

**Mutual of Omaha – Medicare
Ask the Contractor Teleconference (ACT) - MINUTES
“Medicare Secondary Payer”
September 26, 2007
Chairperson: Aileen Sigler**

The Southeast Region ACT, “Medicare Secondary Payer” teleconference was called to order by Aileen Sigler, Medicare Field Representative – Omaha Office, at 1:00 PM Central Time.

Aileen began the teleconference by introducing herself. Other Field Representatives and members of the Home Office staff joined her. The introductions were followed by a discussion of several topics of interest to the providers. These topics were included:

- A description of the purpose and frequency of the Ask the Contractor Teleconferences (ACTs).
- A brief overview of the MSP laws
- How and when to contact the Coordination of Benefits Contractor
- The different types of insurance and when Medicare will be secondary
- The MSP Questionnaire
- Questions and Answers

The introductory discussion was followed by a review of the presentation and handouts that had been e-mailed to the registered teleconference participants prior to the call.

At the conclusion of the presentation, the line was opened up for questions from the audience.

OPEN QUESTION AND ANSWER SESSION:

Q1. On the MSP questionnaire, there is a question concerning whether or not the patient has been in another facility in the last 60 days. Our patient’s are referred from other facilities and we’ve been using those dates, but it seems like there’s not enough space to input the information. Why are they asking for this information?

A1. Tracking where the patient has been in the last 60 days assists with benefit period calculation. The format of the questionnaire and the questions asked do not have to be used verbatim. If you need more room to capture the information, you can change it.

Q2. We have claims that have been returned to us with a reason code, asking us to verify the amount of the primary payment. I called customer service and was told that my value code 44 was incorrect. I then was sent to the MSP department, where they overrode it. Am I going to have to call every time a claim hits this edit?

A2. Without seeing the individual claim, and how it was billed, I am not sure if the edit was valid for your claim or not. Please contact me the next time it happens and I will watch the claim through the system.

Q3. My question is in regards to the condition code 26 on VA claims. From an audit perspective, how does Mutual verify that we received authorization from the VA?

A3. By placing the 26 on the claim, you are attesting that you have the documentation necessary and if you were called upon to present that documentation, you could do so.

Q4. How do the upcoming RAC audits in California impact MSP-related claims?

A4. There is currently a workgroup that is working with the RAC to gather information to provide to our California providers. Please watch our web-site for educational activities regarding this.

Q5. When a Medicare beneficiary, who is a cancer patient, passes out in his son's driveway as he is getting out of his car, would that be a no-fault or liability situation?

A5. Neither. He is simply suffering from a medical condition. It is not automotive or liability related. Medicare is primary in this situation.

Q6. How can we bill for homeless patients that get assaulted? Most of the time we are unable to get any information about what happened, or who is responsible. Do we have to wait the 120 days?

A6. No, you can use a 05 occurrence code if there is no other insurance involved.

Q7. I do IME billing for Medicare Advantage patients. If there is liability insurance involved, I bill their HMO, but my IME claims will get rejected. Do I have to get the other insurance information so my claims don't reject?

A7. Please send an example of this instance so we can look at it in the system.

Q8. If a claim is billed with a 05 occurrence, will that cause a liability or no-fault screen to open on Common Working File? We have seen open screens with no insurance information.

A8. No, it will not. If you are seeing open screens with no information, they were probably opened in error. In those cases, you would call the lead contractor and have them get it closed.

Q9. In the past, we could bill the claim with the 08 condition code if the beneficiary refused to give the other insurance information. This caused the claim to reject, but now I understand that we are not to do that anymore. Can you please clarify?

A9. The 08 condition code can be used if the patient refuses to divulge the insurance information. It will also make the beneficiary liable for the charges on the claim.

When there were no more questions, the call was ended at approximately 1:50 PM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations shall be the final authority.

There were 142 participants on 50 lines for the teleconference.