Welcome to TIM Talks: Business Acumen

“Medicare Billing and Dual Eligible Populations”

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What Does Medicare Cover?

- Part A: Medicare Part A covers inpatient hospital care, skilled nursing facility care, home health services, and hospice.
- Part B: Medicare Part B covers physician services, office visits, screenings, therapies, preventive services, outpatient services, emergency care, ambulance services, medical supplies and durable medical equipment.
- Part C: Medicare Part C is the private health insurance option for Medicare beneficiaries. Medicare Part C is often referred to as Medicare Advantage.
- Part D: Medicare Part D is the prescription drug benefit option.
What are the types of Medicare Providers?

- Organizations can become a Medicare Provider as long as they can provide at least one (1) Medicare service
  - Exception: The one service cannot exclusively be Diabetes Self-Management Training (DSMT)
- Medical Nutrition Therapy is an acceptable service to obtain a Medicare provider number
  - The Organization will submit as a “Group Practice”
  - The dietitian will be the provider linked to the Group Practice application
  - Additional services can be provided based on additional provider types obtained (e.g. LCSW- Therapy, Nurse Practitioner)
What is the Application Process?

- Medicare provider applications are submitted to your MAC
- MAC: Medicare Administrative Contractor
  - Process Medicare FFS claims
  - Enroll providers in the Medicare FFS program
  - Review medical records
  - Respond to provider inquiries
Application Forms

Form Completion Process

• Complete forms simultaneously
• The Primary application is the 855B
• Submit completed application forms to the MAC using the PECOS system
• PECOS
  – Internet-Based Provider Enrollment, Chain and Ownership System
  – Faster than paper-based enrollment
  – Available at: https://pecos.cms.hhs.gov/pecos/login.do
Ownership Interest

- All Medicare Provider applicants must disclose each member that has control of the organization
  - Board Members for a Non-Profit
  - Each person must sign a form stating that they have No Adverse Legal Action History that prevents their participation
  - Liability is shared when fraud occurs
Additional Forms

- CMS Form 588: Authorization for Electronic Funds Transfer
- CMS Form 855i: Registers the provider with Medicare
- CMS Form 855R: Authorizes CMS to pay the organization for professional services rendered by the independent provider
Medicare Part B Deductible

• CMS 2015 Medicare Cost estimates
  – Part A premium
    • Most people don’t pay a monthly premium for Part A
  – Part B premium
    • Most people pay $104.90 each month
    • Total ($104.90 x 12 mo) = $1,258.80/year
  – Part B deductible
    • $147.00 per year (for most beneficiaries)
  – Part C and Part D premiums
    • Amount varies by plan
• Medicare Part B beneficiaries can purchase a Medigap or supplemental policy to cover the 20% coinsurance requirements

• A Medigap policy defined
  • Health insurance sold by private insurance companies to fill gaps in Original Medicare coverage
    • Coinsurance, copayments, deductibles
    • If a beneficiary elects Medicare Advantage, they cannot be sold or use a Medigap policy
    • Beneficiaries with Medicaid (Duals) generally cannot buy a Medigap policy
Medicare Number and Liability

- Submitting Medicare claims for services opens an organization to legal and financial liability
- You must obtain proper insurance coverage to protect against potential liability
  - Professional liability insurance
  - Cyber Insurance
- Liability coverage does not protect against fraud
• A Northeast AAA successfully completed DSMT accreditation along with a Medicare Provider Partner
• After their experience with CCTP they discovered that there was an unmet need for counseling for persons with chronic depression
• The AAA obtained a Medicare provider number and now they provide DSMT/MNT and counseling services for Medicare beneficiaries
  – All three services are billed to Medicare
CBO Example #2

• One of the AAAs in a Southern State obtained DSMT Accreditation
• They partnered with a Home Health agency as the billing partner
• The partnership became contentious and they parted ways
• The AAA obtained their own Medicare provider number and now they are seeking reimbursement directly for DSMT
Common Billing Terms

- **Explanation of Benefits (EOB)** – When a claim for medical insurance benefits is processed, Medicare sends a notice called an EOB to the individual.

- **Current Procedural Terminology (CPT)** - CPT codes are the copyrighted material of the American Medical Association (AMA).

- **G Codes**: Special set of codes that are not described in normal CPB coding. An example of commonly used G codes are the diabetes self-management training (DSMT) codes.
Medicare Providers and Alternative Payment Models

• The Medicare Access and CHIP Reauthorization Act (MACRA) will expand provider participation in Alternative Payment Models (APMs)
• Two primary APMs include the following:
  – Accountable Care Organizations
  – Bundled Payment
• APMs provide an opportunity for Gainsharing and shared savings participation
• Gainsharing requires having a Medicare provider number to participate
Dual Eligible Beneficiaries

• Duals are persons with both Medicare & Medicaid
• Commonly referred to as a Dual Eligible or a Medi-Medi
• Medicaid is required to pay the co-insurance and deductibles for Duals
• Provider must first bill Medicare and then bill Medicaid for the second portion
Coverage for Dual Eligible Beneficiaries

- Participate in Medicare VBP program models
- Duals hold the greatest financial risk in a VBP contract
- Duals Eligible beneficiaries have Medicaid as the Medigap coverage policy
- Medicaid must cover the co-insurance, even if the service is not a current Medicaid covered benefit in that particular State.
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