

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 123	Date: August 17, 2018
	Change Request 10863

SUBJECT: Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual

I. SUMMARY OF CHANGES: This change request further clarifies for providers where and when to obtain information from patients or authorized representatives upon admission or start of care. This includes providers' use of obtaining beneficiary Medicare information using the 270/271 transaction set, use of the CMS model questionnaire, and clarifying policy for provider based and non-provider based services, such as ambulance services.

EFFECTIVE DATE: November 20, 2018

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: November 20, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
R	3/20/20.1/General Policy
R	3/20/20.2/Verification of Medicare Secondary Payer (MSP) Online Data and Use of Admission Questions
R	3/20/20.2/20.2.1/Model Admission Questions to Ask Medicare Beneficiaries
R	3/20.2.2/Documentation to Support the Admission Process
R	5/70/70.1/Reviewing Hospital Files
R	5/70/70.1/70.1.2/Methodology for Review of Admission and Bill Processing Procedures
R	5/70/70.3/ Methodology for Review of Hospital Billing Data
R	5/70/70.3/70.3.3/Review of Hospitals With Online Admissions Query or Use of the X12 270/271 Transaction
R	5/70/70.5/70.5.3/Exhibit 3: Entrance Interview Checklist
R	5/70/70.5/70.5.4/Exhibit 4: Entrance Interview Checklist: Billing Procedures

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Attachment - Business Requirements

Pub. 100-05	Transmittal: 123	Date: August 17, 2018	Change Request: 10863
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SUBJECT: Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual

EFFECTIVE DATE: November 20, 2018

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I. GENERAL INFORMATION

A. Background: Providers are 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. The model questionnaire in Publication 100-05, Chapter 3, Section 20.2.1 lists the type of questions that should be asked of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care with exceptions provided. However, a recent question was received asking whether certain EMS services can be excluded from the questionnaire process. Based on the regulations, the questions must be asked upon admission; however, CMS has updated its policy in this change request to provide further clarification stating that if the hospital asks the MSP questions then there is no need for the provider based ambulance service to also ask the MSP questions. CMS has also updated its instructions to re-emphasize that providers may also view the CMS Common Working File, or reference the X12 270/271 Transaction Set, to confirm with the patient if insurance information has changed. If there are no changes, the MSP questions do not need to be asked.

B. Policy: Based on the law and regulations, providers, physicians, and other 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 must agree "to bill other primary payers before billing Medicare."

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
10863.1	The A/B MACs Part A shall read and take into consideration the updates to Pub. 100-05, Chapter 3 and Chapter 5 as this change request updates language referring to:	X								

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	<ul style="list-style-type: none"> the MSP Model Questionnaire; the provider's use of CWF or the X12 270/271 Transaction Set to obtain beneficiary Medicare information; the provider not asking all the questions when insurance information has not changed; and clarifying policy for provider based and non-provider based services such as ambulance services as to which entity shall ask the MSP questions. 									
10863.2	The A/B MACs Part A shall take into consideration the updated polices in this change request when conducting scheduled hospital reviews.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10863.3	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Richard Mazur, 410-786-1418 or richard.mazur2@cms.hhs.gov , Steve Forry, 410-786-1564 or steve.forry@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

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(Rev. 123, Issued: 08-17-18)

20.2.1- *Model* Admission Questions to Ask Medicare Beneficiaries

Medicare Secondary Payer (MSP) Manual

Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements

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(Rev. 123, Issued: 08-17-18)

20.1 - General Policy

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

Based on the law and regulations, providers, physicians, and other 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 must agree "to bill other primary payers before billing Medicare."

Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries 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. Exceptions to this requirement are discussed below in 1, *3 and 6*. If providers, physicians or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

Section 20.2.1, "Admission Questions to Ask Medicare Beneficiaries," *is a model questionnaire that* may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

NOTE: Providers are 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. *The model questionnaire in Section 20.2.1 lists the type of questions that should be asked of Medicare beneficiaries for every admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1, 3 and 6*

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF) *or the X12 270 transmission and the X12 271 response*. (See §20.2.) If the provider lacks access to CWF, *or does not have a copy of the 271 response*, it will follow the procedures found in §20.2.1. *The X12 270 Transaction Set is used to transmit Health Care Eligibility Benefit Inquiries from health care providers, insurers, clearinghouses and other health care adjudication processors. The X12 270 Transaction Set can be used to make an inquiry about the Medicare eligibility of an individual. The X12 271 Transaction Set is the appropriate response mechanism for Health Care Eligibility Benefit Inquiries.*

NOTE: There may be situations where more than one payer is primary to Medicare (e.g., liability insurer and GHP). The provider, physician, or other supplier 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. This policy, however, will not be a valid defense to Medicare’s right to recover when a mistaken payment situation is later found to exist.

Contractors shall instruct hospital and independent labs, which have already collected and retained MSP information for beneficiaries, that they may use that information for the billing of non-face-to-face reference lab services. However, in situations when there is a face-to-face encounter with the beneficiary, contractors shall instruct hospitals and independent labs that they are required to collect MSP information from the beneficiary when billing for lab services.

Instructions to contractors on how to process reference lab claims submitted on Form CMS-1500 are available by clicking on the following hyperlink: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf>
http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf (After you get to chapter 26, click on section 10.2 in the Table of Contents.)

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. This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.

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 Advantage (MA) Members

If the beneficiary is a member of an MA plan, 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 contractor would have nothing to audit submitted claims against. CMS recommends that providers retain MSP information for 10 years.

A Obtain 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 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 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 3, §20.2.1, 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.

6. Policy for Provider Based and Non-Provider Based Services, such as Ambulance Services

Some hospitals offer provider based services, such as a transfer ambulance service that is affiliated with the hospital. The affiliated provider based service does not need to repeat the MSP questions if the beneficiary has already had their information verified by the provider. In the above example, the hospital-affiliated ambulance provider does not need to ask the MSP questions if the beneficiary is seen by the hospital admissions staff. The admissions staff shall verify the beneficiary's insurance information and it bills the appropriate insurer for the ambulance service.

However, if the provider is an independent provider (such as if the ambulance provider above were not affiliated with the hospital), then the independent provider is responsible for verifying the correct information prior to billing for services.

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.

20.2 - Verification of Medicare Secondary Payer (MSP) Online Data and Use of Admission Questions

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

MSP Online Data Elements

Providers with online capability may now access the following MSP information via CWF from the CWF MSP auxiliary file:

- MSP effective date;
- MSP termination date;
- Patient relationship;
- Subscriber name;
- Subscriber policy number;
- Insurer type;
- Insurer information: Name, group number, address, city, State, and ZIP code;
- MSP type;
- Remarks code;
- Employer information: Name, address, city, State, and ZIP code; and
- Employee data: ID number, and information.

At the provider's discretion, these data may be viewed during either the admission or the billing process. However, the data must be viewed before a bill is submitted to Medicare, and should ideally be viewed before the patient leaves the hospital.

If *the model questionnaire is* used during *the admissions process*, the provider will verify each data element by using the questions found in §20.2.1 to help identify other payers that may be primary to Medicare. It will comply with any instructions that follow a particular question. ***Note: If the provider has the ability to***

submit and receive a X12 270/271 transaction, the admission staff shall ask the beneficiary if any insurance information found on CWF, or the X12 271 response, has changed in lieu of asking all the MSP questions. When submitting the X12 270 transaction the provider must include the beneficiary entitlement date to be sure all MSP periods are received on the X12 271 response. If there are no changes or updates to the beneficiary's insurance then there is no need to ask the questions. However, having access to CWF or the X12 270/271 transaction does not absolve the provider of its responsibility from asking the MSP questions as necessary. If there are changes to the insurance information, or if there is uncertainty regarding information based on conversation, then the provider must ask the MSP questions. Providers must make a notation for auditing purposes that all the questions were not asked upon admission, or during the telephone interview/screening, based on the beneficiary's statement that their insurance information has not changed or does not require updating. The Medicare contractor shall request this notation and confirmation during its hospital review. If the provider lacks access to CWF or it does not utilize the X12 270/271 transaction the provider shall follow the procedures found under §20.2.1. This means the provider shall ask the beneficiary the necessary MSP questions to determine the correct primary payer. The providers are held liable to obtain the correct MSP information so claims are billed to the correct primary payer accordingly per the CMS regulations 42 CFR § 489.20.

20.2.1 – *Model* Admission Questions to Ask Medicare Beneficiaries
(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

The following *model* questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare. This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this *model* questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?

___ Yes; Date benefits began: MM/DD/CCYY

BL IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO BL.

___ No.

2. Are the services to be paid by a government research program?

___ Yes.

GOVERNMENT RESEARCH PROGRAM WILL PAY PRIMARY BENEFITS FOR THESE SERVICES.

___ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?

___ Yes.

DVA IS PRIMARY FOR THESE SERVICES.

___ No.

4. Was the illness/injury due to a work-related accident/condition?

___ Yes; Date of injury/illness: MM/DD/CCYY

Name and address of workers' compensation plan (WC) plan:

Policy or identification number: _____

Name and address of your employer:

WC IS PRIMARY PAYER ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS, GO TO PART III.

No. **GO TO PART II.**

PART II

1. Was illness/injury due to a non-work-related accident?

Yes; Date of accident: MM/DD/CCYY

No. **GO TO PART III**

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.)

Yes.

Name and address of no-fault insurer(s) and no-fault insurance policy owner:

Insurance claim number(s): _____

No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.)

Yes.

Name and address of liability insurer(s) and responsible party:

Insurance claim number(s): _____

No.

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE ACCIDENT. LIABILITY INSURANCE IS PRIMARY PAYER ONLY FOR THOSE SERVICES RELATED TO THE LIABILITY SETTLEMENT, JUDGMENT, OR AWARD. GO TO PART III.

PART III

1. Are you entitled to Medicare based on:

Age. **Go to PART IV.**

Disability. **Go to PART V.**

End-Stage Renal Disease (ESRD). **Go to PART VI.**

Please note that both “Age” and “ESRD” OR “Disability” and “ESRD” may be selected simultaneously. An individual cannot be entitled to Medicare based on “Age” and “Disability” simultaneously. Please complete ALL “PARTS” associated with the patient’s selections.

PART IV – AGE

1. Are you currently employed?

Yes.

Name and address of your employer:

No. If applicable, date of retirement: MM/DD/CCYY

No. Never Employed.

2. Do you have a spouse who is currently employed?

Yes.

Name and address of your spouse's employer:

No. If applicable, date of retirement: MM/DD/CCYY

No. Never Employed.

IF THE PATIENT ANSWERED “NO” TO BOTH QUESTIONS 1 AND 2, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED “YES” TO QUESTIONS IN PART I OR II. DO NOT PROCEED FURTHER.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

- Yes, both.
- Yes, self.
- Yes, spouse.

No. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?

Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to the Health Insurance Portability and Accountability Act (HIPAA), this number was frequently the individual's Social Security Number (SSN); it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No.

5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 20 or more employees?

Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No.

IF THE PATIENT ANSWERED "NO" TO BOTH QUESTIONS 4 AND 5, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR II.

PART V – DISABILITY

1. Are you currently employed?

Yes.

Name and address of your employer:

No. If applicable, date of retirement: MM/DD/CCYY

No. Never Employed.

2. Do you have a spouse who is currently employed?

Yes.

Name and address of your spouse's employer:

No. If applicable, date of retirement: MM/DD/CCYY

No. Never Employed.

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

Yes, both.

Yes, self.

Yes, spouse.

No.

4. Are you covered under the GHP of a family member other than your spouse?

Yes.

Name and address of your family member's employer:

No.

IF THE PATIENT ANSWERED "NO" TO QUESTIONS 1, 2, 3, AND 4, STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED "YES" TO QUESTIONS IN PART I OR 11.

5. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 100 or more employees?

Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No.

6. If you have GHP coverage based on your spouse's current employment, does your spouse's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

No.

7. If you have GHP coverage based on a family member's current employment, does your family member's employer, that sponsors or contributes to the GHP, employ 100 or more employees?

Yes. **GHP IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder/named insured: _____

Relationship to patient: _____

___ No.

IF THE PATIENT ANSWERED “NO” TO QUESTIONS 5, 6, and 7, MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED “YES” TO QUESTIONS IN PART I OR II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage?

___ Yes.

IF APPLICABLE, YOUR GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which you receive GHP coverage:

IF APPLICABLE, YOUR SPOUSE’S GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual’s SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which your spouse receives GHP coverage:

IF APPLICABLE, YOUR FAMILY MEMBER’S GHP INFORMATION:

Name and address of GHP:

Policy identification number (this number is sometimes referred to as the health insurance benefit package number): _____

Group identification number: _____

Membership number (prior to HIPAA, this number was frequently the individual's SSN; it is the unique identifier assigned to the policyholder/patient): _____

Name of policyholder /named insured: _____

Relationship to patient: _____

Name and address of employer, if any, from which your family member receives GHP coverage:

No. **STOP. MEDICARE IS PRIMARY.**

2. Have you received a kidney transplant?

Yes. Date of transplant: MM/DD/CCYY

No.

3. Have you received maintenance dialysis treatments?

Yes. Date dialysis began: MM/DD/CCYY

If you participated in a self-dialysis training program, provide date training started: MM/DD/CCYY

No.

4. Are you within the 30-month coordination period that starts MM/DD/CCYY? (The 30-month coordination period starts the first day of the month an individual is eligible for Medicare (even if not yet enrolled in Medicare) because of kidney failure (usually the fourth month of dialysis). If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the 30-month coordination period starts with the first day of the month of dialysis or kidney transplant.)

Yes.

No. **STOP. MEDICARE IS PRIMARY.**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

Yes.

No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

Yes. **STOP. GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY.**

7. Does the working aged or disability MSP provision apply (i.e., is the GHP already primary based on age or disability entitlement)?

___ Yes. **GHP CONTINUES TO PAY PRIMARY DURING THE 30-MONTH COORDINATION PERIOD.**

___ No. **MEDICARE CONTINUES TO PAY PRIMARY.**

If no MSP data are found in the Common Working File (CWF) for the beneficiary, the provider still asks the types of questions above and provides any MSP information on the bill using the proper uniform billing codes. This information will then be used to update CWF through the billing process.

20.2.2 - Documentation to Support the Admission Process

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

The provider retains a copy of completed admission questionnaires, *the CWF print out or copy of the 271 response including all notations*, in its files (or online) for audit purposes to demonstrate that development for other primary payer coverage takes place. It is not necessary that the completed questionnaire be signed by the beneficiary. Medicare permits providers to retain hard copy questions and responses on paper, optical image, microfilm, or microfiche. Hard copy and data *described in this paragraph* must be kept for at least 10 years after the date of service that appears on the claim. (See Chapter 5 for information about the documentation to be used in a hospital review.) If the provider's admissions questions are retained online, Medicare requires it to retain **negative** and **positive** responses to admission questions for 10 years with DOJ's record retention requirements, after the date of service. Online data may not be purged before then.

Medicare Secondary Payer (MSP) Manual

Chapter 5 - Contractor Prepayment Processing Requirements

Table of Contents *(Rev. 123, Issued: 08-17-18)*

70.3.3 - Review of Hospitals With Online Admissions Query *or Use of the X12 270/271 Transaction*

70.1 - Reviewing Hospital Files

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

In order to conduct an effective review, the contractor shall obtain complete files from the hospital on all beneficiaries represented in the bills selected for review. (See §70.2 concerning sample selections.) For the purposes of this review, a complete file must contain:

- A copy of the completed UB-92 (Form CMS-1450) or its facsimile;
- A copy of the admission questionnaire (the beneficiary's signature on the questionnaire is not required; see §70.3.B) *and/or the X12 270/271 transaction and any notations made to the transaction resulting from the admissions process*. If the hospital uses an online query process, *or the X12 270/271 transaction*, no hardcopy form need appear in the file. Screen prints may be used instead (see §70.1.2.B); and
- Beneficiary's MSN form for all secondary claims.

70.1.2 - Methodology for Review of Admission and Bill Processing Procedures

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

A Entrance Interview

The contractor shall conduct an entrance interview with the admissions staff (including inpatient, outpatient, and emergency) to determine whether the hospital established:

1. Policies identifying other payers primary to Medicare; and
2. A system in which such policies are carried out in practice.

Contractors shall use the checklist found in §70.5.3, Exhibit 3 to conduct the entrance interview. During the interview, the contractor shall request a descriptive walk-through of the admissions process. It is not necessary to observe an actual admission of a beneficiary.

B Review of Hospital Admission Questionnaire

The contractor shall review copies of the hospital's inpatient, outpatient, and emergency room (ER) hospital admission questionnaires *and/ or the X12 270/271 transaction and existing notations*. If the hospital uses an online admission query process, the contractor shall review the system screen prints. If the hospital has both hard copy questionnaires and online questionnaire responses, the reviewer may exercise discretion in deciding whether to review hard copy questionnaires or online responses (or both, if desired). The reviewer shall compare the hospital's admissions questionnaire to the model found in the Medicare Secondary Payer Manual, Chapter 3, § 20.2.1) to ensure that the appropriate questions are being asked to identify other payers that may be primary to Medicare.

Analysis of the admission questionnaire, *including the X12 270/271 transaction and existing notations or system screen prints utilized from the provider online screening process*, for purposes of insuring that it matches the information billed should be undertaken during the review of billing procedures. (See §70.3.B for instructions.)

70.3 - Methodology for Review of Hospital Billing Data

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

A Entrance Interview

The reviewer shall conduct an entrance interview with the billing staff to determine whether the hospital established:

1. Policies concerning billing other payers primary to Medicare; and
2. A system in which such policies are carried out in practice.

Both these areas are to be examined in one interview. The reviewer shall use the checklist found in §70.5.4, Exhibit 4 to conduct the entrance interview. During the interview, the reviewer shall request a walk-through of the billing process.

B Comparing Completed Admission Questionnaire With Bills

The reviewer shall request completed inpatient, outpatient, and ER admission questionnaires (*or the X12 270/271 transaction and existing notations*) or screen prints for hospitals using online admission query systems) for each Medicare beneficiary included in the bill sample. (See §70.2 concerning selection of sample.) It is not necessary that the beneficiary sign the completed questionnaire.

The form may be kept as paper, optical image, microfilm, or microfiche. If the hospital uses online admission screens, it is not necessary to obtain a copy of an admission form or screen print as long as the hospital has documented procedures for collecting and reporting other primary payer information. The reviewer may request screen prints, if necessary. Hospitals with online query systems are encouraged to retain affirmative and negative responses to the questionnaire for 10 years after the date of service. Should a hospital choose not to retain this information for up to 10 years, it does so at its own risk.

The reviewer shall analyze the admission questionnaire, *the X12 270/271 transaction and existing notations*, or online admission query procedures, for Medicare beneficiaries to determine whether the information provided on the questionnaire matches the bill. The reviewer shall check to see whether each response to the questionnaire is reflected on the bill. For example, the reviewer shall check to ensure that the primary payer reflected on the questionnaire is shown as primary on the bill, name and address of insurer(s) on questionnaire matches that on the bill, etc. Reviewers should check this admissions information at the same time the bill review is conducted.

70.3.3 - Review of Hospitals With Online Admissions Query *or Use of the X12 270/271 Transaction*

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

While hospitals that solicit admission data through an online process are not required to retain hard copies of admission questionnaires, they must utilize a specific set of admission questions that seek the appropriate MSP information. The hospital must demonstrate that responses to admission questions asked are retained, and match the information shown on the bill. The reviewer shall use the same review requirements described in §70.3. Although not required, the use of screen prints of admission questions will likely

facilitate easier review, particularly for the bill comparison process described at §70.2. The reviewer shall notify the hospital in advance of any screen prints that are needed. If the provider uses *the X12 270/271 transaction which contains existing notations obtained from the admission's interview copies of transactions must be used as part of your review following the steps outlined in this section.*

70.5.3 - Exhibit 3: Entrance Interview Checklist

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

Admissions Questionnaire and Procedures

A - Admissions Procedures

- 1 When is other payer information solicited? (During billing or during admission?)
- 2 Describe the process followed to solicit MSP information.
- 3 Do admissions staff receive training on soliciting MSP information? If so, describe the training. Do you think the staff understands the admissions questions well enough to solicit information and/or explain to beneficiaries?
- 4 Is MSP information obtained primarily from the patient, Medicare Common Working File, or in some other way?

B – Questionnaire

- 1 Are the admissions questionnaire data solicited through an online query (i.e. are the admissions questions asked and responses retained online) *or through the X12 270/271 transaction?*
- 2 Do you re-administer the questionnaire each time the patient is admitted? (It should be administered once per admission.)
- 3 Do you require the beneficiary's signature on the questionnaire? (No signature is required, and the hospital should be informed, if necessary.)
- 4 Are there written hospital policies, instructions or procedures concerning soliciting primary plan information? (Request copies for review.)
- 5 How long are admission questionnaires, *or copies of the X12 270/271 transaction*, retained, either online, in files, or both? (Requirements are found at §70.3.)

70.5.4 - Exhibit 4: Entrance Interview Checklist: Billing Procedures

(Rev. 123, Issued: 08-17-18, Effective: 11-20-18, Implementation: 11-20-18)

- 1 Does the hospital bill for all bill types?
- 2 Are all claims electronically billed?
- 3 Is the information pertaining to a payer primary to Medicare contained on the admission questionnaire, *the X12 270/271 transaction*, or in an online database, available in its entirety to the billing department? (The billing department must be made aware of a payer primary to Medicare, e.g., working aged, ESRD, liability insurance.)

- 4 Do circumstances arise where the billing department obtains information directly from the patient? How is it obtained? Is the regular admissions form used to obtain the information in these situations?
- 5 Where there is the possibility of payment by a Federal government grant program, how does the hospital bill Medicare? (Determine whether the hospital bills both the grant program and Medicare, or only Medicare.)
- 6 How does the hospital bill the Department of Labor where the services are covered by the Federal Black Lung (BL) program? (The hospital should bill the black lung program first.)
- 7 Does the hospital have the ability to track workers' compensation (WC) cases on succeeding visits to the hospital or the outpatient department? Describe the tracking mechanism. How does the hospital bill for the succeeding visits? (Many times individuals may have to return to the hospital for additional medical services as a result of a WC occurrence.)
- 8 Does the hospital bill more than one primary insurer simultaneously? (Providers are prohibited from billing more than one insurer for primary payment. Reviewer should request a credit balance report for this aspect of the review.)
- 9 Where the patient is in the ESRD coordination period and an employer has paid in part, or should pay for the services, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?
- 10 What is the hospital's policy on submission of no-pay bills?
- 11 Where a GHP or LGHP is the primary payer because the beneficiary is either working aged or disabled, or is involved in a no-fault or liability case, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?