

7. Benefit Coordinator

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7.1 About the Benefit Coordinator

The Benefit Coordinator identifies patients who are eligible for alternate resources such as Medicaid, Medicare, private insurance, and others. This includes

- determining if the patient qualifies for alternate resources,
- assisting the patient with completion of the application, and
- following up with the insurer to assure the coverage.

Besides identifying patients who are eligible for alternate resources, another Benefit Coordinator function is to maximize and enhance patient care through increased revenue from other insurers. Because the Indian Health Service (IHS) may not be able to provide coverage for certain health services, the funds from alternate resources can be utilized in place of Contract Health Services (CHS).

To accomplish the essential activities related to this position, the Benefit Coordinator needs to be on-site and available during the clinic hours of operation.

The Benefit Coordinator needs to maintain statistics daily, monthly, and quarterly of enrollments, approvals/denials of applications, verification, and updating of the RPMS and overall assistance of patients with benefits. These reports need to be submitted to the business office manager or supervisor.

These are the overall responsibilities of the Benefit Coordinator:

- Advocate on behalf of patients with all alternate resource activities.
- Effectively educate patients on alternate resources.
- Effectively utilize or maximize enrollment of patients into an alternate resource program.
- Effectively interview patients to determine eligibility and make appropriate referrals for benefits.
- Work closely with Patient Registration and Contract Health Services in screening potential patients who are eligible for alternate resources.
- Abide by the Privacy Act of 1974 to maintain confidentiality of all records.
- Follow up on pending applications with appropriate alternate resource agencies.

- Make home visits to gather pertinent information/documents from client/patients to complete the application process.
- Monitor and update change in coverage and/or rate code per encounter.

For information related to Benefit Coordinator performance tracking and quality assurance, see Part 1, Chapter 7, “Business Office Quality Process Improvement.”

7.2 Outpatient Identification and Verification Process

The process for identifying and verifying alternate resources for **outpatient** services are:

- Review the scheduled patients either the evening before or morning of, to assess potential patients for referral to the Benefit Coordinator.
 - Have the Registration staff refer any potential patients to the Benefit coordinator’s office.
- For walk-in patients, cross-train the Registration staff on eligibility requirements for alternate resources that may be available.
 - Have the Registration staff refer any potential patients to the Benefit coordinator’s office.
- Screen and/or interview patients by face-to-face contact or telephone contact.
- Obtain the following information:
 - Demographics, including date of birth (DOB), social security number, home mailing address
 - Insurance information, if any
 - Income information
- Verify eligibility:

If the patient . . .	Do this:
is 65 or over,	Contact the Social Security Administration (SSA) for a Medicare update. Determine if the patient has any private insurance prescription drug coverage.
worked for the railroad,	Contact the Medicare Railroad Retirement Office for Railroad Medicare.

If the patient . . .	Do this:
has no insurance, or has/had Medicaid coverage,	Contact the automated state Medicaid Voice Response System, call the Medicaid fiscal agent eligibility help desk, or verify eligibility via the Internet connection with the state Medicaid.
is disabled,	Contact the Social Security Administration to determine if the patient has Supplemental Social Security (SSI).
has had military service,	Contact the local Veterans Administration (VA) office to determine if he/she has VA benefits
(or spouse) is employed and has the company's insurance,	Contact the private insurer eligibility or verification staff person for private insurance validation.
is elderly and/or blind, physically disabled, or has developmental disabilities,	Contact the Social Security Administration
<ul style="list-style-type: none"> • Enter insurance updates into the Resource Patient Management System (RPMS) Patient Registration application <i>or</i> Patient Information Management System (PIMS), such as any new insurance information, or changes in date of birth or social security number. <ul style="list-style-type: none"> – Benefit Coordinator notes can be entered in the Benefits Coordination section of the RPMS Patient Registration Editor. 	

7.3 Eligibility Verification

The Benefit Coordinator, Registration staff, and Contract Health Services verify insurance as part of their daily business processes using the same data base, where the

- Benefit Coordinator verifies new insurance eligibility.
- Registration staff verifies existing or changed insurance.
- Contract Health Services verifies insurance to determine if any coverage should pay before contract health dollars are used.

The process of verifying insurance varies by state and insurer. The verification process can include an automated telephone response system, Internet on-line verification, or a direct telephone call to speak with a customer service representative at the insurance company.

7.3.1 State Medicaid/SCHIP Verification

1. Use the existing automated toll-free telephone voice response system, *OR* contact the existing eligibility help desk representative, *OR* use the Internet Online verification system.
2. Verify eligibility coverage for the past three months.
3. Update eligibility information in the third party eligibility section of RPMS Patient Registration application.
4. Make notation in the Notes section of the RPMS Patient Registration application

7.3.2 Social Security Income (SSI) Disability Verification

1. Use the toll-free automated voice response telephone system, *OR* contact the existing eligibility help desk representative, *OR* use the Internet Online verification system.
 - a. Verify eligibility for the past three months.
 - b. Make notation in the Notes section of the RPMS Patient Registration application, "Medicare Verification."
2. Call the local Social Security Administration Office.
 - a. Verify eligibility coverage for patient's name, date of birth, Medicare identification number, and effective coverage dates for Part A and/or Part B.
 - b. Update eligibility information in the third party eligibility section of the RPMS Patient Registration application.
 - c. Make notation in the Notes section of the RPMS Patient Registration application.

7.3.3 Private Insurance Verification

1. Copy the insurance card.
2. Contact the private insurance customer service representative directly.
3. Update eligibility information in the third party eligibility section of the RPMS Patient Registration application.
4. Make notation in the Notes section of the RPMS Patient Registration application.

7.4 Inpatient Identification and Verification Process

This is process for identifying and verifying alternate resources for **inpatient** services are:

1. Before interviewing the patient in the patient room, print the Admission/Discharge Sheet (listed under the ADT Menu report option).
 - a. At the **ADT Menu** prompt, type **RM** (Reports Menu).
 - b. At the **RM Menu** prompt, type **IRM** (Inpatient Reports Menu).
 - c. At the **IRM Menu** prompt, type **PMI** (Patient Movement Listing) from.
 - d. In **PMI**, specify the date of service.
 - e. Print a summary of the report.
 - f. Return to the **RM Menu** and select the **DAS** (Print A sheets by admit date) option, and print out the half sheets (Clinical Record Brief) of each admitted patient for a specific date of service.
 - g. Go to the **RPMS Patient Registration** application (or PIMS) and review **Pages 4-8** and **Page 11** for alternate resource information.
 - h. Indicate any significant findings on the Clinical Record Brief.
2. Go to the **ADT Menus** and select the **PI** (Patient Inquiry) option to locate the patient's room number.

3. Interview the patient.
4. If the insurance information is not voluntarily provided, call the employer of the responsible party to obtain this information.

7.5 Medicaid Eligibility and Application

7.5.1 Medicaid Eligibility

Each state has the discretion as to which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. Examples of Medicaid eligibility groups are:

- Low income families with children who meet certain of the eligibility requirements in the State's Aid to Families with Dependent Children (AFDC) plan in effect on July 16, 1996
- Supplemental Security Income (SSI) recipients to include aged, blind, and disabled individuals which were in place in the State's approved Medicaid plan as of January 1, 1972
- Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life, so long as the infant remains in the mother's household and she remains eligible.
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal poverty level – set by each state. States are required to extend Medicaid eligibility until age 19 to all children born after September 30, 1983 in families with incomes at or below the Federal poverty level. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any changes in family income.
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Certain Medicare beneficiaries
- Special protected groups who may keep Medicaid for a period of time, such as a person who loses SSI payments due to earnings from work or increase in Social Security benefits.

States also have the option to provide Medicaid coverage for other “categorically needy” groups. Such coverage needs to be verified by the state. Here are some examples:

- Infants up to age one and pregnant women not covered under mandatory rules whose family income is below 185 percent of the Federal poverty level (the percentage is set by each State).
- Optional targeted low income children.
- Certain aged, blind, or disable adults who have incomes above those requiring mandatory coverage, but are below the Federal poverty level.
- Children under age 21 who meet income and resources requirements for AFDC but are not eligible for ADFC.
- Institutionalized individuals with income and resources below specified limits.
- Persons who would be eligible if institutionalized but are receiving care under home and community-based services waivers.
- Recipients of State supplementary payments.
- TB-infected persons who would be financially eligible for Medicaid at the SSI level.
- Low-income, uninsured women screened and diagnosed through a Center for Disease Control and Prevention’s Breast and Cervical Cancer Early Detection Program and determined to be in need of treatment for breast and cervical cancer.

7.5.2 Medicaid Eligibility Dates

Coverage may start retroactive to any or all of the three months prior to the application, if the individual would have been eligible during the retroactive period. Coverage generally stops at the end of the month in which a person’s circumstances change.

7.5.3 Relationship and Coordination between Medicaid and Medicare

Medicare Part A covers the hospital insurance and Part B covers the medical insurance. Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from their State Medicaid program.

If a person is eligible for full Medicaid coverage, Medicare will pay first and the difference will be paid by Medicaid up to the Medicare allowable limit. Medicaid also covers additional services such as nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs not covered by Medicare Part D, eyeglasses and hearing aids.

Qualified Medicare Beneficiaries (QMB) with resources at or below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% of the Federal Poverty Level (FPL) do not have to pay the monthly Medicare Part B premiums.

Qualifying individuals that are not otherwise eligible for full Medicaid benefits and with resources at or below twice the standard allowed under the SSI program will get help with all or a small part of their monthly Medicare Part B premiums, depending on whether their income exceeds the SLMB level but is less than 135% of the FPL.

Medicaid can pay Medicare premiums for Part A, Part B, and Part D deductibles and coinsurance for Qualified Medicare Beneficiaries (QMB) – individuals whose income is at or below 100% of the Federal poverty level and whose resources are at or below the standard allowed under SSI.

Medicaid can also pay the Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals have income below 200% of the Federal poverty level and resources that are no more than twice the standard allowed under SSI.

7.5.4 Medicaid Presumptive Eligibility

The Omnibus Budget Reconciliation Act provides for payment of ambulatory prenatal care to pregnant women during a presumptive eligibility period before they have formally applied for Medicaid. Women qualify for presumptive eligibility if:

- Pregnancy has been medically verified.
- Patient verifies social security number.
- Family income does not exceed 133% of the Federal poverty guidelines.
- There is not a presumptive eligibility in existence for this current pregnancy.
- An application form has been completed.

The following providers can qualify for presumptive eligibility:

- Title X family planning clinics through State Department of Health
- City/County Health Departments
- Peri-natal projects through State Health Departments
- Title V of the Indian Health Care Improvement Act
- WIC program through State Department of Health
- Other health care clinics within individual states, such as migrant health services or rural health clinics
- Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act

Covered services under presumptive eligibility (hospital services are not covered) include:

- Provider, nurse practitioner or nurse midwife services
- Laboratory and radiology
- Dental
- Optometry
- Podiatry
- Speech, physical or occupational therapy
- Durable medical equipment
- Audiology and related services
- Counseling services
- Prescription drugs
- Transportation
- Family planning

7.5.5 Temporary Medicaid Number for Newborn

This is process for obtaining a *temporary* newborn number for State Medicaid. Check your state's guidelines for newborn enrollment process.

1. Call or e-mail the appropriate Income Support Division Office.
2. Provide the following information:
 - Name of newborn
 - Date of birth for newborn
 - Gender of newborn
 - Mother's name
 - Mother's social security number
3. Enter the Temporary Newborn Number in the **RPMS Patient Registration** application on **Page 4**, and enter notations on **Page 8**.
4. Notify Inpatient Billing of the Temporary Newborn Medicaid Number.

7.5.6 Permanent Medicaid Number for Newborn

This is the process for obtaining a permanent Medicaid number for the newborn:

1. Call the State Medicaid Newborn Notification or Inquiry Line.
2. Provide the applicable newborn information
 - Clinic's name and provider number
 - Mother's name
 - Mother's Medicaid number or Social Security Number
 - Mother's date of birth
 - Name of newborn
 - Date of birth for newborn
 - Gender of newborn
 - Gestational age of newborn
 - Weight in grams of newborn
 - Type of delivery for newborn – normal or C-section
 - APGAR score of newborn
3. Enter the newborn's Medicaid number in the **RPMS Patient Registration** application on **Page 4**, and enter notations on **Page 8**.
4. Notify the Billing Department and Contract Health Services of the newborn's permanent Medicaid number.

7.5.7 State Medicaid Application Process

This is the procedure for the application process for State Medicaid:

1. Have the patient complete the appropriate state Medicaid application form and/or presumptive eligibility form:
 - adult patient or spouse without insurance coverage
 - for uncovered children under 19 years of age
 - for pregnant women and their newborns
 - for women who want family planning
2. Interview the patient and/or family members.
3. Complete the state Medicaid application and instruct the patient regarding documents needed and patient rights
 - Copy of birth certificate and/or certificate of Indian blood
 - Proof of state residency
 - Citizenship or immigration status:
 - Copies of both sides of the citizenship or immigration documents. Non-citizens must provide copies of any Immigration and Naturalization Services (INS) cards or letters.
 - Social Security Number
 - Validate the social security number with state and Federal agencies to verify if the patient has Medicare and to determine income status (earned or unearned).
 - If the patient does not have a social security number, assist the patient in applying for one.
 - Wages
 - Copies of check stubs or statement from employer showing gross earnings last month and this month for those individuals listed on the state Medicaid application.
 - Self-employment
 - Copies of current Federal tax forms.
 - Proof of business income and expenses for the last calendar month. Proof of business income includes records, journals, or financial statements that show the amount and date received; proof of business expenses including receipts, bills, or canceled checks that include date, amount, and type of expense.

- Child Support
 - Copies of the court order or child support payment history.
 - Other Income
 - Proof of any income, such as Social Security Administration, Veterans Administration, Railroad Retirement, or disability income.
 - Health Insurance
 - Copies of insurance identification cards.
 - Daycare
 - Proof of amount billed for child care or care of an incapacitated adult.
 - Pregnancy
 - Signed letter from the patient's provider, indicating the expected date of delivery.
4. Fax or mail the presumptive eligibility forms for children within 24 hours and for pregnant women within 5 days.

Upon approval enter the Medicaid eligibility data in the **RPMS Patient Registration** application on **Page 4**, and enter notations on **Page 8**.

In some states the Medicaid application can be completed on the Internet, by telephone, or at locations in the community. In addition, several of the Indian clinics have provided a space for the Medicaid social worker to process applications on-site.

5. Complete follow up to check status of enrollment after two weeks of the submission date.
6. If the application is denied, enter the reason for the denial in the Benefit Coordinators section of the RPMS Patient Registration Editor.
7. Notify the Billing and Contract Health Services of the determination of the application
8. Close out the case and file in the Business office.

7.5.8 Enrollment in Medicaid Managed Care Plans

1. If the patient is not locked into the Medicaid plan for one year, then have the patient complete the Native American Opt Out form.
2. Have patient sign the Opt Out form.
3. Attach a copy of the Patient's Certificate of Indian Blood (CIB).
4. Fax the Opt Out form and CIB to the Native American Opt Out office or, depending on the state, the patient may have to call the customer representative and request formally a health plan change to IHS.
5. Update the change in plans in the **RPMS Patient Registration** application on **Page 4**, and enter an update note on **Page 8**.

7.5.9 Follow-up Procedures for Pending Medicaid Applications

Follow up with patients and alternate resources can be done via home or site visits, telephone calls, or letters.

1. Send a follow-up letter to the patient informing him/her to bring in the pending verification documents.
2. Make follow-up telephone calls with the appropriate agency on a set schedule.
3. Document all follow-up conversations in the **RPMS Patient Registration** application on **Page 8**.