MEDICARE PART A BULLETIN

December 19, 1997 Hospital Medicare Bulletin H-85

TO: All Medicare Hospitals

FROM: Medicare Secondary Payer Department

SUBJECT: **UPDATED HOSPITAL REVIEW INSTRUCTIONS: EFFECTIVE FOR SERVICES FURNISHED ON AND AFTER JANUARY 9, 1998**

ATTENTION MEDICARE BUSINESS OFFICE MANAGER: Please distribute to all appropriate health care facility personnel.

The Health Care Financing Administration (HCFA) has released updated hospital review instructions which become effective for services furnished on and after January 9, 1998. Intermediaries have been instructed by HCFA to copy Medicare Hospital Manual Transmittal 723 and provide it to the hospitals serviced by them. HCFA does not currently know when these instructions will be provided in a hardcopy format to providers via the Medicare Hospital Manual Transmittal process.

The updated hospital review instructions revise certain Medicare Secondary Payer (MSP) policies and procedures. Providers should review these instructions and make the necessary changes to their operations to be compliant. Providers must ensure that they are making the appropriate effort during the admission process to identify other primary payers.

Also, the Balanced Budget Act (BBA) of 1997 extended the End Stage Renal Disease (ESRD) coordination period from 18 months to 30 months for any individual whose coordination period began on or after March 1, 1996. Individuals whose coordination period began prior to March 1, 1996, have an 18-month coordination period. For more information on the HCFA changes regarding the ESRD coordination period, reference General Medicare Bulletin G-301, published September 25,1997.

If you have any questions regarding these instructions, contact our MSP Coordinator by calling 904/ 791-8264.

MedicareHospital Manual
Department of Health and Human Services
Health Care Financing Administration

Transmittal No. 723 Date DECEMBER 1997

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NEW IMPLEMENTING INSTRUCTIONS—EFFECTIVE DATE: JANUARY 9, 1998

Section 468, Consistency in Entering Other Insure Name on Bill, provides specific information to assist hospitals in accurately identifying other payers on the HCFA-1450. The revision also replaces UB-82 billing codes with UB-92 codes.

Section 301.1, Verification of MSP On-Line Data and Use of Admissions Questions, discusses the MSP on-line data elements for those hospitals that can access CWF.

Section 301.2, Admission Questions to Ask Medicare Beneficiaries, includes questions the hospital should ask the beneficiary upon admission.

Section 301.3, Documentation to Support Admission Process, indicates that it is the responsibility of the hospital to document the completed beneficiary questionnaire.

Section 480.1, Reviewing Hospital Files, requires hospitals to provide the intermediary with complete files on all beneficiaries represented in the bills selected for review.

Section 480.4, Selection of Bill Sample, includes what the intermediary needs when reviewing a sample of the submission of hospital bills.

Section 480.6, Review of Hospitals With On-Line Admissions, is added for the intermediary to determine whether the appropriate admissions questions have been asked, retained, and matched to the information shown on the bill.

CHANGED PROCEDURES—EFFECTIVE DATE: JANUARY 9, 1998

The acronym EGHP has been changed to GHP throughout this document.

HCFA-Pub. 10

Section 263.11, Amount of Secondary Medicare Payments Where GHP Pays in Part for Items and Services, includes the calculation for the provider's charges.

Section 263.13, Action by Intermediary to Recover Mistaken Primary Payments, explains that the intermediary has the right to recover mistaken payments directly from the hospital and that the intermediary will direct the hospital to file a proper claim with the GHP. It also eliminates the last sentence which reads, "Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by a GHP."

Section 263.14, Advice to Providers, Physician, and Beneficiaries, eliminates the phrase, "Medicare is secondary" and places the word "first" after the word "directed" and eliminates the word "first" found after "EGHP".

Section 263.16, Claimant's Right to Take Legal Action Against GHP, explains that a claimant has the right to take legal action and collect double damages under certain circumstances.

Section 263.17, Special Rules For Services Furnished by Source Outside Employer Sponsored HMO, changes the phrase "Prepaid Health Plan" to "Employer Sponsored HMO."

Section 301, Identifying Other Primary Payers During the Admission Process, modifies the questions to be used by hospitals in soliciting other payer information from beneficiaries upon admission. The section also reflects changes necessitated by the Omnibus Budget Reconciliation Act (OBRA) of 1993 which modified the Medicare Secondary Payer (MSP) ESRD provisions.

Section 350, Outpatient Registration Procedures, requires the same admissions questions as those required in inpatient admissions.

Section 465, Completion of Form HCFA-l450 for Inpatient and Outpatient Bills for Rural Primary Care Hospital, deletes the sentence "This space is available to report overflow from other items."

Section 480, Review Protocol, reflects a new review protocol and new procedures for MSP hospital reviews, formerly referred to as hospital audits. The process has been completely revised and the section should be reviewed in its entirety.

Section 480.2, Frequency of Review and Hospital Selection, provides hospitals with information stating the percentage of hospitals the intermediary will review for which it has Medicare claims processing responsibility.

Section 480.3, Methodology for Review of Admission Procedures, includes what the intermediary will look for when reviewing a hospital's admissions process.

Section 480.5, Methodology for Review of Hospital Billing Procedures, provides criteria on what the intermediary looks for when reviewing a hospital billing department.

Section 480.7, Intermediary Assessment of Hospital Review, is revised for the intermediary to use when the hospital has been reviewed.

Section 480.8, Exhibits 1 - 2, are updated to be used by the intermediary for each of its hospital reviews. Former Exhibits 1-6 have been eliminated.

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.

These instructions should be implemented within your current operating budget.

COVERAGE OF HOSPITAL SERVICES

Liabilty Insurance

No-Fault Insurance

Limitation on Payment for Services to Employed Aged Beneficiaries and Spouses

EXAMPLE: A Medicare beneficiary who had GHP coverage was hospitalized for 20 days in 1994. The hospital's charges for covered services were $5000. The inpatient deductible had not been met. The gross amount payable by Medicare (as defined in 263.11) would have been $4000 for the stay if there had been no GHP coverage. The GHP paid $4500 (of which $696 was credited to the Medicare deductible). Medicare makes no payment, since the plan's payment was greater than Medicare's gross amount payable of $4000 would have been. No part of the $500 difference between the hospital's charges and the GHP's payment can be billed to the beneficiary since the beneficiary's obligation, the deductible, was met by the GHP payment. The hospital files a no-payment bill reflecting the $696 credited to the deductible.

263.9 Crediting Expenses Toward Deductible and Coinsurance Amounts.—Expenses that serve to meet the beneficiary's Part A or Part B cash or blood deductibles if Medicare were primary payer are credited to those deductibles even if the expenses are reimbursed by a GHP. This is true even if the GHP paid the entire bill and there is no Medicare benefit payable. Also, GHP payments to a hospital are applied to satisfy a beneficiary's obligation to pay a Part A or Part

B coinsurance amount. However, GHP payments are credited to deductibles before being used to satisfy the coinsurance.

263.10 Group Health Plan Denies Claim for Primary Benefits.—

A. Primary Medicare Benefits.—Where a group health plan denies a claim for primary benefits because, for example, the employer does not employ 20 or more employees; or the beneficiary is not entitled to benefits under the plan; or benefits under the GHP are exhausted for the services involved; or the services are not covered by the GHP, submit a claim for Medicare primary benefits, unless you have reason to believe that the GHP should pay primary benefits for the services. For example, if the GHP offers only secondary coverage of services covered by Medicare, and the GHP does not allege that the employer has fewer than 20 employees, do not bill Medicare. Medicare primary benefits may not be paid in this situation even if the GHP has only collected premiums for secondary rather than primary coverage.

B. Annotation of Claims Denied by GHPs.—Whenever a GHP denies a claim for primary benefits, annotate in item 94 "Remarks" of the Medicare claim form the reason for the denial of GHP primary benefits and enter occurrence code 24 and date of denial in items 32 - 35. No attachment is needed to the Medicare claim. The annotation is needed to avoid needless recoupment efforts under 263.13.

263.11 Amount of Secondary Medicare Payments Where GHP Pays in Part for Items and Services.— If a GHP payment for Medicare covered services is less than the hospital's charges for those services and less than the gross amount payable by Medicare (as defined below), and the hospital does not accept and is not obligated to accept the payment as payment in full, Medi care secondary payment can be made. The Medicare secondary payment is the lower of:

- The gross amount payable by Medicare minus the amount paid by the GHP for Medicare covered services;

- The gross amount payable by Medicare minus any applicable deductible or coinsurance amount;

- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full minus the amount paid by the third party payer for Medicare covered services; or

- The provider's charges (or an amount less than the charges that the provider is obligated to accept as payment in full) minus the applicable Medicare deductible and/or coinsurance amounts.

NOTE: The gross amount payable by Medicare is (1) the current Medicare interim reimbursement amount (as defined in §473) for services reimbursed on a reasonable cost basis without considering the effect of the Medicare deductible, or coinsurance, or the payment by the GHP, or (2) the Medicare payment rate (as defined in §475) for hospitals reimbursed on a prospective payment basis without considering the effect of the Medicare deductible or coinsurance or the payment by the GHP.

Detailed reimbursement and billing instructions are in §472 for hospitals reimbursed on a cost reimbursement basis and §475 for hospitals reimbursed on a prospective payment basis.

263.12 Effect of Secondary Payments on Part A Utilization.—Where the conditions in §263.11 are met and a Medicare secondary benefit is payable, utilization is charged the beneficiary. The beneficiary is charged with utilization as specified in §472 for hospitals reimbursed on a cost reimbursement basis and §475A3 for hospitals reimbursed on a prospective payment basis. These procedures are applicable for calculating utilization for stays for which Medicare is secondary only for a portion of the stay.

263.13 Action by Intermediary to Recover Mistaken Primary Payments.—

A. General.—If primary Medicare benefits are paid to a hospital and the intermediary learns that a GHP should have paid primary benefits for the items and services, the intermediary is authorized to recover directly from the hospital.

B. Recovery from the Hospital.—The intermediary will recover Medicare's primary payment and direct you to file a proper claim with the GHP. A proper claim is one that is filed timely and meets all other claims filing requirements specified by the GHP.

You may request a secondary payment once the GHP has processed your claim. If you failed to timely file a proper claim and the GHP denies the claim and you can show that the reason you failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding GHP coverage that is primary to Medicare, you may request a primary payment from Medicare.

C. Recovery When State Medicaid Agency Has Also Requested Refund.—Where both Medicare and Medicaid have paid you incorrect benefits and you recover an amount from a GHP, you are obligated to refund the Medicare payment up to the full amount of the GHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount of its claim do you have the right to reimburse Medicaid or any other entity.

263.14 Advice to Providers, Physicians, and Beneficiaries.—In your professional and public relations activities, inform providers, physicians, and beneficiaries that claims should be directed first to the GHP where there is GHP coverage for the services involved.

263.15 Incorrect GHP Primary Payments.—Your intermediary may advise you that a GHP has incorrectly paid you primary benefits e.g., primary payments made by the GHP of an employer of less than 20employees. In such cases, bill Medicare as primary payer and refund to the GHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for noncovered services.

263.16 Claimant's Right to Take Legal Action Against GHP.—Section 1862(b)(3)(A) of the Act provides that any claimant has the right to take legal action and to collect double damages from a GHP that fails to pay primary benefits or fails to make appropriate reimbursement to Medicare for services

for which the GHP is primary payer.

263.17 Special Rules For Services Furnished By Source Outside Employer Sponsored HMO.—

A. Services By Outside Sources Not Covered.—Where Medicare is secondary payer for a person enrolled in an employer sponsored prepaid health plan (e.g., health maintenance organization (HMO)/ competitive medical plan (CMP)), Medicare does not pay for services obtained from a source outside the HMO if:

- The same type of services could have been obtained as covered services through the HMO, or
- The particular services can be paid for by the HMO (e.g., emergency or urgently needed services). Medicare benefits are precluded under these circumstances even if the individual receives services outside of the HMO's service area, e.g., while the individual is away from home.

At the time of admission, ask beneficiaries that are enrolled in GHPs whether the plan is an HMO. If the individual is enrolled in such a plan, Medicare is not billed. (However, a no-payment bill is required.) Any request for payment is made to the GHP.

This rule also applies to ESRD beneficiaries during the period of 30 months in which Medicare is secondary payer.

NOTE: This restriction only affects Medicare beneficiaries enrolled in an employer sponsored HMO which either is not a Medicare contract or is a Medicare cost contract. Beneficiaries in HMO/CMPs that have Medicare risk contracts are not affected because beneficiaries enrolled in a risk-basis HMO/ CMP are locked into the plan in all instances except for emergency or urgently needed services.

B. Exception.—If a beneficiary obtains services from a source outside the employer sponsored repaid health plan, and has not yet been notified in writing of this special rule, Medicare pays for the services, provided the plan will not pay for the services for legitimate reasons. In general, it is assumed that written notification has not been given to the beneficiary in the absence of evidence to the contrary, e.g., where the intermediary's records indicate that the beneficiary has been notified. Where payment is made for services from a source outside the prepaid health plan, the Medicare Benefits Notice (HCFA-1533), or the EOMB, where applicable, states the following:

"Our records show that you are a member of an employer sponsored prepaid health plan. Since Medicare is secondary payer for you, services from sources outside your health plan are not paid for by Medicare. However, since you were not previously notified of this, we will pay this time. In the future, payment will not be made for nonplan services which could have been obtained from or through the employer sponsored prepaid health plan."

C. Notice to Beneficiary.—Any bills received for Medicare payment from, or on behalf of, a beneficiary enrolled in an employer sponsored prepaid health plan who has been notified previously in writing that Medicare will not pay, are denied and the Medicare Benefits Notice or the EOMB includes the following:

"Our records show that you are a member of an employer-sponsored prepaid health plan. Since Medicare is secondary payer for you, services from sources outside your health plan that could have been obtained from or through the prepaid health plan are not paid for by Medicare. Our records show that you were previously informed of this rule. Therefore, payment cannot be made for the nonplan services you received."

D. Provider's Right to Bill Beneficiary.—If a bill is denied due to the reasons given in subsection C, you can bill the beneficiary your usual charges since the bill has been denied by Medicare.

CHAPTER III
ADMISSION PROCEDURES

300. GENERAL ADMISSION PROCEDURES

Upon admission of a Medicare beneficiary, or soon thereafter as practical, you must verify a patient's eligibility in order to process the bill. You may obtain this eligibility information directly from the patient or through your intermediary's limited Medicare eligibility data. Contact your intermediary to obtain technical instructions regarding how this access may be implemented along with hardware/ software compatibility details.

Disclosure of HCFA eligibility data is restricted under the provisions of the Privacy Act of 1974. This information is confidential, and it may be used only for verifying a patient's eligibility to benefits under the Medicare program. Penalties for misuse may result in being found guilty of a misdemeanor and paying a fine not more than $5,000.

This information does not represent a definitive eligibility status. If the individual is not on file, use the usual admission and billing procedure in effect independent of this data access.

Give Medicare beneficiaries the required Medicare information upon admission. PPS hospitals and acute care hospitals in areas with waivers from PPS (i.e., Maryland, New Jersey, Rochester, and the Finger Lakes area of New York) and those in transition to PPS are required to give Exhibit 3, "An Important Message from Medicare," to beneficiaries. Insert your PRO's name, address, and phone number. Give this handout to each Medicare patient or the patient's representative at the time of admission. (See §312.)

HCFA will not supply copies of the handout.

Ascertain that the patient is a member of an HMO and has a membership card. If he/she is a member of a HMO, contact the HMO specified by the patient or identified on the card. The HMO advises you whether to submit the bill to it or to the intermediary for payment.

If the patient indicates he/she is not a member of an HMO, ask him/her if he/she has other coverage which may be primary to Medicare to determine whom to bill. Follow the admission development chart in 301. If you identify another insurer primary to Medicare, follow §§ 262, 263, 264, or 289 as appropriate.

If you have determined that Medicare is the primary payer, ask the patient if he/she was an inpatient in any hospital or SNF during the prior 60 days. If so, ascertain the number of days of hospitalization he/ she has used in the current benefit period. Enter on the bill the prior stay data obtained from the patient or from your internal records. Presume that prior stays are covered unless you have evidence to the contrary. Maintain the name and address of the prior stay provider until payment is received. Your intermediary may need to ask for this information if a bill has not been received from a prior provider or if additional development is needed. Calculate the applicable deductible, coinsurance, and eligibility where possible based upon your internal records and information obtained from the beneficiary. If the patient indicates he/she was not an inpatient within the last 60 days, apply the inpatient deductible to the current stay if it is covered. Your intermediary determines the accuracy of the bill data after receipt of the claim. The remittance advice you receive from your intermediary reflects the amount of deductible and coinsurance applied. If this amount is different from what you billed, adjust your records accordingly.

If you experience significant problems obtaining information regarding Medicare entitlement or benefits in order to accurately prepare bills, you may contact your intermediary for assistance. However, these requests should be on a nonroutine basis. Your intermediary may temporarily refuse assistance if a pattern of abuse is discovered. Situations which may require intermediary assistance follow:

- When the patient dies following admission. It may be necessary to file timely with an estate;
- When the patient is not in a physical or mental condition to discuss his/her entitlement, and no other person with knowledge of his/her affairs is available;
- When you have reason to believe the beneficiary may need his lifetime reserve days, and his/her signature must be obtained if the available lifetime reserve days are not to be used for this admission and other financial arrangements must be made;
- When you suspect that the beneficiary may have exhausted his/her Medicare benefits, and timely confirmation is needed in order to file for possible supplemental benefits; and
- When the patient has experienced repeated admissions during the same spell of illness, and you are at a loss in explaining available benefits to the beneficiary.

301. IDENTIFYING OTHER PRIMARY PAYERS DURING THE ADMISSION PROCESS

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:

- 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 tobe 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.

You 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. You must accomplish this by asking the beneficiary about other insurance coverage. Section 301.2 lists specific questions which you must ask of Medicare beneficiaries for every admission, outpatient encounter, or start of care.

These questions may be asked in connection with on-line access to CWF. (See §301.1.) If you lack access to CWF, follow the procedures found in §301.2.

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.

301.1 Verification of MSP On-Line Data and Use of Admission Questions.—

A. MSP On-Line Data Elements.—Providers with on-line capability may now access the following MSP information via CWF:

- o MSP effective date;

- o MSP termination date;

- o Patient relationship;

- o Subscriber name;

o Subscriber policy number;

o Insurer type;

o Insurer information: name, group number, address, city, State, and zip code;

o MSP type;

o Remarks code;

o Employer information: name, address, city, State, and zip code (for all contractors, with the exception of 77777); and

o Employee data: ID number, and information.

At your discretion, these data may be viewed either during the admission or 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 used during admission, verify each data element by using the questions found in §301.2 to help identify other payers which may be primary to Medicare. Comply with any instructions which follow a particular question.

301.2 Admission Questions to Ask Medicare Beneficiaries.—The following questions must be asked upon each inpatient and outpatient admission.

A. Questions to Ask Medicare Beneficiaries.—

Part I

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

__yes; Date benefits began: MM/DD/YY

BL IS PRIMARY ONLY FOR CLAIMS RELATED TO BL.

__no.

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

__yes; DVA IS PRIMARY FOR THESE SERVICES.

__no.

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

__yes; Date of injury/illness: MM/DD/YY

Name and address of WC plan:

_____

_____

_____

Policy or identification number _____

Name and address of your employer: _____

_____

_____

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

__no. **GO TO PART II**.

Part II

1. Was illness/injury due to a nonwork related accident?

__yes. Date of accident: MM/DD/YY

__no. GO TO PART III.

2. What type of accident caused the illness/injury?

__automobile

__non-automobile

Name and address of no-fault or liability insurer: _____

_____

_____

Insurance claim number _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

__other.

3. Was another party responsible for this accident?

__yes;

Name and address of any liability insurer _____

_____

_____

Insurance claim number _____

LIABILITY INSURER IS PRIMARY ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

__no. GO TO PART III.

Part III

1. Are you entitled to Medicare based on:

__Age. Go to Part IV.

__Disability. Go to Part V.

__ESRD. Go to Part VI.

Part IV - Age

1. Are you currently employed?

__yes;

Name and address of your employer: _____

_____

__no. Date of retirement: MM/DD/YY

2. Is your spouse currently employed?

__yes;

Name and address of spouse's employer: _____

_____

_____

__no. Date of retirement: MM/DD/YY

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 ANY FURTHER.

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

__yes; __no. **STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR II.**

4. Does the employer that sponsors your GHP employ 20 or more employees?

__yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP: _____

_____

_____

Policy identification number _____

Group identification number _____

Name of policy holder _____

Relationship to patient _____

__no. **STOP. MEDICARE IS PRIMARY PAYER 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. Date of retirement: MM/DD/YY

2. Is a family member currently employed?

__yes;

Name and address of employer: _____

_____

_____

__no.

IF THE PATIENT ANSWERS 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 ANY FURTHER.

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

__yes; __no. **STOP. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED YES TO QUESTIONS IN PART I OR II**.

4. Does the employer that sponsors your GHP, employ 100 or more employees?

__yes. **STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION.**

Name and address of GHP: _____

_____

_____

Policy identification number _____

Group identification number _____

Name of policy holder _____

Relationship to the patient _____

__no. **STOP. 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;

Name and address of GHP: _____

_____

_____

Policy identification number _____

Group identification number _____

Name of policy holder _____

Relationship to the patient _____

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

_____

__no. **STOP. MEDICARE IS PRIMARY.**

2. Are you within the 30 month coordination period?

__yes.

__no. **STOP: MEDICARE IS PRIMARY.**

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

__yes;

__no. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

4. Was your initial entitlement to Medicare (including simultaneous 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.**

5. Does the working aged or disability MSP provision apply (i.e., is the GHP 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.**

B. <u>If Beneficiary Provides Information Which Is Different From That Found on CWF</u>.—If, as a result of asking the preceding questions, the beneficiary provides information to you which is different from that found in CWF, it is important to provide that information on the bill with the proper uniform

billing codes. This information will then be used to update CWF through the billing process.

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE. (SEE §142.3F.) THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

C. If There Are No MSP Data Available On CWF For Beneficiary.—If no MSP data are found in CWFfor the beneficiary, you must still ask the questions found in 301.2A and provide 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.

301.3 Documentation to Support Admission Process.—Retain a copy of completed admission questionnaires in your files (or on-line) 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.

Hard copy questions and responses may be retained on paper, optical image, microfilm, or on microfiche. Hard copy and data must be kept for at least 10 years, in accordance with the Department of Justice's (DOJ's) record retention requirements, after the date of service which appears on the claim. (See §480 for information about the documentation to be used in a hospital review.) If your admissions questions are retained on-line, you are required to retain negative and positive responses to admission questions for 10 years, in accordance with DOJ's record retention requirements, after the date of service. On-line data may not be purged before then.

302. WAIVER OF HEALTH INSURANCE BENEFITS AS A CONDITION OF ADMISSION

You may not require, as a condition of admission or treatment, that a patient agree to waive his/her right to have your services paid for under Medicare. Requiring such a "waiver" is inconsistent with the contract with HCFA and the waiver is not binding upon the patient. You have agreed not to charge an individual (except for specified deductible and coinsurance amounts) for services for which such individual is entitled to have payment made or for which he/she would be entitled if you complied with the procedural and other requirements of the program. Further, under this provision, you must refund any amounts incorrectly collected.

Where a patient who has signed such a waiver nevertheless requests payment under the program, you must bill the intermediary and refund any payments made by the patient, or on his/her behalf, in excess of permissible charges.

303. HOSPITAL PREPAYMENT REQUESTS AND REQUIREMENTS

303.1 Requiring Prepayment as a Condition of Admission Is Prohibited.—You may not require advance payment of the inpatient deductible or coinsurance as a condition of admission for inpatient services. In addition, you may not require that the beneficiary prepay any Part B charges as a condition

of admission, except where you regularly require prepayment from all patients. In such cases, you may collect only the deductible and coinsurance. Where the patient does not have Part B entitlement see §303.3.

303.2 When Prepayment May Be Requested.—In admitting a beneficiary, you may request the deductible or coinsurance amounts only where it appears that the patient will owe them and it is your routine and customary policy to request similar prepayment from nonbeneficiary patients with similar benefits which leaves them responsible for a part of the cost of their hospital services. In admitting the patient, ascertain whether he/she has medical insurance coverage. Where he/she does, ask if he has an Explanation of Benefits (EOB) showing his/her deductible status. If a beneficiary shows he/she met the Part B deductible, do not request or require prepayment of the deductible.

Except in the rare cases where prepayment may be required, any request for payment must be made as a request and without undue pressure. The beneficiary (and his/her family) must not be given cause to fear that admission will be denied for failure to make the advance payment.

Insure that your admitting office personnel are informed and kept fully aware of your policy on prepayment. For this purpose, and for your benefit and that of the public, it is desirable that a notice be posted prominently in the admitting office or lobby to the effect that no patient will be refused admission for inability to make an advance payment or deposit if Medicare is expected to pay the hospital costs.

o Review of the Message is intensified when 5 percent, or 6 inappropriate cases (whichever is greater), are found. Errors are computed on a quarterly basis. If error rate reaches or exceeds the threshold for a quarter, review will be intensified the next quarter. (Review may return to the nonintensified review level when the error rate falls below the threshold after a quarter's review); and

o If the problem continues, i.e., three consecutive quarters, or a pattern of noncompliance is established, the PRO will refer the case to HCFA's Associate Regional Administrator, to consider termination of the provider agreement under §1866(b) of the Act.

315. MEDICARE PARTICIPATING PHYSICIANS/SUPPLIERS DIRECTORY (MEDPARD)

Section 9332(e) of OBRA 1986 requires you to make available to your patients the Participating Physician Directory that carriers publish for the area you service. Also, if your personnel, in the inpatient, outpatient, or emergency areas, refer a patient to a nonparticipating physician for further medical care on an outpatient basis, they must inform the patient that the physician is a nonparticipating physician who may, or may not, accept assignment. They must identify at least one qualified participating physician listed in the Directory who provides the type of service needed.

Carriers will furnish you copies of the Directory and updated copies each year.

350. OUTPATIENT REGISTRATION PROCEDURES

A. Patient Identification.—Upon registration of a Medicare beneficiary, or as soon thereafter as

practical, ask the patient for his/her health insurance card to obtain the HICN. (See 304.) If the patient is unable to provide it, contact the SSO for assistance.

B. Determining Who To Bill.—The procedures for determining whether another payer exists are the same for outpatient situations as for inpatient. Therefore, follow the admission questionnaire procedures found in §301.2 for developing other coverage. If you identify another insurer primary to Medicare, follow §§259, 262, 263, 264, or 289, as appropriate.

C. Source of Admission.—Your registration process must distinguish whether the referral source for this registration/admission is from:

- Your hospital;
- An encounter in another hospital (see subsection F for definition of encounter); or
- Any other source.

Determine the appropriate source of admission by asking the patient who referred him/her to your hospital and whether the referral took place as a result of an encounter in your hospital, another hospital, or elsewhere.

The NUBC decided to use the inpatient coding structure for outpatient source of admission coding on the bill. This requires you to make further distinction as provided by the following coding structure.

1. Physician Referral.—The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).

2. Clinic Referral.—The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

3. HMO Referral.—The patient was referred to this facility for outpatient or referenced diagnostic services by an HMO physician.

4. Transfer From a Hospital.—The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another acute care facility.

5. Transfer From a SNF.—The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of the SNF where he or she is an inpatient.

6. Transfer From Another Health Care Facility.—The patient was referred to this facility for outpatient or referenced diagnostic services by a physician of another health care facility where he or she is an inpatient.

7. Emergency Room.—The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's emergency room physician.

8. Court/Law Enforcement.—The patient was referred to this facility for outpatient or referenced diagnostic services upon the direction of a court of law, or upon the request of a law enforcement agency representative.

Determine the proper source of admission code based on the patient's response and/or any other information you may have available from your pre-registration records or scheduling data. Enter the proper source of admission code in item 18 of Form HCFA-1450, also know as the UB-92.

If the patient was referred for services by a physician at:

- Your hospital, enter codes 2 or 7;
- Another hospital, enter code 4; or
- Some other source, enter codes 1, 3, 5, 6, or 8, as appropriate.

BILLING PROCEDURES

DME

Uniform Billing

Electronic Media Claims Data

HCFA-1450

Billing in Situations Where Medicare Is Secondary Payer

Billing in Medicare Secondary Payer Situations

Review Protocol for Medicare Secondary Payer Hospital Review

Overpayments

Emergency and Foreign Hospital Services

Inpatient Part A.—Enter the UPIN and name of the attending/referring physician. For hospital services, use the Uniform Hospital Discharge Data Set definition for attending physician. This is the clinician primarily responsible for the care of the patient from the beginning of the hospital episode. For SNF services, the attending physician is the practitioner who certifies the SNF plan of care. Enter the UPIN in the first six positions, followed by two spaces, the physician's last name, one space, first name, one space, and middle initial.

Outpatient and Other Part B.—Enter the UPIN of the physician that requested the surgery, therapy, diagnostic tests, or other services in the first six positions followed by two spaces, the physician's last name, one space, first name, one space, and middle initial. If the patient is self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and show no name.

Claims Where Physician Not Assigned a UPIN.—Not all physicians are assigned UPINs. Where the physician is an intern or resident, the number assignment may not be complete. Also, numbers are not assigned to physicians who limit their practice to the Public Health Service, Department of Veterans Affairs, or Indian Health Services. Use the following UPINs to report these physicians:

- INT000 for each intern
- RES000 for each resident
- PHS000 for Public Health Service physicians, including Indian Health Services
- VAD000 for Department of Veterans Affairs physicians
- RET000 for retired physicians
- SLF000 for providers to report that the patient is self-referred
- OTH000 for all other unspecified entities not included above

If more than one referring physician is involved, enter the UPIN of the physician requesting the service with the highest charge.

If referrals originate from physician-directed facilities (e.g., rural health clinics), enter the UPIN of the physician responsible for supervising the practitioner that provided the medical care to the patient.

FL 83. Other Physician ID.

Inpatient Part A Hospital and RPCH.—Required if a procedure is performed. Enter the UPIN and name of the physician or practitioner who performed the principal procedure. If there is no principal procedure, enter the UPIN and name of the physician or practitioner who performed the surgical procedure most closely related to the principal diagnosis. If no procedure is performed, leave this item blank. See FL 82 (inpatient) for specifications.

Outpatient Hospital and RPCH.—Required where the HCPCS code reported is subject to the ambulatory surgical center (ASC) payment limitation, or a reported HCPCS code is on the list of codes the PRO furnishes that requires approval. Enter the UPIN and name of the operating physician.

FL 84. Remarks
Not Required.

FL 85. Provider Representative Signature.
Not Required.

FL 86. Date.
Not Required.

468. CONSISTENCY IN ENTERING OTHER INSURER NAME ON BILL

In order to identify and bill other insurers properly, it is essential that FL 50 of the HCFA-1450, also known as the UB-92, contain the payer's name and be accurately completed to reflect the full name of the responsible party. Vague references to insurers are unacceptable. The Common Working File will no longer recognize the following entries under payer name:

- HCFA;
- Medicare (when entered with nothing following);
- None;
- No (followed by a space or low values);
- N/A;
- N/A (followed by a space or low values);
- Unknown;
- UNK;
- Attorney;
- Insurer;
- Supplement, Supplemental;
- BC, BX, BCBX, BS, Blue Cross, or Blue Shield with no other characters following;
- Any entry containing less than two characters;
- Commercial (when entered with nothing following); and
- Miscellaneous (or Misc).

FL 50 must contain the entire name of the other insurer. Without this information, a bill cannot be properly filed. For example, do not enter "Blue Cross" if the insurer's name is "Blue Cross and Blue Shield of Texas." If your computer system's record length for this field does not accommodate the entire insurer name, use an appropriate abbreviation, e.g., BCBSTX, which will allow proper identification of the payer's name.

If the beneficiary supplies this information during the admission process, be sure to make an accurate notation of the other payer's identification at that time, and check the insurer's identification against the insurance card when it is presented. All aspects of claim development, including providing accurate insurer or other payer identification, are important and are required by your provider agreement.

Review Protocol for Medicare Secondary Payer Hospital Review

480. REVIEW PROTOCOL

Medicare is secondary payer for hospital and medical services for:

o Claims involving Medicare beneficiaries age 65 or older who are insured by GHP coverage based upon their own current employment with an employer that has 20 or more employees, or that of their spouse's of any age, or the beneficiary is covered by a multiple employer, or multi-employer, group health plan by virtue of his or her, or a spouses, current employment status and the GHP covers at least one employer with 20 or more employees (see §263);

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 already secondary to Medicare at the time ESRD occurred;

o Claims involving automobile or non-automobile liability or no-fault insurance (see §262);

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 a large group health plan (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.

The following sections provide a methodology for your intermediary's review of your MSP policies and practices to ensure that hospital procedures comply with the law. Specifically, your intermediary will review your admission and bill processing procedures.

480.1 Reviewing Hospital Files.—Provide your intermediary with complete files on all beneficiaries represented in the bills selected for review. (See §480.4 concerning sample selection.) For purposes of this review, a complete file should contain:

o A copy of the completed UB-92, also known as the HCFA-1450, or its facsimile;

o A copy of the admission questionnaire (the beneficiary's signature on the questionnaire is not required). If you use an on-line query process, screen prints reflecting responses to admission questions should be retained in the file (see §480.3B); and,

o Beneficiary's Explanation of Benefits (EOB) form for all secondary claims.

480.2 Frequency of Reviews and Hospital Selection.—The intermediary will conduct a review of 10 percent of the hospitals for which it has Medicare claims processing responsibility. Special attention may be given to hospitals which:

o Fail to develop MSP claims properly;

o Fail to submit "no payment" bills; and

o Do not submit automobile accident cases - even if they have shock trauma units specializing in emergency admissions.

480.3 Methodology For Review of Admission Procedures.—

A. Entrance Interview.—Your intermediary will conduct an entrance interview with your admissions staff (including inpatient, outpatient, and emergency) to determine whether the hospital has established (1) policies concerning identifying other payers, and (2) a system in which such policies are carried out in practice. During the interview, the reviewer will request a descriptive walk-through of your admissions process and/or may elect to observe an admission in progress.

B. Review of Hospital Admission Questionnaire.—The reviewer may exercise discretion in deciding whether to review hard copy questionnaires or on-line responses, or both. Screen prints are required for the billing procedures component of the review. (See §480.5.) The reviewer will determine whether your admissions questionnaire complies with the mandatory questions found at 301.

480.4 Selection of Bill Sample.—The sample period shall be determined by selecting the sample from one month of your bill submissions. Your intermediary will notify you in advance of the month's claims to be reviewed. For example, if the review will examine December bills, the intermediary will notify you not later than November 30 to permit you to segregate Medicare patient bills in advance. Therefore, your intermediary is not required to perform the review during the same month as the month of bills selected. Provide one month's bills to your intermediary, which selects 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 Intermediary will select the bill sample using the following criteria:

- At least 2/3 of the sample should consist of inpatient bills, the remaining 1/3 should consist of outpatient bills;
- The sample must contain a maximum of 60 bills and a minimum of 20 bills;
- Medicare no-pay bills are to be included in the sample in order to examine the ratio of no-pay bills submitted; and
- The sample is to include a mixture of bill types from your bill universe. Accordingly, if you do not submit ESRD bills, for example, then the reviewer is not required to review that particular bill type.

480.5 Methodology for Review of Hospital Billing Procedures.—

A. Entrance Interview.—The intermediary shall conduct an entrance interview with your billing staff todetermine whether you have established (1) policies concerning billing other payers; and (2) a system in which such policies are carried out in practice. Provide your reviewer with a descriptive

walk-through of the billing process.

B. Comparing Completed Admissions Questionnaire with Bills.—Provide the reviewer with completed inpatient and ER admission questionnaires (or screen prints for hospitals using on-line admission query systems) for each Medicare beneficiary included in the bill sample. (See §480.4 concerning selection of the sample.) You must retain the completed questionnaire on file for 10 years in accordance with DOJ's record retention requirements. It is not necessary that the completed questionnaire be signed by the beneficiary.

For review purposes, on-line users be prepared to produce, upon the reviewer's request, screen prints which reflect the responses that are obtained from the beneficiary. On-line users are required to retain positive and negative responses to the questionnaire for 10 years, in accordance with DOJ's record retention requirements, after the date of service. Therefore, do not purge on-line data before then.

Your intermediary determines whether the information solicited through the admission questionnaire, or on-line admission query procedures, matches the bill.

C. Review of the HCFA 1450 Form.—Provide the reviewer with the HCFA-1450 for each case involving other payers. The reviewer determines whether the amount billed to Medicare is accurate and records this data on Exhibit 2. Your intermediary reviews the HCFA-1450 to determine whether the proper MSP value, occurrence, and condition codes are reflected on the bill, given the information you solicited during the admission process. (See §460 for detailed definitions of these codes. MSPbilling procedures are found at §§472-477.)

480.6 Review of Hospitals With On-line Admissions.—Although hospitals that solicit admissions data through an on-line process are not required to retain hard copies of admissions questionnaires, you must utilize a specific set of admission questions which seek the appropriate MSP information. If you are an on-line hospital, you must demonstrate that responses to admission questions have been asked, are retained, and match the information shown on the bill. Your intermediary should notify you in advance of any screen prints that are needed for the review.

480.7 Intermediary Assessment of Hospital Review.— Your intermediary is to prepare an assessment form (Exhibit 1) for each hospital reviewed. The form should include records selection criteria, the intermediary's findings, and suggested recommendations, if appropriate, as well as a list of the bills reviewed (Appendix A-1). The assessment also includes any discrepancies between your MSP policies and practices, as well as any innovations that you have devised to determine third party payer resources. It is your intermediary's responsibility to send a copy of the assessment to the regional office.

You will be sent a copy of the assessment form, which will indicate whether any follow-up action is needed. If follow-up action is necessary, your intermediary will follow-up every 30 days until you have taken the appropriate corrective action and will report any continued problems after three months to the RO MSP Coordinator.

480.8 Exhibits.—

Exhibit 1 Assessment Form for MSP Hospital Review

Exhibit 2 Survey of Bills Reviewed

EXHIBIT 1

Contractor Name and No.: _____

ASSESSMENT OF MEDICARE SECONDARY PAYER HOSPITAL REVIEW

1. Name of hospital reviewed: _____

2. Number of cases reviewed: _____

3. Period of review (month/year): _____

4. Selection criteria used to determine why hospital was selected for review 480.2 Hospital Manual.

5. Describe findings in accordance with review protocol standards found at 480.

6. Recommendations

cc: HCFA Regional Office, MSP Coordinator
Hospital Reviewed

Attachment: Survey of bills reviewed

EXHIBIT 2

SURVEY OF BILLS REVIEWED