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Medicare Secondary Payer Provisions

I. PURPOSE:

The purposes of this policy are to ensure, through the implementation of prudent and reasonable controls, that: (1) Tenet Healthcare Corporation (Tenet) facilities identify and submit claims to payers, plans, and/or programs in the correct order of financial liability; (2) Medicare is not billed as the primary payer when, by law and pursuant to Medicare Secondary Payer (MSP) provisions, it is the secondary payer; and (3) determinations relevant to payment priority are made in a manner that complies with applicable laws and regulations, including without limitation the MSP provisions.

II. SCOPE:

This policy applies to Tenet, its consolidated subsidiaries and all hospitals and other health care operations owned or operated by Tenet’s consolidated subsidiaries.

III. POLICY:


Tenet facilities shall use standardized procedures for gathering information about all possible payment sources available to a Medicare beneficiary and for determining the responsible primary payer, plan, or program before submitting a claim to Medicare.

IV. GENERAL REQUIREMENTS UNDER APPLICABLE LAW:

A. Medicare Secondary Payer. The Medicare statute (at 42 U.S.C. § 1395y(b)) establishes Medicare as a secondary payer under certain circumstances, including claims involving the following:

(1) certain government programs, including services authorized or covered under workers’ compensation plans, black lung benefits, or services where the Department of Veterans Affairs (VA) has authorized services to be furnished by a non-Federal provider and to be paid for by the VA, excluding CHAMPUS and CHAMPVA (i.e., Medicare is primary to CHAMPUS/CHAMPVA);

(2) automobile or non-automobile liability or no-fault insurance;

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(3) Medicare beneficiaries aged sixty-five (65) or older who are eligible for Medicare on the basis of age with “Employer Group Health Plan” coverage (with an employer that has 20 or more employees) based on his or her own current employment status or the current employment status of his or her spouse. Health insurance plans for retirees or the spouse of retirees do not meet this criteria and are not primary to Medicare;

(4) Medicare beneficiaries under age sixty-five (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) on the basis of his or her own current employment status or the current employment status of a family member;

(5) beneficiaries who are eligible for or entitled to Medicare on the basis of end stage renal disease and are covered by a Group Health Plan, during a limited coordination period of 30 months.

Detailed descriptions of the foregoing categories appear at Sections 260.3 and 301 of the CMS Medicare Hospital Manual.


- B. CMS Common Working File. CMS operates a database referred to as the Common Working File (CWF), which contains information on the MSP status of all Medicare beneficiaries. With the exception of patients enrolled in a Medicare Plus Choice plan, providers are required to collect and report their patients’ MSP information to CMS to ensure that the CWF is current. Providers that fail to comply with these requirements may be subject to adverse certification action, civil money penalties, overpayment recovery actions and/or other enforcement actions.

V. PROCEDURES:

Compliance with this Policy requires each Tenet facility to meet the following general requirements:


A. Hospital Implementation

1. As part of the patient registration process, each Tenet hospital shall complete the on-line MSP Questionnaire (see Attachment A) for each Medicare beneficiary or his/her representative. In all cases, the completion of the MSP Questionnaire and

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the information collected from the Medicare patient or representative shall be accurate, thorough, and current.

- a. Except as specified in subparagraph b below, such coverage and payment data shall be collected for every inpatient and outpatient admission, including recurring outpatient services. For purposes of this policy, a Medicare beneficiary is considered to be receiving recurring services if he or she receives identical services and treatments on an outpatient basis more than once within a billing cycle. For recurring outpatient services, following the initial collection, the MSP information shall be verified once every ninety (90) days.
 - b. Such coverage and payment data does not need to be obtained for hospital reference laboratory services if the hospital does not interface directly with the Medicare beneficiary. For purposes of this policy, reference laboratory services are clinical laboratory diagnostic test (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the Medicare beneficiary and the hospital involved and in which the hospital submits a claim only for such test or interpretation.
2. Each Tenet hospital shall collect from each Medicare beneficiary who receives health care at the Tenet hospital all relevant information about potential sources of payment in sufficient detail to ensure that payers may be billed in the correct order of responsibility and specifically to ensure that Medicare is not improperly billed as a primary payer.
 4. Prior to the submission of a claim to Medicare, each Tenet hospital shall view the data contained in the CWF, which review may occur during the admission or billing process. (See Medicare Hospital Manual §301.1.) If the information obtained from the beneficiary or his or her representative in the course of completing the MSP Questionnaire differs from the information appearing in the CWF, then the information received from the beneficiary, together with the proper uniform billing codes, shall be included in the claim submitted to Medicare through the Part B Carrier or through Tenet's fiscal intermediary, Mutual of Omaha. (See Medicare Hospital Manual §301.2B.)

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5. Any Tenet hospital that submits bills to Medicare Part B physicians or suppliers for services furnished on a contractual basis shall complete those portions of CMS Form 1500 relating to the availability of other health insurance including, without limitation, Sections 9-11 thereof.
6. When a Tenet hospital determines there are multiple primary payers on a Medicare Part A electronic claim, follow the instructions to providers in CMS Transmittal AB-03-011 (February 3, 2003).
7. Each Tenet hospital shall document and maintain in its hospital information system all payment and coverage information collected from Medicare beneficiaries relevant to a determination under the MSP provisions. Such information may be maintained on paper, optical image, microfilm or microfiche, and shall be retained for a period of ten (10) years from collection and documentation.

VI. REFERENCES:

1. Medicare as Secondary Payer, 42 U.S.C. § 1395y(b).
2. Medicare Conditions of Participation, 42 C.F.R. § 489.20(f) – (h).
3. Medicare Hospital Manual (CMS-Pub. 10), §§ 260.3 and 301 *et seq.*
4. [Medicare Secondary Payer Manual \(CMS-Pub. 100-05\)](#).
5. CMS Transmittal A-03-031, Program Memorandum to Intermediaries (April 18, 2003)
6. CMS Transmittal AB-03-011, Program Memorandum to Intermediaries/Carriers (February 3, 2003)
7. OIG Report - Review of Hospital Medicare Secondary Payer Issues (A-04-01-07002) (September 2002).

[Note: Most Tenet hospital's have access to this form online.]

MSP Questionnaire (Dated as of 12/03)

ADMISSION PROCEDURES

The following chart lists the types of questions to ask Medicare beneficiaries upon every inpatient and outpatient admission. The only exceptions are the policies described in §301. Use this chart as a guide to help identify other payers that may be primary to Medicare. Beginning with Part 1, ask the patient each question in sequence. Comply with any instructions that follow an answer. If the instructions direct you to go to another part, have the patient answer, in sequence, each question under the new part.

NOTE: There may be situations where more than one insurer is primary to Medicare (e.g., Black Lung and GHP). **Be sure to identify all possible insurers.**

A. Types of Questions to Ask Medicare Beneficiaries.

Part I

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

_____ yes; Date benefits began: _____ (CCYY/MM/DD)

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: _____ (CCYY/MM/DD)

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: _____ (CCYY/MM/DD)

_____ 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: _____ (CCYY/MM/DD)

2. Is your spouse currently employed?

_____ yes;
Name and address of spouse's employer:
_____ no. Date of retirement: _____ (CCYY/MM/DD)

**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: _____ (CCYY/MM/DD)

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. Have you received a kidney transplant?
_____ yes; Date of transplant: _____ (CCYY/MM/DD)
_____ no.

3. Have you received maintenance dialysis treatments?
_____ yes; Date dialysis began: _____ (CCYY/MM/DD)
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?
_____ 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. **STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.**

6. 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.**

7. 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.**