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HIPAA Eligibility Transaction System (HETS) User Interface (UI) Internet User Guide

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2.0	05/31/2007	Added 'Eligibility Reporting Instructions' to Section 5.3 (regarding 27 month historical and 4 month future date requests.)
2.2	12/21/2007	Added screen changes up to March 2008 HETS-UI release
2.3	01/09/2008	Added UI screen prints to the User Communication Guide
2.4	01/22/2008	Section 6.5: <ul style="list-style-type: none"> • Added Preventive tab description for unclassified HCPCS codes on page 20 • Removed sample categories or date from Figure 12 on page 20
2.5	01/24/2008	Updated Section 3.0 by adding Figure 3: Application Attributes Representation with a description of each application tab.
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3.0	11/03/08	The following change has been made: <ul style="list-style-type: none"> • 5.4.6 Plan descriptions and plan type codes have been updated

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1. INTRODUCTION

This User Guide provides the information necessary for Provider Users to effectively use the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Eligibility Transaction System (HETS) User Interface (UI).

1.1. Background

The HETS-UI Internet application is a web-based transaction application that is compliant with HIPAA. The HETS-UI Internet application enables Users to submit eligibility inquiries and receive Medicare Beneficiary Eligibility Responses.

The Centers for Medicare & Medicaid Services (CMS) designed the HETS-UI Internet application to support the providers' beneficiary eligibility data needs. The HETS-UI Internet application obtains the response data for the transaction from the CMS beneficiary eligibility databases. The beneficiary eligibility databases are considered the authoritative source for beneficiary Part A and B Effective, Termination, Demographic, Managed Care Organization (MCO), and End Stage Renal Disease (ESRD) data. For CMS purposes, authoritative source is where the data originates and is shared with other systems. The Common Working File (CWF), which is a Medicare claims processing system, shares other data (such as Medicare Secondary Payer (MSP), Home Health, Hospice, Skilled Nursing Facility (SNF), and Hospital) with the Internet application through a nightly data exchange with the eligibility databases. CWF is considered the authoritative source for this data.

Other eligibility queries, such as the provider call center Interactive Voice Response (IVR) units and the CWF provider inquiry transactions, receive data directly from the CWF.

As an eligibility requestor, the User might see differences in Medicare Eligibility Responses based on the source of their query (provider IVR, CWF inquiry, HETS-UI Internet application) due to the exchange of information between the sources. Typically these differences are due to a delay, up to 48 hours, in sharing information in nightly exchanges between the sources.

It is CMS' vision that the HETS-UI Internet application's data source will be used for all Eligibility Transaction Responses in the future. Thus, regardless of which Eligibility Transaction is being performed by the User there will be a consistent response.

The data returned on any Eligibility Inquiry that is claims related is only as current as the claims that have been processed by CWF. Thus, the timely submittal of claims by providers directly impacts the data returned on an Eligibility Inquiry.

NOTE: An Eligibility Response does not guarantee payment for a claim.

1.2. Section 508 Compliancy Notes

Section 508 of the Rehabilitation Act of 1973 requires that members of the public with disabilities have access to information and data that is available to individuals without disabilities.

The inquiry and response functions of the HETS-UI Internet application have been tested for Section 508 compliancy using JAWS[®] version 9.0 screen reading software. The online link found on the left-hand navigational panel of each screen provides access to a version of the HETS-UI Internet User Guide that is also compliant with Section 508 of the Rehabilitation Act of 1973.

Users can read individual letters on both the Inquiry and Response screens of this application by using the shortcuts ("hot keys") of their assistive technology software.

The system may return validation or error messages when Users click on the "Submit" button on the Inquiry screen. If this happens, Users can use their software shortcuts ("hot keys") to access descriptions of these errors so they can be corrected before resubmitting the inquiry.

2. REFERENCED DOCUMENTS

This section does not apply to the HETS-UI Internet User Guide.

3. OVERVIEW

The HETS-UI Internet application enables authorized Users to submit inquiries to receive Medicare Beneficiary Eligibility benefit data through a web-based User Interface response. This is an inquiry only system, which allows access and entry of specific data elements to request eligibility information. This system requires the User to enter valid, accurate Medicare beneficiary information. This system is only to be used for authorized Medicare business. Users must agree to the CMS HIPAA Eligibility Transaction System (HETS) Rules of Behavior. (See Section 9, Appendix for a copy of the Rules of Behavior). If Users enter incorrect or invalid information into the Inquiry screen, no beneficiary eligibility information will be returned.

NOTE: Misuse of this system is subject to civil and criminal penalties for falsifying information, wrongful obtaining of information through, and wrongful disclosure of information obtained pursuant to, the Trading Partner Agreement for submission of 270s to Medicare on a real-time basis.

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The application layout, as shown in the Site Map in Figure 1 below, is outlined as follows:

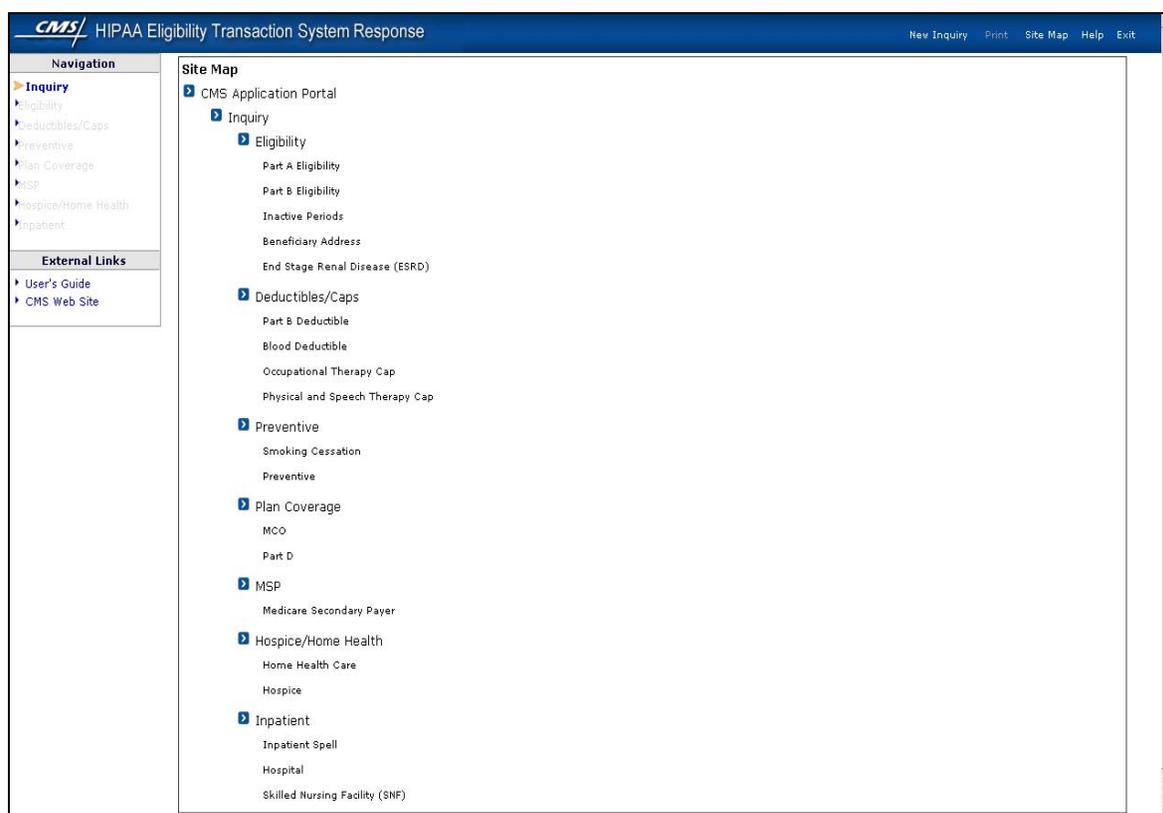
The tab to request eligibility data where specific beneficiary information is entered by the User is as follows:

- Inquiry

The response tabs where eligibility benefits data is received by the User are as follows:

- Eligibility Tab
- Deductibles/ Caps Tab
- Preventive Tab
- Plan Coverage Tab
- MSP Tab
- Hospice/Home Health Tab
- Inpatient Tab

Figure 1: HETS-UI Internet Application Site Map



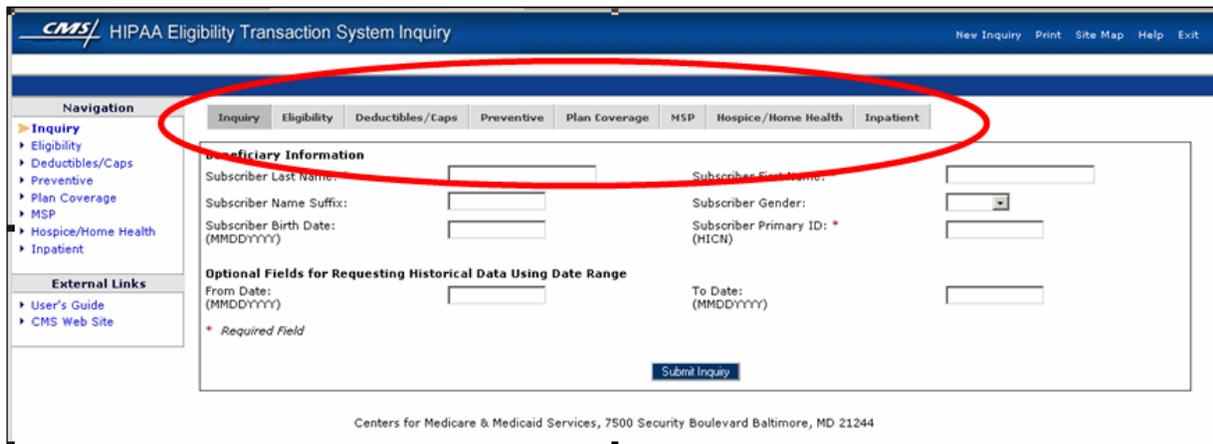
When a User logs into the HETS-UI Internet application, the Inquiry tab (see Figure 2 on the following page) is displayed. After the required data elements are entered and validated, the response tabs are displayed. The User can proceed from tab to tab,

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where beneficiary data is available, by clicking the tab or selecting the hyperlink from the left-hand navigation bar.

NOTE: The response tabs display active data only and are only accessible when pertinent, active beneficiary data is associated with the tab. For example, if the Plan Coverage tab is grayed out and unavailable for selection, the beneficiary is not enrolled in a Medicare Advantage (MA) plan.

Figure 2: Application Tabs



The HETS-UI Internet application offers additional application features, as shown in Figure 3 below, for a more user-friendly environment. All attributes listed below are accessible and viewable from each application tab.

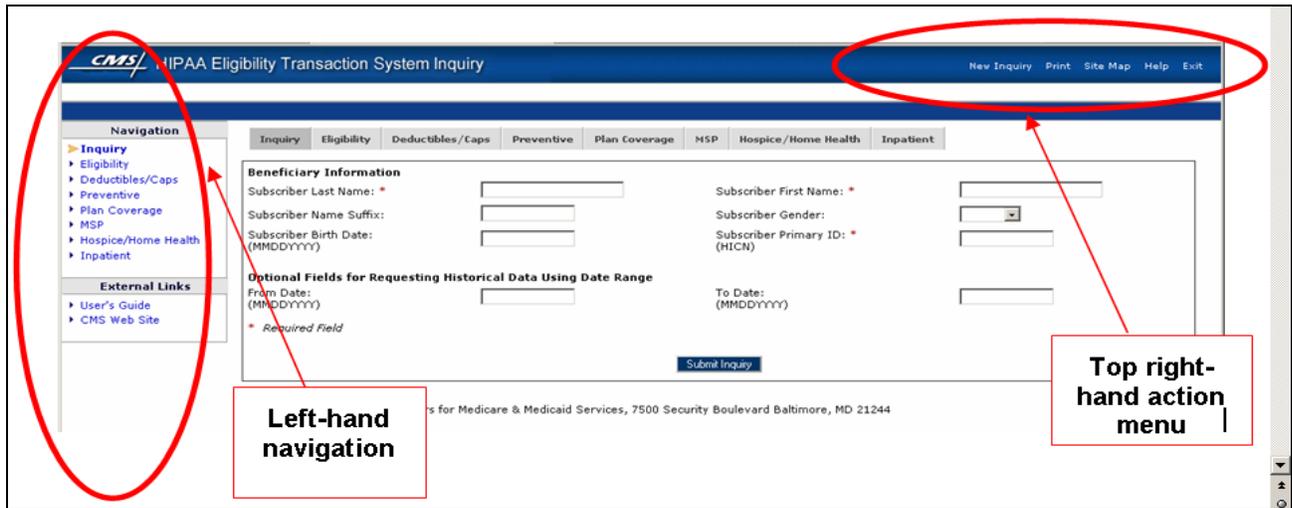
The following are the top right-hand menu items:

- **New Inquiry** – Refreshes the Inquiry tab to allow Users to input a new beneficiary request
- **Print** – Prints the record (tabs) of eligible benefits for the beneficiary in a single report. Click "Print" once for a preview, then click again to print.
- **Site Map** – Provides the design layout of the HETS-UI Internet application
- **Help** – Provides the Help Desk contact information
- **Exit** – Closes the active HETS-UI Internet application session and redirects the Users to the main CMS applications selection page

The following are the left-hand navigation items:

- **Navigation Links** – Offer an alternative selection region for active application tabs
- **External Links** – Provide links to the HETS-UI Internet User Guide and CMS Website

Figure 3: Application Attributes Representation



3.1. Conventions

This document provides screen prints and corresponding narrative to describe how to use the HETS-UI Internet application.

NOTE: The term ‘User’ is used throughout this document to refer to a person who requires and/or has acquired access to the HETS-UI Internet application.

3.2. Cautions & Warnings

The HETS-UI Internet application will suspend a User’s account access when the number of User errors exceeds the CMS parameterized values for either consecutive errors, or the number of total errors in a single web session. This modification is being made to provide greater system security against End-User fraud and abuse. To protect the privacy of beneficiary data, the subscriber last name, subscriber first name, subscriber primary ID (HICN), and subscriber birth date must match the beneficiary’s data maintained by Medicare. Providers/suppliers must use caution to ensure that accurate information is entered into the HETS-UI system in order to prevent User lockout.

Authorized Users of the HETS-UI Internet application agree to use appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted or as required by the HIPAA. Unauthorized disclosure may result in prosecution to the fullest extent of the law.

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Table 1 below identifies incident severity levels and describes the required action.

Table 1: Incident Severity Levels and Required Action

Situation	Action Description
<p>LOW SEVERITY <i>User is very infrequently locked out</i></p>	<p>The External Point of Contacts (EPOC currently referred to as User Group Administrators – UGA) (if applicable) or Security Official contacts Medicare Customer Assistance Regarding Eligibility (MCARE) Help Desk to request reinstatement. MCARE notifies Security Official (and UGA, if applicable) of reinstatement via email.</p>
<p>HIGH SEVERITY <i>User is frequently locked out</i></p>	<p>Security Official contacts MCARE Help Desk to request reinstatement. MCARE notifies Security Official (and UGA, if applicable) that User will remain suspended for at least one week. Security Official will also be required to complete a Corrective Action Plan (CAP) using CMS provided form. CMS must receive and approve CAP before User will be reinstated (User suspension will last at least one week).</p>
<p>SECURITY INCIDENT EMERGENCY SEVERITY <i>User continues to be locked out frequently after a CAP has been submitted OR Organization's Users demonstrate systematic failure to enter valid data</i></p>	<p>Security Official contacts MCARE Help Desk to request reinstatement. MCARE notifies Security Official (and UGA, if applicable) that due to repeated suspensions, User and all other Users in the Organization will be suspended for at least one week. Security Official will also be required to complete an updated CAP using CMS provided form. CMS must receive and approve revised CAP before all organization Users will be reinstated (suspension will last at least one week).</p>

The HETS-UI will display an alert message (see Figure 4 below) within the application's browser window when a User's session is suspended.

Figure 4: Access Denied Alert Message



4. GETTING STARTED

The following sub-sections provide a general walkthrough of the HETS-UI Internet application from initiation through exit. The logical arrangement of the information should enable the User to understand the sequence and flow of the HETS-UI Internet application.

4.1. Set-Up Considerations

CMS screens are designed to be viewed at a minimum screen resolution of 800 x 600. To optimize access to the HETS-UI Internet application, the User should do the following:

- **Disable pop-up blockers** prior to attempting access to the HETS-UI Internet application.
- Use Internet Explorer, version 6.0 or higher.

4.2. User Access Considerations

Users must be granted permission to access the HETS-UI Internet application. All authenticated Users have the same privilege in the HETS-UI Internet application.

4.3. Accessing the System

The HETS-UI Internet application is accessible to Users through the CMS Applications Portal. Only authorized personnel will be able to access the HETS-UI Internet application. Instructions for accessing the HETS-UI Internet application are provided in section 5.2.

4.4. System Organization & Navigation

Specific functionality and screen captures are described in Section 5.4.2.

4.5. Exiting the System

Users can click the Exit link on the top right corner of the HETS-UI window to logout from the HETS-UI Internet application. The Users will be logged out, and the HETS-UI Internet application window will close.

5. USING THE SYSTEM

The following sub-sections provide detailed, step-by-step instructions on how to use the various functions or features of the HETS-UI Internet application.

5.1. CMS Applications

The CMS Applications Portal Main Page contains navigational links that Users can use to access CMS applications. These links are in the blue area, just below the CMS banner on the top of the web page (see the circled area in Figure 5 on the following page).

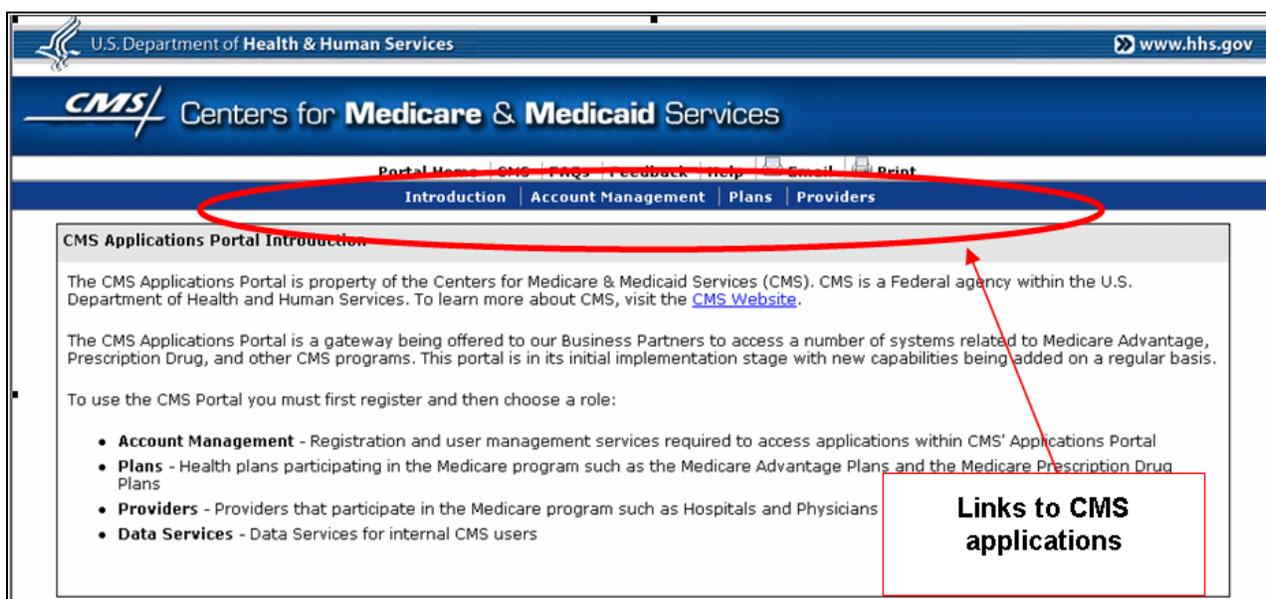
The following are the CMS Applications Portal roles:

- Introduction
- Account Management
- Plans
- Providers

Users should refer to the Individuals Authorized Access to the CMS Computer Services (IACS) User Guide for complete instructions on the CMS Applications Portal. The items below are discussed in the IACS User Guide:

- Introduction
- Account Management
 - New User Registration
 - My Profile
 - Computer Based Training (CBT) for account management
 - Forgot Your User ID?
 - IACS Community Administration Interface
- Plans – For Medicare Plans and Internal CMS Users. This section is not intended for providers.
- Providers – For providers to access the Beneficiary Eligibility data
 - HIPAA Eligibility Transaction System User Interface
 - IACS Community Administration Interface
 - HETS Provider Graphical User Interface (GUI) (HPG)
- Data Services – For Medicare Plans and Internal CMS Users. This section is not intended for providers.

Figure 5: CMS Applications Portal Main Page



5.1.1. Account Management

Use the link on the CMS Applications Portal when a new User requests access to the CMS HETS-UI Internet application, or when existing business partners need to manage their accounts. This page also contains a link to a CBT course on how to use the CMS Applications Portal site.

If a User has forgotten their IACS password, they can use one of the following two methods to retrieve a new password:

- Follow the steps provided by the IACS procedures listed under the My Profile section to manage their CMS computer services account.
- OR
- Contact the MCARE Help Desk using the contact information listed in Section 6.4. of this document.

If a User's session is terminated and the User's account is disabled, the User will have to contact the MCARE Help Desk using the contact information in section 6.4. of this document to restore the User's access.

5.1.2. Plans

This section of the CMS Applications Portal is applicable only for Medicare Plans and internal CMS Users. This section is not intended for providers.

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5.1.3. Providers

This provider's link on the CMS Applications Portal is used to access the HETS-UI Internet application for beneficiary eligibility inquiries.

A business partner will have access to the HETS-UI Internet application only if they are approved Users and have completed the proper application access forms.

5.1.4. Data Services

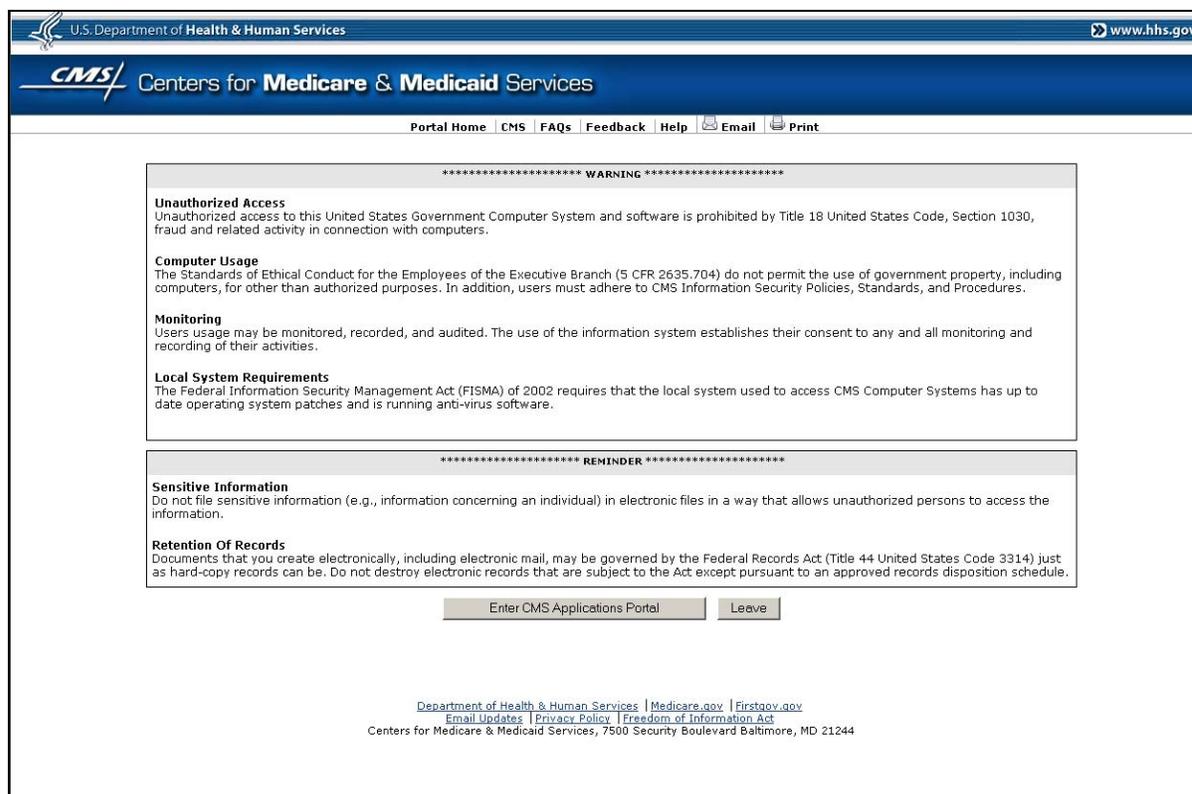
This section of the CMS Applications Portal is applicable only for Medicare Plans and Internal CMS Users. This section is not intended for providers.

5.2. Eligibility and Inquiry Response

Follow the steps below to access the HETS-UI Internet application:

1. To access the CMS Applications Portal, Users must login to the CMS Website at <https://applications.cms.hhs.gov/>. After Users login to the CMS Website the portal page will appear as illustrated in Figure 6 below.

Figure 6: CMS Applications Portal



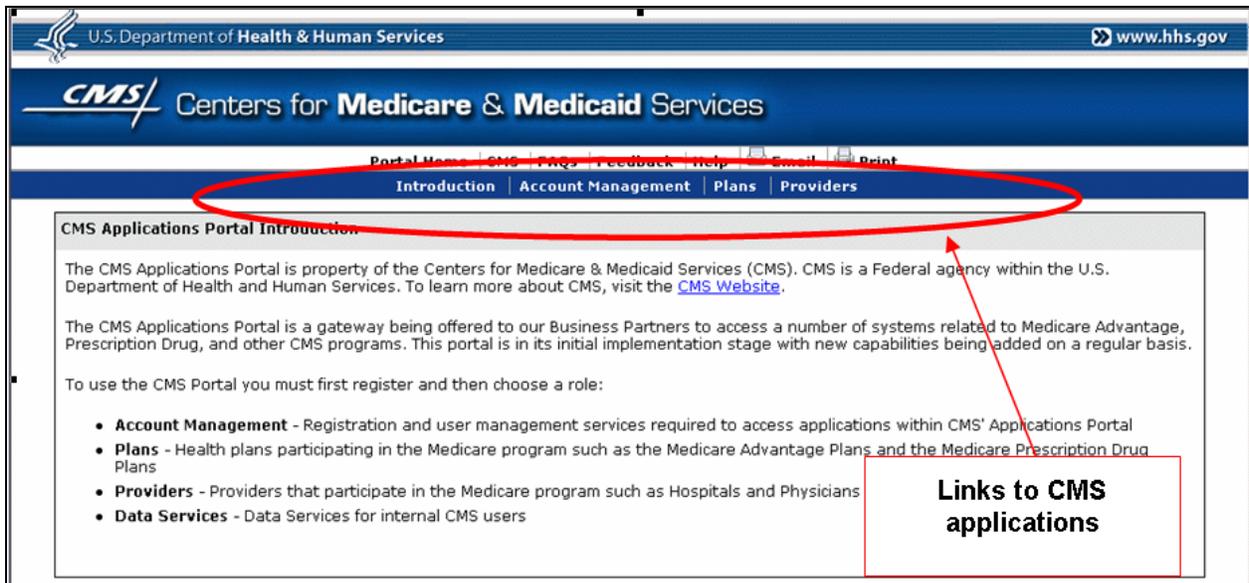
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2. To access the HETS-UI Internet application, the User should click the Enter CMS Applications Portal button.

NOTE: If a User selects the Leave button, they will be directed to the CMS Website (<http://www.cms.hhs.gov/>).

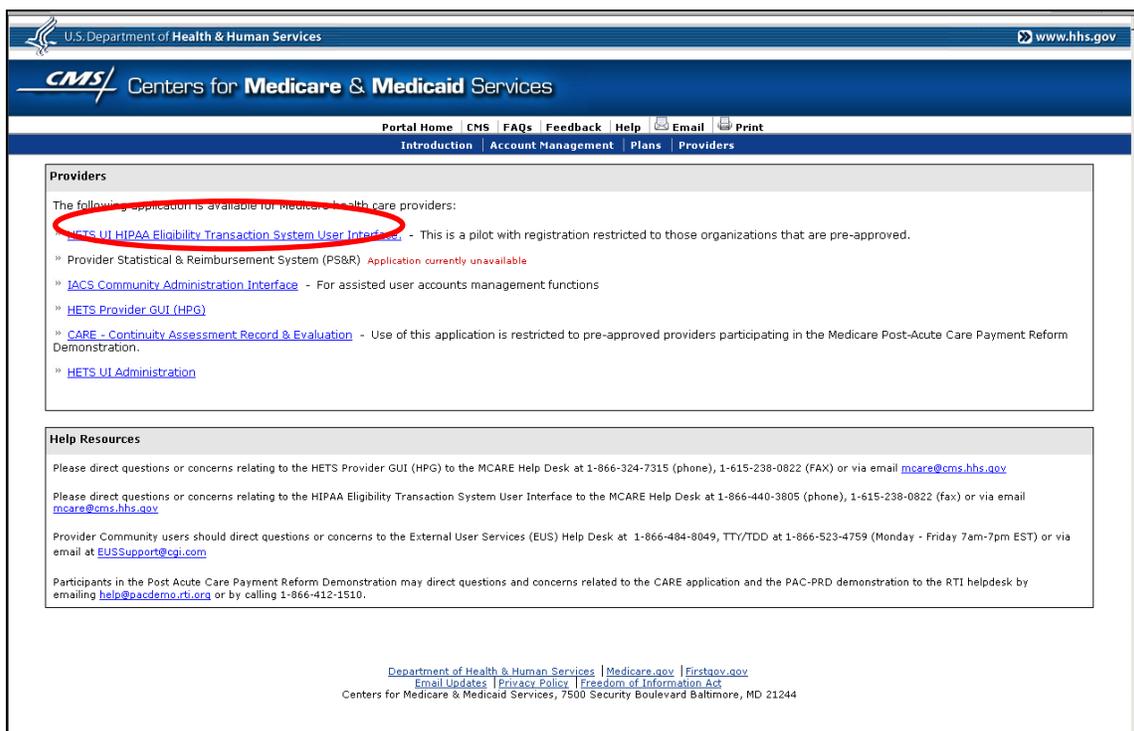
3. After clicking the Enter CMS Applications Portal button, the CMS Applications Portal Main Page will appear as shown in Figure 7 below. From here a User is able to access specific CMS applications.

Figure 7: CMS Applications Portal Main Page



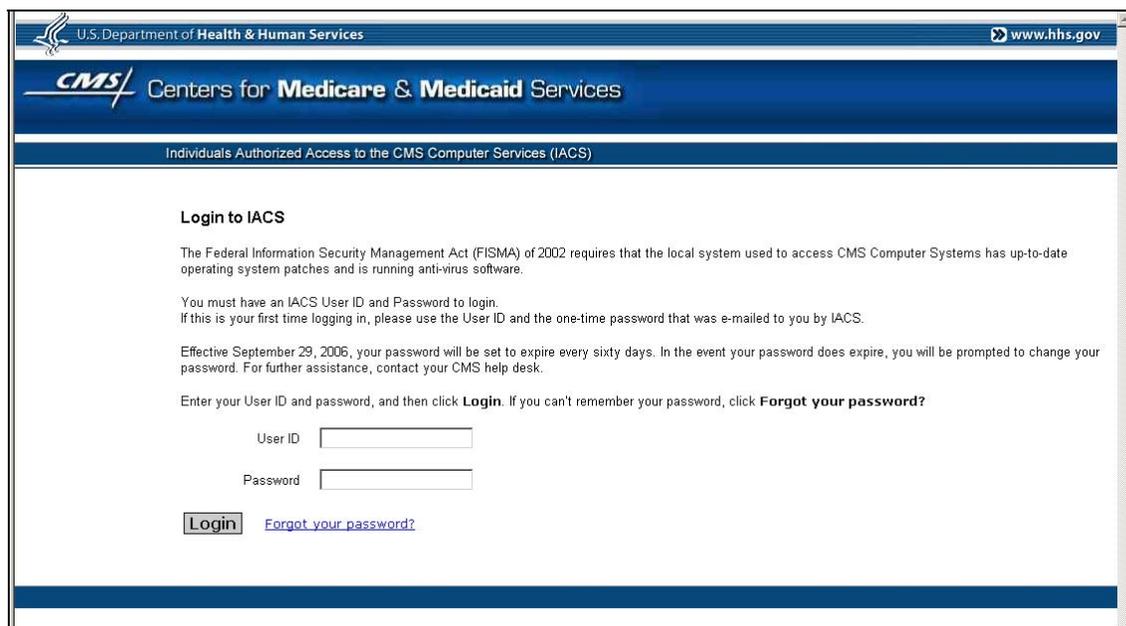
NOTE: For business partners that have been granted access to the HETS-UI on the applications portal page, locate the “Providers” hyperlink in the navigation row. After clicking the Providers link, the Medicare Applications Selection Screen (Figure 8 on the following page) will appear.

Figure 8: Medicare Applications Selection Screen



4. Click the “HETS-UI HIPAA Eligibility Transaction System User Interface” hyperlink. A new window opens (see Figure 9 on the following page) that allows authorized Users to access the HETS-UI Internet application.

Figure 9: IACS Login



5. The User should enter their User ID and Password, and then click the ‘Login’ button.

NOTE: User IDs and Passwords are assigned to individuals. Individuals are strictly forbidden from sharing or “handing off” their User IDs and Passwords with others. The unauthorized use of an individual’s User ID and Password will result in the termination of that User’s ID and Password.

NOTE: If a User enters their password incorrectly three (3) times, the system will lock their account. While their account is locked, they cannot access any other features and they will not be able to access the “Forgot Your Password?” functionality. They must then contact the MCARE Help Desk to get an Administrator to reset their password. When an Administrator resets the password, the User will be sent an email with the temporary one-time password that the User may then use to go in and change the password to one of their choice. After the password has been reset and submitted, the User should completely logout of the application and then close the current window. If the User does not receive the email within 30 minutes, the User must call the MCARE Help Desk. (See Section 6.4 System Support Information).

6. If a User has forgotten their IACS password and has previously answered the IACS Authentication Questions, the User may reset their own password. For more information on answering IACS Authentication Questions, see Section 2.5, Figure 18 of the IACS User Guide (http://www.cms.hhs.gov/MMAHelp/downloads/IACS_UserGuide_8.1.pdf).

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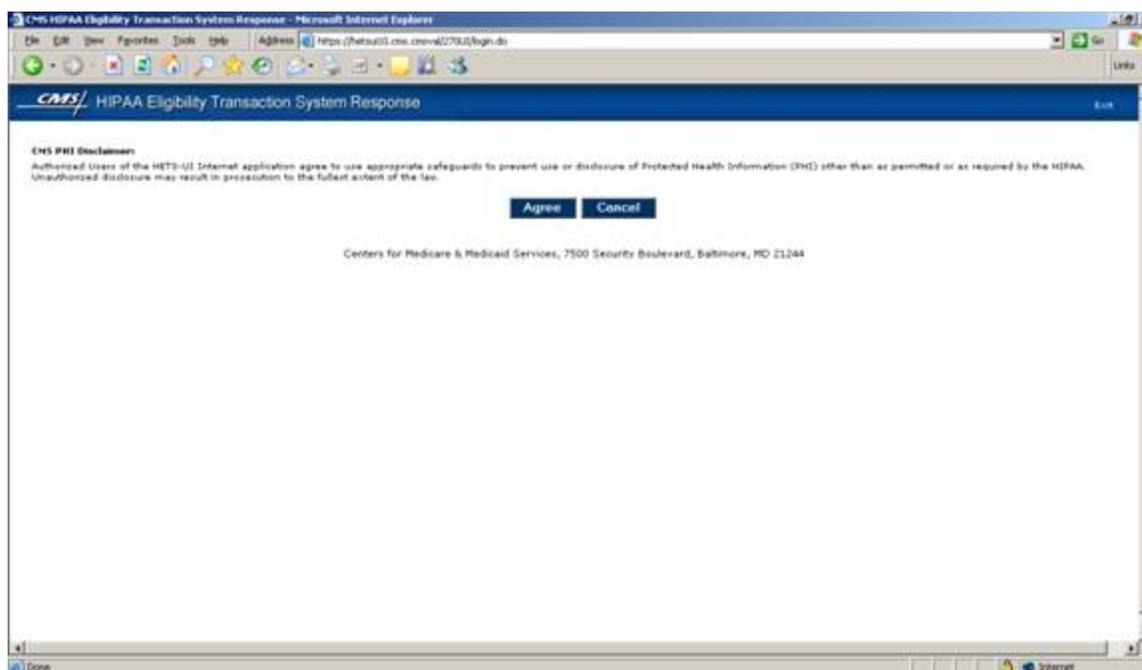
If the User knows they have forgotten their Password, they should enter their User ID in the User ID field, and then click the “Forgot Your Password?” link. An “Identify User” screen will be displayed. Fields for the Authentication Questions the User has previously answered will be displayed. The User must correctly answer at least two of the questions. If they incorrectly answer the questions three times in a row, their account will be locked. The User must call the MCARE Help Desk to have a System Administrator unlock their account. (See Section 6.4. System Support Information).

The User must answer each question on the “Identify User” screen with the exact answer they previously provided, and then click the ‘Login’ button. The “Login to IACS” screen will reappear with a new message above the User ID field indicating that a one-time password has been emailed to the User. The User should go to their email and get their new password. This is a one-time password and the User must change their password when they login. After the password has been reset and submitted, the User should completely logout of the application and then close the current window. If the User does not receive the email within 30 minutes, the User must call the MCARE Help Desk. (See Section 6.4 System Support Information).

7. When the User successfully logs in with their IACS User ID and Password, the IACS system will verify their identity. The IACS service will verify with the HETS-UI Internet Eligibility application software that the User is authorized to access the application.
8. After the User is authorized to access the HETS-UI system, the following PHI/Confidentiality Disclaimer message will be displayed. Users must accept these terms before they will be permitted to access the Beneficiary Inquiry screens:

“Authorized Users of the HETS-UI Internet application agree to use appropriate safe guards to prevent use of disclosure of Protected Health Information (PHI) other than as permitted or as required by the HIPAA. Unauthorized disclosure may result in prosecution to the fullest extent of the law.”

Figure 10: PHI Disclaimer



A PHI Disclaimer will also be displayed on all HETS-UI Screens.

5.3. Medicare Eligibility Benefit Inquiry Screen (HETS-UI)

5.3.1. Inquiry Tab

The User can use the Inquiry Tab (see Figure 11 on the following page) to enter beneficiary information and submit a Medicare Beneficiary Eligibility Request. The User should enter a beneficiary's information into the fields listed below. The following fields are required and are denoted with a red asterisk:

- Subscriber¹ Last Name
- Subscriber First Name
- Subscriber Birth Date
- Subscriber Primary ID (HICN²)

¹ The subscriber is the patient. The patient is also referred to as a beneficiary by Medicare.

² The Health Insurance Claim Number (HICN) is the Medicare beneficiary identifier assigned by Medicare. When looking at the Medicare Health Insurance card, the HICN is the Medicare Claim Number displayed on the card.

Figure 11: Inquiry Tab

The screenshot shows the 'HETS-UI HIPAA Eligibility Transaction System Inquiry' interface. At the top, there is a navigation bar with the CMS logo and the title 'HIPAA Eligibility Transaction System Inquiry'. On the right side of this bar are links for 'New Inquiry', 'Print', 'Site Map', 'Help', and 'Exit'. Below the navigation bar is a sidebar with two sections: 'Navigation' and 'External Links'. The 'Navigation' section has a tree view with 'Inquiry' selected and expanded, showing sub-items like 'Eligibility', 'Deductibles/Caps', 'Preventive', 'Plan', 'MSP', 'Hospice/Home Health', and 'Inpatient'. The 'External Links' section includes 'User's Guide' and 'CMS Web Site'. The main content area is titled 'Inquiry' and contains a form. The form is divided into two main sections: 'Beneficiary Information' and 'Optional Fields for Requesting Historical Data Using Date Range'. The 'Beneficiary Information' section includes fields for 'Subscriber Last Name: *', 'Subscriber First Name: *', 'Subscriber Name Suffix:', 'Subscriber Birth Date: * (MMDDYYYY)', and 'Subscriber Gender:' (a dropdown menu). The 'Optional Fields' section includes 'From Date: (MMDDYYYY)' and 'To Date: (MMDDYYYY)'. A 'Submit Inquiry' button is located at the bottom of the form. At the very bottom of the page, there is a footer: 'Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244'.

NOTE: After a User has successfully logged into the HETS-UI Internet application, they will have the capability to open multiple Inquiry screens. The User can select the Internet Explorer window with the Medicare Applications Selection screen and click the “HETS-UI HIPAA Eligibility Transaction System User Interface” hyperlink again to open a second Inquiry screen. The number of windows that a User can have open will depend on their available system memory.

The User can enter data into optional fields, but the fields are not required to receive a valid Medicare Beneficiary Eligibility benefit response. The optional fields are as follows:

- Subscriber Name Suffix – Even though the suffix is not a required field, the suffix field should be entered if the beneficiary has a suffix printed on their Medicare Health Insurance card. The suffix may be necessary to receive a valid Eligibility response.
- Subscriber Gender
- Optional Fields for Requesting Historical Data Using Date Range

5.3.2. Optional Fields for Requesting Historical Data Using Date Range Logic

The “From Date” and “To Date” fields are optional fields the User can input to request beneficiary eligibility data for a specific time period. If no “From Date” or “To Date” is entered, the system will automatically use the current calendar date for the inquiry.

Based on the “From Date” and “To Date” the system will determine the beneficiary data to display. The application will display a “Beneficiary is Inactive” error message if the User enters a date and/or date range within one of the following scenarios:

- A “From Date” that is before the date of eligibility and no “To Date” is entered

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- A “From Date” that is after the date of termination or date of death
- A specified date range(s) that is outside of the date(s) of eligibility

If the User receives the “Beneficiary is Inactive” error message because of one of the above scenarios, they should retry the Inquiry leaving the date range fields blank. If the beneficiary is currently eligible for Medicare benefits and the User leaves the date range fields blank, the User will see the Effective and Termination (if applicable) dates of eligibility based on the current calendar date.

5.3.3. Eligibility Reporting Instructions

CMS will implement the eligibility request as a real-time single request. The data received in the response will allow a provider to verify an individual’s Medicare eligibility and benefits.

In a continued effort to improve database efficiency, CMS purges Medicare Beneficiary data older than 27 months from the eligibility database supporting the Medicare HETS-UI Internet application.

Since eligibility information is designed to support the payment of claims, and the usual time limit for submitting claims is within 15 to 27 months of the date of service (depending on the month of service), the information source will be purged quarterly of all data older than 27 calendar months. Medicare regulations allow an exception to the timely filing requirements in cases of the Medicare program’s administrative error. In the rare situation where eligibility information older than 27 months may be needed, Provider Contact Centers (PCCs) are available to assist providers or their representatives. The PCC representatives have access to the complete history of eligibility data from the source databases.

Effective 04/20/2007, to avoid misunderstandings and variations in responses, single date or date range requests containing dates older than 27 calendar months prior to the current date and/or more than four calendar months after the current date will be rejected with an ‘E00010 Invalid Date’ error message, as these dates are not within the allowable inquiry period. CMS will compare the requested date or date range in the request to the calculated date. Based on the date the request was received, the HETS-UI Internet application will subtract 27 calendar months and add four months, to determine the eligibility window. With this change made in April 2007, Trading Partners will be aware that requests older than 27 calendar months or greater than four calendar months in the future will be rejected with an ‘E00010 Invalid Date’ error message.

Submitters and CMS will comply with the following:

- Each request will contain only one Patient Request. Each request can have only one ‘From Date’ request date and only one ‘To Date’ request date.

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- The system will respond with current eligibility information if no specific date is contained in the request, or if the request contains a date that is the same as the system processing date.
- Current eligibility information will contain the most recent Medicare benefit information for a patient.
- The system will respond with Medicare benefits provided only for a specific period if the date or date range contained in the request is for that period. The system will accept requests for specific periods up to 27 calendar months in the past and up to four calendar months in the future.
- Benefits provided for a specific period will include Part A spells that fall within 60 days of the date or date range contained in the eligibility request.
- The response is based on information obtained from the CMS database at the time of request and is not considered a guarantee of payment.

Table 2 below provides some examples of system date requests and responses.

Table 2: System Date Request and Response Examples

If Today's Date Is:	Historical Requests Are Accepted Through:	Future Requests Are Accepted Through:
September 2008	June 2006	January 2009
October 2008	July 2006	February 2009
November 2008	August 2006	March 2009
December 2008	September 2006	April 2009

NOTE: If a User requests a future date for which Medicare Co-Insurance and Deductible amounts have not yet been finalized, HETS-UI will return an eligibility response. The Co-insurance and Deductible amounts for the future year will remain blank until the amounts are finalized and updated in CMS' databases.

5.3.4. Data Matching Requirements

To protect the privacy of beneficiary data, subscriber last name, subscriber first name, subscriber primary ID (HICN), and subscriber birth date must match the beneficiary's data maintained by Medicare; otherwise, eligibility data will not be returned on the Eligibility Response tab.

Figure 12 on the following page is a sample of beneficiary data.

Figure 12: Sample Beneficiary Data

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER SEX
000-00-0000-A FEMALE

IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986

SIGN HERE *Jane Doe*

The Medicare beneficiary should be the first source of Health Insurance Eligibility information. When scheduling a medical appointment for a Medicare beneficiary, the beneficiary should be reminded to bring on the day of their appointment all Health Insurance cards showing their Health Insurance coverage. This will not only help determine who to bill for services rendered, but also give the proper spelling of the beneficiary’s first and last name and identify their Medicare Claim Number (also referred to as HICN) as reflected on the Medicare Health Insurance card.

If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, the beneficiary should be encouraged to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

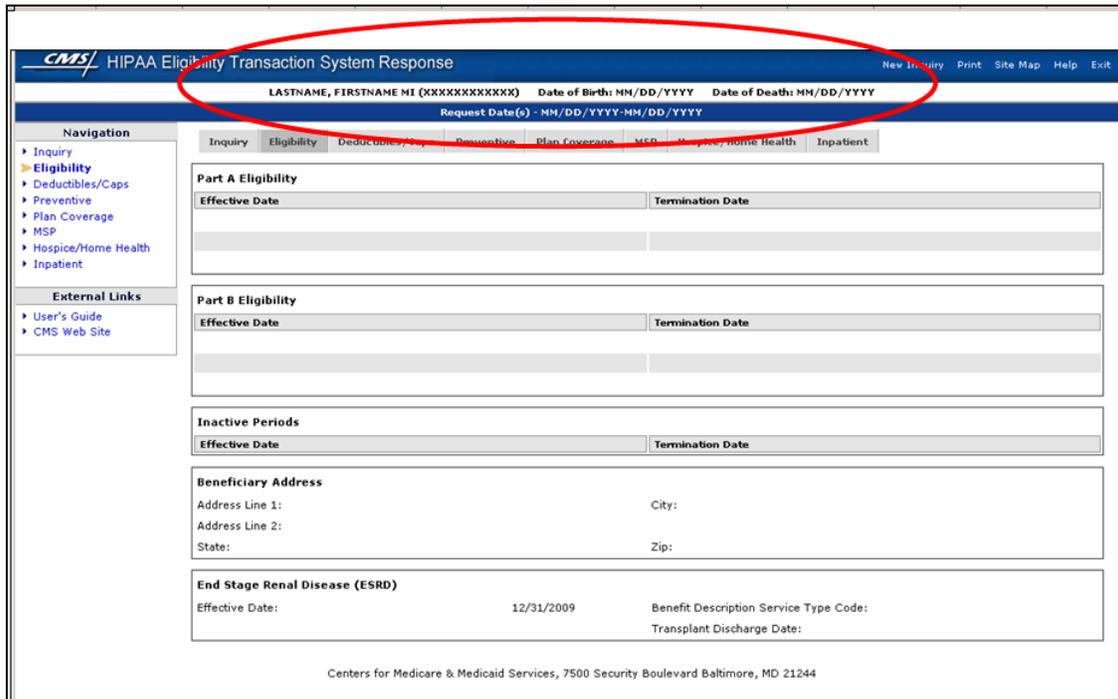
5.4. Medicare Eligibility Benefit Response Screen (HETS-UI)

5.4.1. Static Beneficiary Information

The region circled above the application tabs in Figure 12 on the following page is reserved to display the queried beneficiary’s information. The beneficiary’s information remains the same from tab to tab. Following is the beneficiary information presented in the circled region (Figure 13):

- Last Name
- First Name
- Middle Initial
- Subscriber Primary ID (HICN) [displayed as XXX-XX-XXXXX]
- Subscriber Birth Date [displayed as MM/DD/YYYY]
- Subscriber Date of Death [displayed as MM/DD/YYYY]
- Requested Dates [displayed as MM/DD/YYYY – MM/DD/YYYY]

Figure 13: Tab Header



5.4.2. Medicare Eligibility Benefit Response Tabs

There are seven eligibility response tabs that may contain Medicare Beneficiary Eligibility benefit data. The response tabs include the following:

- Eligibility
- Deductibles/Caps
- Preventive
- Plan Coverage
- MSP
- Hospice/ Home Health
- Inpatient

NOTE: A response tab only displays active data and is only accessible when there is active data associated with the tab and it pertains to the beneficiary. For example, if the Plan Coverage tab is grayed out and unavailable for selection, the beneficiary is not enrolled in an MA plan.

5.4.3. Eligibility Tab

The Eligibility tab (see Figure 14 on the following page) provides information regarding the beneficiary’s Part A and Part B Eligibility, Inactive Periods (e.g. unlawful, deported,

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and incarcerated), Beneficiary Address, and ESRD. If this tab is available, it indicates that the beneficiary has some type of Medicare Eligibility. If eligible for Medicare benefits, the beneficiary will qualify for either a Part A or a Part B Eligibility period. The ESRD section provides information regarding a beneficiary's eligibility to receive Medicare benefits based on permanent kidney failure requiring dialysis or a kidney transplant.

Figure 14: Eligibility Tab

The screenshot displays the 'HIPAA Eligibility Transaction System Response' interface. At the top, it shows fields for 'LASTNAME, FIRSTNAME MI (XXXXXXXXXXXX)', 'Date of Birth: MM/DD/YYYY', and 'Date of Death: MM/DD/YYYY'. Below this is a 'Request Date(s) - MM/DD/YYYY-MM/DD/YYYY' field. The main content area is divided into several sections:

- Navigation:** A sidebar menu with options: Inquiry, Eligibility (selected), Deductibles/Caps, Preventive, Plan Coverage, MSP, Hospice/Home Health, and Inpatient.
- External Links:** User's Guide and CMS Web Site.
- Part A Eligibility:** A table with columns 'Effective Date' and 'Termination Date'.
- Part B Eligibility:** A table with columns 'Effective Date' and 'Termination Date'.
- Inactive Periods:** A table with columns 'Effective Date' and 'Termination Date'.
- Beneficiary Address:** Fields for Address Line 1, Address Line 2, State, City, and Zip.
- End Stage Renal Disease (ESRD):** Fields for Effective Date (12/31/2009), Benefit Description Service Type Code, and Transplant Discharge Date.

At the bottom, the footer text reads: 'Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244'.

NOTE: If either the “Part A Eligibility Benefit” information or “Part B Eligibility Benefit” information does not contain data, it means the beneficiary is not eligible to receive Medicare benefits for the requested period on the inquiry screen. The ESRD section only displays active ESRD data and will not be available if notification has not been received by CMS indicating an ESRD period is active and in effect per the date(s) requested.

The following tables provide information for the Eligibility Benefit tab.

Table 3 on the following page describes the Part A Eligibility Benefit fields.

Table 3: Part A Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part A benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part A benefits. No date in this field means Medicare Part A eligibility has not terminated

Table 4 below describes the Part B Eligibility Benefit fields.

Table 4: Part B Eligibility Benefit Information

Field Name	Description
Effective Date	A date that indicates the start of eligibility for Medicare Part B benefits
Termination Date	A date that indicates the termination of eligibility for Medicare Part B benefits. No date in this field means Medicare Part B eligibility has not terminated

Table 5 below describes the Inactive Period fields.

Table 5: Inactive Periods

Field Name	Description
Effective Date	A date that indicates the start of an inactive period due to unlawful, deported, or incarcerated reasons
Termination Date	A date that indicates the end of an inactive period due to unlawful, deported, or incarcerated reasons

Table 6 below describes the Beneficiary Address fields.

Table 6: Beneficiary Address

Field Name	Description
Address Line 1	The address line 1 of the beneficiary, if available
Address Line 2	The address line 2 of the beneficiary, if available
City	The city of the beneficiary, if available
State	The state of the beneficiary, if available
ZIP	The ZIP code of the beneficiary, if available

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Table 7 below describes the End Stage Renal Disease fields.

Table 7: End Stage Renal Disease (ESRD) Information

Field Name	Description
Effective Date	The date that indicates the start of eligibility for ESRD services
Benefit Description Service Type Code	The Type of Dialysis (14 or 15) services that are being rendered
Transplant Discharge Date	The Date the Transplant services were discharged

5.4.4. Deductibles/Caps

The Deductibles/Caps tab (see Figure 15 below) provides information regarding the beneficiary's Part B Deductibles, Blood Deductibles, Occupational Therapy Cap, and Physical and Speech Therapy Caps.

Figure 15: Deductibles/Caps Tab

The screenshot displays the CMS HIPAA Eligibility Transaction System Response interface. At the top, it shows the CMS logo and the text "HIPAA Eligibility Transaction System Response". Below this, there are fields for "LASTNAME, FIRSTNAME MI (XXXXXXXXXXXX)", "Date of Birth: MM/DD/YYYY", and "Date of Death: MM/DD/YYYY". A "Request Date(s) - MM/DD/YYYY-MM/DD/YYYY" field is also present. The interface features a navigation menu on the left with options like "Inquiry", "Eligibility", "Deductibles/Caps" (which is highlighted), "Preventive", "Plan Coverage", "MSP", "Hospice/Home Health", and "Inpatient". Below the navigation menu, there are tabs for "Inquiry", "Eligibility", "Deductibles/Caps", "Preventive", "Plan Coverage", "MSP", "Hospice/Home Health", and "Inpatient". The main content area shows four sections: "Part B Deductible" with fields for "Deductible Year:" and "Remaining Deductible Amount:"; "Blood Deductible" with fields for "Calendar Year:" and "Number of Units Remaining:"; "Occupational Therapy Cap" with fields for "Calendar Year:" and "Remaining Amount:"; and "Physical and Speech Therapy Cap" with fields for "Calendar Year:" and "Remaining Amount:". At the bottom, it displays the address "Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244".

Table 8 below describes the Part B Deductible fields.

Table 8: Part B Deductible Information

Field Name	Description
Deductible Year	The calendar year associated with the remaining deductible amount
Remaining Deductible Amount	Medicare Part B remaining deductible amount associated with the calendar year indicated

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Table 9 below describes the Blood Deductible fields.

Table 9: Blood Deductible Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining deductible amount
Number of Units Remaining	The remaining Blood Deductible units remaining associated with the calendar year indicated

Table 10 below describes the Occupational Therapy Cap fields.

Table 10: Occupational Therapy Cap Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Occupational Therapy remaining amount associated with the calendar year indicated

Table 11 below describes the Physical and Speech Therapy fields.

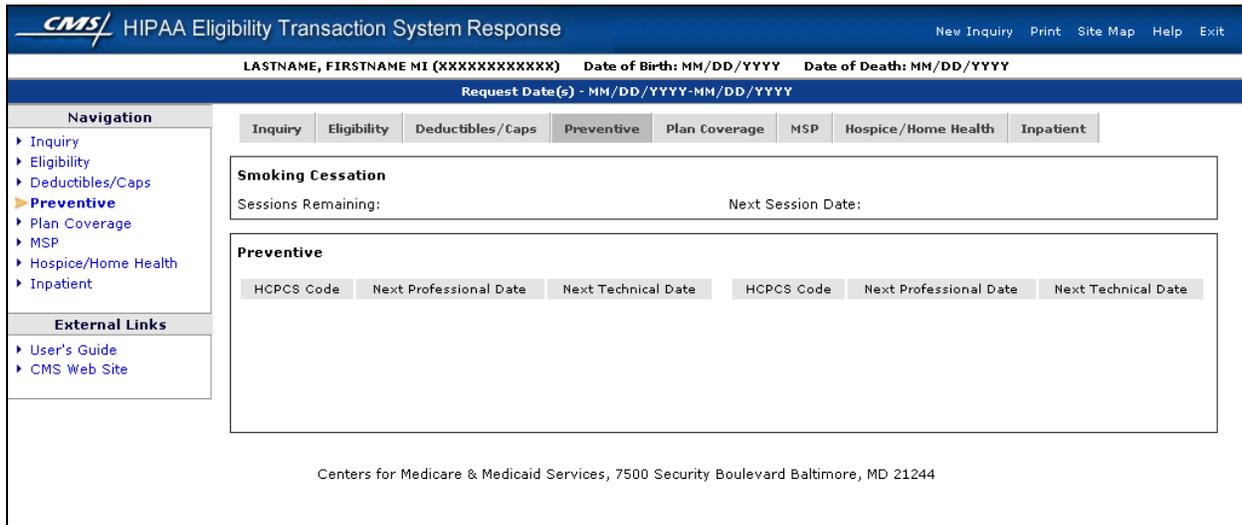
Table 11: Physical and Speech Therapy Information

Field Name	Description
Calendar Year	The calendar year associated with the remaining capitation amount
Remaining Amount	Physical and Speech Therapy remaining amount associated with the calendar year indicated

5.4.5. Preventive Tab

The Preventive tab (see Figure 16 on the following page) provides information regarding the beneficiary's Smoking Cessation and Preventive information. The information on the screen is organized into the Healthcare Common Procedure Coding System (HCPCS) categories (e.g. Cardiovascular, Colorectal, and Diabetes) as shown in Figure 16 on the following page describes the Smoking Cessation fields. Table 13 and Table 14 on the following page describe the Preventive fields.

Figure 16: Preventive Tab



NOTE: Only HCPCS codes for which a particular beneficiary is eligible will be displayed. HCPCS codes that are active or that have been terminated are grouped together under their appropriate categories.

The Preventive tab also contains a special category called "Unclassified." This category will display any newly added HCPCS code that has not yet been defined in the HETS-UI Internet application.

Table 12: Smoking Cessation Information

Fields	Description
Sessions Remaining	Number of Smoking Sessions remaining for a beneficiary
Next Session Date	The next available begin date for Smoking Session program if there are no sessions remaining in their current period

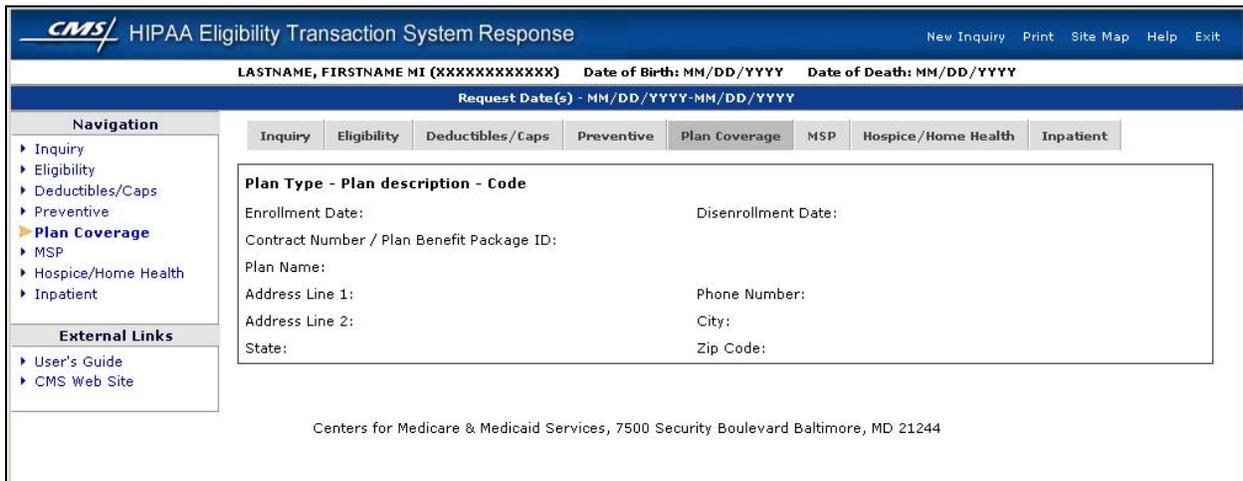
Table 13: Preventive Information

Field Name	Description
HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code
Next Professional Date	The date a beneficiary is next eligible for professional services associated with the indicated HCPCS code
Next Technical Date	The date a beneficiary is next eligible for technical services associated with the indicated HCPCS code

5.4.6. Plan Coverage Tab

The Plan Coverage tab (see Figure 17 below) provides information regarding the beneficiary’s enrollment under MA and Part D contracts and/or MA Managed Care Plans (Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract.

Figure 17: Plan Coverage Tab



Part D contracts provide prescription drug coverage. Medicare claims should not be submitted to the fee-for-service Medicare contractor for the period a beneficiary is enrolled under an MA plan because the MA Organization receives capitation payments from Medicare for the beneficiary’s medical services.

NOTE: Whenever the HETS-UI Internet application indicates that a beneficiary has coverage through a non-Medicare entity (MA or Medicare Drug Benefit plans) the inquiring provider should always contact the non-Medicare entity for complete beneficiary entitlement information.

Part C contracts will return whether the MA is a Health Maintenance Organization Medicare Non Risk (HM), a Health Maintenance Organization Medicare Risk (HN), a Private Fee for Service (IN), a Point of Service (PS), a Preferred Provider Organization (PR), or a Pharmacy (Part D). The response will display only the most current plan description (HM, HN, IN, PS, PR, Part D) and Plan Type Code for a contract. This may happen if a contract’s plan description and Plan Type Code has changed since the beneficiary originally enrolled. Providers are advised to contact the plans if there is any question about the plan’s terms and conditions.

Table 14 on the following page describes the Plan Coverage fields.

Table 14: Plan Coverage Information

Fields	Description
Plan Type	A full plan description followed by Plan Type Code: <ul style="list-style-type: none"> • Health Maintenance Organization Medicare Non Risk – HM • Health Maintenance Organization Medicare Risk – HN • Private Fee for Service – IN • Preferred Provider Organization – PR • Point of Service – PS • Pharmacy – Part D
Enrollment Date	The date that indicates the start of enrollment to the coverage plan
Disenrollment Date	The date that indicates the termination of enrollment to the coverage. No date in this field means the plan enrollment has not terminated.
Contract Number/Plan Benefit Package ID	The contract number followed by the plan number (if on file)
Plan Name	A descriptive name of the beneficiary’s insurance coverage organization
Address Line 1	The Coverage Plan’s Address Line 1
Phone Number	The Coverage Plan’s Contract Telephone Number (if on file)
Address Line 2	The Coverage Plan’s Address Line 2
City	The Coverage Plan’s City Address
State	The Coverage Plan’s State Address
ZIP Code	The Coverage Plan’s ZIP Code

5.4.7. Medicare Secondary Payer (MSP) Tab

When a beneficiary has a primary payer other than Medicare, the Medicare Secondary Payer (MSP) tab (see Figure 18 below) provides the beneficiary's primary insurance information.

Figure 18: Medicare Secondary Payer (MSP) Tab

The screenshot shows the 'Medicare Secondary Payer' tab selected in the CMS HIPAA Eligibility Transaction System Response. The interface includes a navigation menu on the left with options like Inquiry, Eligibility, Deductibles/Caps, Preventive, Plan Coverage, MSP (highlighted), Hospice/Home Health, and Inpatient. Below the navigation menu are 'External Links' for User's Guide and CMS Web Site. The main content area displays the 'Medicare Secondary Payer' section with fields for Effective Date, Termination Date, Insurer Name, Policy Number, Type of Primary Insurance, Address Line 1, City, Address Line 2, State, and Zip Code. The footer of the page reads 'Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244'.

NOTE: The MSP tab only displays active MSP data per the date(s) requested and will not be accessible if there is no MSP data or if notification of coverage primary to Medicare has not been received by CMS.

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The following tables provide information about the MSP Benefit tab.

Table 15 below describes the MSP fields.

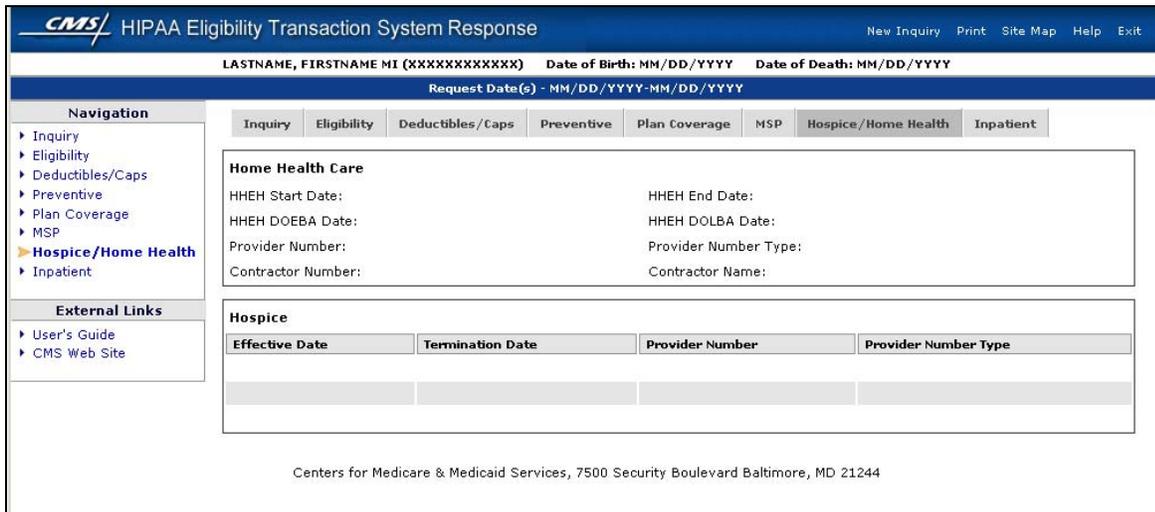
Table 15: MSP Information

Fields	Description
Effective Date	The date that indicates the start of the primary insurer's coverage
Termination Date	The date that indicates the termination of the primary insurer's coverage. No date in this field means primary insurance coverage has not terminated
Insurer Name	The name of the insurance company
Policy Number	The primary insuring organization's policy number for the Medicare beneficiary
Type of Primary Insurance	12 = Medicare Secondary Working Aged Beneficiary or spouse with Employer Group Health Plan 13 = Medicare Secondary End Stage Renal Disease Beneficiary in the 12 month coordination period with an Employer Group Health Plan 14 = Medicare Secondary No-Fault insurance including auto is primary 15 = Medicare Secondary Worker's Compensation 16 = Medicare Secondary Public Health Service (PHS) or other Federal Agency 41 = Medicare Secondary Black Lung 42 = Medicare Secondary Veteran's Administration 43 = Medicare Secondary Disabled Beneficiary Under Age 65 with Large Group Health Plan 47 = Medicare Secondary other liability insurance is primary
Address Line 1	The address Line 1 of the insurance company
Address Line 2	The address Line 2 of the insurance company
City	The city of the insurance company
State	The state of the insurance company
ZIP Code	The ZIP code of the insurance company

5.4.8. Hospice/Home Health Tab

The Hospice/Home Health tab (see Figure 19 below) includes two sections: 1) Hospice and 2) Home Health.

Figure 19: Hospice/Home Health Tab



The Home Health section provides information for each episode start and end date and the corresponding billing activity dates. Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all Home Health services while a beneficiary is under a Home Health plan of care authorized by a physician. Consequently, Medicare payment for all such items and services must be made to a single Home Health Agency (HHA) overseeing that plan. This HHA is known as the primary HHA for Home Health Prospective Payment System (HHPPS) billing purposes. There is no limit to the number of non-overlapping episodes a beneficiary who remains eligible for the Home Health benefit can receive.

The Hospice section provides eligibility information when the hospice benefit is effective and when it terminates. When Hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of their terminal illness during any period their hospice benefit election is in effect, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice provider, they may not receive compensation from the Hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the Hospice.

The HETS-UI system will return separate Hospice Periods if a Medicare beneficiary had two (or more) periods at different Hospice Providers on contiguous days. Each Hospice Period will be returned separately, including the unique Hospice Provider Number.

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NOTE: The Hospice/Home Health tab only displays active Hospice and/or Home Health data and will not be accessible when there have been no claims received by CMS indicating Hospice or Home Health coverage is active and is in effect per the date(s) requested.

The following tables provide information about the Hospice/Home Health tab.

Table 16 below describes the Home Health fields.

Table 16: Home Health Information

Fields	Description
HHEH Start Date	The date the 60-day Home Health episode period started
HHEH End Date	The date that the Home Health episode terminated. No date in this field means the Home Health episode period has not terminated
HHEH DOEBA Start Date	The date of earliest billing activity for spell of illness
HHEH DOLBA End Date	The date of latest billing activity for spell of illness
Provider Number	The NPI or Legacy Provider Number of the Home Health Facility
Provider Number Type	A display of "Legacy" or "NPI" depending on the source of the provider number
Contract Name	A display of the Contract name

Table 17 below describes the Hospice fields.

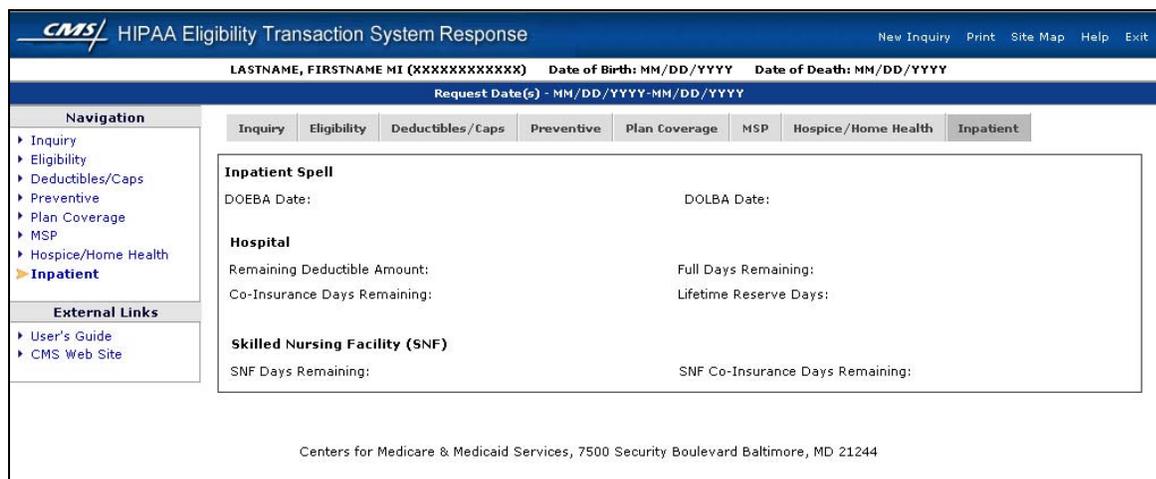
Table 17: Hospice Information

Field Name	Description
Effective Date	The start date of a beneficiary's elected period of Hospice coverage
Termination Date	The termination date of a beneficiary's elected Hospice coverage. No date in this field means the beneficiary's elected period of Hospice coverage has not terminated
Provider Number	The NPI or Legacy provider number of the Hospice Facility
Provider Number Type	A display of "Legacy" or "NPI" depending on the source of the provider number

5.4.9. Inpatient Tab

The Inpatient tab (see Figure 20 below) includes Hospital and Skilled Nursing Facility (SNF) sections. The Hospital section provides hospital benefit and billing information. The SNF section provides SNF benefit and billing information.

Figure 20: Inpatient Tab



The HETS-UI system shall return Hospital default deductibles based on the request start year when the following occurs:

- No Inpatient Spell data returned from the database overlaps or falls within 60 days of the requested date (range)
- Entitlement period and request date period overlap
- Part A Entitlement start year is less than the requested start year

In addition, the HETS-UI system will continue to return the Hospital Inpatient Default Deductible Remaining amounts, Hospital Co-Insurance days, and SNF (Skilled Nursing Facility) Co-insurance days based on the beneficiary’s Part A Entitlement start year when the following occurs:

- No Inpatient Spell data returned from the database overlaps or falls within 60 days of the requested date (range)
- Entitlement period and request date period overlap
- Part A Entitlement start year is greater than or equal to the requested start year

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NOTE: Depending on the date(s) range requested, multiple Hospital and SNF spells might be displayed. The data returned on this screen is directly impacted by timely submission of claims by the provider. The data returned is compiled from claims that have been processed by CWF.

The following tables describe the Inpatient tab.
Table 18 below describes the Inpatient Spell fields.

Table 18: Inpatient Spell Information

Fields	Description
DOEBA Date	The date of earliest billing activity for the spell of illness
DOLBA Date	The date of latest billing activity for spell of illness

Table 19 below describes the Hospital fields.

Table 19: Hospital Information

Field Name	Description
Remaining Deductible Amount	The amount of the inpatient deductible remaining to be met
Full Days Remaining	The full Hospital inpatient days remaining in the spell
Co-Insurance Days Remaining	The Hospital inpatient co-insurance days remaining
Lifetime Reserve Days	The number of lifetime reserve days remaining

Table 20 below describes the SNF fields.

Table 20: SNF Information

Field Name	Description
SNF Days Remaining	The number of SNF days remaining
SNF Co-Insurance Days Remaining	The number of SNF co-insurance days remaining

6. TROUBLESHOOTING & SUPPORT

6.1. Error Messages

Typical error messages that might be encountered on the Medicare Eligibility Benefit Inquiry screen are included in Table 21 below. The table shows the error message, the associated field from the Medicare Eligibility Benefit Inquiry screen, and how the User can resolve the error. The system will only return one error message per transaction.

Table 21: Medicare Eligibility Benefit Inquiry Error Messages

Field Name	Error Message	User Resolution
Not Applicable	Access Denied: Your session has been terminated because you have exceeded the error limit.	Please contact the Medicare Eligibility Help Desk at 1-866-440-3805 to restore your access to the system. The Help Desk is available Monday – Friday from 7AM - 9PM Eastern Time.
Subscriber Last Name	Missing Patient Last Name. Please correct and click the 'Submit Inquiry' button!	No patient last name was entered on the Medicare Eligibility Benefit Inquiry screen. Please enter the required data and submit a new inquiry.
Subscriber Last Name	E00039 – Last Name Mismatch	The User should verify the patient's last name as printed on the Medicare Health Insurance card and submit a new inquiry.
Subscriber First Name	Missing Patient First Name. Please correct and click the 'Submit Inquiry' button!	No patient first name was entered on the Medicare Eligibility Benefit Inquiry screen. Please enter the required data and submit a new inquiry.
Subscriber Last Name	E00077 – First Name Mismatch	The User should verify the patient's first name as printed on the Medicare Health Insurance card and submit a new inquiry.
Subscriber Birth Date	Missing/Invalid Patient Birth Date. Please correct and click the 'Submit Inquiry' button!	An invalid or missing character or an invalid or missing date was entered on the Medicare Eligibility Benefit Inquiry screen. Please correct the date of birth and submit a new inquiry.
Subscriber Birth Date	E00086 – Date Of Birth Mismatch	The User should verify the patient's date of birth and submit a new inquiry. If the User still receives this message, the User can have the patient contact 1-800-Medicare 24 hours a day, 7 days a week to verify what Medicare is showing for date of birth.

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Field Name	Error Message	User Resolution
Subscriber Gender	E00085 – Gender Mismatch	The User should correct or remove the gender entry and submit a new inquiry.
Subscriber Primary ID (HICN)	Missing Patient Primary ID. Please correct and click the 'Submit Inquiry' button!	The User should input the Health Insurance Claim Number (HICN), as shown on the patient's Medicare Health Insurance card, on the Medicare Eligibility Benefit Inquiry screen. The HICN on the Medicare Health Insurance card is referred to as the Medicare Claim Number.
Subscriber Primary ID (HICN)	E00004 – No Matching Bene Record or Occurrence Found on DB	The User should verify the patient's primary ID (HICN) as shown on their Medicare Health Insurance card and submit a new inquiry.
Subscriber Primary ID (HICN)	E00082 – Inactive (XREF) HICN Submitted – corrected HICN XXXXXXXXXXXX.	The User should use the corrected HICN to verify patient Medicare coverage and the User should have the patient request a new Medicare Insurance card with a new number.
Subscriber Primary ID (HICN)	Error: An unforeseen error has occurred. Please try your request again! If this condition continues please call the Medicare Eligibility Help Desk at 1-866-440-3805.	We have made every effort to identify and code the Internet application for all possible error messages. In the event the Internet application has not been coded to return a specific error message, the User will receive this message. Please contact the Help Desk to report this. The Help Desk will try to replicate the response received by the User to identify the error so we can return a more appropriate error message in the future.
From Date	Inappropriate Eligibility "From" Date. Please correct and click the 'Submit Inquiry' button! OR Beneficiary is Inactive OR Beneficiary is Inactive. Date of Death is <MM/DD/YYYY>"	See section 5.3.2 of this User Guide.

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Field Name	Error Message	User Resolution
From Date	E00010 – Invalid date	An invalid character, an invalid date or a date older than 27 months from the current date was entered on the Medicare Eligibility Benefit Inquiry screen. Please correct the date and submit a new inquiry.
To Date	Inappropriate Eligibility “To” Date. Please correct and click the ‘Submit Inquiry’ button! OR Beneficiary is Inactive	See section 5.2 of this User Guide.
To Date	E00010 – Invalid date	An invalid character, an invalid date or a date greater than 4 months in the future from the current date was entered on the Medicare Eligibility Benefit Inquiry screen. Please correct the date and submit a new inquiry.

6.2. Special Considerations

If Users experience any problems while using the HETS-UI Internet application, they should contact MCARE Help Desk support. The contact information is in section 6.4.

6.3. Reporting Security Problems

All Users have a duty to report information security violations and problems to MCARE Help Desk Corporate Information Security on a timely basis so that prompt remedial action can be taken.

All suspected policy violations, system intrusions, virus infestations, and other conditions that might jeopardize CMS information or CMS information systems must be immediately reported to the MCARE Help Desk at (866) 440-3805. The MCARE Help Desk will escalate the security issue, if necessary, to the CMS IT Help Desk as appropriate.

NOTE: With respect to all such interaction, Help Desk personnel require individual identification before transactions can be completed.

6.4. System Support Information

If problems and/or questions arise while accessing the HETS-UI Internet application, Users should contact the Help Desk using the numbers listed in Table 22 on the following page.

Table 22: Points of Contact

Contact	Phone	Email	Role	Responsibility
MCARE	Help Desk phone number: (866) 440-3805 Help Desk fax number: (615) 238-0822 Hours of Operation: Monday - Friday, 7 AM - 9 PM EST	MCARE@cms.hhs.gov	Help Desk support	1 st level User support and problem reporting

7. GLOSSARY

DOEBA

This is the date of the earliest billing activity on record.

DOLBA

This is the date of the latest billing activity on record.

HICN

This is the Health Insurance Claim Number, which is the Medicare beneficiary identifier assigned by Medicare. It is also referred to as the subscriber primary ID and the Medicare claim number.

8. ACRONYMS

Table 23 below identifies acronyms and definitions.

Table 23: Acronyms and Definitions

CAP	Corrective Action Plan
CBT	Computer Based Training
CMS	Centers for Medicare & Medicaid Services
CWF	Common Working File
EPOC	External Point of Contacts (currently referred to as User Group Administrators – UGA)
ESRD	End Stage Renal Disease
HCPCS	Healthcare Common Procedure Coding System
HETS-UI	HIPAA Eligibility Transaction System-User Interface
HHA	Home Health Agency
HHEH	Home Health Episode History
HHPPS	Home Health Prospective Payment System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
IACS	Individuals Authorized Access to the CMS Computer Services
MA	Medicare Advantage
MCARE	Medicare Customer Assistance Regarding Eligibility
MCO	Managed Care Organization
MMDDYYYY	Month, Day, Year,
MSP	Medicare Secondary Payer
NPI	National Provider Identification
PCC	Provider Contact Center
PHI	Protected Health Information
PHS	Public Health Service
POS	Point of Service
PPO	Preferred Provider Organization
RRB	Railroad Retirement Board

SNF	Skilled Nursing Facility
UGA	User Group Administrator

9. APPENDIX

CMS HIPAA Eligibility Transaction System (HETS) Rules of Behavior

The Centers for Medicare & Medicaid Services (CMS) is committed to maintaining the integrity and security of health care data in accordance with applicable laws and regulations. Disclosure of Medicare beneficiary eligibility data is restricted under the provisions of the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA.)

This document reiterates your responsibility in obtaining, disseminating, and using beneficiary's Medicare eligibility data. It also further explains the expectations for providers using this application. The eligibility transaction is to be used for the use of conducting Medicare business only. Acceptance of these rules of behavior is necessary in order to gain access to the system. Violating these Medicare Health Benefit Eligibility Inquiry Rules of Behavior and/or other CMS data privacy and security rules could result in revoked access and other penalties.

The EDI Enrollment process must be executed by each provider that submits/receives EDI either directly to or from Medicare or through a third party. Each provider that will use EDI either directly or through a billing agent or clearinghouse to exchange EDI transactions with Medicare must sign the EDI Enrollment Form

As a reminder, along with other EDI provisions, you agreed to use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access.

Acting on behalf of the beneficiary, providers/users of Medicare data are expected to use and disclose protected health information according to the CMS regulations. The HIPAA Privacy Rule mandates the protection and privacy of all health information. This rule specifically defines the authorized uses and disclosures of "individually-identifiable" health information. The privacy regulations ensures privacy protections for patients by limiting the ways that physicians, qualified non-physician practitioners, suppliers, hospitals and other provider covered entities can use a patients' personal medical information.

Authentication for HIPAA 270/271 Eligibility Data

Authenticating elements that must be granted by the inquirer prior to the release of any beneficiary-specific eligibility information include:

- Beneficiary last name (must match the name on the Medicare card)
- Beneficiary first name (must match the information on the Medicare card)
- Assigned Medicare Claim Number (also referred to as the Health Insurance Claim Number (HICN)), including both alpha and numerical characters
- Date of birth

NOTE: The Medicare beneficiary should be your first source of health insurance eligibility information. When scheduling a medical appointment for a Medicare beneficiary, remind them to bring, on the day of their appointment, all health insurance cards showing their health insurance coverage. This will not only help you determining who to bill for services rendered, but also give you the proper spelling of the beneficiary's first and last name and identify their Medicare Claim Number as reflected on the Medicare Health Insurance card. If the beneficiary has Medicare coverage but does not have a Medicare Health Insurance card, encouraged them to contact the Social Security Administration at 1-800-772-1213 to obtain a replacement Medicare Health Insurance card. Those beneficiaries receiving benefits from the Railroad Retirement Board (RRB) can call 1-800-808-0772 to request a replacement Medicare Health Insurance card from RRB.

Authorized Purposes for Requesting Medicare Beneficiary Eligibility Information

In conjunction with the intent to provide health care services to a Medicare beneficiary, authorized purposes include to:

- Verify eligibility for Part A or Part B of Medicare
- Determine beneficiary payment responsibility with regard to deductible/co-insurance
- Determine eligibility for services such as preventive services
- Determine if Medicare is the primary or secondary payer
- Determine if the beneficiary is in the original Medicare plan or Part C plan (Medicare Advantage).
- Determine proper billing

Unauthorized Purposes for Requesting Beneficiary Medicare Eligibility Information

- To determine eligibility for Medicare
- To acquire the beneficiary's health insurance claim number

Medicare eligibility data is only to be used for the business of Medicare; such as preparing an accurate Medicare claim or determining eligibility for specific services.

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In order to obtain access to eligibility data, as a provider or an individual employed by the provider, you will be responsible for the following:

- Before you request Medicare beneficiary eligibility information and at all times thereafter, you will ensure sufficient security measures to associate a particular transaction with the particular employee.
- Adhere to basic desktop security measures to ensure the security of Medicare beneficiary personal health information:
 - Do not disclose or lend your identification number and/or password to someone else. They are for your use only and serve as your electronic signature. This means that you may be held responsible for the consequences of authorized or illegal transactions.
 - Do not browse or use CMS data files for unauthorized or illegal purposes.
 - Do not use CMS data files for private gain or to misrepresent yourself or CMS.
 - Do not make any disclosure of CMS data that is not specifically authorized.
- You will cooperate with CMS or its agents in the event that CMS has a security concern with respect to any eligibility inquiry.
- You will promptly inform CMS or one of CMS's contractors in the event you identify misuse of "individually-identifiable" health information accessed from the CMS database.
- Each eligibility inquiry will be limited to requests for Medicare beneficiary eligibility data with respect to a patient currently being treated or served by you, or who has contacted you about treatment or service, or for whom you have received a referral from a health care provider that has treated or served that patient.

Medicare health benefit beneficiary eligibility inquiries are monitored. Providers identified as having aberrant behavior (e.g., high inquiry error rate or high ratio of eligibility inquiries to claims submitted) may be contacted to verify proper use of system, made aware of educational opportunities, or when appropriate referred for investigation of possible fraud and abuse or violation of HIPAA privacy law.

Violation of these security requirements could result in termination of systems access privileges and /or disciplinary/adverse action up to and including legal prosecution. Federal, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system.

Criminal Penalties

Trading Partner Agreement Violation

42 U.S.C. 1320d-6 authorizes criminal penalties against a person who, "knowingly and in violation of this part ... (2) obtains individually identifiable health information relating to an individual; or (3) discloses individually identifiable health information to another person." Offenders shall "(1) be fined not more than \$50,000, imprisoned not more than 1 year, or both; (2) if the offense is committed under false pretenses, be fined not more

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than \$100,000, imprisoned not more than 5 years, or both; and (3) if the offense is committed with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, be fined not more than \$250,000, imprisoned not more than 10 years, or both."

False Claim Act

Under the False Claims Act, 31 U.S.C. §§ 3729-3733, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HHS may impose civil money penalties on a covered entity of \$100 per failure to comply with a Privacy Rule requirement. That penalty may not exceed \$25,000 per year for multiple violations of the identical Privacy Rule requirement in a calendar year. A person who knowingly obtains or discloses individually identifiable health information in violation of HIPAA faces a fine of \$50,000 and up to one-year imprisonment. The criminal penalties increase to \$100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to \$250,000 and up to ten years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Criminal sanctions will be enforced by the Department of Justice.