FAQS FOR MSP BASICS WEBINAR

FEBRUARY 5, 2013

What are the exceptions for mailing paper claims?

The Administrative Simplification Compliance Act (ASCA) prohibits payment of initial health care claims not sent electronically as of October 16, 2003, except in limited situations:

- Small Provider Claims — The word "provider" is being used generically here to refer to physicians, suppliers, and other providers of health care services. For Part B claims, physicians and suppliers with fewer than 10 FTEs and that are required to bill a Medicare carrier are classified as small. See section 90.1 of Chapter 24 of the Medicare Claims Processing Manual (Pub. 100-04) for more detailed information on calculation of FTE employees and this ASCA requirement in general.
- Roster billing of inoculations covered by Medicare, except for those companies that agreed to submit these claims electronically as a condition for submission of flu shots administered in multiple states to a single carrier.
- Claims for payment under a Medicare demonstration project that specifies claims be submitted on paper
- Medicare Secondary Payer Claims when there is more than one primary payer and one or more of those payers made an "Obligated to accept as payment in Full" (OTAF) adjustment.
- Claims submitted by Medicare beneficiaries or Medicare Managed Care Plans.
- Dental Claims.
- Claims for services or supplies furnished outside of the U.S. by non-U.S. providers.
- Disruption in electricity or communication connections outside of a provider's control expected to last more than two business days.
- Claims from providers that submit fewer than 10 claims per month on average during a calendar year.

If you believe that you meet these criteria for billing paper claims, contact our Electronic Data Interchange (EDI) department on details for getting a waiver for your office. Their number is 1.866.276.9558 for Ohio and Kentucky Part B customers, 1.866.590.6703 for Ohio and Kentucky Part A customers, or 1.877.299.4500 for Home Health & Hospice customers.

Reference: ASCA self-assessment on the CMS website (http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html).

Can a Medicare replacement (ie.g.., Humana Medicare) be a secondary carrier? If Humana Medicare is primary, would Medicare be secondary if Humana did not authorize skilled coverage, even though beneficiary meets Medicare skilled criteria?

No, Medicare is not secondary payer to a Medicare Replacement Policy. If the patient has a Medicare Replacement policy (Medicare Advantage Plan), that policy takes the place of original Medicare for that patient. Medicare Advantage plans have their own specific criteria they use for coverage determination, and traditional Medicare would not be secondary.

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We have a lot of Medicare/Medicaid patients. Medicaid is starting to deny services (birth control, for example) to these patients due to Medicare denial. What can we do to get things paid?

Since Medicaid is secondary, Medicaid is going to base coverage on the primary coverage on the claim. However, if Medicare does not cover the charge, such as in your example of birth control, we are going to forward that information to Medicaid, who is going to make its own coverage determination. The best bet at this point is to contact Medicaid to get their coverage guidelines for services that are denying.

We have a patient that has several claims related to auto accident. She has Med Pay and the person at fault has liability. We are sending bills to Med Pay and they are forwarding to the other liability insurance. I received a phone call from the liability insurance yesterday and was told they will not pay the bills until Medicare pays, then they will reimburse us. What are we supposed to do?

At this point, the best thing to do is to file a claim for conditional payment with Medicare. The rule for conditional payment under Medicare is: Medicare can make a conditional payment for Worker's Compensation, no-fault, or liability insurance if payment has not been made or cannot be expected to be made by the other insurance, and the promptly billed period has expired. These payments are made based "on the condition" that the Medicare Trust Fund be reimbursed if payment is ever received from the other insurance.

Our patient has coverage through his spouse. The spouse is still working, but the patient has a Medicare Replacement coverage because he is retired and on Medicare. In this instance, would the Medicare Replacement Plan be secondary to the spouse's employer plan?

The Medicare coverage would be secondary if the spouse meets working aged criteria, no matter if it is traditional Medicare or a Medicare Replacement Plan.

When a primary payer applies the payment to the deductible, is the Medicare MSP claim considered "conditional" at that point since we did not receive an actual payment from the primary payer? Or, if the primary payer pays the claim in full, does the MSP claim have to be filed to Medicare?

The Medicare claim is not considered "conditional" if the primary insurer applied charges to the deductible. In both instances, the claim should be filed to Medicare. If there are any changes to the patient's eligibility (retroactive Medicare, MSP updates) we have to use the original claim filing to establish timely filing limitations. If there was no original filing, no adjustment can be made since any new claim activity would not meet timely filing guidelines.

What is the timely filing limit on MSP claims?

It is the same as general filing, which is one year from the date of service.

If a disabled Medicare insured has group insurance through a spouse (which is primary), and the spouse switches to COBRA insurance, does this change which payer primary?

Yes, switching to COBRA coverage may change whether Medicare is primary or secondary. Medicare is secondary when the insurance coverage is based on "current employment," and with COBRA, the person is no longer employed. COBRA is only primary to Medicare in certain ESRD situations.

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To the extent COBRA coverage overlaps the 30-month ESRD MSP coordination period, Medicare is secondary payer for benefits that a GHP:

- Is required to keep in effect under the COBRA continuation requirements where Medicare entitlement occurs first; or
- Is required to keep in effect under the COBRA continuation requirements even after the individual becomes entitled to Medicare based on ESRD (i.e., the bankruptcy situation as described in subsection A above); or
- Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD even though not obligated to do so under the COBRA provisions.

Reference: CMS Medicare Secondary Payer Manual (Pub. 100-05), chapter 2, section 30 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf)

When a patient presents another insurance card along with their Medicare card, how do you know if Medicare is primary or secondary?

The CMS Medicare Secondary Payer Manual contains an MSP Questionnaire that can help determine the patient's insurance status. This can be modified to meet your office's needs.

Reference: CMS Medicare Secondary Payer Manual, (Pub. 100-05), chapter 3, section 20.2.1 (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf)

If a patient has Anthem insurance primary, Medicare secondary and Medicaid tertiary, will MSP cross the claims over to Medicaid?

Yes, those claims will automatically cross over to Medicaid.

When submitting an MSP claim, where should I put the MSP type?

For electronic claims, put the MSP type in Loop 2320, Segment SBR 5. The CGS MSP Job Aid (http://www.cgsmedicare.com/pdf/MSP_JobAid.pdf) can also help with questions like this.

How do we file an MSP claim if we file a code that is not a Medicare approved code, such as a "G" code? Do we change the code to the Medicare approved code?

Yes, you would change the code on the Medicare billing to the Medicare approved code, as long as that code accurately reflects the service you provided.

If Medicare is secondary, and we have to split part of claim (for instance, to indicate professional and technical components separately), we bill the primary insurance for a global X-ray charge. When we send the claim to Medicare and we split the service into the technical and professional component, then total charges from the explanation of benefits will not match. Can you elaborate on how this should be done?

You would treat this situation as a "lump sum primary payment." First, split the patient's charges into the professional component (PC) and technical component (TC) (you will decide how much to charge for each component). Then, calculate the percentage of the total billed charges for each component (for example, the PC is 40% of the total and the TC is 60% of the total billed charge). You will then split the primary payment to match these percentages on your Medicare claim. In this example, you'll split the primary payment into 40% (apply that to the professional component as the "primary paid" amount) and 60% (apply this to the technical component).

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