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JK: The Boomerang Effect – How to Avoid Medicare Advantage Organization Plan and Hospice-Related Rejections

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenter

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Today's PowerPoint Presentation

- PowerPoint available on events calendar
  - Go to the http://www.NGSMedicare.com Web site
  - Select **Part A Home Page**
  - Click on the **Training Events Calendar** under the **Education and Training** section
  - Select the **"The Boomerang Effect – How to Avoid Medicare Advantage Organization Plan and Hospice Related Rejections"** under attachments you will see the PowerPoint presentation link

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Acronyms

ACH – Acute care hospital

CC – Condition code

CMS – Centers for Medicare & Medicaid Services

CPT – Current procedural terminology

CR – Change Request

CWF – Common Working File

DGME – Direct graduate medical education

DME – Durable medical equipment

DOS – Dates of service

DSH – Disproportionate share hospital

EHR – Electronic health record

ESRD – End-stage renal disease

Acronyms

FFS – Fee for service

FISS – Fiscal Intermediary Standard System

HICN – Health Insurance Claim Number

HIPAA – Health Insurance Portability and Accountability Act

HIQA – Health Insurance Query Access

HMO – Health Maintenance organization

ID – Identification

IME – Indirect medical education

IPPS – Inpatient prospective payment system

IRF – Inpatient rehabilitation facility

LCD – Local coverage determination

LIP – Low income payment

Acronyms

LTCH – Long-term care hospital
MAC – Medicare Administrative Contractor
MAO – Medicare Advantage Organization
MSA – Medicare savings account
MU – Medicare University
N&AH – Nursing and allied health
OT – Occupational therapy
PHI – Protected health information
PAI – Patient assessment instrument
PFFS – Private fee for service
PHI – Protected health information
PIN – Personal identification number

Acronyms

POS – Point of service

PPO – Preferred provider organization

PPS – Prospective payment system

PT – Physical therapy

SLP – Speech language pathologist

SNF – Skilled nursing facility

SNP – Special needs plan

TOB – Type of bill

Objective

- Assist Part A providers in understanding when and how to bill in situations in which Medicare patients have enrolled in an MAO plan rather than traditional Medicare or have elected hospice benefit
  - Understanding when and how to bill in these situations will help providers avoid unnecessary claim rejections

Agenda

- Impact of claim rejections on providers
- MAO plans
  - Claim rejection reason code U5233
- Hospice
  - Claim rejection reason code C7010
- References and resources
- Wrap up
- Questions and answers

Polling Question #1

- My facility type is
  - ACH
  - SNF
  - Teaching hospital
  - FQHC
  - Hospice
  - Home health
  - Other

Polling Question #2

- My job at the facility is in
  - Registration/admissions
  - Patient accounting
  - Clinical
  - Management

Polling Question #3

- How do you check for beneficiary eligibility?
  - Verify information provided by beneficiary via IVR
  - Verify information provided by beneficiary via NGSConnex
  - Verify information provided by beneficiary via CWF/HETS
  - Rely on information provided by beneficiary
  - We do not check

Polling Question #4

- Have you submitted claims to Medicare that rejected with reason code U5233?
  - Yes
  - No
  - I'm not sure

Polling Question #5

- Have you submitted claims to Medicare that rejected with reason code C7010?
  - Yes
  - No
  - I'm not sure

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How Do MAO Enrollment and Hospice Elections Really Impact My Claims?

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A Changing Medicare Population

- MAO plan enrollment forecasted to increase from 11.9 million in 2011 to 13.2 million enrollees in 2013
- Number of beneficiaries served by Medicare hospices has increased every year since 1993. Over 1.2 million beneficiaries received hospice care in 2011

The Boomerang Effect: High Rates of Claim Rejections!

- Billing errors related to Medicare HMO plan enrollment and hospice coverage has increased as well
- Chart below reveals number of claims rejected for top Medicare HMO plan and hospice related reason codes from February to July 2014

Reason Code	Feb.	March	April	May	June	July
U5233 (MAO plan)	15,180	15,624	16,467	14,682	16,116	15,578
C7010 (hospice)	2,883	3,221	3,509	3,103	3,346	3,172

Did You Know…

- Top claim submission errors can be found on our website http://www.NGSMedicare.com. Go to Part A > Claims > Top Claim Submission Errors

How Do Rejected Claims Impact Your Facilities?

- Financial
  - In some cases, no Medicare payment
  - Expense of resubmitting claim correctly
- Time
  - Loss of staff time
  - More time spent researching rejections

What Are the Benefits of Preventing Claim Rejections?

- Increase Medicare cash flow
- Ensure that claims are Medicare-compliant upon first claim submission
- Avoid being investigated for Medicare program integrity (fraud & abuse)
- Use staff time better

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Medicare Advantage Organization Plans

What You Need to Know to Avoid Claim Rejections for Reason Code U5233

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Why Claims Reject with Reason Code U5233

- Services fall within or overlap a Medicare Advantage HMO enrollment period and should be processed by HMO
- IP claims for HMO enrollees that must also be submitted to traditional Medicare must be coded properly

Did You Know…

- To submit claims related to MAO plan coverage correctly and avoid claim rejections from traditional Medicare, it is important that providers know what MAO plans are and how these plans affect billing traditional Medicare

What is an MAO?

- Beneficiary chooses a plan other than traditional Medicare as his/her Medicare plan
  - Covers healthcare needs
- MAO Plans are offered by private companies approved by Medicare, and can be set up in different ways
  - HMO, PPO, POS, PFFS (also known as “Indemnity” plans), MSA, SNP

Did You Know…

- Medicare HMO plans must offer all of the services that traditional Medicare offers except hospice care
  - Traditional Medicare covers hospice care for all Medicare beneficiaries, even if patient elected an HMO plan
- HMO plans may offer additional coverage
  - Most include Medicare prescription drug coverage (Part D)
- **Medicare HMO billing rules/regulations are not the same as traditional Medicare**

Eligibility For HMO Plan Enrollment

- In general, an individual is eligible to elect a Medicare HMO plan when he/she:
  - Is entitled to Medicare Part A and enrolled in Part B;
  - Has not been medically determined to have ESRD prior to completing enrollment request;
  - Permanently resides in HMO plan's service area;
  - Completes an enrollment request
    - Individual or his/her legal representative

When Can A Beneficiary Enroll/Disenroll In An HMO Plan?

- Enrollment
  - When newly eligible for Medicare due to age or disability
  - When Medicare eligibility changes from disability to age
  - When enrolling in Part B during general enrollment (must have Part A)
  - Annual enrollment period (October 15 – December 7)
- Disenrollment
  - Annual disenrollment period (January 1 – February 14)
- Special events apply to enrollment and disenrollment

When Does Enrollment or Disenrollment Become Effective?

- Enrollment in HMO plan
  - Generally, effective first of month after beneficiary applies to HMO
  - There are exceptions
- Disenrollment from HMO plan
  - Generally, effective first of month after member disenrolls from HMO
  - There are exceptions

Adapting to Constant Change

- High amount of enrollment/disenrollment changes among seniors in HMO plans
- Extremely important to verify coverage accurately for beneficiaries before submitting claims
- Always obtain both beneficiary's HMO plan ID number and traditional Medicare HICN

How to Check If A Beneficiary Is Enrolled In An HMO Plan?

- Eligibility information available on CWF in HIQA
  - Health Insurance Query Access (HIQA) Manual located in manuals section of http://www.NGSMedicare.com
- JK IVR: 877-567-7205
  - Choose option 1 for eligibility
  - IVR releases plan number, name/address, telephone number and effective/termination dates
  - Choose “I have a question” option if you have a MAO plan ID and need name and address
- NGSConnex - provider online inquiry portal
  - http://www.NGSMedicare.com

HMO Screen – CWF HIQA

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          HIQACRO    CWF  PART A  INQUIRY REPLY                PAGE 01 OF 15
IP-REC  CN 999000000A     NM XXXXXX   IT X   DB XXXXXXXX   SX F     IN 13201
PN xxxxxx     APP        REAS 1       DATETIME 021313 104609  REQ RER
DISP-CODE 01   MSG UNCONDITIONAL ACCEPT
CORRECT    999000000A     NM         IT     DB          SX
A-ENT 110100 A-TRM 000000 B-ENT 070101 B-TRM 000000 DOD 000000 LRSV 60 LPSY 190

DAYS LEFT FULL-HOSP CO-HOSP FULL-SNF CO-SNF  IP-DED BLOOD  DOEBA   DOLBA
CURRENT      60      30      20      80    118400    3    000000  000000
PRIOR
PARTB YR 13 DED-TBM 00000 BLD 3 YR 12 DED-TBM 00000 BLD 3      DI 1000000000
FULL-NAME XXXXXX.XXXXXXX
PER 6 PLAN-TYP HMO             CURR  ID H3359 OPT C ENR 120112 TERM
PRIOR PLAN-TYP HMO             PRIOR ID H5549 OPT C ENR 110110 TERM 113012

PART A YR      BLD  3 PT APL     0.00 OT APL     0.00
CATASTROPHIC A:   DED-TBM BLOOD CO-SNF  FULL-SNF  DOEBA  DOLBA  DED-APL
YEAR   89        0056000   03   008     142    000000 000000 0000000

ESRD:  CODE-1   EFF DATE         CODE-2    EFF DATE
```

Risk-Based vs. Cost-Based HMO Plans

- In HIQA, “OPT” field can have two values:
  - C = Risk-based plan
    - Most common type of plan
    - Submit all claims to Medicare HMO
      - May also need to submit inpatient claims to traditional Medicare contractor (informational)
  - 1 = Cost-based plan
    - Submit all claims to FFS Medicare contractor

What Entity Should I Bill?

- For Medicare HMO option code C enrollees
  - Bill Medicare HMO for all outpatient and inpatient services
  - May also need to submit inpatient claims to traditional Medicare
  - Do not bill outpatient services to traditional Medicare for HMO option code C enrollees
    - Claim will reject with reason code U5233
- For Medicare HMO option code 1 enrollees
  - Bill traditional Medicare for all outpatient and inpatient services

Where Can I Find a List of All HMO Plans?

- http://www.cms.gov
  - Home > Research, Statistics, Data and Systems > Medicare Advantage/Part D Contract and Enrollment Data > MA Plan Directory
  - View directory by contract number or contract name
- JK IVR 877-567-7205
  - Choose “I have a question” option if you have an HMO plan ID and need contact information
  - IVR releases name/address and telephone number

Polling Question #6

- If an HMO plan does not pay a claim in full, a secondary claim can be submitted to traditional Medicare to pay remaining balance.
  - True
  - False

Busting the Myth…

- Do not confuse HMO plan (option C) enrollment with MSP guidelines
  - A beneficiary who is enrolled in an HMO plan (option C) does not also have traditional Medicare
  - Traditional Medicare is not secondary to an HMO plan
  - If HMO plan does not pay a claim, traditional Medicare will not pay

HMO Plan Enrollment for Only Portion of Inpatient Billing Period

- There may be situations when
  - Beneficiary is admitted with traditional Medicare but enrollment in HMO plan becomes effective during stay or
  - Beneficiary is admitted with HMO plan but disenrollment from that plan (and placement into traditional Medicare) becomes effective during stay
- Beneficiary's status at admission determines liability for inpatient PPS claims

HMO Plan Enrollment for Only Portion of Inpatient Billing Period

- For hospitals paid under any PPS:
  - If beneficiary enrolled in HMO at admission, bill HMO for entire stay, even if disenrollment from HMO becomes effective during stay
  - If beneficiary enrolled in traditional Medicare at admission, bill traditional Medicare for entire stay even if enrollment in HMO becomes effective during stay

HMO Plan Enrollment for Only Portion of Inpatient Billing Period

- For cancer hospitals, children's hospitals, CAHs, and SNFs:
  - If beneficiary's enrollment in HMO plan becomes effective during stay, split claim
  - If disenrollment from HMO becomes effective during stay, split claim
  - Split claim = bill HMO for its portion of stay and bill FFS Medicare for its portion of stay

Did You Know…

- HMO plan enrollment should not be confused with MSP coverage. Traditional Medicare is never secondary to a Medicare Advantage Plan. However, there are other reasons you may need to submit a claim to traditional Medicare after HMO processes it…

Billing Traditional Medicare for HMO Option Code C Inpatient Claims

- When HMOs process claims for IP services…
  - Beneficiary information is not updated in CWF
  - Information necessary to calculate IME, DGME, and DSH payments is not tracked
- Providers must submit IP informational or "tracking" claims to traditional Medicare
  - Used to update CWF with accurate information about a beneficiary's inpatient benefit periods and transmit provider data to CMS
- **Outpatient claims should never be submitted to traditional Medicare as informational bills**

Billing Traditional Medicare for HMO Option Code C Inpatient Claims

- If a patient has an option “C” HMO plan, certain providers must bill informational claims to traditional Medicare **after billing HMO for payment** on inpatient claims
  - Teaching hospitals (all types, as applicable)
  - Non-teaching hospitals (ACH, IRF & LTCH)
  - CAHs
  - SNFs

Billing Tips

- Follow specific billing instructions with regard to TOB, CCs and other required claim elements as described
- Obtain traditional Medicare number from patients with Medicare HMO (option C) coverage in order to submit informational claims
- Do not submit as MSP claims

Billing Tips

- Report one or both of the following:
  - CC 04 = HMO Plan enrollee
  - CC 69 = Billing for medical education (IME, DGME and/or N&AH)
- Teaching hospitals must to report **both** CCs 04 and 69
  - Or claim will be rejected with reason code U5233

Instructions for ACH Teaching Hospitals

- Teaching ACH submits
  - Covered TOB (do not submit TOB 110)
  - Covered days/charges
  - CCs 04 and 69
  - FFS Medicare as first payer; do not submit as MSP
  - All other required claim elements
- Medicare processes claim as follows
  - Processed with reason code 37210
  - Pays for medical education via claim

Instructions for Teaching Hospitals Other Than ACHs

- Teaching hospital (other than ACH) submits
  - Covered TOB (do not submit TOB 110)
  - Covered days/charges
  - CCs 04 and 69
  - Traditional Medicare as first payer; do not submit as MSP
  - All other required claim elements
    - IRFs: Must report actual HIPPS code per CR 7674
- Medicare processes claim as follows
  - Rejected with reason code 37574 resulting in TOB 110
  - Pays for medical education via cost report

Instructions for Nonteaching Hospitals

- Non-teaching hospitals (ACHs, IRFs or LTCHs) submit
  - Covered TOB (do not submit TOB 110)
  - Covered days/charges
  - CC 04
  - Traditional Medicare as first payer; do not submit as MSP
  - All other required claim elements
    - IRFs: Must report actual HIPPS code per CR 7674
- Medicare processes claim as follows:
  - Processed with reason code 3719C (TOB remains 111)
  - No claim payment due

Instructions for CAHs

- CAHs submit:
  - Covered TOB (do not submit TOB 110)
  - Covered days/charges
  - CC 04
  - Traditional Medicare as first payer; do not submit as MSP
- Medicare processes claim as follows:
  - Processed with reason code 3719C (TOB remains 111)
  - No claim payment due

Instructions for SNFs

- SNFs submit
  - Covered TOB (do not submit TOB 210)
  - Covered days/charges
  - Room & board charges
  - CC 04
  - Assessment information
  - Traditional Medicare as first payer; do not submit as MSP
- Informational bills are required as long as beneficiary remains skilled
  - Even after benefits exhaust
- If HMO beneficiary no longer requires skilled care
  - SNF discharges using a patient status code 04
  - No-payment bills are not required for beneficiaries that are receiving non-skilled care and are enrolled in an HMO plan
  - If beneficiary again requires skilled care after a period of non-skilled care SNF submits a new admission claim for Medicare to continue spell of illness

Review Question #1

- An inpatient claim should be submitted to Traditional Medicare in addition to the HMO Plan if the beneficiary is in an Option Code C plan and receives covered inpatient services from a SNF
  - True
  - False

Review Question #2

- Providers should bill only the HMO Plan if plan option code is C and it is an outpatient claim. No claim should be submitted to traditional Medicare
  - True
  - False

Tips for Avoiding Rejections for Reason Code U5233

- Ensure registration/admission staff is checking to determine if a patient is enrolled in an HMO plan prior to submitting claims
- For HMO plan option code 1 plans, submit all claims to traditional Medicare
- For HMO plan option code C plans, submit
  - Outpatient claims to HMO plan (not to traditional Medicare)
  - Inpatient claims to HMO plan for payment and then submit informational bills to traditional Medicare using guidelines set forth in this presentation

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The Medicare Hospice Benefit

What You Need to Know to Avoid Claim Rejections for Reason Code C7010

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Why Claims Reject with Reason Code C7010

- Service dates overlap a hospice election period and should be submitted to hospice agency
- Services not related to terminal condition that must be submitted to traditional Medicare are not coded properly

Did You Know…

- To submit claims related to hospice enrollment and avoid claim rejections from traditional Medicare, it is important that providers know what hospice is and how the hospice benefit under Medicare affects billing traditional Medicare

What Is Hospice Care?

- Hospice is a program of care and support for people who are terminally ill
- Some important facts about hospice:
  - Hospice helps people who are terminally ill live comfortably
  - Focus is on comfort, not on curing an illness
  - A specially trained team of professionals and caregivers provide care for “whole person,” including his or her physical, emotional, social, and spiritual needs

What Is Hospice Care?

- Services may include physical care, counseling, drugs, equipment, and supplies for terminal illness and related condition(s)
- Care is generally provided in the home
- Hospice is not only for people with cancer
- Family caregivers can get support

Who Is Eligible For Hospice Benefit?

- Hospice care is a benefit under Medicare Part A
  - Beneficiary must elect hospice benefit to receive it
- To elect hospice, beneficiary must be:
  - Entitled to Medicare Part A
  - Certified terminally-ill by physician and hospice medical director
  - Life expectancy is six months or less if illness runs its normal course

Who Is Eligible For Hospice Benefit?

- In addition, beneficiary must:
  - Sign a statement choosing hospice care instead of other Medicare-covered benefits to treat terminal illness (traditional Medicare still pays for covered benefits for any health problems not related to terminal illness)
  - Receive care for terminal illness from a Medicare-approved hospice program

What Medicare Covers Under Hospice Benefit

- Doctor services
- Nursing care
- Medical equipment (such as wheelchairs or walkers)
- Medical supplies (such as bandages and catheters)
- Drugs for symptom control or pain relief (may pay a small copayment)
- Hospice aide and homemaker services
- PT, OT and SLP
- Social worker services
- Dietary counseling
- Grief and loss counseling for patient and family
- Short-term inpatient care (for pain and symptom management)
- Short-term respite care (may need to pay a small copayment)

Hospice Election Periods

- For billing and coverage purposes, hospice benefit is broken into “election periods”
- First two elections are 90-day periods
- Starting with election period number three
  - Beneficiary has an unlimited number of 60-day election periods available

What Happens to Traditional Medicare Coverage if Hospice is Elected?

- If beneficiary elects hospice care
  - Waives right to FFS Medicare coverage for any treatment related to terminal illness
- If hospice beneficiary requires treatment for condition not related to terminal ill
  - Traditional Medicare coverage continues to help pay for necessary, covered services

Revocation of Hospice Benefit

- Beneficiary
  - May revoke election of hospice care at any time in writing
    - Must file document with hospice and include signed statement of revocation with effective date
      - Forfeits hospice coverage for any remaining days in that election period
      - Resumes FFS Medicare coverage of benefits waived when hospice care was elected
- Please note: An individual may re-elect to receive hospice coverage at any time

Hospice Transfers

- An individual may change designation of particular hospice from which he or she elects to receive hospice care
  - Once in each election period
  - Not considered a revocation of the election

How to Check if a Beneficiary is Enrolled in Hospice?

- Hospice enrollment is included in the eligibility and entitlement information on CWF through HIQA
- JK IVR: 877-567-7205
  - Choose option 1 for eligibility
  - IVR releases hospice name/address, telephone number and effective/termination dates
- Hospice enrollment information not currently available through NGSConnex

Hospice Screen - HIQA CWF

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HIQACOP                    CWF  PART A  INQUIRY REPLY                    PAGE 02 OF 15

 IP-REC  CN 999000000A     NM XXXXXX   IT X   DB XXXXXXXX   SX F
 PAP:                        PAP DATE: 000000

 IMMUNO/TRANSPLANT DATA  COV. IND.:       TRANS. IND.:     DISCH. DATE: 000000
                                                                        000000
                                                                        000000
 HOSPICE DATE   PERIOD 007 OWNER CHANGE 007 PERIOD 006 OWNER CHANGE 006
 START DATE1    121212          000000          101312          000000
 TERM DATE1     020913                          121112
 PROV1          xxxxxx                          xxxxxx

 INTER 1        11004                           11004
 DOEBA DATE     121212                          101312
 DOLBA DATE     013113                          121112
 DAYS USED      051                             060
 START DATE2    000000                          000000
 PROV2

 INTER2
 REVOCATION IND 0                               0
```

Revocation Indicators

- Codes:
  - Blank = No revocation on file
  - Code 1 = Revoked by beneficiary
  - Code 2 = Revoked by MAC

Identifying a Beneficiary's Hospice Agency

- IVR releases hospice name, address and beneficiary effective/termination dates
- If you have hospice agency's provider number (PTAN) you can access name and contact information on the CMS website
- http://www.cms.gov
  - Home > Research, Statistics, Data and Systems > Cost Reports > Hospice
  - Under "Downloads" choose Hospice Reports
  - Open the file and choose "HOSPC_PRVDR_ID_INFO.CSV"
  - Use "Control+F" find option to search for PTAN

What Entity Should I Bill?

- Bill hospice for
  - Services related to terminal condition
- Bill traditional Medicare for
  - Services not related to terminal condition
  - If services are not related provider must report CC 07 (zero seven) on claim to indicate beneficiary elected hospice but provider not treating terminal condition
  - Services rendered after beneficiary revoked hospice

How to Bill if Hospice is Elected for a Portion of an Inpatient Stay

- When a beneficiary elects hospice during an inpatient stay:
  - Bill traditional Medicare for period before hospice election
    - PSC = 51 (discharge to hospice medical facility)
    - Discharge date = effective date of hospice election
  - Bill hospice for period of care after hospice election

How to Bill if Hospice is Revoked for a Portion of an Inpatient Stay

- When a patient revokes hospice during an inpatient stay:
  - Bill hospice for period up to hospice revocation
  - Bill traditional Medicare for period after hospice revocation
    - Admission date = date of hospice revocation
    - Statement from date = date of hospice revocation

Review Question #3

- If a beneficiary becomes terminally ill, he/she is automatically enrolled in hospice coverage.
  - True
  - False

Review Question #4

- If a provider wants to bill traditional Medicare for a hospice beneficiary's claim because the services rendered were not related to beneficiary's terminal illness (hospice condition), what code would provider need to report on its claim?
  - Condition Code 07
  - Occurrence Code 07

Did You Know…

- Medicare beneficiaries enrolled in an HMO plan may elect hospice benefits. When an HMO plan member enrolls in hospice care, hospice is paid by traditional Medicare directly. There are special rules for how other providers submit claims when an HMO plan member elects hospice coverage…

When an HMO Plan Enrollee Elects Hospice…

- Services related to terminal condition
  - Bill hospice directly
- Services not related to terminal condition
  - Bill traditional Medicare directly
    - Append cc 07 to claim

What Happens When an HMO Plan Member Revokes Hospice?

- When an HMO plan member enrolls in hospice and subsequently revokes their hospice benefit, traditional Medicare payment responsibility begins on the date of hospice election and extends to the last day of the month in which hospice election is revoked
- Following scenario (see next slide) illustrates how a facility should bill for services when a patient who has HMO plan coverage elects hospice and subsequently revokes their hospice election…

Billing Scenario – HMO Patient Elects/Revokes Hospice

- Patient elects hospice on 04/07/14, then revokes hospice election on 04/18/14 at 2 PM

Dates of Service	Submit Claims To…
04/01/14 - 04/06/14	Bill HMO plan for all services
04/07/14 - 04/18/14	Bill hospice directly for services related to terminal condition up to hour of hospice revocation; Bill traditional Medicare for services not related to terminal condition
04/18/14 - 04/30/14	Bill traditional Medicare for all services starting on hour of revocation
05/01/14 -	Bill HMO plan for all services

Tips for Avoiding Rejections For Reason Code C7010

- Ensure registration/admission staff is checking to determine if a patient is enrolled in hospice benefit prior to submitting claims
  - If services are related to hospice condition, submit claims to hospice directly
  - If services are not related to hospice condition, submit claims to traditional Medicare with CC 07
  - Follow guidelines set forth in this presentation if
    - Beneficiary elects/revokes hospice during inpatient stay
    - Hospice patient also has HMO plan coverage

What You Should Do Now…

- Share this information with appropriate staff
  - In particular, registration/admission staff
- Search your internal system for reason codes C7010 and U5233 and make appropriate changes
- Review other top reason code errors on http://www.NGSMedicare.com, Part A > Claims > Top Claim Submission Errors
- Take actions necessary to prevent these reason codes
- Attend our future educational events

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References and Resources

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References

- CMS IOM Publication
  - 100-02, *Medicare Benefit Policy Manual*
    - Chapter 9, “Coverage of Hospice Services Under Hospital Insurance”
  - 100-04, *Medicare Claims Processing Manual*
    - Chapter 1, Section 90 “Patient Is a Member of a Medicare Advantage (MA) Organization for Only a Portion of the Billing Period”
    - Chapter 6, Section 90 (SNF), “Medicare Advantage (MA) Beneficiaries”
    - Chapter 11, “Processing Hospice Claims”
  - 100-16, *Medicare Managed Care Manual*
- CRs 2476, 5647, 7674, 7172

IVR Resources

- http://www.NGSMedicare.com > Resources > Contact Us > 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
- http://www.NGSMedicare.com > Resources > Self Service > Interactive Voice Response Conversion Tools
  - Beneficiary Name to Number Converter
  - PTAN and Beneficiary Medicare Number Converter
  - IVR Conversion Tables

NGSConnex Resources

- http://www.NGSConnex.com
  - Quick Steps Job Aid
  - Rules of Behavior
  - Training Material (CBT)
- Provider Contact Centers
  - 888-855-4356 Part A

HETS

- HIPAA Eligibility Transaction System
- Available 24/7, except Mondays, 12:00 a.m.-6:00 a.m.
- Provides same eligibility data as HIQA, with following exceptions:
  - Currently does not provide
    - Lifetime psychiatric day availability
    - Hospice revocation information and election period breakdown*
    - Home health episode dates*
      - *Will be included in upcoming release

Where to Find Information on HETS

- http://www.cms.gov
  - Research, Statistics, Data and Systems > HIPAA Eligibility Transaction System (HETS) Help (270/271)
- CMS website has section devoted to HETS, including:
  - Vendor and registration information
  - HETS user guide
  - FAQs

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Wrap Up

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esMD is Available: Submit ADR Documentation Electronically!

- Providers can submit requested ADR documentation electronically through esMD
- Process is secure, time efficient and cost effective!
- Information on signing up for esMD can be found at following link:
  - How to Submit Medical Records to National Government Services

CMS Research Tool

- Calendar of articles by effective date
  - Organizes *MLN Matters* articles by effective date with descriptive information
  - Represents 12 months (rolling months) of posted articles
  - Updated weekly to reflect posted articles and Change Requests
  - Helpful tool for reviewing upcoming Medicare changes!
    - http://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/Contractor-Resources.html

Education & Training Tab

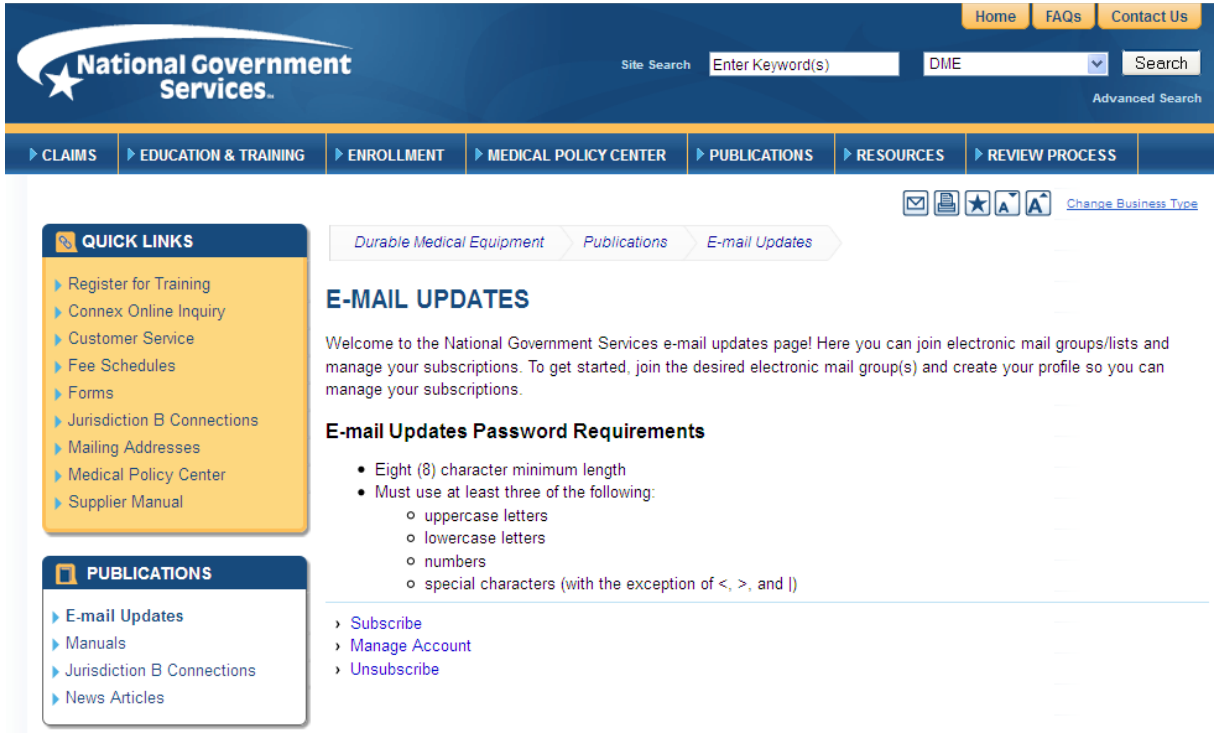
- For a complete listing of our educational activities, visit the **Education & Training tab** on our website!
  - http://www.NGSMedicare.com
- Our Education & Training tab includes links to:
  - Training Events Calendar,
  - Medicare University,
  - New Provider Center,
  - POE Advisory Group and
  - Much more!
- Easiest, fastest way to be aware of all POE information

On The Road Again…

- POE is on the road again this fall, presenting live educational events for JK Part A providers
  - Confirmed dates/locations
    - 9/30/14: GNYHA, New York, NY
    - 10/15/14: HANYS, Rensselaer, NY
    - 10/21/14: Nassau-Suffolk Hospital Council, Hauppauge, NY
    - 10/27/14: Anthem BCBS, Wallingford, CT
    - 10/30/14: St. Vincent's, Bridgeport, CT
- Our focus will be educating staff new to Medicare – providing valuable information and tools to make their job easier
- Stay tuned for additional dates/locations
  - Registration will be available soon on our events calendar

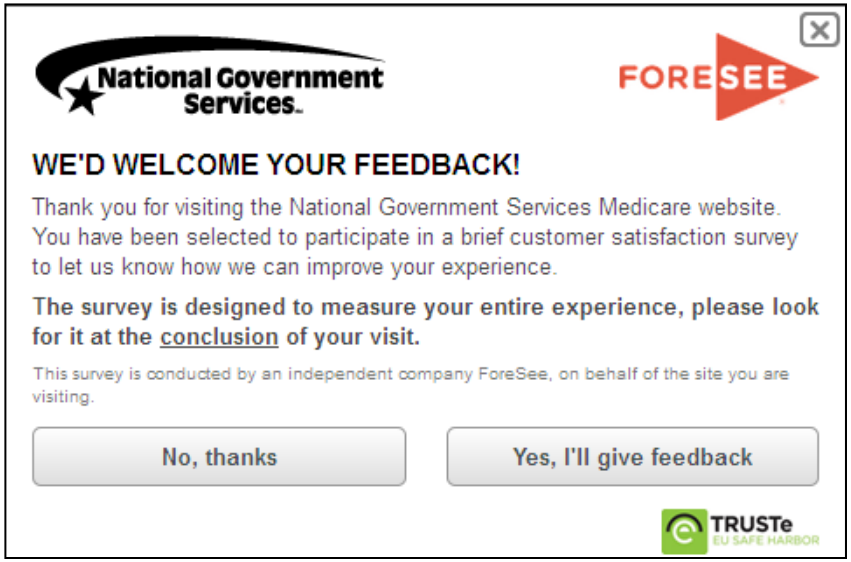
E-mail Updates

- Subscribe to receive the latest, up-to-date Medicare information.



Website Survey

- This is your chance to have your voice heard—Say “yes” when you see this pop-up so National Government Services can make your job easier!



Medicare University

- http://www.MedicareUniversity.com
- Interactive online system available 24/7
- Educational opportunities available
  - Computer-based training courses
  - Teleconferences, webinars, live seminars/face-to-face training
- Self-report attendance

Medicare University Self-Reporting Instructions

- Log on to the National Government Services Medicare University site at http://www.NGSMedicare.com
  - Topic = The Boomerang Effect – How to Avoid Medicare Advantage Organization Plan and Hospice Related Rejections
  - Medicare University Credits (MUCs) = 2
  - Catalog Number = To be provided
  - Course Code = To be provided
  - For step-by-step instructions on self-reporting please visit http://www.NGSMedicare.com > Medicare University > Accessing the Self-Reporting Tool

Continuing Education Credits

- All National Government Services JK Part A and Part B Provider Outreach and Education attendees can now receive one (1) CEU from AAPC for every hour of National Government Services education received
- If you are accredited with a professional organization other than AAPC, and you plan to request continuing education credit, please contact your organization not National Government Services with your questions concerning CEUs

Thank You!

- Follow-up email
  - We send to registered attendees following presentation
  - Provides Medicare University Course Code and requests completion of an online assessment
- Questions?
  - Questions in webinar question box will now be addressed