 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTH SYSTEM	The Johns Hopkins Health System Policy & Procedure	<i>Policy Number</i>	FIN091
	<i>Subject</i>	<i>Effective Date</i>	01-10-08
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POLICY

This policy applies to the Johns Hopkins Health System (JHHS) and the following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center, Inc. (JHBMC), Johns Hopkins Community Physicians (JHCP), Johns Hopkins Home Health Care Group (JHHCG), and Howard County General Hospital (HCGH).

It is the policy of JHHS 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. JHHS will take all reasonable efforts 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.

Once the patient has been identified as having one or more third party payers as primary to his or her Medicare benefits, it is the policy of JHHS to obtain information relative to these other payers, enter it into the Hospital automated billing system and bill such payers as primary to Medicare. All Admitting Offices, Registration, and Patient Financial Services personnel must receive at least one hour of training on MSP requirements annually.

Purpose

With the exception of those patients having dual eligibility for Medicaid and Medicare insurance, Medicare generally pays benefits as secondary (i.e., residual) payer to all other health care benefits to which the patient may be entitled. The purpose of this policy is to assist the JHHS entities named above in their efforts to comply with Medicare regulations by; (1) accurately identifying those situations where other third party payers are primary to Medicare benefits and, (2) billing for services provided to Medicare beneficiaries under such situations as specified by Chapter 3 MSP IOM (Internet Only Manual).

Scope

This policy applies to all settings of care provided by JHHS – (i.e., inpatient, outpatient, emergency, and homecare.) In addition, the MSP development questions need only be asked to beneficiaries entitled to traditional (i.e., fee for service) Medicare Part A and/or Part B coverage. For beneficiaries who have opted for Medicare + Choice coverage (aka Medicare Part C), the appropriate managed care organization should be billed as the primary payer.


REFERENCE

JHHS Finance Policies and Procedures:

- Policy No. FIN044 - Inpatient Admissions and Financial Responsibility
- Policy No. FIN045 - Verification of Insurance Benefits
- Policy No. FIN064 - Third Party Billing Practices

JHHS Patient Financial Services Policies and Procedures:

- Policy No. BIL003 – Medicare Billing Specifics

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PROCEDURE


I. Admission Registration Process

The establishment of third party payers as primary to Medicare will generally take place during the patient admission registration process. Intake/Registration personnel are responsible for obtaining information from patients, family members and other available sources in order to determine whether or not other third party payers might be primary to Medicare. With the exception of reference lab and recurring outpatients, as defined below, all scheduled and non-emergent patients or their responsible family members must be asked the MSP development questions either prior to or during the admission (inpatient) or registration (outpatient) process. Patients presenting in the Emergency Department can be asked the MSP development questions, but only if they are physically able to and only if asking these questions would not represent a delay in providing a medical screening examination or stabilization services. Otherwise, the MSP development questions will be asked after the screening examination or after the patient has been stabilized as applicable.

1. Intake Registration personnel will identify whether or not the patient is entitled to Medicare benefits referring to Medicare guidelines for patients that have other government benefits to ensure correct registration data.
2. Intake Registration personnel will determine if Medicare is secondary to other third party payers by asking either the patients themselves or their responsible family members the MSP development questions as contained in either the automated billing systems or on hard-copy forms.
3. Intake Registration personnel or the provider of care at JHHCG will enter the responses to each of the MSP questions into the automated billing system.
4. An affirmative answer to certain MSP questions requires obtaining a date (e.g., accident date). In such cases, registration personnel will obtain the date from the patient or responsible family member and enter this date into the appropriate field in the automated billing system or on the appropriate form.
5. If the answer to any of the MSP questions indicates that another payer 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.

Hospital Reference Labs

Hospitals must collect MSP information from a beneficiary or his/her representative for hospital reference 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 reference lab services. Hospitals must be able to demonstrate that they collected MSP information from the

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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 hardcopy.

Recurring Outpatient Services

Hospitals 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 hospitals.


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.

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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;

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- 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.

EGHP Coverage

If the patient has coverage through an Employer Group Health Plan (EGHP) as a result of his or her own current employment or through the current employment of a spouse, and the employer providing such an EGHP employs 20 or more employees, Medicare is secondary and the patient account is noted accordingly.

The registrar must obtain the information needed to bill the EGHP as primary and record this information in the automated billing system. This information includes employer name and address, insurance company name and address, policy number and group number.

LGHP Coverage

If the patient is entitled to Medicare benefits on the basis of disability, Medicare benefits are secondary for those individuals who are disabled and have coverage through a Large Group Health Plan (LGHP) based on either his or her own current employment or the current employment of a family member. (Note: in addition to a spouse a family member can include a parent or guardian). To be considered a LGHP, the employer must have employed an average of 100 or more employees during the preceding calendar year.

The registrar must obtain the information needed to bill the LGHP as the primary payer and record this information in the automated billing system.


ESRD

If the patient is entitled to Medicare benefits solely on the basis of having End Stage Renal Disease (ESRD), Medicare benefits are secondary for a limited period of time for those individuals who have coverage under an EGHP, regardless of the number of employees and regardless of the patient's or spouse's employment status. Medicare is secondary to an EGHP for a period of 30-months, which usually begins on the date on which the patient began chronic dialysis treatment.

Patients who have been diagnosed with ESRD sometimes receive kidney transplants. If such patients receive a kidney transplant during the 30-month coordination period, Medicare continues to be secondary to the EGHP until the end of the 30-month period. The 30-month coordination period remains in effect even for those patients who become eligible for Medicare benefits based on either age (i.e., age 65 or over) or disability during the coordination period. For those patients who have received a kidney transplant, the registrar must obtain and record the date of transplant.

Accidents and Injuries

Where the patient is receiving services because of either an accident or an injury where it is

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reasonable to expect that another party may be financially responsible for payment, Medicare is secondary. This would include work related accidents where a workers compensation carrier would be primary, non-work related accidents where a liability company would be primary and automobile accidents where either the patient or another party medical benefit under their automobile insurance policy would be primary.

The registrar should obtain and record the date of the accident or injury in the automated billing system.

Veterans Administration

Medicare beneficiaries who are veterans can request the Veterans Administration to authorize payment for health care services from other than VA hospitals. In cases where the VA has issued such authorization and agrees to pay for these services, Medicare is secondary.

In the event that the registrar does not have an authorization letter on file from the VA, the registrar should obtain a copy of the letter from the patient.

Black Lung and Other Governmental Payers

If the Medicare beneficiary is receiving services related to black lung then the federal Black Lung program may be primary over Medicare. If the patient services are related to respiratory illness (see Section 289.20 of the Department of Labor list of approved black lung procedures), then the patient bill should be sent to:


Federal Black Lung Program
 P.O. Box 740
 Lanham, MD 20706

In other situations, either the patient circumstances or the nature of the health care services themselves place other governmental payers as primary over Medicare. As noted earlier, in some cases Medicare should not be billed at all because the services being provided are categorically non-covered. Registration and Patient Financial Services personnel should exercise judgement in distinguishing those cases where Medicare should be billed as secondary from those cases where Medicare should not be billed at all.

II. Billing Process (JHH/JHBMC/HCGH)

A. Pre-Billing

- As part of the insurance verification process, the Admissions/Registration staff will review with the patient or the patient's designee, either in person or by phone, the MSP questions and document via the on-line MSP questionnaire the responses obtained in the registration host systems. The MSP questions are required data elements and must be completed prior to exiting the insurance verification screens of any account that lists Medicare insurance as the primary, secondary, or tertiary insurance. In addition, the MSP questionnaires are set up to send a warning or error message to the admissions/registration staff when the answer to one or more questions indicates that another third party payer should be primary.
- The billing files are verified using the Caremedic Medicare Eligibility module and this system

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will check for Medicare managed care participation, large group employer primary plans, and any other liability coverage listed within the Medicare system that indicates Medicare does not have primary liability for service. The Caremedic system assigns an "EL" status to the claim and generates an individual eligibility error report with the conflicting insurance data for each account that contains an eligibility error. The error reports will be researched by the designated PFS account representative in order to determine the appropriate filing order of the claim. Such research can include querying the Medicare Common Working File, reviewing prior accounts for the same patient and contacting the patient or responsible family member for additional information.

B. Billing

1. If the account representative determines that Medicare is indeed the primary payer, the financial class is changed to the appropriate code and billed accordingly. The account comments are annotated.
2. If the account representative determines that Medicare should be secondary to another payer, the account representative must change the claim filing sequence on the account, change the financial class to the appropriate code and annotate the account comments.
3. Automobile medical insurance or no fault insurance claims are to be reviewed by the designated Patient Services coordinator prior to submission to Medicare following these guidelines and completing the appropriate UB92 fields:
 - a. Any claims received by the billing staff that contains accident or trauma diagnosis codes should be reviewed for accuracy of the primary payer assignment.
 - b. When a payment or denial notice is received, submit a claim to Medicare with all the
 - c. applicable codes (condition codes, occurrence codes and value codes) and remarks (UB92 field locator 84).
4. In addition to the aforementioned editing, before claims are submitted to Medicare they are processed through an automated editor which identifies any claims that are missing required data elements (e.g. an occurrence code indicating an accident without an accident date). Claims failing this editing process are researched, corrected in the automated billing system and reprocessed through the editing cycle before being billed.

C. Post-Billing (JHH/JHBMC/HCGH)

1. When the primary payer denies or delay payment, the Hospital will bill Medicare for conditional payment for the following reasons:
 - a. Services are covered by the liability insurer, and;
 - b. Claim has been properly filed and reasonable attempts have been made to obtain payment from the third party, but the claim has been outstanding for more than 120 days, or;
 - c. Hospital was unable to file a claim with the primary insurer in time due to physical or

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mental incapacity of the beneficiary.

2. When a Medicare beneficiary has primary coverage with a managed care provider, the account representative/managers inserts the appropriate value codes in UB92 field locators 39 through 41 and reports condition codes in UB92 field locators 24 through 30 prior to submitting a secondary claim to Medicare. If the managed care organization makes a reduced payment because the provider is not in the network or the service is otherwise not covered, submit the claim to Medicare and report the amounts along with the appropriate value codes in UB92 field locators 39 through field locator 41.
3. The account representatives/managers are to utilize the HIQA (Health Insurance Query Part A) eligibility information screens, related account reviews, MSP questionnaire responses, and the billing guidelines contained in the Medicare Hospital Manual for correct identification of primary payers and submission of claims.

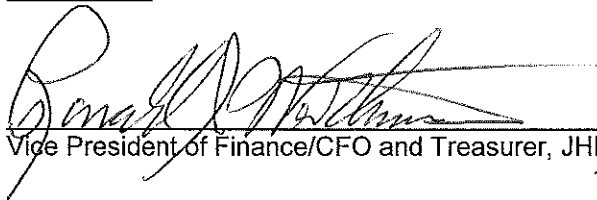
SPONSOR

Deputy Chief Compliance Officer (JHHS)
 Senior Director, Patient Finance (JHH, JHHS, JHBMC, HCGH)

REVIEW CYCLE

Three (3) years

APPROVAL


 Vice President of Finance/CFO and Treasurer, JHHS

7-9-09
 Date