Home Health and Hospice and Medicare Secondary Payer

HH+H Virtual Conference 6/8/2016

Today’s Presenter

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Objectives

- To educate through the use of scenarios on the correct Medicare Secondary Payer (MSP) claim submission
- Provide a resource guide

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Agenda

- MSP Updates
- Scenarios
- Questions and Answers

Medicare Secondary Payer Updates

Claims Received October 2009 to December 2015

- Per Change Request (CR) 6426, providers can not use the Fiscal Intermediary Standard System Direct Data Entry (FISS DDE) to
  - Submit MSP, conditional or Medicare tertiary claims
  - Correct MSP, conditional or Medicare tertiary claims
  - Adjust claims for MSP reasons
    - Claim(s) received returned to provider (RTP) for reason code 31265
- Due to FISS DDE system limitations
  - Providers were unable to enter adjustments from claim adjustment segment (CAS) of primary payer's Remittance Advice (RA 835)
    - Claim adjustment group codes (CAGS), claim adjustment reason codes (CARCs) and amounts

Claims Received On/After 1/1/2016

- Per CR8486, providers can use FISS DDE to
  - Submit MSP, conditional and Medicare tertiary claims
  - Correct MSP, conditional and Medicare tertiary claims
  - Adjust claims for MSP reasons
- FISS process was updated to allow above actions
  - Additional MAP was added to allow providers to enter adjustments from CAS of primary payer's RA (835)
    - CAGS, CARCs and amounts

Claim Entry Page 03 (MAP1719 – NEW)

- New “**MSP Payment Information**” page
  - **Press F11/PF11**, from MAP1713, to access
  - **Press F6/PF6** to display a second page for payer 2
- Up to 20 entries each for primary payers 1 and 2
  - Field names (enter information from primary payer’s RA):
    - **Paid date:** Enter paid date
    - **Paid amount:** Enter paid amount (must equal amount entered for MSP VC)
    - **GRP:** Enter group code(s), also known as CAGC(s)
    - **CARC:** Enter CARC(s)
    - **AMT:** Enter dollar amount(s) associated with **CAGC and CARC**

Did You Know…..

- Although entering the CAGCs and CARCs into FISS DDE is new for providers, providers have been including this information on electronic claim submissions via the 837I claim since October of 2009 per CR6426

MSP Scenarios

Scenario 1

- A provider's new associate has been tasked with completing the Medicare billing for the facility. She understands now how to bill the facility's Medicare primary bills, but she is not sure where she can go to find help in billing the MSP claims.

Scenario 1 Response

- Visit NGSMedicare.com > login > Claims and Appeals > Medicare Secondary Payer > articles on left side of page
  - Prepare and Submit an MSP Claim
  - Prepare and Submit an MSP Conditional Claim
- Visit CMS.gov > Regulations and Guidance > Guidance > Manuals > Internet Only Manuals (IOM) > Publication 100-05 Medicare Secondary Payer Manual
  - Chapter 1 – Background and Overview
  - Chapter 2 – MSP Provisions
  - Chapter 3 – MSP Provider, Physician, and Other Supplier Billing Requirements

Scenario 2

- A HHA has had a March 2016 claim returned for possible MSP involvement. In checking the Common Working File (CWF) it is noted the beneficiary has an open liability record with an effective date in 2008 but no term date. When screening for MSP involvement, the beneficiary indicated a fall in her own home, so no premises med-pay or liability insurance is available. How does this provider get their claim to process as Medicare primary?

Scenario 2 Response

- Part A providers
  - May use an occurrence code 05 along with the date of injury to indicate you researched for other primary payers and determined there are none, Medicare is primary
  - Include comment in the Remarks field, this accident is **not related** to the open 47 MSP record on the CWF
  - Fax documentation received by primary payer to the Benefits Coordination & Recovery Center to close record, information should be on employer or insurance company's letterhead (instructions available on our website)

BCRC Contact Information

- Customer Service Representatives are available:
  - Monday through Friday, 8:00 a.m.-8:00 p.m. ET, except holidays
  - 855-798-2627
  - TTY/TDD: 1-855-797-2627 (hearing and speech impaired)
  - Fax for general correspondence: 405-869-3307
- MSP general correspondence:
  - Medicare – MSP General Correspondence
    P.O. Box 138897
    Oklahoma City, OK 73113-8897

- From http://www.CMS.gov home page
  - Click on Medicare tab
  - Click on Coordination of Benefits & Recovery Overview under Coordination of Benefits & Recovery
  - On your left, you will see many options from which to choose including Contacts page
- BCRC Contacts page:
  - http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html

Additional BCRC Information

- Beneficiary Information regarding BCRC:
  - https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Medicares-Recovery-Process/Downloads/Rights-and-Responsibilities-Brochure.pdf
- CMS BCRC Presentation:
  - https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Medicares-Recovery-Process/Downloads/Reporting-a-Case-to-the-BCRC.pdf
- SE 1416
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1416.pdf

Scenario 3

- A Medicare beneficiary has elected hospice and when screening for MSP involvement the beneficiary's spouse indicated she was entitled to Medicare due to a disability. He informs you he is still working and she is covered under his group health plan (GHP) at work. When you look at her date of birth, it indicates she is 69 years old. You submit a claim to the GHP and they make a partial payment. When getting ready to bill this claim to Medicare, you need to verify that criteria is met for which MSP provision?

Scenario 3 Response

- In this situation, even though the beneficiary was originally entitled due to a disability, the criteria for MSP Disabled indicates the patient must be 64 or younger. Once the beneficiary turned 65, her entitlement changed from Disabled to Working Aged (WA).
  - Value code 12 – amount of partial payment
  - Payer code of A along with primary payer’s name (if submitting claim electronically or via DDE)

Scenario 3 Response – Working Aged

- WA Criteria for Medicare to be Secondary
  - Beneficiary must be 65 or older
  - Beneficiary must be entitled to Medicare Part A
  - Beneficiary or spouse must be currently working
  - Beneficiary must be covered under the GHP of the beneficiary/spouse employer
  - Employer must have 20 or more employees
  - IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 2, Section 10

Scenario 3 Response - Disabled

- Disabled Criteria for Medicare to be Secondary
  - Beneficiary must be 64 or younger
  - Beneficiary must be entitled to Medicare Part A
  - Beneficiary, spouse or family member must be currently working
  - Beneficiary must be covered under the GHP of the beneficiary/spouse/family member employer
  - Employer must have 100 or more employees
  - IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 2, Section 30

Scenario 4

- A 66 year old male beneficiary elects the hospice benefit. His spouse is still working and he is covered under her employer's group health plan. You submit the first month claim to the primary payer, and they pay in full. Are you required to submit a claim to Medicare, showing the claim was paid in full?

Scenario 4 Response

- If this is an inpatient claim, then yes, an MSP claim needs to be submitted to Medicare
- If this is an outpatient claim, you must submit an MSP claim if the beneficiary's Part B annual deductible has not yet been met
  - Value code 12 – amount primary payer paid
  - Payer code of A along with primary payer's name (if submitting claim electronically or via DDE)
  - IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 3, Section 40.1.1

Reminder……

Even if you do not "have" to submit an outpatient MSP claim if the primary paid in full, it is still a good idea to go ahead and submit, as it creates an audit trail. In the event later the primary payer informs you that benefits have exhausted, you will have that audit trail to explain why you are now looking to Medicare for payment.

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Scenario 5

- A beneficiary comes to your home health facility and when going over insurance cards to determine what kind of insurance is available, you see the beneficiary has enrolled in a Medicare Advantage (MA) Plan and does not have traditional Medicare benefits. Do you still need to complete a questionnaire or screening with the beneficiary?

Scenario 5 Response

- 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

- IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 3, Section 20.1.3

Scenario 6

- When reviewing information with a beneficiary who is at your place for medical services, you ask the beneficiary questions to determine if Medicare is primary or secondary. If the determination is that Medicare is primary, the questionnaire/screening form is shredded. Is this acceptable?

Scenario 6 Response

- Providers are required to determine whether Medicare is a primary or secondary … **prior to submitting a bill to Medicare.** It must accomplish this by asking the beneficiary about other insurance coverage.
- For audit purposes, and to ensure that the provider has developed for other primary payer coverage, the provider retains a record of the development or other information on which it based its determination that Medicare is primary payer.
- Medicare permits providers to retain hard copy questions and responses on paper, optical image, microfilm, or microfiche. Hard copy and data must be kept for at least **10 years** after the date of service that appears on the claim. If the provider's admissions questions are retained online, 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 may not be purged before then.
- IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 3, Sections 20.1 and 20.2.2

Scenario 7

- A beneficiary was seen at your facility and had a GHP through her employer. You billed the GHP and received a partial payment from them indicating the beneficiary had a $500 deductible, so their payment was reduced by that amount. Can you bill the beneficiary for that GHP deductible?

Scenario 7 Response

- No. Providers can submit the MSP claim to Medicare. Once Medicare processes the claim, the remittance advice will indicate if any Medicare deductible or co-insurance is owed from the beneficiary. You can pursue the beneficiary for any Medicare deductible, co-insurance or non-covered charges, but you may not pursue the beneficiary for any GHP deductible or co-insurance.
- SE 1227: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1227.pdf
- IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 3, Section 10.1, 10.2, 40.1 and 40.5

Scenario 8

- You have a new Medicare beneficiary patient who is entitled to Medicare due to a disability. When asking about insurance, the beneficiary states he does have COBRA coverage for the next six months. Is COBRA primary to Medicare?

Scenario 8 Response

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a Title X provision that provides continuation of GHP coverage if elected. For **aged or disabled** Medicare beneficiaries, **COBRA continuation coverage is secondary to Medicare** because the coverage is by virtue of COBRA law rather than by virtue of current employment status. For an End Stage Renal Disease (**ESRD)** related Medicare beneficiary, **COBRA continuation coverage, if elected, is primary to Medicare** during the 30-month ESRD coordination period.
- IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 1, Section 20

Scenario 9

- You provided services to a Medicare beneficiary who had auto medical-payment coverage. You have not received a response and it has been 5 months. You submitted a conditional claim to Medicare and received payment. Do you still need to try to collect from the primary payer?

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Scenario 9 Response

- If payment has not been made or cannot be expected to be made promptly by a workers’ compensation plan, liability insurance, or no-fault insurance, Medicare may make a conditional payment, under some circumstances, subject to Medicare payment rules. Conditional payments are made subject to repayment when the primary plan makes payment.
- Subject to Medicare payment rules and other stipulations, primary payers (GHP, liability insurance, including self-insurance, no-fault insurance, and workers' compensation) are **obligated to reimburse Medicare** if they were properly primary to Medicare, but have not paid as primary.
- IOM Publication 100-05 – *Medicare Secondary Payer Manual,* Chapter 1, Section 10.7

Scenario 10

- A beneficiary was involved in an auto accident and holds another party responsible. When contacting the beneficiary to get insurance information regarding the accident, the beneficiary gave you their attorney's name and number. A call was made to the attorney and the attorney instructed you to just bill Medicare, this is a liability case and it will be quite a while before there is a settlement. Can the attorney's name be listed in place of the insurance company's name, since you do not know who that is?

Scenario 10 Response

- CMS requires providers to bill the insurance company
- The attorney needs to give the insurance information so that a clean record can be set up on the CWF
  - Attorney has a fiduciary responsibility to protect his/her client and comply with Federal guidelines
  - Failure to comply is as if the beneficiary refused to comply

Wrap Up

Medicare University Self-Reporting Instructions

- Log on to National Government Services Medicare University
  - http://www.MedicareUniversity.com
    - Topic = **Enter title of webinar**
    - Medicare University Credits (MUCs) = **Enter number**
    - Catalog Number = To be provided
    - Course Code = To be provided
  - Visit our website for step-by-step self-reporting instructions.
    - Click on the **Education** tab, then the **Medicare University Course List** tab, click on the **Get Credit** link. This will open the **Get Credit for Completed Courses** web page.

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Continuing Education Credits

- All National Government Services Part A and Part B Provider Outreach and Education attendees can now receive one CEU from AAPC for every hour of National Government Services education received.
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs.

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions from attendees
  - If you have a question or scenario, on your control panel go to the Question Box and type in your answer, then hit enter
  - Questions will be answered in the order received