage earlier than is prescribed in the disposal schedule shown below when the records are contained on microform. (See §§40.3 and .50ff. for guidelines on retention and disposition guidelines on microform copies of the following records.)

The term "cut off" means the transfer of records to an inactive files area when there is no more than one reference to a file drawer per month. See §§30.70 for guidelines regarding the disposition of non-claims material not transferred to inactive storage.

30.30.1 - Disposition Instructions – Destruction of Records

In accordance with Federal regulations, 36 CFR 1228.58(b)-Destruction of Temporary Records, http://www.access.gpo.gov/nara/cfr/waisidx_05/36cfr1228_05.html paper records to be disposed of normally must be sold as wastepaper. Because the records you maintain are considered restricted, you are required to pulp, macerate, shred, or otherwise definitely destroy the information contained in the records and their destruction must be witnessed by you who created the records or by a contractor employee (see Exhibit 11, Witness Disposal Certification-Sample). The contract for sale must prohibit the resale of all other paper records for use as records or documents. Regardless of medium, records other than paper records (e.g., audio, visual, data tapes, disks, diskettes, etc.) may be salvaged and sold in the same manner and under the same conditions as paper records.

A Witness Disposal Certification must be completed and kept on file for 7 years.

30.30.1.1 - Disposition Instructions When Operating Under a Freeze

When operating under a freeze, you are prohibited from destroying records, and must follow the disposition instructions below in §30.30.1.2. Only after the freeze has been lifted, can you revert back to the normal disposition instructions in §30.30.2.

30.30.1.2 - Disposition Instructions When Medicare Records are Microfilmed

Paper Records

All paper claims that are microfilmed must be retained until CMS notifies you the freeze is lifted.

Microform Records

The master microform must be retained until CMS notifies you the freeze is lifted.

30.30.1.3 - Disposition For Paper-Only Medicare Records

The contractor cuts off the file at the close of the calendar year in which the claim was paid, then transfers the paper records to inactive storage. The paper records must be retained until CMS notifies you the freeze is lifted.

30.30.1.4 - Disposition For Medicare Records that are Imaged/Scanned

Paper

Since imaging can be used to replace paper documents, only when the image will be identical to the paper, you must image/scan both the front and the back of every document.

There is an exception: **Once the back of a claim form is imaged, you do not have to image the back of the rest of the documents imaged on that particular machine, as long as the backs are identical and a certified statement is kept on file stating "the remainder of the backs of the claim forms are identical". However, if the back of a claim form differs in any respect, it must be imaged.**

The contractor must retain the paper records until their certification/quality assurance process (see below) has been completed and the imaged information (the recordkeeping copy) is verified as an identical replication of the paper document. Only then can the paper records be destroyed.

If a scanned document is not identical to the paper document, that paper document must be retained until the freeze is lifted.

Imaged/Scanned Records

Due to the freeze prohibiting the destruction of Medicare records, do not destroy any images of claims records. They are the recordkeeping copy and must be retained until CMS notifies you the freeze is lifted. Once the freeze is lifted, revert back to the normal disposition instructions in §30.30.2.

Sample Quality Assurance Procedure

Certifying images as an exact replication of the paper document means there is a "quality assurance" process in place that verifies that the images are good. Each contractor is responsible for establishing their own "quality assurance" procedures. Below is an example of a quality assurance process.

Standard Procedures for Document Imaging Quality Assurance

1. **The staff member(s) performing the actual scan will:**

a. Observe that all pages successfully pass through scanner and that image displayed on the imaging software preview screen appear accurate.

b. Affix a sticker marked "Scanned" to the top page, write the current date on the sticker and place on top of a pile of scanned material.

2. The staff member(s) responsible for these records will have immediate access to the images, from their desktops, using the imaging software. They will have 30 days to use and review the images. If any problem is detected, the paper will be retrieved and rescanned. After 30 days, the paper copies are subject to proper disposal.

30.30.1.5 - Disposition for Medicare Records When Potential Fraud or Overutilization has been Identified

When potential fraud or overutilization has been identified, retain the recordkeeping copy onsite. If the recordkeeping copy has already been transferred to offsite storage, retrieve and retain onsite until the investigation and subsequent legal action, if any, has been completed (including the exhaustion of all appeals), then destroy 3 months thereafter.

If at the close of this period, the disposition instructions shown in §30.30.1.1 through 30.30.2 remains applicable, retain, transfer, and destroy in accordance with the disposition instructions. If the disposition instructions in §30.30.1.1 through 30.30.2 are no longer applicable, then destroy after the 3 month period following completion of the investigation or subsequent legal action, if any.

If any records are provided to a prosecutorial agency as evidentiary matter, consider such records as disposed of. If any such record is returned by the prosecutorial agency, retain for 3 months, then destroy in accordance with the foregoing disposition instructions unless otherwise directed by the prosecutorial agency.

30.30.1.6 - Disposition for Medicare Records Already in Storage

30.30.2 - Description of Records

1. Medicare Claims Records:

   A. FI 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 FIs; 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. Carrier 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 FI'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 FI or carrier'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. FI and Carrier 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 carriers and CMS-1524 for intermediaries. 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 carrier/intermediary'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 carrier/intermediary. 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. FI and Carrier Letter of Credit Files (FROZEN – DO NOT DESTROY)

These records are authorizations to a Federal Reserve Bank to disburse funds to designated FIs and carriers' 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. FI Payment Vouchers and Transmittal Files (FROZEN – DO NOT DESTROY)

These consist of Form TFS-218, Request for Funds, and similar documents prepared by the FI'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. FI and Carrier 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 carrier'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. FI and Carrier 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. Carrier 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 carrier'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 claim number 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. FI Workload Reports Files

These consist of monthly statistical reports on the status of FI 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 – Carrier 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. FI and Carrier Contract Files

These consist of agreements entered into with FIs and carriers by the Secretary under the provisions of §§1816 and 1842 of the Act by which FIs and carriers 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. FI and Carrier Subcontract Files

These consist of copies of FI and carrier agreements with subcontractors regarding performance of an audit of providers' costs (FIs), 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. FI and Carrier 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. FI Cost Report Files (FROZEN – DO NOT DESTROY)

These consist of cost reports submitted by providers to FIs 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 FI staff accountants and the supporting audit working papers.

Disposition: The FI 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. FI and Carrier Closing Agreements

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

Disposition: The FI or carrier 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 transfer 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 FIs 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. Carrier Claims Processing File

Consists of documents relating to Part B carrier performance. Submitted on a weekly basis electronically to CMS's data center.

Disposition: Destroy after 6 months.

30.40 - Retention of Claims File Materials

After the claims determination payment action and posting to CMS records is completed, the bills and related materials are accumulated in file segments and held before transfer to an approved offsite storage facility (see §30.40.2). Claims records having current value and continuing reference, or claims records otherwise flagged to indicate pending action, are retained as long as the carrier finds necessary.

30.40.1 - Segment File Accumulation Period

In order to facilitate the transfer of material to an approved offsite storage facility, intermediaries and carriers 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 claim number, 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.

30.40.2 - Standard Retention Periods – Microfilmed Claims

Contractors keep each permanent claims records file segment for a period of not less than 6 months or more than 1 1/2 years after the segment has been closed. The contractor bases the selection of a retention period on its experience with the rate and frequency of reference and other criteria. It also should avoid too early transfer to the storage facility, which could result in volume recalls and delays. The contractor bases the exact length of the retention period on its needs and on the arrangements worked out with the storage facility.

The following examples of segment accumulation and retention periods demonstrate some of the ways in which these periods can vary.

EXAMPLES:

Segment File

Accumulation Period	Retention Period	Transfer
a. 6 months		
7/1/05 - 12/31/05	6 months	7/1/06
1/1/06 - 6/30/06	6 months	1/1/07
1/1/06 - 6/30/06	12 months	7/1/06
1/1/06 - 6/30/06	18 months	1/1/07
b. 9 months		
7/1/05 - 3/31/06	6 months	10/1/06
7/1/05 – 3/31/06	12 months	4/1/07
7/1/05 – 3/31/06	18 months	10/1/07
c. 12 months		
1/1/05 - 12/31/05	6 months	7/1/06
1/1/05 - 12/31/05	12 months	1/1/07
1/1/05 - 12/31/05	18 months	7/1/07
d. 18 months		
1/1/05 - 6/30/07	6 months	1/1/08
1/1/05 - 6/30/07	12 months	7/1/08
1/1/05 - 6/30/07	18 months	1/1/09
e. 2 years		
7/1/05 - 6/30/07	6 months	1/1/08
7/1/05 - 6/30/07	12 months	7/1/07

7/1/05 - 6/30/07	18 months	1/1/09

30.40.3 - Retention Period - Microfilmed Material

Intermediaries and carriers who have been authorized to microfilm claims records (see §§50ff) may be permitted to transfer an accumulation of the original source documents to an approved offsite storage facility, after retaining for a shorter period than is outlined in §§30.30.40 – 30.30.40.2.

	Accumulation Period	Retention Period	Transfer
a.	1/1/06 - 1/31/06	1 month	3/1/06
b.	6/1/06 - 6/30/06	1 month	8/1/06

30.50 - Microfilming of Files Material

Some intermediaries and carriers have been authorized to microfilm claims records and other files material; e.g., computer printouts, cancelled checks, financial records. Due to the document freeze, these contractors are not authorized to destroy original source documents but are permitted to transfer an accumulation of these documents to an offsite storage facility after microfilming and verification of the quality and completeness of the film. (See §30.30.2, item 3, concerning destruction the hard copy Medicare Summary Notices after microfilming.) The accumulation period may be daily, weekly, or monthly, depending on volume. Generally, contractors should not make shipments of less than three cartons. They coordinate transfer procedures with the storage facility.

In §30.90, Exhibits 6-12 contain various sample forms to be used by contractors when microfilming files material. These forms are not supplied by CMS. Reproduction of the forms is the responsibility of the contractor.

30.50.1 - Microfilming Procedures

A – General

The contractor must authenticate each roll of film containing reproductions of Medicare claims records by including certificates of authenticity at the start and at the end of the filmed documents. (Material other than claims records need not be authenticated.) The contractor produces these certificates and target cards as needed, using the language contained in the examples in §80, Exhibits 6-12. The camera operator completes a report for each roll that is microfilmed. See Exhibit 12, for an example of a roll report. The contractor films claims records without attachments (e.g., coding sheets) overlaying data on the record. If data on the attachment is needed for reference purpose, the contractor films it separately.

To ensure that the camera is working efficiently when files material is being microfilmed, the contractor films a microcopy resolution test chart on the first roll in the morning and the first roll in the afternoon. It gives these rolls priority processing so that any camera malfunction is discovered as soon as possible. Exhibit 11 provides an example of a resolution test chart that cannot be used for actual tests. Usable charts are available from microfilm suppliers.

B - Normal Filming

The contractor films the start certificate (see Exhibit 5) after any target (or flash) cards that identify or index the documents on the film and before the records are filmed. It files the end certificate (Exhibit 6) after the last document and before any end target card. It retains documents in the order they were filmed for ease in reviewing the processed microfilm.

The following is an example of normal filming sequence:

OUT START OF FILM	LEADER <ABOUT-2 FEET	ROLL NUMBER CARD	TITLE CARD	FILING SEQUENCE CARD	START CERTIFICATION OF AUTHENTICITY CARD	TEST* CHART	

\ / \ / \	DOCUMENT	DOCUMENT	DOCUMENT	LAST DOCUMENT	LAST CERTIFICATE OF AUTHENTICITY CARD	\ / \ / \

/ \ / \	END CARD	←	TRAILER ABOUT 2 FEET	*Filmed Twice Each Day END OF FILM /	\ / \ / \

C – Corrections

If the camera operator notices that a document has been incorrectly filmed due to being twisted, folded, or torn, photograph a correction card (see Exhibit 7) right after the incorrect document.

The following is an example of correction filming sequence:

\ / \ / \	DOCUMENT	DOCUMENT (TORN)	CORRECTION CARD	DOCUMENT (REPAIRED)	DOCUMENT	/ \ / \

D - Filming Retakes and Additions

When the processed microfilm roll is reviewed, some documents may be illegible or incorrectly photographed. Other documents may have been out of file or omitted at the time of the original microfilming. The contractor will re-photograph these documents and splice onto the front of the completed microfilm roll. If splicing is not practical, it will maintain the retakes and additions as a separate microfilm roll. It will photograph a start of retake or addition card (Exhibit 8) immediately before the documents to be rephotographed or added. Photograph an end of retake or addition certificate (Exhibit 9) immediately after the last document to be rephotographed. The following is an example of retake or addition filming sequence:

\ / \ / \	START RE-TAKE OR ADDITION CARD	DOCUMENT	DOCUMENT	DOCUMENT	END OF ADDITION OR RETAKE CERTIFICATE	\ / \ / \

30.50.2 - Microfilming Index Label

Affix an index label to each contents of the roll microfilm and provide reference markers. It lists the normal filming and the retakes and additions.

Below is an example of an index label:

Title: Roll No.
CMS-1453
CONTENTS INDEX
Index Point 1
CMS-1453 Control Number
00400 Through 00450
Index Point 2
CMS-1453 Control Number
00451 Through 00499
Index Point 3
Retakes 00427, 00451, 00478
Index Point 4
Additions 00429, 00446, 00463
END OF ROLL
End of Roll

30.50.3 - Retention and Destruction of Microfilm

A - Master Microfilm

After producing the number of copies of the microfilm required for reference purposes, the contractor retains the master microfilm as a security file. It stores it at an offsite location so that copies may be made in the event the reference copies are destroyed. It disposes of the master microfilm at the time the storage facility disposes of the hardcopy contained on the film. (See §30.30 for records disposition instructions.)

(The contractor need not maintain a master microfilm security file of records such as computer printouts when complete computerized backup data is retained. It disposes of the master microfilm when there is no longer a need to produce reference copies of the microfilm.)

B - Copies of Microfilm

The contractor retains one copy of the microfilm as a reference copy to be kept on site for use when needed. It disposes of this copy with the master microfilm. (See subsection A above.)

The contractor may dispose of any other reference copies of the microfilm 2 years after the end of the calendar year in which the documents were filmed. These copies may be retained for a longer period if they are needed for reference purposes but not longer than the master microfilm.

C - Destruction of Microfilm

The contractor should destroy microfilm by shredding as this method provides the most complete destruction of the data on the film. Other methods of destroying film, e.g., exposure to extreme heat or boiling, do not eradicate the data as completely or efficiently. Shredders exist that can destroy both film and reels. The contractor should retain cartridges or magazines which contained the microfilm for reuse because of the high cost of replacement.

If a contractor does not have a shredder and purchase of a shredder is not cost justified, it should check local sources such as microfilm equipment vendors, microfilm service bureaus, banks, and insurance companies for a shredder that it can use to destroy its film. If a shredder cannot be located, the contractor should contact its regional office for assistance.

30.60 – Annual Report of Medicare Records

The Centers for Medicare & Medicaid Services (CMS) conducts a reporting of total records on hand in current file rooms, offices, and offsite storage facilities. Since Medicare claims records and related records created and maintained by you must be included, you must prepare an Annual Report of Medicare Records (See Exhibit 13).

Each contractor shall prepare this report every year as of September 15, regardless of your fiscal year ending date, and mail one copy to reach the address shown below no later than September 30:

Centers for Medicare & Medicaid Services
Records Officer, OSORA/IRMG
Mail Stop, SL-12-16
7500 Security Boulevard
Baltimore, MD 21244-1850

30.70 - Disposition of Non-Claims Materials

Non-claims materials, as defined in §30.10.1B, may be disposed of by the contractor. Retained CMS bill copies (where records were submitted on tape) may be destroyed.

In disposing of this material, the contractor must:

- Ensure the confidentiality of information regarding a particular beneficiary, provider, physician, or supplier by protective shredding, mutilation, or contractual provisions with the subcontractor regarding similar protective measures.

- Provide for offsetting expenditures with salvage value received when contractual relationships have been established with a local contractor for the sale of non-claims materials for its salvage value. In such cases, the contractor records the salvage value received, and offsets the initial expense of purchasing such materials by such value received.

30.80 – Standards for All Records Storage Facilities

A facility that is used to store Federal records, must meet the minimum structural, environmental, property and life safety standards as outlined in 36 CFR 1228.228-Facility Requirements http://www.access.gpo.gov/nara/cfr/waisidx_05/36cfr1228_05.html by October 1, 2009. You must submit a Facility Standards for Record Storage Facilities Inspection Checklist (see Exhibit 14) for all storage facilities used to house CMS records to the CMS Records Officer.

The facility must be constructed with non-combustible materials and building elements, including walls, columns and floors. You may request a waiver of this requirement from the National Archives and Records Administration through CMS for an existing records facility with combustible building elements to continue to operate until October 1, 2009. Your request must provide documentation that the facility has a fire suppression system specifically designed to mitigate this hazard and that the system meets the requirements in 36 CFR 1228.230--Fire Safety Requirements http://www.access.gpo.gov/nara/cfr/waisidx_05/36cfr1228_05.html. Requests for waivers must be submitted to your CMS Regional Office contact who will forward to the CMS Records Officer for final approval by the National Archives and Records Administration.

Exhibit 1 – Preprinted Container Label

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 intermediary or carrier in this block.

Description of Records – Enter "Part A Intermediary or Part B Carrier – Medicare bills and related claims records received, processed and paid (including dates)," or "Part A Intermediary – 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, e.g., "086-12-8462—093-14-2362".

Exhibit 2 - Minimum Label Data Required for Unlabeled Boxes

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

CARTON _____ OF _____ CARTONS

CMS

INTERMEDIARY or CARRIER NAME

CITY, STATE

FISCAL INTERMEDIARY or CARRIER - 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 Intermediary or Carrier with city and State address.

Description of Records.--For Medicare bills and related records, show: "Fiscal Intermediary or Carrier name - Paid Medicare Bills (inclusive dates)." For fiscal records, canceled checks, and related records, show: " Fiscal Intermediary or Carrier - 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 (e.g., 086-12-8462A--093-14-2362T).

Exhibit 3 – Records Transmittal and Receipt – Standard Form 135

Click on the link below then scroll down and click on “Records Transmittal and Receipt Form – SF135”.

http://www.archives.gov/records_center_program/forms/sf_135_intro.html

Exhibit 4 – Reference Request – Federal Records Center – Optional Form 11

Click on the link below to access Optional Form 11

http://www.gsa.gov/forms

Exhibit 5 - Certificate of Authenticity – START

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, health insurance claim number)

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

Exhibit 6 – Certificate of Authenticity – END

CONTRACTOR NAME AND ADDRESS

CERTIFICATE OF AUTHENTICITY

END

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

ENDING WITH

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

Exhibit 7 – Correction Card

CORRECTION CARD
CORRECTION THIS DOCUMENT HAS BEEN REPHOTOGRAPHED TO ASSURE LEGIBILITY

Exhibit 8 – Start of Retake or Addition Certificate

RETAKE OR ADDITION CARD
START OF RETAKE OR ADDITION The images appearing between this point and the "End of Retake or Addition" are true copies of records, which were missing or provide unsatisfactory on inspection of the original microfilm reel. For a description of rephotographed material, see operator's "Retake or Addition Certificate" at the end of this section.

Exhibit 9 – Retake or Addition Certificate

CONTRACTOR NAME AND ADDRESS

CERTIFICATE OF AUTHENTICITY

RETAKES OR ADDITIONS

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

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

Exhibit 10 – Resolution Test Chart

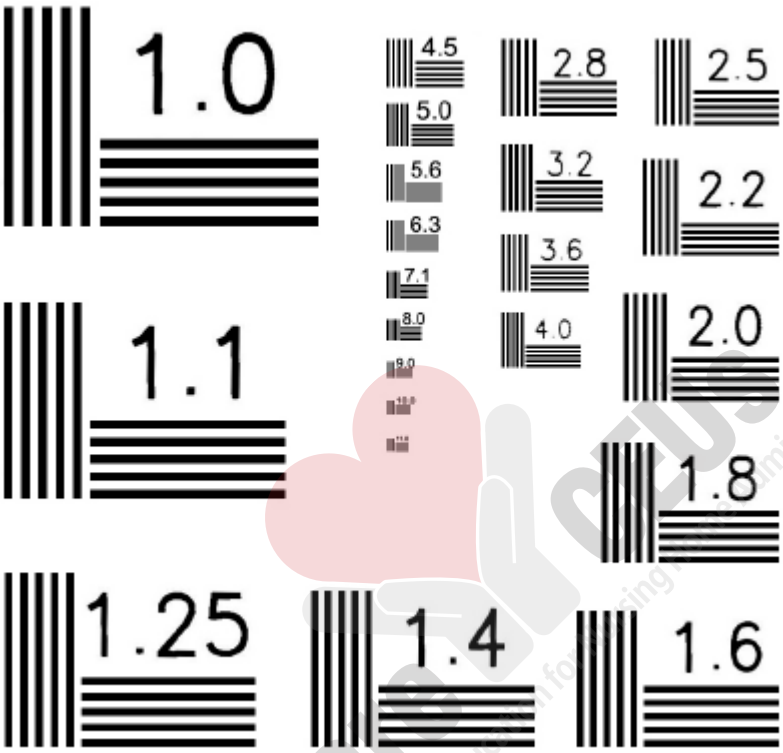


Exhibit 11 – Witness Disposal Certification (Sample)

WITNESSED DISPOSAL CERTIFICATION

Disposal Date: _____

Medicare Contractor: _____

Address: _____

_____

Disposal Location: _____

_____

Volume by Cubic Feet (e.g., number of boxes): _____

Description & Year(s) of Records Destroyed:

_____

_____

_____

_____

I certify that I witnessed the proper destruction of CMS Medicare records approved for disposal on the date and location named in this document.

Print Name: _____

Title: _____

Signature: _____

Date: _____

Exhibit 12 – Roll Report

ROLL REPORT

THEIR ROLL NO.

AGENCY NAME		OUR ORDER NUMBER

CAMERA NO.	LIGHT LEVEL	IRIS	REDUCTION

FILMING TIME

LUNCH TIME	BREAK TIME	PREP TIME	WAITING TIME	SET-UP TIME	TRAVEL TIME

PROCESSING DEPARTMENT

DATE PROC.	DEV. TIME	CHEM. TEMP	REMARKS	PROCESSOR

INSPECTION DEPARTMENT

APPROVED RESHOOTS	FOOTAGE	INSPEC. TIME	INSPECTORS INTIALS	DENSITY

RESHOOTS WILL BE FOUND ON

THIS ROLL FOR ROLL NUMBERS

REMARKS

OPERATOR'S INITIALS

Exhibit 13 – Report of Medicare Records

ANNUAL REPORT OF MEDICARE RECORDS			
Name & Address of Medicare Contractor			
Name, Title and Phone # of the Person Submitting the Report			
Type of Medicare Contractor (Carrier/Intermediary/DMERC, etc.)			
	Current File Room	**Offsite Storage**	**Storage Costs**
1. Total Records on Hand at the End of the Reporting Period			
a. Magnetic Tape Included in Line 1			
b. Microfilm Included in Line 1			
c. CDs included in Line 1			
d. Paper included in Line 1			
2. Records Transferred to Storage During Reporting Period (provide the number of boxes)			

a. To Offsite Storage Included in Line 2			$
b. To Onsite Storage Included in Line 2			$
TOTAL STORAGE COSTS (Add 2a+b)			$
3. Total Records in Offsite Storage During the Contract Period			

For the purpose of this report, volume may be calculated according to the following table of cubic foot equivalents:

1 record storage box……1 cubic foot

Letter-size filing cabinet…….1½ cubic feet per drawer

Legal-size filing cabinet……..2 cubic feet per drawer

Magnetic Tape…….1 cubic foot per 7 reels

Microfilm…….1 cubic foot per 108 rolls

CDs……..¼ cubic foot per 12” case holder

Exhibit 14 – Inspection Checklist – Facility Standards for Records Storage Facilities

Facility Standards for Records Storage Facilities **Inspection Checklist** **(Effective date of checklist September 2005)**		
Agency:		
Facility:	Common Name:	
	Street Address	
	City, State & Zip	
Facility Director or Representative:	<<Typed name>> <<Typed Title>> □ Comments explaining or disagreeing with inspection findings are attached.	
Inspector:	_____ _____ <<Typed name>> Date <<Typed Title>>	
Facility Description:		

Compliance with 36 CFR 1228.228 Facility Requirements				
§1228.228 paragraph:	Requirement	OK	No	Other
(a)	The facility must be constructed with non-combustible materials and building elements, including walls, columns, and floors.			
(a) exception 1	If the roof is constructed of combustible material it is protected by a properly installed and maintained wet-pipe automatic sprinkler system.			
(a) exception 2	Existing records storage facility with combustible building elements has an approved waiver from NAS that allows continued use until October 1, 2009 provided documentation has been submitted that indicates a fire-suppression system designed to mitigate the risk is present.			
(b)	A facility with two or more stories must be designed or certified by a licensed fire protection engineer and civil/structural engineer to avoid catastrophic failure of the structure due to an uncontrolled fire on one of the intermediate levels.			
(c)	The building must be sited a minimum of five feet above and 100 feet from any 100 year flood plain areas, or be protected by an appropriate flood wall (see FEMA flood maps)			
(d)	The facility must be designed in accordance with national, regional, state or local building codes (whichever is most stringent) to provide protection from building collapse or failure of essential equipment from earthquake hazards, tornadoes, hurricanes, and other natural disasters.			
(e)	Roads, fire lanes, and parking areas must permit unrestricted access for emergency vehicles.			
(f)	A floor load limit must be established for the records storage area by a licensed structural engineer. … The allowable load limit must be posted in a conspicuous place and must not be exceeded.			
(g)	The facility must ensure that the roof membrane does not permit water to penetrate the roof. (New buildings: effective 9/28/2005; existing buildings: effective 10/1/2009)			

(h)	Piping (with the exception of sprinkler piping and storm water roof drainage piping) must not be run through the records storage area unless supplemental measures … are used to prevent water leaks …. (New buildings: effective 9/28/2005; existing buildings: effective 10/1/2009)			
(i)(1)	All storage shelving must be designed and installed to provide seismic bracing that meets the requirements of the applicable state, regional, and local building code (whichever is most stringent).			
(i)(2)	Racking systems, steel shelving, or other open-shelf records storage equipment must be braced to prevent collapse under full load. Each shelving unit must be industrial style shelving rated at least 50 lbs per cubic foot supported by the shelf.			
(i)(3)	Compact shelving, if used, must be designed to permit proper air circulation and fire protection …			
(j)	The records storage area must be equipped with an anti-intrusion alarm system … meeting the requirements of UL 1076, Proprietary Burglar Alarm Units and Systems (level AA) …. The alarm system must be monitored in accordance with UL 611, Central Station Burglar Alarm Systems.			
(k)	The facility must comply with the requirements for a Level III facility. (Appendix A -- see separate checklist)			
(l)	Records contaminated by hazardous materials … must be stored in separate areas having separate air handling systems from other records.			
(m)	The facility must have an Integrated Pest Management program.			

(n) (n.1) (n.2) (n.3) (n.4) a. b. c.	The following additional requirements apply only to new facilities: (1) No mechanical equipment containing motors in excess of 1 HP within records storage areas (excluding material handling and conveyance equipment that have operating thermal breakers on the motor). (2) No high-voltage electrical distribution equipment (i.e., 13.2kv or higher) in records storage areas. (3) A redundant source of primary electrical service … should be provided … . Manual switching between sources of service is acceptable. (See text in rule; applies to HVAC, fire and security alarms.) (4) For new facilities that store permanent records: a. A facility storing permanent records must be kept under positive pressure. b. No intake louvers in loading dock areas, parking or other areas subject to vehicle traffic. c. Separate air supply and exhaust system for loading docks.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(a)	The fire detection and protection system must be designed or reviewed by a licensed fire protection engineer. Review requires submission of a report under the seal of a licensed fire protection engineer; see rule text for minimum requirements.			
(b)(1)	All walls separating records storage areas from each other and from storage areas within the building must be 3-hour fire resistant.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(b)(2)	The quantity of Federal records stored in a single fire compartment shall not exceed 250,000 cubic feet.			
(c)(1)	For existing records storage facilities, at least 1-hour rated fire barrier walls must be provided between the records storage area(s) and other auxiliary spaces.			
(c)(2)(a)	For new records storage facility, 2-hour-rated fire barrier walls must be provided between the records storage area(s) and other auxiliary spaces.			
(c)(2)(b)	For new facilities, at least one exterior wall of each stack area must be designed with a maximum fire resistive rating of one-hour, or, if rated more than one-hour, there must be at least one knock-out panel in one exterior wall of each stack.			
(d)	Penetrations in the walls must not reduce the specified fire resistance ratings.			
(e)	The fire resistive rating of the roof must be a minimum of ½ hour.			
(e) alternate	Unrated roof is protected in accordance with NFPA 13.			
(f)	Openings in fire barrier walls must be protected by self-closing or automatic Class A fire doors, or equivalent doors that maintain the same rating as the wall.			
(g)	Roof support structures that cross or penetrate fire barrier walls must be cut and independently supported on each side of the fire barrier wall.			
(h)	If fire barrier walls are erected with expansion joints, the joints must be protected to their full height.			
(i)	Building columns in records storage areas must be 1-hour fire resistant.			
(i) alternate	Unrated columns are protected in accordance with NFPA 13.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(j)(1)	Automatic roof vents for routine ventilation purposes must not be designed into new records storage facilities.			
(j)(2)	Automatic roof vents, designed solely to vent in the case of a fire, with a temperature rating of at least twice that of the sprinkler heads are acceptable.			
(k)	Where lightweight steel roof or floor supporting members are present, they must be protected either by applying a 10-minute fire resistive coating to the top chords of the joists, or by retrofitting the sprinkler system with large drop sprinkler heads. (see rule text)			
(l)	Open flame (oil or gas) unit heaters or equipment, if used, must be installed or used in any records storage area in accordance with NFPA 54 and the UMC.			
(m)	For existing records storage facilities, boiler rooms or rooms containing equipment operating with a fuel supply … must be separated from records storage areas by a 2-hour rated fire barrier wall with no openings directly from those rooms to the records storage area(s). Such areas must be vented directly outside to a location where fumes will not be drawn back into the facility.			
(n)	For new records storage facilities, boiler rooms or rooms containing equipment operating with a fuel supply … must be separated from records storage areas by a 4-hour rated fire barrier wall with no openings directly from those rooms to the records storage area(s). Such areas must be vented directly outside to a location where fumes will not be drawn back into the facility.			
(o)	For new records storage facilities, fuel supply lines must not be installed in areas containing records, and must be separated from such areas with 4-hour-rated construction.			
(p)	Equipment rows running perpendicular to the wall must comply with NFPA 101 Life Safety Code, with respect to egress requirements.			

Compliance with 36 CFR 1228.230 Fire Safety Requirements				
§1228.230 paragraph:	Requirement	OK	No	Other
(q)(1)	No oil-type transformers, except thermally protected devices included in light ballasts, may be installed in records storage areas.			
(q)(2)	All electrical wiring must be in metal conduit, except that armored cable may be used where flexible wiring connections to light fixtures are required			
(q)(3)	Battery charging areas for electric forklifts must be separated from records storage areas with at least a 2-hour rated fire barrier wall.			
(r)	Hazardous materials … must not be stored in records storage areas.			
(s)	All records storage and adjoining areas must be protected by a professionally designed fire-safety detection and suppression system that is designed to limit the maximum anticipated loss from any single fire event to a maximum of 300 cubic feet of records destroyed. For systems in accordance with App. B, attach checklist. For other designs, see § 1228.242 for documentation requirements.			

Compliance with 36 CFR 1228.232, Environmental Control Requirements				
§1228.232 Paragraph:	Requirement	OK	No	Other
(a)	Paper-based temporary records must be stored under environmental conditions that prevent the active growth of mold. (See rule text)			
(b)	Nontextual temporary records, including microforms and audiovisual and electronic records, must be stored in records storage space that will ensure their preservation for their full retention period. Effective 9/28/2005 for new records storage facility and 10/1/2009 for existing facilities. (See rule text)			

(c)	Paper-based permanent, unscheduled, and sample/select records must be stored in records storage space that provides 24 hour/365 days per year air conditioning equivalent to that required for office space. (See rule text) Effective date: New facilities, 9/28/2005; existing facilities 10/1/2009			
(d)	Nontextual permanent, unscheduled and/or sample/select records: see parts 1230, 1232, and/or 1234 of 36 CFR Chapter XII.			

List of Attachments		
Description	Yes	N/A
Minimum Security Requirements Check List (Appendix A)		
Fire-Safety Check List (Appendix B)		
Certification of fire-safety detection and suppression system (36 CFR 1228.242)		
Exceptions caused by Code Conflicts (36 CFR 1228.234)		
Waiver request(s) (36 CFR 1228.236)		
Other: (Describe)		

Notes	
Reference (§ and ¶)	Comments

Facility Standards for Records Storage Facilities

Supplemental Check Lists: Appendix A and Appendix B

Compliance with Federal Facility Security Standards, Level III

(36 CFR Part 1228 Appendix A)

(Complete for ALL facilities)

Citation	Requirement	OK	No	Part
S1	Control of facility parking			

Compliance with Federal Facility Security Standards, Level III (36 CFR Part 1228 Appendix A) (Complete for ALL facilities)				
Citation	Requirement	OK	No	Part
S2	Receiving/shipping procedures			
S3	Intrusion detection system with central monitoring			
S4	Meets Life Safety Standards			
S5	Adequate exits from records storage areas			
S6	High security locks on entrances/exits			
S7	Visitor control/screening system			
S8	Prevent unauthorized access to utility areas			
S9	Provide emergency power to critical systems			
S10	Conduct background security checks and/or establish security control procedures for service contract personnel			

Compliance with 36 CFR Part 1228 Appendix B (Complete this section ONLY if the facility claims to be using the system described in Appendix B)				
Paragraph	Requirement	OK	No	Part
2a.	The records storage height must not exceed the nominal 15 feet (+/-3 inches) records storage height.			
2b.	All records storage and adjoining areas must be protected by automatic wet pipe sprinklers.			
2c.	1. The sprinkler system must be rated at no higher than 285 degrees Fahrenheit utilizing quick response (QR) fire sprinkler heads.			

Compliance with 36 CFR Part 1228 Appendix B (Complete this section ONLY if the facility claims to be using the system described in Appendix B)				
Paragraph	Requirement	OK	No	Part
	2. The sprinkler system must be designed by a licensed fire protection engineer to provide the specified density for the most remote 1,500 square feet of floor area at the most remote sprinkler head in accordance with NFPA 13 (1996), Standard for the Installation of Sprinkler Systems.			
	3. Installation of the sprinkler system must be in accordance with NFPA 13 (1996), Standard for the Installation of Sprinkler Systems.			
	4. Contractor's Material and Test Certificates per NFPA 13 chapter 8.			
	5. Hydraulic Calculations.			
2d.	1. Maximum spacing of the sprinkler heads must be on a 10-foot grid.			
	2. The positioning of the heads must provide complete, unobstructed coverage, with a clearance of not less than 18 inches, but not more than 60 inches, from the top of the highest stored materials.			
2e.	The sprinkler system must be equipped with a water-flow alarm connected to a continuously staffed fire department or central station, with responsibility for immediate response.			
2f.	1. A manual fire alarm system must be provided with central station services or other automatic means of notifying the municipal fire department.			
	2. A manual alarm pull station must be located adjacent to each exit.			
2g.	All water cutoff valves in the sprinkler system must be equipped with automatic closure alarm connected to a continuously staffed station, with responsibility for immediate response.			
2h.	A dependable water supply free of interruption must be provided. This normally requires a backup supply			

Compliance with 36 CFR Part 1228 Appendix B (Complete this section ONLY if the facility claims to be using the system described in Appendix B)				
Paragraph	Requirement	OK	No	Part
	system having sufficient pressure and capacity to meet both fire hose and sprinkler requirements for 2 hours.			
2i.	Interior stand-pipe stations equipped with 1 ½ inch diameter hose may be provided in the records storage areas if required by the local fire department, enabling any point in the records storage area to be reached by a 50-foot hose stream from a 100-foot hose lay. If hose is provided, the cabinets must be marked "For Fire Department Use Only."			
2j.	Where fire hose cabinets are not required, stand-pipes must be provided at each floor landing in the building core or stair shaft. Hose outlets must have easily removable adapter and cap. Threads and valves must be compatible with the local fire department's equipment. Spacing must be so that any point in the records storage area can be reached with a 50-foot hose stream from a 100-foot hose lay.			
2k.	In addition to the designated sprinkler flow demand, 500 gpm must be provided for hose stream demand. The hose stream demand must be calculated into the system at the base of the main sprinkler riser.			
2l.	1. Fire hydrants must be located within 250 feet of each exterior entrance or other access to the records center that could be used by fire-fighters.			
	2. All hydrants must be at least 50 feet away from the building walls and adjacent to a roadway usable by fire apparatus. Fire hydrants must have at least two 2-½ inch hose outlets and a pumper connection. All threads must be compatible with local standards.			
2m.	Portable water-type fire extinguishers (2½ gallon stored-pressure type) must be provided at each fire alarm striking station (see also NFPA 10).			

Compliance with 36 CFR Part 1228 Appendix B (Complete this section ONLY if the facility claims to be using the system described in Appendix B)				
Paragraph	Requirement	OK	No	Part
2n.	1. Where provided, the walking surface of the catwalks must be of expanded metal at least 0.09-inch thickness with a 2-inch mesh length. The surface opening ratio must be equal or greater than 0.75.			
	2. The sprinkler water demand for protection over bays with catwalks where records are not oriented perpendicular to the aisles must be calculated to give 0.3 gpm per square foot for the most remote 2,000 square feet.			

40 – Shared System Maintainer and Medicare Contractor Responsibilities for System Releases

40.1 – Standardized Terminology for Claims Processing Systems

This is a responsibility for both FIs and carriers. Medicare requires implementation of a limited number of shared systems by all FIs and carriers for their claims process and related functions. This eliminates the need for each contractor to repeat development of the basic system.

The shared system maintainers, the carriers and the FIs shall use a standardized terminology to refer to common systems maintenance elements in all discussions, reporting, and documentation. A chart of topics, showing how each system currently refers to them, and what they are called is located at 40.1.2. The list is not exhaustive and both CMS and the maintainers shall add to it, deciding with each addition, the common term we shall use to describe it. Carriers and FIs have a stake in this standardization, since many access the Information Management (INFOMAN) databases each system maintainer populates to determine the status of changes of interest to them. Carriers and FIs also participate in discussions with each other, the maintainers, the various testing sites and with CMS, and using a common terminology will minimize confusion and misunderstanding.

The FIs and carriers shall examine their use of the system status information issued by the Shared System Maintainers to determine if they have internal applications that need to be adjusted to adopt the standardized terminology. If they have internal systems or processes that must be modified to reflect the standardization required by this instruction, they shall make those changes to coincide with the shared system changes.

40.1.1 - Standard Terminology Chart

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
QUESTION	Request for assistance and/or reported potential system problem	TAR "telephone assistance request"	PCN – telephone assistance request	PROB/CSR	PLOG "problem log"
PROBLEM	Confirmed system and/or documentation problems	PAR "project assistance request"	PLOG	PROB	PLOG

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
CR	Change Request - Any software modification made to the system as a result of a CMS mandate, user or maintainer initiated action	PAR	CR	CR/CMR	CR "change request" or PLOG depending on CMS direction.
CMS Status	CMS needs take action by answering a question, finalizing an instruction, etc.	CMS REVCMS MANDATE	CMS	ENT Entered	MCCB or CMS
CONF Status	PROBLEM, CR or proposed action is under discussion in a functional workgroup	CONF			
NSC Status (non-system change)	CMS CR does not require shared system change. May require FI or carrier maintenance			NSC in SLC	
RESEARCH Status	The system maintainer completes high level review of required changes by analyzing them and determining the intent of the change request	Research	PREQ	INP In process	ANLZ (analysis)
REQS Status	The system maintainer finalizes the business requirements	TAR - Referred PAR - REVIEW	REQS	INP In process	REQS (requirements)
WALKTHROUGH Status	The system maintainer presents the systems solution to the CR in a structured walkthrough discussion with CMS and Beta testers			CWT	

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
WORK Status	The system maintainer completes technical design, coding and unit testing the system change	PAR - WORK	WORK	DCG Design Control Group Technical Approval	PROG (programming and unit testing)
ALPHA Testing	Maintainer System Testing	PAR - TEST	QUAL	REL Release Ready	TEST (Alpha testing)
BETA Testing	Testing (Beta)	PAR - BETA	RLSE	REL Release Ready	BETA
UAT	User Acceptance Testing	PAR - RELEASE	LOAD	REL Release Ready	BETA (is for BETA and HOST testing)
USER Status	Back to user to provide more information or examples, assess solution	TAR - CUST PAR - N/A	Status I (PLOGs)	INP OR “W”	BETA (is for BETA and HOST testing)
SCHED Status	Scheduled to go out with a release date assigned for implementation	SCHED	PROD	REL Release Ready	NDM
RESOLVED	PROBLEM has been resolved: question answered, potential system anomaly explained or correction identified and scheduled for release			CLOSED	
RELEASE	Quarterly Release	Release	Quarterly release	Release	Quarterly Release
FOLLOW-UP	What Maintainers send out to augment a release or correct PROBLEMS directly			Post-Release Resync	

STANDARD TERM	DESCRIPTION	FISS	MCS	VMS	CWF
	related to a newly-installed release				
EMER Release	What Maintainers send out to fix Priority 1, 2, and urgent PROBLEMS	Release	Emergency release	Emergency Elevate	Priority or Emergency NDM 'network data mover' old name for Connect:Direct
OFF-QTR RELEASE	What Maintainers send out to fix non-urgent PROBLEMS between releases or to prepare for an upcoming release (e.g. update provider profile data)	Release	Priority release	Weekly / Off-Release Elevate	Special release NDM
Test Case	A description of an input situation and of the expected results associated with a specific test objective. (a Test Case may optionally include test steps provide to additional granularity)	Test Script	Test Script	Test Case	Test Case
Test Set	A group of test cases with a common goal (e.g., a test set to validate a specific CR, a regression test set)		Test Packet	Test Plan	

40.2 – Release Software

CMS intends to continue to closely manage standard system software changes to assure that an effective change control process is in place. This means that maintainers must receive approval

from their CMS system maintenance lead (see section VI) or CMS project officer before any follow-up release by the standard maintainer can be scheduled and installed.

Control of System Changes

All maintainers of the standard systems (CWF, FISS, APASS, MCS, VMS, GTEMS, and HPBSS systems) must use the same quarterly release schedule, i.e., on or about January 1, April 1, July 1, and October 1. The specific schedule for each quarterly release will be determined by CMS.

All follow-up release changes (except emergencies) to the quarterly schedule must be held and released on a predetermined schedule in coordination with CMS. Emergency changes may be released as problems are identified without prior approval. The schedule for follow-up release of changes must be forwarded to your CMS system maintenance lead or CMS project officer for prior approval.

Follow-up release changes are to be limited to the correction of priority 1 and 2 problems and errors that prevent effective operation of the production system. Priority 3, priority 4 and/or priority 5 problems may be corrected in a follow-up release when pre-approved by CMS. The CMS maintenance lead will advise you of the approval decision within 24 – 48 hours.

If a system problem is identified, Medicare organizations must submit documentation to their CMS system maintenance lead outlining the problem and the reason correction is needed at this time. Section V of this instruction outlines the minimum information required by CMS for approval.

Problem Priority Classifications for Follow-Up Releases

Listed below are CMS's problem priority classifications and examples. These are similar to the problem priority classifications that were used for the Y2K re-certification testing period.

Priority 1 Classification

Production:

The problem prevents the accomplishment of a mission critical capability for which no acceptable workaround is known.*

This priority also includes problems where code must be fixed immediately in order for the normal production region functions or services to continue. For example, if the production region is down in a job resulting in an incomplete cycle or the system is pricing a significant volume of claims incorrectly causing over or under payment. The maintainer may make priority 1 changes on its own authority. These corrections must be reported to the CMS maintenance lead or to the project officer the next business day.

EXAMPLES:

- ABENDS on-line or batch (Inability to run a cycle)
- Inaccurate payment or no payment of claims (significant impact/high volume)

- Necessary file updates cannot be accomplished (payment files, history files)
- Interface failures affecting claims processing

Beta/User Acceptance Testing:

The problem would prevent the accomplishment of a mission critical capability if the current test software is moved into the production environment. This priority also includes problems where code must be fixed immediately in order for the normal test region functions or services to continue. For example, if the test region is down in a job causing the cycle to not complete or the system is pricing claims incorrectly with a potentially significant claim volume or payment impact, the issue would be classified as a priority 1. The maintainer must work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- ABENDS; inability to run a cycle or test
- Inaccurate payment or no payment of claims (potentially significant impact)
- Necessary file updates cannot be accomplished (payment files, history files)
- Interface failures affecting test conditions

Priority 2 Classification

Production:

The problem adversely affects the accomplishment of a mission critical capability so as to degrade performance and for which no acceptable work-around is known.* This means the problem adversely affects the payment of benefits with a small claim volume or payment impact, the completion of CMS required reporting, or inaccurate information is being sent providers, beneficiaries or CMS. For example, if the information on an outgoing document to the provider community or Medicare Summary Notice is incorrect, the issue would be classified as a priority 2. The system maintainer must work with the CMS maintenance lead for approval to implement a fix.

EXAMPLES:

- Inaccurate payment or no payment of claims (small impact/low volume)
- Inaccurate CMS required report
- Inaccurate messages to the beneficiary, provider or CMS
- ABENDs with limited impact (ex. One contractor)

Beta/User Acceptance Testing:

The problem would adversely affect the accomplishment of a mission critical capability so as to degrade performance if current test software is moved into the production environment. This means the problem adversely affects the payment of benefits with a potentially small claim volume or payment impact, the completion of CMS required reporting, or inaccurate information is being sent to providers, beneficiaries or CMS. For example, if the information on an outgoing document to the provider community is

incorrect, the issue would be classified as a priority 2. The maintainer must work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- Inaccurate payment or no payment of claims (potentially small impact)
- Inaccurate CMS required report
- Inaccurate messages to the beneficiary, provider or CMS

Priority 3 Classification

Production:

The problem adversely affects the accomplishment of mission critical capability so as to degrade performance and for which an acceptable workaround is known.*

This means the problem could have significant impact but the work-around alleviates the impact. This allows the system maintainer adequate time to code a fix and sufficiently test before the corrected software is delivered for production installation. The system maintainer must work with the CMS maintenance lead to implement a fix.

EXAMPLES:

- Impact of problem could be significant or minimal
- Problem correctable by contractor workaround*
- ABENDs with an acceptable workaround*

Beta/User Acceptance Testing:

The problem would adversely impact the accomplishment of a mission critical capability so as to degrade performance if current test software is moved into the production environment.

If moved into the production environment before correcting an acceptable workaround could be instituted to prevent the adverse impact.** The system maintainer must work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- Potential impact of problem could be significant or minimal
- Problem affects CMS required reporting

Priority 4 Classification

Production:

The problem is an operator inconvenience or annoyance, which does not affect a required mission essential capability. The system maintainer must request approval to code and implement a fix from its CMS maintenance lead.

EXAMPLES:

- Problems affects non-mission critical functions
- Operational procedure with workload impact that should be automated
- Impact of problem is minimal
- Correctable by contractor workaround*

Beta/User Acceptance Testing:

The problem is a test inconvenience or annoyance, which does not affect a required mission essential or test capability. If moved into the production environment before correcting, an acceptable workaround could be instituted to prevent the inconvenience.** The system maintainer should work immediately to code a fix to be installed before moving the software into production.

EXAMPLES:

- Problem affects non-mission critical functions
- Operational procedure with workload impact that should be automated
- Impact of problem is minimal
- Correctable by contractor workaround*

Priority 5 Classification

Production:

All other documented system problems. These could include operator errors, an inability to reproduce the reported problem, a problem with insufficient information, or documentation errors. The system maintainer should request approval from the CMS maintenance lead before coding and implementing any system enhancements.

EXAMPLES:

- Contractor requested enhancements
- Documentation errors (i.e. Business requirements)
- Problem affects non-mission critical functions
- Minimal impact

Beta/User Acceptance Testing:

All other documented system test problems. These could include operator errors, an inability to reproduce the reported problem, a problem with insufficient information, or test documentation errors. The system maintainer should work to correct these issues as soon as possible but any system enhancements should be discussed with the CMS maintenance lead.

Examples:

- Test region or processing enhancements
- Test documentation errors (i.e. business requirements)
- Problem affects non-mission critical test functions
- Minimal impact

* An acceptable workaround is a temporary alternative solution to a confirmed problem in the shared system that will insure the contractor is able to accomplish a mission critical capability. What makes the workaround "acceptable" is it must be agreeable to both the maintainer and contractor and does not cause an excessive burden to the contractor. If the maintainer and contractor cannot come to an agreement on what is "acceptable" the decision will be made by CMS.

** CMS does not recommend using workarounds in the test region in order to "pass" test cases. The institution of a workaround should be used in order to implement a CMS mandate where the system maintainer may not have time to adequately code a fix before the software is delivered for production installation.

Routine File Maintenance/Updates

CMS does not require pre-approval or special documentation of routine file maintenance/updates or other routine activities necessary for effective operation of the Medicare system, Medicare processes and/or testing (e.g., MR/UR screen updates, provider and beneficiary file updates). All contractors and data centers should continue with their normal file maintenance routines.

Testing Prior to Installation of CMS Approved Follow-up Releases

CMS explains expectation for each Medicare organization's testing responsibility (i.e., standard system maintainer testing, contractor testing, CWF host testing, Beta testing).

Information Required for Requesting CMS Approval

The following must be submitted to the CMS maintenance lead or project officer when requesting that a problem be implemented in a follow-up release. If the system maintainer already has a process in place for communicating system problems to CMS, that process may be used as long as all information below, at a minimum, is captured.

MAINTAINER NAME:

Problem Description:

Brief non-technical business description of the fix.

How Found:

Explain how the problem was found. Also explain why you believe it was not found by release testing.

Problem Impact:

This information is needed to determine the scope of the problem in terms of payments, provider types, beneficiaries, number of potential claims impacted, it a work around is available, etc.

Problem Priority Classification:

Is this problem prioritized as an emergency, 1, 2, 3, 4, or 5.

Release Options:

Explain the options for scheduling and implementing the fix.

Technical Recommendation for Release timing:

Explain the recommended timing for installing the release.

CMS System Maintenance Leads

Maintainers must forward schedules and documentation of all changes as required in the memorandum to your CMS maintenance lead as indicated below. If your current process is to forward this information to your project officer, continue to do so. Your CMS maintenance leads will advise you of backup staff.

40.2.1 - Implementing Validated Workarounds for Shared System Claims Processing by All Medicare Contractors

Medicare contractors shall implement workarounds within the shared systems for problems when formally defined as a Priority 3 or Priority 4 without obtaining written permission from a Project Officer or Regional Office.

Shared system problems that are formally defined as a Priority 3 or a Priority 4 have acceptable workarounds which provide temporarily alternative solutions. In order for a Medicare contractor to implement a workaround, the shared system maintainer must first validate the problem, confirm that the workaround exists, is systematically viable and does not cause adverse affects. The implementation of such workarounds will eliminate delay in adjudication of Medicare claims and the payment to providers. Utilizing a Priority 3 or Priority 4 workaround shall not diminish the integrity of the shared systems and shall not include such actions as deactivating standard edits. The shared system's priorities are formally defined at Section 40.2 of this chapter.

40.3 - Standard System Testing Requirements for Maintainers, Beta Testers, and Contractors

Medicare requires implementation of a limited number of standard systems that must be used by all FIs and carriers. This eliminates the need for each Medicare Contractor to repeat development of the basic system.

CMS requires that the standard system quarterly release be subjected to the complete testing life cycle prior to production release. The goal is to ensure that all changes function as intended and that the implementation of changes does not degrade or otherwise unintentionally affect existing system capability and function prior to implementation. This requires that the standard system be subjected to all levels and types of testing including unit testing, integration testing, systems testing, functional testing, interface testing, performance testing, regression testing, and operational testing. Definitions are provided in subsection 40.3.9.

The Standard System Maintainer and the Medicare Contractor each have specific roles in testing the standard system quarterly release. Additionally, CMS contracts with an FI, Carrier, DME MAC, and CWF Host to act as a Beta tester for the FISS, MCS, VMS, and CWF systems respectively.

Effective with the January 2006 Release the CMS Single Testing Contractor (STC) will assume primary responsibility for testing the Medicare Standard Systems and CWF. The STC will be fully responsible for meeting the requirements of the Beta tester as outlined in Chapter 7, Section 40.3, including all subsections. STC interface testing with HIGLAS will be initiated in April 2006 as a shadow test on Part A. The STC shall also initiate Railroad Board (RRB) testing with the April 2006 release. Three Medicare Contractor numbers have been established to accommodate STC testing. They are 00888 for Carrier systems testing, 00388 for Fiscal Intermediary systems testing, and 44410 for DMEMAC systems testing.

This section identifies the testing responsibilities for each organization to ensure that each standard system quarterly release satisfies all CMS requirements. All organizations shall have processes in place to meet these requirements. Testing activities will generally begin 3 to 4 months in advance of the release date, particularly for standard system maintainers and the CWF maintainer.

40.3.1 – Maintainers and Beta Testers – Required Levels of Testing

Review subsection 40.3.9, Definitions, for a description of key testing terminology.

1. Maintainers of a Standard System or the CWF shall plan and execute all the essential levels of testing. At a minimum this includes Unit testing, Integration testing, System testing, and Regression testing. Maintainers are also responsible for performing Interface Testing.

2. Beta testers may initiate testing at the integration level, but are primarily dedicated to testing at the system level, including regression testing. Beta testers are also responsible for performing Interface Testing, which includes full data exchanges between the Standard system, CWF, and other systems (e.g., HIGLAS when implemented).

3. Maintainers and Beta testers shall maintain a test environment that enables system-testing activities to replicate the production environment, as closely as required to effectively test. CMS provided all Beta testers with a date simulation tool to facilitate executing test cases with future dates (e.g., service dates, admission dates) without turning off edits or altering effective dates in the test environment.

40.3.2 – Minimum Testing Standards for Maintainers and Beta Testers

1. The Standard System Maintainer (SSM), the CWF Maintainer (CWFM), and the designated Beta tester shall fully test the quarterly release to ensure it is ready to be elevated to production. For the quarterly release to be considered fully tested, all the requirements contained within the release must be tested. Maintainers and Beta testers must be able to demonstrate the degree to which each discrete requirement within a CR has been tested and by which test cases. It is therefore mandatory that the testers maintain traceability between test cases and the discrete requirements being implemented in the release. Additionally, for each CR or transmittal under test, the Maintainer and Beta tester must ensure that each discrete requirement specified in the **Business Requirements** section of any CR/transmittal has been fully tested. The Maintainer and Beta tester shall specifically:

    - Maintain a repository of Test Requirements against which all test cases must be traced.

    - Prepare and execute a set of Test Cases that demonstrate the requirements were correctly implemented for all change requests within the quarterly release.

    - Maintain traceability between each Test Case and the requirement that the case was designed to test.

2. The Maintainer and Beta tester shall distinguish each Test Requirement with a unique Requirement Identifier. The Requirement Identifier must be a number or qualifier preceded by the CMS CR number and SSM CR number, separated by dashes. The format of the Requirement Identifier is: [SSM CR No.]-[CMS CR No.]-[Requirement No.], where:

    - SSM CR No. – is a number that identifies a CMS mandate or user change request under test. Free form text can also be used to identify changes not associated with maintainer CR numbers, e.g., "Regression" to indicate regression testing. Avoid spaces and use underscore symbol "_" instead. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Requirement Identifier.

    - CMS CR No. – is a minimum 4-digit number that identifies the CMS CR associated with the maintainer CR number. If no CMS CR is associated with a maintainer CR, use "0000". Dashes are not allowed. Avoid spaces and use underscore symbol "_" instead. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Requirement Identifier.

    - Requirement No. – is a number that uniquely identifies the requirement with the CR. For any requirement taken from the Business Requirements section of a CMS CR, use the actual number from the Requirement # column. Do not repeat the CMS CR number. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Requirement Identifier.

      Example: Maintainer CR 22522 corresponds to CMS CR 2634. Business Requirement 2.8 was taken directly from CMS CR 2634. The Requirement Identifier would be 22522-2634-2.8.

3. The Maintainer and the Beta tester shall complete Test Case specifications that include specific input situations and the expected results associated with a single test purpose. Each test case specification must include the following:

    - A unique Test Case Identifier (which includes a cross-reference to the requirement in which the case is designed to test);
    - The specific objective or purpose of the case;
    - Input specifications (i.e., a description of the input situation[s]);
    - Output specifications (i.e., a description of the expected results); and
    - Intercase dependencies - in instances where the test results of one test case may impact other test cases, the test case specification must identify the other test case(s) and describe the relationship(s).

    Refer to section 40.3.10, Test Case Specification Standard, for the specific format required to electronically maintain test cases.

4. All Test Cases must contain a unique Test Case Identifier. The CMS standard for the Test Case Identifier is the Requirement Identifier, followed by a number that uniquely qualifies the test case specification, separated by a dash.

    The format of the Test Case Identifier is: [Requirement Identifier]-[Test Case Number], where:

    - Requirement Identifier – is the actual identifier of the requirement being testing by the case.
    - Test Case Number – is a number that uniquely qualifies the test case. This is generally a sequential number. This is necessary since more that one test case is often needed to test a single requirement. Dashes not allowed within this number; they are reserved for separation between the individual numbers in the Test Case Identifier.

      Example: Two test cases were developed to test the implementation of Requirement 22522-2634-2.8 (see example above). The unique Test Case Identifier for the two test cases would be 22522-2634-2.8-01 and 22522-2634-2.8-02.

5. The Maintainer and the Beta tester shall document and execute **both** positive and negative test cases to ensure the requirements of the release are correctly implemented.

    - Positive test cases are required to ensure that the system is directly fulfilling the requirements as specified. One or more positive test cases are required for each requirement. As an example, if a program mandate effects a change for services beginning on July 1, a positive test case would include service dates in July or later and validate that the actual mandate was correctly implemented.

- Negative test cases test cases are required to ensure that the system does not perform an incorrect action. As an example, if a program mandate effects a change for services beginning on July 1, a negative test case would ensure that implementing the mandate did not negatively impact claims with service dates prior to July 1. Unlike positive test cases, a negative test case may not be applicable to every requirement within a CR. Additionally, although due diligence might necessitate a negative test case, the need may be mitigated by an existing case in your regression test set.

6. The Maintainer and Beta tester shall document all test cases and the actual results for each test case electronically. Each test case and the associated results must be stored in a test management repository (i.e., TestDirector) and must at a minimum contain the data elements outlined in the CMS Test Case specification standard. See subsection 40.3.10 for the Test Case specification standard.

7. The Maintainer and Beta tester shall maintain a test log that provides a record of each test execution. Test Log requirements may be fulfilled by correctly using the TestDirector "run" feature as outlined in the Quarterly Release Test Management User Guide.

8. The Maintainer and Beta tester shall execute a full regression test set on their system for every quarterly release. Each testing entity shall perform regression testing within their designated testing window as outlined in subsection 40.3.7, Timeframe Requirements.

9. The Maintainer and Beta Tester shall perform interface testing.

    - The Maintainer and Beta Tester shall validate that all output files are correctly created by the their system. The SSM and Beta Tester shall validate that their system can accept and correctly process all input files.

    - The Standard System Maintainer and Beta Tester shall perform interface testing that includes full data exchanges (both ways) between the standard system and any principal claims processing adjudication or financial system (e.g., the CWF and HIGLAS respectively). The Beta tester is required to perform data exchanges with HIGLAS after HIGLAS is implemented at Beta tester's data center.

    - The Standard System Maintainer and Beta tester shall complete an integrated system test with the CWF. Each Maintainer and Beta tester shall coordinate the maintenance of test data baselines, such as beneficiary data, with the CWF Beta tester.

40.3.3 – Testing Standards Applicable to all Beta Testers

1. The FISS, MCS, and VMS Beta testers shall complete integrated testing with the CWF Beta tester, using coordinated beneficiary data, in the execution of their test cases. All test cases involving CWF functionality (related to claims adjudication) must be executed in an integrated test with the CWF. This requires full data exchanges between testing entities including:

    - Satellite files being sent from the standard systems to the CWF Beta tester; and

- Response files being sent from the CWF to the standard system Beta testers.

2. Each Beta tester shall:

   - Utilize the standard CMS Test Management tool and repository to documents all test cases and results.

   - Follow the procedures outlined in the Quarterly Release Test Management User Guide in order to complete the documentation of test runs and results.

3. The Beta tester shall review all Maintainer release documentation for completeness, accuracy, and usability. Any questions, problems, or issues with the documentation shall be forwarded to both the Maintainer and CMS.

4. The Beta Tester shall conduct performance testing to reasonably assure that the system provides acceptable response times, throughput rates, and processing windows and can accommodate production workloads.

5. The CMS testing requirements outlined in section 40.3 may require the Beta tester to test a specific type of bill, specialty, or claim situation for which they do not possess the required level of expertise. In these instances, the Beta tester must partner with a Medicare Contractor that possesses both the expertise and capabilities to test the specialty or claim type. As an example, should a Beta tester not have the operational capability or expertise to process Home Health claims, they are expected to partner with an RHHI to complete the required HHA testing. Ultimately, the Beta tester is responsible for ensuring all test cases are exercised. Any partnerships that are established to complete the testing requirements, shall be arranged and managed by the Beta tester.

40.3.4 – Testing Requirements Applicable to the CWF Beta Tester

The CWF Beta tester shall act as a test host and exchange data with entities testing the FISS, MCS, and VMS standard systems. The testing entities include all standard system maintainers and the standard system Beta testers.

40.3.5 – Contractor (User) Testing Requirements

Medicare Contractors are not mandated to prepare and execute test cases that cover Medicare business requirements implemented within the base system in standard system and CWF quarterly releases. Maintainers and Beta testers are fully responsible for testing the base functionality. The Medicare Contactors (users) shall test their local/unique components and conduct a limited, end-to-end, operational test.

1. Contractors shall fully test their local components and processing rules prior to production implementation of the quarterly release. This testing is applicable for all local components and processing rules modified since the previous quarterly release.

A. Contractors shall test any system components they maintain and implement to support claims processing in addition to the base system. This includes front-end and back-end components such as those for EDI entry and translation, EDI outbound processing, and printing (e.g., MSN generation).

B. Contractors shall test changes they make to user control files, facilities, and tables in order to implement new Medicare policy or business rules. Examples of these facilities include but are not limited to auto adjudication facilities (e.g., SuperOps and MCS SCF) and the MCS SPITAB.

C. A Medicare Contractor shall fully test any standard system functionality that was:

- Developed by the standard system maintainer solely for them, or
- Developed by the standard system maintainer under a special project in which they were the exclusive participant.

An example would be a carrier working with CMS on a special demonstration project. In this example the carrier shall fully test the standard system functional that was implemented for the demonstration project.

2. Contractors shall complete a limited end-to-end operational test that incorporates the standard system release, integrated with their other claims processing components. These components include the front-end for claims receipt, translators, the CWF, the financials, and back-end EDI and report generation. The test must ensure that processing is contiguous from claims entry, to claims adjudication, and ultimately remittance and Medicare Summary Notice generation. Through contiguous processing, the interfaces between all key claims processing components must be exercised. The banking system interfaces such as National Clearing House (NCH) transfers need not be exercised. The test is limited in the number of test cases that are required, since maintainers and Beta testers are testing the base functionality of the standard system.

A. Contractors shall ensure that the integrated systems software can complete cycles without system abends and produce the expected output. The Medicare Contractor shall ensure their operational test:

- Exercises all claims entry points not fully incorporated in the base system such as paper and EMC front-end components;
- Includes all allowable standard electronic formats and versions;
- Includes a variety of claims types; and
- Includes all components that support their claims workload and interfaces to the standard system.

B. The operational test shall include the most recent standard system release received prior to the initiation of the test. The Medicare Contractor shall initiate the test as required to ensure its completion and the reporting of any problem prior to production implementation.

3. CMS strongly encourages the standard system user community to promote:

   - Standardizing their system nationally,
   - Centralizing any table maintenance that implements national Medicare policy at the system maintainer level, and
   - Minimizing local variations.

4. Medicare Contractors may perform additional testing on the standard system or duplicate Beta testing tasks as time permits. At the discretion of their Regional Offices, Medicare Contractors may be required to separately document any testing they perform in addition to their mandated testing.

5. Medicare Contractors shall test any business rule or event with future dates that they code or set-up in their Auto Adjudication Software (AAS), prior to implementing the rule or event into production. Examples of AAS include but are not limited to SuperOp, SCF, the Shack, and the Mill.

   a. Fiscal Intermediaries and Part A/B Medicare Administrative Contractors (MACS) shall submit their date simulation recommendations to the FISS FWG in advance and participate in discussions at the FWG calls, as required to reach consensus on a date simulation schedule.

   b. Carriers and Part A/B MACS shall submit their date simulation recommendations to the MCS FWG in advance and participate in discussions at the FWG calls, as required to reach consensus on a date simulation schedule.

   c. DME-MACS shall submit their date simulation recommendations to the DMOP TAG in advance and participate in discussions at the DMOP TAG calls, as required to reach consensus on a date simulation schedule.

   d. The FISS FWG, MCS FWG, and DMOP TAG shall use the "system date request process" to provide the EDC(s) their latest "run-date simulation" schedule for their FISS, MCS, and VMS UAT environments.

   e. The FWG or DMOP TAG shall maintain their "run-date simulation" schedule for a **minimum** of 14 calendars days in advance. Here is an example of a "run-date simulation" schedule:

Calendar Date	System Run Date	Calendar Date	System Run Date	Calendar Date	System Run Date
09/08/2008	10/01/2008	09/17/2008	11/01/2008	09/26/2008	12/05/2008
09/09/2008	10/02/2008	09/18/2008	11/02/2008	09/27/2008	12/06/2008
09/10/2008	10/03/2008	09/19/2008	12/05/2008	09/28/2008	12/08/2008

09/11/2008	10/04/2008	09/20/2008	12/06/2008	09/29/2008	12/09/2008
09/12/2008	10/14/2008	09/21/2008	12/07/2008	09/30/2008	12/10/2008
09/13/2008	10/15/2008	09/22/2008	10/17/2008	10/01/2008	12/11/2008
09/14/2008	10/16/2008	09/23/2008	10/31/2008	10/02/2008	12/12/2008
09/15/2008	10/17/2008	09/24/2008	11/01/2008	10/03/2008	10/03/2008
09/16/2008	10/31/2008	09/25/2008	11/02/2008	10/04/2008	10/04/2008

f. The FISS FWG, MCS FWG, and DMOP TAG shall provide a copy of their "run-date simulation" schedule to their CWF test host.

g. The FISS FWG and MCS FWG shall provide a copy of their "run-date simulation" schedule to the HIGLAS test site as required to accommodate their HIGLAS enabled contractors.

40.3.6 – Testing Requirements Applicable to all CWF Data Centers (Hosts)

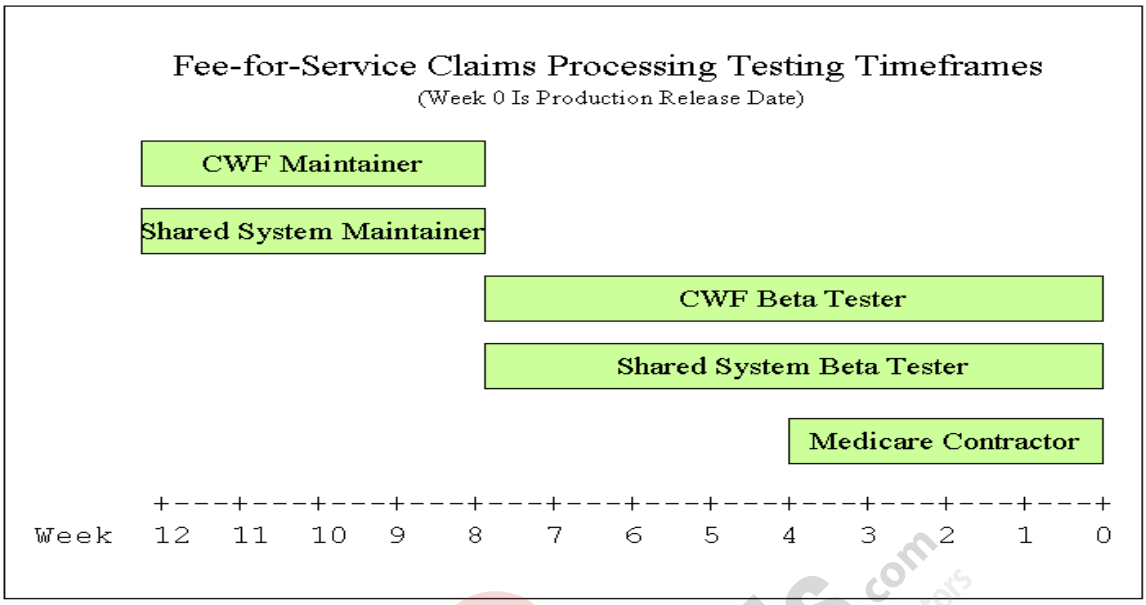
Each CWF data center or CWF sector host shall:

- Forward all satellite software and documentation to the satellites (contractors) to which they serve as the primary production host;
- Install the CWF quarterly release software in a designated test region;
- Make the designated test region available their satellites (users) for testing;
- Coordinate test data, such as beneficiary data, with the user testers;
- Process all satellite files submitted by the users and return all corresponding reply files generated for users;
- Report release problems to the CWF Maintainer and CMS;
- Verify with CMS that each of its satellites submitted at least one test file during user testing; and
- The CWF Host shall support future date testing by the FIs, Carriers, and MACs.
- The CWF Host shall review date simulation schedule submitted by the FISS FWG, MCS FWG, and DMOP TAG.

40.3.7 – Timeframe Requirements for all Testing Entities

The SSM, CWFM, Beta tester, and Medicare Contractor shall operate under the testing timeframes shown below for each quarterly release:

Timeframe Requirements for Testing Entities



1. The Medicare **Contractor** or **User** testing period shall begin four weeks prior to production implementation.

2. The **Beta** testing period shall begin eight weeks prior to production implementation. The CWF and standard system Beta testers shall have an exclusive four-week testing timeframe prior to the initiation of user testing.

    - The Beta tester shall complete a functional System Test and Regression Test before the standard system is released to the User community.

    - Beta testing must also continue through the User testing period. The Beta tester may initiate performance testing during the user testing period.

3. Exclusive CWFM and SSM testing shall continue until Beta testing is initiated eight weeks prior to production implementation. The SSM and CWFM shall complete a Unit Test (on all components), Integration Test, System Test, and Regression Test prior to distributing the standard system release to the designated Beta tester. For all integration, system, and regression testing, the SSM shall use the most recent version of any third party or CMS provided software components (e.g., Pricer, OCE, MCE, Grouper) they are provided. The SSM shall continue testing beyond the exclusive maintainer-testing window due to the late receipt of some third party or CMS provided software components such as the Pricers and OCE.

40.3.8 – Testing Documentation Requirements

1. The SSM, Beta tester, and Medicare Contractor shall maintain documentation that fully demonstrates the requirements of this transmittal were met for each quarterly release. At a minimum the SSM, Beta tester, and Medicare Contractor shall maintain the following test documentation to demonstrate full compliance:

    - Test Requirement and Test Case repository with traceability;
    - Test Log;
    - Test Status for the execution (run) of each test case (i.e., Pass, Fail, Not Run);
    - Actual Results for the run of each test case in which the actual results did not match the expected results; and
    - Documented proof of each test run, i.e., screen shots, scheduler job logs, etc.

2. The SSM, Beta tester, and Medicare Contractor shall:

    - Maintain all test documentation for the four quarterly releases prior to the current release under test. The documentation must be available for review by CMS (or its agent).
    - Document all software defects (problems) within the CMS specified repository such as INFOMAN.

3. The SSM shall communicate all confirmed software defects (problems) and fixes directly to CMS in writing through their CMS Maintenance Lead or other designee as specified by the CMS Project Officer.

4. The Medicare Contractor shall provide any testing documentation to their CMS regional office upon request.

Additional requirements for selected standard system and CWF maintainers, Beta test sites, and CWF hosts may be contained in these organizations' individual contracts. Electronic screen shots may be incorporated/attached into the results of TestDirector has proof of online results. Test Log requirements may be fulfilled by correctly using the TestDirector “run” feature as outlined in the Quarterly Release Test Management User Guide.

40.3.9 – Definitions

These definitions are provided to ensure common understanding.

Base Standard System - The FISS, MCS, VMS, or CWF system, which is routinely released by the Standard System Maintainer (i.e., Pinnacle, EDS, ViPS) to their respective user community prior to any user customization. This includes all components released by the Maintainer, including but not limited to the claim adjudication subsystem, the financial subsystems, and other integrated components (i.e., Pricer, OCE, MCE, Grouper).

Functional Testing – Testing to ensure that the functional requirements have been met.

Integration Testing – Testing combinations of interacting software components the make up parts of a system.

Interface Testing – Testing conducted to evaluate whether subsystems or systems pass data and control to one another correctly.

Local Components – A Local Component as referenced in section 40.3 is any component or module that supports Medicare claims processing, but is not part of the Base System and is under the control and maintenance of the Medicare Contractor (i.e., FI, Carrier, A/B MAC, or DMEMAC/DMERC).

Maintainer – The Maintainer is an entity to which CMS directly contracts to maintain a Medicare claim processing standard system (FISS, MCS, VMS, or NGD) or the Common Working File (CWF) system. The Maintainer, as referenced in section 40.3, does not refer to an entity to which a Medicare Contractor (Carrier, Fiscal Intermediary, or DME Regional Contractor) subcontracts to operate their data center or perform other claim processing support activities.

Operational Testing – Testing conducted to evaluate a system in its operational environment. Testing to ensure that the aggregate operational systems and their interfaces can be operated securely with the instructions provided.

Performance Testing – Testing that applies heavy transaction and processing loads to the system to ensure that response times, throughput rates, and processing windows remain acceptable and can accommodate production workloads.

Regression Testing – Testing conducted on a system or components to verify that modifications have not caused unintended effects and that the system or components still complies with its requirements.

Regression Test Set – A set of selectable test cases designed to exercise a system over its functional capabilities and assure that it still works properly after changes have been applied.

Requirement Identifier – A unique number assigned to each requirement comprised of the Standard System Maintainer CR Number, the CMS CR Number, and an alphanumeric element to uniquely qualify each requirement. For testing purposes CMS requires that each Test Case Identifier incorporate the Requirement Identifier to which it is traced.

Stress Testing – Testing that applies a steadily increasing load to the system until it reaches the point where performance degrades to unacceptable levels.

System Testing – Testing to discover any incorrect implementation of the requirements or incompatibilities in the software/hardware environment. System testing includes functional testing, performance testing, and operational testing.

Test Case Specification – A description of an input situation and of the required results associated with a specific test objective or purpose.

Test Case Identifier – A unique identifier assigned to each test case.

Test Log – A chronological record of relevant detail about the execution of tests. Relevant details include run date, run time, test status, and actual results.

Test Requirement - A specific requirement that is under test and to which one or more test cases are traced. Test requirements may be derived from various types of requirements i.e., business functional requirements, performance requirements etc. Note: Any well-written requirement that is "testable" may be considered a Test Requirement. Any requirement contained in the Business Requirements section of a CR or transmittal, also constitutes a test requirement.

Test Set – A collection of test cases that have a common usage.

Unit Testing – The testing of individual units (i.e., software components, modules) or groups of related units. It is the lowest level of testing and is usually performed by programmers. Unit testing may be both functional (requirements oriented) and structural (i.e. logic oriented, code coverage oriented).

40.3.10 - Test Case Specification Standard

Purpose: This standard establishes a controlled outline for the contents and presentation of a Test Case Specification used by the standard system maintainers and the Beta testing contractors.

Applicability: This standard is applicable to all Test Case Specifications developed by the standard system maintainers and the Beta testing contractors.

Data Element	Description	Allowable Values or Format	Comments
Test Case Specification Identifier	Multi-part indicator that uniquely identifies the test case specification.	See Test Case Specification Identifier Standard.	
Test Purpose	A free form field that captures the intent of the test and identifies any key components of the test, e.g., specific codes.	See attached example.	

Input Specification	A free form field that captures critical information used to exercise the system functionality. Information could be grouped into the following topics: Claim Data Requirements Claims History Beneficiary Information Provider Information	See attached example.	
Intercase Dependencies (Predecessor Transaction Identifier)	The test case specification identifier of the transaction that must be entered into and processed by the system prior to processing the transaction described by the test case specification.	See Test Case Specification Identifier Standard.	
Output Specification	A free form declarative statement that identifies the expected results from performing all the steps, as a collection, within the test.		
Test Type	A one-character indicator to identify whether the test is positive or negative.	P = Positive Test N = Negative Test	**TestDirector Plan Tab** **(Required User Defined Fields)**
Originator	A one-character indicator to identify the originating entity (designer) of the test case.	B = Beta C = CMS/QRTM M = Maintainer	
Test Status	Summary indicator for a test case.	PS = Passed FA= Failed NR = Not Run IN = Incomplete ID = Invalid Data IC = Invalid Case	**Required** **Test Execution (Run)** **Elements**

Test Results	Free form declarative statement of actual results for a test case when the actual results do not match the expected results.		

Optional Information: Industry best practices demonstrate that additional granularity may be necessary to document discrete key test actions that should be executed and documented. These items are referred to as test steps. A test case specification may have one or more test steps. When documenting test steps, the following standard applies:

Step Number	Unique identifier for each test step.	"Step n" Where "n" is a sequential counter for each step starting at 1. There is at least one test step in each test case specification, but usually contains multiple test steps.	**Optional Test Case Elements**
Step Description	A free form declarative statement that identifies the action taken to perform the test. The step description statement usually begins with a verb.		
Expected Step Results	A free form declarative statement that identifies the expected results from performing the associated step description.		

Example #1

	Test Case Identifier	4393-2342-12.1-001
	Test Purpose	To confirm that the FI claims processing systems accept, process and assign a reason code to Hospital claims with services denied based on a Local Medical Review Policy (LMRP) submitted on Type of Bill (TOB) 141 (Hospital other or referred diagnostic services; admit through discharge), generating Medicare Summary Notice (MSN) message 15.20 (The following policies were used when we made this decision) auto-filling LMRP identification (ID) number L481 (Breast Imaging; Mammography/Breast Echography [Sonography]/Breast) associated with the edit for each fully denied service.
Input Specification	**Claims History**	Mammography service previously rendered and paid $\leq$ 11 months
	Beneficiary Information	Beneficiary has elected English as primary language. Female Age: $\geq$ 40
	Provider Information	Provider Number Range: XX0001 - XX0999
	Claim Data Requirements	TOB: 141 (Hospital other or referred diagnostic services; admit through discharge) Revenue Code #1: 403 (Other imaging services; screening mammography) Units #1: 1 HCPCS Code #1: 76091 (Mammography; bilateral) Revenue Code #2: 403 (Other imaging services; screening mammography) Units #2: 1 HCPCS Code #2: 76092 (Screening mammography; bilateral [two view film study of each breast]) Diagnosis Code: V76.12 (Other screening mammography)
	Intercase Dependencies	None
	Output Specification	Claim will be assigned a reason code indicating services denied based on LMRP ID# L481, generating MSN message 15.20.
	Test Type	P
	Originator	C
	Test Status	PS
	Test Results	Claim was assigned appropriate reason code

Example #2

	Test Case Identifier	4419-2825-5.2-001
	Test Purpose	To confirm that the FI claims processing systems accept, process, and assign reason code 30 (Payment adjusted because the patient has not met the required eligibility, spend down, waiting or residency requirements) to Inpatient Hospital claims submitted on Type of bill (TOB) 111 (Hospital Inpatient Part A; admit through discharge) with Dates of Service (DOS) on 01/01/2004 when a beneficiary is not lawfully present in the United States.
Input Specification	**Claims History**	None
	Beneficiary Information	Beneficiary must be unlawfully present in United States. Beneficiary elected English as primary language
	Provider Information	Provider Number Range = XX0001-XX0999
	Claim Data Requirements	TOB = 111 DOS = 01/01/2004
	Intercase Dependencies	None
	Output Specification	Claim will be assigned reason code 30 indicating beneficiary is not lawfully present in the United States, generating MSN message 5.7 (Medicare payment may not be made for the item or service because on the date of service, you were not lawfully present in the United States).
	Test Type	P
	Originator	C
	Test Status	PS
	Test Results	Claim was assigned appropriate reason code

40.3.11 - Next Generation Desktop (NGD) Maintainer Requirements

CMS is continuing to fully deploy the Next Generation Desktop (NGD) to the contractors' beneficiary customer service departments. The NGD is a single call center application that will be used by Medicare Customer Service Representatives (CSRs) to answer inquiries and perform operations on behalf of CMS beneficiaries and the American public.

The NGD is designed to pull customer service-needed information into a common desktop application. As such, the NGD requires data exchange with CMS shared systems (VMS, CWF, FISS, MCS) and standard systems (EDB/MBD, MBR, GHP/MMCS). Note: NGD may integrate with additional systems as future releases are developed.

Because NGD integrates with the shared systems, periodic changes will be made as a result of the shared systems quarterly release process. The NGD maintainer will be required to update NGD as part of either a service pack or a patch to the system. The NGD maintainer will be required to perform the various activities associated with changes to the NGD (i.e., unit and system testing). In addition to the shared systems quarterly release schedule, the NGD will adhere to a separate quarterly release process for NGD-specific updates and defect correction.

The NGD maintainer shall follow all of the requirements identified in Section 40.3 for the shared system maintainers except as indicated below:

1. Section 40.3.1 Maintainers and Beta Testers –Required Levels of Testing, #3 is not applicable to NGD Beta testers.

2. Section 40.3.2 (#2) Minimum Testing Standards for Maintainers and Beta Testers, for NGD naming conventions, the NGD Maintainer should refer to the NGD test Plan.

3. Section 40.3.2 (#4) Minimum Testing Standards for Maintainers and Beta Testers, for NGD test case identifiers, the NGD maintainer should refer to the NGD System Test Plan.

4. Section 40.3.7 Timeframe Requirements for Testing Entities – NGD testing timeframes are as follows:

- The NGD User testing period shall begin 2 weeks prior to production implementation.

- The NGD Beta testing period shall begin 4 weeks prior to production implementation. The NDG Beta testers shall have an exclusive 2 week testing timeframe prior to the initiation of user testing.

  -The Beta tester shall complete a functional System Test and Regression Test before the system is released to the User community.

  -Beta testing must also continue through the User testing period.

- Exclusive NGD System Maintainer testing shall continue until Beta testing is initiated 4 weeks prior to production implementation. The NGD Maintainer shall complete a Unit Test (on all components), Integration Test, System Test, and Regression Test prior to distributing the shared system release to the designated Beta Tester.

5. Section 40.3.8 Testing Documentation Requirements (#2) For NGD, documentation of all software defects (problems) should be through ClearQuest.

50 – Contractor Implementation of Change Requests *and Compliance with Technical Direction Letters*

POLICY

The contractors must implement change requests (CRs) *and comply with technical direction letters (TDLs)*. The CMS expects contractors to implement all issued CRs *and comply with all issued TDLs*. A CMS Central Office (CO) representative will send to contractors on a quarterly basis, a TDL that includes a sample Cover Letter/Attestation Statement, and instructions for completing and downloading these reports.

The CR Implementation Report will contain all CRs to be implemented within that fiscal quarter. *Analysis and Design CRs for Shared System Maintainers will not be included in the report, therefore, contractors will not be required to report on "For Analysis Only" CRs. In addition, contractors will not be required to add "For Analysis Only CRs" to the "CRs Added by Contractor" section of the report.*

The TDL Compliance Report will contain all TDLs issued that fiscal quarter, with the exception of contractor-specific TDLs. TDLs issued to a specific contractor or contractors shall be added by that contractor in the "TDLs Added by Contractor" section of the report.

CMS will notify the contractors, via a TDL within one week of the end of the fiscal quarter that the reports are available to download via the Electronic Change Information Management Portal (eChimp). The contractors shall enter all applicable information into the reports and send the completed reports to the CMS CO mailbox at CR_IMPL_REPORTS@cms.hhs.gov. NOTE: There are no spaces in this Web address. Underscore "_" separates the words CR_IMPL_REPORTS. The reports are due no later than the 28th of the month in which the reports are due. If the report due date of the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date. Each MAC shall also send a copy of the report to its respective deliverables mailbox or to the CMS ART system, pending direction from the MAC Contracting Officer's Technical Representative (COTR).

Each MAC shall complete and submit one CR Implementation Report by jurisdiction, one TDL Compliance Report by jurisdiction, a cover Letter/Attestation Statement, and if necessary, a separate explanation document that is no longer than one page for each CR or TDL. This explanation document would explain, for example, why the CR or TDL was not implemented/complied with at all or not implemented/complied with timely.

Each *legacy* contractor shall complete *and submit* one CR Implementation Report *by contract number, one TDL Compliance Report by contract number*, a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each CR *or TDL*. This explanation document would explain, for example, why the CR *or TDL* was not implemented*/complied with* at all or not implemented*/complied with* timely.

- Quarter 1 includes October, November and December. The report for Quarter 1 is due no later than February 28th.
- Quarter 2 includes January, February and March. The report for Quarter 2 is due no later than May 28th.
- Quarter 3 includes April, May and June. The report for Quarter 3 is due no later than August 28th.

- Quarter 4 includes July, August and September. The report for Quarter 4 is due no later than November 28th.

In addition, each contractor shall write and maintain written procedures on its change management process (i.e., Standard Operating Procedures – SOP). Elements should include, but are not limited to, written procedures for the timely downloading of CMS instructions (issued CRs) from the CMS DRIMAILBOX, written procedures of the contractor's CR *and TDL* distribution process (including, but not limited to, the dissemination of provider education information), written procedures for CR implementation *and TDL compliance* (including written documentation to verify implementation*/compliance*).

Contractors shall retain the written documentation to verify CR *and TDL* implementation*/compliance* using CMS's records retention guidelines.

Upon request from CMS, contractors shall supply the written procedures of their change management process, as well as written documentation to verify CR *and TDL* implementation*/compliance* to CMS.

Implementation Date

I. Definition

Refer to section 50.4.2 of this chapter for the definition of the implementation date.

II. Supporting Information

For any instruction affecting providers, regardless if there are systems or non-systems changes, CMS gives at least 90 days' advance notice to the providers. That is, CMS must issue the instruction at least 90 days prior to the implementation date to give providers enough time to implement the instruction. The vehicle used to alert providers 90 days prior to an instruction's implementation date is the CMS Quarterly Provider Update, which can be accessed at: http://www.cms.hhs.gov/QuarterlyProviderUpdates/01_Overview.asp

There are four exceptions to the 90 days' advance notice policy: (1) the instruction is contractor specific and therefore does not affect providers; (2) the instruction is a correction/clarification where the previously issued instruction contained typos or errors of fact or omissions; (3) the instruction is a routine or recurring item (which qualifies it to be included on the Mid-Quarter List in the Provider Update); and (4) the instruction is approved by the CMS Administrator to be published immediately or by a certain date.

For a system change, the initiator of the CR will specify an implementation date that corresponds to one of the quarterly release dates. Usually, the quarterly release date will be the first Monday of the quarter. *Non-recurring system changes are usually issued five months in advance of the implementation date.* On occasion, an off-cycle release date can be approved by OSORA and/or the Administrator. This exception tends to occur most frequently with the implementation of National Coverage Determinations (NCDs) *and corrections to finals*.

For a non-system change that has no impact on providers, the initiator of the CR may specify the implementation date as 30 days from issuance. *For a non-system change that has provider impact, the initiator of the CR may specify the implementation date as 90 days from issuance*.

After the comment period ends and the initiator of the CR has addressed all comments, he/she prepares a final CR package for CMS clearance. The last part of the CMS clearance process involves obtaining approval from the Medicare Change Control Board (MCCB). The MCCB, in consultation with the initiator of the CR, will determine the time period needed for implementing each change request. After the clearance process is completed, the Office of Strategic Operations and Regulatory Affairs/Issuances & Records Management Group (OSORA/IRMG) will insert the actual implementation date before issuing the CR as a final instruction.

COMPLETING AND SUBMITTING THE QUARTERLY CR IMPLEMENTATION REPORT

A/B MACs and DME MACs shall complete the CR Implementation Report, as follows for each jurisdiction. MACs with multiple jurisdictions shall complete a separate sheet within the Excel workbook for each jurisdiction. Intermediaries, Carriers *and* RHHIs shall complete the CR Implementation Report, as *follows*, for each contractor number. *Legacy contractors with multiple contractor numbers shall complete a separate sheet within the Excel workbook for each contractor number.*

Header Rows

The report contains four header rows.

1. *Header Row 1, Contains the title, "CR Implementation Report (CRIR) – Quarter X (MMM-MMM) YYYY," where X is the number of the quarter, MMM-MMM are the months included in that quarter, and YYYY is the Calendar Year. This data will be completed by CMS CO.*

2. Item 1: *Header Row 2,* Contractors shall enter the "Contractor Name" in Item 1 of the report.

3. Item 2: *Header Row 2,* Contractors shall enter *the "Date Report Submitted" to CMS* in Item 2 of the report *in MM/DD/YYYY*. [*This is the date the report is e-mailed to CMS CO.]*

4. Item 3: *Header Row 2, Report Due. This is the date the report is due to CMS CO. This date will be completed by CMS CO.*

5. Item 4: *Header Row 3, Jurisdiction. MACs shall enter the Jurisdiction pertaining to this report. Legacy contractors shall not complete this field.*

6. Item 5: *Header Row 3, CRIR Contractor Contact.* Contractors shall *enter the first and last name of the individual CMS CO should contact to ask questions regarding information in this report.*

7. Item 6: *Header Row 4, Contractor Number. Legacy* Contractors shall enter *the contractor number associated with this report. MACs shall not complete this field.*

8. *Item 7: Header Row 4, Contact Phone Number.* Contractors shall enter the *phone number in xxx-xxx-xxxx format for the contact named in Item 5.*

Details Rows

Below the header Rows, Detail Rows shall be completed as follows:

1. Item 8: *No. This field contains a consecutive number to track the number of CRs on the report. CMS CO will complete this field for all CRs included on the report by CO. If the contractor adds additional CRs in the section "CRs Added by Contractor", they should continue numbering from the previous CMS entered row in item 8a. For example, if CMS included 15 CRs on the report, the contractor shall begin numbering in this field with 16.*

2. Item 9: *CMS CR #. CMS CO will complete this field with the CMS CR numbers issued during the quarter. [If contractors believe CMS inadvertently omitted a CR that should have been included in the report, the contractor shall complete item 9a below the "CRs Added by Contractor" heading for each CR number added.]*

3. Item *10: CMS Transmittal #. CMS CO will complete this field with the CMS CR transmittal numbers issued during the quarter. If a CR was issued with multiple transmittals, the word "multiple" will be entered in this field. [If contractors believe CMS inadvertently omitted a CR that should have been included in the report, the contractor shall complete item 10a below the "CRs Added by Contractor" heading for each CR number added.]*

4. Item *11: Subject. CMS CO will complete this field with the subject for all CMS CRs issued during the quarter. [If contractors believe CMS inadvertently omitted a CR that should have been included in the report, the contractor shall complete item 11a below the "CRs Added by Contractor" heading for each CR number added.]*

5. Item *12*: *CMS Published Impl. Date MM/DD/YYYY. CMS CO will complete this field with the CMS Published Implementation date in MM/DD/YYYY format for all CRs issued during the quarter. [If contractors believe CMS inadvertently omitted a CR that should have been included in the report, the contractor shall complete item 12a below the "CRs Added by Contractor" heading for each CR number added.]*

6. Item *13*: *Applicable Workload? (Y/N).* Contractors shall *complete this field for all CRs on the report with a 'Y' if the CR is applicable to their Part A and/or Part B or the DME Workload, or a 'N' if the CR is not applicable to their Part A and/or Part B or the DME workload. The CR is considered applicable to the contractor if any of the business requirements in the CR were required to be implemented by the contractor in the reporting period. [If contractors believe CMS inadvertently omitted a CR that should have been included in the report, the contractor shall complete item 13a below the "CRs Added by Contractor" heading for each CR number added.]*

7. Item 1*4*: Contractor *Actual Impl. Date: MM/DD/YYYY. Contractors* shall enter *the date in (MM/DD/YYYY format) on which all requirements for the CR that apply to the*

contractor and were due to be implemented in the reporting period were actually complete. If the CR is not applicable to the contractor (the contractor answered 'N' for Item 13) then this field shall remain blank. [If contractors believe CMS inadvertently omitted a CR that should have been included in the report, the contractor shall complete item 14a below the "CRs Added by Contractor" heading for each CR number added.]

8. *Item 15: Comments/Reasons for Delay in Implementation. If the contractor did not meet the implementation date for the CR (the date entered in Item 14 is after the date entered in Item 12), the contractor shall select one of the following reasons from the drop-down list in this field:*

   a. 01-Due date changed due to TDL
   b. 02-MLN Delay
   c. 03-CMS Delay
   d. 04-CR Approved or Pending a Waiver
   e. 05-Other

   If the delayed implementation of a CR is due to an MLN Delay, contractors shall leave the implementation date field blank, select 02 – MLN Delay and report the CR in the next quarter with an implementation date that corresponds with the date of the published newsletter.

9. Item 16: *Additional Explanation.* Contractors shall enter *additional comments regarding the implementation of this CR in this field.*

   a. This field is required if contractor responded '05-Other' in Item 15.

   b. This field is required if contractor responded '04-CR Approved or Pending Waiver in Item 15

      i. If approved, the waiver number (in the following format: "DB-xxx") shall be entered. [The waiver number is the tracking number CMS assigns to the waiver. It is located in the upper left section of the waiver letter.]

      ii. If a contractor to date has not received an approval or denial from CMS for the waiver, the contractor shall enter the comment "pending waiver" and the date of the waiver request (in MM/DD/YY format).

      iii. There are no waivers for MACs regarding the implementation of CRs.

   c. While not required, contractors are also encouraged to include any additional information they feel CMS may find useful in reviewing this report in Item 16.

   d. If comments exceed 100 characters, the contractors shall submit with the completed CR Implementation Report a separate explanation document, no longer

than one page, for each CR that is not implemented by the CMS Published Implementation Date.

10. *CRIR Totals. This section summarizes the totals for the detail rows for the page(s).*

    a. *Item 17. Number of CRs CMS Included In This Report. This field is completed by the CMS CO.*

    b. *Item 18. Number of CRs Contractor Included In This Report. This field is completed by the contractor.*

    c. *Item 19. Total Number of CRs In This Report. This field is calculated. The contractor shall not update this field.*

    d. *Item 20. Number of CRs applicable To Contractor. This field is completed by the contractor.*

    e. *Item 21. Number of Applicable CRs Completed by Implementation Date. This field is calculated. The contractor shall not update this field.*

    f. *Item 22. % of Applicable CRs Completed by Implementation Date. This field is calculated. The contractor shall not update this field.*

    g. *Item 23. Reasons for Delay. These fields are calculated. The contractor shall not update this field.*

    h. *Item 24. # of CRs Not Implemented by Published Implementation Date. This field is calculated. The contractor shall not update this field.*

11. *Each Legacy Contractor shall,* by contractor number, submit, via e-mail and by the report due date, one completed CR Implementation Report (which includes an Excel Report(s), a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each CR) to the CMS CO mailbox. [The CMS CO mailbox is: CR_IMPL_REPORTS@cms.hhs.gov. NOTE: There are no spaces in this web address. Underscore "_" separates the words CR_IMPL_REPORTS.] If the report due date of the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date.

12. *Each MAC shall by jurisdiction submit, via e-mail and by the report due date, one completed CR Implementation Report (which includes an Excel Report(s), a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each CR) to the CMS CO mailbox. [The CMS CO mailbox is: CR_IMPL_REPORTS@cms.hhs.gov. NOTE: There are no spaces in this Web address. Underscore "_" separates the words CR_IMPL_REPORTS.] If the report due date of the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date.*

13. *Each MAC shall also send a copy of the report to its respective deliverables mailbox or to the CMS ART system, pending direction from their MAC Contracting Officer's Technical Representative.*

COMPLETING AND SUBMITTING THE QUARTERLY TDL COMPLIANCE REPORT

A/B MACs and DME MACs shall complete the TDL Compliance Report, as follows for each jurisdiction. MACs with multiple jurisdictions shall complete a separate sheet within the Excel workbook for each jurisdiction. Intermediaries, Carriers, RHHIs, A/B MACs and DME MACs shall complete the TDL Compliance Report as follows for each contractor number. Legacy contractors with multiple contractor numbers shall complete a separate sheet within the Excel workbook for each contractor number.

Header Rows

The report contains four header rows.

1. *Header Row 1, Contains the title, "TDL Compliance Report (TCR) – Quarter X (MMM-MMM) YYYY," where X is the number of the quarter, MMM-MMM are the months included in that quarter, and YYYY is the Calendar Year. This data will be completed by CMS CO.*

2. *Item 1: Header Row 2, Contractors shall enter the "Contractor Name" in Item 1 of the report.*

3. *Item 2: Header Row 2, Contractors shall enter the "Date Report Submitted" to CMS in Item 2 of the report in MM/DD/YYYY format. [This is the date the report is e-mailed to CMS CO.]*

4. *Item 3: Header Row 2, Report Due. This is the date the report is due to CMS CO. This date will be completed by CMS CO.*

5. *Item 4: Header Row 3, Jurisdiction. MACs shall enter the Jurisdiction pertaining to this report. Legacy contractors shall not complete this field.*

6. *Item 5: Header Row 3, TCR Contractor Contact. Contractors shall enter the first and last name of the individual CMS CO should contact to ask questions regarding information in this report.*

7. *Item 6: Header Row 4, Contractor Number. Legacy Contractors shall enter the contractor number associated with this contract. MACs shall not complete this field.*

8. *Item 7: Header Row 4, Contact Phone Number. Contractors shall enter the phone number for the contact named in Item 5.*

Detail Rows

Below the Header Rows, Detail Rows shall be completed as follows:

1. *Item 8: No. This field contains a consecutive number to track the number of TDLs on the report. CMS CO will complete this field for all TDLs included on the report by CO. If the contractor adds additional TDLs in the section "TDLs Added by Contractor", they should continue numbering from the previous CMS entered row in item 8a. For example, if CMS included 15 TDLs on the report, the contractor shall begin numbering in this field with 16.*

2. *Item 9: TDL #. CMS CO will complete this field with the TDL number for each public TDL issued during the quarter. There are some TDLs that are not issued to all contractors. Contractors who received a TDL during the reporting period that was not included in the top portion of the report by CMS CO should include that TDL number in item 9a below the TDLs Added by Contractor heading for each TDL number added.*

3. *Item 10: CMS Component. CMS CO will complete this field with the CMS Component responsible for issuing the TDL. [If contractors added TDLs to the section "TDLs Added by Contractor" they do not need to complete item 10a for those TDLs.]*

4. *Item 11: Subject. CMS CO will complete this field with the subject for all TDLs issued during the quarter. [If contractors added TDLs to the section "TDLs Added by Contractor" item 11a shall be completed by the contractor with the subject for those TDLs.]*

5. *Item 12: CMS Issued Date MM/DD/YYYY. CMS CO will complete this field with the Issued date in MM/DD/YYYY format for all TDLs issued during the quarter. [If contractors added TDLs to the section "TDLs Added by Contractor" item 12a shall be completed by the contractor with the issued date for those TDLs.]*

6. *Item 13: Contractor Compliance? (Yes or No). Contractors shall complete this field for all TDLs on the report with a Yes, if the contractor has received, reviewed and complied with the instructions in the TDL, if applicable to the contractor. Contractors shall complete this field for all TDLs on the report with a No if the contractor has received and reviewed, but has not complied with the instructions in the TDL, if applicable to the contractor. [If contractors added TDLs to the section "TDLs Added by Contractor" item 13a shall be completed by the contractor with the compliance for those TDLs.]*

7. *Item 14: Applicable to Contractor? (Yes or No). Contractors shall complete this field for all TDLs on the report with a Yes if the TDL is applicable to the contractor or a No if the TDL is not applicable to the contractor. [If the contractor added TDLs to the section "TDLs Added by Contractor" item 14a shall be completed by the contractor.]*

8. *Item 15: Comments/Reason for Delay. If the contractor did not comply with the instructions in the TDL, the contractor shall select one of the following reasons from the drop-down list in this field:*

    a. *01- Due date changed due to TDL*
    b. *02- System Changes Required to Comply*
    c. *03- CMS Delay*
    d. *04 –TDL Approved or Pending a Waiver*

e. *05- Other*

9. *Item 16: Additional Explanation. Contractors shall enter additional comments regarding the compliance of the TDL in this field.*

    a. *This field is required if contractor responded '05-Other' in Item 16.*

    b. *This field is required if contractor enters '04-TDL Approved or Pending a Waiver' in Item 16.*

        i. *If approved, the waiver number (in the following format: "DB-xxx") shall be entered. [The waiver number is the tracking number CMS assigns to the waiver. It is located in the upper left section of the waiver letter.]*

        ii. *If a contractor to date has not received an approval or denial from CMS for the waiver, the contractor shall enter the comment "pending waiver" and the date of the waiver request (in MM/DD/YY format).*

        iii. *There are no waivers for MACs regarding the implementation of TDLs.*

    c. *While not required, contractors are also encouraged to include any additional information they feel CMS may find useful in reviewing this report in Item 17.*

    d. *If comments exceed 100 characters, the contractors shall submit with the completed TDL Compliance Report a separate explanation document, no longer than one page, for each TDL that is not implemented by the CMS Compliance Date.*

10. *TCR Totals. This section summarizes the totals for the detail rows for the page(s). All fields except one are calculated. If the contractor added any TDLs to the 'TDLs Added by Contractor' section of the report, the contractor must enter the total number of TDLs they added to item 18 'Number of TDLs Contractor Included in This Report' field of this section. No other fields in this section shall be updated by the contractor.*

11. *Each Legacy Contractor shall, by contractor number, submit, via e-mail and by the report due date, one completed TDL Compliance Report (which includes an Excel Report(s), a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each TDL) to the CMS CO mailbox. [The CMS CO mailbox is: CR_IMPL_REPORTS@cms.hhs.gov. NOTE: There are no spaces in this web address. Underscore "_" separates the words CR_IMPL_REPORTS.] If the report due date of the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date.*

12. *Each MAC shall, by jurisdiction, submit via e-mail and by the report due date, one completed TDL Compliance Report (which includes an Excel Report(s), a Cover Letter/Attestation Statement, and, if necessary, a separate explanation document that is no longer than one page for each TDL) to the CMS CO mailbox. [The CMS CO mailbox is: CR_IMPL_REPORTS@cms.hhs.gov. NOTE: There are no spaces in this web address. Underscore "_" separates the words CR_IMPL_REPORTS.] If the report due date of*

the 28th falls on a weekend or a holiday, each contractor, including MACs, shall submit the report on the next business day following the due date.

13. *Each MAC shall also send a copy of the report to its respective deliverables mailbox or to the CMS ART system, pending direction from their MAC Contracting Officer's Technical Representative.*

50.1 – CR Implementation Report *(CRIR) Template*

Upon direction from CMS via a Technical Direction Letter, contractors shall download the CR Implementation Report Template from the Electronic Change Information Management Portal (eChimp), User Tools Page, Number 4. Supporting Documents & Templates link. From there, contractors shall click the link that reads CRIR Template.

50.2 – *TDL Compliance Report (TCR) Template*

Upon direction from CMS via a Technical Direction Letter, contractors shall download the TCR Template from eChimp, User Tools Page, Number 4. Supporting Documents & Templates link. From there, contractors shall click the link that reads TCR Template.

50.3 – Sample Cover Letter/Attestation Statement

CR Implementation Report

Contractor Name:

Contractor/*Jurisdiction* Number:

Date Report Submitted to CMS: [MM/DD/CCYY]

Subject: Attestation Statement: Implementation of Change Requests, Qtr.__, FY__ [Include the appropriate quarter and fiscal year in the Subject line.]

Attention: CMS Central Office (CO) Medicare Contractor Management Group (MCMG)

In accordance with the Centers for Medicare & Medicaid Services (CMS) Change Requests 2884, 6102 *and 7468*, I attest that all instructions required to be implemented within Quarter __ [1, 2, 3 or 4 – select appropriate quarter] of FY __ [Enter appropriate fiscal year.] have been implemented. Exceptions are explained in Item 1*5* of the CR Implementation Report or attached if the explanation exceeds 100 characters.

Sincerely,

[Name of Contractor Certifying Official.]

[Title of Contractor Certifying Official.]

Technical Direction Letter Compliance Report

Contractor Name:

Contractor/Jurisdiction Number:

Date Report Submitted to CMS: [MM/DD/CCYY]

Subject: Attestation Statement: Compliance with Technical Direction Letters, Qtr.__, FY__ [Include the appropriate quarter and fiscal year in the Subject line.]

Attention: CMS Central Office (CO) Medicare Contractor Management Group (MCMG)

In accordance with the Centers for Medicare & Medicaid Services (CMS) Change Request 7468, I attest that all instructions required to be complied with within Quarter __ [1, 2, 3 or 4 – select appropriate quarter] of FY __ [Enter appropriate fiscal year.] have been complied with. Exceptions are explained in Item 16 of the TDL Compliance Report or attached if the explanation exceeds 100 characters.

Sincerely,

[Name of Contractor Certifying Official.]

[Title of Contractor Certifying Official.]

50.4 – Change Request (CR) Definitions

50.4.1 – Issue Date

The date the Centers for Medicare and Medicaid Services (CMS) publishes a change request (CR).

When a CR has passed through all phases of the change management process, it is then ready for publication; that is, the CMS is ready to make the instructions contained in the CR available to contractors, maintainers, providers, beneficiaries and/or any group or organization that may be affected, as appropriate. The CMS publishes CRs by posting them as Transmittals, on the CMS Web site.
Note: The issue date is named "Date" on the Transmittal form, One-Time Notification, Recurring Update Notification, and the Standard CR forms. It is sometimes referred to as the "transmittal date."

50.4.2 – Implementation Date

The implementation date identified in a change request (CR) is the date by which Medicare fee-for-service contractors and shared system maintainers shall apply all changes detailed in the business requirements, unless otherwise specified. It is the date when all necessary updates to infrastructure, business processes and/or supporting technology changes shall be completed and operational in order to execute new/modified policy and procedure.

For CRs that do not require changes to the shared systems (non-system changes), contractors are usually given 30 to 90 days from issuance to implement the CR.

For CRs that do require changes to the shared systems (system changes), a date is specified that usually corresponds with one of the quarterly shared system release dates. The date is usually the first Monday of the quarter (for example, January 3, April 4, July 5, or October 3 for 2011).

Unless otherwise stated, the implementation date is the same for all business requirements listed within a specific CR. In some instances, a separate implementation date(s) may be given for a particular business requirement(s) within a CR.

Implementation and effective dates are frequently not the same. The list below contains the scenarios for the differences:

- The effective date and implementation date are different because the first day of the quarter is not a Monday;

- The effective date and the implementation date are different because the effective date occurs after the implementation date;

- The effective date and the implementation date are different because the effective date occurs before the implementation date, but both dates are in the future; or

- The effective date and the implementation date are different because the effective date occurs before the implementation date, and the effective date is in the past, while the implementation date is in the future.

50.4.3 – Effective Date

The effective date identified in a change request (CR) is the date on which any new rules, laws, processes and/or policies become active.

Beginning on this date, Medicare contractors shall apply the new rules to process Medicare claims according to their updated business processes and supporting technology.

The effective date is normally a mandated date resulting from legislation or a regulation. In the case of National Coverage Determinations (NCDs), the effective date is the first day the item or service that is the subject of the NCD is covered nationally under the Medicare Program.

Effective dates are not always future dates; sometimes, they are in the past. When this happens, the Centers for Medicare and Medicaid Services (CMS) instructs contractors, using business requirements, how to process claims for the period between the effective date and the implementation date. Typically, the effective date is the first day of any given fiscal year quarter or the first day of the month.

50.4.4 – Date of Service

The date of service (DOS) is the date a provider renders service to a beneficiary. Unless otherwise specified, the effective date of a change request is the date of service.

For the purpose of processing claims, the effective date for applying processing rules, laws, processes, and/or policies is the date the beneficiary received a service from a provider. For Durable Medical Equipment (DME) claims with spanned dates of service, the ViPS Medicare System (VMS) will use only the “From” DOS as the date the supplier rendered a service to a beneficiary. For example, if a new rule or law became effective on January 1, 2011, and a beneficiary received service on December 27, 2010, then that service would not be covered under the new rule. If the beneficiary received the service on or after January 1, 2011, then that service would be covered by the new rule.

More service-specific information on the Date of Service can be found in. Pub.100-02, Medicare Benefit Policy Manual and Pub. 100-04, Medicare Claims Processing Manual.

60 – Procedures for Modifying Shared System Edits and Capturing Audit Trail Data

POLICY

Contractors must implement processes and procedures for adding, deleting, inactivating, bypassing or otherwise modifying all shared system edits. Contractors must also have the capability to document and track those modifications. Modifications to maintainer coded edits must additionally include documentation that provides the rationale for the modification, the expected duration of the change, the impact of the change with respect to potential over or underpayments, claims volumes, affect on providers and / or beneficiaries, etc. In addition, the claims operations manager or equivalent area manager must document approval of the edit modification followed by CMS approval before any maintainer coded edit change has been made.

Intermediaries and carriers shall examine their current processes for modifying shared system edits and adjust them to incorporate the appropriate levels of internal controls. These controls must be documented and available upon request for review by CMS or an auditor. In addition, contractors must limit the number of personnel with the security clearance to modify maintainer coded shared system edits to ten (10).

Should the reason for an edit modification be because of a shared system deficiency, that associated problem must be documented and reported to the maintainer by the contractor. The shared system maintainer and contractor must prioritize the appropriate systems changes to correct edit deficiencies and schedule them for correction as soon as possible via existing change management processes. Should there not be consensus with the contractors regarding schedule, CMS maintenance staff should be consulted.

Shared system maintainers must have the capability to track edit changes made by a contractor to the maintainer coded shared system edits. The shared systems must be able to identify who modified the edit, what was modified and when the alteration was made.

60.1 – CMS Standard File for Reason Codes

The FI Edits Evaluation Workgroup is tasked with identifying the inventory of contractor inactivated edits, documenting the reasons why the edits are turned off, and making a decision as to whether they should remain inactive or not. Transmittal 338, (Change Request (CR) 5927) issued on May 2, 2008, created the ‘CMS Standard’ field within the existing FISS Reason Code File which contains the status that was determined by the FI Edits Evaluation Workgroup for each individual code that was reviewed. The ‘CMS Standard’ field indicators are as follows:

- ‘A’ = Active
- ‘I’ = Inactive
- ‘ ‘ = Blank

NOTE: The terms ‘Active’ & ‘Inactive‘ are defined as:

- Active = Reason code status is equal to ‘S’, ‘P’, ‘ ‘ (blank), ‘D’, ‘R’, ‘T’, or is not equal to ‘S MDLTD’; and

- Inactive = Reason code status is equal to ‘A’ or is equal to ‘S MDLTD.’

Each quarter, as necessary, CMS will issue an updated CMS Standard File for Reason Codes which is loaded into the system by the FISS maintainer via a Recurring Update Notification.

70 – Change Management Process -- Electronic Change Information Management Portal (eChimp)

The Centers for Medicare & Medicaid Services' (CMS's) Division of Change Management (DCM) is responsible for the coordination and distribution of the draft Medicare Fee-for-Service (FFS) Change Requests (CRs) for Point-of-Contact (POC) Review. To that end, the DCM has developed the Electronic Change Information Management Portal (eChimp), a user-friendly, Web-based application to streamline and automate the change management process.

In September 2004, the initiators of the CRs began creating and submitting CRs to the DCM via eChimp. In the past, the DCM distributed the draft Medicare FFS CRs to only 15 contractor POCs and shared system maintainers (SSMs) for POC review. The SSMs forwarded the CRs to their users for review which increased the time to market the CR and sometimes resulted in the submission of late comments. Therefore, beginning January 3, 2006, the DCM will continue to notify the CMS and SSM POCs of the draft Medicare FFS CRs that are in POC review and also notify all the Medicare FFS contractor POCs as well via eChimp 2.0. The DCM will implement eChimp 2.0 on a voluntary basis for its internal CMS staff. Initiators of CRs may create and submit a CR for POC review using eChimp 2.0 beginning January 3, 2006. However, effective February 6, 2006, eChimp 2.0 will be implemented on a mandatory basis (i.e., all CRs will be initiated, submitted and reviewed in eChimp 2.0). The POCs will continue to receive the POC Review e-mail for CRs initiated and submitted in eChimp 1.0 which will contain the CR and the attachments until February 6, 2006. In addition to receiving the POC review e-mail with the CR and the attachments, POCs will also receive the POC review e-mail alert for CRs that are initiated and submitted in eChimp 2.0 which will not contain the CR file and the attachments. However, these e-mail alerts will contain a link for the POCs to click to review and submit comments on the CR via eChimp 2.0.

NOTE: Beginning February 6, 2006, contractors and maintainers should not reply to any e-mails from eChimp@cms.hhs.gov nor should they send any e-mail to eChimp@cms.hhs.gov. Effective February 6, 2006, we will not accept any e-mails sent to that address.

The notification of the draft Medicare FFS CRs will be distributed via an E-mail from eChimp to the CMS, contractor and SSM POCs, which will no longer contain the files and documents associated with the draft CR. Once the POCs receive the e-mail notification from eChimp that notifies them that a CR is currently in POC review, they shall log in to eChimp via a link that will be provided in the E-mail notification. Once logged in, they shall review the draft CR and provide comments to CMS via eChimp by the POC Review Comment due date. To maintain as much efficiency as possible with such a large number of prospective reviewers, each POC may submit only one set of comments on behalf of their contractor or maintainer organization and that submission must be identified as such. If the CR impacts Part A, Part B, DME and/or RHHI and it makes more sense to submit the comments separately (to keep the content clear), then two sets of comments from the contractor site or maintainer organization will be acceptable. No response received will be considered a concurrence. NOTE: It is the responsibility of the POCs to notify appropriate staff that a CR has entered POC review and to share the information with

them. Each individual who has access to eChimp will also have the ability to review, download and print the CR files and share the files, either electronically or hardcopy, with other staff members who do not have eChimp access.

We believe that expanding the POC review process to all of the Medicare FFS contractors and SSMs will not only decrease the time to market the CRs, but will also increase the quality of the review of the CRs by allowing a wider audience of those potentially impacted by the change the opportunity to comment. We also believe that this expansion to the POC review process will reduce the number of late comments submitted as well as reduce the number of corrected CRs now necessary as a result of uncoordinated and/or untimely POC comments.

CMS realizes that expanding the POC review process to all of the Medicare FFS contractors and SSMs could potentially cause a lack of efficiency and an administrative burden if the above-outlined POC review process is not adhered to. Therefore, we will pilot this expanded POC review process for approximately 3 months effective February 6, 2006. At the conclusion of the 3 months, we will evaluate the pilot and adjust the POC review process, if necessary.

80 - Fee-for-Service Contractor Workload Transitions

Fee-for-Service contractor workload transitions occur when: 1) a Medicare carrier or fiscal intermediary's Title XVIII contract is either non-renewed or is terminated; or 2) a Medicare Administrative Contractor's (MAC) period of performance ends or its contract is terminated. When either of these two circumstances occurs, the outgoing contractor must work with the new incoming contractor to transfer the Medicare workload without any disruption to providers and beneficiaries.

During a transition, the outgoing contractor has responsibilities and processes for closing out its Medicare contract and shutting down its operation. It must also assist the new incoming contractor in its efforts to assume the Medicare claims administration functions. Concurrently, the incoming contractor must establish an operational infrastructure and ensure that all data, records, and functions are properly transferred from the outgoing contractor. Both parties have a responsibility to ensure that the transition is conducted seamlessly and that all contractual obligations are met during the transition.

"This course was developed from the public domain document:
Medicare Administrative Contractor Workload Implementation Handbook –
The Medicare Contractor Management Group (MCMG)."