CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 228 **Date: JULY 16, 2004**

CHANGE REQUEST 3267

I. SUMMARY OF CHANGES: This is a clarification for CR3064. Since CMS is no longer requiring hospital labs or independent labs to collect MSP information in order to bill Medicare for reference lab services, where there is no face-to-face encounter with a beneficiary, labs will enter "None" in Block 11 of Form CMS-1500 when submitting CMS-1500 forms. Carriers shall then process these claims using existing claims processing instructions. A hyperlink to chapter 26, section10.2 of the Claims Processing manual will be listed in chapter 3, section 20.1 of the MSP manual.

NEW/REVISED MATERIAL – EFFECTIVE DATE: December 8, 2003
IMPLEMENTATION DATE: August 16, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/10.2/Items 1-11-Patient and Insured Information

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 228	Date: July 16, 2004	Change Request 3267

SUBJECT: - General Policy

I. GENERAL INFORMATION: CLARIFICATION OF CR3064 – This clarification is needed primarily to instruct carriers on how to process claims from labs, when the claims are submitted on Form CMS-1500. Specifically, carriers are to instruct labs to enter "None" in Block 11 of Form CMS-1500 when filing claims to Medicare for reference lab services when there is not a face-to-face encounter with a Medicare beneficiary. Entering "None" in Block 11 will prevent the claims from being "denied as unprocessable." Section 943 of the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA) mandates that the Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer *(MSP)* provisions) in the case of reference laboratory services described in subsection (b) of section 943, if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory. When either independent or hospital labs have face-to-face encounters with the beneficiaries, the labs are expected to collect the MSP information. If the lab previously had a face-to-face encounter with a beneficiary, collected and retained MSP information, but is now billing for a non-face-to-face lab service, the lab may use that information for billing.

A. Background: Prior to the enactment of the new Medicare law, hospitals were required to collect MSP information every 90 days in order to bill Medicare for reference lab services (see transmittal A-02-021).

B. Policy: The Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) of section 943 of MMA. Therefore, pursuant to section 943 of MMA, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) of section 943 of MMA.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3267.1	Intermediaries and Carriers shall not require independent reference labs to ask questions or obtain information relating to MSP provisions in the case of reference laboratory services as described in section 943, subsection (b) of MMA, in order to bill Medicare for these reference lab services.	Intermediaries and Carriers
3267.1.1	Carriers shall instruct labs, that submit claims on CMS-1500 forms, to enter "None" in Block 11 of Form CMS-1500 for reference lab services as described in section 943, subsection (b) of MMA, in order to bill Medicare for these reference lab services.	Carriers
3267.2	Intermediaries shall not require hospitals (including critical access hospitals) to ask questions or obtain information relating to MSP provisions in the case of reference laboratory services as described in section 943, subsection (b) of MMA, in order to bill Medicare for these reference lab services.	Intermediaries
3267.3	Intermediaries shall not include claims for reference laboratory services, as described in section 943, subsection (b) of MMA, in the sample of claims that are reviewed during MSP hospital audits. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.	Intermediaries
3267.4	Intermediaries and Carriers shall instruct labs, which have collected and retained MSP information for beneficiaries, that they may use that information for billing purposes of non-face-to-face lab services.	Intermediaries and Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None.

D. Contractor Financial Reporting /Workload Impact: None.

E. Dependencies: None.

F. Testing Considerations: None.

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: December 8, 2003 **Implementation Date: August 16, 2004** **Pre-Implementation Contact(s): Brian Pabst, BPabst@cms.hhs.gov** **Post-Implementation Contact(s): Local Regional Office MSP coordinator.**	**These instructions shall be implemented within your current operating budget.**

10.2 - Items 1-11 - Patient and Insured Information

(Rev. 228, Issued 07-16-04, Effective: December 8, 2003/Implementation: August 16, 2004)

B3-3005.2, B3-3005.4, B3-4020.1, B4-2010.1, TR-1712

Item 1 - Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a - Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.

Item 2 - Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.

Item 3 - Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item 4 - If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5 - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6 - Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7 - Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4 and 11 are completed.

Item 8 - Check the appropriate box for the patient's marital status and whether employed or a student.

Item 9 - Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**

NOTE: Only Participating Physicians and Suppliers are to complete Item 9 and its subdivisions and only when the Beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the Participating Physician or Supplier.

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See Chapter 28.)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a - Enter the policy and/or group number of the Medigap insured proceeded by **MEDIGAP, MG, or MGAP**.

NOTE: Item 9d must be completed if the provider enters a policy and/or group number in item 9a.

Item 9b - Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Item 9c - Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St. MD 21204."

Item 9d - Enter the 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.
If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Items 10a through 10c - Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d - Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11 - THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.
If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.
If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service, where there has been no face-to-face encounter with the beneficiary. The claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare - Circumstances under which Medicare payment may be secondary to other insurance include:

Group Health Plan Coverage
Working Aged;
Disability (Large Group Health Plan); and
End Stage Renal Disease;

No Fault and/or Other Liability; and

Work-Related Illness/Injury:
Workers' Compensation;
Black Lung; and
Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.