medicare university

# Fundamentals of Medicare – Part 1

## Building Your Medicare Knowledge Base

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National Government Services

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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  - Go to our website
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  - Under the Register button for this event, you will see the Presentation link
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# Objectives

- Provide a basic understanding of the fundamentals of the Medicare Program

# Agenda

- Medicare Basics
- Protecting Your Bottom Line: Initial Medicare Beneficiary Screening
- Medicare Part A
- Hospice Benefit Overview
- Provider Self-Service Tools
- Additional Information

# 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 end Stage Renal Disease (ESRD)
  - Medicare benefits offer coverage for
    - Part A - Hospital Insurance
      - Inpatient – examples: hospital, SNF, IRF, IPF
    - 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

# History of Medicare

- Effective 7/1/1966
  - Initially covered persons 65 and over
- 1972 – Coverage expanded to include
  - Persons with disabilities
  - Persons with ESRD
- 1983 – Hospice benefit established
- 2006 – Medicare prescription drug coverage (Part D) began

# Did You Know

- 2021 marks the 56th 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 (HHS) oversees two major agencies
  - CMS
    - Responsible for writing the rules and regulations for the Medicare Program
  - Public Health Services
- HHS administers
  - Hospital Insurance (Part A)
  - Voluntary SMI (Part B)

# Centers for Medicare & Medicaid Services (CMS)

- 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*

# Medicare Contractors

- Private insurance companies
  - Under contract with federal government
- Medicare Administrative Contractor (MAC) process
  - Both Part A and Part B claims
  - Federally Qualified Health Center
  - Home health and hospice
  - Durable Medical Equipment (DME)
- Contractors bound by service area
  - Additional contractors include CERT, RA (RAC), SMRC, BCRC plus more

# Comprehensive Error Rate Testing (CERT)

- 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
- Additional Recovery Audit Program Information

# Supplemental Medical Review Contractor (SMRC)

- SMRC National contractor: Noridian Healthcare Solutions SMRC - 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 were in compliance with coverage, coding, payment, and billing practices

# National Government Services

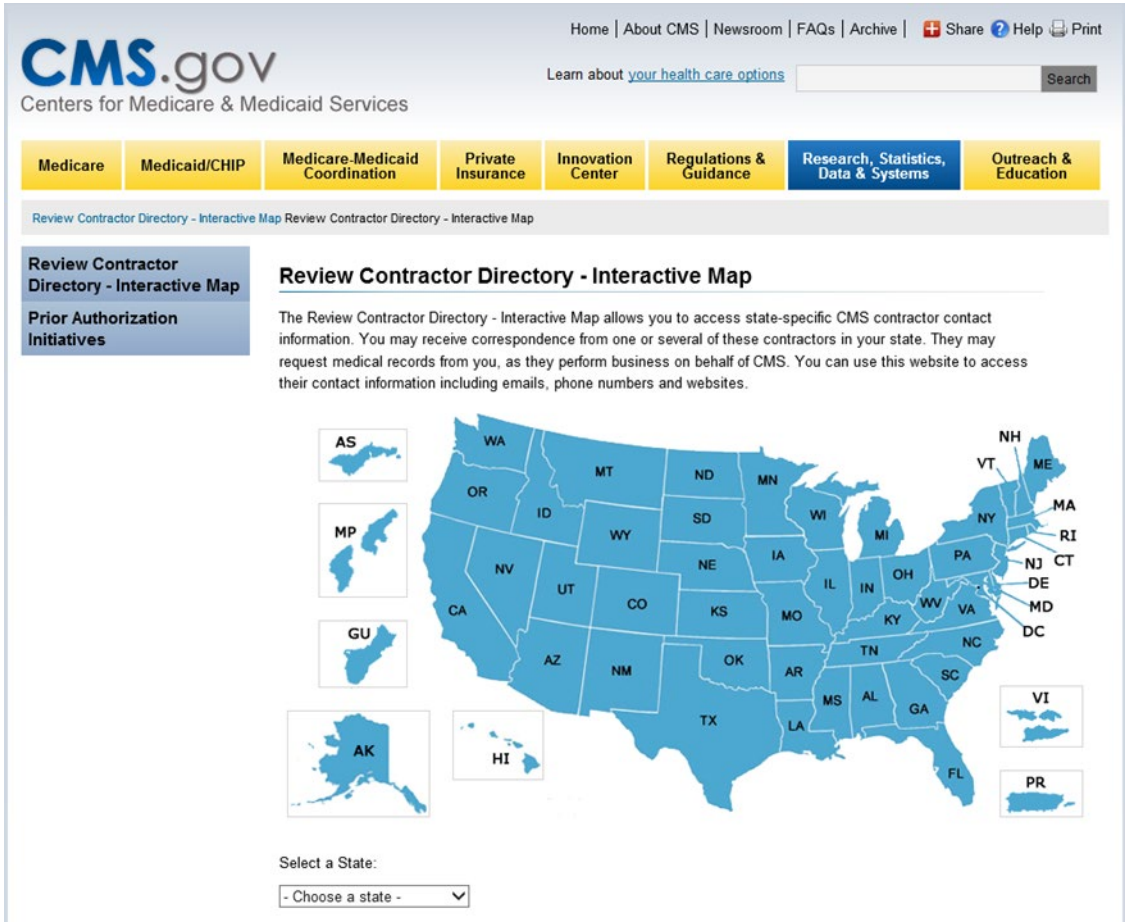
- Traditional fee-for-service contractor serving over 27.2 million people with Medicare in 20 states and 5 U.S. territories.
- NGS serves 240 members of Congress.
- NGS administers Medicare for Jurisdictions 6 and K (J6 and JK)
  - Medicare Part A (hospital insurance) and Medicare Part B (medical insurance)
  - Medicare home health and hospice for large number of states
  - Medicare free-standing FQHC contract in 44 states
  - Develops and maintains web-based self-service tools
    - Allows Medicare providers to have millions of interactions to answer their educational and billing needs
- NGS Website

# Locating Contractors (MACs and more)

Review Contractor Directory - Interactive Map

Select the state and the information populates below the map

List of MACs by state: MAC Website List



# 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 100-08, *Medicare Program Integrity Manual*, Chapter 10
  - 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
  - No 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

- Involuntary termination
  - Medicare regulations state CMS may terminate provider Medicare agreement under certain circumstances such as:
    - Not compliant with Medicare guidelines and/or regulations
    - No longer meets appropriate requirements for participation
    - Failed to supply cost report information
    - Refuses to participate in audits of financial and/or medical records

# Payment Exceptions

- Payment can continue for up to 30 days for services furnished on or after termination date for beneficiaries admitted prior to termination date
- Payment may be made for services under plan of treatment for up to 30 days following effective termination date of home health agency or hospice if plan was established before termination date

# Collecting Overpayments from Terminated Providers

- If contractor discovers overpayment due from terminated provider
  - Provider contacted with request for lump sum payment
  - Additional collections activities follow, as appropriate
- If provider no longer with Medicare but still participating in Medicaid Program
  - Action to withhold federal share of Medicaid payments initiated, as appropriate

# How Medicare is 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 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, SS, 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 Social Security (SS) benefits or disabled individual receiving SS benefits for 24 months
  - Must speak with SS if wish 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
  - Date of death (DOD)

# Medicare Eligibility Based on Disability

- Disabled individuals receiving SS 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

- 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
    - $471.00 per month for 2021
  - 30–39 quarters (7 ½ –10 years) – Base premium with 45% reduction
    - $259.00 per month for 2021

# Medicare Part A Deductible

- Cost-sharing refers to monetary amount that is patient's responsibility: Deductible and coinsurance
- Beneficiary is charged per benefit period
- 2021 Inpatient hospital cost-sharing amounts

| Part A | Cost Sharing |
|---|---|
| Part A inpatient hospital deductible | $1484.00/benefit period |
| Part A coinsurance (61st–90th day) | $371.00/day |
| Part A LTR (91st–150th day) | $742.00/day |
| Part A – After 150 inpatient days | All costs |
| SNF coinsurance (21st–100th day) | $185.50/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 2021 deductible is $1,484.
- 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
  - $148.50 per month for 2021
  - Late enrollment penalty – 10%
- Beneficiaries with higher incomes will pay a higher premium
  - Sliding scale
- 2021 annual deductible = $203.00

# Part B Coinsurance

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

# Did You Know

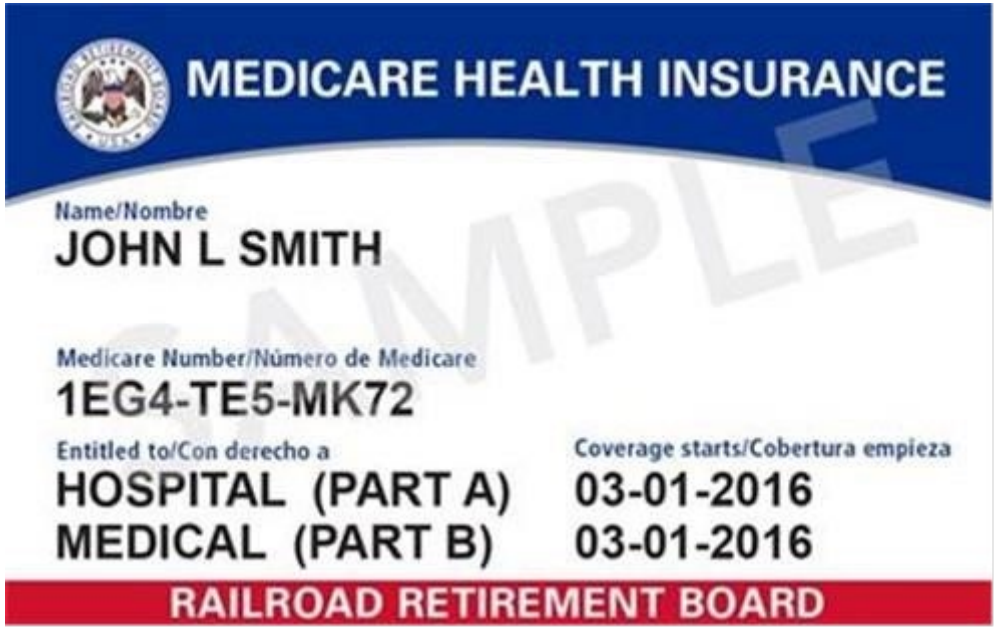
- A provider may not collect any applicable deductible or co-insurance from a patient who has both Medicare and Medicaid
- Beneficiaries with both Medicare and Medicaid
  - Not responsible for any applied deductible or the co-insurance
  - Responsible for any co-pay determined by Medicaid
- Additional Information: SE1128 “Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)”

# Medicare Card

- Used for Medicare Parts A and B

# Medicare Card

- Beneficiary with Railroad Medicare



# Medicare Card

- Proof of “traditional” Medicare enrollment
  - Full name, Medicare Beneficiary Identifier (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 MyMedicare.gov account
  - Or call 1-800-MEDICARE (1-800-633-4227)/TTY 1-877-486-2048

# 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: 800-772-1213
  - Hearing Impaired TTY number: 800-325-0778
    - Monday through Friday from 7 a.m. to 7 p.m.
- Social Security website

# Protecting Your Bottom Line: Initial Medicare Beneficiary Screening

# Patient Registration

- Patient presents insurance information and/or cards
- Provider determines proper order of insurance
  - Must know COB (Coordination of Benefit)/MSP (Medicare Secondary Payer) concepts
- Provider verifies Medicare eligibility
  - Patient
  - CWF (Common Working File)/FISS (Fiscal Intermediary System System)
  - HETS (HIPAA Eligibility Transaction System) - electronic
  - IVR (Interactive Voice Response System)
  - NGSConnex

# Verify Medicare Beneficiary Eligibility

- Must verify eligibility frequently – check 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 Members

- 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 (CB)
  - 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

# 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

✓ Recent Update: MM 11945, effective12/7/2020, "Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries"

# The Common Working File

- Maintains national beneficiary records
  - Entitlement, date of birth, and date of death
  - Recent benefit periods (including any deductibles due)
  - MAO enrollment
  - Home health episode
  - Preventive services
  - Hospice enrollment
  - MSP information
- CWF access methods will be discussed later

# 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 posthospital services and availability of services
  - Discuss results of evaluation with patient or individual acting on his/her behalf

# Medicare Part A

# 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 about the Two-Midnight Rule
      - MLN Matters® article MM10080 *"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 hospital stay
  - 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

# 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

- You can prevent claim rejections and claims RTP by having registration staff check beneficiary eligibility prior to claim submission

# Hospice Benefit Overview

# Did You Know

- Hospice is a special benefit available for beneficiaries with a terminal illness
  - Medicare Payment Systems: *Hospice Payment System*

# 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 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 traditional Medicare benefits for all services related to terminal illness
- All hospice-related care received from Medicare-certified hospice
  - Beneficiary can receive care under traditional Medicare for services not related to the terminal illness
    - Condition Code 07

# 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

# Hospice: Other Items and Services

- Hospice is responsible for providing any and all items/services included in POC as necessary for the palliation and management of the terminal illness and related conditions
- Bereavement Counseling
  - Required hospice service
    - Provided up to one year following patient's death
    - Consists of counseling services provided to individual's family after their death
- Special Modalities
  - Hospice may use chemotherapy, radiation therapy, and other modalities for palliative purposes if it determines that these services are needed

# Noncovered Hospice Services

- Under the hospice benefit, Medicare will not pay for
  - Treatment intended to cure terminal illness
  - Care related to the terminal condition from a provider that is not the elected hospice
  - Services not medically reasonable and necessary
  - Services not covered by Medicare

# Hospice Election Periods

- Unlimited number of hospice benefit periods
- Benefit periods consist of
  - Two 90-day periods (not renewable)
  - If beneficiary continues on hospice, then may receive an unlimited number of 60-day periods
- Must verify hospice benefit election as part of Medicare eligibility verification process prior to providing services
  - FISS/CWF
  - IVR
  - NGSConnex

# Submitting Claims for Hospice Beneficiaries

- When elected, all services related to terminal illness must be submitted by hospice provider
- Claims for services not related to hospice beneficiary's terminal condition rejected by traditional Medicare unless provider reports condition code 07 on claims

# Did you know?

- All services related to the terminal condition must be arranged through the hospice that is responsible for the patient
  - Hospice is not responsible for services provided outside of the plan of care
  - If a beneficiary seeks services for the terminal illness or related conditions without the hospice arranging it, then the beneficiary is liable for the cost of the services
    - Patient liability in this situation applies for any services including, but not limited to, labs, diagnostics, inpatient stays and emergency room visits

# Provider Self-Service Tools

# Did You Know

- Registration staff can quickly and accurately access beneficiary eligibility information using provider self-service tools
  - Prevent common eligibility-related claim error reason codes
  - Reduce time and money spent reviewing claim errors
  - Save cost of reprocessing claims unnecessarily

# Contact Us: NGS Toll-Free Phone Numbers and Additional Information

- Check our website for specific telephone number to use
  - Log in/Select whether you want information for
    - Part A
    - Part B
    - FQHC (federally qualified health center)
    - HH+H (home health and hospice)
  - Once logged in select the “Contact Us” link that is listed under the Search box then
    - Interactive Voice Response System, or
    - Provider Contact Center

# What is the IVR?

- Interactive voice response (IVR) system
  - Research application used to provide general/common Medicare beneficiary and/or claim information
  - Text-to-speech technology
  - Uses natural language
  - Allows you to speak directly into the telephone to make a selection
- CMS mandates providers utilize the IVR instead of contacting a customer care representative to access beneficiary eligibility and general information
- Providers who call a customer care representative with a question that can be answered by the IVR are referred back to the IVR

# System Availability

- IVR menu options that require system access limited to CWF's availability
  - Monday–Friday
  - 5:00 a.m.–6:00 p.m. CT/6:00 a.m.–7:00 p.m. ET
- Saturday
  - 6:00 a.m.–2:00 p.m. CT/7:00 a.m.–3:00 p.m. ET
- Note: 'I Have a Question' option is available 24-hours per day, seven days per week

# Benefits of Using IVR

- Anyone having access to a phone can call
  - No computer needed
  - No sign up required
- Great for various departments
  - Admissions
  - Billing
  - Accounting
- Minimal “training” necessary

# Benefits of Using IVR

- Extended hours
  - Convenient for different work schedules
- Stay on call as long as needed
  - Great for getting as much information as necessary
- Uses same system as PCC, NGSConnex, FISS DDE
  - No need to verify information with PCC

# IVR Research (Main Menu) Options

- Patient eligibility
- Claims status
- Checks
- Remittance statements
- Provider enrollment status
- Patient status
- I have a question
- Check appeals status

# Patient Eligibility
# Provider Validation Elements

- NPI
- PTAN
- Last five (5) digits of TIN
- Beneficiary MBI
- Beneficiary first and last name
- Beneficiary DOB
- DOS

# Patient Eligibility
# Available Information

- Part A and Part B effective and termination dates
- MSP type and insurer information
- Hospital inpatient, SNF, LTR benefit days
- Amount applied to Part B deductible, PT/OT limits (current and prior year)
- Home health and hospice effective and termination dates

# IVR Resources

- Access: NGS website> Select “Contact Us’ under search box > select “Interactive Voice Response System”
  - National Government Services Part A Provider IVR User Guide
  - Part A IVR Flow Chart
  - Part A IVR Navigation Guide
  - Part A Touch-Tone Card/Eligibility Checklist
  - Using the IVR to Avoid Top Claim Rejections and Return to Provider Errors
  - Interactive Voice Response Conversion Tools
    - Beneficiary Name to Number Converter
    - PTAN and Beneficiary Medicare Number Converter
    - IVR Conversion Tables
- IVR Conversion Tools

# Checking Beneficiary Eligibility

- HETS (X12N 270/271 Version 5010 eligibility and response files)
  - Part A providers: CMS will terminate CWF eligibility queries in FISS DDE via HIQA, HIQH, ELGA, ELGH and HUQA at date to be announced
    - SE1249 – Termination date to be determined; CMS will provide at least 90 days advanced notice of termination date
      - CR 8248 “Termination of the Common Working File ELGA, ELGH, HIQA, HIQH and HUQA Part A Provider Queries”
        - » Does not impact use of IVR for eligibility inquiries
        - » Does not impact claim submission/correction in DDE
    - CWF Eligibility Sunset and CWF Eligibility Sunset FAQs

# What Is NGSConnex?

- Self-service, web application created and maintained by National Government Services
- Provides
  - Claim status
  - Beneficiary eligibility
  - Initiate/Check status of reopening/redetermination requests
  - Submit documentation in response to ADR
  - Financial data
  - Submit credit balance report
  - Provider demographics
  - Ability to order remittances
  - And more!

# What Is NGSConnex?

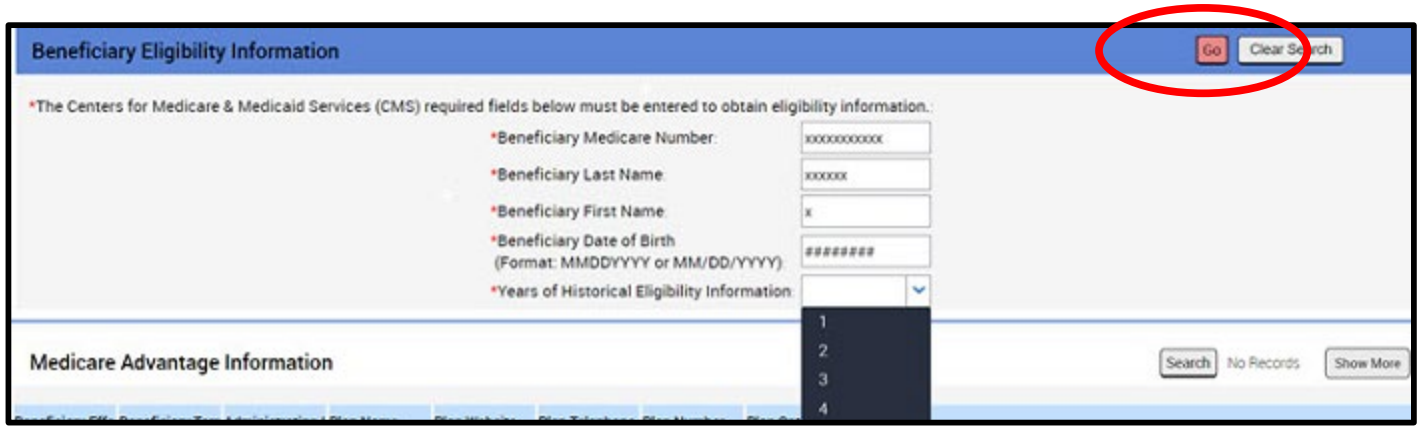
- Self-service
- Similar to other options available
  - IVR; PCC
  - CWF; HETS
  - FISS
- Note: Options that require system access limited to CWF's availability:
  - Monday–Friday: 7:00 a.m.–6:00 p.m. ET
  - Saturday: 7:00 a.m.–3:00 p.m. ET

# How to Access

- NGS website
- Need
  - Internet access
  - Email address
- No cost
- Additional Information
  - NGS Website → Provider Resources → NGSConnex
    - We have many You Tube videos to assist you! Link to all is included on our website per above link - select "NGSConnex Videos"

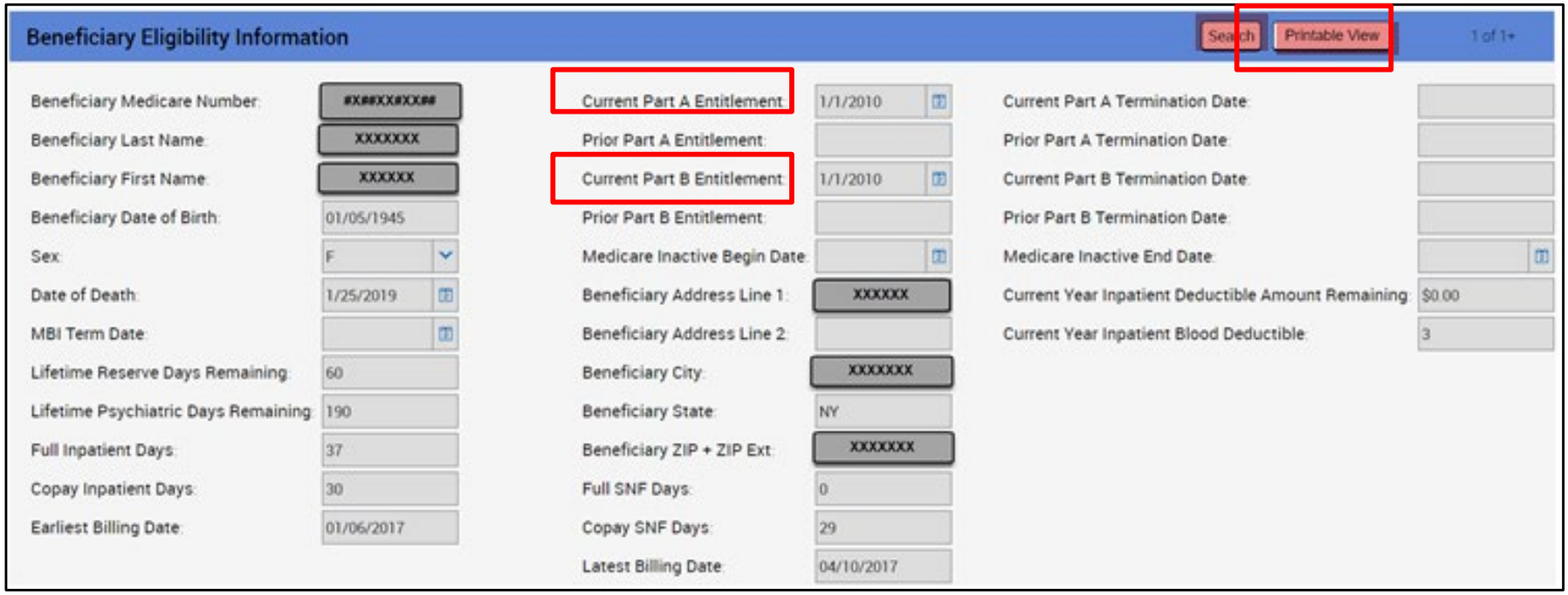
# NGSConnex Eligibility

Enter the beneficiary demographic information exactly as it appears on the beneficiary's Medicare card



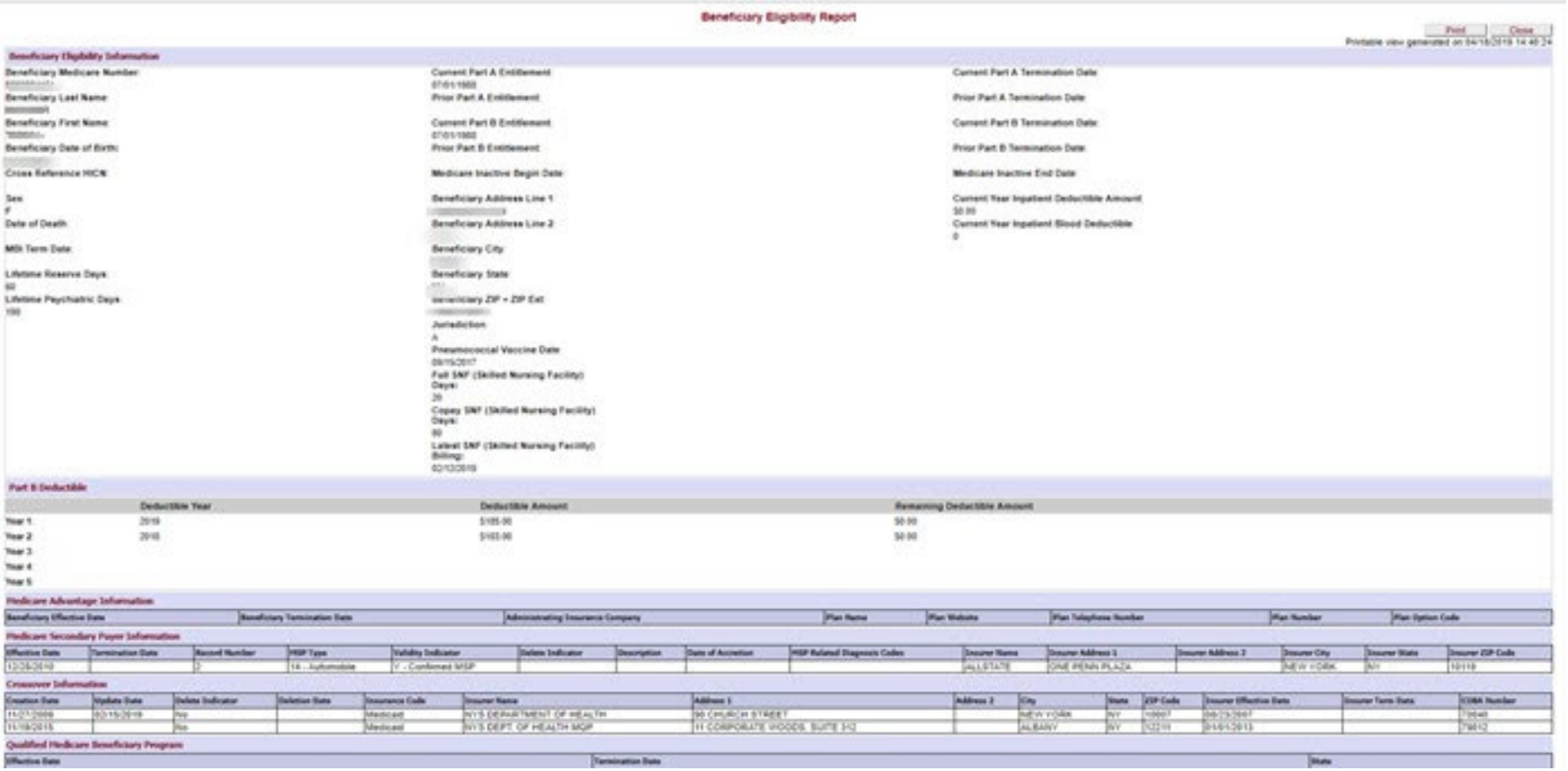

**Navigation Tip:** Enter the Beneficiary Last Name, First Name exactly as it appears on their Medicare card. You only need to enter the first six letters of the last name, and the first letter of the first name.

# NGSConnex Eligibility



# NGSConnex Eligibility

## Printable view



Beneficiary Eligibility Report

Print Close

Printable view generated on 04/16/2019 14:40:24

Beneficiary Eligibility Information

| | | |
|---|---|---|
| Beneficiary Medicare Number: | Current Part A Entitlement: 07/01/1968 | Current Part A Termination Date: |
| Beneficiary Last Name: | Prior Part A Entitlement: | Prior Part A Termination Date: |
| Beneficiary First Name: | Current Part B Entitlement: 07/01/1968 | Current Part B Termination Date: |
| Beneficiary Date of Birth: | Prior Part B Entitlement: | Prior Part B Termination Date: |
| Cross Reference HICN: | Medicare Inactive Begin Date: | Medicare Inactive End Date: |
| Sex: F | Beneficiary Address Line 1: | Current Year Inpatient Deductible Amount: $0.00 |
| Date of Death: | Beneficiary Address Line 2: | Current Year Inpatient Blood Deductible: 0 |
| MSI Term Date: | Beneficiary City: | |
| Lifetime Reserve Days: 60 | Beneficiary State: | |
| Lifetime Psychiatric Days: 190 | Beneficiary ZIP + ZIP Ext: | |
| | Jurisdiction: A | |
| | Pneumococcal Vaccine Date: 09/15/2017 | |
| | Full SNF (Skilled Nursing Facility) Days: 20 | |
| | Copay SNF (Skilled Nursing Facility) Days: 80 | |
| | Latest SNF (Skilled Nursing Facility) Billing: 02/12/2019 | |

Part B Deductible

| | Deductible Year | Deductible Amount | Remaining Deductible Amount |
|---|---|---|---|
| Year 1 | 2019 | $185.00 | $0.00 |
| Year 2 | 2018 | $183.00 | $0.00 |
| Year 3 | | | |
| Year 4 | | | |
| Year 5 | | | |

Medicare Advantage Information

| Beneficiary Effective Date | Beneficiary Termination Date | Administrating Insurance Company | Plan Name | Plan Website | Plan Telephone Number | Plan Number | Plan Option Code |
|---|---|---|---|---|---|---|---|

Medicare Secondary Payer Information

| Effective Date | Termination Date | Record Number | MSP Type | Validity Indicator | Delete Indicator | Description | Date of Accretion | MSP Related Diagnosis Codes | Insurer Name | Insurer Address 1 | Insurer Address 2 | Insurer City | Insurer State | Insurer ZIP Code |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 12/26/2018 | | 2 | 14 - Automobile | V - Confirmed MSP | | | | | ALLSTATE | ONE PENN PLAZA | | NEW YORK | NY | 10119 |

Crossover Information

| Creation Date | Update Date | Delete Indicator | Deletion Date | Insurance Code | Insurer Name | Address 1 | Address 2 | City | State | ZIP Code | Insurer Effective Date | Insurer Term Date | CWA Number |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 11/27/2008 | 05/15/2018 | No | | Medicaid | NYS DEPARTMENT OF HEALTH | 90 CHURCH STREET | | NEW YORK | NY | 10007 | 04/23/2007 | | 73648 |
| 11/18/2015 | | No | | Medicaid | NYS DEPT OF HEALTH MGP | 11 CORPORATE WOODS, SUITE 3-C | | ALBANY | NY | 12211 | 01/01/2013 | | 73612 |

Qualified Medicare Beneficiary Program

| Effective Date | Termination Date | State |
|---|---|---|

National Government Services

medicare university

# Sign up for NGSConnex Today

- NGSConnex website
- Training materials available on the NGSConnex home page
  - Quick Steps Job Aid
  - Rules of Behavior
  - CBT Material
- Additional information on NGSConnex
  - NGS website > Provider Resources > NGSConnex

# NGSConnex Support

- Our Provider Contact Center handles NGSConnex support (Monday through Friday from 8 AM – 4 PM)
  - J6 Part A telephone number: 877-702-0990
    - J6 Part IVR: 877-309-4290 (IVR Hours – refer to slide 84)
  - JK Part A telephone number: 888-855-4356
    - JK IVR: 877-567-7205 (IVR Hours – refer to slide 84)
- NGSMedicare.com
  - "Contact Us"
    - Provider Contact Center

# Additional Information and Resources

# Information for Providers

- NGSMedicare.com
  - Medicare Monthly Review
    - Published monthly
    - Updates and changes to Medicare
    - New and revised LCDs
    - Upcoming educational sessions
  - Electronic mailing list (Email Update)
    - New Medicare information (billing and coverage)
    - Provider education and training announcements
- NGS YouTube Videos
- NGS Twitter: @NGSMedicare

# Provider Outreach and Education

- Experienced representatives proficient with Medicare coverage and billing
- Provider education
  - Teleconferences, webinars, seminars and CBTs
  - Medicare University
  - New provider education classes
  - Articles in provider bulletin
  - Provider training guides and job aids
  - Speaking engagements for associations

# CMS MLN Products

- CMS has many helpful resources available
  - MLN Publications & Multimedia
- Did you know that CMS offers web-based training (WBT) courses?
  - MLN Web-Based Training
  - Many professional associations accept CMS' MLN WBT courses for continuing education credit
- CMS YouTube Videos
- CMS Twitter: @CMSGov

# CMS MLN Products

- Medicare Payment System MLN Educational Tool includes:
  - What's Changed and Introduction
  - ACH Inpatient PPS
  - Hospice PSS
  - SNF PPS
  - ASC Payment System
  - Hospital OPPS
  - IPF PPS
  - IRF PPS
  - LTCH PPS
  - Resources

# Beneficiary Resources

- Annual Version of Medicare & You Publication – a CMS Handbook for Beneficiaries – published annually
  - Beneficiary Resources
  - 1-800-Medicare (1-800-633-4227)
    - Available 24 hours/day; 7 days/week
    - To speak to a live person: either say “agent: or press 0
  - Medicare.gov
  - State Health Insurance Assistance Program Regional Ship Locator (regional SHIP)
  - State Health Insurance Assistance Program Local Medicare Help (local assistance)
  - Social Security Administration

# Annual “Medicare Amounts” Job Aid

- Annual Medicare premium, deductible, coinsurance information in a downloadable format – many languages offered
- CMS MLN Matters® MM12024 *“Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2021”*

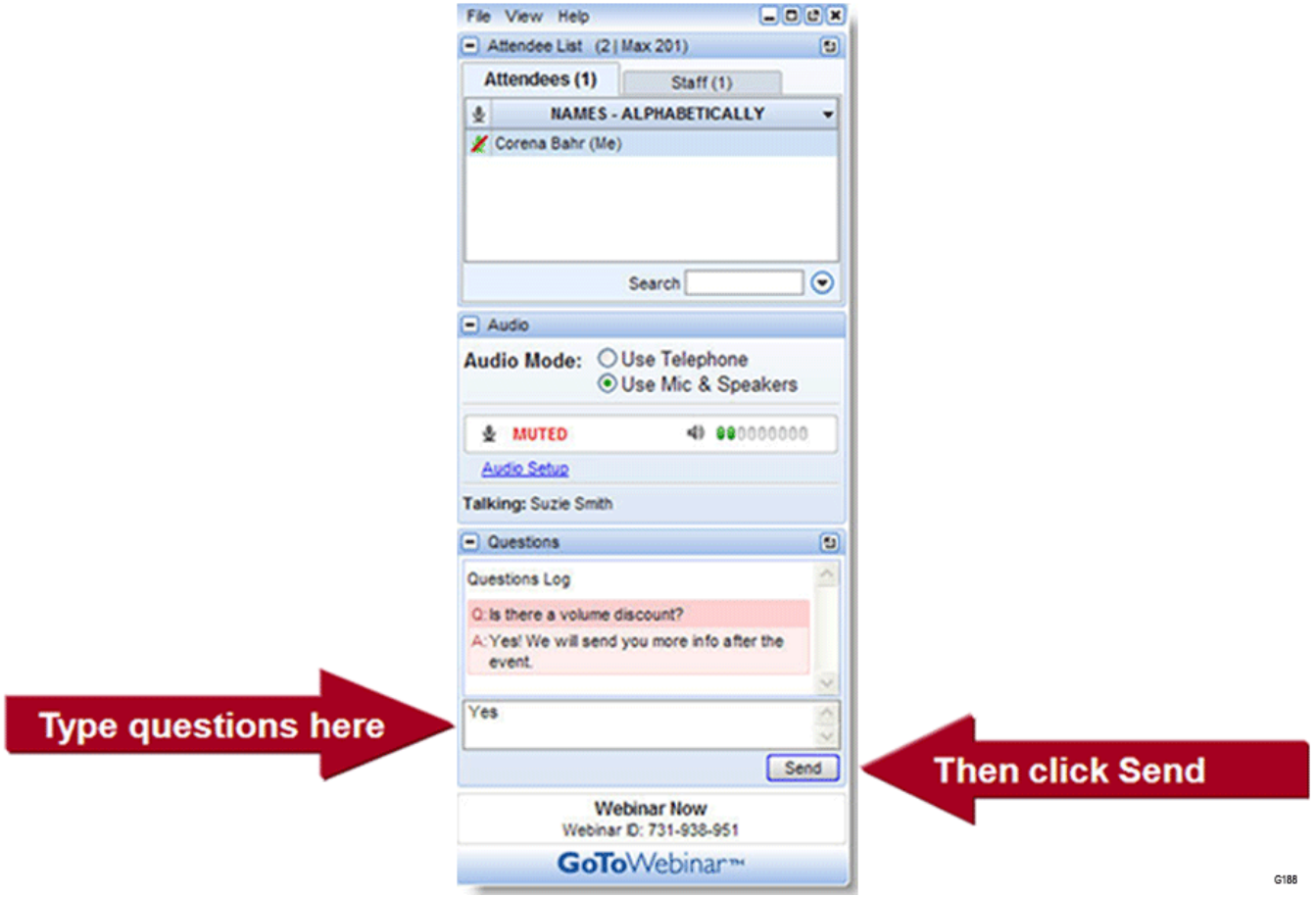
# MLN Connects®
# National Provider Calls

- Educational conference calls on new and changing Medicare programs and policies
  - In-depth presentations by CMS subject matter experts providing the latest information on topics specific to Medicare providers and suppliers, such as ICD-10, PQRS, and provider enrollment
  - Question and answer sessions with CMS experts
  - No cost to participate
  - 24/7 access to call materials (e.g., presentation slides, written transcripts, audio recordings, and CMS videos on YouTube)
  - Continuing education credit for participation awarded by many professional associations and credentialing organizations
- Learn more/register for upcoming calls on the MLN® Calls & Webcasts web page
  - Bookmark this webpage for quick access to upcoming calls!

# MLN Connects® Provider eNews

- A weekly electronic publication containing:
  - MLN Connects® National Provider Calls and other event reminders
  - CMS program updates and policy details
  - Claim, pricer, and code information
  - Medicare Learning Network® educational product announcements
- View past issues or subscribe to the eNews (Electronic Mailing Lists) at Newsroom or MLN® News & Updates
- Note: Providers who are subscribed to their MAC's listserv already receive the CMS eNews

# To Ask a Question Using the Questions Box



# Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?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