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

FINAL

Version: 4-1

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REVISION HISTORY

Document Revision History

Version	Date	Description of Changes
1.0	03/12/2007	Baseline Version (Published to CMS Website)
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: 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.**
2.6	02/06/2008	Formatting changes related to the Table of Contents
2.7	03/19/2008	Document updated with MCO changes & 508 Compliancy Notes
2.8	08/18/2008	The changes for this release include the following: Lockout process (sections 3.2, 6.1) Returning only one error message per transaction (section 6.1)
2.9	09/19/08	The following changes have been made: 5.2 PHI/Confidentiality Disclaimer message has been added 5.4.6 MCO plans' contact phone number has been added 5.4.8 Update to Hospice Periods being returned 5.4.9 Part A Hospital and Skilled Nursing default deductible and co-insurance information has been added

Version	Date	Description of Changes
3.0	11/03/08	The following change has been made: 5.4.6 Plan descriptions and plan type codes have been updated
3.1	01/05/09	Changes include: 5.3.2 Added information about date format error message 5.3.3 Removed references to the E00010 Error Message 5.4.6 Updated section with Indemnity – IN Plan Coverage 6.1 Updated Error Messages on Table 21
3.2	06/15/09	Changes include: 5.2 Added unauthorized IACS error message and screen shot. 5.3.1 Removed note about the capability to open multiple Inquiry screens. 5.3.1 Added note about matching rule for optional beneficiary data. 5.3.3 Replaced references to "co-insurance" with "co-payment" 5.4.9 Updated Figure 21 and replaced references to "co-insurance" with "co-payment" 6.1 Updated Table 21 to include Message and User Resolution for error code E00028, E00097, and the Unanticipated Response Error.
3.3	12/15/09	Changes include: 5.4.7 Added "WC" code and description to Table 15. 6.1 Updated Table 21 with correct error message for codes E00028 and E00097. 6.4 Updated HelpDesk fax number

Version	Date	Description of Changes
3.4	04/26/10	Changes include: Figure 8 Replaced with new Medicare Applications Selection Screen, including new HelpDesk fax number Figure 9 Replaced with new IACS Login screen Section 5.2 Added a step (Step 6) for explanation of new "Forgot Your User ID?" button. Section 5.2, Step 6 became Step 7. Updated hyperlink for IACS User Guide and replaced references to a link with references to a button for "Forgot Your Password?". Updated CMS website addresses to the new standard (cms.gov instead of cms.hhs.gov). One exception to the new website continues to be the Applications website address in Section 5.2.
3.5	11/15/10	Changes include: Updated Figures 5, 6 and 7 to reflect updated CMS Applications Portal pages. Updated Figure 18 and Table 14 for MCO Bill Option Code for the Plan Coverage tab. Updated Figure 20 and Tables 16 and 17 for removal of Provider Number and Provider Number Type. Updated Figure 21 and Tables 19 and 20 for Co-Payment Amount on the Inpatient tab.
3.6	03/04/2011	Changes include: Updated Section 5.4.5 and Table 12 with tobacco cessation counseling.

Version	Date	Description of Changes
4-0	12/9/2011	Changes include: Updated Section 5.3.1 to indicate that gender is not validated against the Medicare Database. Also updated required fields section to indicate the three inquiry scenarios. Updated Section 5.4.3 to indicate that unlawful periods will not display. Also added three new categories which will display on the Deductibles/Cap Tab which are Pulmonary Rehabilitation, Cardiac Rehabilitation and Intensive Cardiac Rehabilitation. Updated wording in Section 5.4.3 Updated Section 5.4.4 to include Cardiac and Pulmonary Rehab. Update 5.4.6 to show new field "Contract Website Address" Update Section 5.4.8 to show new Home Health Certification information and the addition of the Revocation Code within the Hospice section of the Hospice/Home Health Tab. Renumbered tables as appropriate. Updated the error messages in table 25. Removed 'Internet' from the Guide name and any reference to the application. Changed UI system to UI application. Updated table 26 for web addresses. Updated all screen shots to display new PHI or changed data fields

Version	Date	Description of Changes
4-1	3/9/2012	Changes Include: Tables 25 and 26 and Figures 4, 8 and 22 – Updated MCARE hours of operation. Updated Section 5.4.4 to show the new Technical and Professional split for Pulmonary, Cardiac and Intensive Cardiac Rehabilitation. Added new screen shot for Figure 16- Deductibles/Caps Tab. Added new screen shot for Site Map in Section 3, Figure1. Updated example in Table 2. Updated example in Section 5.3.3

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

The Centers for Medicare & Medicaid Services (CMS) designed the HETS-UI application to support the providers' beneficiary eligibility data needs. The HETS-UI 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 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 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 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 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 User Guide.

3. OVERVIEW

The HETS-UI 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.

The application layout in the Site Map (Figure 1) 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 Site Map
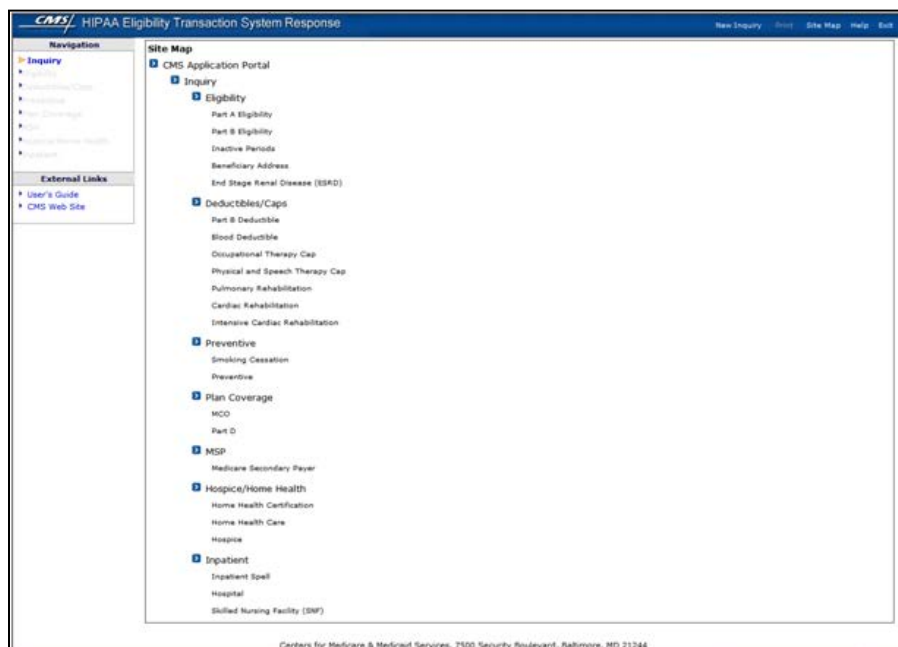
When a User logs into the HETS-UI application, the Inquiry tab (Figure 2) is displayed. After the required data elements are entered and validated, the response tabs are displayed. The User can proceed from tab to tab, where beneficiary data is available, by clicking the tab or selecting the hyperlink 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 application offers additional application features (Figure 3) 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 application
- **Help** – Provides the Help Desk contact information
- **Exit** – Closes the active HETS-UI 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 User Guide and CMS Website

Figure 3: Application Attributes Representation
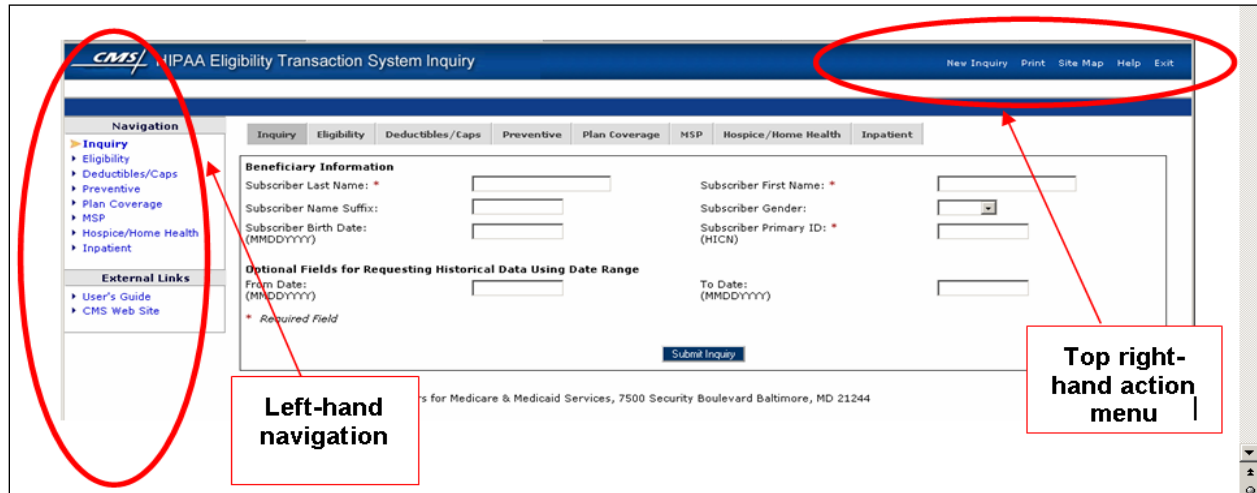
3.1. Conventions

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

3.2. Cautions & Warnings

The HETS-UI 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 application in order to prevent User lockout.

Authorized Users of the HETS-UI 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.

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

Table 1: Incident Severity Levels and Required Action

Situation	Action Description
LOW SEVERITY *User is very infrequently locked out*	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.
HIGH SEVERITY *User is frequently locked out*	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).
SECURITY INCIDENT EMERGENCY SEVERITY *User continues to be locked out frequently after a CAP has been submitted* OR *Organization's Users demonstrate systematic failure to enter valid data*	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).

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

Figure 4: Access Denied Alert Message

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 - 7PM Eastern Time.

4. GETTING STARTED

The following sub-sections provide a general walkthrough of the HETS-UI 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 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 application, the User should:
- ***Disable pop-up blockers*** prior to attempting access to the HETS-UI application.
- Use Explorer, version 6.0 or higher.

4.2. User Access Considerations

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

4.3. Accessing the System

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

4.4. System Organization & Navigation

Specific functionality and screen captures are described in Section 5.4.2 of this document.

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 application. The Users will be logged out, and the HETS-UI application window will close.

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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 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 (Figure 5).

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
    - 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
    - Provider Statistical & Reimbursement System (PS&R) – This link is not intended for HETS users.
    - IACS Community Administration Interface
    - HETS Provider Graphical User Interface (GUI) (HPG)
    - CARE – Continuity Assessment & Evaluation – This link is not intended for HETS users.
    - HETS UI Administration

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 application, or when existing business partners need to manage their accounts.

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

- Select the My Profile link and then select the "Forgot Your User ID?" button. The User will follow Step 6 in Section 5.2 of this document.
  OR
- Contact the MCARE Help Desk using the contact information listed in Section 6.4. of this document.

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

- Select the My Profile link and then select the "Forgot Your Password?" button. The User will follow Step 7 in Section 5.2 of this document.
  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.

5.1.3. Providers

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

A business partner will have access to the HETS-UI 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.
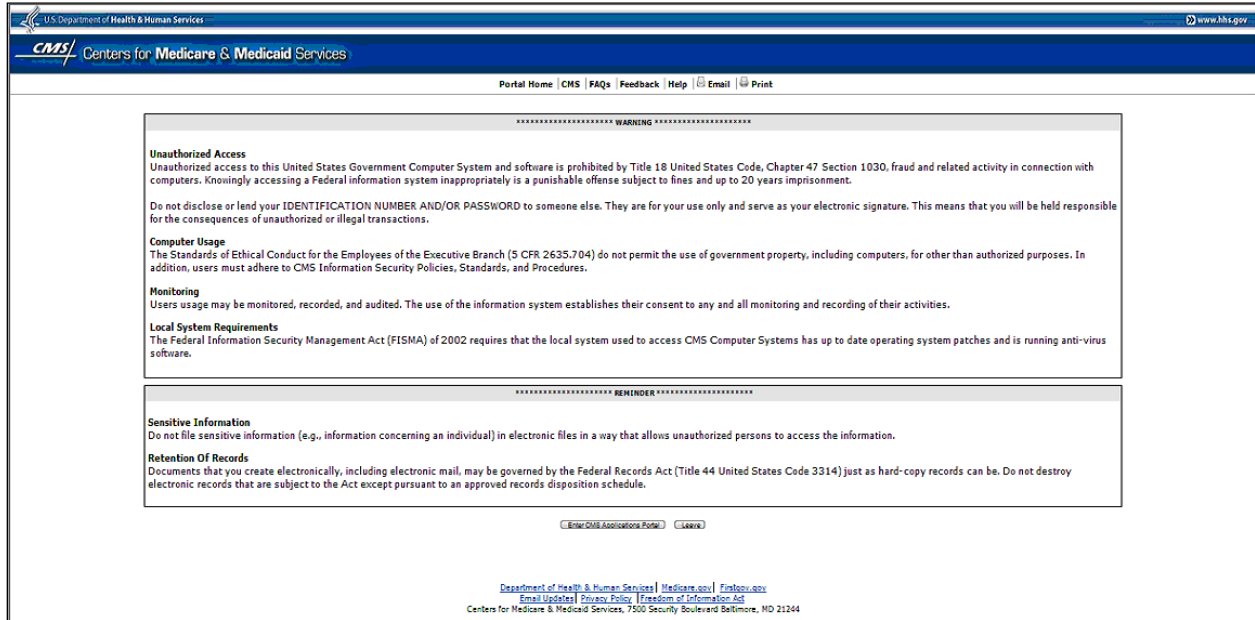
5.2. Eligibility and Inquiry Response

Follow these steps to access the HETS-UI 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.

Figure 6: CMS Applications Portal

2. To access the HETS-UI 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.gov/).

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

Figure 7: CMS Applications Portal Main Page
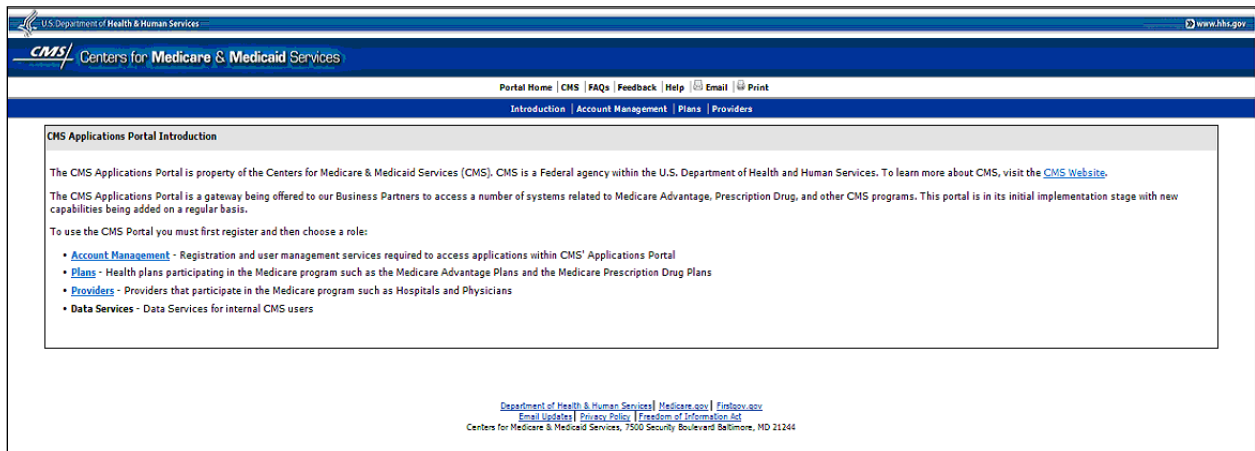
   NOTE: For business partners that have been granted access to the HETS-UI on the applications portal page, locate the "Providers" hyperlink in the navigation

row. After clicking the Providers link, the Medicare Applications Selection Screen (Figure 8) will appear.

Figure 8: Medicare Applications Selection Screen

4. Click the "HETS-UI HIPAA Eligibility Transaction System User Interface" hyperlink. A new window opens (Figure 9) that allows authorized Users to access the HETS-UI application.

Figure 9: IACS Login

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

   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.

   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. They must 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. If the User does not receive the email within 30 minutes, the User must call the MCARE Help Desk (Section 6.4 System Support Information). After the password has been reset and submitted, the User should completely logout of the application and then close the current window.

6. If the User has forgotten their IACS User ID, they should click the "Forgot Your User ID?" button. A "Forgot Your User ID?" screen will be displayed with fields for First Name, Last Name, Date of Birth, Social Security Number and Email. The User must complete all fields and click the "Next" button. A "User ID Recovery-Authentication" screen will be displayed. The User must answer the questions they selected during the IACS registration process with the exact answer they previously provided, and then click the "Next" button. A confirmation screen will display the message "Your user ID was sent to the email address on file" message and a "Close" button. The User selects the "Close" button and checks their email for their IACS User ID. If the User does not receive the email within

30 minutes, the User must call the MCARE Help Desk. (Section 6.4 System Support Information).

If the User incorrectly answers 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. (Section 6.4. System Support Information).

7. 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, refer to the IACS User Guide for CMS Applications. (http://www.cms.gov/MAPDHelpDesk/07_IACS.asp#TopOfPage).

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?" button. 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. (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. (Section 6.4 System Support Information).

8. 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 Eligibility application software that the User is authorized to access the application.

9. After the User is authorized to access the HETS-UI application, 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 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.

10. If the User is not authorized to access the HETS-UI application, the IACS error message in Figure 11 will be displayed. The User must contact the MCARE Help Desk using the system support information in Section 6.4 of this document.

Figure 11: IACS Error Message for Unauthorized Access

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

5.3.1. Inquiry Tab

The User can use the Inquiry Tab (Figure 12) to enter beneficiary information and submit a Medicare Beneficiary Eligibility Request. There are three options that may be used when submitting an inquiry which are as follows:

Option #1
- Subscriber[1] Last Name

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

- Subscriber First Name
- Subscriber Birth Date
- Subscriber Primary ID (HICN[2])

Option #2
- Subscriber Last Name
- Subscriber Birth Date
- Subscriber Primary ID (HICN)

Option #3
- Subscriber Last Name
- Subscriber First Name
- Subscriber Primary ID (HICN)

Figure 12: Inquiry Tab

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

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[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.

NOTE: If data is entered into an optional field other than Subscriber Gender, and the data entered does not match the beneficiary's data maintained by Medicare, eligibility data will not be returned on the Eligibility Response tab. Subscriber Gender information is not validated against the data maintained by Medicare.

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.

A User will receive the "Invalid 'From Date' Format" error message when an invalid character or an invalid date is entered on the Medicare Eligibility Benefit Inquiry screen. The user is prompted to correct the date and submit a new 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
- 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 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.

Based on the date the request was received, the HETS-UI application will subtract 27 calendar months and add four months, to determine the eligibility window. Trading Partners must be aware that requests older than 27 calendar months or greater than four calendar months in the future will be rejected, and the error message, "Date(s) of Service Not Within Allowable Inquiry Period", will be displayed.

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.
- 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 illustrates the allowable request date ranges.

Table 2: Request Date Calendar

If the Current Month Is:	Historical Requests Are Valid Through:	Future Requests Are Valid Through:
January	October, 3 years ago	May of the current year
February	November, 3 years ago	June of the current year
March	December, 3 years ago	July of the current year
April	January, 2 years ago	August of the current year
May	February, 2 years ago	September of the current year
June	March, 2 years ago	October of the current year
July	April, 2 years ago	November of the current year
August	May, 2 years ago	December of the current year
September	June, 2 years ago	January of the following year
October	July, 2 years ago	February of the following year
November	August, 2 years ago	March of the following year
December	September, 2 years ago	April of the following year

Example: If an eligibility request is sent on March 1, 2012, requests from December 1, 2009 through July 1, 2012 will be accepted.

<u>NOTE</u>: If a User requests a future date for which Medicare Co-Payment and Deductible amounts have not yet been finalized, the HETS-UI application will return an eligibility response. The Co-Payment 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 13 is a sample of beneficiary data.

Figure 13: Sample Beneficiary Data

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 14 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 14):

- 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 14: Tab Header
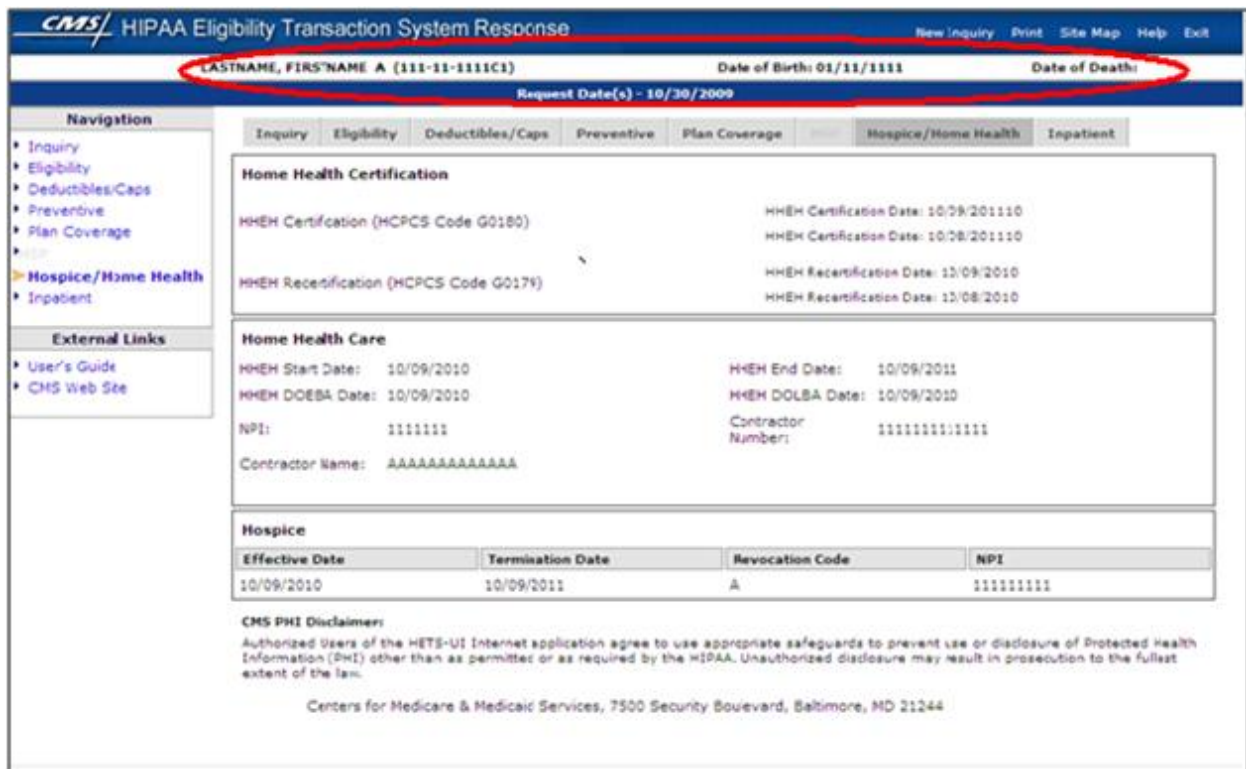
5.4.2. Medicare Eligibility Benefit Response Tabs

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 (Figure 15) provides information regarding the beneficiary's Part A and Part B Eligibility, Inactive Periods (e.g. unlawful, deported, and incarcerated), Beneficiary Address, and ESRD. If this tab is available, it indicates that the beneficiary has some type of Medicare Eligibility. If there is eligibility for Medicare benefits, the screen will display the beneficiary's Part A and/or Part B Eligibility period(s) as appropriate. 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 15: Eligibility Tab

NOTE: The Part A, Part B, and ESRD sections of this screen will display any eligibility data for date(s) that were requested by the user on the Inquiry screen. Periods of

ineligibility during that same requested period (due to incarceration, illegal alien status, etc.) would instead be displayed in the "Inactive Periods" section.

The following tables provide information for the Eligibility Benefit tab.

Table 3 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 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 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 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

Table 7 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 (Figure 16) provides information regarding the beneficiary's Part B Deductibles, Blood Deductibles, Occupational Therapy Cap, and Physical and Speech Therapy Caps and Pulmonary, Cardiac and Intensive Cardiac Rehabilitation sessions.

Figure 16: Deductibles/Caps Tab
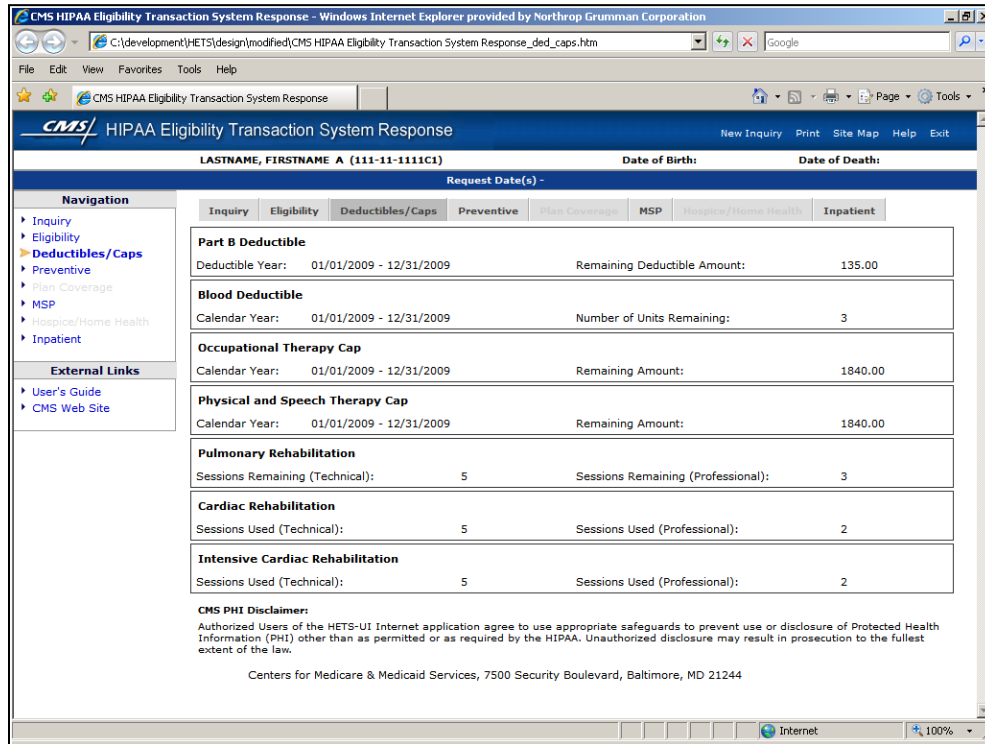
Table 8 describes the Part B Deductible fields.

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

Table 9 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 Blood Deductible units remaining associated with the calendar year indicated

Table 10 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 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

Table 12 describes the Pulmonary Rehabilitation fields.

Table 12: Pulmonary Rehabilitation Information

Field Name	Description
Sessions Remaining (Technical)	The number of Pulmonary Rehabilitation sessions remaining for the Technical Component.
Sessions Remaining (Professional)	The number of Pulmonary Rehabilitation sessions remaining for the Professional Component.

Table 13 describes the Cardiac Rehabilitation fields.

Table 13: Cardiac Rehabilitation Information

Field Name	Description
Cardiac Rehabilitation Sessions Used (Technical)	The number of Cardiac Rehabilitation sessions used for the Technical Component.
Cardiac Rehabilitation Sessions Used (Professional)	The number of Cardiac Rehabilitation sessions used for the Professional Component.

Table 14 describes the Intensive Cardiac Rehabilitation fields.

Table 14: Intensive Cardiac Rehabilitation Information

Field Name	Description
Intensive Cardiac Sessions Used (Technical)	The number of Intensive Cardiac Rehabilitation sessions used for the Technical Component.
Intensive Cardiac Sessions Used (Professional)	The number of Intensive Cardiac Rehabilitation sessions used for the Professional Component.

5.4.5. Preventive Tab

The Preventive tab (Figure 17) provides information regarding the beneficiary's Smoking/Tobacco 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. Table 15 describes the Smoking/Tobacco Cessation fields. Table 16 describes the Preventive fields.

Figure 17: Preventive Tab
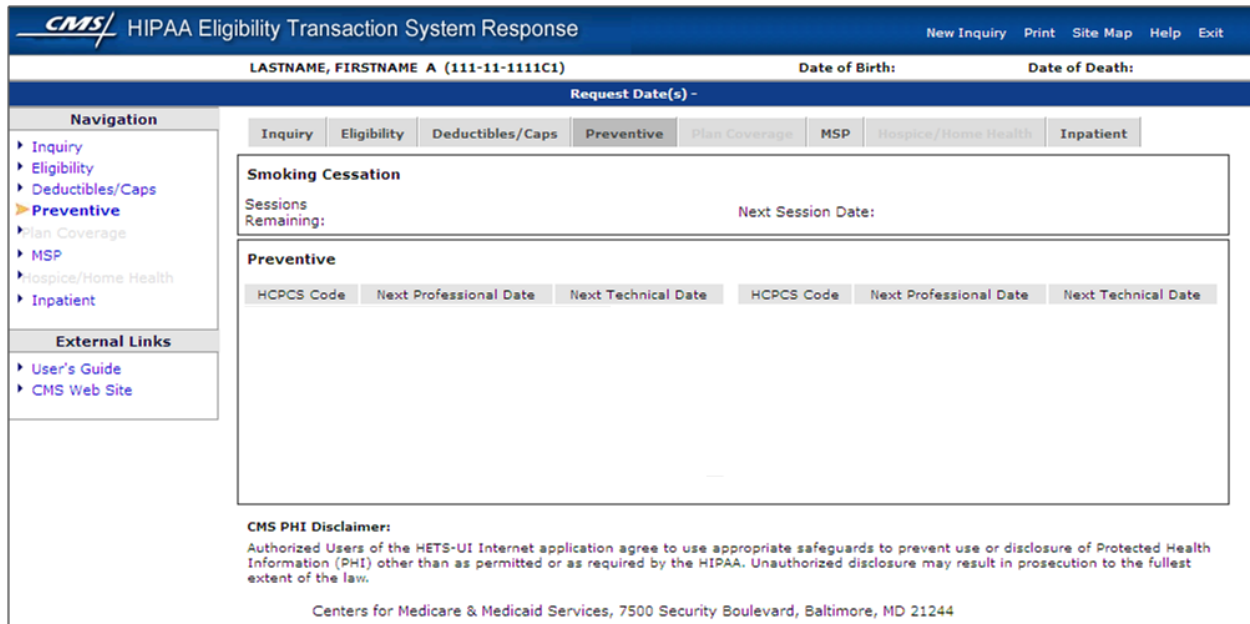
NOTE: Only HCPCS codes for which a particular beneficiary is eligible will be displayed and grouped together under their appropriate categories.

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 application.

Table 15 describes Smoking Cessation fields.

Table 15: Smoking Cessation Information

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

Table 16 describes Preventive fields.

Table 16: Preventive Information

Field Name	Description
HCPCS Code	A Healthcare Common Procedure Coding System (HCPCS) code

Field Name	Description
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 (Figure 18) 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 18: 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 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), an Indemnity (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 17 describes the Plan Coverage fields.

Table 17: Plan Coverage Information

Fields	Description
Plan Type	A full plan description followed by Plan Type Code: • Health Maintenance Organization Medicare Non Risk – HM • Health Maintenance Organization Medicare Risk – HN • Indemnity – 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)
MCO Bill Option Code	The bill option code of the Plan Type. This field only applies to plan types HM, HN, IN, PR, and PS. This field will not be displayed for Part D plan type.
Contract Website Address	Contract's website address that will provide information on the beneficiary's insurance
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) displayed as XXX-XXX-XXXX
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 (Figure 19) provides the beneficiary's primary insurance information.

Figure 19: Medicare Secondary Payer (MSP) Tab

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.

Table 18 describes the MSP fields.

Table 18: 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

Fields	Description
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 Workers' 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 WC = Workers' Compensation Medicare Set-aside Arrangement
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 (Figure 20) includes three sections: 1) Home Health Certification, 2) Home Health Care and 3) Hospice.

Figure 20: Hospice/Home Health Tab

The Home Health Certification section provides information regarding when the beneficiary's Home Health Plan of Care was certified and/or recertified.

The Home Health Care 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 Medicare Part B. These physician professional services are billed to Medicare Part A by the Hospice.

The HETS-UI application 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.

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.

Table 19 describes the Home Health Certification fields.

Table 19: Home Health Certification Information

Field Name	Description
HHEH Certification (HCPCS code G0180)	The HCPCS code used when the Beneficiary became certified for home health care services.
HHEH Certification Date	The date the beneficiary was certified to receive home health care services.
HHEH Recertification (HCPCS Code G0179)	The HCPCS code used when the Beneficiary became recertified for home health care services.
HHEH Recertification Date	The date the beneficiary was recertified to receive home health care services.

Table 20 describes the Home Health Care fields.

Table 20: Home Health Care 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.
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
NPI	The NPI Number of the Home Health Facility
Contractor Number	A display of the Contractor number
Contractor Name	A display of the Contractor name

Table 21 describes the Hospice fields.

Table 21: 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

Field Name	Description
Revocation Code	Code indicating whether hospice coverage was terminated or not. "0" indicates continuing hospice coverage. "1"," 2" or "3" means hospice coverage was terminated (revoked).
NPI	The NPI Number of the Hospice Facility

5.4.9. Inpatient Tab

The Inpatient tab (Figure 21) 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 21: Inpatient Tab
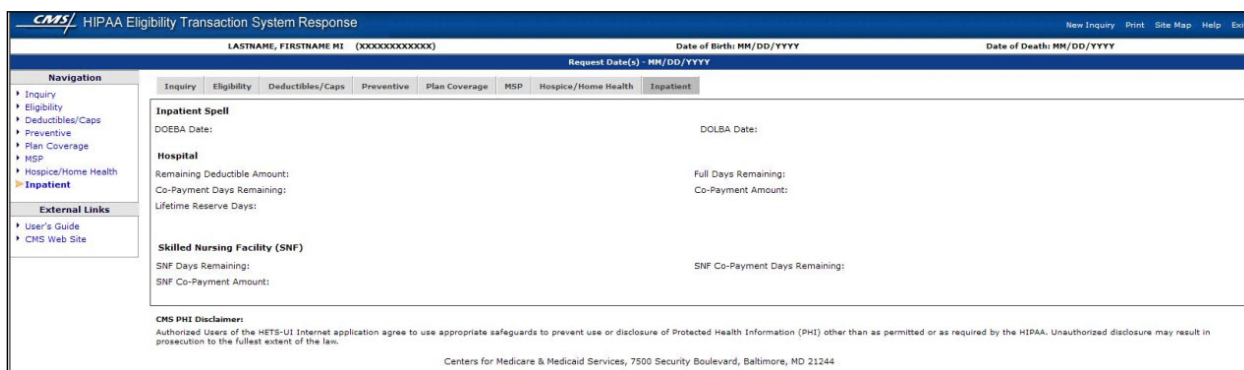
The HETS-UI application shall return Hospital default deductibles based on the request start year when the following occurs:

- 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 application will continue to return the Hospital Inpatient Default Deductible Remaining amounts, Hospital Co-Payment days, and SNF (Skilled Nursing Facility) Co-Payment 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

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.

Table 22 describes the Inpatient Spell fields.

Table 22: 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 23 describes the Hospital fields.

Table 23: 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-Payment Days Remaining	The Hospital inpatient co-payment days remaining
Co-Payment Amount	The amount of the inpatient co-payment
Lifetime Reserve Days	The number of lifetime reserve days remaining

Table 24 describes the SNF fields.

Table 24: SNF Information

Field Name	Description
SNF Days Remaining	The number of SNF days remaining
SNF Co-Payment Days Remaining	The number of SNF co-payment days remaining
SNF Co-Payment Amount	The amount of SNF co-payment

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 25. 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 25 describes the error messages and resolution.

Table 25: Medicare Eligibility Benefit Inquiry Error Message

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 MCARE Help Desk at 1-866-440-3805 to restore your access to the system. The Help Desk is available Monday – Friday from 7AM - 7PM Eastern Time.
Not Applicable	Unanticipated response received from the database. Please contact the Medicare Eligibility Help Desk at 1-866-440-3805 to report this response.	This error is generated when the User has not agreed to the PHI Disclaimer or when the User's session has been idling for longer than the allowable timeframe. The User should log out or exit from the Eligibility screen, close the active browser and begin a new session by logging in and selecting 'Accept' for the PHI Disclaimer agreement as required.
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 Last Name	Invalid/Missing Subscriber/Insured Name.	The patient last name entered on the Medicare Eligibility Benefit Inquiry screen is greater than 40 characters in length.
Subscriber First 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 First Name	Invalid/Missing Subscriber/Insured Name.	The patient first name entered on the Medicare Eligibility Benefit Inquiry screen is greater than 30 characters in length.
Subscriber First Name	Missing minimal criteria for any of the search options. Please correct and click the 'Submit Inquiry' button.	The User should enter Subscriber Date of Birth or Subscriber First Name in order to make the search. Refer to section 5.3.1 for search options.

Field Name	Error Message	User Resolution
Subscriber Birth Date	Invalid Patient Date of Birth. 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	Missing minimal criteria for any of the search options. Please correct and click the 'Submit Inquiry' button.	The User should enter Subscriber Date of Birth or Subscriber First Name in order to make the search. Refer to section 5.3.1 for search options.
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.
Subscriber Primary ID (HICN)	Missing Patient Primary ID (HICN). 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)	Patient Primary ID must be at least 7 characters. Please correct and click the 'Submit Inquiry' button.	The User should input a HICN that is at least 7 characters in length.
Subscriber Primary ID (HICN)	Patient Primary ID must be at most 12 characters. Please correct and click the 'Submit Inquiry' button.	The User should input a HICN that is at most 12 characters in length.
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.

Field Name	Error Message	User Resolution
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	"Invalid 'From Date' Format. Please correct and click the 'Submit Inquiry' button." OR Beneficiary is Inactive OR Beneficiary is Inactive. Date of Death is <MM/DD/YYYY>"	Refer to section 5.3.2 of this User Guide.
From Date	Date(s) of Service Not Within Allowable Inquiry Period	The requested date (or date range) is more than 27 months old or more than 4 months in the future. Please correct the date and submit a new inquiry. Refer to section 5.3.3 of this User Guide for additional information.
From Date	'From Date' Cannot be Greater Than 'To Date'. Please correct and click the 'Submit Inquiry' button.	The User receives this message when the 'From date' is greater than the 'To Date'.
From Date	E00028 – Termination Date Must Be Greater Than Effective Date.	The User receives this message when the From Date is blank and the To Date is prior to the Current Date. The User should enter a valid From Date and submit a new inquiry.
To Date	"Invalid 'To Date' Format. Please correct and click the 'Submit Inquiry' button." OR Beneficiary is Inactive	Refer to section 5.3.2 of this User Guide.

Field Name	Error Message	User Resolution
To Date	Date(s) of Service Not Within Allowable Inquiry Period	The requested date (or date range) is more than 27 months old or more than 4 months in the future. Please correct the date and submit a new inquiry. Refer to section 5.3.3 of this User Guide for additional information.
Not Applicable	D00006 Data Error	This message is returned when multiple matches are found in the database. The User should enter additional matching criteria and submit a new inquiry.

6.2.   Special Considerations

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

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 application, Users should contact the Help Desk using the numbers listed in Table 26.

Table 26 describes the Points of Contact.

Table 26: Points of Contact

Contact	Phone	Email	Role	Responsibility
MCARE	Help Desk phone number: (866) 440-3805 Help Desk fax number: (410) 907-2193 Hours of Operation: Monday - Friday, 7 AM - 7 PM ET	MCARE@cms.hhs.gov	Help Desk support	1st level User support and problem reporting
HETS Help	Website	http://www.cms.gov/HETSHelp/	System support	Overview of System Functionality User Guides, System Connectivity, System Outages, Best Practices, Upcoming Changes, Audit Process
Fee For Service	Website	http://www.cms.gov/center/provider.asp	Bene status support	Fee Schedules, Educational Resources, Contact info for MAC, Carrier, FI, Provider and Supplier Resources

The Help Desk Support screen (Figure 22) also displays the contact information should Users need assistance with the HETS-UI application.

Figure 22: Help Desk Support

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 27 identifies acronyms and definitions used in this document.

Table 27 - Acronyms and Definitions

Acronym	Definition
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

Acronym	Definition
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-payment
- 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.

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 inquires 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 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.