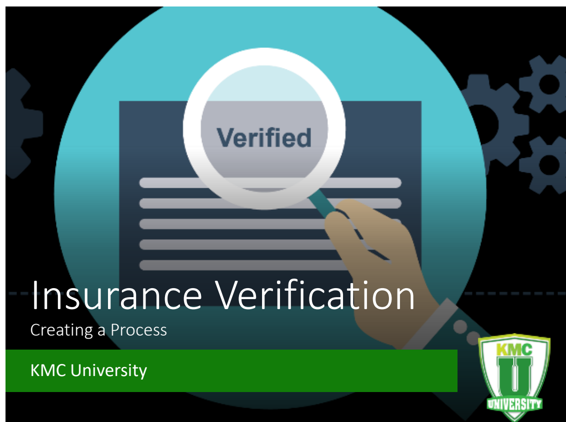

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Why Verify?

- Confirm patient eligibility and method of coverage
- Determine the patient's responsibility
- Clarify covered codes and determine if there are any specific requirements or exclusions

3

The Benefits

- Decrease in costly denials
- Increased awareness in payer policy
- Patients who understand their insurance coverage

4

heads up

Healthcare Reform

- Termination of Coverage Due to Non-Payment
- Marketplace Metal Plans- Essential Benefits
- Grandfathered Plans

5

Which is Primary?

- The **Dependent/Nondependent Rule** applies to the **health insurance plan subscriber** and the subscriber's spouse.
- **Birthday rule**, a child has parents who both have coverage the health plan of the parent whose **birthday** comes first in the calendar year is designated as the primary plan
- **Longer/Shorter** If none of the these **rules** determines the order of benefits, the Plan covering a person **longer** pays first. The Plan covering that person for the **shorter** time pays second.

Coordination of Benefits Birthday Rule

- Only the *month and the day are considered*, not the parents' years of birth.

FOR EXAMPLE:

- If the mother's birthday month is March and the father's birthday month is June, then the mother's health plan is **primary**
- If both parents have the same birthday, then the plan which covered the parent longer is **primary** over the plan which covered the parent for a **shorter** time.

6

The Overlooked Payers

7

Why Verify?

- Claim Closed
- Claim Challenged
- Exhausted Benefits
- Silent PPO
- PIP Claim Not Filed

8

HIS FAULT
HER FAULT
THEIR FAULT
NOT ME

The Impact

Office Exam $160.00
X-rays $110.00
Manipulation Therapy x 12 visits $780.00
Therapy/Modalities $660.00
Re-exam $90.00
Total $1800.00

9

Workers' Comp Verification is Necessary

- To confirm the services that are covered (approved injury diagnosis)
- The patient may not have reported the injury to the employer
- The patient may not have authorization for treatment
- The employer may not have workers' compensation (WC)coverage (the patient is a sub-contractor)

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Why Verify Medicare?

Is it so easy that it doesn't require verification?

Everyone has the same coverage, right?

11

MEDICARE HEALTH INSURANCE
JOHN L SMITH
1EG4-TE5-MK72
PART A
PART B
The Traditional
Covers 80%
Patient Responsible
20% plus deductible
Medicare Coverage Start Date
Type of Medicare Coverage

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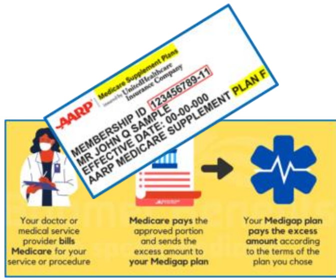
Filling in the Gap



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Intake Process

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Arkansas Blue MEDICARE

Medicare Advantage

Enrollee Name JANE T SMITH
Enrollee ID ABC1234567890
Issuer 123456789
Group Number: 12345

Plan S1234_001
Rx Bin 012345
Rx PCN AA123
Rx Group AAA00123
Issued: 01/2020

15

Medicare
-Complete
-Advantage
PPO
HMO
PFFS

16

PFFS Aware!

- A provider that decides not to accept the plan's terms and conditions of payment should not provide services to a member, except in emergencies. If the provider nonetheless furnishes non-emergency services, then the provider will become a deemed provider under the plan for that specific visit and be subject to the plan's terms and conditions whether the provider agrees to them or not.
- A deemed provider can decide whether or not to accept the PFFS plan's terms and conditions of payment each time the provider sees one of the plan's members. However, the provider cannot change his or her mind about accepting the terms and conditions of payment after providing services to the member.

17

Working Medicare Beneficiary

18

When Medicare is Secondary

- I'm 65 or older and have group health plan coverage based on my own current employment status or the current employment status of my spouse.
- **If the employer has 20 or more employees, then the group health plan pays first, and Medicare pays second.**
- **If the employer has less than 20 employees and isn't part of a multi-employer or multiple employer group health plan, then Medicare pays first, and the group health plan pays second.**

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Know Who Pays First

Medicare & Other Health Benefits:
Your Guide to
Who Pays First

20

Medicare Savings Program

Qualified Medicare Beneficiary (QMB) Program

If your monthly income and total assets are under the limit, you might be eligible for a QMB.

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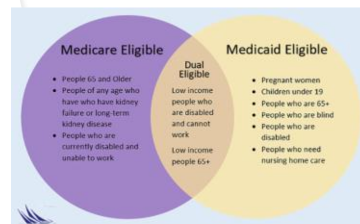
Dually Eligible Individuals

- "Dually eligible beneficiaries" generally describes beneficiaries enrolled in Medicare and Medicaid.



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QMB ONLY

Medicaid pays Part A (if any) and Part B premiums. Medicaid pays Medicare deductibles, coinsurance, and copayments for services furnished by Medicare providers for Medicare-covered items and services

QMB Plus

Same as QMB ONLY and includes "full Medicaid" coverage in addition to coverage for Medicare premiums and cost-sharing

23

Billing Requirements

All original Medicare and Medicare Advantage providers and suppliers – not only those that accept Medicaid – **cannot charge QMBs for Medicare cost sharing for covered Parts A and B services.**

If a provider bills a QMB for Medicare cost-sharing, or turns a bill over to collections, the provider must recall it. **If the provider collects any cost-sharing money from a QMB, the provider must refund it.**

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I Don't Accept Medicaid Patients

All Medicare suppliers and providers **-- even those that do not accept Medicaid** -- must refrain from billing QMBs for Medicare cost-sharing for Parts A and B covered services.

HEADS UP!!

States require all providers, including Medicare providers, **to enroll in their Medicaid system for provider claims review, processing, and issuance of the Medicaid Remittance Advice.** If a claim is automatically crossed over to another payer, such as Medicaid, it is customarily noted on the Medicare RA.

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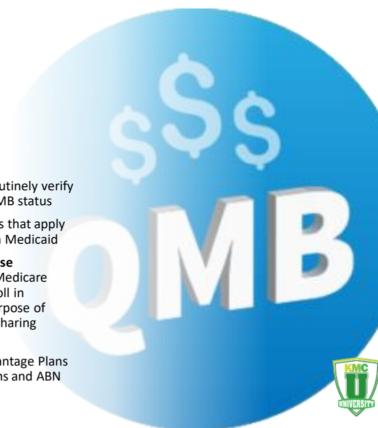
QMB Compliance

- Establish processes to routinely verify Medicare patients for QMB status
- Determine billing process that apply to seeking payment from Medicaid
- Ask about **limited-purpose enrollment process** for Medicare providers seeking to enroll in Medicaid for the sole purpose of claiming Medicare cost-sharing reimbursement
- Note that Medicare Advantage Plans may have their own terms and ABN forms



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Cannot bill a QMB patient!

Billing of QMBs Is Prohibited by Federal Law

Federal law bars Medicare providers and suppliers from billing an individual enrolled in the QMB program for Medicare Part A and Part B cost-sharing under any circumstances (see Sections 1902(n)(3)(B), 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and 1848(g)(3)(A) of the Social Security Act [the Act]). The QMB program provides Medicaid coverage of Medicare Part A and Part B premiums and cost sharing to low income Medicare beneficiaries. QMB is an eligibility category under the Medicare Savings Programs. In 2016, 7.5 million individuals (more than one out of eight beneficiaries) were enrolled in the QMB program.

Providers and suppliers may bill State Medicaid agencies for Medicare cost-sharing amounts. However, as permitted by Federal law, States can limit Medicare cost-sharing payments, under certain circumstances. Regardless, persons enrolled in the QMB program have no legal liability to pay Medicare providers for Medicare Part A or Part B cost-sharing. Medicare providers who do not follow these billing prohibitions are violating their Medicare Provider Agreement and may be subject to sanctions (see Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A), and

27

Resources

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VA Verification Process

Join	Join the Community Network
Obtain	Obtain Referral from VA
Follow	Follow the Authorization
Review	Review the Documentation Guidelines
Send	Send copy of documentation to VA (dedicated address or portal)
Review	Review the Billing Guidelines
Submit	Submit the claims to the assigned TPA for your region
	Stay up to date ! Sign up for newsletters

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Managing Referrals - HSRM

ccracommunity.va.gov

CCRA Community Care Referral & Authorization

Figure 1: HSRM Referral Lifecycle

VA | VA or Community Provider | VA

1 Approved · 2 Sent · 3 Accepted or Rejected · 4 First Appointment Made · 5 Initial Care Given · 6 EOC Complete

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Portal Features

- Referral Tracking
- Imaging & Lab Reports
- Ability to Download & Upload Documents
- Run Reports

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UTAH DEPARTMENT OF HEALTH MEDICAID

A Bridge to Wellness for Utah's Vulnerable

Medicaid Home | Apply for Medicaid | Medical Programs | Medicaid Members | Health

Patient Eligibility Verification

The Eligibility Lookup Tool is a website that allows a provider to electronically view a member's Medicaid eligibility and plan Lookup Tool will also tell you if the patient is restricted to a specific provider and if the patient is responsible for co-pays.

To verify your patient's eligibility on the portal you will need the information off of the Medicaid card which includes membe A provider must also have a Provider ID (NPI or API) known to Medicaid.

In order to be in compliance with HIPAA, we must assure that only those that have the right to this information have access. State of Utah by creating a Utah-ID account. If not currently logged in, you will be redirected and prompted to log in. If you login to access the Eligibility Lookup Tool. Due to security, there is a 20-minute inactivity timeout feature on the Eligibility I

Click here for more information and instructions if you have not previously created a Utah-ID account.

Eligibility Lookup Tool

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Coverage by CPT Code

For a list of provider types for which coverage and/or rates do not apply (as shown by this lookup tool), please click here.

Generally, the fees represented here are only for fee-for-service claims paid directly by Utah Medicaid using Utah Medicaid's fee schedule. This fee schedule does not account for any enhancement in fee schedule amounts (i.e., rural physician enhancements, rural dental enhancements, etc.).

All individuals eligible under Targeted Adult Medicaid (effective 11/1/2017) are eligible for Traditional Medicaid. However, Targeted Adult Medicaid individuals ages 19 or 20 are not eligible for EPSDT (CHEC) services.

If you would like to view the entire fee schedule, rather than searching for a particular code, please use our Fee Schedule Download Tool.

If you would like to view the entire diagnosis schedule, please use our Diagnosis Schedule Download Tool.

Select Provider Type: -

Enter Code:

Date of Service: 1/29/2018 (MM/DD/YYYY)

33

Code: 98940

Name: CHIROPRACT MANIPULATIVE TREAT;SPINAL,1-2 REGIONS

Type Of Service: Global

Updated On: 01/27/2018

Special Note: LIMITATION: Chiropractic visits are limited to 12 per 12-month period including any combination of CPT codes 98940, 98941, and 98942. OTHER: Service not covered for Targeted Adult Medicaid members.

	Traditional	Non-Traditional	PCN
Coverage Status:	Covered	Not Covered	Not Covered
Billable by Provider:	Yes	No	No
Charge Factor:	$20.44	N/A	N/A
Effective Start Date:	07/01/2017	07/01/2017	07/01/2017
Effective End Date:	---	---	---
Allowed Age Range:	Only 6 through 20	None	None
Prior Authorization Required?	Quantity limit applies - See Special Note Above	N/A	N/A
Prior Authorization Age Range:		None	None
Prior Authorization Limit:	0	0	0
Co-Payment Required:	Yes	N/A	N/A
PostOp Days Allowed:	None	N/A	N/A
Assistant Surgeon Modifier:	No	N/A	N/A

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noridian

Jurisdiction E - Medicare Part B
California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands

Contact Us | Help | Tools | Noridian Medicare Portal (NMP) Login

Browse by Topic | Browse by Specialty | Fees and News | Policies | Medical Review | Education and Outreach | Enrollment | Forms

JE Part B / Contact / Interactive Voice Response (IVR)

CONTACT
- CMS Comments on Noridian
- Congressional Inquiries
- Contractor Medical Director (CMD)
- Email Addresses

IVR Conversion Tool | IVR Guide | NMP vs. IVR Comparison

Interactive Voice Response (IVR)

Access the below IVR related information from this page.

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You will receive the following eligibility information if applicable:

- When a Health Insurance Claim number is provided, the IVR will advise caller if an MBI has been r
- Enrolled in MDPP – If the beneficiary is eligible to receive MDPP services from an MDPP supplier
- Medicare Part A and B effective dates
- Qualified Medicare Beneficiary (QMB)
- Date of Death
- Part B deductible
- PT/OT amounts
- Medicare primary or secondary status (based on the date provided) - Reason Medicare is secondar Effective and Termination Dates
- Medicare Advantage Information - Name and Contractor ID; Type of Plan; Address and Telephone Termination Dates
- Home Health Information – Name and Address of the Home Health Provider
- Hospice Information – Name and Address of the Hospice Provider

Interactive Voice Response (IVR)

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Extra Tools Available

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Eligibility is NOT the Same as Verification

38

A robust tool but limited for detailed benefits...

39

Availity Essentials

40

Tools

KMC University

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Tools You Need

- A Verification Form Template
- Access to online payor websites to locate Summary Benefits & Coverage(SBC) and Medical Review Policy (MRP)

42

One Verification Form Does Not Fit All

In order to properly verify insurance, one master form will not do the trick. The types of questions that must be asked for different payer classes necessitate different forms, considerations and questions. For example, to properly verify Medicare, you must consider whether the patient has elected to be in Part B or Part C Medicare, or has a supplemental, or secondary policy. For a personal injury claim, there may be up to four parties involved, including attorneys. For this reason, KMC University offers master, customizable forms for each type of payer, along with training on each. These can be found in the KMC University Library course on Verification. Here is a sampling of the master forms available.

Worker's Compensation Verification Form
Medicare Verification Form
Major Medical Verification Form
Personal Injury Verification Form

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What Questions Do You Ask?

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John Doe Chiropractic Office
Major Medical Verification Form

Patient Account #:

This Insurance Verification Form is ○Primary ○Secondary

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Oceanside Chiropractic
Major Medical Verification Form

Patient Account #: 00009876

This Insurance Verification Form is ☒Primary ○Secondary

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John Doe Chiropractic Office
Medicare Verification Form

Patient Account #:

47

Kathy's Chiropractic Heaven
Medicare Verification Form

Patient Account #: ROS-1234

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John Doe Chiropractic Clinic and Wellness Center
Personal Injury Verification Form
Patient Account #:

Section A - Patient Data
Name:
SS Number: Date of Birth:

Section B - Accident Data
Date of Accident: Date of First Visit:
Type of accident: Motor Vehicle Slip and Fall Pedestrian Other:

Section C - 1st Party Information
Policy Holder:
SS Number: DOB:
Insurance Company:
Policy #: Claim #:
Phone:
Claims Address:
Adjuster: Phone: FAX:
Email:
$ AMOUNT AVAIL: $ AMOUNT REMAINING:
Accident reported: Yes No Claim opened: Yes No By: PT CA
Will lien/AOB be honored? Yes No Date Sent:
Will benefits pay directly to provider: Yes No
If no, can benefits be payable to client but mailed to provider: Yes No
Notes requested with claims: Yes No

Notes
Date: Reference#: CA Initial:

Section D - 3rd Party Information
Policy Holder:
SS Number: DOB:
Insurance Company:
Policy #: Claim #:
Phone:
Claims Address:
Adjuster: Phone: FAX:
Email:
Accident reported: Yes No Claim opened: Yes No By: PT CA
Will lien/AOB be honored? Yes No Date Sent:
Will benefits pay directly to provider: Yes No
If no, can benefits be payable to client but mailed to provider: Yes No
Notes requested with claims: Yes No

Notes
Date: Reference#: CA Initial:

Section E - Attorney
Attorney Name:
Phone: Fax:
Address:
Contact:
Will lien/AOB be honored: Yes No Date Sent:
Receive claims/notes: Along the way End of care

Notes
Date: Reference#: CA Initial:

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John Doe Chiropractic and Wellness Center
Worker's Compensation Verification Form
Patient Account #:

Section 1 - Patient Data
Injured Worker's Name:
Date of Birth: Date of Injury:
SS#/ID#: Date of 1st visit:

Section 2A - Employer Information
Employer: Phone Number:
Address:
City: State: Zip:
EMPLOYER Self-Insured? Yes No Federal? Yes No
Filed First Report of Injury? Yes No
Contact:
Assigned Claim #:
Authorization Status: Pending Denied Authorized Date:

Section 2B - Referral
Is referral required from other physician? Yes No
Has referral been received? Yes No Date of referral:
Physician Name: Phone Number:
Office Name: Fax Number:
Address:
City: State: Zip:
Notes Requested? Yes No Notes Received? Yes No

Section 2C - Authorization Notes

Section 3 - Worker's Compensation Carrier
Carrier/MCO: Phone Number:
Address:
City: State: Zip:
Website URL:
Case Manager:
Case Manager Email:
Claim #: Other ID #:
Claim Denied: Yes No Date: Denial Reason:
Authorized by: Date:
Approval Details (Allowed Conditions, DX, Injury, Visit#):
Proof of Auth. Rcvd.: Yes No If yes, Fax Email Other:
MCO/WC Billing Information:
Address:
City: State: Zip:
Notes sent with claim: Yes No Notes sent by Fax: Yes No Fax#:
Other Billing Requirements:
Process for Submitting Treatment Request:

Misc. Notes:

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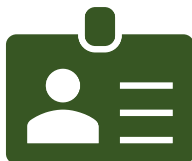
The Process



- New Patient Data Collection- Demographics & Insurance information
- Eligibility Check – confirm card is valid
- Good Faith Estimate - if applicable
- Verification- identifying and confirming covered services, limitations, exclusions and patient responsibility
- Medical Review Policy
- Financial Policy
- Financial Report of Findings (FROF)

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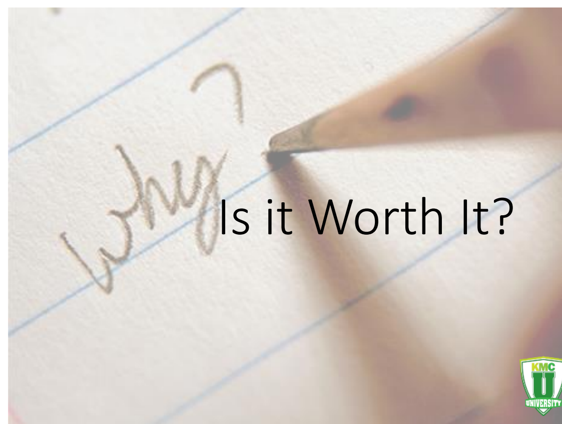

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Legal Precedent

Indiana Court Appeals- St. Mary's Medical Center **vs.** United Farm Bureau Family Life Insurance Co.

"acted in good faith without prior knowledge of the insurer's mistake"

City of Hope Medical Center **vs.** Superior Court 8 Cal. App. 4th 633 (1992)

" Insurance was denied the ability to recoup money ..based on their error....inability to determine coverage..."

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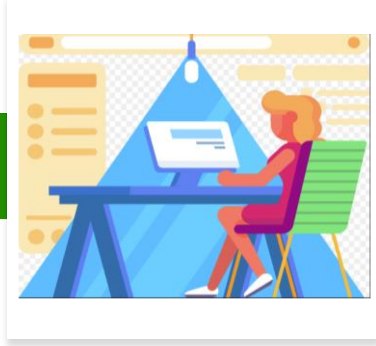

Let's Find Your Payer Portals & Verify

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Break Out Room

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