Welcome To Medicare Packet

Welcome

Thank you for enrolling in Medicare. Wisconsin Physicians Service (WPS) is a Medicare fee-for-service Part A and B Medicare Administrative Contractor (MAC). We have two jurisdictions:

- Jurisdiction 5: Iowa, Kansas, Missouri, Nebraska, and National
- Jurisdiction 8: Indiana and Michigan

As a MAC, we process claims, first level appeals (redeterminations), provider enrollment applications, and we complete overpayment activities.

We are here to help our providers and their staff have a positive Medicare experience. This welcome packet will assist you with:

- Information to help you understand Medicare
- Resources to help you locate more materials
- Understanding acronyms for common Medicare terminology

About Medicare

Medicare is the largest health insurance payer in our country. Medicare covers people with disabilities and people over 65. The Social Security Administration (SSA) or the Railroad Retirement Board (RRB) deems people eligible for Medicare.

Medicare is under the Department of Health & Human Services (DHHS). The Centers for Medicare & Medicaid Services (CMS) oversees Medicare's daily operations.

It is important to understand the different parts of Medicare. Each one has a unique purpose and benefits.

Medicare has four main parts:

- Part A – Hospital or facility coverage
- Part B – Medical coverage
- Part C – Medicare Advantage Plans
- Part D – Medicare Prescription Drug Plan coverage

The Parts of Medicare

Many people refer to Part A and B together as traditional Medicare or original fee-for-service Medicare.

Part A

Under Medicare Part A, each person working in the United States and its territories pays into a trust fund. This is through the Federal Insurance Contribution Act or FICA. Most people qualify for this part premium free. A small percentage or people pay a monthly premium. The premium can change yearly.

The federal government uses the money to help pay for medically necessary inpatient care in a hospital, psychiatric facility, skilled nursing facility, or religious non-medical institution. The money also helps pay for medically necessary outpatient care in a:

- Community mental health center
- Comprehensive outpatient rehabilitation facility
- End-stage renal disease facility
- Federally qualified health center
- Histocompatibility laboratory
- Home health agency
- Indian health services organization
- Organ procurement organization
- Rural health clinic

Medicare also provides coverage for comfort measures at the end of life under the hospice benefit.

Patients may need to pay for a portion of the service provided. This includes a deductible, co-insurance, or co-payment.

Part B

Under Medicare Part B, each person pays a monthly premium and annual deductible. Part B covers:

- Professional services by:
    - Doctors
    - Other qualified heath care professionals
- Supplier services such as:
    - Ambulance
    - Mammography centers
    - Ambulatory surgical centers
    - Mass immunizations
    - Part B drug vendors
    - Independent clinical laboratories
    - Portable X-ray suppliers
    - Independent diagnostic testing facilities
    - Radiation therapy centers
    - Intensive cardiac rehabilitation suppliers

Part C

Often people refer to Medicare Part C as Medicare Advantage. Part C allows people to have more options in the Medicare program. People must have Parts A and B, choose a Part C plan, and follow the rules of the plan. Plan types include:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service (PFFS) Plan
- Special Needs Plan (SNP)
- HMO Point of Service (HMOPOS)
- Medical Savings Account (MSA)
- Medicare Cost Plans
- Demonstration/Pilot Programs
- Program of All-inclusive Care for the Elderly (PACE)
- Medication Therapy Management

The Medicare Advantage plan replaces original Part A and B. It pays for the services offered under Medicare. Private insurance companies administer the plans and make payments. The plan pays differently than Part A and B. Patients with a Part C plan still have Medicare, just a different form of Medicare.

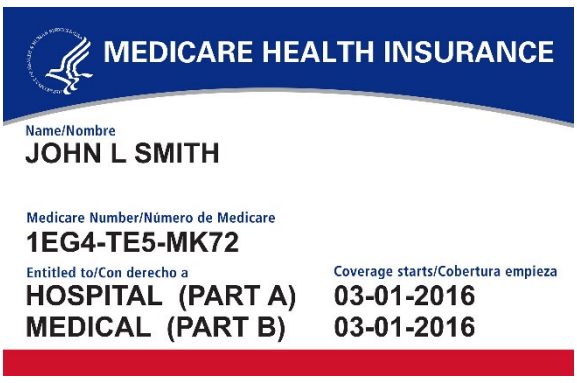
Part D

Part D is coverage for outpatient prescription drugs. Typically, Part D covers any self-administered drug picked up at a pharmacy. Each plan has its own list of covered drugs and beneficiaries choose the plan that best fits their needs. Part D coverage may be part of a Medicare Advantage Plan's coverage.

Medicare Cards

The Social Security Administration (SSA) and Railroad Retirement Board (RRB) issue cards indicating Part A and B eligibility. Part C and D plans issue cards unique to their respective plan.

The SSA or RRB card identifies the person by name, Medicare Beneficiary Identifier, and Part A or B eligibility dates. If the patient is eligible under the Railroad Retirement Board, the bottom of the card will indicate this.





Claims

A provider sends a request for payment on a claim. Medicare accepts electronic and paper claims. Medicare uses various contractors to process claims. These contractors are the Medicare Administrative Contractors (MACs).

Electronic Claims

Providers submit two types of electronic claims:

- 837I electronic transaction sent by:
  - Facilities
  - Facility owned medical providers
- 837P electronic transaction sent by:
  - Medical professionals
  - Suppliers, such as lab and ambulance companies

Paper Claims

Providers submit two types of paper claims:

- UB 04 claim form (CMS 1450) sent by:
  - Facilities
  - Facility owned medical providers
- CMS 1500 claim form sent by:
  - Medical professionals
  - Suppliers, such as lab and ambulance companies

Claims Processing

Medicare uses the Fiscal Intermediary Shared System (FISS) to process UB 04 and 837Iclaims. The CMS 1500 and 837P claims processing occurs in the Multi-Carrier System (MCS).

Medicare contracts with private companies (MACs) to process claims. MACs perform many activities including:

- Medicare FFS claims processing
- Make and account for Medicare FFS payments
- Enroll providers in the Medicare FFS program
- Handle provider reimbursement services and audit institutional provider cost reports
- Handle redetermination requests (1st stage appeals process)
- Respond to provider inquiries
- Educate providers about Medicare FFS billing requirements
- Establish local coverage determinations (LCDs)
- Review medical records for selected claims
- Coordinate with CMS and other FFS contractors

For more information, see the CMS web page Medicare Administrative Contractors: https://www.cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs

A and B (A/B) MAC

MACs provide both Part A and B Medicare benefit administration and claim processing duties.

DME MAC

Durable Medical Equipment (DME) is medical equipment and supplies for everyday or extended use. A health care provider must order DME for Medicare to cover it. DME may include:

- Oxygen equipment
- Wheelchairs
- Crutches
- Diabetic blood testing strips

A DME MAC administers then DME benefit and processes DME claims.

Home Health and Hospice (HH+H) MAC

The HH+H MAC is an A/B MAC with more duties relating to home health and hospice claims. The HH+H duties are for different states than the A/B MACs.

Medical Review

Medical review is the collection of information and clinical review of medical records by Medicare contractors. Medical review ensures that Medicare pay for services meeting all Medicare coverage, coding, and medical necessity requirements. Medical review directs activities toward areas where data analysis indicates vulnerabilities or questionable billing patterns.

Medical Review Goal

The goal of the medical review program is to reduce payment error. To meet the goal, medical review identifies and addresses provider's coverage and coding billing errors.

To achieve the medical review program's goal, Medicare contractors:

- Use data analysis to proactively identify patterns of providers' potential billing errors concerning Medicare coverage and coding
- Review data and reports from other contractors and government entities
- Take action to prevent and address the identified error
- Publish local medical review policy providing guidance about items and services eligible for payment under the Medicare statute
- Publish educational materials as they relate to the medical review process

Targeted Probe and Educate (TPE)

TPE is medical review and education by the MAC to help providers quickly improve documentation and billing patterns. The goal is to help providers and suppliers reduce claim denials and appeals through one-on-one help. Below is an outline of the TPE process:

- MACs use data analysis to choose providers
- Providers receive a documentation request for 20-40 claims
- A nurse from the MAC educates a point of contact person
    - Requests missing records or portions of records
- MACs use data analysis to see if changes occurred
    - If providers show improvements, the MAC releases them from review
    - If providers do not show improvements, the MACs complete up three rounds of education before referring to CMS

Medicare Secondary Payer

Federal law requires many different types of insurance to consider charges before Medicare. Law refers to this program as Medicare Secondary Payer or MSP. The MSP program breaks insurance types into two categories: employment group health plans and non-group health plans.

When Medicare covers a service, it coordinates benefits with the primary payer. Medicare may pay more money, remove patient liability, or not consider the charges as part of the Medicare program. If Medicare pays first then receives information about a primary insurance, Medicare takes the payment back. Medicare must consider the Coordination of Benefits to make a new claim determination.

Group Health Plan (GHP)

A GHP is insurance through employment of a Medicare recipient, their spouse, or legal guardian. The person with Medicare does not have to enroll in the insurance. If elected, the employment insurance is the primary payer in most cases.

GHP has three categories, and each category has its own rules:

- Employer Group Health Plan (EGHP)
    - Medicare recipient is age 65 or over
    - The plan covers 20 or more full-time employees or the equivalent
- Large Group Health Plan (LGHP)
    - Medicare recipient is less than age 65
    - The plan covers 100 or more full-time employees or the equivalent
- End-Stage Renal Disease (ESRD)
    - The patient's ESRD diagnosis drives coverage
    - During the first 30 months of coverage, Medicare is secondary
    - Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) follows the same rules

Non-Group Health Plan (NGHP)

NGHPs are insurance plans related to injury or illness of a Medicare recipient. The Medicare patient has a certain diagnosis that causes claim denials when not reporting the insurance information. Claims unrelated (as shown by diagnosis) to the illness or injury will process with Medicare as the primary payer.

- No-Fault Insurance
    - Related to an accident or other situation where the state requires no-fault insurance
- Liability Insurance
    - Related to an accident or other situation where the state requires liability insurance
- Worker's Compensation
    - Related to a job-related accident or other situation where the state requires worker's compensation insurance
- Federal Black Lung
    - A form of workers' compensation paid by the United States Department of Labor
    - Medicare defines the diagnosis codes affected in the Internet-Only Manual (IOM) Publication 100-05, *Medicare Secondary Payer (MSP) Manual*, Chapter 6 – Medicare Secondary Payer (MSP) Common Working File (CWF) Process (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/msp105c06.pdf), Section 40.10

MSP Contractor

The MSP Contractor consolidates the activities supporting the collection, management, and reporting of other insurance coverage for beneficiaries. The contractor acts to identify the health benefits available to a beneficiary. Once identified, they coordinate the payment process to prevent Medicare benefits payment mistakes.

The contractor uses Medicare rules to decide if the other insurance is the primary payer for health care costs. To do this, they:

- Investigate when learning a person has other insurance. Information comes from these sources:
    - Beneficiary
    - Doctor or provider of service
    - EGHP
    - Liability, no-fault, and workers' compensation insurance
    - Attorney
- Update primary payer information on Medicare databases when coverage changes occur.
- Establish MSP occurrence records on the Common Working File (CWF). The records keep Medicare from paying when another party should pay first.
- Transmit other health insurance data to the Medicare Beneficiary Database (MBD) for the proper coordination of prescription benefits.
- Recover mistaken payments where the beneficiary must repay Medicare due to a payer before Medicare.
- Resolve outstanding debts and refer delinquent debt to the Department of Treasury for further collection actions.

MACs

MACs process claims when another payer is responsible for processing the claim before Medicare considers it. They use claim forms and CMS systems data to avoid making primary payments in error.

When systems indicate other insurance is the primary payer, MACs ensure the needed information is on the claim. If the information is not present, MACs return it to the provider. The provider must bill the proper party and provide the information to the MAC.

Appeals

An appeal occurs when a dissatisfied party requests a review of the initial claim determination. Dissatisfied parties include:

- Patient
- Provider of service
- Patient's appointed representative
- Patient's legal guardian or power of attorney

Medicare has five appeal levels. Contractors complete levels one and two. Different federal employees complete the remaining levels.

- Redetermination by the MAC
- Reconsideration by the Qualified Independent Contractor (QIC)
- Decision by the Office of Medicare Hearings and Appeals
- Review by the Medicare Appeals Council
- Judicial review in a Federal District Court

MACs

The MAC performs the first level of appeal (redetermination). A redetermination is a review of the claim by the MAC's personnel not involved in the initial claim determination.

Qualified Independent Contractor (QIC)

Any party to the redetermination dissatisfied with the MAC's decision may request a second level appeal (reconsideration). A reconsideration is a review of the administrative record, including the initial determination and redetermination, by a QIC.

For more information on appeals, see the CMS web page Original Medicare (Fee-for-service) Appeals: https://www.cms.gov/medicare/appeals-and-grievances/orgmedffsappeals

WPS Government Health Administrators

Wisconsin Physicians Service (WPS) Health Insurance began serving Medicare in 1966. We bring over 50 years of service to the Medicare program. Government Health Administrators (GHA) is the division of WPS currently working with CMS.

Our mission is to provide service and value considered by our customers to be the very best. We remain committed to providing the best in service to Medicare beneficiaries and providers through:

- Emphasis on uncompromising business ethics
- Long-term sustained performance excellence

Our goal is to serve our Medicare customers effectively while lowering our costs and improving productivity.

WPS Government Health Administrators serves as:

- The Jurisdiction 5 (J5) MAC providing Part A and Part B benefit administration for:
  - Iowa
  - Kansas
  - Missouri
  - Nebraska
  - Part A J5 national providers
- The Jurisdiction 8 (J8) MAC providing Part A and Part B benefit administration for Indiana and Michigan
- A subcontractor for other CMS contracts

Important facts about WPS Government Health Administrators, include:

- We perform in the top tier of Medicare contractors as measured by CMS evaluations of operating performance
- We are ISO 9001-2015 certified, demonstrating our commitment to quality and customer service
- We serve more than 140,000 providers and over 7 million Medicare beneficiaries
- We process 130 million claims annually with more than $47 billion in benefit payments

Acronyms

Medicare uses many acronyms. Full lists are available on the CMS and WPS Government Health Administrators websites.

CMS Acronym List: https://www.cms.gov/acronyms

WPS Government Health Administrators Acronym List:
https://www.wpsgha.com/wps/portal/mac/site/home/acronyms

Resources

CMS Resources

CMS Website

- The location for the rules and regulations that govern Medicare. It is the official communication from the federal government about the program.
  - https://www.cms.gov/

CMS Social Media Page

- CMS uses Twitter, LinkedIn, and YouTube to help deliver provider education.

Medicare Learning Network (MLN)

- The Medicare Learning Network contains CMS' educational products. It contains various forms of education.
    - https://www.cms.gov/training-education/medicare-learning-network/resources-training
- MLN web-based training links to all web-trainings.
    - https://www.cms.gov/training-education/medicare-learning-network/web-based-training
- MLN electronic mailing lists: sign up for the email messages about Medicare changes.
    - https://www.cms.gov/training-education/medicare-learning-network/newsletter

Internet-Only Manuals (IOMs)

- The IOM defines the beneficiaries covered under Medicare, what tasks each contractor must perform, and claims processing guidance. It is one of the most essential items for day-to-day operating instructions.
    - https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms

National Correct Coding Initiative (NCCI)

- The NCCI edits promote national correct coding methodologies. They control improper coding leading to inappropriate payment of Part B claims.
    - https://www.cms.gov/ncci-medicare

Medicare Secondary Payer (MSP)

- The page explains what MSP is, the types of insurance, and provides links to training.
    - https://www.cms.gov/medicare/coordination-benefits-recovery/overview/secondary-payer

WPS Government Health Administrators Resources

Website

- Our website contains claims processing instructions, contact information, and system availability.
    - https://www.wpsgha.com

Electronic Newsletter (eNews)

- WPS Government Health Administrators uses email as the primary form of provider communication. We send three scheduled emails each week.
    - Monday includes news about what is happening with Medicare
    - Wednesday contains educational offerings
    - Thursday is a highlight of the CMS releases for the week (CMS MLN Connects Newsletter).
- WPS Government Health Administrators publishes policy updates monthly.
- WPS Government Health Administrators releases urgent news as needed. The goal is to keep providers informed of Medicare situations.

- A sign-up box is in the footer of each WPS Government Health Administrators web page:
    - https://visitor.r20.constantcontact.com/manage/optin?v=001B5adRlY4IqbdpjSTi0Brmrn7fvBMq1Jr

MAC Customer Experience (MCE) Surveys

- Qualtrics provides experience management solutions to many federal agencies, including CMS. WPS Government Health Administrators offers MCE surveys our website. These surveys help us identify potential improvements. We offer the following three types of surveys:
    - Pop-up box appears (digital experience survey)
    - Persistent "Feedback" tab always located on the screen. The placement varies depending on the internet browser.
    - Business function surveys in the left sidebar of the associated Topic Centers. These surveys are specific to recent interactions.

Portal Registration

- WPS Government Health Administrators offers a transactional section or portal. The portal is an interactive tool containing many functions. A few of the functions are:
    - Eligibility verification
    - Printing remittance notices
    - Medicare Beneficiary Identifier (MBI) lookup
    - Claim status
- The Portal User Manual (https://www.wpsgha.com/wps/portal/mac/site/self-service/guides-and-resources/portal-user-manual) is a guide to help users. The manual:
    - Explains the functions of the portal
    - Provides steps to help set-up an account
    - Provides helpful tips for using the portal
- Provider Portal registration and log-in web page: https://www.wpsgha.com/wps/portal/mac/site/login

YouTube Channel

- WPS Government Health Administrators offers training videos and encore presentations on our YouTube channel.
    - https://www.youtube.com/channel/UCscLmgYJDEJ8Zh2_r_SivUw

Other Resources

Comprehensive Error Rate Testing (CERT)

- The CMS web page provides information about the CERT program: https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert

- The CERT contractor maintains a portal for providers to gather information. You will find checklists for documentation, contact information, and guidance for submitting records: https://c3hub.certrc.cms.gov/

Recovery Audit Contractor (RAC)

- The Medicare Fee for Service (FFS) Recovery Audit Program's mission is to identify, correct, and prevent improper payments.
    - https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program
- Jurisdiction 5 RAC (Region 2)
    - Cotiviti, LLC
        - https://www.cotiviti.com/markets/cms-rac
    - CMS approved J5 issues
        - https://www.cotiviti.com/cms-approved-issues-cotiviti
- Jurisdiction 8 RAC (Region1)
    - Performant Recovery, Inc.
        - https://performantrac.com/
    - CMS approved J8 issues
        - https://performantrac.com/audit-issues/

Qualified Independent Contractor (QIC)

- CMS level 2 appeals page
    - https://www.cms.gov/medicare/appeals-grievances/fee-for-service/second-level-appeal
- QIC portal pages
    - C2C Innovative Solutions, Inc.
        - https://www.c2cinc.com/QIC-Part-B-North
    - MAXIMUS Federal Services, Inc.
        - https://medicareappeal.com/part-west

Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC)

- Jurisdiction A
    - CT, DE, MA, ME, MD, NH, NH, NY, PA, RI, VT, District of Columbia
    - Clinician's Corner
        - https://med.noridianmedicare.com/web/jadme/policies/clinicians-corner
    - Jurisdiction A YouTube channel
        - https://www.youtube.com/channel/UCWtCmCDYPzpMKEZKhlH5bYQ/videos
- Jurisdiction B
    - IL, IN, KY, MI, MN, OH, WI
    - Physician's Corner
        - https://www.cgsmedicare.com/jb/mr/phys_corner.html
    - Jurisdiction B YouTube channel
        - https://www.youtube.com/playlist?list=PLhd41fU4P-NW1hUpq84ZCMYHygVdlMlE6
- Jurisdiction C
    - States:

        - AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV
    - Territories
        - Puerto Rico, U.S. Virgin Islands
    - Physician's Corner
        - https://www.cgsmedicare.com/jc/mr/phys_corner.html
    - Jurisdiction C YouTube channel
        - https://www.youtube.com/playlist?list=PLhd41fU4P-NUgz8oQg14-SxSLAW3hFJ8R
- Jurisdiction D
    - States:
        - AK, AZ, CA, HI, ID, IA, KS, MO, MT, NE, NV, ND, OR, SD, UT, WA, WY
    - Territories
        - American Samoa, Guam, Northern Mariana Islands
    - Clinician's Corner
        - https://med.noridianmedicare.com/web/jddme/policies/clinicians-corner;jsessionid=E48B9A034A6226102775E01944F5C89B
    - Jurisdiction D YouTube channel
        - https://www.youtube.com/channel/UCWtCmCDYPzpMKEZKhlH5bYQ