

MSP: Complying With the MSP Questionnaire/Screening Process

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Today's Presenter

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Objectives

- To assist providers of Medicare services with understanding the need to complete screening with the Medicare beneficiary (or their representatives) to ensure proper billing

Agenda

- Provider responsibilities regarding completing the questionnaire/screening
- Provider responsibilities regarding verification of information at the Common Working File (CWF)
- Determining primary payer
- HETS
- Exceptions to completing the MSP questionnaire/screening

Provider Responsibilities Regarding Completing the Questionnaire/Screening



Provider Agreement

- Medicare provider agreement states (42 CFR Section 486.20(f, g))
 - The provider agrees to the following:
 - Maintain a system that during the admission process identifies any primary payers other than Medicare...
 - To bill other primary payers before Medicare
 - Submit MSP claims when required

Providers are Required ...

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.

- 3 Exceptions
 - Reference Labs
 - Medicare Advantage Members
 - Provider Based and Non-Provider Based Services (Ambulance)

Who Collects MSP Information?

- MSP information is typically collected by admissions/registration staff
- This staff must know
 - When and how often to collect MSP information
 - How to collect the MSP information
 - What information to collect
 - Criteria for each MSP Provision
 - Relevance of each MSP question
 - How to assist beneficiary in understanding MSP questions
 - How to determine who is proper primary payer

MSP Questionnaire/Screening

- MSP model questionnaire found in CMS IOM Publication 100-05 – *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
 - Guide to help identify other payers primary to Medicare
 - Guide to identify MSP situations
 - Instructions after questions to facilitate transition between questions

CMS' Model MSP Questionnaire

- Contains questions that may help identify payers primary to Medicare
- Has three parts; each with questions to ask in sequence
 - **Part I** – Information about Black Lung, WC, No-Fault (automobile and other types) and Liability
 - **Part II** – Information about Medicare entitlement and employer GHPs
 - **Part III** – Information about patient if ESRD Medicare entitlement applies (dual entitlement: Age and ESRD or Disability and ESRD)
- Refer to CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2.1
 - Updated by [CR11945](#)

Collect Additional Information for Billing Purposes

- Collect additional information if applicable:
 - From Veterans with VA coverage who want to use VA coverage instead of Medicare
 - From beneficiaries receiving services covered by Government Research Grant
 - Retirement dates of beneficiary and/or spouse
 - If person is retired, he/she does not have current employment status for purposes of Working Aged or Disabled MSP provisions
 - CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 1, Section 50
 - If beneficiary/spouse cannot call his/her retirement date, follow CMS' policy for reporting retirement dates on claims

When to Collect MSP Information

- You may collect MSP information
 - Prior to service
 - At time of service
 - During service
 - At conclusion of service
- You must collect MSP information before submitting claim to Medicare
 - Unless service or situation is exception

MSP Questionnaire vs Screening

- Hospitals required to complete MSP questionnaire for each inpatient admission and outpatient encounter with a Medicare beneficiary
 - May use CMS' model questionnaire or own version, as long as compliant with model questionnaire
- Other provider types to complete questionnaire or screening process as often as necessary to ensure correct billing

Recommendation: Develop Internal Procedures for Screening Process

- Although we cannot require providers to develop internal written procedures for conducting your MSP screening process, we recommend you do so in order to provide consistency amongst those who conduct your MSP screening process

Beneficiary Unable to Respond or Refuses to Respond to MSP Questions

- When providers can't complete MSP questionnaire/form
 - Beneficiary was **unable** to respond, perhaps due to health condition
 - Beneficiary **refuses** to respond
 - Stated will not provide responses/information to you **or**
 - Has not responded to your attempts to reach him/her
- Providers may develop procedures for staff to follow
 - Include details as to when, how often and how you will contact beneficiary for information (telephone calls, mail, certified mail, etc.)
 - Document all efforts made

Beneficiary Unable to Respond

- In your procedures, include steps to
 - Ask beneficiary again at later time
 - Ask beneficiary's authorized representative or family member (someone who is also completing other required paperwork)
- If all of your actions are unsuccessful
 - Use any MSP information in Medicare's records for beneficiary
 - If there is MSP record in CWF, submit claim to that plan
 - If there is no MSP record in CWF, submit claim to Medicare as primary
 - Do not bill Medicare as primary in known MSP situations such as accidents for which there is primary payer
 - Adjust claim to MSP if you later identify and bill primary payer

Provider Responsibilities Regarding Verification of Information at the Common Working File (CWF)

Check for MSP Information in Medicare's Records

- Providers can check for MSP information by
 - Viewing online MSP records in CWF via FISS DDE
 - Beneficiary/CWF selection (MAP1759) OR **CWF Part A selection** (HIQA/HIQH)
 - Refer to our *FISS DDE Provider Online Manual*
 - Using CMS' HETS
 - 270 Inquiry/271 Response
 - Using IVR system
 - Using NGSConnex
- Part of your Medicare eligibility verification process

Updates to the MSP Questionnaire

- [MLN Matters®10863](#) MM10863: Updating Language to Clarify for Providers Chapter 3, Section 20 and Chapter 5, Section 70 of the Medicare Secondary Payer Manual
- [MLN Matters®11945](#) MM11945: Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries REVISED

Validate MSP Record Information With Beneficiary or Representative

- Per CR10863
 - If there is no MSP record in CWF or HETS 271 response
 - Ask beneficiary or representative questions about other insurance unless service is exception
 - If there is an MSP record in CWF or HETS 271 response
 - Ask beneficiary or representative if there are **any changes/updates?**
 - If no, you do not need to ask questions about other insurance; use this information for billing and notate why you did not ask
 - » If you are uncertain about this response, ask questions about other insurance
 - » If you need information unrelated to MSP record, ask questions about other insurance
 - If yes, ask questions about other insurance and contact BCRC as necessary
 - Exception for provider-based services

CR11945

- Modifies and streamlines the model admission questions for provider to ask Medicare beneficiaries (or representatives) upon admission or start of care
- While some questions are not on the revised model questionnaire, CMS still expects providers to collect that information and report it when submitting a claim
 - Retirement dates

MSP Record at the Common Working File (CWF)

- In addition to completing the MSP questionnaire/screening, providers also need to check for any open MSP record for the beneficiary at the CWF
- At the provider's discretion, data may be viewed during either admission or billing process. However, data must be viewed **before a claim is submitted to Medicare**, and ideally should be viewed before patient leaves the hospital.
- CMS IOM Publication 100-05, *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2

CWF Record

- Record found that identifies the same information provided by the beneficiary regarding other primary payer
- If no record found, may need to contact Benefits Coordination & Recovery Center (BCRC) to create new record
- If record found, but information is different than what beneficiary provided, record may need to be corrected by the BCRC

Determining Primary Payer

CMS' Documentation Requirements to Support MSP Screening Process

- Retain following items to demonstrate development for primary payers occurred:
 - Completed MSP questions
 - Beneficiary is not required to sign completed questionnaire
 - Hospitals must be able to provide notation explaining why MSP questionnaire is not completed if requested during MSP Hospital Review
 - CWF print out or copy of 271 response including all notations
- Maintain MSP information for ten years from DOS
- Retain responses to questions on paper, optical image, microfilm or microfiche

Tip: Review Completed MSP Questionnaire/Form Prior to Billing

- Your billing staff must
 - Have access to your completed MSP questionnaires/forms since these have information regarding payers that may be primary to Medicare
 - Be able to view any notation indicating MSP questionnaire/form was not completed and why
 - **Example:** Beneficiary or representative stated MSP record in CWF did not need updates or changes

Determine Proper Order of Payers

- Determine which plan is primary, secondary, tertiary, etc. payer
 - Use collected MSP information and your knowledge of MSP provisions
 - In general, Medicare is primary when beneficiary
 - Has no other insurance or coverage
 - Has insurance or coverage but it does not meet MSP provision criteria requirements
 - Had insurance or coverage, it met MSP provision criteria requirements but it is no longer available
 - In general, other payer(s) is primary when beneficiary
 - Has insurance or coverage that meets MSP provision criteria requirements and it is available

Submit Claims According to Determination You Make

- Submit claims to Medicare accordingly
 - If Medicare is primary
 - Submit Medicare primary claim
 - If another payer is primary
 - Submit claim to that other payer first and Medicare secondary if required
 - May need to submit conditional claim to Medicare if primary payer does not pay for a valid reason or does not pay promptly (within 120 days; accidents only)
 - If there is more than one primary payer
 - Submit claims to those payers and to Medicare third (tertiary), etc.

Did You Know

- During your MSP screening process with the beneficiary, you may learn of information that could change a beneficiary's existing MSP record in CWF or that would require the set up of a new MSP record in CWF. If so, you may need to contact the BCRC.
 - Refer to MSP Resources – 2021 handout

HIPAA Electronic Transaction System (HETS)

Get Connected to HETS

- Complete the Trading Partner Agreement (TPA) form
- Use CMS' R2018Q400 Companion Guide to complete application
- Submit questions or concerns to www.mcare@cms.hhs.gov
 - Include all requested information
 - Form is typed, not hand written (except signatures)
 - Include all pages of application
 - Save as a single file
 - Encrypted

Getting Connected to HETS

- Once TPA Form Approved
 - Receive submitter ID
 - Submitter ID required on all 270/271 transactions
 - Test
 - After successful testing may submit real-time production inquiries

CMS Resources for HETS

- Rules of Behavior

- <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/EligibilityTransactionSystemInquiriesRulesofBehavior.pdf>

- Best Practices for Managing HETS Connections

- <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/BestPracticesforManagingHETSConnections.pdf>

- CMS HETS 270/271 Companion Guide

- <https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/Downloads/R2018Q400HETS270271CompanionGuide.pdf>

Utilizing HETS

Purpose: HETS allows users to submit HIPAA compliant 270 eligibility request files over a secure connection and receive 271 response files. Submitters must develop or acquire a tool to construct and send 270 eligibility request files and receive and deconstruct 271 eligibility response files in a real-time environment. HETS 270/271 application supports real-time transactions only. The HETS 270/271 application does not accept batch transactions.

CMS – About HETS 270/271

<https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/About-HETS.html>



CMS Update to Questionnaire/Screening

- CR 10863
 - If provider has ability to submit and receive a 270/271 transaction, may submit a 270 inquiry **at the start of care/upon admission**
 - Once 271 response is received, ask beneficiary if any insurance information on the 271 response has changed
 - If response is no updates or changes, no need to complete MSP questionnaire/screening
 - Must notate on 271 response that questions not asked because nothing has changed or needs updating/creating a record
 - If response is yes or there is uncertainty regarding information based on conversation, must complete MSP questionnaire/screening

What This Means for Providers

- If using HETS
 - Admission staff must have access to HETS
 - Must be used at the time of admission/registration or during telephone interview/screening
 - When submitting 270 Inquiry, include beneficiary entitlement date
 - Understand if any updates/changes, need to complete questionnaire/screening with beneficiary

Important to Note

- Provider notates on 271 response all questions were not asked based on beneficiary's statement insurance has not changed or does not require updating
- If the provider lacks access to CWF or it does not utilize the 270/271 transaction the provider shall follow the procedures found under §20.2.1. This means the provider shall ask the beneficiary the necessary MSP questions to determine the correct primary payer.
- CMS IOM Pub 100-05 – *Medicare Secondary Payer Manual*, Chapter 3, Section 20.2

What this means for Providers

- Previously stated, if provider is completing a questionnaire/screening with beneficiary:
 - At the provider's discretion, data may be viewed during either admission or billing process. However, data must be viewed **before a claim is submitted to Medicare**, and ideally should be viewed before patient leaves the hospital.
- This comment does not apply if utilizing HETS instead of completing questionnaire/screening
 - HETS must be used during admission

Exceptions to Completing the MSP Questionnaire/Screening

Reference Lab Services

- Description:
 - 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.
- CMS will not require independent reference laboratories to collect MSP information in order to bill Medicare for reference laboratory services as described above.

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.

Provider Based Services

- Provider based services, such as transfer ambulance services, do not need to repeat MSP questions/screening if they are affiliated with a hospital, if beneficiary was seen by hospital admissions staff and MSP screening was completed
- Independent providers (not affiliated with hospital) are still responsible for completing MSP questionnaire/screening with beneficiary
- Effective 11/20/18

Not Quite an Exception.....

- Policy for recurring outpatient services
 - Complete questionnaire/screening at start of care
 - If beneficiary is receiving recurring services
 - Identical services and treatments on an outpatient basis more than once within a billing cycle
 - Update every 90 days

Thank You!

- Follow-up email
 - Attendees will be provided a Medicare University Course Code
- Questions?

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