



MO HEALTHNET COST SHARING FOR MEDICARE PART C/MEDICARE ADVANTAGE PLANS

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Medicare Part C Cost Sharing

The Centers for Medicare and Medicaid Services (CMS) established a program under Part C of Medicare referred to as the Medicare Advantage Program. The federal Medicare Program has contracted with private health insurance organizations to provide health coverage to beneficiaries that have opted to enroll in a Medicare Advantage plan. These plans have been approved by Medicare but are administered by private organizations. Medicare Advantage plans include Medicare Health Maintenance Organization Plans (HMO), Medicare Preferred Provider Organization Plans (PPO), Medicare Private Fee-For-Service Plans (PFFS) and Medicare Special Needs Plans (SNP). These plans were previously referred to as Medicare + Choice Plans.

Traditional Medicare Part A and Medicare Part B will no longer cover the medical costs for an individual that has enrolled in a Medicare Advantage plan. As with traditional Medicare Part A and Part B, individuals enrolled in Medicare Advantage/Part C plans share in the costs of their medical care by paying a deductible, coinsurance and/or co-payment amount.

For dates of service beginning October 1, 2007, MO HealthNet Division (MHD) will pay one-hundred percent (100%) of the Medicare Advantage/Part C cost sharing for MO HealthNet participants who are Qualified Medicare Beneficiary (QMB Only) and Qualified Medicare Beneficiary Plus (QMB Plus) participants. A QMB Plus is an individual who meets all the standards for QMB eligibility but who also meets the financial criteria for full Medicaid coverage.

Providers can determine if a MO HealthNet participant is QMB eligible by checking the MHD eligibility file. Medicare Part C will also be reflected on the eligibility file, as well as Medicare Part A and Medicare Part B. However, providers are required to submit the Medicare claims

to the Medicare Advantage/Part C plan for participants who have Medicare Advantage/Part C coverage. Eligibility can be verified by either of the following methods:

- Access the "Verify Participant Eligibility" link at www.emomed.com or
- Access the Interactive Voice Response (IVR) at 573-635-8908. After entering the participant's ID number and date of service, you will hear eligibility information.

Under the eligibility response from emomed, a participant with Medicare Advantage/Part C coverage will be indicated by an eligibility/benefit segment with an Insurance Type "HN-Health Maintenance Organization (HMO) Medicare Risk".

Medicare Part C Crossover Claims for QMB or QMB Plus Participants

Medicare Advantage/Part C plans do not forward electronic crossover claims to MHD. Therefore, providers must submit Medicare Advantage/Part C crossover claims through the MHD online internet billing system at www.emomed.com. The following tips will assist you in successfully filing your Medicare Advantage/Part C crossover claim through the MHD billing website:

- Access the MHD billing website at www.emomed.com. Choose the appropriate Part C crossover claim format. Enter the information exactly as you did on your Medicare Advantage/Part C plan claim. Do not use the Medicare Part A or Part B crossover claim format.
- There are "HELP" screens at the bottom of the page to provide instructions in completing the crossover claim format the "Other Payer" header detail and "Other Payer" line detail screens. Print each "HELP" screen in its entirety for reference when completing a claim on the Internet.
- The filing indicator for Medicare Advantage/Part C crossover claims is 16.
- There must be an "Other Payer" header detail screen completed for every crossover claim format. This provides information that pertains to the whole claim.
- Medicare Advantage/Part C institutional claims need only the "Other Payer" header detail screen completed and not the "Other Payer" line detail screen.
- Medicare Advantage/Part C outpatient and professional crossover claims need the "Other Payer" header detail screen completed without group code, reason code and adjustment amount information. An "Other Payer" line detail screen is required to be completed for each claim detail line.
- You must select the appropriate code from the five (5) codes available in the "Group Code" drop down box on the "Other Payer" header and detail screens. For example, the "PR" code (patient responsibility) is understood to be the code assigned for deductible, coinsurance, co-payments and noncovered charges shown on your Medicare Advantage/Part C explanation of benefits.
- The codes to enter in the "Reason Code" field on the "Other Payer" header and detail screens are found on your Medicare Advantage/Part C Plan explanation of benefits. If no codes are listed, you should choose the most appropriate code from the list of "Claim Adjustment Reason Codes" that can be accessed <http://www.wpc-edi.com/codes/Codes.asp>. For example, you would enter "Reason Code" of "001" for deductible amounts, "002" for coinsurance amounts and "003" for co-payment amounts.

- If there is a commercial health insurance payment or denial to report on the crossover claim, you must complete an additional "Other Payer" header detail screen. You must also complete an additional "Other Payer" line detail screen(s) as appropriate.

Medicare Part C Coordination of Benefits for Non-QMB Participants

For non-QMB MO HealthNet participants enrolled in a Medicare Advantage/Part C Plan, MHD will process claims in accordance with the established MHD coordination of benefits policy. The policy can be viewed in Section 5.1.A of the MO HealthNet Provider Manual at <http://manuals.momed.com>. In accordance with this policy, the amount paid by MHD is the difference between the MHD allowable amount and the amount paid by the third party resource (TPR). Claims should be filed using the appropriate claim format (i.e. CMS-1500, UB-04). **Do not use a crossover claim.**

Examples of coordination of benefits on a dual eligible (non-QMB participant) enrolled in a Medicare Advantage/Part C Plan are shown below:

Example 1:

- The provider submits a claim to MHD for \$100.00.
- The claim to MHD shows the Medicare Advantage/Part C plan paid \$60.00, a contractual write off of \$30.00 and participant co-payment of \$10.00.
- The MHD allowable amount on the claim is \$45.00. MHD would not make any additional payment as the Medicare Advantage/Part C plan's reimbursement amount of \$60.00 is more than the MHD allowable amount of \$45.00.

Example 2:

- The provider submits a claim to MHD for \$100.00.
- The claim to MHD shows the Medicare Advantage/Part C plan paid \$60.00, a contractual write off of \$30.00 and participant co-payment of \$10.00.
- The MHD allowable amount on the claim is \$65.00. The MHD payment would be \$5.00. (The difference between the MHD allowable amount and the Medicare Advantage/Part C plan payment.)

Inpatient Hospital Certification Reviews for Medicare Part C Participants

Inpatient hospital claims for deductible and coinsurance for MO HealthNet patients with Medicare Part C benefits are exempt from admission certification. However, if Medicare Part C benefits have been exhausted and a claim is submitted for MO HealthNet only days, admission certification requirements must be met. Pre-admission certification is required also for denied Medicare Part C inpatient hospital claims including exhausted benefits. Before requesting a pre-certification, the provider must exhaust all appeals through the Medicare Advantage/Part C plan appeals process and have a final denial that can be submitted to Health Care Excel (HCE) with the pre-certification request.

For non-QMB MO HealthNet participants enrolled in a Medicare Advantage/Part C Plan, admissions require certification. Additional information regarding inpatient hospital certification reviews is covered in Section 13.31 of the MO HealthNet hospital provider manual available at www.dss.mo.gov/mhd/providers/index.htm.

MHD Timely Filing for Medicare Part C Crossover Claims

The timely filing requirements outlined in Section 4.1.B of the MO HealthNet Provider Manual also apply to Medicare Part C crossover claims for QMB and QMB Plus MO HealthNet participants. As stated in the Provider Manual, claims that initially have been filed with Medicare within the Medicare timely filing requirement and that require separate filing of a claim with MHD meet the timely filing requirement by being submitted by the provider and received by the state agency within twelve (12) months from the date of service or six (6) months from the date on Medicare's provider notice of the allowed claim, whichever is later. Claims denied by Medicare must be filed by the provider and received by the state agency within twelve (12) months from the date of service. The counting of the twelve (12)-month time limit begins with the date of service and ends with the date of receipt. The counting of the six (6)-month period begins with the date of adjudication of Medicare payment and ends with the date of receipt.

MHD Timely Filing for Medicare Part C Coordination of Benefits Claims

The timely filing requirements outlined in Section 4.1.A and 4.1.C of the MO HealthNet Provider Manual also apply to Medicare Part C coordination of benefits claims for non-QMB MO HealthNet participants. Claims from participating providers who request MO HealthNet reimbursement must be filed by the provider and must be received by the state agency within twelve (12) months from the date of service. The counting of the twelve (12)-month time limit begins with the date of service and ends with the date of receipt. Claims for participants who have other insurance must first be submitted to the insurance company (Medicare Advantage/Part C Plan). However, the claim must still meet the MHD timely filing guidelines outlined above. Claim disposition by the Medicare Advantage/Part C Plan after one (1) year from the date of service does not serve to extend the filing requirement. If the provider has not had a response from the Medicare Advantage/Part C Plan prior to the twelve (12)-month filing limit, they should contact the MHD Third Party Liability (TPL) Unit at (573) 751-2005 for billing instructions. It is recommended that providers wait no longer than six (6) months after the date of service before contacting the MHD TPL Unit. If the MO HealthNet state agency waives the requirement that the third-party resource's adjudication must be attached to the claim, documentation indicating the third-party resource's adjudication of the claim must be kept in the provider's records and made available to the division at its request. The claim must meet the MO HealthNet timely filing requirement by being filed by the provider and received by the state agency within twelve (12) months from the date of service.

The twelve (12) month initial filing rule may be extended if a third-party payer, after making a payment to a provider, being satisfied that the payment is correct, later reverses the payment determination, sometime after the twelve (12) months from the date of service has elapsed, and requests the provider return the payment. Because a third-party resource was clearly available to cover the full amount of liability, and this was known to the provider, the provider may not have initially filed a claim with the MO HealthNet state agency. Under this set of circumstances, the provider may file a claim with the MO HealthNet state agency later than twelve (12) months from the date of service. The provider must submit this type of claim to the MO HealthNet Division, Third Party Liability Unit at P.O. Box 6500, Jefferson City, MO 65102-6500 for special handling. The MO HealthNet state agency may accept and pay this specific type of claim without regard to the twelve (12) month timely filing rule; however, all

claims must be filed for MO HealthNet reimbursement within twenty-four (24) months from the date of service in order to be paid.

Participant Liability

If an enrolled MO HealthNet provider does not want to accept MO HealthNet as payment but instead wants the patient (participant) to be responsible for the payment (be a private pay patient), there must be a written agreement between the patient and the provider in which the patient understands and agrees that MO HealthNet will not be billed for the service(s) and that the patient is fully responsible for the payment for the service(s). The written agreement must be date and service specific and signed and dated both by the patient and the provider. **The agreement must be done prior to the service(s) being rendered.** A copy of the agreement must be kept in the patient's medical record.

If there is no evidence of this written agreement, the provider cannot bill the patient and must submit a claim to MO HealthNet for reimbursement for the covered service(s).

If MO HealthNet denies payment for a service because all policies, rules and regulations of the MO HealthNet program were not followed (e.g., Prior Authorization, Second Surgical Opinion, etc.), the patient is not responsible and cannot be billed for the item or service.

All commercial insurance benefits must be obtained before MO HealthNet is billed.

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One for the red or white card.

**Provider Communications Hotline
573-751-2896**