FIRST COAST
SERVICE OPTIONS, INC.

MSP Presentation

Background & Basics

Presented by: Keith Ewing 2013

My Background

- Keith Ewing, CPA
- Lead Senior Auditor, First Coast Service Options
- Accounting & Finance
- 4 years at FCSO - PARD
- 2 years doing MSP Reviews
- Keith.Ewing@FCSO.com

Objectives

- Review the back ground of the Medicare Secondary Payer Questionnaire.
- Understand CMS Requirements for completion of the MSPQ.
- Discuss an overview of the MSP Hospital Review Process.
- Discuss common provider problems.
- Discuss suggestions for process improvement and future prevention of findings.

MSP - Background

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"In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment. The MSP provisions have protected Medicare Trust Funds by ensuring that Medicare does not pay for items and services that certain health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage. Medicare statute and regulations require that all entities that bill Medicare for items or services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those items or services."

- http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

What Is Medicare Secondary Payer (MSP)?

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- "The MSP provisions protect the Medicare Trust Fund by ensuring that Medicare does not pay for services and items that certain other health insurance or coverage is primarily responsible for paying. The MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage. The MSP requirement provides the following benefits for both the Medicare Program and providers, physicians, and other suppliers:"
- http://www.cms.gov/Medicare/Coordination-of-Benefits/MedicareSecondPayerandYou

What Is Medicare Secondary Payer (MSP)? Cont.

- "**National program savings** – Medicare saves more than $8 billion annually on claims processed by insurances that are primary to Medicare.
- • **Increased provider, physician, and other supplier revenue** – Providers, physicians, and other suppliers that bill a primary plan before billing Medicare may get more favorable reimbursement rates. Providers, physicians, and other suppliers can also reduce administrative costs when health insurance or coverage is properly coordinated.
- • **Avoidance of Medicare recovery efforts** – Providers, physicians, and other suppliers that file claims correctly the first time may prevent future Medicare recovery efforts on that claim."
- http://www.cms.gov/Medicare/Coordination-of-Benefits/MedicareSecondPayerandYou

What Is Medicare Secondary Payer (MSP)? Cont.

- "To realize these benefits, you must have access to accurate, up-to-date information about all health insurance or coverage that Medicare beneficiaries may have. Medicare regulations require that all entities that bill Medicare for services or items rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those services or items. "

- http://www.cms.gov/Medicare/Coordination-of-Benefits/MedicareSecondPayerandYou

Medicare Secondary Payer Questionnaire (MSPQ)

- The following questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission. Providers may use this as a guide to help identify other payers that may be primary to Medicare.

MSPQ

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- This questionnaire is a model of the type of questions that may be asked to help identify Medicare Secondary Payer (MSP) situations. If you choose to use this questionnaire, please note that it was developed to be used in sequence. Instructions are listed after the questions to facilitate transition between questions. The instructions will direct the patient to the next appropriate question to determine MSP situations.
- Providers are responsible for the contents of the MSPQ

Example MSPQ

Pub 100-05 MSP Ch
3 SEC 20.2.1

Primary Payer

- “Primary payers are those that have the primary responsibility for paying a claim. Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage. Medicare is also the primary payer in certain instances, provided several conditions are met.” -
- http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

Medicare As Secondary Payer

70 - Hospital Review Protocol for Medicare Secondary Payer
(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

- Federal law mandates that Medicare is the secondary payer for:
- • Claims involving Medicare beneficiaries age 65 or older who are insured by GHP coverage based upon their own current employment with an employer that has 20 or more employees, or that of their spouse's of any age, or the beneficiary is covered by a multiple employer, or multi-employer, group health plan by virtue of their, or a spouse's, current employment status and the GHP covers at least one employer with 20 or more employees;

Medicare As Secondary Payer (cont.)

70 - Hospital Review Protocol for Medicare Secondary Payer
(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

- Federal law mandates that Medicare is the secondary payer for:
- • Claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage that was already secondary to Medicare at the time ESRD occurred;
- • Claims involving liability or no-fault insurance;
- • Claims involving government programs, e.g., WC, services approved and paid for by the Department of Veterans Affairs (DVA), or BL benefits; and

Medicare As Secondary Payer (cont.)

70 - Hospital Review Protocol for Medicare Secondary Payer
(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

- Federal law mandates that Medicare is the secondary payer for:

- • Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans of employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon their own current employment status or the current employment status of a family member.

When Should Medicare Be Primary / Secondary

MSP-Fact-Sheet-CM
S102

Overview of the MSP Review

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- Selection – Select hospitals to be reviewed
- Notify – Notify hospitals of the review
- Sample – Review a sample of claims
- Visit – Schedule the visit at the hospital
- Investigate – Review questionnaires and Claims detail
- Report – Report findings within specified timeframes
- Follow up – Follow up on identified deficiencies

Notification to Provider

- Notify the selected hospital that there will be a review of the month's claims being reviewed.

1. Inform the provider that the universe for sampling will include claims from two months of processed claims.

Claim Selection to Provider

- Notify the selected hospital of the claims that have been selected for review.
  - The selected claims will be sent to the provider with in 15 days of the Notification Letter.
  - The provider will be given 30 days to respond with the requested information.

70.2 - Selection of Bill Sample (Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

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- The bill universe shall consist of Medicare inpatient, outpatient, and subunit claims for which a primary or secondary Medicare payment was made. The reviewer shall select the sample using the following criteria:

- • The reviewer shall include Medicare no-pay bills in the sample in order to examine the ratio of no-pay bills submitted by the hospital to those actually billed

- • Both Medicare primary and secondary bills are to be included in the sample.

Visiting the Provider Onsite

- Conduct an onsite hospital MSP compliance review to assess the effectiveness of the inpatient, outpatient and emergency room MSP protocol.
  1. Conduct an entrance interview with the admissions staff
  2. Conduct an entrance interview with the billing staff
  3. Request completed copies of the hospital's inpatient, outpatient and emergency room (ER) hospital admission questionnaires, if not already received.
- Conduct admission observation / walk-though
- The onsite visit should be completed in a maximum of two days

Investigation

- Compare the hospital's admission questionnaire to the CMS model to ensure that it includes all mandatory questions
- Obtain and review the Form CMS-1450, also known as the UB-04, for each claim in the sample to determine if the billed amount is accurate and to conduct the comparison to admission questionnaire
- Use intermediary paid history files, MSP control files and any other relevant data to assist in evaluating hospital procedures used in processing claims included in the sample

Reporting

- Complete the assessment form
  1. Include selection criteria, findings and recommendations
  2. Include any discrepancies between the hospital MSP policies and practices
  3. Include any hospital innovations that have been/are being devised to determine primary payer plans
  4. Note any discrepancies between the hospital's MSP policies and those required by law
  5. Document instances where an improper claim has been filed on the assessment form

- Complete the survey of bills reviewed
  1. Indicate whether any follow-up action is needed in the appropriate column

Reporting cont.

2. Briefly, describe action required and timeframe within which follow-up will commence, when follow up action is required.

- Send a copy of the assessment form, with its attachment, to the MSP Coordinator in the Regional Office (RO)
  - Send the hospital a copy of the assessment form

Most Common Problems

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- No MSP Questionnaire
- Submission of No Pay Bills
- Incomplete Questionnaire
- Conflicts on the MSP Questionnaire
- Staff Confusion
- Credit balances not reported timely
- Condition Code not used when necessary
- Occurrence code not used correctly
- Value Code used inappropriately

Most Common Problems

- No MSP Questionnaire

CH 3 20.2.1 - Admission Questions to Ask Medicare Beneficiaries (Rev. 53, Issued: 06-09-06, Effective: 09-11-06, Implementation: 09-11-06)

- The following questionnaire contains questions that can be used to ask Medicare beneficiaries upon each inpatient and outpatient admission.

CH 3 20.1 - General Policy
(Rev. 37, Issued: 10-14-05, Effective: N/A, Impleme.: N/A)

- **2. Policy for Recurring Outpatient Services**
- Hospitals must collect MSP information from the beneficiary or his/her representative for hospital outpatients receiving recurring services. Both the initial collection of MSP information and any subsequent verification of this information must be obtained from the beneficiary or his/her representative. Following the initial collection, the MSP information should be verified once every 90 days. If the MSP information collected by the hospital, from the beneficiary or his/her representative and used for billing, is no older than 90 calendar days from the date the service was rendered, then that information may be used to bill Medicare for recurring outpatient services furnished by hospitals. This policy, however, will not be a valid defense to Medicare's right to recover when a mistaken payment situation is later found to exist.

CH 3 20.1 - General Policy (Rev. 37, Issued: 10-14-05, Effective: N/A, Implementation: N/A)

- **NOTE:** A Medicare beneficiary is considered to be receiving recurring services if he/she receives identical services and treatments on an outpatient basis more than once within a billing cycle.
- Hospitals must be able to demonstrate that they collected MSP information from the beneficiary or his/her representative, which is no older than 90 days, when submitting bills for their Medicare patients. Acceptable documentation may be the last (dated) update of the MSP information, either electronic or hardcopy.

CH 3 20.1 - General Policy
(Rev. 37, Issued: 10-14-05, Effective: N/A, Impleme.: N/A)

- **3. Policy for Medicare Advantage (MA) Members**
- If the beneficiary is a member of an MA plan, hospitals are not required to ask the MSP questions or to collect, maintain, or report this information.

Hospital Reference Lab Policy

- Pursuant to section 943 of the Medicare Prescription Drug, Improvement & Moderation Act of 2003, (MMA) hospitals are no longer required to collect MSP information for reference laboratory services. Independent reference labs no longer need the information to bill Medicare for reference laboratory services. This policy also applies to critical access hospitals.

Most Common Problems

- Submission of no-pay bills
  - No pay bills must be submitted with correct condition, occurrence and value codes and amounts.

Most Common Problems

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- Incomplete Questionnaire

Most Common Problems

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- Conflicts on the MSP Questionnaire

Most Common Problems

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- Staff Confusion

Most Common Problems

- Credit balances not reported timely

Most Common Problems

- Condition Code not used when necessary.

70.3.1.1 - General Review Requirements

- **A. Condition Codes: FLs 24 thru 30**
- The following condition codes must be completed where applicable:
- • 08 - Beneficiary would not provide information concerning other insurance coverage;
- • 09 - Neither patient nor spouse employed;
- • 10 - Patient and/or spouse is employed, but no GHP; or,
- • 28 - Patient and/or spouse's GHP is secondary to Medicare.

Medicare HMO

- Condition Codes 04 / 69 should be used to indicate Medicare HMO (shadow claims).

70.3.1.4 -Workers' Compensation Bills

- **A. Condition Codes: FLs 24 thru 30**
- Condition codes should be completed with condition code 02 if the condition is employment related

Most Common Problems

- Occurrence code not used correctly
- Occurrence code for accident related claims
- Retirement Dates 18-19

70.3.1.1 - General Review Requirements (Rev. 1, 10-01-03)

70.3.1.1 - General Review Requirements (Rev. 1, 10-01-03)

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- RETIREMENT DATES
- In relation to the reporting of occurrence codes 18 and 19, referenced above, hospitals are now instructed that when precise retirement dates cannot be obtained during the intake process, they should follow this policy:
- When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, report his or her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, report the beneficiary's Medicare entitlement date as his or her retirement date.

70.3.1.1 - General Review Requirements (Rev. 1, 10-01-03) cont.

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- If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it has been at least five years since the beneficiary retired, enter the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, the provider reports the retirement date as January 4, 1997. As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.
- If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

70.3.1.3 - Accident Bills (Rev. 1, 10-01-03)

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- **A. Occurrence Codes and Dates: FLs 39 thru 34**
- The following occurrence codes should be completed to show the type and date of the accident:
- • 01 - Auto accident;
- • 02 - Auto accident with no-fault insurance;
- • 03 - Accident involving civil court process;
- • 04 - Employment related accident;
- • 05 - Other accident

Most Common Problems

- Value Code used inappropriately

70.3.1.1 - General Review Requirements (Rev. 1, 10-01-03)

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- **C. Value Codes and Amounts: FLs 39 thru 41**
- Value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services. Where the hospital is requesting conditional payment, zeros should be entered beside the appropriate value code in this item.

70.3.1.2 -Working Aged Bills (Rev. 1, 10-01-03)

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- **A. Value Codes and Amounts: FLs 39 thru 41**
- The following value code and amount fields should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.
- • 12 - Working aged/beneficiary/spouse with group health plan coverage

70.3.1.3 - Accident Bills (Rev. 1, 10-01-03)

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- The following value codes and amounts should be completed to show the type of the other coverage and the amount paid by the other payer for Medicare covered services:
- • 14 - Automobile, or other no-fault insurance;
- • 47 - Any liability insurance;
- When occurrence codes 01 thru 04 and 24 are entered, they must be accompanied by the entry of the appropriate value code in FLs 39-41 (shown here) if there is another payer involved.

70.3.1.4 -Workers' Compensation Bills

- **B. Value Codes and Amounts: FLs 39 thru 41**
- The following value code and amount should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.
- • 15 - Workers' compensation

70.3.1.5 - ESRD Bills (Rev. 1, 10-01-03)

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- **A. Value Codes and Amounts: FLs 39 thru 41**
- The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.
- • 13 - ESRD beneficiary in 30-month period with group health plan coverage

70.3.1.6 - Bills for Federal Government Programs (Rev. 1, 10-01-03)

- **A. Value Codes and Amounts: FLs 39 thru 41**
- The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services:
- • 16 - PHS, other Federal agency; and,
- • 41 - Black lung.

70.3.1.7 - Disability Bills (Rev. 1, 10-01-03)

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- **A. Value Codes and Amounts: FLs 39 thru 41**
- The following value codes and amounts should be completed to show the type of other coverage and the amount paid by the other payer for Medicare covered services.
- • 43 - Disabled beneficiary with large group health plan coverage

70.3.1.7 - Disability Bills (Rev. 1, 10-01-03)

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- **D. Payer Identification: FL 50A**
- Payer identification should be completed to show the identity of the other payer primary to Medicare. All additional entries across line A (FLs 51-55) supply information needed by the payer named in FL 50A.

Best Practices

- Training
  - Formal and documented training for all new staff
    - This should include graded assessments give to the staff
  - Annual training for existing staff
  - The staff should understand the admissions questions well enough to solicit information and/or explain to beneficiaries
    - The response of Unknown should be avoided.

Best Practices

- Detailed Policies & Procedures
  - Detailed written polices and procedures for the admission and MSPQ process.
  - Policies and procedures for the follow up process in the event the patient was unable to complete the MSPQ at the time of admission.

Best Practices

- Regular Internal Audits
  - Internal audits should be conducted to ensure the policies and procedures are being correctly completed.

Best Practices

- System Safe Guards
  - System Automated edits and warnings when potential errors may have occurred.
  - Software to verify patient eligibility

MSP Resource Locations

- FCSO Website
  - http://medicare.fcso.com/MSP/
- MSP Manual – Chapter 5
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c05.pdf
- MSP Manual – Chapter 3
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf

MSP Resource Locations

- CMS MSP Training Materials
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

MSP Resource Locations

- MSP for Providers, Physician, and Other Supplier Billing Staff
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/Downloads/Medicare-Secondary-Payer-MSP-Fact-Sheet-CMS102.pdf

MSP Resource Locations

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- Your Billing Responsibilities
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/Your-Billing-Responsibilities.html

MSP Presentation

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- Any Questions????????