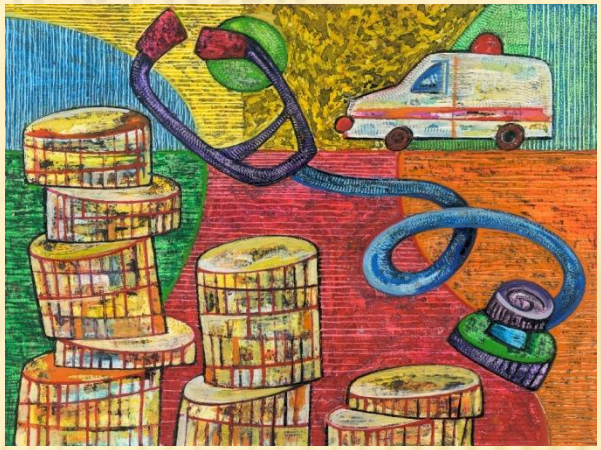
EFFECTIVE COMPLIANCE WITH ABN AND MSPQ REGULATIONS



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An informed individual is a vital link to accomplishing our goals and serving the needs of the patient. Through education and compliance we help make a difference.

COMPLIANCE WITH CONDITIONS OF PARTICIPATION

- Today's program is a workshop where we will share ideas and benchmark on our shared challenges with Medicare Regulatory requirements.
- The Medicare Conditions of Participation Agreement (COP) becomes the document we live by and it covers an umbrella of regulations for the provider to adhere to.
- Under this COP there are administrative, clinical, and revenue cycle management regulations. Where Medicare started in 1968 looks nothing like it does today.
- Revenue Cycle activity affecting the COP are obtaining required signatures, informing the patient of rights, delivering special notices, ensuring the services are covered by Medicare, and obtaining accurate billing information. Then follows billing and collecting from the correct primary payer and handling any overpayments in accordance with federal program regulations.

COMPLETION OF THE ADVANCE BENEFICIARY NOTICE FOR MEDICARE PATIENTS

Medicare requires use of Advance Beneficiary Notices to inform patients of non covered items ordered by physicians and the expected cost.

Financial Liability Protections
Applicable laws related to financial liability protections can be found in Title 18 (XVIII) of the Social Security Act:

- Limitation On Liability - §1879 (a) through(g)
- Refund Requirements - §§ 1834(a)(18); 1834(j)(4); 1842(l); & 1879(h)
- Statutory exclusions from Medicare benefits - §1862(a).

Expedited Determination Process by the QIO
These apply to Non-hospital processes, and hospitals

The Financial Liability Protection provisions (FLP) of the Social Security Act (the Act) protect beneficiaries, health care providers and suppliers under certain circumstances from unexpected liability for charges associated with claims that Medicare does not pay. The provisions include:

- The provider believes that a Medicare covered item or service may be denied because it is not reasonable and necessary
- The Act requires the provider notify a beneficiary in advance when s/he believes that items or services will likely be denied either as not reasonable and necessary or as constituting custodial care.
- If such notice (in the form of an ABN or as otherwise noted in §40.2) is not given, providers may not shift financial liability to beneficiaries for these items or services if Medicare denies the claim.

Compliance with Limitation On Liability Provisions:

A healthcare provider/supplier (herein also referred to as a "notifier") who fails to comply with the ABN instructions risks financial liability and/or sanctions. LOL provisions shall apply as required by law, regulations, rulings and program instructions. Additionally, when authorized by law and regulations, sanctions under the **Conditions of Participation (COPs)** may be imposed.
The Medicare contractor will hold any provider who either failed to give notice when required or gave defective notice financially liable.

- How do you identify ABN situations in your hospital or provider setting?
- Do you have a written policy on dealing with ABN issuance?
- Do you use software that checks the physician order against ordered services? Does a clinical team member assist with the decision process on issuing an ABN?
- Does your Admitting/Collections policy listing contain guidance on ABN's?
- Common areas where ABN's are issued: Imaging and Labs
- Upcoming Local Coverage Determinations on Pacemakers

DETERMINE WHERE YOUR ERRORS START

- What are your common staff errors? Know them and take action to correct them. What each of us do everyday is very important.
- Sign up for government and professional associations list serves. You are expected to know governmental changes that affect your role in healthcare.

USES OF THE ABN-REFERENCE MATERIAL

- **Fee For Service Advance Beneficiary Notice of Non-coverage**
  The Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare (fee for service) beneficiaries in situations where Medicare payment is expected to be denied. Guidelines for mandatory and voluntary use of the ABN are published in the Medicare Claims Processing Manual, Chapter 30, Section 50.
- Home Health Agencies (HHAs) now use the ABN in place of the Home Health Advance Beneficiary Notice (HHABN), Option Box 1, Form CMS-R-296. Please check the HHCCN web page for more information on the discontinuation of the HHABN and notice requirements for HHAs.
- Note: Skilled nursing facilities (SNFs) must use the ABN for items/services expected to be denied under Medicare Part B only.
- MLN Training Material on CMS- Nice Booklet for Training
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf

MEDICARE SECONDARY PAYER REGULATIONS

- In 1980, Congress enacted provisions that made Medicare the secondary payer to certain additional primary plans (group health plans, workers' compensation plans, liability insurance, or no-fault insurance). To help you identify such Medicare Secondary Payer (MSP) situations, CMS has developed a model Medicare Secondary Payer Questionnaire (found in IOM 100.05 (Medicare Secondary Payer Manual) Chapter 3, Section 20.2.1). You can use this model questionnaire as a guide, at each inpatient and outpatient admission, to help identify other payers that may be primary to Medicare.

- MLN material Brochure- http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/Downloads/Medicare-Secondary-Payer-MSP-Fact-Sheet-CMS102.pdf
- Medicare Secondary Payer Questionnaire by viewing CR5087 at ***http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R53MSP.pdf***.

TODAY'S SITUATION

- Hospitals are audited regularly by CMS MAC units. FCSO has audited Bay Area Hospitals regularly since 2009
- The audits are conducted in accordance with federal audit guidelines and a standard series of questions
- Audit samples are usually thirty claims with 2/3 being inpatient and the rest outpatients…
- But they slice and dice the mix…
- A certain number of each type of Medicare patient is selected:
  - Working Elderly
  - Medicare HMO Encounter Data
  - Disability
  - Working Spouse with GHP Primary
  - Zero Pay Outpatient Claims

MEDICARE MSP REGULATIONS- YOUR GROUNDWORK

- **Adopt a strong policy and train extensively.** Falls at home the most missed accident.
- MSPQ quality checks and follow-up on missed questionnaires
- Internal Auditing and observation of registrars when asking the MSPQ.
- Prepare your team for the review there will be a desk review of claims and interviews of billers and registrars.

TIMELINE FOR MSPQ REVIEW
45-60 DAYS FROM 1ST NOTICE TO OUTCOME LETTER

- Your facility is notified in writing of your selection for Audit
- A claim sample request is sent within days
- You have thirty days to submit requested claim documents, training materials on Medicare, and compliance policies related to Medicare, Admissions and collections.
- Review the claims they select very carefully plan your “action plan” if you think one maybe needed or expected. Execute it before the onsite review.

THE END
QUESTIONS–DISCUSSION

HELPFUL WEB SITES AND CONTACTS

http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Statutory-Guidance.html

- *ABN Manual Instructions: http://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-CMS-Manual-Instructions.pdf*