Medicare Guidelines for Patient Access

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Objectives

Increase knowledge and understanding of the Medicare CWF and MSP guidelines to positively affect hospital collections and work flow.

What are the ways that a person can qualify for Medicare benefits?

- 1.
- 2.
- 3.

Medicare Overview

A federal health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (ESRD): Permanent kidney failure requiring dialysis or a kidney transplant.

How many parts of Medicare are there and what are they?

Four Parts to Medicare

Part A - Hospital Insurance

- Helps pay for inpatient hospital care, inpatient care in a Skilled Nursing Facility (SNF), home health care and hospice care.
- Medicare Part A has deductibles and coinsurance, but is generally premium premium-free.

Part B - Medical Insurance

- Helps pay for the following types of services:
  - Doctors' services
  - Outpatient hospital services
  - Durable Medical Equipment (DME) supplies
  - Ambulance services
  - And other medical services and supplies that are not covered by Medicare hospital insurance (Part A)
- Medicare Part B has premiums, deductibles and coinsurance amounts for which the beneficiary is responsible
- Premiums, deductibles and coinsurance amounts are set each year according to formulas established by law
- New payment amounts begin each January 1

Four Parts to Medicare

- **Part C - Medicare Advantage Plans**
  - A Medicare program that gives beneficiaries more choices among health plans
- **Part D - Prescription Drug Coverage**
  - A beneficiary may select a Part D Plan to help lower prescription drug costs
  - Part D Drug Plans may also help protect against higher costs in the future
  - Medicare Prescription Drug Coverage is insurance provided by private companies
  - Beneficiaries choose the drug plan and pay a monthly premium
  - Like other insurance, if a beneficiary decides not to enroll in a drug plan when they are first eligible, they may pay a penalty if they choose to join later

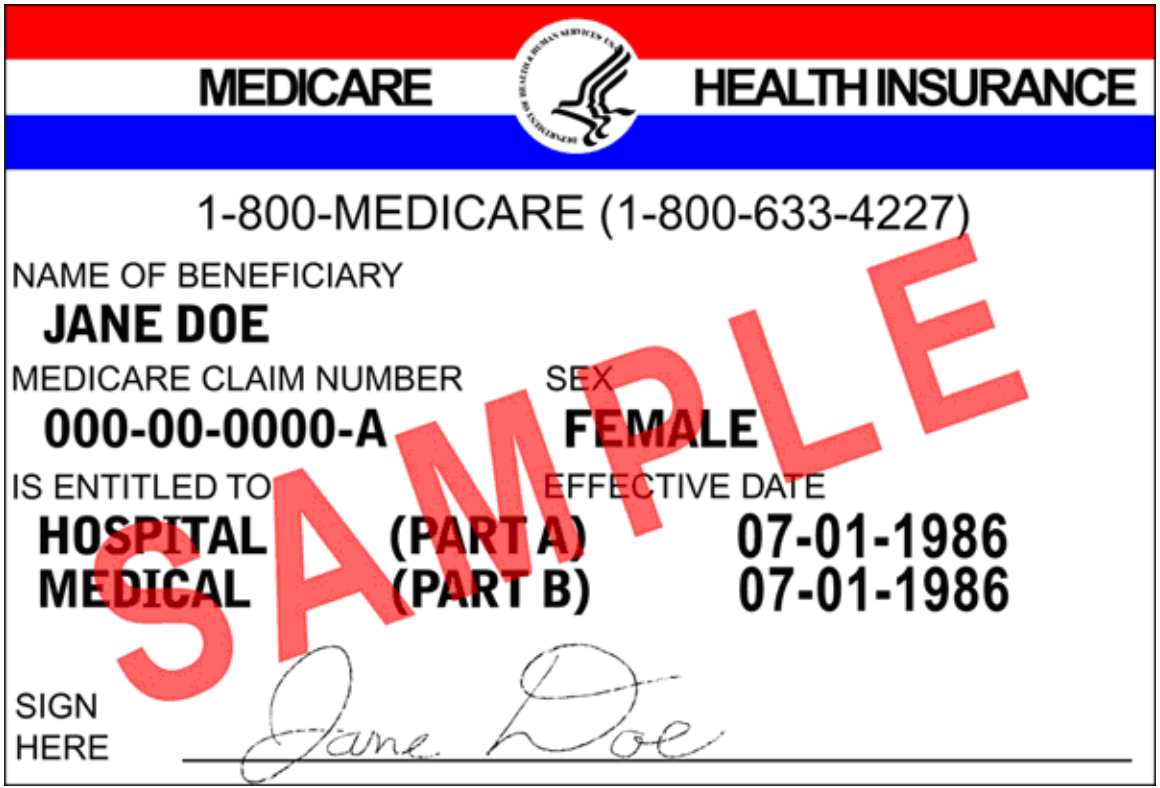
Noridian

- Companies such as Noridian are contractors of CMS responsible for the administration of the Medicare program for a specific territory or jurisdiction.
- Noridian is Medicare Administrative Contractor (MAC) Jurisdiction One (J1).
- J1 *is comprised of California*, Nevada, Hawaii, Guam, American Samoa and the Mariana Islands.

Eligibility

Enrollment of beneficiaries into the Medicare program is handled by the Social Security Administration (SSA) or Railroad Retirement Board (RRB).

- Noridian does not determine eligibility for Medicare or handle enrollment issues.
- The card will not show a termination date or enrollment in a Medicare Advantage Plan.



Health Insurance Claim Number

- The Social Security number followed by one of these codes is often referred to as HIC, BIC or claim number. The Social Security Administration Office assigns these codes once you apply for benefits.
- Beneficiary Identification Code (BIC)or the Meaning of the letter after the SSN or HICN.

Examples

***A** = Retired worker over 65 or disabled worker

B = Wife of retired worker (over 65)

B1 = Husband of retired worker

B2 = Wife whose entitlement is dependent on the care of a child

B3 = Second Wife

B4 = Second Husband

B6 = Divorced wife / Ex-Wife

B9 = Divorced second wife

C = Child of retired or deceased worker,

numbers after the C denote order of children claiming benefit

D = Widow

D1 = Widower

D6 = Surviving divorced wife

Health Insurance Claim Number

E = Mother of a child of a deceased worker

E1 = Divorced mother of a child of a deceased worker

F1 = Aged dependent father

F2 = Aged dependent mother

***HA** = Disabled worker

HB = Wife of disabled worker

HC = Child of disabled worker

***J1** = Special "over 72" benefit, has A and B

K1 = Wife of "over 72" benefit, has A and B

***M** = Has Part B Medicare only, Not eligible for Part A but can purchase Part A Coverage

***T** = Has A and B Medicare, no SSA benefits

W = Disabled widow

***Denotes the recipient's own social security number.**

Number is subject to change with entitlement changes

NOTE: This list is not complete, but shows the most common beneficiary codes.

Inpatient Deductible

- The Part A inpatient deductible and coinsurance amounts are determined by benefit periods
  - 2013 Part A Hospital Insurance
    - Deductible $1,184.00
    - Coinsurance $296.00 per day for 61st-90th day
    - Lifetime reserve days $592.00 per day for 91st-150th day
  - 2013 Part A SNF Coinsurance
    - $148.00 per day for 21st-100th day

Benefit Period

- **Ends when there has been no inpatient hospital care or daily skilled care, in a SNF, for 60 consecutive days.**
- Benefit periods extend throughout the period of a covered level of care, even though Part A benefits may be exhausted.
- Use DOLBA (Date of Last Billing Activity) **to determine if a beneficiary has had no inpatient hospital care or skilled care for 60 consecutive days.**

Lifetime Reserve Days (LTR)

- Available after hospital benefit period days have been exhausted.
- There are 60 non-renewable days for inpatient hospital services. Once LTR days are used they are gone.
- The utilization of these days are optional.
- **get example of letter

Retirement Date

Medicare Secondary Payer (MSP) Manual

Chapter 5 - Contractor Prepayment Processing Requirements

Table of Contents

(Rev. 81, 07-29-11)

30.1 - Further Development Is Not Necessary

(Rev. 1, 10-01-03)

Transmittal R1854A3

Medicare providers are required by law to obtain other payer information and to certify that such development has occurred. Submission of the following types of information by a hospital is to be accepted without further inquiry.

Claim containing a MSP value code and payment amount;

Condition codes 05, 09, 10, 11, 26, 28, and 29 are shown on the bill;

Occurrence codes 05, 06, 12, 20, 23, 24, 25, 18, 19, and dates are shown on the bill;

Use of remarks field for further clarification;

Claim denied because active MSP record, but claim not filed as MSP;

MSP claim filed and information on claim matches MSP CWF record; and

MSP record shows "not active," and claim was filed with Medicare as primary payer.

When such information is submitted, do not attempt further development. The bill automatically updates CWF in the preceding situations. The hospital reviews must ensure that bill submissions are proper and comply with the law's requirements. (See §70.)

In relation to the reporting of occurrence codes 18 and 19, as referenced above, hospitals adhere to the following policy when precise retirement dates cannot be obtained during the intake process:

POLICY: **When a beneficiary cannot recall his or her retirement date but knows it occurred prior to his or her Medicare entitlement dates, as shown on his or her Medicare card, the provider reports the beneficiary's Medicare A entitlement date as the date of retirement. If the beneficiary is a dependent under his or her spouse's group health insurance and the spouse retired prior to the beneficiary's Medicare Part A entitlement date, the provider reports the beneficiary's Medicare entitlement date as his or her retirement date.**

If the beneficiary worked beyond his or her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his or her precise date of retirement but it is determined that it has been at least five years since the beneficiary retired, the provider enters the retirement date as five years retrospective to the date of admission. (That is, if the date of admission is January 4, 2002, the provider reports the retirement date as January 4, 1997, in the format currently used.) As applicable, the same procedure holds for a spouse who had retired at least five years prior to the date of the beneficiary's hospital admission.

If a beneficiary's (or spouse's, as applicable) retirement date occurred less than five years ago, the provider must obtain the retirement date from appropriate informational sources, e.g., former employer or supplemental insurer.

Occurrence Code 18 = Date of Retirement of Patient/Beneficiary

MSP Code Definitions/Types

MSP Code definitions	-	Value Codes
A = Working Aged		Value Code 12
B = End Stage Renal Disease (ESRD)		Value Code 13
D = Auto Liability		Value Code 14
E = Workers' Compensation		Value Code 15
G = Disability		Value Code 43
H = Federal Black Lung Program		Value Code 41
I = Veteran's Administration (VA)		Value Code 42
L = Liability Other (i.e., slip and fall, or malpractice)		Value Code 47
F = Government Research program (formerly Public Health Service)		Value Code 16

W=Workers' Compensation Medicare Set-Aside Arrangement (WCMSA)

Value Code 44 = Contract Allowed Amount (contracted Ins)

Condition Code 77 = is entered when a provider accepts or is obligated to accept payment from the primary payer as PIF.

Occurrence Code 18 = Date of Retirement of Patient/Beneficiary

***This occurrence code cannot be used if a beneficiary has insurance coverage because of employment/working aged (MSP Code 'A').**

**See Noridian example

Occurrence Codes

- Get definition

MSP Changes/Updates

- The MSP Questionnaire must match provided by the patient regardless of the information provided by Endeavor/Noridian as provided by the patient.

- Upon any discrepancies, the Patient Registration Staff/CBO Staff will notify the beneficiary of his/her responsibility to contact the Medicare Coordination of Benefits Contractor at 1-800-999-1118 with changes/updates. Beneficiary is ultimately responsible for total charges if the CWF information is not updated.

MEDICARE ELIGIBILITY DOCUMENTATION

- Sample documentation of Medicare eligibility

Example:

4/23/13 MCWFI CWF INQUIRY INFORMATION RECEIVED

Remarks: PER PALMETTO GBA CWF; HIC #000000000A ,
PART A EFF: 000000 TERM 000000
PART B EFF: 000000 TERM 000000,
NO HMO, NO MSP, NO HOSPICE INFORMATION AVAILABLE.
DOLBA: 000000 DOEBA:000000 HOSP DAYS 60-30 LRSV 60.

CWF – Eligibility

- HIQACOP CWF PART A INQUIRY REPLY **PAGE 02 OF 14**
- IP-REC CN 123456789A NM VENTURA IT H DB 01231921 SX F
- PAP: PAP DATE: 000000
- IMMUNO/TRANSPLANT DATA COV. IND.: TRANS. IND.: DISCH. DATE: 000000
- 000000
- 000000
- HOSPICE DATE PERIOD 002 OWNER CHANGE 002 PERIOD 001 OWNER CHANGE 001
- **START DATE1 121906**
- **TERM DATE1 122006**
- **PROV1 *051617***
- **INTER 1 00454**
- **DOEBA DATE 121906**
- **DOLBA DATE 122006**
- **DAYS USED 002**
- **START DATE2 000000**
- **PROV2**
- INTER2
- **REVOCATION IND 0**

Hospice information is on page 2

Hospice is responsible to pay for visits/admissions related to Hospice condition. MA does NOT provide hospice benefits. If admission/visit is not related to the Hospice condition, the primary payor is Medicare .

Revocation indicator must be 1.
0 = Beneficiary has not revoked hospice benefits.
1 = Beneficiary has revoked hospice benefits.

CWF – Eligibility

IP-REC CN 123456789A NM OLVERA IT C DB 01291944 SX F PAGE 16 OF 17

SUBSCRIBER NAME: POLICY NUM:
EFF DTE: 08/04/2006 TRM DTE: PATIENT REL: 01 SELF, BENE IS
MSP CODE: W = WCSA POLICY HOLDER FOR
INSURER INFORMATION: PARTY FOR D, E, L
NAME : ANA VENTURA REMARKS CD: 1 2 3
ADDRESS 1 : 1301 N TUSTIN AVE
ADDRESS 2 :
CITY SANTA ANA STATE CA ZIP CODE 92705
GROUP NUM :
TYPE : A = INSURANCE OR INDEMNITY

B. Workers' Compensation Medicare Set-Aside Arrangements (WCMSAs)

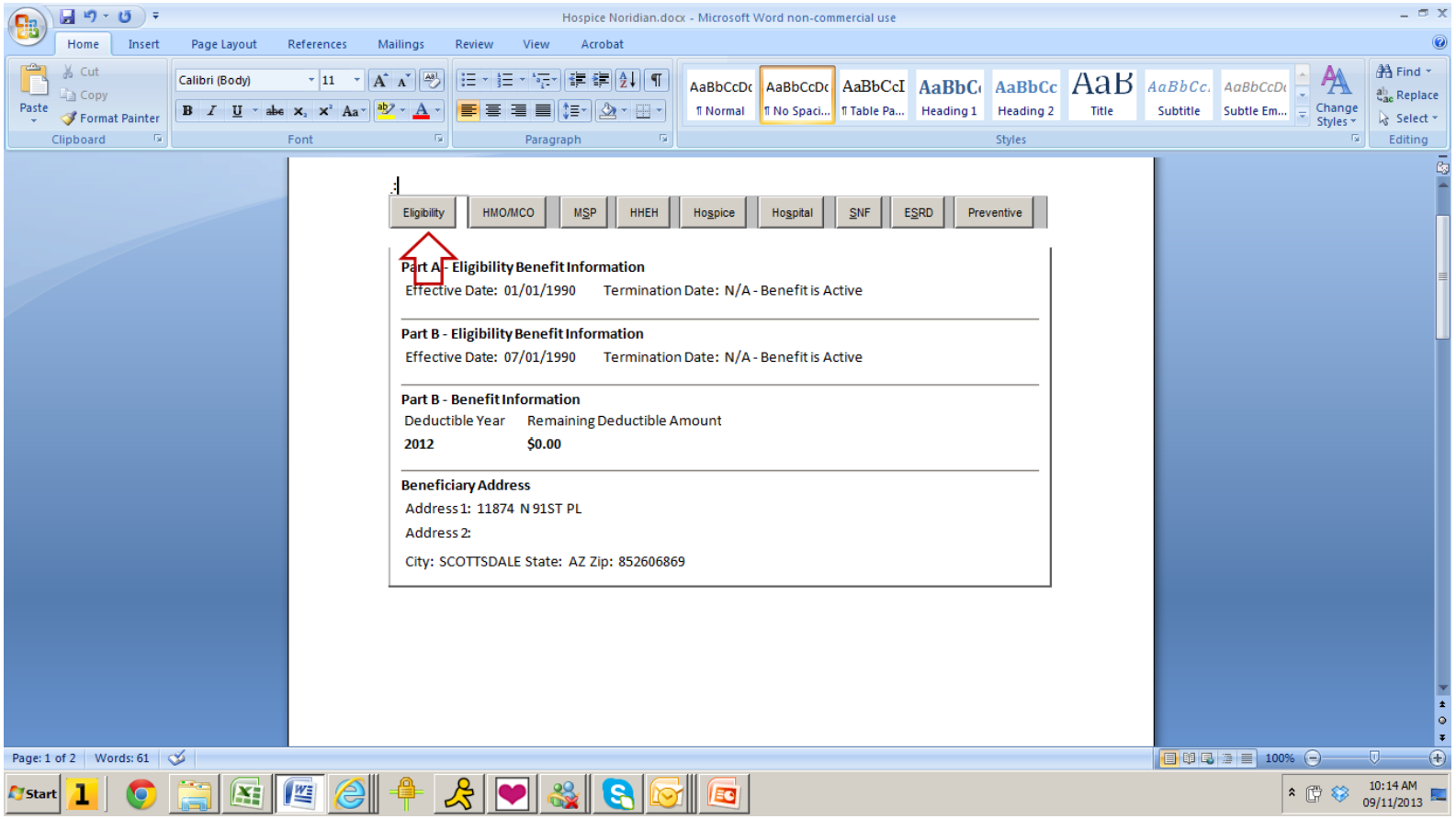
A WCMSA is an allocation of funds from a workers' compensation (WC) settlement, judgment or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. Where a WC settlement specifies that a portion of the settlement is for a WCMSA, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for as set forth in the following sections, Medicare will to pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease.

MSP Audit!

- Participants
  - Patient Access Director
  - PFS Management
- Required

- Policies
- Changes
- Corrective Actions
- Time Frames

Noridian/Endeavor - Hospice



Noridian/Endeavor - Hospice