ORGANIZATION POLICY

POLICY TITLE: PROPER IDENTIFICATION OF PRIMARY PAYORS TO ENSURE COMPLIANCE WITH MEDICARE SECONDARY PAYOR RULES

POLICY NUMBER: 1228

POLICY:

It is the policy of Onslow Memorial Hospital 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 Hospital 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, other 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 Hospital in complying with the Medicare Secondary Payor rules is in collecting complete and accurate information about a patient's insurance coverage. Insurance data collection is most often the responsibility of Patient Access personnel. Because Patient Access personnel must collect a substantial amount of information from patients, the admissions 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. 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 Hospital for no less than 10 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 Hospital bill in its entirety, registration personnel must still obtain information regarding the patient Medicare benefits (e.g., HICN, effective dates, etc.) and enter it into the automated billing system.
7. Where applicable, registration personnel must appropriately sequence Medicare as the secondary, tertiary or quaternary payer in the automated billing system.
8. The Hospital must collect MSP information from a beneficiary or his/her representative for hospital lab services. 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 non-patient lab services. The Hospital 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 Hospital 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 Hospital.

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.

Additionally, there are select outpatient services that are subject to a daily billing cycle that would qualify under Medicare's definition of recurring services with respect to the collection of MSP data.

Wound Care and Anticoagulation services are two areas where similar services are provided two or more times weekly and would therefore, meet the criteria outlined by Medicare as to what constitutes recurring services under MSP guidelines. However, while these services can be considered recurring in nature based on similarity and frequency of visits, they do not meet Medicare's criteria for monthly billing. In these areas, the MSP information could be collected on the initial visit and verified once every 30 days to ensure the correct sequencing of payors and timely identification of changes in insurance coverage.

10. The situations under which another third party payer might be primary over Medicare include the following:

- Patient has Employer Group Health Plan (EGHP) coverage through either his/her current employment or through the current employment of a spouse;
- 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;
- Patient has been diagnosed with End Stage Renal Disease (ESRD) and has EGHP coverage through either his/her current or former employment or that of a spouse;
- Patient is injured and another party is responsible - e.g., workers comp, automobile accident, no fault, etc;
- Patient is a veteran of the armed services and the Veterans Administration has agreed to pay benefits as primary payer; or

- Another government program is responsible for payment - e.g. Black Lung, National Institute of Health, etc.

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