Determining Eligibility Virtual Training

3/2/2017

Question & Answers

Q: Is there a description of the upcoming trainings? Specifically interested in Practitioner 101

A: Please visit the Medicaid Providers Webpage: www.michigan.gov/medicaidproviders >> select Medicaid Provider Training>>select Medicaid Trainings, a list of the upcoming trainings will be listed. In order to see further details please select Register Here. This takes you to Adobe Connect where you can select Event Details based on the training of choice. Practitioner 101 specifically will go over helpful tools when submitting a professional claims. However, this will not go over how to bill professional claims. Once the virtual training event date has passed the training will be removed from the upcoming list and a recording of the training will appear back on the Medicaid Provider Training page. Please also visit the Medicaid Alerts webpage for further tips and informational tools.

Q: Please explain MA-EXP

A: MA-EXP is not a benefit plan, Medicaid expansion is shown as MA-HMP, Healthy Michigan Plan. This plan provides health care benefits to adults 19 through 64 years of age, not covered by or eligible for Medicaid, with family income at or below 133% of the federal poverty level (FPL) and who are not eligible for or enrolled in Medicare. Eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology.

Q: If a child has the benefit plan Children's Special Health Care Service (CSHCS) and has been placed on hospice, is there a way to determine that in CHAMPS?

A: The beneficiary would have a level of care (LOC) reflecting hospice coverage, as long as the paperwork has been filled out and submitted by the local MDHHS office.

Q: What does it mean if the "Other Insurance" is a "Y" but not a hyperlink? Does this mean they have Medicare?

A: If you see this please screenshot this information and contact provider support with the member ID and the date eligibility was checked; as this should not be happening.

Q: Can an explanation of the Document Management Portal (DMP) Training be given?

A: The DMP training will cover how to upload documents to a specific beneficiary or TCN directly in CHAMPS.

Q: What does SNF billing stand for?

A: Skilled Nursing Facility

Q: How do we determine if a patient's eligibility is pending, in regards to Search MA Pending Eligibility option under the Member Eligibility inquire- specifically what criteria is required to pull a pending eligibility?

A: Pending Eligibility can be verified once the recipient ID, CIN or card number has been assigned. The day an application is registered a recipient ID and case number will be assigned within 24 hours. Pending eligibility is noted with a "T" at the end of the case number.

Q: To determine if a member's coverage was retro-active would we used the Transaction date?

A: The transaction date could give a good indication that eligibility was issued retro-active; however, it is highly recommended to search the beneficiary eligibility using a date span if you feel this is the case.

Q: How can eligibility be verified if the case worker is not updating the system on their end?

A: If the worker is not updating a beneficiaries eligibility there would be no way of verifying a beneficiary's eligibility appropriately. There is no way to determine eligibility if it is not reflected within CHAMPS.

Q: Is there any way to determine Medicaid/HMP eligibility if you are not a provider and do not have access to CHAMPS?

A: No, if a provider is not an enrolled provider with Michigan Medicaid a beneficiary's eligibility information will not be given out.

Q: A beneficiary that has LOC 22, and signed into hospice, what steps need to be done to get that LOC changed to 16 other than faxing a hospice membership notice?

A: The only step that needs to be done to change the LOC 22 to a LOC 16 is the Hospice Membership Notice. Reminder there is Hospice Virtual Training on March 21, 2017.

Q: If a beneficiary has spend-down as a benefit plan, are the providers required to submit the claim for processing?

A: No, however, please make sure to tell the beneficiary prior to services that they will be responsible for the services. If a beneficiary has spend-down on the date of service, and MA is billed the claim will deny and could result in not being able to bill the beneficiary. However, if the beneficiary comes back and lets you know they have received MA coverage we ask that you please accept this.

Q: If a patient comes in as a cash pay and they obtain retro benefits 2-3 months later, does the provider have to retro bill?

A: Prior to rendering services to a cash patient let them know that they will be held responsible for the cost of the services provided. However, if a beneficiary comes back in and lets your facility know they have received retro-MA we do ask that you accept this.

Q Can clarification be made regarding when a patient has CSHCS, MA and MA-MC?

A: If services being billed are not covered within their CSHCS benefit, then the MA-MC should pick up the services being rendered, but again only if the services are not related to their CSHCS qualifications. If a beneficiary is in a managed care (MC) they become the primary payer not Medicaid. Their MA benefit will still show as active.

Q: Inpatient copay of $50.00. Is this for all Medicaid patients regardless of MA or MA-HMP?

A: Yes, with the exception of emergent admissions.

Q: How is it known if Medicaid considers the inpatient stay as emergent so not to bill the copay to the beneficiary?

A: If the admission was emergent (through the emergency department) and when billing the emergency indicator is utilized when billing, it would be assumed the inpatient stay was emergent.

Q: What should be done when searching for eligibility but an error of duplicate records is received? The beneficiary did not have their Medicaid number available.

A: Please email or call provider support so we can correct the duplicate record.

Q: Can explanation be given regarding pregnant patients with ESO, and how to bill these services?

A: ESO covers emergency services only. To qualify for ESO Medicaid, non-citizens must meet all Medicaid eligibility requirements not related to immigration status. Pregnant ESO beneficiaries may also qualify for pregnancy-related services under the MDHHS Maternity Outpatient Medical Services (MOMS) program.

Q: How should situations be handled where pregnant patients have ESO, how do we bill this situation?

A: For the purpose of ESO coverage, Federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: Place the person's health in serious jeopardy, or cause serious impairment to bodily functions, or cause serious dysfunction of any bodily organ or part.

Q: How do we know if a spend-down has been met?

A: If a beneficiaries spend-down has been met an active MA coverage will show as a benefit plan within eligibility date span in question. The MA benefit plan will have a start date of when the spend-down was met, and the spend-down would have an end date indicated.

Example: Spend down benefit DOS 1/1/17-1/12/17…..MA benefit would show 1/13/17-1/31/17

Q: In regards to spend-down, do the patients pay the providers first and then take the receipt to the case worker to show the payment?

A: No, payment is not required at the time of the service.

Q: Can there be a training in regards to Medicaid Spend-down? Our office has many issues with this benefit.

A: A spend-down presentation would not really qualify for a virtual training session in a group setting; however, please visit www.michigan.gov/medicaidproviders >> Medicaid Provider Training >> select 1-on-1 Appointment Request: We would be more than happy to assist. 1-on-1 presentations can be done via phone, individual virtual trainings or in person depending on the location.

Q: If a beneficiary has spend-down does the facility submit the bills to Medicaid or do we bill the patients? In regards to a Hospice agency that bills Medicaid for room and board when a patient is in a SNF.

A: Nursing facilities need to notify the county worker that a patient is residing in the nursing facility done with form MSA 2565 (Facility Admission Notification), once complete the resident will then have MA as a benefit plan and will have a patient pay.

Q: What are the specific coverage types that would cover DME suppliers?

A: DME supplies would be covered by MA, MA-MC, MA-HMP. However the Medicaid Provider Manual will provide additional information. Please review the Medical Supplier Chapter for exact coverage details as place of service also plays a role in reimbursement.

Q: What do we do when CHAMPS shows that a patient is in a nursing facility but the facility has a discharge date? Who is responsible for updating this information?

A: Family members of the beneficiary need to make contact with a caseworker to end the LOC 02.

Q: How can eligibility be looked up for over 1 year to see if a child had MA?

A: For all eligibility over 1 year, provider support will need to be contacted as providers cannot access this information. This is why MA eligibility should be checked prior to/on the date of service.

Q: Is there a way to access a written copy of this training to have for future reference? It was difficult to write everything down.

A: This presentation can be downloaded within the files pod. However, we will also include the presentation when we send out the Q&A's. Also, a recording of this training will be available on the Medicaid Provider Training webpage within the next couple of weeks.

Q: Can QMB be explained?

A: QMB is a benefit plan that is part of the Medicare Savings Program (MSP), also known as the Buy-In program. A client must be entitled to Medicare Part A. Under certain income limits, Medicaid pays for Medicare Part B Premiums, deductibles and co-insurances. This is an all-inclusive benefit.

Q: Is there facility room and board coverage with QMB Medicaid?

A: No there is no room and board coverage within the QMB eligibility. If a beneficiary is in a nursing facility their caseworker should review their eligibility as beneficiaries shouldn't usually have the QMB benefit while in the facility.

Q: Is there someone who can be contacted regarding questions about gaining access to CHAMPS for our associates at 12 different sites so they can verify Medicaid Eligibility?

A: Yes, please contact provider enrollment at 1-800-292-2550 option 4 or email ProviderEnrollment@michigan.gov

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Q: If a patient shows active TPL and it is determined it is no longer active, and an Insurance Coverage Request Form has been completed to have it removed from the patient's profile, how long does this take once it's submitted to MDHHS?

A: Medicaid currently receives a direct file from BCBS, BCN and Delta Dental, eligibility issues with these primary carriers need to be taken to them specifically. For other carriers please wait 5-10 days, if still having issues please contact provider support.

Q: Is there another other than contacting the caseworker for updating TPL? We have clients who tell us they have contacted their case worker several times but the TPL information is still not updated. In some cases the insurance in question has been terminated for over a year.

A: Medicaid currently receives a direct file from BCBS, BCN and Delta Dental, eligibility issues with these primary carriers need to be taken to them specifically. Other carriers

please wait 5-10 days if still having issues please contact provider support. Here is the form- https://minotifytpl.state.mi.us/tedpublic/coveragerequests/index

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Q: In regards to the TPL information not being updated, I contact provider support and am told that the subscriber needs to contact their caseworker. That is the problem.

A: If the TPL form has yet to be initiated, it's highly recommended that this is done. However, it is the patient's responsibility to provide all other insurance information to their local office worker so the beneficiary would also need to understand what needs to be done on their end.

Q: Is there another time to watch this presentation?

A: This presentation will be uploaded to the Medicaid Providers Training page which can be found by going to www.michigan.gov/medicaidproviders >> Medicaid Provider Training, within the next couple of weeks.

Q: Are FQHC's required to send a claim to Michigan Medicaid if a beneficiary has spend-down?

A: You do not need to bill Medicaid for beneficiaries who have spend-down. However, the beneficiary needs to take the bill to their case worker.

Q: Will https://healthplanbenefits.mihealth.org/login.aspx?ReturnUrl=% link continue to work for verifying eligibility or do we need to transition to CHAMPS to remain an active user?

A: CHAMPS is always the best route to go when checking eligibility. However, if a beneficiary has a spend-down the exact spend-down amount will be listed on the website listed.

Q: What does the following statements mean, "Cost Share Met" and "CAP Amount"? How is the dollar amount determined?

A: Please review Policy Bulletin MSA 14-11 and 15-53 for further clarification regarding cost sharing.

Q: When someone has privet insurance coverage, what does "Coverage Type IO" mean?

A: Please reference the Commercial/Other Insurance Coverage Type Codes found our CHAMPS Quick Links webpage.