MSMS MICHIGAN STATE MEDICAL SOCIETY Reimbursement Advocate Alert

Billing Medicaid Patients for Co-Insurance and Deductible

A physician may not collect any applicable deductible or co-insurance from a patient who has both Medicare and Medicaid. When Medicare approves a service, Medicare pays the physician 80% and the patient is responsible for the remaining 20%. In addition, Medicare will apply the appropriate deductible amounts for the allowed services. Patients are generally responsible for payment of the deductible and co-insurance.

However, when a patient also has Medicaid, the patient is not responsible for any applied deductible or the co-insurance. The physician's enrollment status with Medicaid does not change this requirement. The patient is responsible for any co-pay determined by Medicaid.

If you have further questions, please access the CMS MLN Matters article, Prohibition of Balance Billing Qualified Medicare Beneficiaries (QMBS) (SE 1128)

Why it's important to check eligibility and benefits at every visit

It's very important to check member eligibility and benefits every time you provide services. You can't rely on the member's ID card to tell the whole story. Here are some reasons why it's important:

- **Coverage may not yet be in effect.** With health care reform, more members are purchasing individual or family health care coverage directly from Blue Cross or Blue Care Network or through the Health Insurance Marketplace. These individuals receive ID cards once they enroll, but their coverage isn't active until they pay their first month's premium and their effective date occurs. In addition, if the member pays the first payment but doesn't make subsequent payments, the account becomes delinquent and coverage ceases. Members receiving government subsidized premiums who are in their second or third month of premium delinquency will have their claims held until the premiums are paid in full or until the contract is cancelled at the end of the three-month Advanced Premium Tax Credit grace period. So, even though members may show you an ID card, their coverage may not be in effect. You should check each member's eligibility and benefits at every visit.

- **Members may not be familiar with their coverage.** Members covered by group products -- often through an employer -- are covered according to the benefit designs selected by the group. These members may not be fully aware of what's covered and what's not covered. You should check the benefits these members have and also confirm that the benefits are effective on the date of service. The same is true for a member who has coverage through an individual plan. In addition, groups and individuals both have costs in mind when they select the benefit plans that work best for them. A more economical benefit plan with lower premiums may offer a more limited benefit package and this sometimes isn't clear until the member arrives in your office. If you can help members understand what their plan offers and what it doesn't, they may avoid unexpected out-of-pocket costs.

- **Benefits can change.** A member can sign up for coverage but later change that coverage. Members with individual policies can change coverage for any reason during the open enrollment period. After the open enrollment period is over, members with a qualifying event may still be able to change coverage. So a member may present an ID card that no longer accurately represents the coverage he or she has.

Three ways to check eligibility and benefits

- Online using web-DENIS or through a 270/271 electronic standard transaction
- By calling our automated phone system, PARS (formerly CAREN)
- By calling Provider Inquiry

What this means for physicians

Having a Blue Cross or Blue Care Network ID card doesn't necessarily mean the member has coverage that is currently in effect. You may find more and more situations in which ID cards are presented for coverage that's not in effect.

Be aware that Blue Cross and Blue Care Network won't reimburse claims for services that are not in effect at the time of service. It's important to check each member's eligibility and benefits at every visit.

Get Continuing Medical Education credits, mobile app for anticoagulation toolkits

Last year, the Michigan Anticoagulation Quality Improvement Initiative created and shared two anticoagulation toolkits: one for physicians who administer anticoagulation medication and the other for patients receiving anticoagulation medication.

The toolkits are free and available at anticoagulationtoolkit.org.

Recently, the collaborative has taken the toolkits to a new level by offering Continuing Medical Education credits (2 AMA PRA Category 1 credit hours) to individuals who review the toolkit and score 70 percent or better on a 10-question exam. You can find the education activity at the Office of Continuous Professional Development at the University of Michigan.

Additionally, the toolkit now has a free iPhonemobile app. The app includes three different interactive tools, along with the ability to view the entire toolkit.

The Michigan Anticoagulation Quality Improvement Initiative plans to add more interactive tools in the future. If you download it, use it and like it, please rate the app so others are encouraged to download it as well. The toolkits provide practitioners and patients with an up-to-date, reliable, and easy-to-use source of information on anticoagulation.

For additional information about the Michigan Anticoagulation Quality Improvement Initiative, please contact the Blue Cross project lead, Karlie Witbrodt, at kwitbrodt@bcbsm.com

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Updated information on billing and medical necessity guidelines for observation stays

Hospitals and physicians may bill for observation stays only when observation care is the medically appropriate level of care for the member. Currently, a maximum of 48 hours of observation care may be reimbursed, for all members. For BCN Advantage℠ members only, a minimum of eight hours of observation care must be billed. When a member is admitted for inpatient care but the admission is denied, the following guidelines apply:

- If the member was actually in observation and observation care was the appropriate level of care for the member's condition at the time, the services the member received may be billed as observation.

- If the member did not spend time in observation, the services rendered during the member's stay should be billed as outpatient services. This applies to BCN HMO (commercial) members only. Refer to the Blue Care Network Referral and Clinical Review Program to determine what referral and clinical review requirements apply. Currently, neither referral nor clinical review is required for the observation stay itself. In the future, however, clinical review may be required for observation stays, to ensure the member's situation meets medical necessity criteria for that level of care.

More information about observation stays is available as follows:

- **In the BCN Provider Manual:**
  - Care Management chapter - "Guidelines for observations and inpatient hospital admissions" section
  - BCN Advantage chapter - "BCN Advantage Care Management program" section
  - Claims chapter - "Billing guidelines for observation stays" section

- To access the BCN Provider Manual, log in to web-DENIS, click BCN Provider Publications and Resources and, finally, click Provider Manual.

- **On BCN's billing instructions:**
  - Observation: instructions for professional services
  - Observation stay: instructions for facilities To access the billing instructions, log in to Provider Secured Services. Click on web-DENIS, click BCN Provider Publications and Resources and, finally, click Billing.

- **In the January-February 2014 issue of BCN Provider News** - article on page 15 titled "Determining medical necessity for BCN Advantage members: inpatient vs. observation stay" This article updates the information in an earlier article about observation stays that was published in the March-April 2015 issue of BCN Provider News.

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