Medicare Hospital Manual

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2115

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
301(Cont.) - 303.4	3-5 - 3-8 (10 pp.)	3-5 - 3-8A (9 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: June 10, 2002*

Section 301, Identifying Other Primary Payers During the Admission Process, provides instructions on the reporting of retirement dates in relation to Medicare Secondary Payer (MSP) occurrence codes 18 and 19.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Medicare is the secondary payer under certain circumstances. The following will help hospital admission staffs recognize the circumstances under which Medicare should not pay as primary and to identify the party which is responsible for primary payment.

The law mandates that Medicare is secondary payer for:

o Claims involving Medicare beneficiaries age 65 or older who have GHP coverage based upon their own current employment status with an employer that has 20 or more employees, or that of their spouse of any age, or based upon coverage by a multiple employer, or multi-employer group health plan by virtue of his/her own, or a spouse's, current employment status and the GHP covers at least one employer with 20 or more employees. An individual has current employment status if (1) he or she is actively working as an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship; or (2) is not actively working, but meets all of the following conditions: retains employment rights in the industry, has not had his or her employment terminated by the employer, is not receiving disability payments from an employer for more than 6 months, is not receiving social security disability benefits, and has GHP coverage based on employment that is not COBRA continuation coverage. Examples of individuals who fall in the second group are teachers, employees who are on furlough or sick leave, and active union members between jobs;

o Claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage which was secondary to Medicare at the time ESRD occurred;

NOTE: The Balanced Budget Act of 1997 extended the ESRD coordination period to 30 months from 18 months for any individual whose coordination period began on or after March 1, 1996. Individuals whose period began before that date have an 18-month coordination period. This issue may need to be clarified with ESRD beneficiaries upon admission.

o Claims involving automobile or nonautomobile liability or no-fault insurance;

o Claims involving government programs; e.g., workers' compensation (WC), services authorized and paid for by the Department of Veterans Affairs (DVA), or Black Lung (BL) benefits; and

o Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans of employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon his or her own current employment status or the current employment status of a family member.

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., automobile insurer and GHP). Be sure to identify all possible payers.

Policy for Hospital Reference Labs

Hospitals must collect MSP information from a beneficiary or his/her representative for hospital reference lab services. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 60 calendar days from the date the service was rendered, then that information may be used to bill Medicare for non-patient reference lab services furnished by hospitals. This procedure is available ONLY with respect to hospital reference lab services. Hospitals should keep an audit trail to show they used MSP information obtained from the beneficiary or his/her representative which is no older than 60 days when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy. The provider also should document who supplied the MSP information. While a hospital is permitted to bill as described above using

information in file from the beneficiary or his/her representative, if the hospital's use of outdated or inaccurate information leads to Medicare making an incorrect primary payment, the hospital will be liable to repay the overpayment. Moreover, the hospital will not be considered to be "without fault" in causing the overpayment under §1870 of the Act (42 USC 1395gg) because it could have collected, had it chosen to do so, more recent and accurate information from the beneficiary.

Policy for Recurring Outpatient Services

For hospital outpatients receiving recurring services, hospitals must gather or verify beneficiary MSP information. Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his/her representative. Following the initial collection, the MSP information should be verified once during each subsequent monthly billing cycle during which recurring services are furnished to a Medicare beneficiary. (If a hospital bills on other than a monthly cycle, (e.g., 45 days or 60 days), then it must gather or verify the MSP information within no more than 30 calendar days from the last date the information was gathered or verified).

NOTE: A Medicare beneficiary is considered to be receiving recurring services if he/she receives identical services and treatments on an outpatient basis more than once within the same monthly billing cycle or, if the billing cycle is longer than monthly, within the same 30-day period.

Policy for Medicare+Choice Organization (M+CO) Members

If the beneficiary is a member of an M+CO, hospitals are not required to ask the MSP questions or to collect, maintain, or report this information.

Policy for Medicare Secondary Payer (MSP) Retirement Dates

During the intake process, when a beneficiary cannot recall his/her precise retirement date as it relates to coverage under a group health plan as a policyholder or cannot recall the same information as it relates to his/her spouse, as applicable, follow the policies, specified below.

When a beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, report his/her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his/her retirement date.

If the beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but you determine it has been at least 5 years since the beneficiary retired, enter the retirement date as 5 years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, report the retirement date as January 4, 1997, in the format you are currently using.) As applicable, the same procedure holds for a spouse who had retired at least 5 years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than 5 years ago, you must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

301.1 Verification of MSP On-Line Data and Use of Admission Questions.--

A. MSP On-Line Data Elements.--Providers with on-line capability may now access the following MSP information via CWF:

- o MSP effective date;
- o MSP termination date;
- o Patient relationship;
- o Subscriber name;
- o Subscriber policy number;
- o Insurer type;
- o Insurer information: name, group number, address, city, State, and zip code;
- o MSP type;
- o Remarks code;
- o Employer information: name, address, city, State, and zip code (for all contractors, with the exception of 77777); and
- o Employee data: ID number, and information.

At your discretion, these data may be viewed either during the admission or billing process. However, the data must be viewed before a bill is submitted to Medicare and should ideally be viewed before the patient leaves the hospital.

If used during admission, verify each data element by using the questions found in §301.2 to help identify other payers which may be primary to Medicare. Comply with any instructions which follow a particular question.

301.2 Types of Admission Questions to Ask Medicare Beneficiaries.--The following chart lists the types of questions to ask Medicare beneficiaries upon every inpatient and outpatient admission. The only exceptions are the policies described in §301. Use this chart as a guide to help identify other payers which may be primary to Medicare. Beginning with Part 1, ask the patient each question in sequence. Comply with any instructions which follow an answer. If the instructions direct you to go to another part, have the patient answer, in sequence, each question under the new part.

NOTE: There may be situations where more than one insurer is primary to Medicare (e.g., Black Lung and GHP). Be sure to identify all possible insurers.

A. Types of Questions to Ask Medicare Beneficiaries.--

Part I

1. Are you receiving Black Lung (BL) Benefits?

__ yes; Date benefits began: CCYY/MM/DD

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

__ no.

2. Are the services to be paid by a government program such as a research grant?

__ yes; Government Program will pay primary benefits for these services

__ no.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility?

__ yes; DVA IS PRIMARY FOR THESE SERVICES.

__ no.

4. Was the illness/injury due to a work related accident/condition?

__ yes; Date of injury/illness: CCYY/MM/DD

Name and address of WC plan:

Policy or identification number

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

__ no. **GO TO PART II.**

Part II

1. Was illness/injury due to a nonwork related accident?

__ yes. Date of accident: CCYY/MM/DD

__ no. **GO TO PART III**.

2. What type of accident caused the illness/injury?

__ automobile

__ non-automobile

Name and address of no-fault or liability insurer:

Insurance claim number

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

__ other.

3. Was another party responsible for this accident?

__ yes;

Name and address of any liability insurer

Insurance claim number _____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

___ no. **GO TO PART III**

Part III.

1. Are you entitled to Medicare based on:

___ Age. **Go to Part IV.**

___ Disability. **Go to Part V.**

___ ESRD. **Go to Part VI.**

Part IV - Age

1. Are you currently employed?

__ yes;

Name and address of your employer:

__ no. **Date of retirement: CCYY/MM/DD**

2. Is your spouse currently employed?

__ yes;

Name and address of spouse's employer:

__ no. **Date of retirement: CCYY/MM/DD**

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

__ yes; __ no. **STOP.** **MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II**.

4. Does the employer that sponsors your GHP employ 20 or more employees?

__ yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION**.

Name and address of GHP:

Policy identification number

Group identification number

Name of policy holder

Relationship to patient

__no. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part V - Disability

1. Are you currently employed?

__yes;

Name and address of your employer:

__ no. **Date of retirement: CCYY/MM/DD**

2. Is a family member currently employed?

__ yes;

Name and address of employer:

__ no.

IF THE PATIENT ANSWERS NO TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II. DO NOT PROCEED ANY FURTHER.

3. Do you have group health plan (GHP) coverage based on your own, or a family member's, current employment?

__ yes; __ no. **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP, employ 100 or more employees?

__ yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number

Group identification number

Name of policy holder

Relationship to the patient

__no. **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II.**

Part VI - ESRD

1. Do you have group health plan (GHP) coverage?

__ yes;

Name and address of GHP:

Policy identification number

Group identification number

Name of policy holder

Relationship to the patient

Name and address of employer, if any, from which you receive GHP coverage:

_ no. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

__ yes; Date of transplant: CCYY/MM/DD

__ no.

3. Have you received maintenance dialysis treatments?

__ yes; Date dialysis began: CCYY/MM/DD

If you participated in a self dialysis training program, provide date training started: CCYY/MM/DD

__ no.

4. Are you within the 30 month coordination period?

__ yes.

__ no. **STOP.** **MEDICARE IS PRIMARY**.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
__ yes;

__no. **STOP.** **GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD**.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

____ yes; **STOP.** **GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD**.

____ no. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

__ yes; **GHP CONTINUES TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD**.

__ no; **MEDICARE CONTINUES TO PAY PRIMARY**.

B. If Beneficiary Provides Information Which Is Different From That Found on CWF.--If, as a result of asking the preceding questions, the beneficiary provides information to you which is different from that found in CWF, it is important to provide that information on the bill with the proper uniform billing codes. This information will then be used to update CWF through the billing process.

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE. (SEE §142.3F.) THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

C. If There Are No MSP Data Available On CWF For Beneficiary.--If no MSP data are found in CWF for the beneficiary, you must still ask the questions found in §301.2A and provide any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

301.3 Policy for Provider Records Retention of MSP Information.--42 CFR 489.20(f) states that the provider agrees to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. Based on this regulation, hospitals must document and maintain MSP information for Medicare beneficiaries. Without this documentation, your intermediary would have nothing to audit submitted claims against. It is not necessary that the completed questionnaire be signed by the beneficiary. Hard copy questions and responses may be retained on paper, optical image, microfilm, or on microfiche. Furthermore, since CMS may pursue providers, physicians, and other suppliers under

the False Claims Act and the Federal Claims Collection Act for up to 10 years after a claim is paid, it would be prudent for hospitals to retain these records for up to 10 years. Should a hospital choose not to retain this information for up to 10 years, it does so at its own risk.

302. WAIVER OF HEALTH INSURANCE BENEFITS AS A CONDITION OF ADMISSION

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

Where a patient who has signed such a waiver nevertheless requests payment under the program, you must bill the intermediary and refund any payments made by the patient, or on his/her behalf, in excess of permissible charges.

303. HOSPITAL PREPAYMENT REQUESTS AND REQUIREMENTS

303.1 Requiring Prepayment as a Condition of Admission Is Prohibited.--You may not require advance payment of the inpatient deductible or coinsurance as a condition of admission for inpatient services. In addition, you may not require that the beneficiary prepay any Part B charges as a condition of admission, except where you regularly require prepayment from all patients. In such cases, you may collect only the deductible and coinsurance. Where the patient does not have Part B entitlement see §303.3.

303.2 When Prepayment May Be Requested.--In admitting a beneficiary, you may request the deductible or coinsurance amounts only where it appears that the patient will owe them and it is your routine and customary policy to request similar prepayment from nonbeneficiary patients with similar benefits which leaves them responsible for a part of the cost of their hospital services. In admitting the patient, ascertain whether he/she has medical insurance coverage. Where he/she does, ask if he/she has an Explanation of Benefits (EOB) showing his/her deductible status. If a beneficiary shows he/she met the Part B deductible, do not request or require prepayment of the deductible.

Except in the rare cases where prepayment may be required, any request for payment must be made as a request and without undue pressure. The beneficiary (and his/her family) must not be given cause to fear that admission will be denied for failure to make the advance payment.

Insure that your admitting office personnel are informed and kept fully aware of your policy on prepayment. For this purpose, and for your benefit and that of the public, it is desirable that a notice be posted prominently in the admitting office or lobby to the effect that no patient will be refused admission for inability to make an advance payment or deposit if Medicare is expected to pay the hospital costs.

303.3 Hospital May Require Prepayment for Noncovered Services.--With regard to noncovered services (e.g., personal comfort items, a private duty nurse), you may deny such services for which the beneficiary has not paid or offered satisfactory assurance of payment if that is your practice with your non-beneficiary patients. For example, you need not furnish a private room or TV set to a patient who requests it but is unable to prepay or offer the assurance of payment which you usually require.

Where the aged person has exhausted his covered inpatient hospital benefits and in cases where an aged person cannot supply satisfactory evidence of entitlement under Part A, you are free to apply to such persons your usual policy with respect to requiring prepayment or other assurance of payment where the patient has no insurance. Also, for the beneficiaries receiving covered inpatient services who are not enrolled for medical insurance (Part B), you can apply your usual policy on prepayment or assurance of payment with regard to services of salaried physicians provided.

303.4 Compliance with Agreement.--You must conform to the policy set forth in this instruction. Noncompliance will be considered in determining whether you are honoring your agreement under which you may not charge for services for which payment may be made under the Medicare program.