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Fundamentals of Medicare

Building Your Knowledge Base
5/21/2024

Closed Captioning: *Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms*

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objective

Provide an understanding of the fundamentals of the Original Medicare Program

Today's Presenters

Provider Outreach & Education

- Michael Dorris
- Jean Roberts, RN, BSN, CPC

Agenda

- Medicare Basics
- Medicare Eligibility
- Medicare Part A Overview
- Medicare-Approved FQHCs and Rural Health Clinics Overview
- Home Health & Hospice Benefit Overview
- Medicare Part B Overview
- Beneficiary Screening
- Provider Self-Service Tools
- Additional Resources
- Questions and Answers

Medicare Basics

What is the Medicare Program?

- Federally-administered health insurance program which covers people over 65 years of age and certain younger people with disabilities or ESRD
  - Medicare benefits offer coverage for
    - Part A - Hospital Insurance
      - Inpatient – examples: hospital, SNF, HH+H
    - Part B – Supplementary Medical Insurance (SMI)
      - Examples: Outpatient (Part B of A), Physician (Part B)
    - Part C - MAO/HMO
      - Example: Medicare Advantage
    - Part D - Prescription drugs

Did You Know

- 2024 marked the 59th anniversary of Medicare and Medicaid
  - 7/30/1965 - Legislation signed into law establishing Medicare and Medicaid programs
- Former President and Mrs. Harry Truman were honored with the first two Medicare cards

Administration

United States Department of Health and Human Services oversees two major agencies

- CMS
- Public Health Services

CMS administers

- Hospital insurance (Medicare Part A)
- Voluntary
- SMI (Medicare Part B)
- Other parts of the Medicare program

Centers for Medicare & Medicaid Services

- Central office located in Baltimore, MD
  - Ten regional offices
- Oversees Medicare, Medicaid and SCHIP
  - Establishes policies for paying health care providers
    - Responsible for writing Medicare rules and regulations
  - Assesses quality of health care facilities and services
  - Assures Medicare is run properly by contractors
    - Coverage regulations: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*
    - Billing regulations: CMS IOM Publication 100-04, *Medicare Claims Processing Manual*

CMS Strategic Plan

Medicare Contractors

Private insurance companies

Under contract with federal government

Medicare Administrative Contractor process

Both Part A and Part B claims
Federally Qualified Health Center
Home health and hospice
Durable Medical Equipment

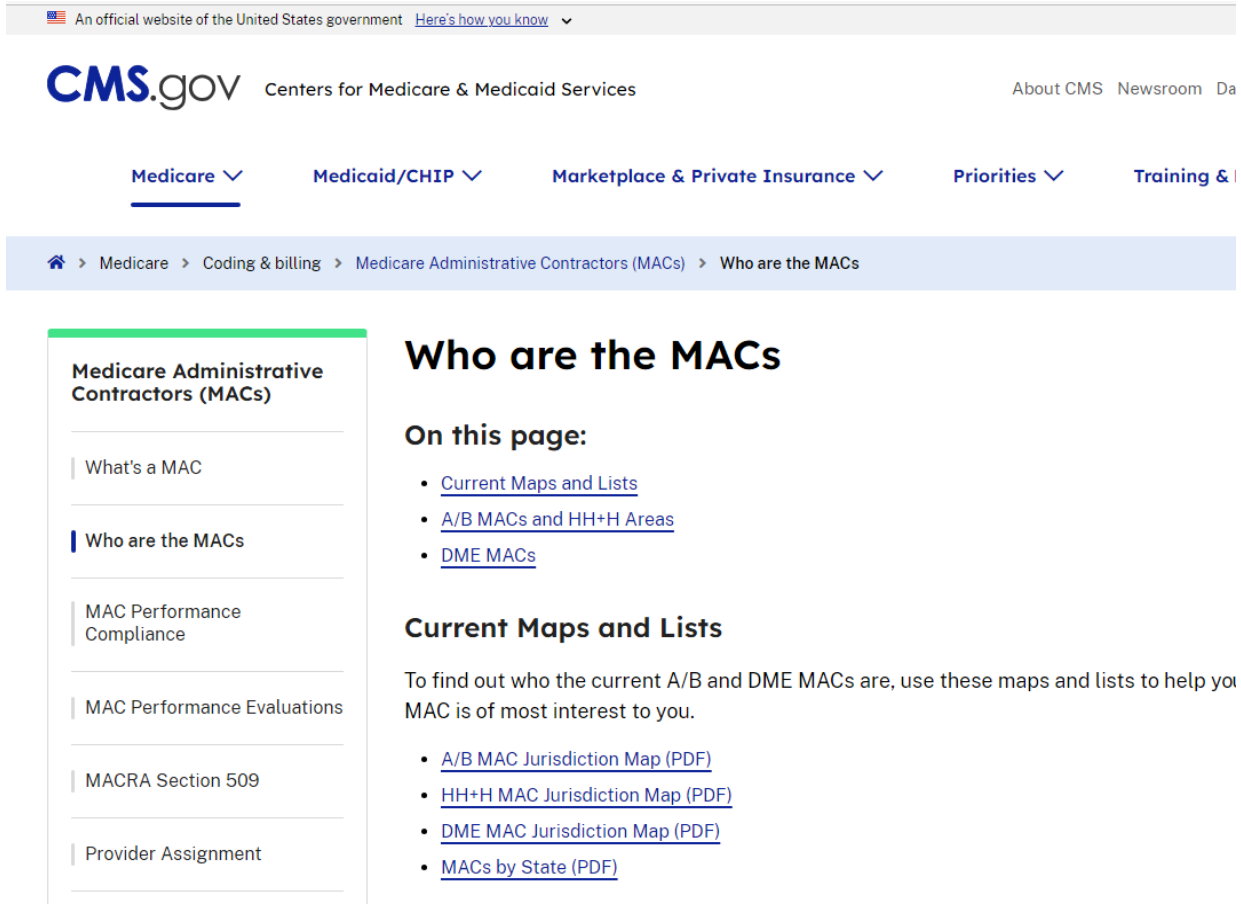
Contractors bound by service area

Additional contractors include CERT, RA (RAC), SMRC, COB&R plus more

What's a MAC and more

- What's a MAC | CMS

- List of MACs by state: Who are the MACs | CMS



Comprehensive Error Rate Testing

- CERT contractor
  - Randomly selects sample of paid claims
  - Requests medical records from billing and ordering provider by letter, phone and fax
  - Reviews claims along with medical records to see if documentation supports all services billed
  - Determines if claim or service processed correctly and in compliance with all Medicare policies, procedures and guidelines
  - Additional Information about the CERT program

Recovery Audit Contractor (RAC or RA)

- RAs contract with CMS to identify Medicare improper payments
- RA program mission
  - Reduce improper payments through efficient detection and collection of overpayments
  - Identify underpayments so actions may be taken to prevent future improper payments
- RAs review claims on post payment basis using same Medicare policies as MAC
  - LCDs, NCDs, CMS manuals
- Recovery Audit Program Information

Supplemental Medical Review Contractor

- SMRC national contractor contracts with CMS to:
  - Assist in lowering improper payment rates
  - Increase efficiencies of medical review functions
- Primary task
  - Conduct medical review
    - Evaluate medical records and related documents
    - Determine whether Medicare claims are compliant with coverage, coding, payment, and billing practices
- National contractor: Noridian Healthcare Solutions SMRC

Provider Enrollment

- No provider shall receive payment for services furnished to a Medicare beneficiary unless the provider is enrolled in the Medicare program
  - Essential: Each provider must enroll with the appropriate Medicare fee-for-service contractor
  - Part A providers use form CMS-855A
  - For additional information: CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 10
  - MLN® Educational Tool: Medicare Provider Enrollment Educational Tool

Participating Providers

- Providers who receive Medicare reimbursement must comply with rules including
  - Not charging individuals for covered items and/or services
  - Returning any money incorrectly collected
  - Not discrimination when providing services
    - Medicare beneficiaries versus non-Medicare patients

Termination of Provider Participation

- Voluntary (provider-requested) termination
  - File written notice to CMS stating intention to terminate, and
  - Inform CMS official date termination takes effect

Termination of Provider Participation [2]

- Involuntary termination
  - Medicare regulations state CMS may terminate provider Medicare agreement under certain circumstances such as:
    - Noncompliance with Medicare guidelines and/or regulations
    - No longer meets appropriate requirements for participation
    - Fails to supply cost report information
    - Refuses to participate in audits of financial and/or medical records

How is Medicare Funded?

- Medicare Part A
  - Usually premium-free when based on age
    - Funded through payroll tax deductions
    - All people in Medicare-covered employment
- Medicare Part B
  - Funded through monthly premiums
    - Elective enrollment

Medicare Fraud and Abuse

- What is Medicare fraud?
  - Fraud is the intentional deception of misrepresentation that an individual:
    - Knows to be false or does not believe to be true; and
    - Knows the deception could result in some unauthorized benefit to himself/herself or some other person.
- What is Medicare abuse?
  - Abuse involves incidents or unintentionally practices that are:
    - Not medically necessary as defined by Medicare guidelines; or
    - Inconsistent with accept sound medical, business, or fiscal practices
- How Do I Report Suspected Fraud or Abuse?

Medicare Eligibility

Medicare Eligibility

- Persons aged 65 and older
  - Worked 40 quarters (ten years)
  - Medicare-covered employment
- Disabled individuals
  - Under age 65, coverage begins receiving disability benefits for 24 months (entitlement to Social Security, SSA, benefits)
  - Individuals with ALS (Amyotrophic lateral sclerosis/Lou Gehrig's disease)
    - 24-month waiting period is waived
- ESRD
  - Maintenance dialysis; kidney transplant

Medicare Eligibility Based on Age

- Automatic enrollment (Part A and Part B)
  - Aged 65 and receiving SSA benefits or disabled individual receiving SSA benefits for 24 months
  - Must speak with SSA to disenroll/decline Part B coverage
- Coverage starts on first day of the month person turns age 65
- Coverage ends
  - Following voluntary termination
  - Last day of third month of nonpayment of premiums
  - DOD

Medicare Eligibility Based on Disability

- Disabled individuals receiving SSA benefits for 24 months
- Usually premium free
- Beneficiaries automatically given Part A and Part B
  - Indicate on card included in enrollment package if Part B coverage is declined
- Coverage ends
  - Month after notification of disability termination
  - DOD

Medicare Eligibility Based on ESRD

- Coverage begins
  - Maintenance dialysis – after three month waiting period
  - Kidney transplant – month beneficiary admitted as inpatient in preparation for transplant
- Coverage ends
  - Last day of 12th month after dialysis discontinued
    - Unless transplant received or restart dialysis
  - Last day of 36th month after transplant
  - DOD

Manual Enrollment

- Patient who does not meet automatic enrollment requirements, but is
  - Age 65
  - Enrolled or will enroll in Part B
  - U.S. citizen or legal alien residing in U.S. five years prior to enrollment
- Monthly premium applies
- Contact local SSA office
  - Initial/general enrollment period
    - Initial: Three months before through four months after 65th birthday
    - General: January 1–March 31 each year (plus 10% penalty)

Manual Enrollment [2]

- Initial enrollment period
  - Three months before through four months after 65th birthday
- General enrollment period
  - If past initial enrollment period, enrollees must wait until next general enrollment (plus 10% penalty)
  - January 1–March 31 each year; effective July 1
- Special enrollment period
  - Patient did not enroll within enrollment period due to GHP/LGP coverage
  - Eight-month period following last month of GHP/LGHP coverage

Medicare Part A Premium

- Automatic enrollee – usually premium free
- Voluntary (manual) enrollee – pay premium if worked less than 40 quarters
  - Less than 30 quarters (7 ½ years) – Base premium
    - $505.00 per month for 2024
  - 30–39 quarters (7 ½ –10 years) – Base premium with 45% reduction
    - $278.00 per month for 2024

Medicare Part A Deductible

- Cost sharing refers to monetary amount that is patient's responsibility: Deductible and coinsurance
- Beneficiary is charged per benefit period
- 2024 Inpatient hospital cost sharing amounts

Part A	Cost Sharing
Part A inpatient hospital deductible	$1632.00/benefit period
Part A coinsurance (61st–90th day)	$408.00/day
Part A LTR (91st–150th day)	$816.00/day
Part A – After 150 inpatient days	All costs
SNF coinsurance (21st–100th day)	$204.00/day
SNF – after 100 inpatient days	All costs

Did You Know

- Coinsurance is one-fourth (1/4) of the Part A deductible amount
- LTR coinsurance is one-half (1/2) of the Part A deductible amount
- SNF coinsurance is one-eighth (1/8) of Part A deductible amount
  - Hint: Part A 2024 deductible is $1,632.00
- Resource: CMS IOM Publication 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3

Medicare Part B Premium and Deductible

- Medicare Part B – standard monthly premium
  - $174.00 per month for 2024
  - Late enrollment penalty – 10%
- Beneficiaries with higher incomes will pay a higher premium
  - Sliding scale
- 2024 annual deductible = $240.00

Part B Coinsurance

- Part B coinsurance
  - Calculation based on payment methodology
  - 20% of Medicare-approved amount
  - 20% of fee schedule amount
  - Based on APC for services paid under OPPS

Annual “Medicare Amounts” Job Aid

- Annual Medicare premium, deductible, coinsurance information in a downloadable format – many languages offered
- CMS MLN Matters® MM13365 *“Medicare Deductible, Coinsurance, & Premium Rates for Calendar Year (CY) 2024”*

Medicare Card

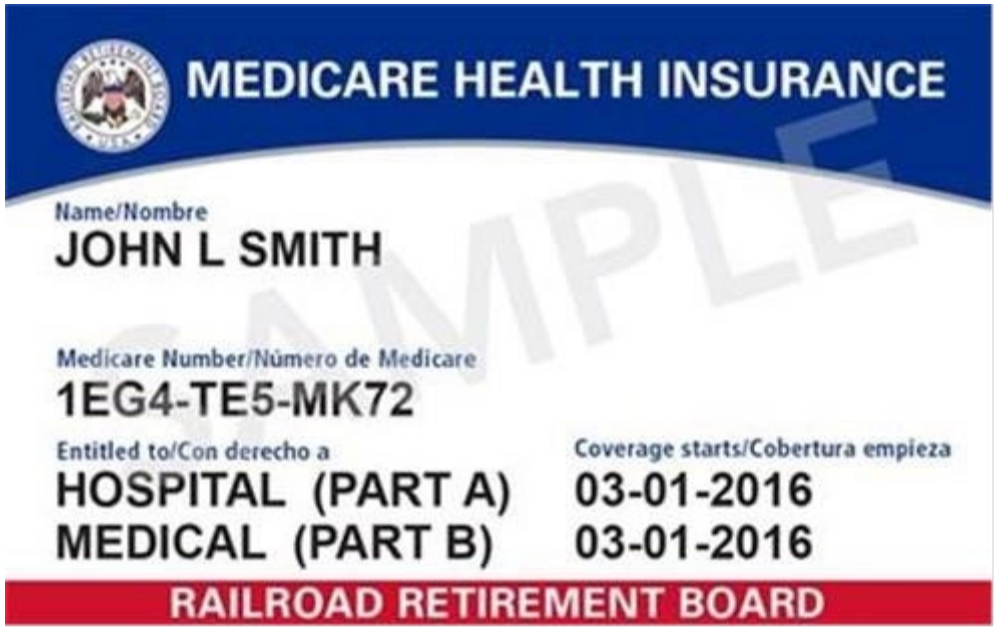
- Proof of Medicare enrollment
  - Full name, MBI, Gender
  - Effective date for Part A and Part B
- Card can be reissued, but not if
  - Part A or Part B terminated
  - Beneficiary enrolls in MA/HMO or elects hospice
    - MA/HMO plan enrollee is issued a different card
- Beneficiary can print card from his/her Medicare.gov account
  - Or call 1-800-MEDICARE (1-800-633-4227)/TTY 1-877-486-2048

Medicare Card

- Used for Medicare Parts A and B

Medicare Card

- Beneficiary with Railroad Medicare



Did You Know

- A provider may not collect any applicable deductible or co-insurance from a patient who has both Medicare and Medicaid
- Beneficiaries with both Medicare and Medicaid
  - Not responsible for any applied deductible or the co-insurance
  - Responsible for any co-pay determined by Medicaid
- MLN Matters® SE1128: *Prohibition Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program*

Social Security Administration

- Beneficiaries should contact SSA about
  - Medicare enrollment
  - Correct/update name, address, etc.
  - Premium billing and payment
  - General Medicare questions (not claim related)
  - Replacement Medicare cards and questions regarding enrollment
- 24-hour telephone number: 1-800-772-1213
  - Hearing Impaired TTY number: 1-800-325-0778
    - Monday through Friday from 7 a.m. to 7 p.m.
- Social Security website

Medicare Part A Overview

Medicare Part A

- Often referred to as “Hospital Insurance”
- Only covers overnight inpatient stays
- Five major benefits
  1. Inpatient hospital services
  2. Inpatient SNF care
  3. Skilled services by home health agency
  4. Hospice care
  5. Blood transfusions

Inpatient Hospital Services

- Inpatient admission may be covered when certain conditions are met
  - Care can only be provided in hospital
  - Doctor formally admits via order for inpatient admission
  - Expectation patient remains at least overnight
    - Even if discharged/transferred and does not use bed overnight
    - CMS two-midnight rule
      - CMS Fact Sheet: *Two-Midnight Rule*
      - CMS CR 10080: *Clarifying Medical Review of Hospital Claims for Part A Payment*

Inpatient Hospital Services

- Covered services – treat patient's illness/injury
  - Room and board
    - Semiprivate room
    - Private room under certain conditions
  - Ancillary services
    - Drugs/medications
    - Laboratory, x-ray and radiology services

Inpatient Days

- Limited number of days paid by Medicare
  - Certain days renewed when new benefit period starts
  - Certain days not renewed at all
  - Benefit days not transferable to family members
  - Unused days not carried over to new benefit period

Inpatient Benefit Days

- 90 renewable days available per benefit period
  - First 60 days = full days
    - Inpatient deductible applied
  - Next 30 days = coinsurance days
    - Patient's daily responsibility

Inpatient Psychiatric Hospital Days

- Up to 190 days in a free-standing IPF
  - Not a separate set of benefit days
  - 150 inpatient psychiatric hospital benefit days that can be used in any benefit period
  - Beneficiary will need to start a new benefit period in order to use the remaining 40 days
  - 190-day maximum benefit applies only to free-standing IPFs and not to IPFs within a hospital as a distinct part unit

Lifetime Reserve Days

- 60 nonrenewable days for extended hospital stays
  - For use after regular 90 days used in current benefit period
  - Not renewed when new benefit period starts
- Patient has daily responsibility amount for LTR days
- Patient can elect not to use LTR days
  - Provider must inform patient of this right
  - Patient responsible for cost of stay past regular benefit period days

Benefit Period

- Tracks beneficiary days used during inpatient stay
  - Limited number of days Medicare pays
    - 150 inpatient hospital days
      - 60 full days (renewable)
      - 30 coinsurance days (renewable)
      - 60 LTR days (not renewable)
    - 100 SNF days
      - 20 full days (renewable)
      - 80 coinsurance days (renewable)

Starting a Benefit Period

- Benefit period begins
  - Beneficiary admitted to qualified hospital or SNF as inpatient
    - After Medicare entitlement date
    - New benefit period does not start due to new illness or injury

Ending a Benefit Period

- Benefit period ends
  - 60 consecutive days from date of discharge
    - Does not end if admitted to any facility prior to 60th day
      - Continues to use any remaining days available
  - Inpatient not receiving skilled care for 60 days in a row
    - SNF only

Hospital and SNF Benefit Period

- Hospital and SNF days used separately
  - Linked to same benefit period
  - Not bound by calendar year
- Benefit days cannot be carried over from one benefit period to next
- Reminder: Medicare beneficiary monetary responsibility
  - Beneficiary charged per benefit period
    - Deductible and coinsurance

Two SNF Coverage Requirements

- Technical (must meet all)
  - Beneficiary enrolled Medicare Part A
  - Medicare certified SNF
  - SNF days available
  - Three-day qualifying inpatient hospital stay (observation days do not count)
  - 30-day transfer from qualifying hospital stay
- Medical (must meet one)
  - Daily skilled care for condition treated or arose during qualifying hospital stay or
  - Rehabilitation services ordered by physician

SNF Services

- Covered services – treat patient's illness or injury
  - Room and board
    - Semiprivate room
    - Private room under certain conditions
  - Therapies (PT, OT and SLP)
  - Skilled nursing services
  - Certain off-site services provided during stay
- Reminder: Medicare beneficiary monetary responsibility
  - Coinsurance charge per day

SNF Benefit Days

- Beneficiary receives up to 100 days per benefit period
  - 20 full days
  - 80 coinsurance days
- Benefits exhausted (100 days used)
  - No Medicare payment made under Part A after day 100
  - Some services covered under Part B
  - Benefits can be renewed
    - Facility-free for 60 consecutive days
    - Nonskilled level of care for 60 consecutive days

Inpatient Hospital Discharge Planning

- Hospitals must
  - Have discharge planning process for all patients
  - Include discharge planning evaluation in patient's medical records
    - Evaluation must include evaluation of likelihood of patient needing post-hospital services and availability of services
  - Discuss results of evaluation with patient or individual acting on his/her behalf

Noncovered Hospital Services

- Medicare does not cover items and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
  - SSA section 1862(a)(1) is basis for denying payment for types of care, or specific items, services or procedures that are not excluded by any other statutory clause and meet all technical requirements for coverage
- MLN® Booklet MLN906765: *Items & Services Not Covered Under Medicare*

Did You Know

- A beneficiary can have a benefit period in a SNF lasting several years
  - No 60-consecutive day break in skilled care or
  - Not facility-free for 60 consecutive days

Did You Know

- A Medicare provider of service can prevent claim rejections and claims RTP by having registration staff check beneficiary eligibility prior to claim submission

Medicare-Approved Federally Qualified Health Centers and Rural Health Clinics Overview

What are FQHCs and RHCs?

- FQHCs, established in 1990 and effective 1991
- RHCs, established in 1978 to address inadequate supply of physicians in underserved rural areas
- Facility engaged primarily in providing services typically furnished in outpatient clinic setting
  - Defined in section 1861(aa)(2) of Social Security Act

Medicare-Certified FQHCs

- There are three types of organizations eligible to enroll in Medicare
  - Health center program grantees
  - Health center program look-alikes
  - Outreach health programs/facilities

Medicare-Certified RHCs

- To be eligible, must meet both location requirements
  - Non-urbanized area, as determined by U.S. Census Bureau Area designated or certified within previous four years by Secretary, HHS, as one of four types of shortage areas accepted for RHC certification
- Mobile clinics
  - Must have fixed schedule specifying date and location for services
  - Each location must meet location requirements
- Existing RHCs
  - Not currently required to continue to meet location requirements
  - If plan to relocate or expand, contact CMS Regional Office for location requirements

FQHC Requirements

- Meet all requirements contained in section 330 of Public Health Services Act
- Meet other health and safety requirements
- Not be concurrently approved as an RHC
- HRSA-designated Medically-Underserved Area (MUA) or Medically-Underserved Population (MUP)
- Staffing

RHC Requirements

- Can be either independent or provider-based
- Cannot be rehabilitation agency, facility primarily for mental health treatment or concurrently approved as FQHC
- Must have arrangements with one or more hospitals to furnish medically necessary services not available in RHC
- Must employ an NP or PA
- Must have NP, PA, or CNM working at least 50 percent of time clinic open to provide patient care
  - Does not include travel time

FQHCs & RHCs Requirements

- Must have available drugs and biologicals necessary for treatment of emergencies
- Must directly furnish routine diagnostic and laboratory services
- Must furnish the following six laboratory tests onsite
  - Blood sugar
  - Examination of stool specimens for occult blood
  - Hemoglobin or hematocrit
  - Pregnancy tests
  - Primary culturing for transmittal to certified laboratory
  - Urine chemical examination by stick and/or tablet method
- FQHC: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 13, Section 50.2- FQHC services

FQHCs & RHCs Services

- Physician services
- Services and supplies furnished incident to physician's services
- NP, PA, CNM, CP or CSW services
  - Within scope of practice under state law
- Services and supplies furnished incident to NP, PA, CNM, or CP services
- Certain nursing visits to homebound individuals furnished by RN or LPN
- Certain preventive services
- Telehealth services through 2024

Home Health and Hospice Benefit Overview

Home Health Coverage Requirements

- Skilled medical care in beneficiary's home for treatment of illness or injury
  - Can be paid under Part A or Part B, coinsurance and deductible applied
- Requirements for coverage
  - Physician established plan of care (create/certify/recertify)
  - Need for intermittent skilled care (nursing care/PT/OT/SLP)
  - Beneficiary considered homebound
  - Care provided by Medicare-certified HHA

Services Covered by Home Health

- Part-time or intermittent skilled nursing care by licensed nurse
- Home health aide services (bathing, using toilet or dressing) on part-time or intermittent basis
  - Only if also receiving skilled care (nursing care or therapy)
- Certified as medically necessary: PT, SLP, and OT

Services Covered by Home Health

- Medical social services (counseling, finding community resources) to help patient with social/emotional concerns related to the illness
- Certain medical supplies (wound dressings)
- Certain medical equipment (wheelchair or walker)

Did You Know

- For more information on Medicare payment and coverage
  - MLN Educational Tool: *Medicare Payment Systems Home Health Prospective Payment System & Coverage*

Hospice Coverage Requirements

- Must be entitled to Medicare Part A
- Beneficiary's doctor certifies as terminally ill with prognosis of life expectancy six months or less if the illness runs its normal course
  - Initial certification must be done by the hospice medical director or the physician member of the hospice Interdisciplinary Group (IDG) and the patient's attending physician if they have one
  - Subsequent certifications must be done by the hospice medical director or the physician member of the hospice's IDG

Hospice Coverage Requirements

- Beneficiary must elect the benefit by signing a Medicare hospice election statement
  - Waives all rights to Medicare benefits for all services related to terminal illness
- All hospice-related care received from Medicare-certified hospice
  - Beneficiary can receive care under Medicare for services not related to the terminal illness

Services Covered by Hospice

- Nursing services
- Physicians' services
- Medical social services
- Counseling services
- Aide services
- Drugs related to terminal condition, including outpatient drugs for pain relief and symptom management
- Medical appliances and supplies
- OT, PT, SLP
- Short-term inpatient care, including respite care
- Resource: CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 9, Section 40.1

Did You Know

- For more information on Medicare payment and coverage
  - MLN Educational Tool: *Medicare Payment Systems Hospice Payment System & Coverage*

Medicare Part B Overview

Medicare Part B (Medical Insurance)

- Other medical care (outside of inpatient stay)
  - Outpatient facilities, outpatient clinic visits
  - Doctor's office visits
  - Emergency room services
  - Observation
  - Diagnostic and screening tests
  - Outpatient surgery
  - Preventive services

Medicare Part B of A Services

- Covered outpatient hospital services may include:
  - Emergency or observation services, which may include an overnight stay in the hospital or services in an outpatient clinic (including same-day surgery)
  - Laboratory tests billed by the hospital
  - Mental health care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it
  - X-rays and other radiology services billed by the hospital
  - Medical supplies, like splints and casts
  - Preventive and screening services
  - Certain drugs and biologicals as part of an outpatient service or procedure

Medicare Part B of A Services

- Outpatient facilities, outpatient clinic visits
  - Part B of A services are outpatient facilities services billed on a 1450 or electronic equivalent claim to Part A
  - Part B services are those by physicians and NPP and are billed on a 1500 or electronic equivalent to Part B

General Exclusions – Medicare Part B

- Exclusions include but are not limited to
  - Services not reasonable and necessary
  - Custodial care
  - Dental services
  - Routine foot care
  - Cosmetic surgery
  - Services paid for by another governmental entity
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 16

Protecting the Bottom Line: Initial Medicare Beneficiary Screening

Patient Registration

- Patient presents insurance information and/or cards
- Provider determines proper order of insurance
  - Must know COB/MSP concepts
- Provider verifies Medicare eligibility
  - Patient
  - CWF/FISS
  - HETS
  - NGS IVR
  - NGSConnex

Verify Medicare Beneficiary Eligibility

- Must verify eligibility frequently by checking for:
  - Type of Medicare coverage
    - Traditional versus Medicare Advantage
  - Any additional coverage
    - Primary or secondary to Medicare
  - Deductible
  - Therapy amount year-to-date
  - ESRD coverage
  - Current home health or hospice period
  - Current inpatient at another facility
  - Preventive services – next eligible date

Verify Benefit Period

- For inpatient admissions:
  - Was patient an inpatient in a hospital or SNF within past 60 days?
    - If yes,
      - Determine number of days used in current benefit period
      - Name/address of provider(s)
      - Calculate applicable deductible and coinsurance due (if any)
    - If no,
      - Apply deductible (hospital inpatient only)

Identify HMO Beneficiaries

- Identify HMO coverage, verify coverage start/end dates via system (FISS, CWF, IVR, NGSConnex)
- Type and code indicates where to send claim
  - Cost-based (Option code 1)
    - Send claim to Medicare contractor
  - Risk-based (Option code C)
    - Send claim to HMO
- Web address Medicare HMOs
    - MA Plan Directory

Identifying Home Health/Hospice Beneficiaries

- Identify Home Health benefit period/Hospice election period, and verify coverage start/end dates via system (FISS, CWF, IVR, NGSConnex)
  - Develop payment arrangement for HH Consolidated Billing
  - Identify services unrelated to hospice terminal illness
    - Condition Code 07

Identify Medicare Beneficiary with ESRD

- People with Medicare may have ESRD
  - Must check for ESRD due to ESRD CB requirements
    - ESRD CB requires that certain Part B items and services are always included in ESRD CB
      - Not separately payable when provided by providers, other than ESRD facility
  - Additional information and list of services subject to ESRD CB

Medigap Policies

- Health insurance sold by private insurance companies to fill “gaps” in Medicare FFS
  - Beneficiaries enrolled in FFS Medicare Part A and Part B
  - Coinsurance and deductibles
  - Some offer extra benefits not covered by Medicare
- Standardized plans allow beneficiaries to choose based on cost
  - Must clearly be identified as “Medicare Supplement Insurance”

Common Working File

- Maintains national beneficiary records
  - Entitlement, DOB, and DOD
  - Recent benefit periods (including any deductibles due)
  - MAO enrollment
  - Home health episode
  - Hospice enrollment
  - Preventive services
  - MSP information

What is MSP?

- Beneficiary has coverage primary to Medicare
  - Based on federal laws known as **MSP provisions**
    - Help determine proper order of payers
    - Make certain payers primary to Medicare
    - Each has **criteria/conditions** that must be met
      - If all **are met,** services are subject to that provision making that other insurer primary and **Medicare secondary**
      - If one or more **are not met**, services are not subject to that provision; **Medicare is primary** unless criteria/conditions of another are met
- CMS MLN Booklet, MLN 006903: *Medicare Secondary Payer*
- CMS MLN Fact Sheet, MLN7748519: *Medicare Secondary Payer: Don't Deny Services & Bill Correctly*

Providers' MSP-Related Responsibilities Per Medicare Provider Agreement

Determine if Medicare is primary payer for beneficiary's services

Identify payers primary to Medicare

Submit claims to primary payer(s) before Medicare

May be more than one payer primary to Medicare

Submit MSP claims to Medicare when required

Follow claim submission guidelines

How to Identify Payers Primary to Medicare

- Check for MSP information in Medicare's records
  - Providers must check for MSP records for beneficiary in CWF
    - For each service rendered
- Collect MSP information from beneficiary or representative (MSP screening process)
  - Providers may need to ask questions about other insurance
    - For every IP admission or OP encounter, with some exceptions
      - You may not need to ask questions at all
      - You may need to ask questions but not as often

Medicare Secondary Payer Screening Process

- If patient not in Medicare HMO, conduct MSP screening process
  - Registrar discusses questions with beneficiary
  - Keep copy of answers either hardcopy or electronically
- Provider must compare information gathered with Medicare system information prior to submitting claims
- MLN Matters® MM11945, effective 12/7/2020: *Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries*

If Medicare is primary

Submit Medicare primary claim

If another payer is primary

Submit claim to that 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 promptly (within 120 days; accidents only)

If more than one payer is primary

Submit claims to those payers and to Medicare third (tertiary)

Beneficiary Coordination & Recovery Contractor

- When the MSP record on CWF is incorrect and Medicare is the primary payer. In this situation.
  - Submit Medicare primary claim and report the reason Medicare is the primary payer.
- Medicare contacts the BCRC with the information from your claim so they can correct the applicable MSP record for the beneficiary on the CWF
  - The BCRC reviews/investigates the new information
  - If appropriate, BCRC corrects the applicable MSP record on CWF
- Note: If no claim coding is available for the reason Medicare is primary payer and why the MSP record for the beneficiary on the CWF needs correction, do not contact the BCRC
  - Providers may refer beneficiaries and other entities to the BCRC
- BCRC Contact: 1-855-798-2627 FAX: 405-869-3307 TTY/TDD: 1-855-797-2627

ABN

- ABN is issued when an item or service isn't reasonable and necessary under Medicare program standards, including care that's:
  - Not indicated for the diagnosis, treatment of illness, injury, or to improve the functioning of a malformed body member
  - Experimental and investigational or considered research only
  - More than the number of services allowed in a specific period for that diagnosis
- Advance Beneficiary Notice of Non-coverage (ABN), Form (CMS-R-131)

How to Request Electronic Funds Transfer and Electronic Remittance Advice?

- Set Up Electronic Funds Transfer (EFT)
  - EFT is a means of receiving Medicare payment electronically
  - Complete and return Electronic Funds Transfer (EFT) Authorization Agreement (CMS-588) form
- Electronic Remittance Advice (ERA)
  - ERA is a notice of payment that explains reimbursement decisions made on processed claims
- EDI Enrollment
  - EDI Guided Enrollment User Guide
- **Note:** EDI Enrollment process recently updated – review the entire *EDI E-Signature User Guide* before enrolling or revalidating enrollment

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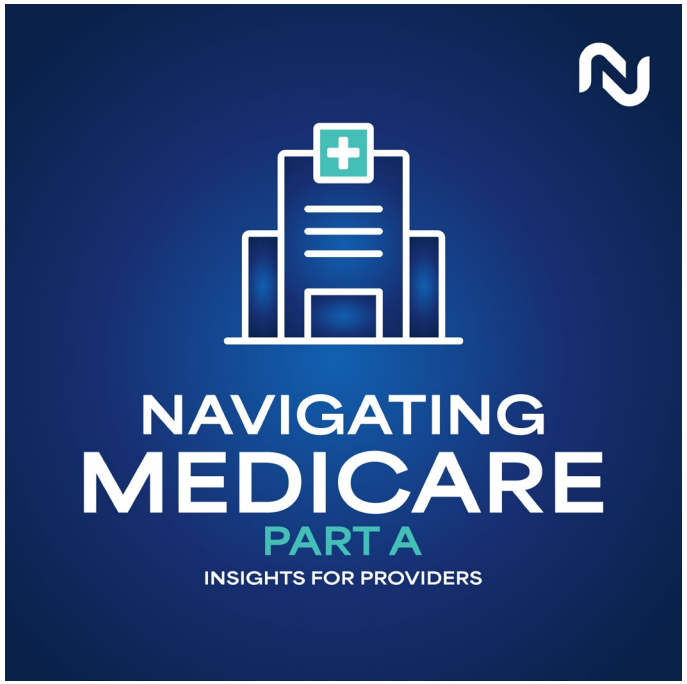
Navigating Medicare: Part A Insights for Providers



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Questions?

Thank you!