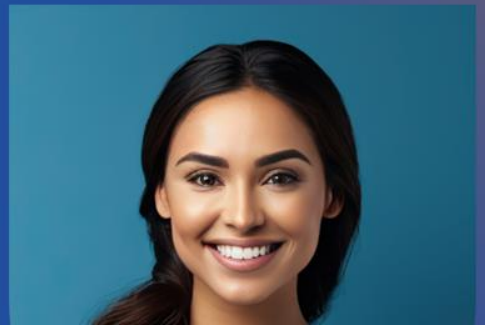
Advanced Revenue Cycle Management

Changes in 2024 - Payer Eligibility, VBID & Beyond

From Referral to Payment- How Payer Verification and Benefits Management Impact Claims and Payments



Next Webinar Schedule

- **December 12th**

The Hospice Medical Review Environment: Risks and Response

- **January 10th**

Medicare Hospice Cost Reports and CAP Reports Overview

- **February 8th**

2024 Superbowl of Hospice Knowledge

REGISTRATION PAGE

HOSPICE PRAYER ELIGIBILITY CHALLENGES

Presented By:

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CEO of ARCM

Helping your Hospice.....

- Confirm Medicare Eligibility
- Identify Medicare Secondary Coverage
- Learn about the VBID Expansion and how you may have VBID patients even in states and areas not participating
- Understand the Impact of the Medicare Data Breach

Confirm Insurance Coverage

Referrals

- Confirm insurance coverage, primary, secondary, tertiary
- Enter all in EMR
- Obtain copies of insurance cards whenever possible and upload into patient record
- Notify patient of any obligations based on copays and deductibles
- Confirm Medicaid coverage for Room and Board Patients
- Obtain all authorizations and follow all payer requirements to get paid

Medicare Eligibility

Medicare patients

- Confirm MBI
- Spelling of first and last name
- Date of birth
- Social security number if MBI unknown

Obtaining Medicare Eligibility Reports

Pull Medicare eligibility through

- eSolutions
- EASE
- Online Provider Services (OPS)
  - MyCGS
  - NGS Connex
  - Palmetto GBA e-Services
- Automated phone system
- Other portal or EMR

HIQH vs HETS
HETS Challenges for Hospice

- HIQH/HIQA was real time information with full hospice history
- HETS pulls information from CWF once daily
- HETS does not always show Elections if billing has not processed
- HETS benefit periods appear once billing is processed
- HETS does not always give a revocation date if billing is not completed through revocation date
- Not all eligibility reports pull full hospice history since 2016 split of elections and benefit periods
- Reports vary across providers, while all are supposedly pulling all fields available from HETS

Eligibility 1

Hospice

Hospice						
Effective Date	Effective Date	Termination Date	DOEBA	DOLBA	Days Used	Message
06/11/2021	06/11/2021	08/09/2021	06/11/2021	07/31/2021	51	Revocation Code-0

Hospice Elections

Hospice Elections information not found

Eligibility 2

Hospice

Period number is assigned to the hospice benefit period based upon the number of hospice period occurrences reported by Medicare.
There is no guarantee this designation is accurate because actual period designation is determined when the claim is received by Medicare.

Period	Period Start	Period End	Revoc. Code	NPI	NOE Date	Earliest Billing	Latest Billing	Days Used
11	06/11/2021	08/09/2021	0			06/11/2021	07/31/2021	51
10	02/09/2006	04/08/2006	0			02/09/2006	04/08/2006	59
9	12/11/2005	02/08/2006	0			12/11/2005	02/08/2006	60
8	10/12/2005	12/10/2005	0			10/12/2005	12/10/2005	60
7	08/13/2005	10/11/2005	0			08/13/2005	10/11/2005	60
6	06/14/2005	08/12/2005	0			06/14/2005	08/12/2005	60
5	04/15/2005	06/13/2005	0			04/15/2005	06/13/2005	60
4	02/14/2004	04/14/2005	0			02/14/2004	04/14/2005	60
3	12/16/2005	02/13/2005	0			12/16/2005	02/13/2005	60
2	09/28/2004	12/13/2004	1			09/28/2004	12/13/2004	77
1	06/30/2004	09/27/2004	0			06/30/2004	09/27/2004	90

Reading Eligibility Reports

Review Eligibility Information in the DDE User's Manual from PGBA

https://www.palmettogba.com/Palmetto/Providers.Nsf/files/DDE_Guide_S2_Bene_Eligbility.pdf/$File/DDE_Guide_S2_Bene_Eligbility.pdf

Examples

Personal Information

Insured/Subscriber Information	Subscriber ID:
Name: Jane Doe	XXXXXXXXXXX
MBI End Date:	PO BOX 61
Address:	09/23/1952
Date of Birth:	
Date of Death:	
Gender:	FEMALE
Eligibility Date Range:	10/26/2017 - 02/26/2022

Medicare Part A Eligibility

Effective	Termination
08/01/2015	Not found

Medicare Secondary Payer

Secondary Payer information not found

Hospice

Hospice information not found

Hospice Elections

Hospice Elections information not found

Plan Coverage

Plan Type	Message	Enrollment Date	Disenrollment Date	Contract/Plan Benefit Pkg	Plan Name
PPO	MA Bill Option Code - C	01/01/2020	Not found	R2604	UnitedHealthcare Medicare Silver

Personal Information

Insured/Subscriber Information	BUDDY SMITH
Name:	123456789
MBI End Date:	
Address:	263 WEST ROAD
Date of Birth:	04/05/1946
Date of Death:	
Gender:	MALE
Eligibility Date Range:	10/22/2017 - 02/22/2022

Eligibility

Medicare Part A Eligibility

Effective	Termination
04/01/2006	Not found

Medicare Part B Eligibility

Effective	Termination
04/01/2006	Not found

Medicare Entitlement Reasons

Part A: 0-Beneficiary insured due to age

OASI Part B: 0-Beneficiary insured due to age

Plan Coverage

No Plan Found

Medicare Secondary Payer

Secondary Payer information not found

Hospice

Hospice
Hospice information not found

Election Date	Message	NPI
10/01/2021	Revocation Code-0	987654321

Personal Information

Insured/Subscriber Information	John Doe
Name:	6XXXXXXXXX
MBI End Date:	
Address:	19504 Old Road
Date of Birth:	10/07/1950
Date of Death:	
Gender:	MALE
Eligibility Date Range:	10/22/2017 - 02/28/2022

Eligibility

Medicare Part A Eligibility

Effective	Termination
01/01/2008	Not found

Medicare Part B Eligibility

Effective	Termination
04/01/2018	Not found

Medicare Entitlement Reasons

Part A: 0-Beneficiary insured due to age OASI

OASI Part B: 0-Beneficiary insured due to age OASI

Plan Coverage

Plan coverage information not found

Medicare Secondary Payer

Insurer Name	Policy Number	Effective Date	Termination Date	Type of Primary Insurance
ANTHEM, INC.	123456789	05/01/2021	Not found	Medicare Secondary or Spouse w/ Employer Health Plan

Hospice

No Prior Hospice Found

Medicare Eligibility for Hospice

- Patient must have Part A with no termination date
- Patient must have any prior hospice elections closed before next hospice can bill, except for transfers
- If a prior hospice has an open election and the patient is not a transfer, enter your Notice of Election within the five-day timely filing window to qualify for an exception
- If the patient is an incoming transfer, confirm it is the only transfer in the current benefit period
- Even if the patient has Medicare Secondary, all Medicare guidelines must be followed to bill balances

Medicare Hospice History- Prior Hospice Elections

- Verify prior hospice elections
- Did the patient have hospice coverage within the past 60 days? This will determine high and low-rate days
- Has the prior hospice completed billing?
- **Contact them to confirm discharge date-** document call information- name of person, date, etc.
- **Hospices cannot admit on the same day that the prior hospice discharges except for transfers**
- Verify benefit period to determine if face-to-face is needed

MSP- Medicare Secondary Payer

- Patients with Medicare Secondary will have primary payer information on the MSP page
- MSP page will indicate what type of policy the patient has, the effective date, and termination date, if terminated
- If termination field is blank, policy is open and must be billed first in most situations
- All requirements of primary insurer and Medicare must be met in order to bill remaining balances to Medicare (Timely NOE, F2F, CTIs)
- Must obtain primary payer authorization, follow billing timelines, etc.
- Must have a successfully processed or denied primary claim to bill Medicare

MSP- Medicare Secondary Payer

- MSP information from eligibility
  - MSP CODE MSP code indicators-
  - Valid values are:
    - 12 = Working Aged
    - 13 = End Stage Renal Disease (ESRD)
    - 14 = Auto/Liability
    - 15 = Worker's Compensation
    - 16 = Federal - Public Health
    - 41 = Black Lung
    - ·43 = Disabled
    - ·47 = Any Liability
- ·EFF DATE Effective date of the primary insurance (MM/DD/CCYY)
- ·TERM DATE Termination date of the primary insurance (MM/DD/CCYY)

Unsure What Payer is Primary? Use the Coordination of Benefits Provider Tool

- https://www.cms.gov/medicare/coordination-of-benefits-and-recovery/providerservices/downloads/pro_othertool.pdf
- https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/msp_fact_sheet.pdf

Medicare Secondary Billing Manual

- https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/msp105c03.pdf

Hospice Value Based Insurance Design (VBID) Model Pilot Program

Is the hospice located in an area covered by Medicare Managed Care Plans participating in the VBID Pilot Program?

If no, all patients with Medicare Advantage Plans will be covered by Traditional Medicare Part A for hospice.

Exception: If a patient lived in a VBID area prior to your services, and chose a participating plan, you must bill the plan even though you are not in that plan's area.

If yes...

Medicare Advantage Plan Hospice Coverage

Hospice MA Carve-In Pilot Program

- Review Medicare Advantage “Plan” page of eligibility- MA information
- Starting with admissions on January 1, 2020, verify plan page to confirm if we must bill the participating MA plan as part of the VBID hospice carve-in program.
- NOT ALL PLANS ARE PARTICIPATING. Hospices only bill participating plans.
- Enter payers as Medicare and MA plan and both must be billed as primary.
- Very important! Medicare NOEs for patients covered under participating plans MUST be sent to Medicare and the MA plan within the five-day window.

Medicare Advantage Plan Hospice Coverage

Hospice MA Carve-In Pilot Program

- For patients who elect hospice with traditional Medicare in years prior to a plan's participation in VBID, the patient remains covered under Medicare Part A even if they have chosen a VBID plan, or choose one at a later date.
- For patients who elect hospice in a year when any VBID plan is active in their area, coverage can change if the patient elects hospice under traditional Medicare but later chooses to enroll in a participating VBID plan.
- We recommend establishing a best practice of monthly verifications. Hospices should run Medicare eligibility and review the MA plan page for all active patients on the first of each calendar month.

VBID Plan Information for Hospice Providers

- https://innovation.cms.gov/innovation-models/vbid#cy2023

Medicare Data Breach- Over 600,000 Medicare Recipients Issued New MBIs

- Because of two separate data breaches, Medicare end dated the MBIs of over 600,000 recipients and issued new numbers.

https://www.cms.gov/newsroom/press-releases/cms-responding-data-breach-contractor

What New MBIs Mean for Providers

- Patients already on hospice services may have an NOE and claims with a compromised MBI.
- When Medicare end dates the MBI, new claims will not process.
- Hospices must obtain the new MBI from the patient or family.
- If the MBI was not received in the mail by the patient, hospices can obtain the new number by using the MBI lookup tool in your Medicare Administrative Contractor's online portal.

What New MBIs Mean for Providers

- The new MBI should be tied to the old MBI and claims using the new MBI should process without issue.
- This tie in does not always work as it should, because within the Medicare system the patient's two MBIs become disassociated and are not "linked".
- Immediate calls to your MAC should be made requesting reassociation and detailed notes should be kept.
- Follow up frequently until the issue is resolved.

What New MBIs Mean for Providers

- Newly referred Medicare patients may have end dates on the MBIs providers are given upon admission.
- When running Medicare eligibility on referral, it's most important to pay close attention to the message that the MBI has been end dated.
- If that message is overlooked, an NOE will not process and will be considered untimely after five days, with no grounds for appeal.
- This is considered provider error and the days until a valid NOE is submitted with the new MBI will be non covered.

Commercial, Medicaid, and VA Eligibility and Authorizations

- Verify with patient or family all insurance coverage for the patient
- Obtain a copy of front and back of all insurance cards
- Confirm benefits via online portal or by phone (however payer is set up with the agency)

Best Practice: Run eligibility on all non-Medicare patients at regular intervals (monthly) to monitor changes or termination of coverage. This includes MA carve in patients who may change plans during open enrollment OR terminate MA plan and convert back to traditional Medicare.

VA/VACCN vs Medicare

- Patient choice to use VA benefit or Medicare benefit
- Determined by where the referral comes from- If from VA, must bill VA benefit
- Medicare is NOT secondary to VA
- Both are government benefits and patient must choose one or the other
- Verify contract for VACCN as all patients should now be under the Community Care Network.
- The VA referral will be signed by a VACCN physician. If patient chooses a different attending physician, the physician must be in the VACCN network for VA claims to process and pay.

Required Insurance Information

Obtain a card copy from patient or family whenever possible. If not possible, information needed includes-

- Plan and policy information
- Authorization phone number or portal
- Electronic payer ID or mailing address to submit claims
- If patient is not insurance policy subscriber, obtain name and date of birth of primary policy holder

Required Insurance Information
continued

Verify patient policy eligibility information including-

- Policy is primary payer for patient, and if not, coordinate with the family to confirm policy is correct or if updates may be needed
- Policy coverage dates- verify no coverage termination date posted
- Hospice benefit- covered benefit? yearly max? policy year? lifetime max?
- Patient copays and deductibles

Best practice- always obtain benefits and eligibility in writing via payer portal, fax or email

Obtaining Commercial Insurance Authorizations

- Reserve all contracts for reference regarding authorization requirements by CPT code vs HCPCS code vs Revenue code, authorization request deadlines, timely filing of claims, claims formatting, etc.
- Authorization requests should follow contract requirements and contain specific CPT, HCPCS, and/or revenue codes, as outlined.
- Authorization requirements- obtain written authorization whenever possible- by email and/or fax
- When given verbal phone authorizations, obtain name and call reference number from representative.
- Comply with all record requests as a prerequisite to obtaining authorizations- CTI, H&P, F2F, etc.
- Monitor and obtain reauthorizations as needed
- Know the requirements for higher levels of care- separate authorizations needed for Continuous Home Care and GIP?
- Remember to authorize MD visits, if allowed by payer contract

Questions?

Please ask any questions you may have.

If you have questions after our call concludes, please feel free to email us anytime.

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THANK YOU

Thank you for attending our presentation and please reach out if we can be of further assistance.

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