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| **Miracle Healthcare LLC** | **Policy Number 1100** |
| **Policy and Procedure Manual** | **RHC Billing Manual** |
| **Subject** | **Medicare Secondary Payor Requirements for Rural Health Clinics** |
| **Effective Date** | **5/1/2017** |
| **Review Date** | **4/30/2018** |

**POLICY STATEMENT**

It is the policy of **NAME OF RURAL HEALTH CLINIC** to determine whether or not a patient is eligible for Medicare benefits, and if so, to determine if one or more third party payers might be responsible for payment before Medicare considers payment. The Clinic will take all reasonable steps to obtain information (from patients and/or responsible family

members in order to determine on a pre-billing basis if another third party might be primary to the patients Medicare benefits.

**PURPOSE**

Under certain circumstances a patient qualified for Medicare coverage may also be covered by other insurance. such as an employer's group health plan, another private health insurance, workers' compensation insurance, an automobile liability policy, or no-fault insurance. In these situations. the non-Medicare insurance is considered the primary insurance coverage, and Medicare coverage is considered secondary. To the extent that

payment is made by a primary payer, Medicare payment for the claim is reduced.

A primary insurance payer is obligated to pay prior to any obligation on behalf of Medicare. If a patient's primary payer is no-fault insurance, the insurance payments may be used to satisfy Medicare deductible and co-insurance requirements. If a primary payer covers less than the full amount of any charges, then the amount actually paid is deducted from the amount Medicare otherwise owes. And if a primary payer payment exceeds Medicare's payment amount, no Medicare payment is made.

The largest challenge to the Clinic in complying with the Medicare Secondary Payor rules is in collecting complete and accurate information about a patient's insurance coverage during the check in process. The receptionist is often responsible for answering the phones and checking in patients. Because the receptionist must collect a substantial amount of information from patients, the check in process often is lengthy and involved. Often times, patients, or those providing information about the patient, may be under stress because of the need for medical attention and in a hurry to finish the questioning. Accordingly, great care should be placed on following the procedures set forth in this policy in order to obtain accurate results from the process.

**PROCEDURE**

1. l. A Medicare Secondary Payor (MSP) questionnaire will be asked of and completed for all patients that are covered by Medicare. This MSP questionnaire process was developed to accurately determine whether or not Medicare is the primary payer for services that are provided to a patient. The MSP questionnaire results (whether produced in hard copy or electronic format) will be retained by the Clinic for no less than I 0 years from date of service.
2. All patients must be interviewed to complete the registration and determine proper primary insurance coverage.
3. All required questions in the MSP screen for each patient encounter must be asked and an answer input into the system.
4. Assure that health care coverage is identified and entered into the patient's account in the correct sequence and according to the MSP questionnaire.
5. If the answer to any of the MSP questions indicates that another payor is primary, registration personnel must obtain the information needed to bill the other third party as primary to Medicare and enter this information into the automated billing system.
6. Although one or more parties have been identified as primary to Medicare and may even pay the Clinic bill in its entirety, registration personnel must still obtain information regarding the patient Medicare benefits and enter it into the automated billing system.
7. Where applicable, registration personnel must appropriately sequence Medicare as the secondary, tertiary or quintenary payer in the automated billing system.
8. The Clinic must collect MSP information from a beneficiary or his/her representative for Clinic lab services. If the MSP information collected by the Clinic, 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 non-patient lab services. The Clinic 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 hard copy.
9. Recurring Outpatient Services. The clinic must collect MSP information from the beneficiary or his/her representative for Clinic 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 Clinic, 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 Clinic. 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.
10. The situations under which another third party payer might be primary over Medicare include the following:
11. Patient has Employer Group Health Plan (EGHP) coverage through either his/her current employment or through U1e current employment of a spouse;
12. Patient is disabled and has Large Group Health Plan (LGHP) coverage through his/her current employment or through the current employment of a family member;
13. Patient has been diagnosed with End Stage Renal Disease (ESRD) and has EGHP coverage through either his/her cunent or former employment or that or a spouse:
14. Patient is injured and another party is responsible- e.g., workers comp, automobile accident, no fault, etc;
15. Patient is a veteran of lhe armed services and the Veterans Administration has agreed to pay benefits as primary payer; or
16. Another government program is responsible for payment- e.g. Black Lung, National Institute of Health. etc.

**Reference Material – What is MSP?**

The MSP provisions protect the Medicare Trust Fund by ensuring Medicare does not pay for items and services when other health insurance coverage is primary to Medicare. The MSP provisions apply to situations where Medicare is not the primary or first payer of claims. In these cases, the MSP requirements provide the following benefits for you and the Medicare Program:

1. **National program savings** – The Centers for Medicare & Medicaid Services (CMS) enforcement of the MSP provisions saved the Medicare Program roughly $8.5 billion in Fiscal Year (FY) 2015.
2. **Increased provider, physician, and other supplier revenue** – If you bill a primary plan before billing Medicare, you may get more favorable reimbursement rates. Also, properly coordinated health coverage may expedite the payment process and reduce your administrative costs.
3. **Avoidance of Medicare recovery efforts** – If you file claims correctly the first time, you prevent future Medicare recovery efforts on claims.

To get these benefits, you must access accurate, up-to-date information about your Medicare beneficiary’s health insurance coverage. Medicare regulations require anyone submitting Medicare claims to determine whether Medicare is the primary payer for items or services provided to the beneficiary.

**How Do You Gather Accurate MSP Data from the Beneficiary?**

As a Medicare provider, you must determine whether Medicare is the primary or secondary payer for each inpatient admission or outpatient encounter prior to submitting a claim to Medicare. You can do this by asking Medicare beneficiaries about other coverage. The questions you ask can help you verify the Common Working File (CWF) information is correct and up to date.

CMS developed an MSP questionnaire for providers to help identify other payers that may be primary to Medicare. This questionnaire models the type of questions that help identify MSP situations. Refer to the MSP questionnaire in the Medicare Secondary Payer Manual, Chapter 3, Section 20.2.1. (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf>) Your Medicare Administrative Contractor (MAC) may also offer questionnaire tools.

You should retain a copy of completed MSP questionnaires for at least 10 years after the date of service. You may keep hard copy files, optical images, microfilms, or microfiches. If you store these files online, you must keep both negative and positive responses to questions.

**Tip for Providers**

**Providers who use CMS Form-1450, or its electronic equivalent, should report condition code 08 (“beneficiary would not furnish information concerning other insurance coverage”) when a beneficiary refuses to answer or provide you with other payer information.**

If you do not furnish Medicare with a record of other health insurance or coverage that may be primary to Medicare on any claim and there is an indication of possible MSP considerations, the BCRC may request that the beneficiary, employer, insurer, or attorney complete a Secondary Claim Development (SCD) Questionnaire. The BCRC may send an SCD Questionnaire when:

1. The MAC receives a claim with an EOB attached, or remittance advice, from an insurer other than Medicare.
2. The beneficiary self-reports or beneficiary’s attorney identifies an MSP situation
3. The third-party payer submitted MSP information to a MAC or the BCRC.

For more information on “Secondary Claim Development,” visit the CMS Reporting Other Health Insurance webpage.

**What Happens if You Submit a Claim to Your MAC without Providing the Other Insurer’s Information?**

Medicare may erroneously pay the claim as primary if it meets all Medicare requirements, including coverage and medical necessity guidelines. However, if the beneficiary’s MSP record in the CWF indicates another insurer should have paid primary to Medicare, Medicare will deny the claim. If the MAC does not have enough information on the claim or correspondence, it may forward the information to the BCRC, and the BCRC may send the beneficiary, employer, insurer, or attorney an SCD Questionnaire for additional information. The BCRC will review the response information on the questionnaire and take the proper action.

For more information on proper MSP billing, refer to the Medicare Secondary Payer Manual, Chapter 3.

**What Happens if You Fail to File Correct and Accurate Claims?**

You must file a proper and timely claim with the appropriate primary payer. Not filing a proper and timely claim with the appropriate primary payer may result in a claim denial by that payer. Policies vary depending on the payer; please check with the payer to learn about its specific policies.

Federal law permits Medicare to recover its erroneous payments. Medicare will require the return of any payment it erroneously paid as the primary payer. Also, Medicare can fine providers, physicians, and other suppliers up to $2,000 for knowingly, willfully, and repeatedly providing inaccurate information related to the existence of other health insurance or coverage.

**Source: Medicare Secondary Payer (MSP) Manual Chapter 3 - MSP Provider, Physician, and Other Supplier Billing Requirements *(Rev. 87, 08-03-12)***

**20.1 - General Policy**

**(Rev. 37, Issued: 10-14-05, Effective: N/A, Implementation: N/A)**

Based on the law and regulations, providers, physicians, and other suppliers are required to file claims with Medicare using billing information obtained from the beneficiary to whom the item or service is furnished. Section 1862(b)(6) of the Act, (42 USC 1395y(b)(6)), requires all entities seeking payment for any item or service furnished under Part B to complete, on the basis of information obtained from the individual to whom the item or service is furnished, the portion of the claim form relating to the availability of other health insurance. Additionally, 42 CFR 489.20(g) requires that all providers must agree “to bill other primary payers before billing Medicare." Thus, any providers, physicians, and other suppliers that bill Medicare for services rendered to Medicare beneficiaries must determine whether or not Medicare is the primary payer for those services. This must be accomplished by asking Medicare beneficiaries, or their representatives, questions concerning the beneficiary's MSP status. Exceptions to this requirement are discussed below in 1 and 3. If providers, physicians or other suppliers fail to file correct and accurate claims with Medicare, and a mistaken payment situation is later found to exist, 42 CFR 411.24 permits Medicare to recover its conditional or mistaken payments.

Section 20.2.1, "Admission Questions to Ask Medicare Beneficiaries," may be used to determine the correct primary payers of claims for all beneficiary services furnished by a hospital.

**NOTE:** Providers are required to determine whether Medicare is a primary or secondary payer for each inpatient admission of a Medicare beneficiary and outpatient encounter with a Medicare beneficiary prior to submitting a bill to Medicare. It must accomplish this by asking the beneficiary about other insurance coverage. Section 20.2.1 lists the type of questions it must ask of Medicare beneficiaries for **every** admission, outpatient encounter, or start of care. Exceptions to this requirement are discussed below in 1 and 3.

EXCEPTIONS

These questions may be asked in connection with online access to Common Working File (CWF). (See §20.2.) If the provider lacks access to CWF, it will follow the procedures found in §20.2.1.

**NOTE:** There may be situations where more than one payer is primary to Medicare (e.g., liability insurer and GHP). The provider, physician, or other supplier must identify all possible payers.

This greatly increases the likelihood that the primary payer is billed correctly. Verifying MSP information means confirming that the information previously furnished about the presence or absence of another payer that may be primary to Medicare is correct, clear, and complete, and that no changes have occurred.

**1. Policy for Hospital Reference Lab Services and Independent Reference Lab Services**

Background

Section 943 (TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYER (MSP) PROVISIONS) of the Medicare Prescription Drug, Improvement & Modernization Act of 2003 states:

“(a) IN GENERAL. – The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare Secondary Payer provisions) in the case of reference lab services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

“(b) REFERENCE LABORATORY SERVICES DESCRIBED. – Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.”

**Policy**

The Centers for Medicare & Medicaid Services (CMS) will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above. Therefore, pursuant to section 943 of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, CMS will not require hospitals to collect MSP information in order to bill Medicare for reference laboratory services as described in subsection (b) above. 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.

Contractors shall instruct hospital and independent labs, which have already collected and retained MSP information for beneficiaries, that they may use that information for the billing of non-face-to-face reference lab services. However, in situations when there is a face-to-face encounter with the beneficiary, contractors shall instruct hospitals and independent labs that they are required to collect MSP information from the beneficiary when billing for lab services.

Instructions to contractors on how to process reference lab claims submitted on Form CMS-1500 are available by clicking on the following hyperlink:

<http://www.cms.hhs.gov/manuals/104_claims/clm104c26.pdf> (After you get to chapter 26, click on section 10.2 in the Table of Contents.)

**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.

**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.

**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.

**4. Policy for Medicare Secondary Payer (MSP) Retirement Dates**

During the intake process, when a beneficiary cannot recall his/her precise retirement date as it relates to coverage under a group health plan as a policyholder or cannot recall the same information as it relates to his/her spouse, as applicable, hospitals must follow the policy below.

When a beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement dates, as shown on his/her Medicare card, hospitals report his/her Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his/her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, hospitals report the beneficiary's Medicare entitlement date as his/her retirement date.

If the beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement but the hospital determines it has been at least five years since the beneficiary retired, the hospital enters the retirement date as five years retrospective to the date of admission. (Example: Hospitals report the retirement date as January 4, 1998, if the date of admission is January 4, 2003) 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 hospital must obtain the retirement date from appropriate informational sources; e.g., former employer or supplemental insurer.

**5. Policy for Provider Records Retention of MSP Information**

Title 42 CFR 489.20(f) states that the provider agrees to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. Based on this regulation, hospitals must document and maintain MSP information for Medicare beneficiaries. Without this documentation, the contractor would have nothing to audit submitted claims against. CMS recommends that providers retain MSP information for 10 years.



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**Resources**

Table 2 provides resources about MSP provisions.

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| **Resource** | **Location** |
| CMS MSP Website | CMS.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html |
| “Medicare & Other Health Benefits: Your Guide to Who Pays First” | Medicare.gov/pubs/pdf/02179.pdf |
| MLN Matters Article SE1217 “Guidance for Correct Claims Submission When Secondary Payers Are Involved” | CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1217.pdf |
| MLN Guided Pathways | CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided\_Pathways\_Provider\_ Specific\_booklet.pdf |

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| **Table 3. Embedded Hyperlink** | **Complete URL** |
| BCRC Contacts | https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html |
| Coordination of Benefits & Recovery Overview | https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview.html |
| Mandatory Insurer Reporting for GHPs | https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Overview.html |
| Mandatory Insurer Reporting for NGHPs | https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html |
| Medicare Claims Processing Manual, Chapter 1 | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf |

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| **Table 3. Hyperlink Table (cont.) Embedded Hyperlink** | **Complete URL** |
| Medicare Learning Network® (MLN) Web-Based Training Course | https://learner.mlnlms.com |
| Medicare Secondary Payer Manual | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html |
| Medicare Secondary Payer Manual, Chapter 3 | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf |
| Medicare Secondary Payer Manual, Chapter 4 | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c04.pdf |
| MLN Matters® Article MM7355 | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7355.pdf |
| MLN Matters® Article MM8875 | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8875.pdf |
| MLN Matters Article SE1416 | https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1416.pdf |
| Reporting Other Health Insurance | https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Beneficiary-Services/Reporting-Other-GHP-Insurance/Reporting-Other-Health-Insurance.html |
| Review Contractor Directory – Interactive Map | https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map |
| Section 1862(b)(2)(A)(ii) of the Social Security Act | https://www.ssa.gov/OP\_Home/ssact/title18/1862.htm#act-1862-b |

**Table 4**

**NAME OF RURAL HEALTH CLINIC**

**Medicare Secondary Payor Training Videos**

Note: The following videos are recommended to help understand the role of the RHC in fulfilling its obligation for Medicare Secondary compliance.

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| **Date** | **Title** | **Link** |
| 11/11/2014 | Medicare Secondary Payer (MSP) Billing - Part A & HHH | <https://www.youtube.com/watch?v=2RsIIFtbUtE>  |
| 4/1/2014 | Medicare Secondary Payer (MSP) Webcast: Conditional Billing - Part A & HHH | <https://www.youtube.com/watch?v=OOqwg9LGRwA>  |
| 9/10/2015 | Top 15 Medicare Secondary Payer Myths Debunked | <https://www.youtube.com/watch?v=mVfqfjopIhk> |

Appendix A – Sample MSP Form

**NAME OF RHC**

MEDICARE SECONDARY PAYER (MSP) INFORMATION

Must be completed on EVERY Visit for Medicare Patients per

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdf>

**NAME OF RHC** is required under Medicare Regulations to seek other payers for Medicare beneficiaries every visit as this saves Medicare $8.5 billion annually and protects the Medicare Insurance Trust for future generations.

PATIENT ARE YOU ENTITLED TO ANY BENEFITS FROM:

1. Black Lung Program
2. Government Program
3. Veterans Administration
4. Workers Compensation Coverage (Injury at Work)
5. Auto Insurance Accident Coverage
6. Currently Employed or spouse with Medical Coverage (Age 65 or Above)
7. Receiving Medicare Coverage due to Age, Disability, Renal Failure (ESRD) and **HAVE GROUP HEALTH COVERAGE**

 YES\_\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_

If **NO**, **SIGN AND DATE FORM AND RETURN TO RECEPTIONIST**

If **YES, please provide the name of your employer and insurance carrier and your Insurance card.**

|  |  |
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| Please Provide the following information for the | Primary Insurance Company. |
| Insurance Name |  |
| Insurance Address |  |
| Insurance Address (City, State, Zip) |  |
| Insurance Policy Number |  |
| Insurance Subscriber |  |
| Patient Signature & Date |  |
| Witness Signature & Date |  |

The information in this document was received from the patient and neither **NAME OF RHC** or their physicians nor staff are liable for any misrepresentations by the patient.

For Office Only: Use Condition Code 08 if patient does not provide requested information.