

**Ask the Contractor Teleconference (ACT) – MINUTES
“HMO and Hospice Overlap Billing”
Wisconsin Physician’s Service – Medicare
December 20, 2007
Chairperson: Jason Killion**

The Central Region ACT, “HMO and Hospice Overlap Billing” teleconference was called to order by Jason Killion, Medicare Outreach Analyst – Omaha Office, at 10:00 AM Central Time.

Jason began the teleconference by introducing himself. He was joined by other Outreach Analysts and members of the Provider Education staff. The introductions were followed by a brief description of the information available on the WPS Medicare website. Participants were encouraged to sign up for the WPS and CMS electronic mailing lists.

The introductory discussion was followed by a review of the presentation and handouts that had been e-mailed to the registered teleconference participants prior to the call.

At the conclusion of the presentation, the line was opened up for questions from the audience.

OPEN QUESTION AND ANSWER SESSION:

Q1. What happens if the beneficiary has a Skilled Care Facility stay that is covered by the Medicare Advantage Plan, but there is no 3-day qualifying hospital stay? Do we still have to submit the claim?

A1. Yes, the claim would still be submitted and you would just need to place the 04 condition code on the claim but would not need the 58 condition code. System will bypass the 3-day requirement when the 04 condition code is on the claim.

Q2. Are claims submitted on all Medicare Advantage Beneficiaries or just the ones that come in and go private pay or Medicaid while staying in the building? This is for a SNF.

A2. All the Medicare Advantage beneficiaries’ claims would have to be submitted.

Q3. Do we have to get the Medicare number on all these people?

A3. Yes.

Q4. Is there a way to find out the beneficiaries Medicare number on their behalf?

A4. The beneficiary should have their red, white, and blue Medicare card, but if they don’t, they can contact the Social Security office to obtain their Medicare number.

Q5. Do we bill the Medicare Advantage plan as primary and Medicare as Secondary on these claims?

A5. No, Medicare would replace the Medicare Advantage plan on the reporting claim. If the Medicare Advantage plan was primary, then you would report Medicare as primary.

Q6. Is the system ready to accept these claims?

A6. As of this time, the system is ready to accept these claims. However, it is always recommended to keep checking the Claims Processing and Payment Issues section on the WPS Medicare Website. You

can also sign-up for our Electronic Mailing List so you will automatically be informed when this and other sections have been updated.

Q7. If a claim is rejected for a Medicare Advantage Plan, will there also be an edit that rejects for the Hospice on the same claim? This is assuming the beneficiary has both a MA plan and Hospice.

A7. No, the way the system edits there can only be one reject placed on the claim.

Q8. If a claim is incorrectly billed to regular Medicare and is rejected for the beneficiary having a Medicare Advantage plan, will that rejected claim data be kept to record the needed information or do we have to submit a new claim?

A8. A new covered claim with the 04 condition code will need to be submitted.

Q9. When does this requirement go into affect for Skilled Nursing Facilities?

A9. It will be implemented on January 7, 2008 for claims starting January 1, 2008.

Q10. How do you bill if a beneficiary has a skilled level of care, drops to a non-skilled level of care, & then goes back to skilled?

A10. You will bill the first skilled level as covered with the 04 condition code and show a discharge when the drop to non-skilled using the 04 patient status code. No bill is required during the non-skilled level of care. When the beneficiary returns to skilled, then you treat it as a new admission. Remember that the system will bypass the qualifying hospital stay requirement. This information is from transmittal 1394 and will update the Online Manual Pub 100-4, Chapter 6, Section 90.2 on March 17, 2008.

Q11. We use PC-ACE PRO; will we be able to submit these claims using PC-ACE and are updates needed to be able to do this?

A11. You will be able to use PC-ACE PRO to submit these claims and there are no updates needed for PC-ACE to be able to do this. You are just adding a condition code.

Q12. Are the no-pay claims going to show on remits?

A12. Yes, these claims will populate on your remit.

The teleconference ended at approximately 10:38 AM Central Time.

The references included in this presentation are for informational purposes only. The current Medicare regulations will prevail.

There were 59 participants on 33 lines for the teleconference.