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Please Note!

- The views and opinions expressed in this presentation are solely those of the author, Kathy Mills Chang.
- Kathy and/or KMC University does not set practice standards
- We offer this only to educate and inform
- Medicare information provided today is not new and is available in the public domain

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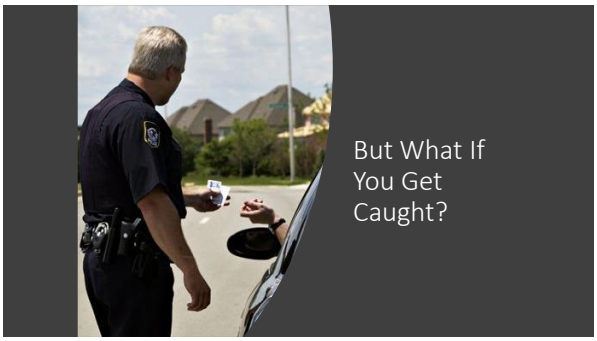

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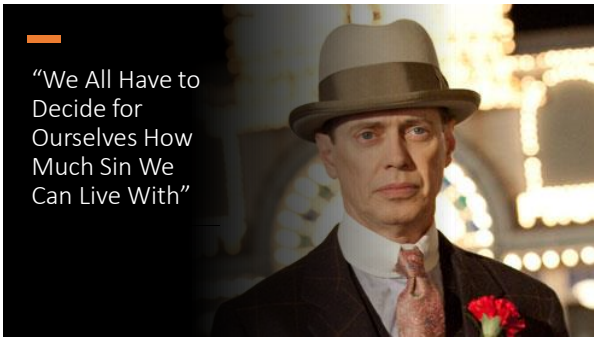

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Many In the Profession Feel Like This

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Know the Rules that Govern Healthcare

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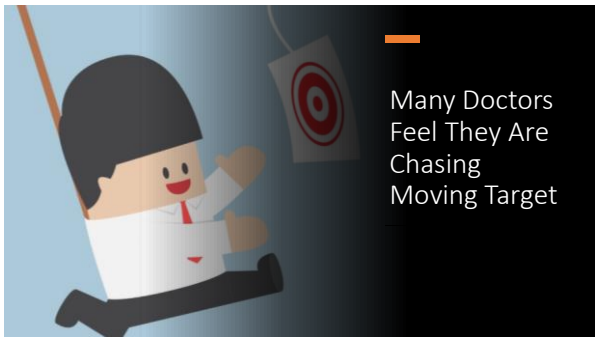

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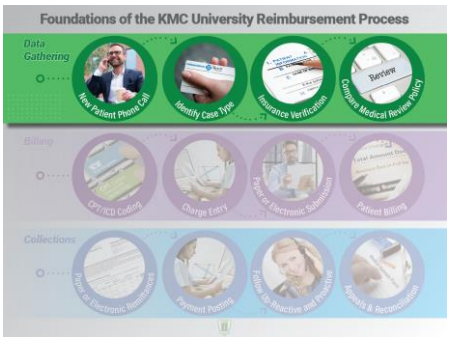

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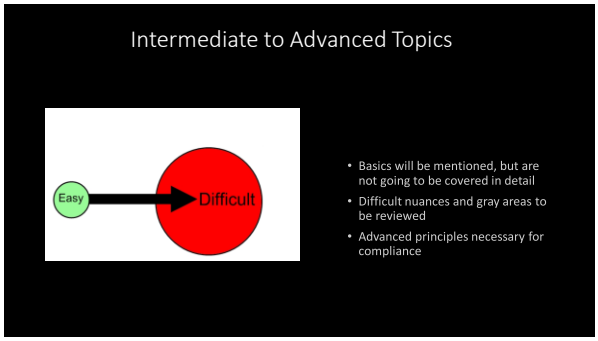

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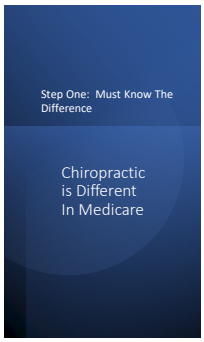

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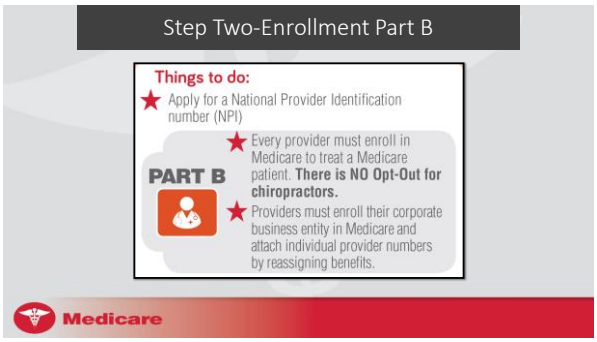

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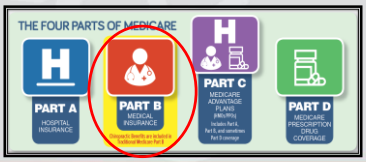
Types of Medicare Coverage: Part B

- Basic Medicare Part B coverage is what most of the senior population have
- Medicare Part B is optional
- Medicare Part B is usually the primary coverage



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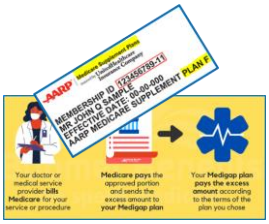
Filling in the Gap



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Intake Process

22

Working Medicare Beneficiary

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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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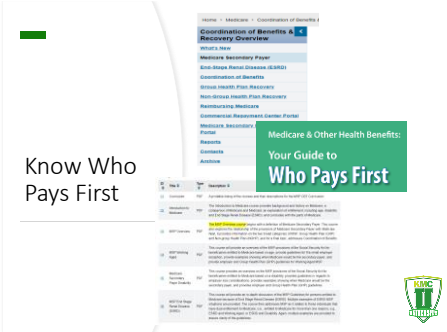

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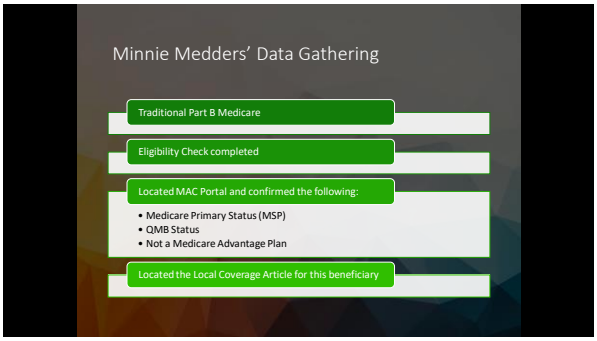

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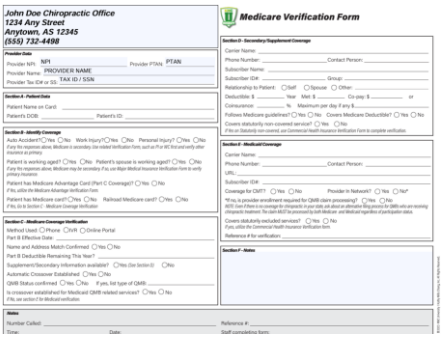

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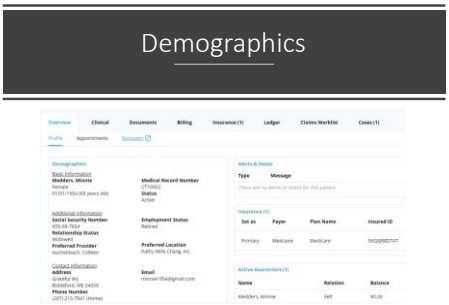

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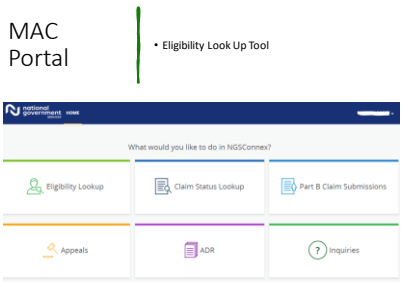

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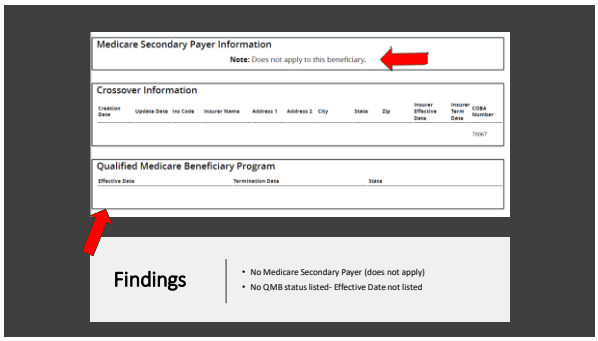

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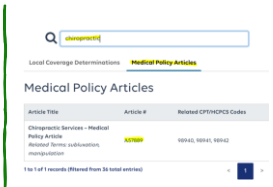
Finding the Coverage Documents



- LCDs
- Medical Policy Articles

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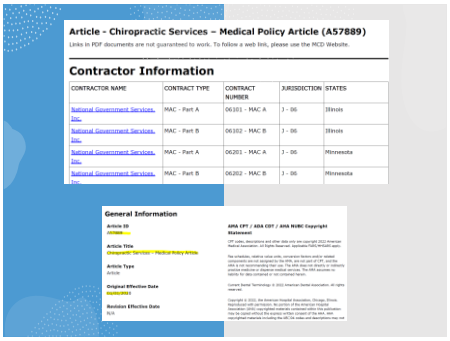

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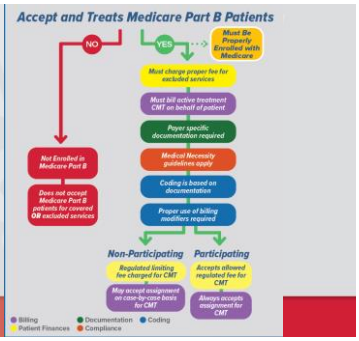
Obligations of DCs When Agreeing to Accept and Treat Medicare Part B Patients



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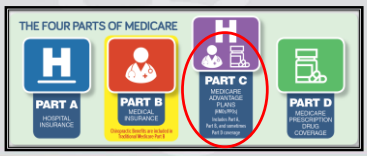
Types of Medicare Coverage: Part C

- Also known as Medicare Advantage Plans or Replacement Plans— "Managed Care Medicare"
- Redirects benefits to a private carrier
- No Part A or B



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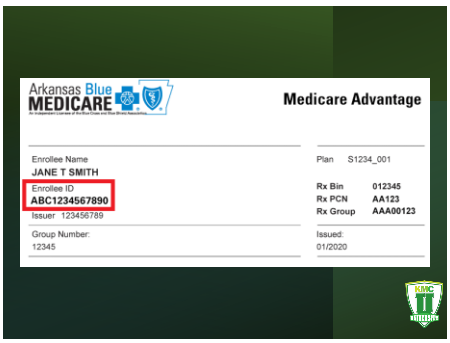

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Medicare
-Complete
-Advantage
PPO
HMO
PFFS

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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.

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Meet Henry Humes

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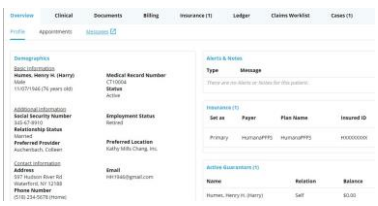
Henry Humes Data Gathering

- Medicare Advantage
- Plan Type PFFS
- Routine Office Visit



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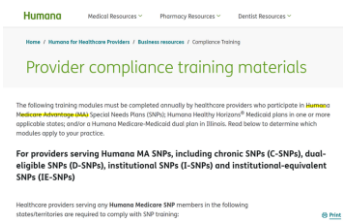
Medicare Advantage Payer Requirements for Providers



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- You must identify all your out of network plans
- Do not assume you can treat the patient like all your other self-pay or uninsured patients without reviewing the payer's requirements
- Pay close attention to PFFS plans

"If you treat a PFFS plan beneficiary and submit bills for their services, you are considered a "deemed provider" and automatically become part of the network while treating that patient. That makes you subject to all fee restrictions and appeals processes associated with that plan for that date of service."

The Out of Network Doctor

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Checking the Local MAC

Medicare Advantage

Effective Date	Termination Date	Administering Ins Co	Plan Name	Plan Website	Plan Phone Number	Contract Number	Plan Number	Plan Option Code Description
01/01/2023	12/31/2023	Humana Gold	PFFS	www.HUMANA.com/medicare	888-XX-XXXX	H1234	115	C - Submit claims to the MA plan. Exception: If an MA plan enrolled beneficiary elects

Effective Date	Termination Date	Administering Ins Co	Plan Name	Plan Website	Plan Phone Number	Contract Number	Plan Number	Plan Option Code Description
								the Medicare hospice benefit, submit claims to NGS.

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Check the Medical Review Policy & Resources

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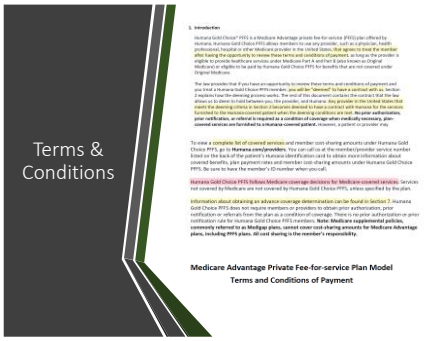
Terms & Conditions



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This is Why We Verify!

- Does the patient have traditional Medicare or Medicare Advantage for the year 2023? **Medicare Advantage**

47

This is Why We Verify!

- What is the name of the patient's insurance for the calendar year 2022? Wellcare Dual Access Open

Medicare Advantage

Effective Date	Termination Date	Administering Ins Co	Plan Name	Plan Website	Plan Phone Number	Contract Number	Plan Number	Plan Option Code Description
01/01/2022	12/31/2022	AMERICAN PROGRESSIVE LIFE & HLTH INS COMPANY OF NY	Wellcare Dual Access Open	www.wellcare.com/medicare	8888889355	H0000	115	C - Submit claims to the MA plan. Exception: If an MA plan enrolled beneficiary elects

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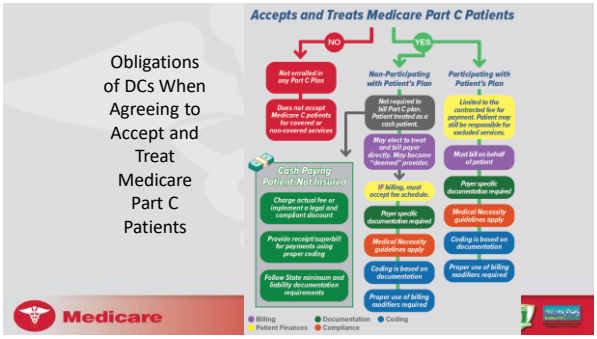

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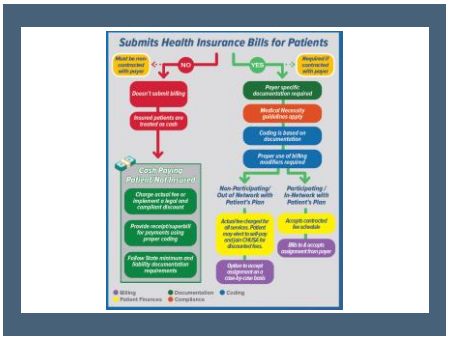

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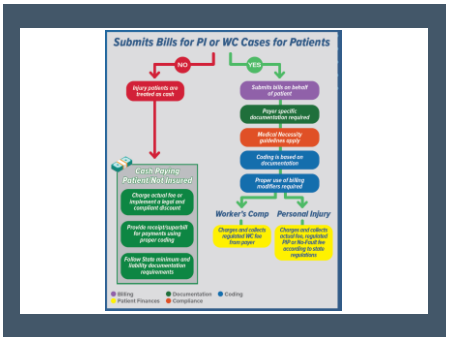

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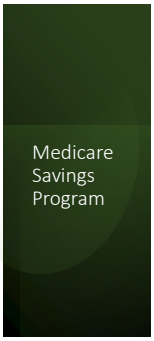

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Dual Eligibles - The following describes the various categories of individuals who, collectively, are known as dual eligibles. Medicare has two basic coverages: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit.

Medicare is designed to cover only a portion of your healthcare costs; therefore those who have financial challenges can occasionally be covered under both Medicare and Medicaid. In this case, you would be considered "dual-eligible" and can then fill in gaps that Medicare won't cover.

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Helpful Resources

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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

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Locate
QMB Status
for the Dual Eligible Patient

- Local MAC
- The Medicare Advantage Payer Portal
- Medicaid Payer Portal
- Remittance Advice (Medicare)

56

The Basic: QMB Only

1. Qualified Medicare Beneficiaries (QMBs) without other Medicaid (QMB Only) - These individuals are entitled to Medicare Part A, have income of 100% Federal poverty level (FPL) or less and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Federal financial participation (FFP) equals the Federal medical assistance percentage (FMAP).

Medicare

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2. QMBs with full Medicaid (QMB Plus) - These individuals are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and, to the extent consistent with the Medicaid State plan, Medicare deductibles and coinsurance, and provides full Medicaid benefits. FFP equals FMAP.

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SLMB and SLMB Plus

Medicare ?? Medicaid

3. Specified Low-Income Medicare Beneficiaries (SLMBs) without other Medicaid (SLMB Only) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. FFP equals FMAP.

QMB

4. SLMBs with full Medicaid (SLMB Plus) - These individuals are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not in exceed twice the limit for SSI eligibility, and are eligible for full Medicaid benefits. Medicaid pays their Medicare Part B premiums and provides full Medicaid benefits. FFP equals FMAP.

Medicaid Fee-for-Service

Medicare

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Medicaid Only

8. Medicaid Only Dual Eligibles (Non QMB, SLMB, QDWI, QI-1, or QI-2) - These individuals are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits. They are not eligible for Medicaid as a QMB, SLMB, QDWI, QI-1, or QI-2. Typically, these individuals need to spend down to qualify for Medicaid or fall into a Medicaid eligibility poverty group that exceeds the limits listed above. Medicaid provides full Medicaid benefits and pays for Medicaid services provided by Medicaid providers, but Medicaid will only pay for services also covered by Medicare if the Medicaid payment rate is higher than the amount paid by Medicare, and, within this limit, will only pay to the extent necessary to pay the beneficiary's Medicare cost-sharing liability. Payment by Medicaid of Medicare Part B premiums is a State option; however, States may not receive FFP for Medicaid services also covered by Medicare Part B for certain individuals who could have been covered under Medicare Part B had they been enrolled. FFP equals FMAP.

Medicare

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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

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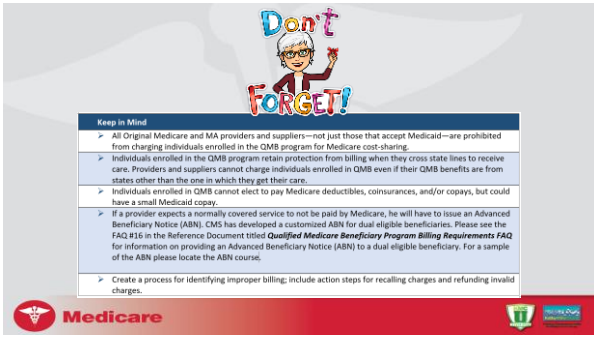

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I Don't Accept Medicaid Patients

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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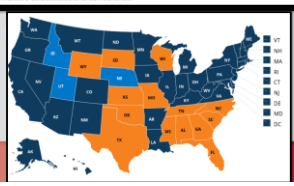
The Medicaid Conundrum

Statutory Authority for Payment of QMB Cost-Sharing Amounts

Section 1902(a)(10)(E) of the Social Security Act (hereinafter "the Act") directs state Medicaid agencies to reimburse providers for QMB cost-sharing amounts [as defined in §1905(p)(3)], "without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan." (emphasis added). Section 1902(n)(2) of the Act does permit the state to limit payment for QMB cost sharing to the amount necessary to provide a total payment to the provider (including Medicare, Medicaid, required nominal Medicaid copayments, and third party payments) equal to the amount a state would have paid for the service under the State Plan. When the crossover claim is for Medicare-covered services that are not included in the Medicaid State Plan, the state is still liable to pay the crossover claim, but may establish reasonable payment limits, approved by CMS, for the service. The actual crossover payment made to a provider by Medicaid (plus the QMB's personal liability for any nominal copayments under Medicaid, if applicable) is considered payment-in-full for Medicare deductibles and coinsurance.



Medicare

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Services Not Covered by the Medicaid State Plan

As noted earlier in this Informational Bulletin, a Medicaid agency's obligation to adjudicate and reimburse providers for QMB cost sharing exists even if the service or item is not covered by Medicaid, irrespective of whether the provider type is recognized in the State Plan and whether or not the QMB is eligible for coverage of Medicaid state plan services. For Full Benefit Dual Eligibles who are not eligible as QMBs, a state may elect to limit coverage of Medicare cost sharing to only those services also covered in the Medicaid State Plan.

Provider Enrollment

The state may require Medicare-certified providers to execute a Medicaid provider agreement and enroll in the state's Medicaid program in order to submit claims for reimbursement of QMB cost sharing, but the state should have a mechanism to ensure that providers who enroll only for that purpose are not included in lists of providers available to other beneficiaries. Alternately, a state may utilize a simplified, limited-purpose enrollment process for Medicare providers seeking to enroll in Medicaid for the sole purpose of claiming Medicare cost-sharing reimbursement while in compliance with the provider screening and enrollment requirements included in the CMCS Informational Bulletin issued December 23, 2011 (http://www.medicaid.gov/FederalPolicy-Guidance/downloads/CIB-12-23-11.pdf). As noted above, however, regardless of the specific enrollment mechanism chosen, states must enable all Medicare-enrolled providers, including those who are out-of-state, some mechanism by which they can get the state to process their Medicare crossover claims, including claims for QMB cost sharing.

Summary Therefore, in circumstances where a provider has submitted a claim to Medicaid for processing in accordance with the timely filing provisions of 42 CFR §424.44; and the provider has executed the necessary provider agreement according to a state's procedures for provider enrollment, the state must process the claim in accordance with the timely claims processing provisions of 42 CFR §447.45 and must issue the provider an RA for those claims as required by the SMM.

Medicare

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New Q17: Can a provider bill a dual eligible beneficiary for statutorily excluded services that Medicare never covers?

A17: If Medicare expressly excludes coverage for a given item or service and the beneficiary has QMB coverage without full Medicaid coverage, the provider could bill the beneficiary for the full cost of care.

However, if the beneficiary has full Medicaid coverage, Medicaid coverage may be available for excluded Medicare services if the State Medicaid policy covers these services and the provider who delivers the service participates in Medicaid. Since Medicare coverage is excluded, Medicaid will cover the service as it would for any another Medicaid beneficiary who does not have Medicare coverage. The Medicaid Remittance Advice will reflect what Medicaid will pay for the service the nominal Medicaid copay amount (if any). If the Medicaid Remittance Advice indicates that Medicaid will not cover the service, the provider can bill the beneficiary for care, subject to any state laws that limit patient liability.

Please keep in mind that for statutorily excluded services that Medicare never covers, an ABN does not have to be issued. We encourage providers to issue an ABN as a courtesy to the beneficiary so they are aware of their potential financial liability.

Medicare

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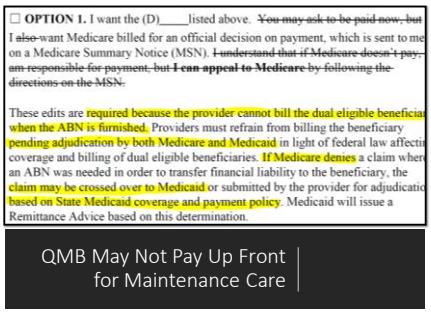

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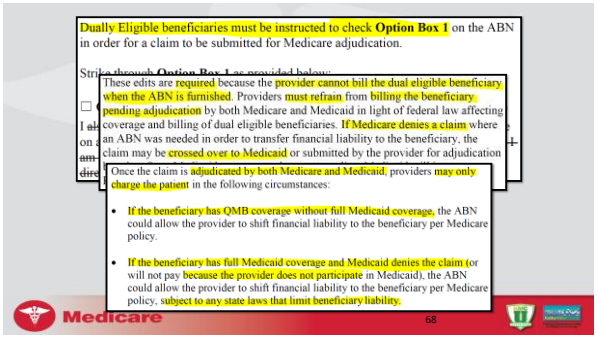

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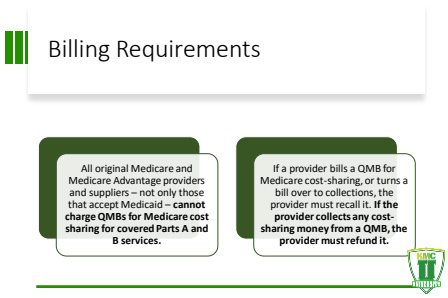

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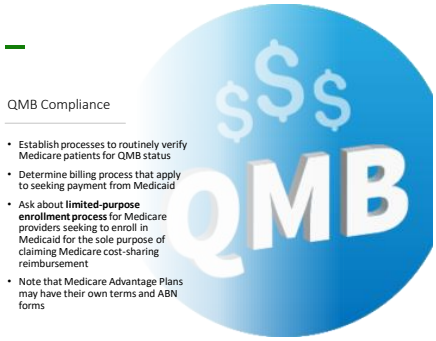

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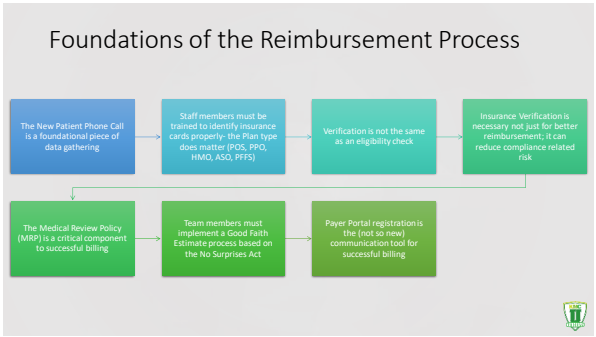

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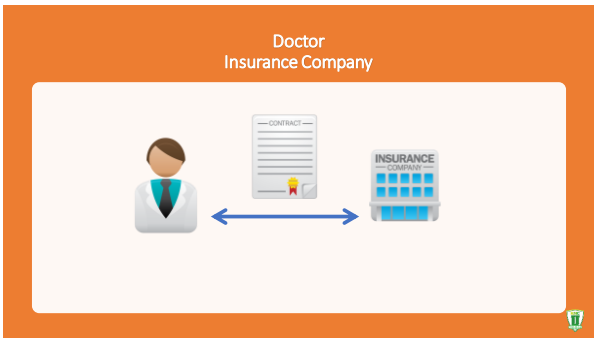

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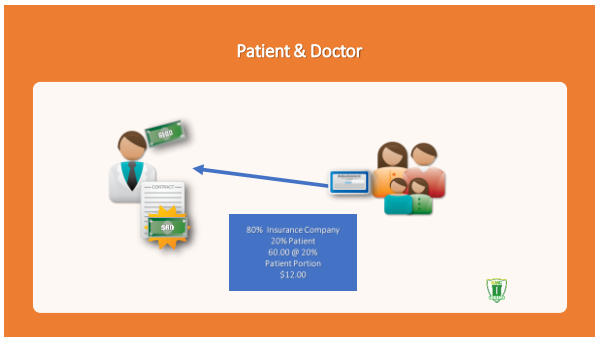


73

The Patient's Insurance Card

- Identify Type of Plan
- Provider's Network Status
- Confirm address for claim submission
- Confirm patient is eligible and active
- Fill out a Verification Form for the Verification Process

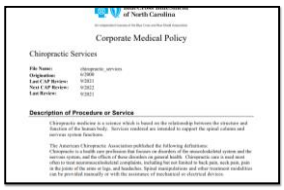
74

75

Provider Resources

- Policies & Guidelines
- Forms & Guides
- Credentialing
- Claim Submission
- Provider Appeals

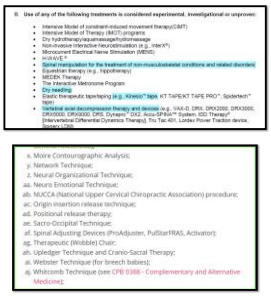
76



Coverage Details

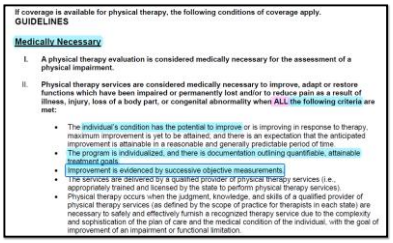
77

What is Not Covered?



78

Medical Necessity Requirements



If coverage is available for physical therapy, the following conditions of coverage apply.
GUIDELINES

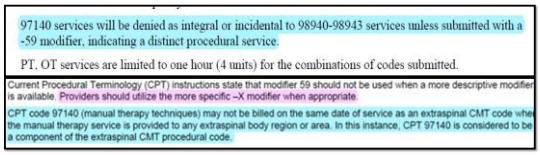
Medically Necessary

I. A physical therapy evaluation is considered medically necessary for the assessment of a physical impairment.

II. Physical therapy services are considered medically necessary to improve, adapt or restore functions which have been impaired or permanently lost and/or to reduce pain as a result of illness, injury, loss of a body part, or congenital abnormality when ALL the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, maximum improvement is yet to be attained, and there is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.
- Improvement is evidenced by successive objective measurements.
- The services are delivered by a qualified provider of physical therapy services (i.e., appropriately trained and licensed by the state to perform physical therapy services).
- Physical therapy occurs when the judgment, knowledge, and skills of a qualified provider of physical therapy services (as defined by the scope of practice for therapists in each state) are necessary to safely and effectively furnish a recognized therapy service due to the complexity and sophistication of the plan of care and the medical condition of the individual, with the goal of improvement of an impairment or functional limitation.

79



97140 services will be denied as integral or incidental to 98940-98943 services unless submitted with a -59 modifier, indicating a distinct procedural service.

PT, OT services are limited to one hour (4 units) for the combinations of codes submitted.

Current Procedural Terminology (CPT) instructions state that modifier 59 should not be used when a more descriptive modifier is available. Providers should utilize the more specific –X modifier when appropriate.

CPT code 97140 (manual therapy techniques) may not be billed on the same date of service as an extraspinal CMT code when the manual therapy service is provided to any extraspinal body region or area. In this instance, CPT 97140 is considered to be a component of the extraspinal CMT procedural code.

Payer Specific Modifier Guidance

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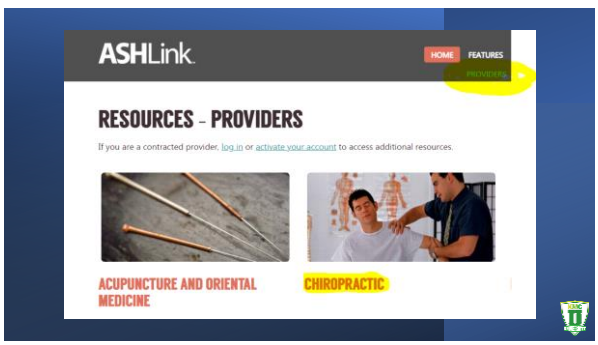
One Stop Shopping Resources

81

Availity is where healthcare connects
Payer-provider collaboration starts here!

Payer Collaboration Sites
One stop log in to access a variety of payer portals

82



ASHLink
HOME FEATURES PROVIDERS

RESOURCES - PROVIDERS

If you are a contracted provider, log in or activate your account to access additional resources.

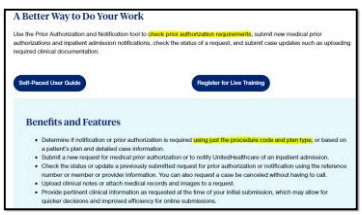
ACUPUNCTURE AND ORIENTAL MEDICINE

CHIROPRACTIC

83

Enter Procedure Code and Plan Type with the Prior Authorization Tool

MANAGED CARE
UHC Prior Authorization Resources



A Better Way to Do Your Work

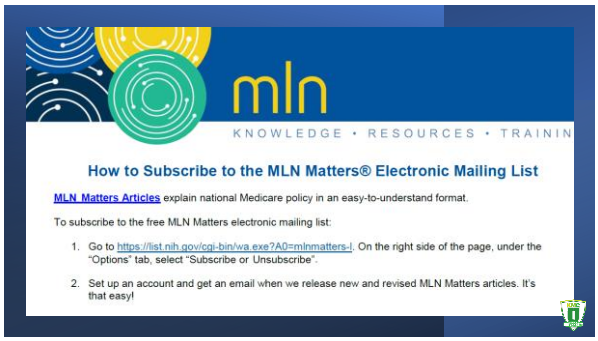
Use the Prior Authorization and Notification tool to check prior authorization requirements, submit new medical prior authorizations and inpatient admission notifications, check the status of a request, and submit case updates such as uploading required clinical documentation.

Self-Paced User Guide | Register for Live Training

Benefits and Features

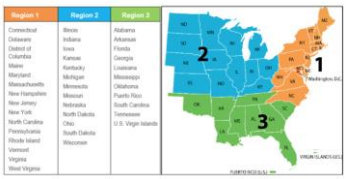
- Determine if notification or prior authorization is required using just the procedure code and plan type, or based on a patient's plan and detailed case information.
- Submit a new request for medical prior authorization or to notify UnitedHealthcare of an inpatient admission.
- Check the status or update a previously submitted request for prior authorization or notification using the reference number or member or provider information. You can also request a case be canceled without having to call.
- Upload clinical notes or attach medical records and images to a request.
- Provide pertinent clinical information as requested at the time of your initial submission, which may allow for quicker decisions and improved efficiency for online submissions.

84



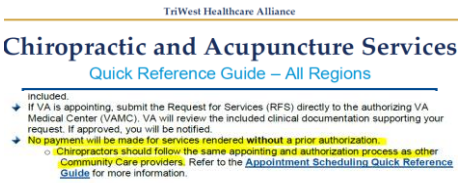
85

VA Optum Regions



86

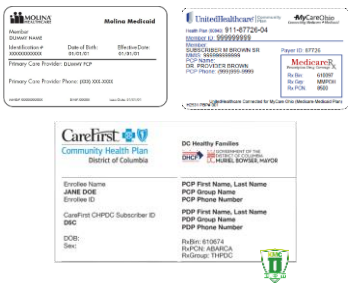
Follow the Rules



87

Look for words : Community Plan; Community Health; Home State Health; Department of Social Services

Keep an Eye Out for Medicaid Cards

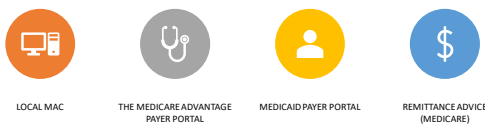


88

Find Your State Medicaid Status

89

Locate QMB Status for the Dual Eligible Patient



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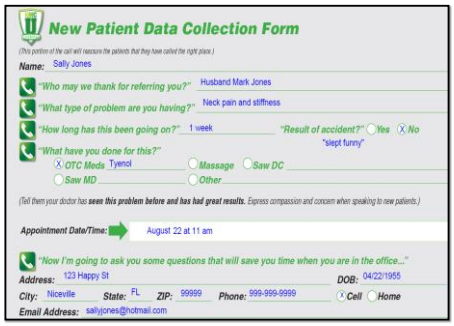

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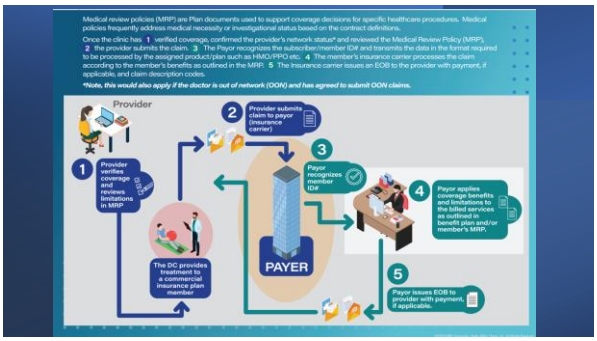

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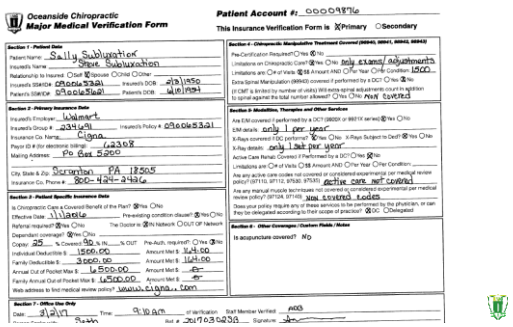

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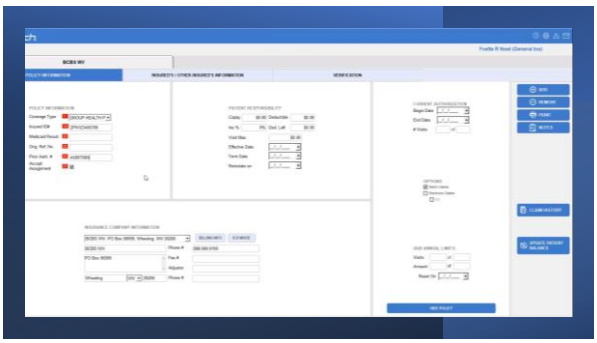

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You Don't Have to KNOW All the Answers…

- Follow Official Coding Rules and Guidelines
- Have *current* coding resources available
- Rely on a certified coding specialist when you have questions, not your buddy!
- Ongoing training is essential and your obligation!

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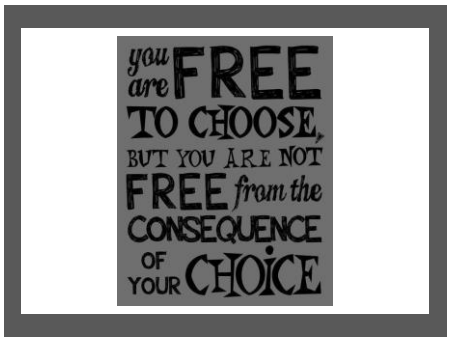
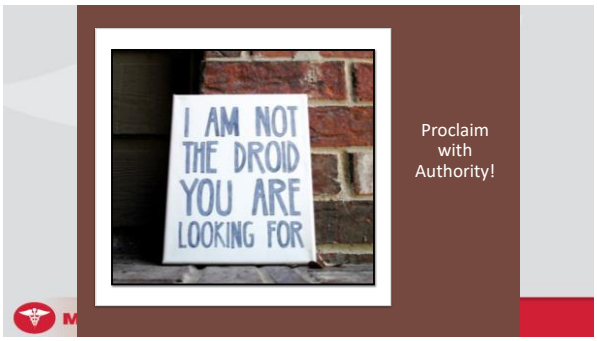

you are FREE
TO CHOOSE,
BUT YOU ARE NOT
FREE from the
CONSEQUENCE
OF
YOUR CHOICE

97


I AM NOT
THE DROID
YOU ARE
LOOKING FOR
Proclaim
with
Authority!

98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