CMS Manual System

Pub 100-05 Medicare Secondary Payer

Transmittal 38

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: OCTOBER 14, 2005

Change Request 4056

SUBJECT: Hospital Audit Workload Updates

I. SUMMARY OF CHANGES: Updating the hospital audit sections in chapter 5 of the Medicare Secondary Payer Internet Only Manual to clarify the workload expectations for a contractor having multiple states for which they have claims processing responsibility. Also, in preparation of the implementation of Medicare Contracting Reform, replacing references to fiscal intermediary with contractor.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 14, 2006

IMPLEMENTATION DATE: January 14, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	**Chapter / Section / SubSection / Title**
R	5/70/Hospital Review Protocol for Medicare Secondary Payer
R	5/70/70.1/Reviewing Hospital Files
R	5/70/70.1/70.1.1/Frequency of Reviews and Hospital Selection Criteria
R	5/70/70.1/70.1.2/Methodology for Review of Admission and Bill Processing Procedures
R	5/70/70.2/Selection of Bill Sample

R	5/70/70.3/Methodology for Review of Hospital Billing Data
R	5/70/70.3/70.3.1/Review of Form CMS-1450
R	5/70/70.3/70.3.2/Use of Systems Files for Review
R	5/70/70.4/Assessment of Hospital Review
R	5/70/70.5/Exhibits
R	5/70/70.5/70.5.1/Exhibit 1: Assessment of Medicare Secondary Payer Hospital Review
R	5/70/70.5/70.5.2/Exhibit 2: Survey of Bills Reviewed
R	5/70/70.5/70.5.3/Exhibit 3: Entrance Interview Checklist
R	5/70/70.5/70.5.4/Exhibit 4: Entrance Interview Checklist: Billing Procedures

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-05	Transmittal: 38	Date: October 14, 2005	Change Request 4056

SUBJECT: Hospital Audit Workload Updates

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is updating the hospital audit sections in chapter 5 of the Medicare Secondary Payer Internet Only Manual to clarify the workload expectations for a contractor having multiple states for which they have claims processing responsibility. Also, in preparation of the implementation of Medicare Contracting Reform, CMS is replacing references to fiscal intermediary with contractor.

B. Policy: MMA Section 911 addresses Medicare Contractor Reform. As part of the issuance of the Request for Information, questions arose regarding workload expectations specific to contractors having responsibility for multiple states. This instruction seeks to address these issues.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4056.1	Contractors shall conduct reviews on 10% of the hospitals (or a maximum of 20, whichever is the lesser of the two) in each state for which it has Medicare claims processing responsibility.	X								
4056.2	Multiple contractors having a presence in one state shall communicate with each other to ensure that duplicate reviews do not occur and that, as a combined total, the multiple contractors do not review more hospital providers than would have been reviewed if only one contractor processed claims for all hospital providers in that state.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4056.3	The contractor shall select the sample of claims from two months of the hospital's processed claims history.	X								
4056.4	The contractor shall provide the listing of claims selected for review within 15 days of the date of initial notice.	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4056.5	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire instruction must be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic.	X								

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations: None

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 14, 2006 **Implementation Date:** January 14, 2006 **Pre-Implementation Contact(s):** Suzanne Ripley **Post-Implementation Contact(s):** Suzanne Ripley	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.**

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Medicare Secondary Payer (MSP) Manual
Chapter 5 - Contractor Prepayment Processing Requirements

70 - Hospital Review Protocol for Medicare Secondary Payer

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Federal law mandates that Medicare is the secondary payer for:

- Claims involving Medicare beneficiaries age 65 or older who are insured by GHP coverage based upon their own current employment with an employer that has 20 or more employees, or that of their spouse's of any age, or the beneficiary is covered by a multiple employer, or multi-employer, group health plan by virtue of their, or a spouse's, current employment status and the GHP covers at least one employer with 20 or more employees;
- Claims involving beneficiaries eligible for or entitled to Medicare on the basis of ESRD (during a period of 30 months) except where an aged or disabled beneficiary had GHP or LGHP coverage that was already secondary to Medicare at the time ESRD occurred;
- Claims involving liability or no-fault insurance;
- Claims involving government programs, e.g., WC, services approved and paid for by the Department of Veterans Affairs (DVA), or BL benefits; and
- Claims involving Medicare beneficiaries under age 65 who are entitled to Medicare on the basis of disability and are covered by an LGHP (plans of employers, or employee organizations, with at least one participating employer that employs 100 or more employees) based upon their own current employment status or the current employment status of a family member.

The following sections provide a methodology for reviewing hospitals' MSP policies and practices to ensure that hospital procedures comply with the law. The *contractor* shall review hospital admission and bill processing procedures.

70.1 - Reviewing Hospital Files

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

In order to conduct an effective review, the *contractor shall obtain* complete files from the hospital on all beneficiaries represented in the bills selected for review. (See §70.2 concerning sample selections.) For the purposes of this review, a complete file must contain:

- A copy of the completed UB-92 (Form CMS-1450) or its facsimile;
- A copy of the admission questionnaire (the beneficiary's signature on the questionnaire is not required; see §70.3.B). If the hospital uses an online query process, no hardcopy form need appear in the file. Screen prints may be used instead (see §70.1.2.B); and
- Beneficiary's MSN form for all secondary claims.

70.1.1 - Frequency of Reviews and Hospital Selection Criteria

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Each year the *contractor* shall conduct a review of 10 percent of the hospitals *(or a maximum of 20, whichever is the lesser of the two) in each state* for which it has Medicare claims processing responsibility. Hospitals to consider for review include those which:

- Fail to develop MSP claims properly;
- Fail to submit "no payment" bills; and
- Do not submit auto accident cases (even if they have shock trauma units specializing in emergency admissions).

The *contractor* shall refrain from repeatedly selecting the same hospital for review each year. A hospital reviewed within the last 12 months is not to be reviewed the following year if there are hospitals that were not reviewed during the preceding 12 months, unless serious deficiencies are identified. The objective of hospital reviews is to review all hospitals in the contractor's geographic area. The review period generally lasts a maximum of two days.

Multiple contractors having a presence in one state shall communicate with each other to ensure that duplicate reviews do not occur and that, as a combined total, the multiple contractors do not review more hospital providers than would have been reviewed if only one contractor processed claims for all hospital providers in that state.

70.1.2 - Methodology for Review of Admission and Bill Processing Procedures

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

A - Entrance Interview

The *contractor* shall conduct an entrance interview with the admissions staff (including inpatient, outpatient, and emergency) to determine whether the hospital established:

1. Policies identifying other payers *primary to Medicare*; and
2. A system in which such policies are carried out in practice.

Contractors shall use the checklist found in §70.5.3, Exhibit 3 to conduct the entrance interview. During the interview, *the contractor* shall request a descriptive walk-through of the admissions process. It is not necessary to observe an actual admission of a beneficiary.

B - Review of Hospital Admission Questionnaire

The *contractor* shall review copies of the hospital's inpatient, outpatient, and emergency room (ER) hospital admission questionnaires. If the hospital uses an online admission query process, *the contractor* shall review the system screen prints. If the hospital has both hard copy questionnaires and online questionnaire responses, the reviewer may exercise discretion in deciding whether to review hard copy questionnaires or online responses (or both, if desired). The reviewer shall compare the hospital's admissions questionnaire to the model found in the Medicare *Secondary Payer Manual*, Chapter *3*, § *20.2.1*) to ensure that *the appropriate questions are being asked to identify other payers that may be primary to Medicare.*

Analysis of the admission questionnaire for purposes of insuring that it matches the information billed should be undertaken during the review of billing procedures. (See §70.3.B for instructions.)

70.2 - Selection of Bill Sample

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

The sample period shall be determined by selecting the sample from *two* month*s* of the hospital's *processed claims history*. The *reviewer (i.e., contractor)* shall notify the hospital in advance of the month's claims to be reviewed. For example, *notice would be given on 11/30/xx that a random sample would be selected from the provider's October and November processed claims history*. The reviewer is not required to perform the review during the same month as the month of bills selected. The reviewer shall make an effort to conduct the review within three months after the sample period.

The reviewer shall provide the listing of claims selected for the review within 15 days of the date of initial notice. The provider should compile the data requested and return it to the reviewer within 30 days. (For example, notice is given 11/30/xx. The sample selection is completed by 12/15/xx. Data is given back to the reviewer by 01/15/xx. The reviewer should be able to schedule an onsite review by 02/01/xx.)

The bill universe shall consist of Medicare inpatient, outpatient, and subunit claims for which a primary or secondary Medicare payment was made. The reviewer shall select the sample using the following criteria:

- At least 2/3 of the sample should consist of inpatient bills. The remaining 1/3 is to be outpatient bills. The split is to be determined at the reviewer's discretion;
- The sample must contain a minimum of 20 bills and a maximum of 60 bills;
- The reviewer shall include Medicare no-pay bills in the sample in order to examine the ratio of no-pay bills submitted by the hospital to those actually billed;
- The sample is to include a mixture of bill types from the hospital's bill universe. Accordingly, if the hospital does not submit ESRD bills, then the reviewer is not required to review that particular bill type; and
- Both Medicare primary and secondary bills are to be included in the sample.
- Claims for reference laboratory services shall <u>not</u> be included in the sample of claims that are audited during MSP hospital reviews. *Reference laboratory services, as defined in section 943 of The Medicare Prescription Drug, Improvement & Modernization Act of 2003, "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."* This is effective for reference laboratory service claims with dates of service of December 8, 2003 and later.

70.3 - Methodology for Review of Hospital Billing Data

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

A - Entrance Interview

The reviewer shall conduct an entrance interview with the billing staff to determine whether the hospital established:

1. Policies concerning billing other payers *primary to Medicare*; and
2. A system in which such policies are carried out in practice.

Both these areas are to be examined in one interview. The reviewer shall use the checklist found in §70.5.4, Exhibit 4 to conduct the entrance interview. During the interview, the reviewer shall request a walk-through of the billing process.

B - Comparing Completed Admission Questionnaire With Bills

The reviewer shall request completed inpatient, outpatient, and ER admission questionnaires (or screen prints for hospitals using online admission query systems) for each Medicare beneficiary included in the bill sample. (See §70.2 concerning selection of sample.) It is not necessary that the beneficiary sign the completed questionnaire.

The form may be kept as paper, optical image, microfilm, or microfiche. If the hospital uses online admission screens, it is not necessary to obtain a copy of an admission form or screen print as long as the hospital has documented procedures for collecting and reporting other primary payer information. The reviewer may request screen prints, if necessary. Hospitals with online query systems are encouraged to retain affirmative and negative responses to the questionnaire for 10 years after the date of service. Should a hospital choose not to retain this information for up to 10 years, it does so at its own risk.

The reviewer shall analyze the admission questionnaire, or online admission query procedures, for Medicare beneficiaries to determine whether the information provided on the questionnaire matches the bill. The reviewer shall check to see whether each response to the questionnaire is reflected on the bill. For example, the reviewer shall check to ensure that the primary payer reflected on the questionnaire is shown as primary on the bill, name and address of insurer(s) on questionnaire matches that on the bill, etc. Reviewers should check this admissions information at the same time the bill review is conducted.

70.3.1 - Review of Form CMS-1450

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

The reviewer shall obtain all Form CMS-1450s, also known as the UB-92, for each case included in the sample. The reviewer shall separate the bills according to bill type. The reviewer shall determine the amount billed to Medicare for each case. The reviewer shall review Form CMS-1450 for the following MSP data to determine if the billed amount is accurate and to conduct the comparison process using the admissions questionnaire described at §70.5.3, Exhibit 3. Item numbers reflect Form CMS-1450 field locators.

70.3.2 - Use of Systems Files for Review

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

The reviewer shall use *the processing contractors'* paid history files, MSP control files, and any other relevant data to assist in evaluating hospital procedures used in processing claims included in the sample. The purpose of a review is to determine whether the hospital has filed any improper claims. This can be accomplished by reviewing certain files before the on-site review, and other files after the review, subject to the reviewer judgment concerning the most effective use of a particular file.

The following areas should be reviewed against the *contractors'* internal files:

- Claims denied to determine whether a hospital is using information from an admission questionnaire properly;
- Claims paid to determine if proper amounts are being billed;
- No-pay bills. The reviewer shall check the *contractor claims* files to determine if the hospital is submitting no-pay bills;

- Adjustments to determine whether an automatic adjustment was needed. The reviewer may exercise discretion in determining what documentation is needed to justify the adjustment made; and
- IRS/SSA/CMS data match denials to determine whether a claim reflects changes in the beneficiary's current employment status.

In cases where the reviewer ascertains that an improper claim has been filed, the reviewer shall document these instances on the assessment form. (See §70.5.1, Exhibit 1.)

70.4 - Assessment of Hospital Review

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

The reviewer shall complete the assessment form (§70.5.1, Exhibit 1) for each hospital reviewed. The reviewer shall include selection criteria for the hospital, findings, and suggested recommendations, if appropriate. The reviewer shall include any discrepancies between the hospital's MSP policies and practices, as well as any hospital innovations that have been/are being devised to determine *primary plan* resources. The reviewer shall note any discrepancies between the hospital's MSP policies and those required by law. The reviewer shall complete the Survey of Bills Reviewed, provided as an attachment to the assessment form. (See §70.5, Exhibit 2.) The reviewer shall indicate whether any follow-up action is needed in the appropriate column. If no follow-up action is needed, the reviewer shall enter "none." If action is needed, the reviewer shall briefly describe action required and time frame within which follow-up will commence. It is not necessary to estimate when action will be completed. The *contractor* shall send a copy of the assessment form, with its attachment, to the MSP Coordinator in the RO within 30 days of the date the review is completed.

The contractor shall send the hospital a copy of the assessment form as well. It shall follow-up every 30 days until appropriate corrective action is taken. It shall report continued problems after three months to the RO MSP Coordinator.

70.5 – Exhibits

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Exhibit 1 - Assessment of Medicare Secondary Payer Hospital Review
Exhibit 2 - Survey of Bills Reviewed
Exhibit 3 - Entrance Interview Checklist: Admissions Questionnaire and Procedures
Exhibit 4 - Entrance Interview Checklist: Billing Procedures

70.5.1 - Exhibit 1: Assessment of Medicare Secondary Payer Hospital Review

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Contractor Name and No.: _____

ASSESSMENT OF MEDICARE SECONDARY PAYER HOSPITAL REVIEW

1 Name of hospital reviewed

2 Number of cases reviewed

3 Period of review (month/year)

4 Selection criteria used to determine why hospital selected for review. (See §70.1.1)

5 Describe findings in accordance with review protocol standards found at §70.3 and §70.4.

6 Recommendations

cc: CMS Regional Office, MSP Coordinator

Hospital Reviewed

Attachment: Survey of bills reviewed.

70.5.2 - Exhibit 2: Survey of Bills Reviewed

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Name of Beneficiary	HICN	Bill Type	Follow-Up Action Needed (Action Date)

70.5.3 - Exhibit 3: Entrance Interview Checklist

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

Admissions Questionnaire and Procedures

A - Admissions Procedures

1 When is other payer information solicited? (During billing or during admission?)

2 Describe the process followed to solicit MSP information.

3 Do admissions staff receive training on soliciting MSP information? If so, describe the training. Do you think the staff understands the admissions questions well enough to solicit information and/or explain to beneficiaries?

4 Is MSP information obtained primarily from the patient, Medicare Common Working File, or in some other way?

B - Questionnaire

1 Are the admissions questionnaire data solicited through an online query (i.e. are the admissions questions asked and responses retained online)?

2 Do you re-administer the questionnaire each time the patient is admitted? (It should be administered once per admission.)

3 Do you require the beneficiary's signature on the questionnaire? (No signature is required, and the hospital should be informed, if necessary.)

4 Are there written hospital policies, instructions or procedures concerning soliciting *primary plan* information? (Request copies for review.)

5 How long are admission questionnaires retained, either online, in files, or both? (Requirements are found at §70.3.)

70.5.4 - Exhibit 4: Entrance Interview Checklist: Billing Procedures

(Rev. 38, Issued: 10-14-05: Effective/Implementation Dates: 01-14-06)

1 Does the hospital bill for all bill types?

2 Are all claims electronically billed?

3 Is the information pertaining to a payer primary to Medicare contained on the admission questionnaire, or in an online database, available in its entirety to the billing department? (The billing department must be made aware of a payer primary to Medicare, e.g., working aged, ESRD, liability insurance.)

4 Do circumstances arise where the billing department obtains information directly from the patient? How is it obtained? Is the regular admissions form used to obtain the information in these situations?

5 Where there is the possibility of payment by a Federal government grant program, how does the hospital bill Medicare? (Determine whether the hospital bills both the grant program and Medicare, or only Medicare.)

6 How does the hospital bill the Department of Labor where the services are covered by the Federal Black Lung (BL) program? (The hospital should bill the black lung program first.)

7 Does the hospital have the ability to track workers' compensation (WC) cases on succeeding visits to the hospital or the outpatient department? Describe the tracking mechanism. How does the hospital bill for the succeeding visits? (Many times individuals may have to return to the hospital for additional medical services as a result of a WC occurrence.)

8 Does the hospital bill more than one primary insurer simultaneously? (Providers are prohibited from billing more than one insurer for primary payment. Reviewer should request a credit balance report for this aspect of the review.)

9 Where the patient is in the ESRD coordination period and an employer has paid in part, or should pay for the services, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?

10 What is the hospital's policy on submission of no-pay bills?

11 Where a GHP or LGHP is the primary payer because the beneficiary is either working aged or disabled, or is involved in a no-fault or liability case, does the hospital show the name, group number of the insurer, proper value code, and proper amount on the bill?