Program Memorandum Intermediaries

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

Transmittal A-02-021 **Date: MARCH 22, 2002**

CHANGE REQUEST 2104

SUBJECT: Medicare Secondary Payer (MSP) Information Collection Policies Changed for Hospitals

Beneficiary-specific data on third-party payers obligated to be primary payers to Medicare are maintained by the Centers for Medicare & Medicaid Services (CMS) for the purpose of ensuring that the Medicare Program processes claims properly. The basis for provider collection of these data is found in law and regulations, a synopsis of which is provided below:

Background

Based on the law and regulations, providers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Social Security Act (the Act) (42 USC §1395y(b)(6)) requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR §489.20(g) requires that all providers must agree "… to bill other primary payers before billing Medicare…." Thus, any provider that bills Medicare for services rendered to Medicare beneficiaries, including non-patient (reference lab) services, must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Hospital Manual §301.2, "Types of Admission Questions to Ask Medicare Beneficiaries," may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital. If providers fail to file proper claims with Medicare, the Secretary's regulations at 42 CFR §411.24 permit Medicare to recover its conditional payments from them.

In order to conform to the law and regulations, the provider must verify MSP information prior to submitting a bill to Medicare. This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming that the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred.

CMS has recently re-evaluated the paperwork burden associated with hospital collection of certain MSP data and is making changes to its associated data collection requirements, as described below. For the hospital reference labs and recurring outpatient services policies only, this Program Memorandum (PM) supersedes Intermediary Transmittal Number A-01-116 and Hospital Manual Transmittal 777, both of which were transmitted on September 25, 2001. Publish this PM exactly as written in your next regularly scheduled provider bulletin.

1. 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.

2. 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.

The *effective date* for this PM is March 31, 2002.

The *implementation date* for this PM is March 31, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after March 31, 2003.

If you have any questions, contact your regional office MSP coordinator.