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

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Related Change Request (CR) Number: CR 10863
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PROVIDER TYPE AFFECTED

This MLN Matters article is intended for provider and hospital-affiliated services billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

Change Request (CR) 10863 furnishes providers and hospitals with additional clarification regarding when and where to obtain information from Medicare beneficiaries, or authorized representatives, for inpatient admissions or outpatient encounters. Make your staff aware of this clarification.

BACKGROUND

Prior to submitting a bill to Medicare, you must determine whether Medicare is the primary or secondary payer for each beneficiary's inpatient admission or outpatient encounter by asking the beneficiary about any other insurance coverage that may be primary to Medicare.

Specifically, Section 1862(b)(6) of the Social Security Act (The Act), (https://www.ssa.gov/OP_Home/ssact/title18/1862.htm, (42 USC 1395y(b)(6)), https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partE-sec1395y.pdf) requires all entities seeking payment for any item or service furnished under Medicare Part B to complete (based on information obtained from the individual to whom the item or service is furnished) that portion of the claim form related to the availability of other health insurance.

Additionally, 42 CFR 489.20(g) (https://www.govregs.com/regulations/expand/title42_chapterIV_part489_subpartB_section489.

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20#title42_chapterIV_part489_subpartB_section489.20) requires all providers agree to bill other primary payers before billing Medicare.

CR10863 provides clarification to this process:

1. The Medicare Secondary Payer (MSP) Manual, Chapter 3 (MSP Provider, Physician, and Other Supplier Billing Requirements), Section 20.2.1(Model Admission Questions to Ask Medicare Beneficiaries) provides a model questionnaire listing the type of questions hospitals may use to determine the correct primary payers of claims for all beneficiary services that you furnish. This updated manual is an attachment to CR10863.
2. If you have access to the Common Working File (CWF), your admission staff may ask the beneficiary if any insurance information it contains has changed. If there are no changes to the beneficiary's insurance, then there is no need to ask the questions. However, if insurance information has changed, you must ask the MSP questions. Further, you need to notate (for auditing purposes) that all the questions were not asked upon admission based on the beneficiary's statement that their insurance information has not changed. Notations may be cited on the CWF screen print verifying the MSP information in the system is correct or the notations may be attached to the CWF print out. Your MAC may request this notation and confirmation during its hospital review.
3. The HIPAA Eligibility Transaction System (HETS) Health Care Eligibility Benefit Inquiry and Response (270/271) Transaction Set is used to transmit Health Care Eligibility Benefit Inquiries from health care providers, insurers, clearinghouses and other health care adjudication processors. You can use the HETS 270/271 transaction set to make an inquiry about the Medicare eligibility of an individual and to identify insurance that is primary or secondary to Medicare.

   Similar to the CWF process, if you have the ability to submit and receive a HETS 270/271 transaction set and, upon review, there are no changes to the beneficiary's insurance then there is no need to ask the questions. However, if there are changes, you must ask the MSP questions. Further, you need to notate (for auditing purposes) that all the questions were not asked upon admission based on the beneficiary's statement that their insurance information has not changed as your MAC may request this notation and confirmation during its hospital review. Notations may be cited on the 270/271 screen print verifying the MSP information in the system is correct or the notations may be attached to the HETS 270/271 print out.

4. Some hospitals offer provider-based services, such as a provider affiliated transfer ambulance service. The affiliated hospital-based service does not need to ask the MSP questions if the hospital admission staff has already asked the questions or verified the beneficiary's insurance information. The admissions staff would then bill the appropriate insurer for the ambulance service.

   However, if the ambulance service is not affiliated with the hospital, then the ambulance service is responsible for collecting and/or verifying the correct insurance information prior to billing for services.

ADDITIONAL INFORMATION

The official instruction, CR10863, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R123MSP.pdf. You will find the updated MSP Manual, Chapter 3, Sections 20 and Chapter 5, Section 70 as attachments to this CR.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
August 17, 2018	Initial article released.