



WPS Medicare Part B Department and Self- Service Technology Guidebook

Which resource should I use for what information?

**PRESENTED BY
MEDICARE PART B
PROVIDER EDUCATION
WISCONSIN PHYSICIANS SERVICE**

A CMS contractor serving
IOWA, KANSAS, NEBRASKA, and MISSOURI



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Introduction

A common question asked of WPS Medicare is “Which WPS Medicare Part B department should I contact?” In this guide we will explore the different departments’ roles and functions, as well as the use of self-service technologies to help providers determine the best WPS Medicare resource to use.

The guide is broken down into departments and self-service technologies. When referring to the different departments and technologies, be sure to note the appropriate time to contact each area. We will look at the following departments and self-service technologies:

- Appeals
- Provider Customer Service
- Electronic Data Interchange (EDI)
- Financial/ Medicare Secondary Payer (MSP)
- Provider Enrollment
- Interactive Voice Response (IVR) Toll Free Phone Unit
- CMS Secure Net Access Portal (C-SNAP)

Each of the focus areas describes the core function, general information about the area, and contact information. While this guide does provide a general overview, not all possible scenarios are addressed, and guidance is given as to the appropriate contact.

The guide will first explore departments, followed by self-service technology.

DEPARTMENTS

Departments are used in WPS Medicare to determine what workload will be handled by which employees. WPS Medicare departments allow representatives to focus their knowledge in certain areas and provide the best customer service to our provider community.

Appeals

Appeals Core Functions

- Processing written redetermination requests
- Telephone and written reopenings due to clerical errors and omissions
- Providing support to the Qualified Independent Contractors (QIC)
 - Forwarding case files related to reconsideration requests
- Processing claim adjustments based on revised decisions at subsequent levels of the appeal process.

Appeals Contact Information

Reopening Phone Number and Hours:
(866) 590-6730
8:00am to 4:00pm CT M-F

WPS Medicare Appeals Website:

<http://www.wpsmedicare.com/j5macpartb/departments/appeals/>

Written Reopening or Redetermination Request:

IA	KS	MO	NE
WPS Medicare Part B Appeals Department P.O. Box 8550 Madison, WI 53708-8550	WPS Medicare Part B Appeals Department P.O. Box 7238 Madison, WI 53707-7238	WPS Medicare Part B Appeals Department P.O. Box 14260 Madison, WI 53708-0260	WPS Medicare Part B Appeals Department P.O. Box 8667 Madison, WI 53708-8667

Redetermination and Reconsiderations

Submitting Redetermination Requests

If you are dissatisfied with the claim denial or believe a claim was not properly paid, you may request a redetermination. Redeterminations are the first of five Medicare appeals levels and the only level WPS Medicare Appeals is responsible for. All redetermination requests must be submitted in writing within 120 days of the initial claim determination or overpayment demand letter date.

Providers, physicians, or other suppliers with appeal rights must submit written requests indicating what they are appealing and why. There are two acceptable written ways of doing this:

1. A completed **CMS-20027** or **WPS Redetermination Request Form** constitutes a request for redetermination. Completed means that all applicable spaces are filled out and all necessary attachments are attached.
2. A written request not on the **CMS-20027** or **WPS Redetermination Request Form** must contain the following information:
 - Beneficiary name
 - Medicare Health Insurance Claim Number (HICN)
 - Specific service(s) and/or item(s) for which the redetermination is being requested
 - Specific date(s) of the service
 - Name and signature of the party or the representative of the party

Note: The signature must be on the request for redetermination. Signatures contained on medical records are not acceptable as valid signatures for redetermination requests.

Requests for redetermination of non-assigned claims must include a completed Appointment of Representative form (CMS-1696) or a written statement from the beneficiary giving authorization for you to submit a request on his/her behalf.

If a request for redetermination is being submitted by an attorney, the request must contain an appropriate authorization stating that the attorney is acting on behalf of the provider or supplier. If this is not received, the response to the request is only sent to the provider, and the beneficiary alone receives a copy.

Tips for Filing Reconsiderations

Timely Filing

- If you disagree with the 10% claim filing reduction and can show good cause for submitting the claim past the time limit, submit a redetermination request.
- If you are asking to have the 120-day redetermination filing deadline waived, your request must contain an explanation of the reason you were not able to file your request within 120 days of the initial determination or overpayment demand letter date.
- If you have passed the time limit for filing an appeal, you could consider requesting a reopening.

Initial Determination Date

- This is the date that the claim first processed or the date of the overpayment (demand) letter.
- If you have submitted a claim multiple times with different information and continue to get the same denial, the initial determination date is the date the first claim processed.
- If you are submitting different information and receiving different denials, the “initial determination date” would be the date of the claim with the different denial processed.
- If you receive an “unprocessable” denial or remark code MA 130 (“Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the

claim is unprocessable. Please submit a new claim with the complete/correct information."), the claim does not have appeal rights. You must resubmit the claim.

Redetermination Dismissal Notices

Incomplete or untimely redetermination requests will be dismissed. If you disagree with the dismissal, you should follow the instructions in the dismissal letter. You have two options if you disagree with the dismissal:

1. If you have information that establishes good cause for the late filing, you can ask that WPS Medicare vacate your dismissal. You must file a request to vacate within six months of the date of the dismissal notice.
2. If you think we incorrectly dismissed your request, you may request a **reconsideration** of the dismissal from the QIC. You must explain why you feel the dismissal was incorrect.

Disagree with Overpayment Assessment

- All overpayment (demand) letters provide instructions on steps to take if you disagree with the assessment of the overpayment.
- Please submit a copy of the overpayment (demand) letter with your redetermination request. Including the copy of the demand letter alerts us to notify the financial department to halt recoupment until the redetermination decision is reached.
- We can halt the recoupment process only if a valid redetermination request is received.
- If your request is considered incomplete, it will be dismissed and recoupment will not be stopped. A complete redetermination request provides an explanation of why you disagree and identifies the specific claims you wish to appeal.
- For cases involving multiple beneficiaries and dates of service a spreadsheet is helpful. Generally, this is also provided with your demand letter. This is important information to include with your redetermination request.

Disagree with Redetermination Decision

- If you disagree with a redetermination decision for any reason, the next step in the appeal process is to request reconsideration from the Qualified Independent Contractor (QIC). Reconsideration requests should be submitted on the CMS Reconsideration Request form, CMS Form 20033 located on the CMS Website at <http://www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf>
- Please mail reconsideration requests to the appropriate QIC address. Do not submit these to WPS Medicare Appeals.
First Coast Service Options, Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL 32232-5208

Telephone and Written Reopening

Contact Information

Reopening Phone Number and Hours:

(866) 590-6730

8:00am to 4:00pm CT, M-F

Written Reopening or Redetermination Request:

IA	KS	MO	NE
WPS Medicare Part B Appeals Department P.O. Box 8550 Madison, WI 53708-8550	WPS Medicare Part B Appeals Department P.O. Box 7238 Madison, WI 53707-7238	WPS Medicare Part B Appeals Department P.O. Box 14260 Madison, WI 53708-0260	WPS Medicare Part B Appeals Department P.O. Box 8667 Madison, WI 53708-8667

WPS provides toll-free telephone lines for providers to request a telephone reopening of claims which denied due to a clerical error or omission. CMS defines “clerical error or omission” as human or mechanical errors on the part of the party or the contractor, such as:

- Mathematical or computational mistakes;
- Transposed procedure or diagnostic codes;
- Inaccurate data entry;
- Misapplication of a fee schedule;
- Computer error; or,
- Denial of claims as duplicates which are denied as a result of a clerical error or minor omission and require a change on the face of the claim (e.g., adding or removing a modifier) in order for the claim to be reopened.
- Incorrect data items, such as provider number, use of a modifier or date of service.

When to contact Reopenings

Types of issues that can be performed as clerical error or minor omission reopenings (if the change will allow additional payment) include:

- Increase in the number of services or units (without an increase in the billed amount);
- Addition/Change/Deletion of modifiers such as 24, 25, 54, 58, 59, 76, 78, 79 or GA (exception: Modifiers 54 and 78 are reduction modifiers and cannot be added to a paid claim as this would create an overpayment issue);
- Transposed procedure codes;
- Change in the place of service (if the change will allow an additional payment); and
- Addition or change in a diagnosis on a denied service.

Exception: Date of service may be changed even when the service in question has already been paid.

Below are the types of issues that cannot be performed as clerical error or minor omission reopenings. For these issues providers must submit a redetermination request in writing.

- Any action that would create an overpayment;
- Appeal on established overpayment;
- CERT (Comprehensive Error Rate Testing);
- Provider Enrollment issues;

- Wrong payee;
- Adding services that were not previously billed (i.e. increase in the number of services with an increase in the billed amount);
- Complex claim situations (such as ambulance, claims with modifiers 22, 55, 62, 66, or GY or any claim which requires analysis of documentation);
- CMS input (e.g. services after date of death);
- There is a pending or finalized higher level appeal request; or
- There are multiple surgeries on multiple claims for the date of service in question.

The telephone reopening staff will only take information needed to make the adjustment for the reopening of a claim related to minor clerical errors. The representatives answering this line are not able to answer questions regarding claims payment, billing guidelines, coverage, or the appeals process. Providers should use the WPS Medicare Customer Service Provider Toll-Free line.

Confirmations for a Reopening

WPS Medicare only gives confirmations for faxes; the reopenings taken by telephone are not given a confirmation number.

Tips to Help with a Reopening

If the claim originally denied as unprocessable (lacking needed information) or was never submitted, submit a new claim.

If the claim in question is in process, you must wait until after the claim has processed before requesting a reopening.

WPS Medicare accepts three reopening requests per each phone call. If a provider has more than three requests, here are some additional options:

- Providers can mail reopening requests to WPS Medicare.
- Providers may make multiple phone calls.
- For a large volume of claims, the providers should submit a written reopening request.

Note: At the discretion of the Reopening Representative (RR), the provider may be allowed to submit some requests via fax. The RR will provide a fax number and a confirmation number. The confirmation number is only valid for this specific call and situation.

Providers should use the WPS Medicare Customer Service Provider Toll-Free line.

Customer Service

Customer Service Core Functions:

The WPS Medicare Customer Service department is available from 8 am - 5 pm CT, Monday through Friday, to answer claims-related questions regarding the following topics:

- Medicare billing
- Medicare coverage
- Questions regarding claims processing

Contacting Customer Service:

Customer Service Phone Number and Hours:

(866) 503-3807

8:00am to 5:00pm CST, M-F

General Correspondence Addresses:

IA	KS	MO	NE
WPS Medicare Part B General Correspondence P.O. Box 8550 Madison, WI 53708-8550	WPS Medicare Part B General Correspondence P.O. Box 7238 Madison, WI 53707-7238	WPS Medicare Part B General Correspondence P.O. Box 14260 Madison, WI 53708-0260	WPS Medicare Part B General Correspondence P.O. Box 8667 Madison, WI 53708-8667

When to Contact Customer Service

Customer Service Representative (CSR) staff provide information on the following:

- Detailed explanations of claim denials
- Educational assistance on claim submission
- Educational assistance on resolving claim or payment issues
- Answers to questions on Medicare policies or procedures
- Setting up an overpayment, or the reason why an overpayment was set-up
- Guidance on locating information on the Website
- Help determining what is the best action to take on a claim (see explanation below)

CSRs are unable to give the following information, because providers are required to use self-service technologies:

- Claim status (IVR & C-SNAP)
- Beneficiary eligibility (IVR & C-SNAP)
- Claim adjustments (IVR & C-SNAP)
- Duplicate Remittance Advice notices (IVR)
- Coding advice (Medical Society or professional organization)

Our Customer Service staff can help you with issues that you cannot resolve by use of the IVR, C-SNAP, or Website. CSRs can help you find certain information that is available on the Website, such as fee schedule information, policy information, and appeals information.

Customer Service Representatives can help educate you on how to resolve claim or payment issues. If you are unsure of what your next steps are for claim resolution, we can help you sort this out. Different actions CSRs may recommend are to correct and resubmit your claim, call in a phone reopening, or request a written redetermination. Customer Service does not perform any claim adjustments or reopenings; if it is determined that this action is needed, you may be referred to another area.

If you have identified a claim that has been overpaid, you may send in a voluntary refund to our Financial area. If, for some reason, this will not work for you, you may call Customer Service and ask the representative to set up an overpayment. This information will be referred to the Financial unit for action.

Self-service Tools

Providers must use self-service tools, such as the IVR (Interactive Voice Response System) or C-SNAP (CMS Secure Net Access Portal) to obtain patient eligibility and claim status. This allows CSRs to better assist callers who have questions that cannot be answered via the use of self-service tools. These tools allow providers to obtain information outside of call center hours, and allow providers to check on a number of patients and/or claims in one call or visit. For more information, review the C-SNAP and IVR sections of this guidebook.

Website

WPS Medicare offers providers a free Website containing a wide variety of information. The Website is available at <http://www.wpsmedicare.com>, and we highly encourage providers and their staff to check the Website, IVR, or C-SNAP to obtain answers, prior to contacting Customer Service.

Website feedback is an important tool for change. If providers complete the Website Customer Satisfaction Survey, it helps WPS Medicare improve the Website. Complete the survey to indicate both things on our Website that you like or would like changed. Your feedback is invaluable and is to make our site as user friendly as possible.

Remittance Advice

Your Remittance Advice is a valuable source of information. It provides payment dates and amounts, denial or rejection explanations, and much more. Providers are urged to refer to this information prior to contacting the call center. If you need any assistance interpreting the information on your remit, you may wish to make use of the education products offered by CMS such as the guide *Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers and Billers*, which can be downloaded from the following location: http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf

If you are in need of a duplicate copy of your Remittance Advice, you can order one from the IVR for as many individual claims as you need. If you need an entire remittance advice, you will need to make this request in writing. We ask that you carefully maintain your Remittance Advice notices, as these are costly to reproduce.

Other Tips:

If you receive a claim denial as duplicate, there is a claim payment in history or an identical claim which is currently processing. Verify claim status in this situation; Customer Service does not provide claim status. By checking the IVR or C-SNAP, you will learn whether the initial submission of the claim was paid or whether you will need to wait for it to complete processing.

Electronic Data Interchange (EDI)

EDI Core Function: Is to consult and service providers regarding issues of Electronic Data Interchange (EDI).

The WPS Electronic Data Services department has a dedicated staff whose primary function is to consult and service providers regarding issues of Electronic Data Interchange (EDI). Our staff is experienced in dealing with a variety of provider specialties, billing services, and software vendors.

EDI Contact Information

Providers who are interested in becoming an EDI trading partner with WPS should call Medicare Part B EDI 866-503-9670.

When to Contact EDI

Contact EDI with questions regarding:

- Electronic Claims Transmissions
- Electronic Submitter IDs
- Completing the electronic claim form
- Verifying the receipt of an electronic submission
- Technical support for PC-ACE Pro32 (free billing software)
- Questions regarding the Electronic Bulletin Board
- Questions regarding pre-pass edit reports
- Medicare Remit Easy Print questions (MREP)

What to call other areas for:

- Claims status
- Appeals
- C-SNAP technical questions
- Explanation of claims processing paper guidelines

Medicare Secondary Payer (MSP)/ Financial

MSP/Financial Core Function: Recovery of debts from beneficiaries and providers resulting from excess MSP and non-MSP payments.

MSP/ Financial Contact Information

Phone Number and Hours:

(866) 503-9694

8:00am to 4:00pm CST, M-F

Addresses:

MSP/ Financial Checks

IA	KS	MO	NE
WPS Medicare Part B MSP Unit P.O. Box 8820 Marion, IL 62959-0902	WPS Medicare Part B MSP Unit P.O. Box 8830 Marion, IL 62959	WPS Medicare Part B MSP Unit P.O. Box 8860 Marion, IL 62959-0906	WPS Medicare Part B MSP Unit P.O. Box 8850 Marion, IL 62959-0905

MSP/ Financial Correspondence

IA	KS	MO	NE
WPS Medicare Part B MSP Unit P.O. Box 8850 Madison, WI 53708- 8550	WPS Medicare Part B MSP Unit P.O. Box 7238 Madison, WI 53707- 7238	WPS Medicare Part B MSP Unit P.O. Box 14260 Madison, WI 53708- 0260	WPS Medicare Part B MSP Unit P.O. Box 8667 Madison, WI 53708- 8667

When to Call the MSP/Financial Department:

- 1) You received a demand letter from us, and you have questions about the collection process. ***Provider Customer Service Call Center should be contacted if you have questions as to why you were assessed an overpayment.***
- 2) You wish to set up an extended repayment plan and have questions about that process.
- 3) It has been longer than 70 days since you sent in a voluntary refund, **or** it has been longer than 50 days since you notified us of an overpayment and you have not seen any correction.

MSP Debt – Claims processed with Medicare as the primary payer that should have been reimbursed with Medicare as the secondary payer would be considered overpaid. The difference in the reimbursement between the Medicare primary payment and secondary payment is MSP debt.

Any other type of overpayment that occurs due to error in claims submission or claims adjudication is considered non-MSP debt. At WPS Medicare, we refer to this as *Financial Debt*.

Debt Collection Activity – Provider Specific

If a provider discovers that they were overpaid, they are obligated to report the overpayment to the Medicare contractor. This can be accomplished by submitting a voluntary refund or by reporting the overpayment through a telephone contact.

Voluntary Refunds

To initiate a voluntary refund, the provider must submit a refund check to Medicare along with documentation to support the overpayment finding. The following is the preferred documentation:

- Medicare Voluntary Refund form – found on our Medicare Website.
- A statement describing the reason for the refund.
- The remit/EOB with overpaid claims designated or a detailed spreadsheet with claim level overpayment details displayed. ***For MSP refunds, the primary payer EOB is a required piece of documentation.***
- 100% refunds with follow-up rebilling for procedure code, place of services changes etc.

WPS Medicare Part B Action: Voluntary refunds are cash receipts that are set up as Accounts Receivables (A/Rs) within our financial processing systems. When the refund is received, the A/R is established, the cash receipt is immediately applied to it and we close the receivable. If we receive a larger refund than needed to cover the debt, we apply the excess funds to other open debt the provider may have on their account.

When no other open debt exists, a refund check is issued along with a special payment notice. In advance of the refund, we send a letter of explanation regarding the excess funds, designating specific patient account information.

Once completed, the adjusted claims will appear on the provider remit showing a reason code of FB. The voluntary refund process may take 60 days to complete. For MSP, it may take longer, up to 125 days, if the patient MSP record needs to be updated at the COB Contractor.

Immediate Offset

WPS Medicare recently implemented an immediate offset process via fax. This allows providers to submit the immediate offset form to us, along with their list of established overpayments/debt. The immediate offset form is found on the WPS Medicare Website along with complete instructions for submission.

WPS Medicare Part B Action: With immediate offset, we will set the providers account to begin offset within one business day of receiving the fax. The A/R will be closed when satisfied through offset.

Overpayment Reporting

To report an overpayment by telephone, contact the WPS Medicare Part B Provider Call Center. The Customer Center Representative will ask for certain information in order to establish the overpayment.

As a result of reporting the overpayment, providers will receive a demand letter from Medicare requesting the necessary refund. In response to the demand letter, please submit the following:

- A copy of the demand letter – be careful to include the page detailing the claim information to help us apply the refund to the appropriate accounts.
- Your refund check

WPS Medicare Part B Action: When an overpayment is reported, we will initiate claims adjustments to reduce the payment. By reducing the paid amount, an Accounts Receivable is established and a demand letter is sent out for repayment of the debt. The demand letter will request the exact amount due to cover the reported overpayment. If excess money is sent with the demand letter, it will be refunded. It will not be applied to other open debt.

This type of overpayment correction may take 45 or more days to process. Submitting duplicate requests and/or corrected claims within that timeframe will likely result in full denials.

Involuntary Refunds

When the Medicare contractor discovers an overpayment, it is obligated to take recovery action. The contractor will notify the provider of an overpayment by way of a demand letter. This will be the same demand letter as used in the overpayment process above.

Once the demand letter is sent, the debtor has 30 days to pay the full amount due. If full payment is not received within 30 days, interest begins to accrue on the balance. On the 31st day, a second demand letter is sent along with a copy of the first demand letter.

If full payment is not received forty days after the date of the first demand letter, the contractor will begin to recoup the overpayment by offset on the 41st day. If payment is received after the debt is recovered by offset, a refund check will be sent to the provider.

If payment is not received by the 90th day, it is considered delinquent and may be eligible for referral to the Department of Treasury. The provider may receive a third demand letter or Intent to Refer Letter (i.e., 120 days from the determination date). This letter informs the debtor that if full payment is not received within sixty days, the debt will be referred to the Treasury for cross-servicing.

If a refund is received any time within the debt collection process, the check will be accepted and the Account Receivable will be closed.

Other Overpayment-Related Concerns:

- 1) You received a demand letter and you disagree with it, request a redetermination.
- 2) The provider remit indicates WO and payment was withheld. You can match the remit FCN to the claim number on the demand letter that was sent. The demand letter contains the patient account and claim information.
- 3) If you want us to send you a demand letter as described in the overpayment process above. Call the Provider Call Center and request that an overpayment be set up. It is preferred that a voluntary refund be initiated.

- 4) If you identify a claim submission error that results in a partial overpayment (e.g., procedure code change, modifier change, place of service change), the preferred method is to refund 100% of the Medicare paid amount and submit a corrected claim. You may request a redetermination in writing. You will receive a demand letter for the overpayment once the claim reopening is completed.
- 5) If you identify a full overpayment, a voluntary refund is very efficient.

Provider Enrollment

Provider Enrollment Core Function: Provider enrollment is a critical function for ensuring that only qualified individuals and entities meeting Centers for Medicare & Medicaid Services (CMS) eligibility criteria are enrolled in the Medicare program and receive reimbursement for services furnished to Medicare beneficiaries.

IA/KS/NE/MO Contact Information:

Phone: (866) 503-7664
8:00am to 4:00pm CT, M-F

Address:

WPS Medicare Part B
Provider Enrollment
P.O. Box 8248
Madison, WI 53708-8248

When to Contact Provider Enrollment

Contact provider enrollment in the following situations:

- Questions about completing the CMS 855 provider enrollment forms
- Questions regarding status of a pending application
- Questions regarding eligibility criteria for Medicare enrollment
- Questions about Medicare's participation program
- Questions regarding opting out of Medicare
- Questions regarding changes to Medicare provider enrollment information

Internet-Based Medicare Enrollment (PECOS Web):

Now there's a better way for physicians and non-physician practitioners to enroll or make a change in their Medicare enrollment information. The Internet-based Provider Enrollment, Chain and Ownership System (PECOS) will allow physicians and non-physician practitioners to enroll, make a change in their Medicare enrollment, or view their Medicare enrollment information on file with Medicare.

Internet-based PECOS is a scenario-driven application process with front-end editing capabilities and built-in help screens. The scenario-driven application process will ensure that physicians and non-physician practitioners complete and submit only the information necessary to enroll or make a change in their Medicare enrollment record. Internet-Based PECOS can be found at:

<https://pecos.cms.hhs.gov/pecos/login.do>

Provider Enrollment cannot begin processing your Internet application until we receive the original signed and dated certification statement within 15 days after successful submission of your Internet-based application. Failure to submit this could result in rejection of your application and would require you to start over.

SELF-SERVICE TECHNOLOGY

The Centers for Medicare & Medicaid Services (CMS) encourages all providers and their staff to use different self-service technologies. The goal is for the technologies to handle the less complicated inquiries, leaving the more complex issues to specific departments to handle. CMS and WPS Medicare believe self-service technologies will make Medicare information available to everyone and in the most cost-effective manner.

WPS Medicare posts information on self-service technology and a comparison of the following tools on our Website at: <http://www.wpsmedicare.com/j5macpartb/selfservice/>

CMS Secure Net Access Portal (C-SNAP)

C-SNAP Core Function: Provide a Web-based self-service tool to the WPS Medicare provider community which allows access to patient eligibility and claim status. C-SNAP is a free self-service Internet portal available to you 24 hours a day, 7 days a week, at no cost.

C-SNAP Contact Information:

Website: <https://www.medicareinfo.com/apps/cms/home.do> (Portal Access)

Technical Support: (877) 476-8116 (C-SNAP CSR Support)
8:00 am to 4:00 pm CT, Monday thru Friday

C-SNAP offers you the following information:

Use C-SNAP to:

- Check patient eligibility information on
 - Part A and B Effective and Termination Dates
 - Part A and B Entitlement Ineligibility Dates
 - Part A and B Deductible Information
 - Blood Deductible Pints Remaining
 - Date of Death
 - Corrected Medicare Number- If Changed
 - Whether Medicare is the Primary Payer
 - Smoking Cessation Sessions Remaining
 - Railroad Beneficiary Eligibility Information
 - Medicare Secondary Payer Information (MSP)
 - Medicare Managed Care Organization Information
 - End Stage Renal Disease Information
 - Hospice Information
 - Home Health Information
 - Preventive Services Information
 - Skilled Nursing Facility Information
 - Part D Information
 - Therapy Caps
- Checking claim status (Assigned claims)

- Claim Control Number
- Date of Service(s)
- Status of a Claim
- Date the Claim Processed
- Amount Submitted
- Amount Paid
- Check Number
- Claim Control Number
- Information by Claim Line
- Date Medicare Received the Claim
- Line Item Information
- Supplemental Information
 - Secured Messaging
 - Submitting a Redetermination Request
 - Checking the Status of a Redetermination Request Submitted on C-SNAP

What is secured messaging?

Secured messaging allows providers and their staff to contact Medicare via secured on-line communication. The messages are able to contain confidential information, such as:

- Provider Transaction Access Number (PTAN)
- Health Insurance Claim Number (HICN)
- Patient's personal information
- The Medicare Internal Control Number (ICN)

What type of questions can be submitted over secured messaging?

- Technical support questions
- Claims-related questions (Medicare has 45 business days to answer)
- Policy-related questions (Medicare has 45 business days to answer)
- Any other question about the Medicare program (Medicare has 45 business days to answer)

When to Contact C-SNAP Technical Support

Contact C-SNAP Technical Support with technical questions or for C-SNAP registration assistance.

Technical questions include:

- Password resets
- Questions on registering
- Adding or removing locations
- Adding or removing users
- Site navigation
- Understanding screen information.

Do not call for non-technical questions, such as:

- Policy questions
- Duplicate remits

- Clarification on claim denials.

Interactive Voice Response (IVR)

IVR Core Function: The IVR is an automated, self-service system offered to our WPS Medicare provider community. It gives Medicare patient eligibility and claim status quickly and easily over the telephone. The IVR is speech-enabled and also allows for touch-tone entry using the telephone keypad.

Contact Information:

- (866) 590-6702

The IVR is available 24 hours a day, 7 days a week. However, the standard hours of operation when all IVR functions are available are:

- Monday – Friday, 7:00 am – 6:00 pm CT.

Note: Functions requiring the entry of a National Provider Identifier (NPI), a Provider Transaction Access Number (PTAN), and a Taxpayer Identification Number (TIN), such as eligibility and claim status, have limited hours due to system availability.

What is Available from the IVR?

Contact the IVR for:

- Checking Patient Eligibility
 - Part B Deductible Information
 - Date of Death
 - Corrected Medicare Number- If Changed
 - Whether Medicare is the Primary Payer
 - Medicare Secondary Payer Information (MSP)
 - Medicare Managed Care Organization Information
 - Therapy Caps
- Checking Claim Status (Assigned Claims)
 - Status on a Claim
 - Amount Submitted and Allowed
 - Amount Applied to Deductible
 - Date Processed
 - Amount Paid and Date Paid
 - Check Number
 - Submitted for Crossover
 - Claim Control Number
 - Information by Claim Line
- Provider Summary
 - Pending Claims Count and Dollar Amount
 - Approved-to-Pay Claims and Dollar Amount
 - Last Check Issued to PTAN
 - Month and Year-to-Date Claims and Dollar Amount
- Checks
 - Number

- Issue Date
- Amount
- Cashed Date or Date of Last Activity
- Check Status
- Supplemental Information
 - Procedure Code Pricing for Search Criteria
 - Medicare News
 - Appeals Rights
 - Frequently Requested Phone Numbers
 - Frequently Requested Addresses

Disclaimer

The information contained in this guidebook has been designed as guidance only. The information contained on the Centers for Medicare & Medicaid Services (CMS) Website, publications, and other sources overrides any information that may be different in the guidebook. This guide is a tool to assist providers. Every reasonable effort was made to ensure the accuracy of the information. However, the provider has the ultimate responsibility for correct submission of claims. WPS Medicare bears no liability for results or consequences of any misuse of the information.