# MEDICARE SECONDARY PAYER BASICS

## Webinar Questions | Wednesday, February 21, 2018

**Question:** Where do I go to print out the latest Medicare Secondary Payer Questionnaire?

**Answer:** Admissions Questions to Ask Medicare Beneficiaries ** Providers may use the one in the manual as a guide to help identify other payers primary to Medicare and is a model of the type of questions that may be asked to help identify MSP situations. The one provided was developed to be used in sequence with instructions listed after the question to facilitate transition between questions.

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

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**Question:** How do we bill MSP claims when the beneficiary has more than one open liability on the CWF file? (Ex: Auto- No fault, & Liability)?

**Answer:** Bill with the liability record applicable to the claim. Ex: If there is an Auto-No Fault and a Liability, compare the diagnosis and insurer documentation to the matching record on the CWF. You will need to also make sure to compare the dates of service to the effective and term dates of the CWF record. This would also apply if there is an open liability and a GHP. If the claim is not related to the liability and the insurer payment is from a GHP, you would bill the claim using the GHP.

**Reference:** CMS Medicare Secondary Manual (Pub 100-05) chapter 2, section 40
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf

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**Question:** What is a Validity Code?

**Answer:** The Validity Code is used to indicate if a Common Working File (CWF) is confirmed, under investigation, or not confirmed: An abbreviated description is below:

Overview of CWF MSP Processing:

- I - MSP coverage under investigation,
- Y - Confirmed - beneficiary has MSP coverage,
- N - Confirmed - beneficiary does not have MSP coverage,
- D - Deleted record.

**Reference:** CMS Medicare Secondary Payer Manual (Pub 100-05) chapter 6, section 10.1
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c06.pdf

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**Question:** If we are unable to get information from the patient about an auto or premise, but then patient gets an attorney. Would it be appropriate to report to the BCRC the attorney's information?

**Answer:** Condition Code 08 is used when a beneficiary actively refuses to give other health information. Use this code along with remarks to indicate refusal to supply other insurance information. Submit the claim as Medicare primary.

 

Condition Code 08 alerts the Benefits Coordination & Recovery Center (BCRC) to develop for other insurance information (including contacting the beneficiary). CMS Medicare Secondary Payer Manual, chapter 5, section 30.3.1

**Reference:** CMS Medicare Secondary Payer Manual (Pub 100-05) chapter 5, section 30.3.1 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c05.pdf

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**Question:** If the patient answers YES to VA benefits and NO to did the VA authorize, does that mean we have to bill the VA or just Medicare?

**Answer:** When a VA-eligible beneficiary chooses to receive services in a Medicare Certified Facility for which the VA has not authorized, the facility shall use Condition Code 26 to indicate the patient is a VA eligible patient and chooses to receive services in a Medicare Certified provider instead of a VA facility and value code 42 with the amount of the VA payment for the authorized days. The VA would need to be billed to determine the amount reported with value code 42.

**Reference:** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9818.pdf

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**Question:** Our Nursing Facility bills for Outpatient Therapy Services, should we have an MSPQ filled out before treatment?

**Answer:** Yes. As a Part A institutional provider rendering recurring outpatient services, the MSP questionnaire should be completed prior to the initial visit and verified every 90 days.

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

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**Question:** Patient had Kidney Transplant and Medicare coverage became effective 3 days after the transplant. Who is primary, the commercial coverage or Medicare?

**Answer:** The commercial insurance is primary.

**Reference:** CMS Medicare Secondary Payer Manual (Pub 100-05) chapter 2, section 20 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c02.pdf

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**Question:** Does a claim need to be submitted if primary has paid at 100% and no co insurance or deductible?

**Answer:** For inpatient claims, submit a no payment bill for determining the benefit period. A claim is not required for outpatient services.

**Reference:** CMS Medicare Secondary Payer Manual (Pub 100-05) chapter 3, section 40.1 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf

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**Question:** Exactly what codes are needed on a conditional auto accident claim that was billed at least 120 days ago and remains unpaid?

**Answer:** Please reference Medicare Secondary Payer FAQ #8 on the CGS Part A Website. Go to FAQ's on the left bar and click on it. FAQs will be in alphabetical order. When you click on the question and press 'Enter' the answer will be displayed.

**Reference:** https://www.cgsmedicare.com/parta/faqs/msp_faqs.html#

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**Question:** If a claim is billed to Medicare with a 07 condition code indicating the claim is not Hospice related and Medicare processes the claim leaving the deductible amount, who is responsible for paying the deductible?

**Answer:** The patient is responsible for a deductible amount for inpatient and outpatient services.

**Reference:** CMS Medicare General Information, Eligibility, and Entitlement Manual (Pub 100-01), chapter 3 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ge101c03.pdf

 

**Question:** Why is the BCRC able to open a file with no information at all/example no name of insurance, etc.? Just that it is a liability file?

**Answer:** This is part of their process to initiate an investigation when they are contacted and provided with information to indicate the patient has other insurance.

**Reference:** https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html

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**Question:** Is there a date that can be added to the CWF/HIQA to show when the Eligibility screen was last updated?

**Answer:** Medicare Administrative Contractors are unable to make changes to the eligibility screens because the responsibility is assigned to the Common Working File (CWF) maintainer.

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**Question:** I would like to know where it states that we are required to accept Medicare allowed amount only for 'no fault' insurance claims. I only find detailed requirements on this for liability claims.

**Answer:** If the provider later receives payment from no-fault insurance, it refunds the Medicare payment by submitting an adjustment bill.

**Reference:** CMS Medicare Secondary Payer Manual (Pub 100-05) chapter 3, section 30.2.1.1 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c03.pdf

 