Program Memorandum Intermediaries

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

Transmittal A-01-116 **Date: SEPTEMBER 25, 2001**

CHANGE REQUEST 1685

SUBJECT: Medicare Secondary Payer (MSP) Policies Relaxed for Hospitals

Beneficiary-specific MSP data are maintained by the Centers for Medicare & Medicaid Services (CMS) for the purpose of ensuring that the Medicare Program pays claims in the correct order of financial liability. The basis for provider collection of these data is found in law and regulations, a synopsis of which is provided below:

MSP Requirements

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. If providers fail to file correct and accurate claims with Medicare, 42 CFR 411.24 permits Medicare to recover its conditional payments from them.

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.

NOTE: In order to conform to the law and regulations, the provider should 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 in operational policy to relax associated data collection requirements, as described below. With the exception of the contact information and the effective/implementation date information and instructions at the end of this Program Memorandum (PM), 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 sixty (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 collected MSP information 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.

2. 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.

This procedure is available ONLY with respect to recurring outpatient services. Hospitals should keep an audit trail to show they collected MSP information from the beneficiary or his/her representative which is no older than 30 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.

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 Provider Records Retention of MSP Information

42CFR 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.

Furthermore, since CMS may pursue providers, physicians, and other suppliers under the False Claims Act and the Federal Claims Collection Act for up to ten (10) years after a claim is paid, it would be prudent for hospitals to retain these records for up to ten (10) years. Should a hospital choose not to retain this information for up to ten (10) years, it does so at its own risk.

The *effective date* for this Program Memorandum (PM) is January 1, 2002.

The *implementation date* for this PM is January 1, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after January 31, 2003.

If you have any questions, contact Thomas Bouchat at 410-786-4621 or e-mail at TBouchat@cms.hhs.gov.