Medicare Hospital Manual

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

Transmittal 799 **Date: MARCH 14, 2003**

CHANGE REQUEST 2104

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
301 (Cont.) – 301 (Cont.)	3-5 – 3-6 (2 pp.)	3-5 – 3-6 (2 pp.)

MANUALIZATION/CLARIFICATION--*EFFECTIVE DATE: N/A*

Section 301, Identifying Other Primary Payers During the Admission Process, manualizes Program Memorandum A-02-021 (Change Request 2104) dated March 23, 2002, regarding policy and instructions to hospitals on the Medicare Secondary Payer (MSP) program. The purpose of that issuance was to clarify the policies regarding hospital reference lab services and recurring outpatient services.

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 90 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. Hospitals must be able to demonstrate that they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy.

Policy for Recurring Outpatient Services

Hospitals must collect MSP information from the beneficiary or his/her representative for hospital outpatients receiving recurring services. 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 every 90 days. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for recurring outpatient services furnished by hospitals.

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 a billing cycle.

Hospitals must be able to demonstrate that they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy.

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.