CMS Manual System

Pub. 100-05 Medicare Secondary Payer

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

Transmittal 11 **Date: FEBRUARY 27, 2004**

CHANGE REQUEST 3064

I. SUMMARY OF CHANGES: The Medicare Prescription Drug, Improvement & Modernization Act of 2003 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 provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory."

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 8, 2003
***IMPLEMENTATION DATE: March 29, 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	3/20/1/General Policy
R	5/70/2/Selection of Bill Sample

***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

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SUBJECT: - General Policy

I. GENERAL INFORMATION 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 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.

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: Intermediaries shall inform affected providers by posting either a summary or relevant portions of this document on their Web site within two weeks. Also, intermediaries shall publish this same information in their next regularly scheduled bulletin. If they have a listserv that targets affected providers, they shall use it to notify subscribers that information about the "Medicare Secondary Payer (MSP) Policy for Hospital Reference Lab Services and Independent Reference Lab Services" is available on their Web site.

A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters no later than two weeks from the issuance date of this instruction. You must post this article on your Website and include it in a listserv message (if applicable) to the affected provider/supplier communities within one week of the availability of the article. In addition, you must include this article in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

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

Requirement #	Requirements	Responsibility
3064.1	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
3064.2	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
3064.3	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

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: March 29, 2004** **Pre-Implementation Contact(s): TBouchat@cms.hhs.gov.** **Post-Implementation Contact(s): Local Regional Office MSP coordinator.**	**These instructions shall be implemented within your current operating budget.**

20.1 - General Policy

(Rev. 11, 02-27-04)

Based on the law and regulations, providers, physicians, suppliers 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 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, physicians, suppliers must agree "…to bill other primary payers before billing Medicare..." Thus, any providers, physicians, suppliers that bill Medicare for services rendered to Medicare beneficiaries, including nonpatient (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. If providers fail to file correct and accurate claims with Medicare, 42 CFR 411.24 permits Medicare to recover its conditional payments from them.

Section 20.2.1, "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.

NOTE: In order to conform to the law and regulations, the provider, physician, supplier is required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. Section 20.2.1 lists the type of questions it must ask of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF). (See §20.2.) If the provider lacks access to CWF, it will follow the procedures found in §20.2.1.

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

1. Policy for Hospital Reference Lab Services and Independent Reference Lab Services

Background

Section 943 (TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYER (MSP) PROVISIONS) of the Medicare Prescription Drug, Improvement & Modernization Act of 2003 states:

> *"(a) IN GENERAL. – 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 provisions) in the case of reference lab services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.*
>
> *"(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation."*

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) above. Therefore, pursuant to section 943 of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above.

2. Policy for Recurring Outpatient Services

A-02-021

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.

3. 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.

4. 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, hospitals must follow the policy 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, hospitals 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, hospitals 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 the hospital determines it has been at least five years since the beneficiary retired, the hospital enters the retirement date as five years retrospective to the date of admission. (Example: Hospitals report the retirement date as January 4, 1998, if the date of admission is January 4, 2003) As applicable, the same procedure holds for a spouse who had retired at least five 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 five years ago, the hospital must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

5. Policy for Provider Records Retention of MSP Information

Title 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, the intermediary would have nothing to audit submitted claims against CMS recommends that providers retain MSP information for 10 years.

A - Obtain Auto, Non-Auto Liability or No-Fault Insurance Information

Providers are required to obtain information on possible Medicare Secondary Payer situations. Medicare patients, or their representatives, at admission or start of care, are asked if the services are for treatment of an injury or illness which resulted from an automobile accident or other incident, for which auto, liability or no-fault insurance may pay, or for which another party is held responsible. This includes an incident that occurs on the provider's premises. The provider obtains the name, address, and policy number of any automobile or non-automobile

liability or no-fault insurance company or any other party that may be responsible for payment of medical expenses that resulted from the accident or illness.

B - Obtain Workers' Compensation (WC) Information

Providers are expected to inquire of the beneficiary or representative at the time hospitalization is ordered, at admission, or when the service is rendered, whether the condition is work-related. When the patient or the patient's physician indicates that the condition is work-related or there is other indication that it is work-related, the provider is required to ask the patient or the patient's physician, wherever possible, whether WC is expected to pay. (Generally, where hospital services are covered under a WC program, the WC carrier or the employer will authorize the services in advance.)

If the patient denies that WC benefits are payable for a condition which the provider believes may be covered by WC, a supplementary statement is attached to the billing form containing information about the circumstances of the accident and the reasons it is claimed that WC benefits are not payable.

C - Obtain GHP Data from Working Aged Beneficiaries

To obtain the information needed to ascertain whether to bill a GHP as primary payer, providers ask beneficiaries age 65 or over admitted for inpatient care or receiving outpatient care, or their representatives, selected questions. See Chapter 4, §30.4.2.1, of this MSP manual for the model questionnaire. These include the age of the beneficiary, the employment status of the beneficiary and the spouse, whether the beneficiary is covered under a GHP because of the beneficiary's or the spouse's current employment, and the patient's identification number and the name and address of the GHP.

D - Obtain GHP Data from Disabled Beneficiaries

Providers are required to identify individuals who meet the disability provisions by asking every Medicare beneficiary under age 65 if the individual has group health coverage based on their own current employment status or the current employment status of a family member. If the individual has such coverage, the provider requests the name and address of the employer plan and the individual's identification number and bills the plan for primary benefits, except where the provider has information that clearly shows that the employer plan is not primary payer. If the individual responds negatively to either question, or the provider has otherwise determined that the employer plan is not primary payer, the provider bills Medicare for primary benefits.

E - Obtain GHP Data from ESRD Beneficiaries

Health care providers identify beneficiaries who are entitled to Medicare based on ESRD through information available to them (e.g., the beneficiary's Medicare card) and to ascertain whether the services may be payable under a GHP during the 30-month coordination period. Providers determine whether the services were rendered in the coordination period by checking their own records, e.g., information contained on Form CMS-2728 or, if the potential Medicare payment

is $50 or more, with other providers or facilities, or the beneficiary's physician, if necessary, to determine the date the individual started a regular course of dialysis or the date the individual received a kidney transplant (or entered a hospital to receive a transplant) or the date an individual began a course of home dialysis. If the individual is in the 30-month coordination period, the provider asks if the beneficiary is insured under a group health insurance plan of his or her own, or as a family member. If the response is yes, the provider asks for the name and address of the plan and the beneficiary's identification number. A coordination of benefits (COB) period may be applicable even if an ESRD beneficiary or his (her) spouse is not currently employed throughout the COB period. The beginning date of a COB period is different when an individual receives a kidney transplant or receives home dialysis than when an individual receives regular (outpatient) dialysis (3-month waiting period).

If the information obtained does not indicate GHP coverage, the provider annotates the bill to that effect (e.g., GHP coverage lapsed, benefits exhausted). If the information indicates that GHP coverage exists, the provider obtains the information indicated above from the beneficiary or the beneficiary's representative.

For audit purposes, and to ensure that the provider has developed for other primary payer coverage, the provider retains a record of the development or other information on which it based its determination that Medicare is primary payer. See Chapter 5, §30, for action to take where a claim is received for primary benefits and there is reason to believe that Medicare may be secondary payer.

70.2 - Selection of Bill Sample

(Rev. 11, 02-27-04)

A3-3693.4, HO-480.7

The sample period shall be determined by selecting the sample from one month of the hospital's bill submissions. The intermediary shall notify the hospital in advance of the month's claims to be reviewed. For example, if the review examines December bills, the intermediary shall notify the hospital no later than November 30 to permit the hospital time to segregate Medicare patient bills in advance. The reviewer is not required to perform the review during the same month as the month of bills selected. The reviewer shall make an effort to conduct the review within three months after the sample period. The hospital shall provide the reviewer with one month's bills from which to select the bill sample.

The bill universe shall consist of Medicare inpatient, outpatient, and subunit claims for which a primary or secondary Medicare payment was made. The reviewer shall select the sample using the following criteria:

- At least 2/3 of the sample should consist of inpatient bills. The remaining 1/3 is to be outpatient bills. The split is to be determined at the reviewer's discretion;
- The sample must contain a minimum of 20 bills and a maximum of 60 bills;
- The reviewer shall include Medicare no-pay bills in the sample in order to examine the ratio of no-pay bills submitted by the hospital to those actually billed;
- The sample is to include a mixture of bill types from the hospital's bill universe. Accordingly, if the hospital does not submit ESRD bills, then the reviewer is not required to review that particular bill type; and
- Both Medicare primary and secondary bills are to be included in the sample.
- *Claims for reference laboratory services, as described in section 943, subsection (b), listed below, of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, shall not be included in the sample of claims that are audited during MSP hospital reviews. This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.*

(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.