20.2.1 - Model Admission Questions to Ask Medicare Beneficiaries

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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), NOFAULT 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

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

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

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?

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)

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 (INLUDING 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?

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)?

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

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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.

References: CMS IOM Publication 100-05, 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

Change Request 11945, Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries