

The following presentation was presented during
the Indian Health Service

Patient Registration & Patient Benefits Coordination Training

July 12-15, 2022

If you have questions about this presentation you may contact the presenter(s) or you may send an email to ihbusinessoffice@ihs.gov

Please note: The aim of this presentation is to share and facilitate the sharing of helpful information, but please note that it may reflect presenters' opinions and not necessarily those of the Indian Health Service or the U.S. Department of Health and Human Services.



Types of Coverage, Covered Services & Enrollment Periods

Dustie Cummins, Patient Benefit Coordinator
Crow Service Unit

July 13, 2022





Types of Coverage

- **Medicaid**: health coverage for eligible low-income adults and children; administered by state based on federal requirements; funded by state and federal funds.
- **Medicare**: health insurance for people 65 or older. You're first eligible to sign up for Medicare 3 months before you turn 65. You may be eligible to get Medicare earlier if you have a disability.
- **Marketplace**: a resource where individuals, families and small businesses can compare and purchase health insurance, with or without an advance tax credit.
- **VA Healthcare**: if qualified, provides coverage for needed health services at the VA, IHS or in the community.
- **Employer Sponsored Insurance**: group health coverage for an employee where the employer plays for some or all of the costs.





Enrollment Periods

- Medicaid: enroll anytime; annual recertification based on application date.
- Medicare: initial enrollment starts three months prior to 65th birthday, the month of your birth, and three subsequent months. Open enrollment is Jan-Mar annually.
 - Special enrollment – uncommon except if an individual qualifies for a Medicare Savings Program.
 - A penalty of 10% per year without Medicare Part B will be enforced if a beneficiary buys in “late”
 - 8 months post retirement/spouse retirement to buy in without a penalty, if an employer sponsored plan was maintained.
- Marketplace: for the general public open enrollment is Nov 1 – Dec 15, unless qualified for special enrollment period. Enrolled tribal members can enroll and change plans monthly.
- VA Healthcare: apply anytime; annual renewal unless qualified based on service connected disability of 50-100%, then there is no renewal needed.
- Employer Sponsored Insurance: usually have 30-60 days to enroll from hire date; there’s typically an annual open season at the end of each calendar year or fiscal year, depending on the organization.





Covered Services



The Affordable Care Act requires non-grandfathered health plans to cover 10 Essential Health Benefits:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care





Covered Services



Medicaid

Covered services can vary by state, make sure to be familiar with your state's services

Website: [Member Services \(mt.gov\)](http://Member Services (mt.gov))

Medical:

- Primary care
- Urgent care
- Hospital
- Surgery
- Rehabilitative services
- Immunizations
- Emergency services
- Diagnostics: Laboratory & Radiology
- Family Planning
- Maternity care
- Durable Medical Equipment
- Physical/Occupational/Speech Therapy

Dental:

- Adult: preventative, anesthesia/sedation, restorative, periodontal, surgery; annual cap of \$1,125
- Dentures: Partials every 5 years & Full every 10 years; 1 lost pair in a lifetime
- Children: All services, orthodontia when medically necessary, no cap

Vision:

- Adults: exam every 24 months (unless medically necessary) and eyewear every two years
- Children: exam and eyewear every year



Covered Services



Medicaid, continued

Mental Health Services

Adults:

- Crisis and emergency services
- Individual, group, and family counseling
- Inpatient and outpatient therapy
- Medication management
- Psychological testing.
- Adults with Severe or Disabling Mental Illness (SDMI)
 - Adult group and foster home
 - Community-based rehabilitation
 - Illness management and recovery
 - Dialectic behavior therapy (including coping skills)
 - Assertive community treatment
 - Case Management
 - Partial hospitalization
 - Day treatment

Children:

- Individual, group, and family counseling
- Outpatient mental health assessments
- Acute inpatient hospital services
- Partial hospitalization services
- Individual and family counseling
- Targeted case management
- Day treatment services
- Psychological testing
- Community-based psychiatric rehabilitation and support
- Comprehensive school and community treatment
- Therapeutic youth group home
- Extraordinary needs aid if in a group home
- Home support services
- Therapeutic family and foster care
- Psychiatric residential treatment facility



Covered Services



Medicaid, continued:

Hearing/Audiology:

- Hearing aids and repairs

Prescription Drugs:

- Most drugs are covered
- May need prior authorization for non-formulary prescriptions

School Based Services:

- Speech/physical/occupation therapy,
- private nursing
- help with daily activities
- specializes transportation
- mental health
- orientation and mobility specialists for blind or low vision

Transportation:

- Must be approved prior to appointment.
- Reimbursement of privately owned vehicle mileage, specialized non-emergency transportation, commercial transportation (taxi, bus, etc.)
- Meals and lodging when required to remain overnight.





Covered Services

Medicare

Website: [Parts of Medicare](#) | [Medicare](#)

Medicare Part A: known as Hospital Insurance. Usually does not have a cost unless an individual or their spouse have not met the required work quarters.

- inpatient care in hospitals
- skilled nursing facility care
- hospice care
- home health care.

Medicare Part B: known as Medical Insurance. Have a monthly premium of \$170.50, there are programs to assist in covering these costs.

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits)

What is not covered by Medicare Parts A & B?

- Long-Term Care
- Most dental care
- Eye exams related to prescribing glasses
- Dentures
- Cosmetic surgery
- Acupuncture
- Hearing aids and exams for fitting them
- Routine foot care





Covered Services



Medicare, continued

Website: [Parts of Medicare | Medicare](#) & [What Medicare covers | Medicare](#)

Medicare Part D: known as Drug Coverage. Helps cover the cost of prescription drugs (including many recommended shots or vaccines). You join a Medicare drug plan in addition to Original Medicare, or you get it by joining a Medicare Advantage Plan with drug coverage. Plans that offer Medicare drug coverage are run by private insurance companies that follow rules set by Medicare.

Medicare Supplemental Insurance (Medigap): Extra insurance you can buy from a private company that helps pay your share of costs in Original Medicare. Policies are standardized, and in most states named by letters, like Plan G or Plan K. The benefits in each lettered plan are the same, no matter which insurance company sells it, prices vary by company.

Medicare Part C: known as Medicare Advantage, this is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for health and drug coverage. These “bundled” plans include Part A, Part B, and usually Part D. In most cases, you’ll need to use doctors who are in the plan’s network. Plans may have lower out-of-pocket costs than Original Medicare. Plans may offer some additional benefits that Original Medicare doesn’t cover — like vision, hearing, and dental services. There is usually a monthly premium for the plan, in addition to the Medicare Part B Premium, however there can be premium free plans.



Covered Services

VA Health Benefits

Website: [About VA Health Benefits | Veterans Affairs](#)

Each Veteran's medical benefits package is unique, however basic health care services from VA include:

- Preventative: exams, education, immunizations genetic counseling
- Hospital: surgeries, medical treatments, kidney dialysis, acute care, specialized care
- Urgent and Emergency care services
- Other: mental health, assisted living and home health care, prescription drugs

All Veterans receive coverage for most care and services, but only some will qualify for added benefits like dental care. The full list of your covered benefits depends on:

- Priority group, ([VA Priority Groups | Veterans Affairs](#)) and
- The advice of your VA primary care provider (your main doctor, nurse practitioner, or physician's assistant), and
- The medical standards for treating any health conditions you may have

Care in the community is possible with prior approval. [Veterans Overview - Community Care \(va.gov\)](#)

IHS can be financially reimbursed from VA when an eligible and enrolled Veteran receives care at IHS.

[IHS/THP/UIO Reimbursement Agreements Program—Information for Providers - Community Care \(va.gov\)](#)





Covered Services

Marketplace Insurance

Website: [Get 2022 health coverage. Health Insurance Marketplace® | HealthCare.gov](https://www.healthcare.gov)

Covered services include the 10 essential health benefits:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency Services
- Hospitalization
- Pregnancy, maternity, and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)

Additional benefits:

- Birth control coverage
- Breastfeeding coverage

Some plans may also offer:

- Dental
- Vision
- Medical Management (weight management, back pain, and diabetes)



INSURANCE ELEMENTS AND VERIFICATION OF INSURANCE

Melissa Bigbow
Registrar – Lawton Indian Hospital

July 13, 2022





What is Insurance verifications?



- A key role in the Patient Registration process is the collection, verification, and updates of 3rd party resources.
- Verifying any and all 3rd party resources for every patient, every visit, is vital to the revenue cycle.
- Registration Clerks should have access to 3rd party verification tools such as Availity, Passport, Change Health, MyAbility, and 3rd party provider portals.
- Active coverage, termination dates, dates of birth, name spelling, policy holder information, and other primary payers are all important details that Registration Clerks should verify during the patient interview.





Importance of real time insurance verifications



- When a patient's insurance is not properly updated during the patient interview, this creates additional work for the entire Revenue Cycle.
- Not obtaining the correct insurance information at the time of service can also deny the hospital the opportunity to bill for services, receive reimbursements, and causes denials.
- Best practice is for Registration Clerks to insure insurance information is correct before the patient departs to their appointments.
- Missing or invalid insurance information creates additional barriers for the POS team, PBC department, PRC, and all other clinics.





KEY INFORMATION TO VERIFY IS CORRECT



- NAME SPELLING
- DATE OF BIRTH
- MEMBER ID/POLICY NUMBER
- GROUP NAME
- GROUP NUMBER
- ACTIVE COVERAGE DATES
- OTHER PRIMARY PAYER





Subscriber
 Member ID R6 [REDACTED]
 DOB May [REDACTED]
 Gender Female

[Edit](#)

Plan / Coverage Date Jan 02, 2022 - Dec 31, 9999



BlueCross BlueShield of Oklahoma

[Patient Cost Estimator](#)

[Patient Care Summary](#)

Patient Information

[Coverage and Benefits](#)

[Pre-Authorization Info](#) ▲

Either the patient's ID, name, date of birth, or address in the response does not match the information sent in the request. The response reflects correct information. To avoid future errors in submission, please update this information in your computer system.

Subscriber Information

408 QUAIL RUN S
 [REDACTED]

Group Number 111

Member ID R6 [REDACTED]

Plan / Product Information

Active Coverage **Individual**

Insurance Type Preferred Provider Organization (PPO)

Plan / Product BASIC

Coverage Date Jan 02, 2022 - Dec 31, 9999

Service Types

Health Benefit Plan Coverage

Active Coverage **In Network**

Plan / Product BASIC

Service Types

Dental Care
 Medical Care
 Mental Health
 Pharmacy



OTHER PRIMARY PAYERS



- Often, patients do not disclose other insurances they may have, or changes in their insurance.
- A very important step in the verification process is to check for “Other or Additional payers.”
- Primary payers are those that have the primary responsibility for paying a claim.
- If the claim is sent in the wrong order, i.e. the wrong primary payer, the claim will come back denied.
- This will exhaust resources of hunting down the information and correcting it on the back end.





Payer Details

Other or Additional Payers

Payer BCBSOK

No Additional Payer Information

Provider Details

Requesting Provider

Name LAWTON INDIAN HOSPITAL

NPI 1760489223

Place Of Service On Campus-Outpatient Hospital

Benefit Disclaimer

UNLESS OTHERWISE REQUIRED BY APPROPRIATE LAW, THIS NOTICE IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITATIONS AND THE MEMBER'S ELIGIBILITY STATUS ON THE DATE OF SERVICE. PAID-TO-DATE AMOUNTS REFLECT ONLY FINALIZED CLAIMS.



Medicare secondary payer questionnaire (mispq)



- Completing the MSPQ for all Medicare patients is a CMS requirement, and also how Registration determines if Medicare is the primary payer.
- Medicare remains the primary payer for beneficiaries who are not covered by other types of health insurance or coverage. Medicare is also the primary payer in certain instances, provided several conditions are met.
- The MSPQ is designed to determine the primary payer with a series of quick questions to the patient.





Common Situations of Primary vs. Secondary Payer Responsibility



- Individual is age 65 or older, is covered by a GHP through current employment or spouse's current employment AND the employer has less than 20 employees:
- Individual is age 65 or older, is covered by a GHP through current employment or spouse's current employment AND the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):
- Individual is age 65 or older, is self-employed and covered by a GHP through current employment or spouse's current employment AND the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):





Disability and Employer GHP:

- Individual is disabled, is covered by a GHP through his or her own current employment (or through a family member's current employment) AND the employer has 100 or more employees (or at least one employer is a multi-employer group that employs 100 or more individuals)

End-Stage Renal Disease (ESRD):

- Individual has ESRD, is covered by a GHP and is in the first 30 months of eligibility or entitlement to Medicare





Contact Information:

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Registrar

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Sequencing or Coordination of Benefits for Registration

LESLIE A REECE, CPC, CPCO
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July 13, 2022





What is Coordination of Benefits?



- When a patient has two (or more) insurance plans those plans will work together to pay claims. This is called coordination of benefits. A few general rules define how each of those payers will pay on the claim. Both companies will work together to:
 - Avoid duplicate payments by making sure the two plans don't pay more than the total amount of the claim.
 - Establish which plan is primary (pays first) and which plan pays secondary.
 - This practice helps reduce the cost of insurance premiums.





Determining Coordination of Benefits



Birthday Rule

- Whose birthday falls first in a calendar year? This becomes primary payer (claim is submitted to this payer first)
 - Partner 1: April – BCBS - Primary
 - Partner 2: August – Aetna - Secondary
- If both partners have the same birthday, then subscriber with longest coverage becomes primary.





Determining Coordination of Benefits-MSP



- ❑ Medicare Secondary Payer Guidelines
 - Disability
 - Workman's Comp

BCRC Benefits Coordination & Recovery Center (BCRC) is responsible for recovery of mistaken liability, no-fault or worker's compensation collectively referred to as NonGroup Health Plans. This is a situation where we did not obtain the information of these types of claims using MSP guidelines, and Medicare made a payment as primary when they were not primary.





Sequencing Payers



- Determines primary payer, secondary payer, etc.

Determined by Category

- Medical
- Dental
- Optometry
- Pharmacy
- Mental Health





Sequencing Payers



- Determines effective date of billing order
- May be set as a requirement in site parameters
 - INSURER SEQUENCING REQ'D: YES//





IHS REGISTRATION EDITOR (page 4) INDIAN HEALTH HOSPITAL
 =====
 PATIENT,EIGHT (upd:DEC 11, 2007) HRN:XXXXX DIRECT ONLY
 =====

SUMMARY COVERAGE

SEQ	INSURER SUBSCRIBER	COVERAGE TYPE POLICY NUMBER	ELIG BEGIN - ELIG END	
1.	NM NEW MEXICO MEDICAID PATIENT,EIGHT	29 004579	01/01/2007	A
2.	D-AARP PATIENT,EIGHT	D 666154231	01/01/2006	A
3.	MEDICARE PATIENT,EIGHT	A 666154231A	01/01/2005	A
	MEDICARE PATIENT,EIGHT	B 666154231A	01/01/2005	A

=====
 Enter S(equence), A(dd) insurer, E(dit) insurer, T(oggle seq category)
 V(iew) Historical Sequence Dates L(ist inactive eligibilities): S

Select one of the following:

- M MEDICAL COVERAGE
- D DENTAL COVERAGE
- O OPTOMETRY COVERAGE
- R PHARMACY COVERAGE
- P MENTAL HEALTH COVERAGE
- T THIRD PARTY LIABILITY COVERAGE
- W WORKMAN'S COMP COVERAGE
- U SUMMARY PAGE

Enter response:M

Roll & Scroll
Example





PATIENT,EIGHT

(upd:DEC 11, 2010) HRN:4561 DIRECT ONLY

MEDICAL COVERAGE

SEQ	INSURER SUBSCRIBER	COVERAGE TYPE POLICY NUMBER	ELIG BEGIN - ELIG END
1	MEDICARE PATIENT,EIGHT	A 666154231A	01/01/2005
2	MEDICARE PATIENT,EIGHT	B 666154231A	01/01/2005
3	D-AARP PATIENT,EIGHT	D 666154231	01/01/2006
4	NM NEW MEXICO MEDICAID PATIENT,EIGHT	29 004579	01/01/2007

Roll & Scroll

Enter a list or range of numbers (1-4): 2,4
 YOU ENTERED THE SEQUENCE 2,4, IS THIS CORRECT (Y/N) ? YES
 WHAT IS THE EFFECTIVE DATE OF THIS PRIORITY SEQUENCE ? : T..





PATIENT,EIGHT

(upd:DEC 11, 2010) HRN:4561 DIRECT ONLY

MEDICAL COVERAGE

SEQ	INSURER SUBSCRIBER	COVERAGE TYPE POLICY NUMBER	ELIG BEGIN - ELIG END
-----	-----------------------	--------------------------------	-----------------------

SEQ DATE: 05/07/2008

- | | | | |
|----|---|-----------------|------------|
| 1. | MEDICARE
PATIENT,EIGHT | B
666154231A | 01/01/2005 |
| 2. | NM NEW MEXICO MEDICAID
PATIENT,EIGHT | 29
004579 | 01/01/2007 |

Roll & Scroll

*** THIS SEQUENCE REFLECTS THE LATEST PRIORITY SEQUENCE DATE ***

Last edited by: POSTER, MARY on May 07, 2010

Enter S(equence), A(dd) insurer, E(dit) insurer, T(oggle seq category)
V(iew) Historical Sequence Dates::





DEMO,PATIENT EPT

01/01/2000 (22y) MALE

SSN XXX-XX-9999 Show

HRN 999916

Last Updated 1/12/2022 (CHROMY,DIANE)

Eligibility Status CHS & DIRECT View

Active Insurance YES

PCP

RHI NO

Sensitive NO

Veteran YES



Profile **Benefits** Appointments

Errors 1 Warnings 2 Print

Alternate Resources Sequencing Benefits Cases Prior Authorizations

AOB & ROI

Change AOB & ROI

Assignment of Benefits 08/15/2019

Release of Information 08/06/2019

Alternate Resources

Status Active

Add Insurance Guarantor

MEDICARE

MEDICARE

Active

View Detail

Subscriber DEMO,PATIENT EPT

Policy No. 411805050

Address PO BOX 3111

MECHANICSBURG, PENNSYLVANIA, 17055-1857

(855)252-8782

Start Date	End Date	Coverage
08/01/2018		A
08/06/2019		B

BPRM

MINNESOTA MEDICAID

MEDICAID

Active

View Detail

Subscriber DEMO,PATIENT EPT

Policy No. 00000000

Address 400 SO 4TH ST SUITE 201

MINNEAPOLIS, MINNESOTA, 55415

(877)620-9090

Start Date	End Date	Coverage
01/01/2022		MA

Home Profile **Benefits** Prior Auths Scheduling Settings Reports

Tasks 0

8:54 AM





DEMO,PATIENT EPT

01/01/2000 (22y) MALE

SSN XXX-XX-9999 Show

HRN 999916

Last Updated 1/12/2022 (CHROMY,DIANE)

Eligibility Status CHS & DIRECT View

Active Insurance YES

PCP

RHI NO

Sensitive NO

Veteran YES

Profile **Benefits** Appointments

Errors 1 Warnings 2 Print

Alternate Resources **Sequencing** Benefits Cases Prior Authorizations

Category MEDICAL

Add Sequence

DEMO,PATIENT EPT

01/01/2000 (22y) MALE

SSN XXX-XX-9999 Show

HRN 999916

Last Updated 1/12/2022 (CHROMY,DIANE)

Eligibility Status CHS & DIRECT View

Active Insurance YES

PCP

RHI NO

Sensitive NO

Veteran YES

Resource Sequence

Category [required] MEDICAL Effective Date of Priority [required] 7/8/2022

Attached Sequences

Sequence Remove

#	Insurer	Coverage Type	Policy Number	ELIG Begin	ELIG End

Save Cancel





DEMO, PATIENT EPT

01/01/2000 (22y) MALE

SSN XXX-XX-9999 [Show](#)

HRN 999916

Last Updated 1/12/2022 (CHROMY, DIANE)

Eligibility Status CHS & DIRECT [View](#)

Active Insurance YES

PCP

Resource Sequence

Category [required] Effective Date of Priority [required]
MEDICAL 7/8/2022

Attached Sequences

#	Insurer	Coverage Type	Policy Number	ELIG Begin	ELIG End

Sequence [Remove](#)

MEDICARE	A	08/01/2018
MEDICARE	B	08/06/2019
MINNESOTA MEDICAID	MA	01/01/2022



Resource Sequence

Category [required] Effective Date of Priority [required]
MEDICAL 8/6/2019

Attached Sequences

Sequence Remove

#	Insurer	Coverage Type	Policy Number	ELIG Begin	ELIG End
1	MEDICARE	B	411805050A	08/06/2019	
2	MINNESOTA MEDICAID	MA	00000000	01/01/2022	
3	MEDICARE	A	411805050A	08/01/2018	

TA DAH!! We are sequenced in BPRM for outpatient services.

Save Cancel





SCENARIOS FOR PRACTICE!





SCENARIO:



- Mr. Laptop is a 42-year old executive actively employed with Hilton Hotels. He is in town conducting a new employee orientation when he has chest pain. He has United Healthcare and Delta Dental through his employer and Mutual of Omaha through his wife's employer. Determine his coordination of benefits for today's visit.





ANSWER:



- United Health Care
- Mutual of Omaha
- Would you ask for, and then enter his dental information?
 - Yes. That way your information is complete.
 - This is a personal preference item, and a suggestion to gather as much as you can





SCENARIO:



- Ms. Apple is a 27-year old marketing assistant. On the job for 20 days, she schedules an appointment to see a doctor for a runny nose. You interview her and she states that she signed up for coverage with Aetna but doesn't have an insurance card to show her benefits. She does, however, give you her dental card. You call for additional information and find out that Ms. Apple's health insurance doesn't take effect until 90 days of employment. If Ms. Apple is nonIndian, how would you determine her coordination of benefits for today's visit?
- Would you add her dental insurance?





ANSWER:



- Self-Pay
 - Patient is a nonben, responsible for her bill.
 - Add dental insurance only if the clinic will continue to see her as a patient.





SCENARIO:



- Ms. Phone is a healthy 71-year old retiree from the public school system. She receives Medicare Part A and Part B as well as benefits from her retirement plan with BCBS of Arizona. She is seeing her primary care physician today for her annual check-up.
- Is she required to fill out an MSP (Medicare Secondary Payer) form, and why is it important to get this information?





ANSWER:



- She is not working, so coverage is Medicare Part B first, then BCBS would be secondary.
 - The MSP points you in this direction as it asks questions to assist in determining who is primary.
- Yes – complete that MSP every 90 days for outpatient. (System prompt).
 - New training through our MAC (Novitas) has begun to emphasize completing this every time. *This has become a “best practice” where the information is obtained without fail.*





SCENARIO:



- Mr. Cloud presents himself at your facility with a laceration (cut) on his hand. When you interview him, he indicates that this happened while he was cutting wood at work. What additional questions would you ask Mr. Cloud?





ANSWER:



- Enter as Workman's Comp.
- Contact employer and obtain information regarding WC carrier.
- Make sure first report of incident report is in file.





SCENARIO:



- Mrs. Humphrey is a 37-year old homemaker that is participating in a Breast and Cervical Cancer research program that is funded by her state. As a participant, she is required to get a mammogram as well as other-related procedures. She is also covered under her husband's Advantage HMO plan. She is receiving a mammogram today. Determine her coordination of benefits for today's visit.





ANSWER:



- Bill Breast and Cervical cancer organization. As a condition of participation, she must have the procedures and they are payable through the organization.
- Check with your organization's process, as there may be special requirements you may need to collect (income) for billing these state plans.





SCENARIO:



- Mrs. Brown brings her 3-year old son, Cody for immunizations. Mrs. Brown is a 32 year-old secretary who carries the Great West Health plan. She indicates that Cody isn't covered under her health plan, but that he is covered under Mr. Brown's plan with AWHP. Cody is also enrolled in the State's Children Health Insurance Program. Determine Cody's coordination of benefits for today's visit.





ANSWER:



- Bill Mr. Brown's plan first.
- Children's Health Insurance Program for all services other than immunizations.
- What is billable? All immunizations? Check with your facility (only for your own knowledge).





SCENARIO:



- Ms. Flower is being seen in the walk-in clinic for an injured back. During the interview process you discover that she fell while shopping in a local grocery store. Ms. Flower does not have insurance, however, the store manager has verified her story. Determine her coordination of benefits for today's visit.





ANSWER:



- Enter in the system as Third-Party Liability.
- Confirm the carrier to be billed with the store
- Confirm with your facility the process for billing Third-Party Liability, Tortfeasor or FMCRA cases. There is a difference in process for federal facilities, and tribal facilities, possibly urbans as well. You are responsible for identifying and starting the process.





Resources



- National Association of Insurance Commissioners (NAIC) Website
www.naic.org
- Centers for Medicare/Medicare Services (CMS) COB Website
www.cms.hhs.gov
- Medicare Secondary Payer (MSP) Manual Website
www.cms.hhs.gov
- Medicare Coordination of Benefits Website
www.cms.hhs.gov/medicare/cob/attorneys/att_home.asp
- Medicare Secondary Payer (MSP) Form Website –Other Insurer Tool
www.rimedicare.org





Contact information:

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218-444-0509 office

Pronouns: *she/her/hers*

