20.2.1 - Admission Questions to Ask Medicare Beneficiaries

(Rev.)

The following 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 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 ONLY FOR CLAIMS RELATED TO BL.
   ___ No.

2. Are the services to be paid by a government program such as a research grant?
   ___ Yes; Government Program will pay primary benefits for these services
   ___ No.

3. 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.

4. Was the illness/injury due to a work related accident/condition?
   ___ Yes; Date of injury/illness: MM/DD/CCYY
   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 non-work related accident?
   ___ Yes; Date of accident: MM/DD/CCYY
   ___ 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 PAYER 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/CCYY
   ___ No. Never Employed.

2. Is your spouse currently employed?
   ___ Yes.
   Name and address of spouse's employer:
   ___________________________________________________
   ___________________________________________________
   ___________________________________________________
   ___ No. 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.
   ___ 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. 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.  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/CCYY
   ___ No.  Never Employed.

2. If married, is your spouse currently employed?
   ___ Yes.

   Name and address of your spouse’s employer:
   ___________________________________
   ___________________________________
   ___________________________________

   ___ No.  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 family member’s current employment?
   ___ Yes.

   ___ No.  STOP.  MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED “YES” TO THE QUESTIONS IN PART I OR II.
4. Are you covered under the group health plan of a family member other than your spouse?

_____Yes.

Name and address of your family member’s employer:

_________________________________

_________________________________

_________________________________

_____No.

5. Does the employer that sponsors the 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 (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. STOP. MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED “YES” TO QUESTIONS IN PART I OR II.

Part VI - ESRD

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

If yes, 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:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

___ 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: CCYY/MM/DD
   ___ 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 primarily based on age or disability entitlement?

___ Yes. **STOP. 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.