

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10359	Date: September 15, 2020
	Change Request 11945

Transmittal 10342, dated September 4, 2020, is being rescinded and replaced by Transmittal 10359, dated, September 15, 2020 to include the full language in the last sentence in Section 20.2.2 of IOM Pub. 100-05, which is currently truncated. All other information remains the same.

SUBJECT: Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries

I. SUMMARY OF CHANGES: This change request modifies and streamlines the model admission questions for providers to ask Medicare beneficiaries or authorized representatives upon admission or start of care. No other updates have been made to the hospital admissions or billing process.

EFFECTIVE DATE: December 7, 2020

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

IMPLEMENTATION DATE: December 7, 2020

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	3/20/20.2/20.2.1-Model Admission Questions to Ask Medicare Beneficiaries
R	3/20/20.2/20.2.2 - Documentation to Support the Admission Process

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**

Number	Requirement	Responsibility								
		A/B MAC			D M E	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E	C E I
		A	B	H H H		
11945.3	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:

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

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

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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ATTACHMENTS: 1

20.2.1 - Model Admission Questions to Ask Medicare Beneficiaries

(Rev. 10359; Issued: 09-15-20 Effective: 12-07-20 Implementation: 12-07-20)

The following *outline of questions provides points of data to gather from Medicare beneficiaries that are helpful for providers to determine who has primary payment responsibility for a claim or set of claims by asking the questions upon each inpatient and outpatient admission. The information assists in the proper coordination of benefits to ensure adherence to Medicare Secondary Payer (MSP) provisions as outlined in section 1862(b) of the Social Security Act.*

Part I. INFORMATION ABOUT BLACK LUNG, WORKERS' COMPENSATION (WC), NO-FAULT AND LIABILITY

- 1. Are you receiving benefits under the Black Lung Benefits Act (BL)?*
- 2. If yes, the following BL information is required to submit claims appropriately:*
 - Date Black Lung Benefits began*

Note: BL is the primary payer for claims related to BL.
- 3. Was the illness/injury due to a work-related accident/condition?*
- 4. If yes, the following WC information is required to submit claims appropriately:*
 - Name and address of employer*
 - Name and address of insurance carrier*
 - Policy or claim number*
 - Date of the workplace illness or the injury*

Note: WC is the primary payer only for services related to work-related injuries or illness.
- 5. Are you receiving treatment for an injury or illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?*
- 6. If yes, the following no-fault/auto insurance information is required to submit claims appropriately:*
 - Name and address of insurance carrier*
 - Policy or claim number*
 - Date of illness or injury*

Note: No-fault insurance is the primary payer only for services related to the accident.
- 7. Are you receiving treatment for an injury, or illness, which another party may be liable?*
- 8. If yes, the following liability information is required to submit claims appropriately:*
 - Name and address of insurance carrier*
 - Policy or claim number*
 - Date of illness or injury*

Note: Liability insurance is the primary payer only for services related to the liability settlement, judgment, or award.

Part II. INFORMATION ABOUT MEDICARE ENTITLEMENT AND GROUP HEALTH PLANS

- 1. Are you entitled to Medicare based on Age, Disability or ESRD?*

Note: If entitlement is based solely on ESRD, skip Part II and complete Part III. Stop after completing Part II if you are entitled to Medicare based on Age or Disability.
- 2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member?*

If yes, the employer GHP may be primary to Medicare. Continue below. If no, stop here as Medicare is primary.

3. *How many employees, including yourself or spouse, work for the employer from whom you have GHP coverage? (1-19, 20 – 99 or 100 or more)*
Note: If you are aged and there are 20 or more employees, your GHP is primary. If you are disabled and your employer, spouse, or family member employer, has 100 or more employees, your GHP is primary.
4. *The following employer GHP information is required to submit claims appropriately:*
 - *Name and address of the employer (your own or your spouse's/family member's) through which you receive GHP coverage*
 - *Name and address of GHP*
 - *Policy number (sometimes referred to as the health insurance benefit package number)*
 - *Group number*
 - *Date the GHP coverage began*
 - *Name of policyholder (if coverage is through your spouse/other family member)*
 - *Relationship to patient (if other than self)*

Part III. INFORMATION ABOUT THE PATIENT IF ESRD MEDICARE ENTITLEMENT APPLIES (INCLUDING DUAL ENTITLEMENT: AGE AND ESRD OR DISABILITY AND ESRD)

1. *Do you have employer group health plan (GHP) coverage through yourself, a spouse, or family member if dually entitled based on Disability and ESRD?*
If yes, the employer GHP may be primary to Medicare. Continue below.
2. *Have you received a kidney transplant?*
 - *Date of transplant*
3. *Have you received maintenance dialysis treatments?*
 - *Date dialysis began*
4. *Are you within the 30-month coordination period?*
Note: 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) regardless of entitlement due to age or disability. 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.
5. *Were you receiving GHP coverage prior to and on the date of Medicare entitlement due to ESRD (or simultaneous entitlement due to ESRD and Age or ESRD and Disability)?*
Note: If yes, the GHP is primary during the 30-month coordination period.
6. *The following information is required to submit claims appropriately:*
 - *Name and address of the employer (your own or your spouse's/family member's) through which you receive GHP coverage*
 - *Name and address of GHP*
 - *Policy number (sometimes referred to as the health insurance benefit package number)*
 - *Group number*
 - *Name of policyholder (if coverage is through your spouse/other family member)*
 - *Relationship to patient (if other than self)*

20.2.2 - Documentation to Support the Admission Process

(Rev. 10359; Issued: 09-15-20 Effective: 12-07-20 Implementation: 12-07-20)

The provider retains a copy of completed admission *questions*, 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 primary payer coverage takes place. It is not necessary that the *beneficiary sign the completed questions*. *However, providers may identify the date when the questions are asked*. 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 review.) 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 cannot be purged before then.