

Section 6 – Eligibility and Coverage

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Eligibility and Coverage

In a needs assessment survey of Wisconsin’s local health departments in the summer of 2012, the following were the top five reasons given for denial of claims:

- Service not covered
- Date of service not covered
- LHD is out-of-network
- Coding error on claim
- Claim applied to deductible

All of these reasons can be addressed by taking the time, prior to rendering the service, to find out how your claim will be process by verifying the patient’s eligibility and benefit coverage for the service.

Key Concepts:

- Eligibility concept
- Coverage concept
- Patient Intake Process
 - Gather information
 - Interpreting ID Cards
- Verifying eligibility and coverage
- Online verification
- Coverage and Benefits (for immunizations)
 - Commercial plans
 - Medicare
 - Medicaid

Prior to rendering service(s) to a patient, you need to determine what program and/or insurance coverage will reimburse you for the vaccine and/or the administration. There are two verifications you need to address:

Eligibility

- Is the patient eligible for the program/health plan for the date of service?
- Is the patient eligible under more than one program/health plan?
- Is your LHD considered a participating provider for this program/health plan?

Coverage

- What is the coverage, or benefits, that will be provided by the program/health plan?
- Are all preventive immunizations covered under the medical portion of a program/health plan, or are some covered under a separate drug plan?
- Will a deductible, copayment or coinsurance be applied to the immunization?

Patient Intake Process

The following steps should be taken and information gathered to make sure that eligibility has been determined.

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Gather Information

There are basic data elements required to bill all types of insurance. When the patient first presents for a service or calls to make an appointment, basic demographic and insurance information needs to be gathered so that eligibility can be verified and coverage levels determined. Development of a form that can satisfy both billing and authorizations is the ideal, as demonstrated in **Appendix 27**, which was developed by the Iowa Billing Project team.

In addition to gathering the information, request a photo ID and the **original** health insurance card from the patient. Make copies of both sides of the card to place in the paper file or scan for electronic filing. If the copy isn't fully readable, be sure to note the illegible information in pen directly off the original card. This should happen at every visit. The reason for making the copy is to prevent fraud (e.g., using someone else's ID card to get free benefits). If initial contact is made by phone, make sure to get the information so you will be able to complete verification prior to their arrival.

Appendix 28 contains a decision tree that includes Medicaid, Medicare and private insurance and when to use private vs. public vaccine. It also indicates what and to whom services are billed.

The California Innovative Implementation Billing Project document developed an easy to use chart (**Figures 1 and 2**) to make sure you address all required information:

Adult with Private Insurance	Adult with Medicaid	Adult with Medicare
Patient's full name at it is spelled on insurance card	Patient's full name at it is spelled on insurance card	Patient's full name at it is spelled on insurance card (legal name)
Date of Birth	Date of Birth	Date of Birth
Address, city, state, zip code	Address, city, state, zip code	Address, city, state, zip code
Phone number	Phone number	Phone number
Gender	Gender	Gender
Guarantor's contact information and mailing address	Guarantor's contact information and mailing address	Guarantor's contact information and mailing address
Policy holder's name and date of birth	Patient's Medicaid card	Patient's Medicare card
Patient's relationship to policy holder	Consent for treatment	Patient's supplemental insurance information, if applicable
Type of plan (e.g., PPO, POS, HMO)	Assignment of benefits	Patient's Part D Insurance card
Identification number		Identification (e.g., driver's license, state identification)
Payer telephone number for benefit verification		Assignment of benefits
Patient's insurance card(s) (copy of front/back)		Consent for treatment
Consent for treatment		
Patient's financial disclosure and assignment of benefits		

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Figure 1 - Adult Eligibility Chart

Minor with Private Insurance	Minor with Medicaid
Patient's full name at it is spelled on insurance card	Patient's full name at it is spelled on insurance card
Date of Birth	Date of Birth
Address, city, state, zip code	Address, city, state, zip code
Phone number	Phone number
Gender	Gender
Guarantor's contact information and mailing address	Guarantor's contact information and mailing address
Policy holder's name and date of birth	Legal guardian/custody information and type of identification (e.g., Driver's license)
Patient's relationship to policy holder	Patient's Medicaid card
Type of plan (e.g., PPO, POS, HMO)	Legal Guardian's financial disclosure and assignment of benefits
Identification number	Consent for treatment
Payer telephone number for benefit verification	
Legal guardian/custody information and type of identification (e.g., Driver's license, state identification)	
Patient's insurance card(s) (copy of front/back)	
Legal Guardian's financial disclosure and assignment of benefits	
Consent for treatment	

Figure 2 - Child Eligibility Chart

Interpreting the Identification Card (ID)

The ID card is your source of information required to establish eligibility, obtain benefits, and submit the claim to the payer. Cards come in many different shapes and sizes. They are usually the size of a credit card and can be printed on paper, sturdy card stock or even plastic with information contained on a magnetic strip. Some will have effective/end dates, but many do not carry a date at all. To ensure you have the most current version, check the card at every visit.

Commercial Payer ID Cards

Looking at **Figure 3**, we can find the following:

Member ID and name: This used to be the policy holder's Social Security Number, but due to privacy concerns, this has been replaced, in most cases, with a random number, and then each member might have a specific suffix, like *-01, -02, -03*.

Payer's name: This is sometimes hard to determine as there are parent companies and networks involved. In our sample, US Health and Life

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Insurance is the parent company and Trilogy Health Networks would be considered the payer.

Network name:

In the Sample ID Card (Back) box below, you see that outside of the Trilogy service area, PHCS and MultiPlan are the networks that would be used instead of Trilogy. Since your patients are probably residents of your city or county, this probably will not apply. But you need to check carefully so you know if claims go to a different location or network.

Service Phone numbers:

The most important number is probably that of Customer Service, where you can call to verify eligibility and obtain benefits information. While immunizations probably don't require pre-authorization, that number, along with other service numbers, should be displayed in case you have questions.

Claim Submission:

Somewhere on the card, it should tell you where to submit paper claims. Again, this may not be directly to the payer's address, so check closely.

EDI Payer ID:

The payer ID is listed so that you can provide that to your clearinghouse for electronic claims.

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<p>Customer Service: Claims questions, Member Eligibility, and Covered Benefits: 866-429-3242 Automated Fax Back System: 888-494-4600 Prior Authorization: 866-802-1326 Provider Network Information: 866-429-6628</p> <p>Website: www.ushealthandlife.com</p>	<p>Claim Submission Address:</p> <p>Trilogy Health Networks P.O. Box 1171 Milwaukee, WI 53201 (Paper Claims)</p> <p>EDI Payer ID #62777 (Electronic Claims)</p>
<p>Sample ID Card (Front):</p> 	<p>Sample ID Card (Back):</p> 

Figure 3 - Trilogy Insurance ID Card sample

Some payers have the same information on where to send claims, but they use a logo to identify the actual plan the patient has, which is important to obtain eligibility and benefits. WEA Trust Insurance Plan uses this method (**Figure 4**):

Card Identification	Health Plan	Logo
POS (followed by region)	Point of Service or Point of Service Trust Select	
Trust Preferred	Preferred Provider	

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Blank under logo	Front-end Deductible, Health Conversion WEA-MedPlus	
WEA Trust PPO	WEA Trust State Preferred Provider Plan	

Figure 4 - WEA Trust Logo Samples

Some payers put the copays or coinsurance amounts right on the card (**Figure 5**). Most cards will not indicate whether the group is a grandfathered plan, requiring providers to call the payer to determine if a copay or coinsurance applies to immunizations or preventive office visits (such as interperiodic visits).

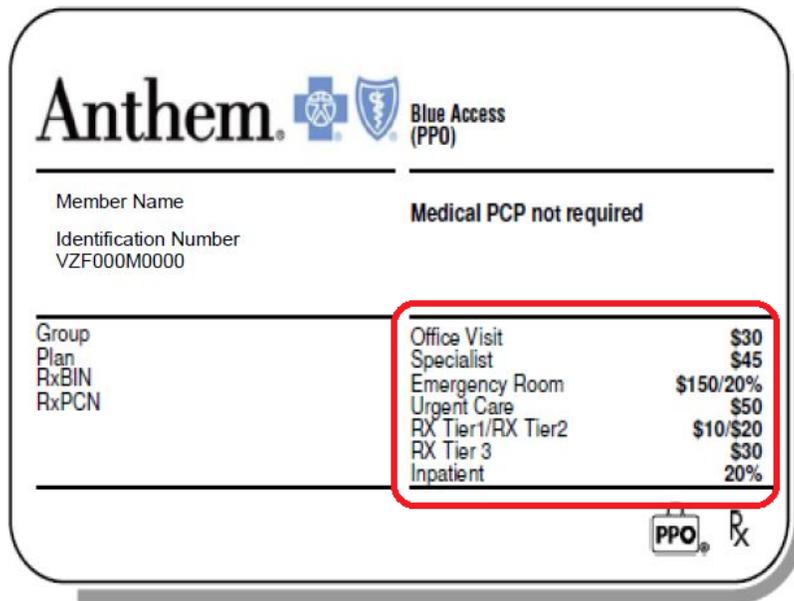


Figure 5 - Anthem PPO Card sample

If your office has a PDF Capable Barcode Scanner, then you would be able to use the advanced magnetic strip and bar code ID Cards some payers have issued. You have to enroll with the plan; information should be available on their website. A sample card is shown in **Figure 6** below.

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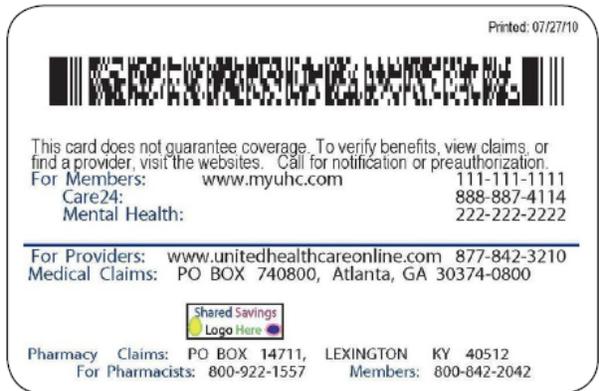


Figure 6 - UHC magnetic strip ID card

When you scan the card, the information looks more like code, than English, which is why you need the payer’s key to reading the data (**Figure 7**) – again, this is a sample of UHC’s cards¹:

What information is in the bar code?

Health plan ID	Rx BIN	Date issued
Member ID/name	Rx PCN	
Medical group ID	Rx group ID	

What does the data from the scan look like?

%WH9118772604363927310^WHITEJBAC/SUBSCRIBER/C^GR0123456
 ^BN610494^PC9999^RGUHEALTH^DI07/09/10?

Start	Health Plan ID	Member ID	Delimiter	Member name*	Medical Group label	Medical Group ID
%WH	9118772604	363927310	^	WHITEJBAC/ SUBSCRIBER/C	GR	0123456

RxBIN label	RxBIN ID	Rx PCN label	Rx PCN ID	RxGrp label	RxGrp ID	Date Issued label	Date Issued	End
BN	610494	PC	9999	RG	UHEALTH	DI	07/09/10	?

* Member name format: The member name will appear “Last, First, MI” and is separated by slashes.
 When there is no middle initial on file, then only one slash will appear between the last and first names.

Figure 7 - UHC key to reading scanned ID card data

Medicare ID Cards

Figure 8 is an example of the CMS Medicare ID card (front):

¹ Source: <https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=74559b24553c2110VgnVCM100000c520720a>

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**Please Read the Enclosed Material
Before Making Your Choice**

If you **DO** want Medical Insurance, out out your Health Insurance Card. Your coverage and your Medical Insurance premium begin on the date shown. **Throw away the rest of this form.**

If you do **Not** want Medical Insurance, carefully follow the instructions on the back of this form.

MEDICARE
HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER **000-00-0000-A** SEX **FEMALE**

IS ENTITLED TO **HOSPITAL (PART A) MEDICAL (PART B)** EFFECTIVE DATE **07-01-1986**

SIGN HERE _____

**DO NOT SEND CLAIMS FOR PAYMENT OF
MEDICARE BENEFITS TO THIS (A) ADDRESS**

Form CMS-40 (01/2002)

Figure 8 - Medicare Part A/B card sample (front)

Figure 9 is a CMS Medicare ID card (back):

1. Carry your card with you when you are away from home.
2. Let your hospital or doctor see your card when you require hospital, medical, or health services under Medicare.
3. Your card is good wherever you live in the United States.

WARNING: Issued only for use of the named beneficiary. Intentional misuse of this card is unlawful and will make the offender liable to penalty. If found, drop in nearest U.S. Mail box.

Centers for Medicare & Medicaid Services
Baltimore, MD 21244-1850
Form CMS-1956 (01/2002)

If you have questions about Medicare, call 1-800-MEDICARE (1-800-633-4227; TTY/TDD: 1-877-486-2048) or visit us at www.medicare.gov.

I DO NOT WANT MEDICAL INSURANCE **Check Here**

Written Signature (or Legal Representative)

SIGN HERE _____

Signature by Mark (X) Must Be Witnessed

Signature of Witness _____

Address of Witness _____

If you DO NOT want Medical Insurance

1. Check the box above (top right), sign your name, and return the entire form in the enclosed envelope. Do NOT tear off the Medicare card. It would be improper to use it since you do not want Medical Insurance. You must return the form BEFORE the Medical Insurance effective date shown on the card.
2. Since you are entitled to Hospital Insurance even though you do not want Medical Insurance, we will send you a new card showing that you have Hospital Insurance only.

Figure 9 - Medicare Part A/B card sample (back)

Figure 10 is a Medicare Railroad Retirement Card:

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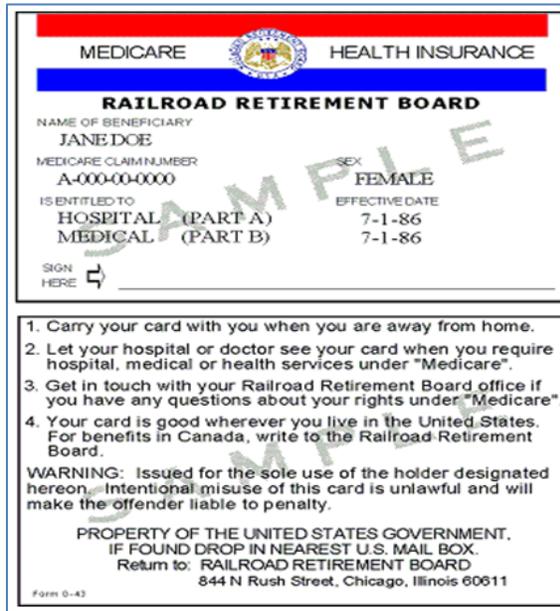


Figure 10 - Railroad Medicare card (front & back)

Medicare Advantage cards will look like a regular health plan card. **Figure 11** shows the United HealthCare Medicare plan ID card:

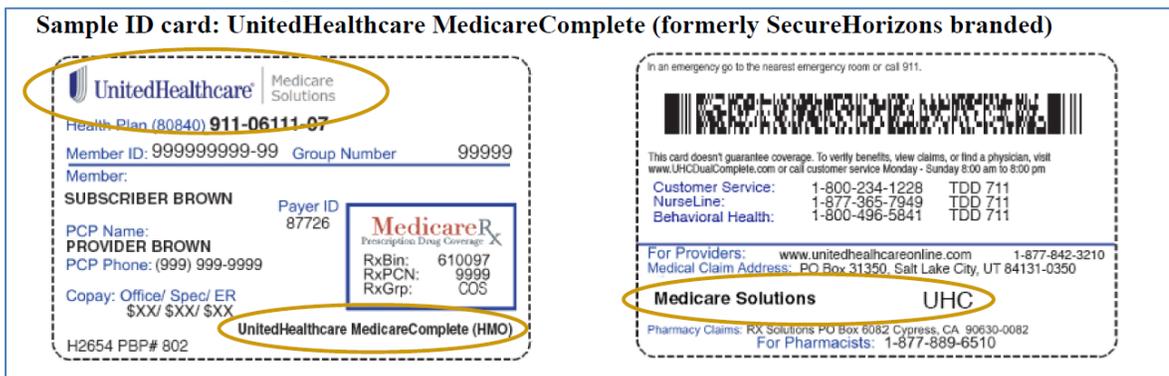


Figure 11 - Medicare Advantage card (front & back)

Figure 12 is a Medicare Part D Card from Express Scripts:



Figure 12 - Medicare Part D card (front & back)

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Medicaid ID card

Figures 13 and 14 are the WI Medicaid ID cards for health services:



Figure 13 - Wisconsin Medicaid ID card (front and back)



Figure 14 - WI Medicaid Senior Care Rx Card (front and back)

Verify Eligibility and Coverage

Now that you have gathered all the required data, you need to contact the payer for specifics regarding the patient's eligibility under their stated coverage. In some cases, payers might have real-time eligibility information on their website or through a clearinghouse. But in most cases, you will need to contact the payer via phone.

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Commercial Payers Tips

- Many insurance companies verify coverage through an online system designed specifically for health care providers. This is the most efficient way to verify coverage, so if the payer has one, use it.
- Have all the appropriate information available before you call. If the information is different, but the eligibility and/or coverage is effective, be sure to note the new information for the claim. This can happen because people aren't always diligent in using their updated cards.
- When calling for eligibility and/or benefit coverage information, it is best to group calls by payer so you don't make multiple calls to the same payer.
- Avoid calling in the morning, especially Monday mornings, as hospitals call during that time to verify coverage for new admissions.
- Have the representative verify your provider status, and make sure you are given the correct benefits for your status. For instance, if you are non-participating/out-of-network for the plan, and the representative tells you there is no deductible or copay, which might be a red flag they gave you in-network benefits.
- Be sure they are giving you the specific patient's benefits and are not just giving a general "covered" answer because the service is an immunization. Remember that grandfathered plans don't have to give free preventive services.
- Ask if the service will be covered. Sometimes you may be asked for a procedure code.
- Be sure to find out if there is a copayment or coinsurance that you can collect on the service.
- Verify that this is the primary insurance coverage.
- Verify that you have the correct claim mailing address or EDI payer ID so that the claim isn't unnecessarily delayed.
- **Always** note the name of the person who gives you the information. Getting a reference number for the call is also critical in any potential appeal process. Currently, most insurers assign a type of ID number to every call, just like they do for every claim. This person will also tell you that they cannot guarantee benefits – don't worry, this is standard practice.

Medicare

With the transition from WPS to NGS for Medicare Part B occurring during the writing of this manual, it is important that you follow any instructions from NGS for a smooth transition. As a preview, instead of using the C-SNAP system for verifying beneficiary eligibility or getting status of claims only, you will now use NGS's Connex system (**Figure 15**) accessible

at [http://www.ngsmedicare.com/wps/portal/ngsmedicare!/ut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP0os3gDP2MXRzdTEwMLEzNTA09XRzNjI0tzI2dTQ_2CbEdFAP6YobQ!/.](http://www.ngsmedicare.com/wps/portal/ngsmedicare!/ut/p/c4/04_SB8K8xLLM9MSSzPy8xBz9CP0os3gDP2MXRzdTEwMLEzNTA09XRzNjI0tzI2dTQ_2CbEdFAP6YobQ!/)

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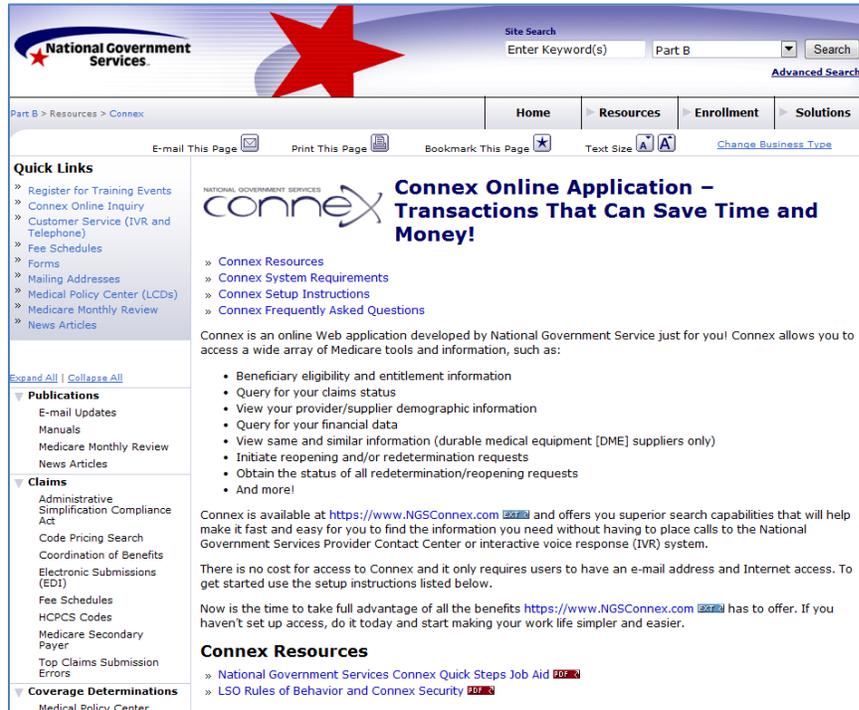


Figure 15 - NGS Medicare Part B Online System

On this site you can:

- Check beneficiary eligibility and entitlement information
- Query for your claims status
- View your provider/supplier demographic information
- Query for your financial data
- Initiate reopening and/or redetermination requests
- Obtain the status of all redetermination/reopening requests

Medicaid

Each enrolled member receives an identification card². Possession of a program identification card does not guarantee enrollment. It is possible that a member will present a card during a lapse in enrollment; therefore, it is essential that providers verify enrollment before providing services.

The ForwardHealth card does not need to be signed to be valid; however, adult members are encouraged to sign their cards. Providers may use the signature as another means of identification.

The toll-free number on the back of each of the cards is for *member use only*.

If a provider finds discrepancies with the identification number or name between what is indicated on the ForwardHealth card and the provider's file, the provider should verify enrollment with Wisconsin's EVS (Enrollment Verification System).

² Topic #266 - ForwardHealth Identification Cards

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When the member's 10-digit identification number on the ForwardHealth card does not match the EVS response, if the EVS indicates the member is enrolled, services should be provided.

If a member's name on the ForwardHealth card is different than the response given from EVS, providers should use the name from the EVS response.

Members do not receive a new ForwardHealth card if they are enrolled in a state-contracted MCO (managed care organization) or change from one MCO to another. Providers should verify enrollment with the EVS every time they see a member to ensure they have the most current managed care enrollment information.

To see how to use the enrollment section of and LHD's provider account for Wisconsin Medicaid, to the Forward Health Portal >> Providers >> Portal User Guides >> Enrollment Verification User Guide.

Figures 16 through 18 show how to find eligibility information:

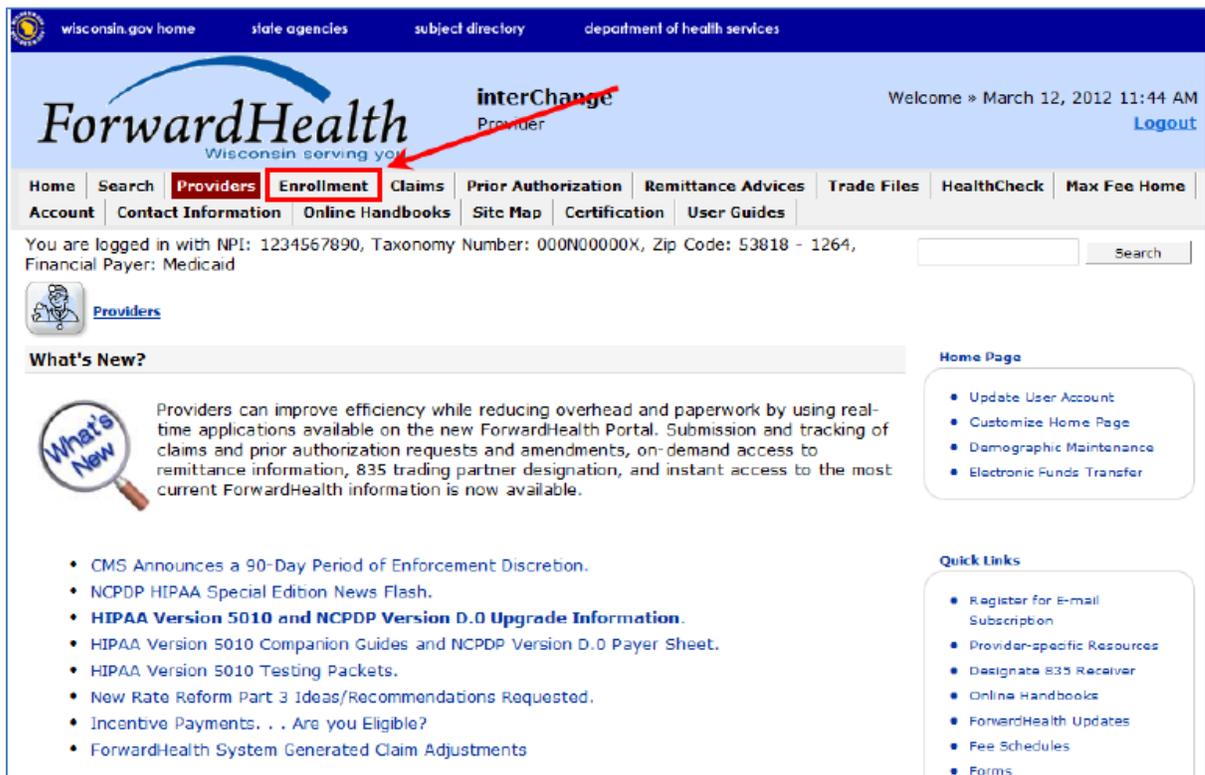


Figure 16 - Forward Health Enrollment tab on provider screen

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Enrollment Verification ?

Required fields are indicated with an asterisk (*).

- [View the Enrollment Verification User Guide](#)
- One of the following is required:
 - Member ID
 - Social Security Number and Date of Birth
 - Member First/Last Name and Date of Birth

Member ID

Last Name First Name

Social Security Number Date of Birth

From Date of Service* To Date of Service*

[Search Enrollment Verification History](#)

Figure 17 - Forward Health Eligibility Search screen

For future DOS, if the *inquiry is made prior to the 20th of the current month*, users may enter a From DOS and To DOS up to the end of the current calendar month. For example, if the date of the request is for November 15, 2013, users may request dates up to and including November 30, 2013.

For future DOS, if the *inquiry is made on and after the 20th of the current month*, users may enter a From DOS and To DOS up to the end of the following calendar month. For example, if the date of the request was November 25, 2013, users could request dates up to and including December 31, 2013.

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Enrollment Verification

Required fields are indicated with an asterisk (*).

- [View the Enrollment Verification User Guide](#)
- One of the following is required:
 - Member ID
 - Social Security Number and Date of Birth
 - Member First/Last Name and Date of Birth

Member ID First Name

Last Name Date of Birth

Social Security Number To Date of Service*

From Date of Service*

[Search Enrollment Verification History](#)

For your reference, the enrollment verification tracking number 120720000B verifies the enrollment information below only for the following time frame of 03/12/2012 through 03/31/2012.

Search Results

Member Information

Member ID	1111111111	Name	NICOLE MEMBER
Date of Birth	01/01/1970	County	Dane
Medicare ID		Address	1 ANY STREET MADISON WI, 53703

Benefit Plan

Payer	Benefit Plan	Effective Date	End Date
MEDICAID	Medicaid	03/12/2012	03/31/2012

Non-Emergency Transportation Services Enrollment

Provider Name	Effective Date	End Date
LOGISTICARE SOLUTIONS, LLC	03/12/2012	03/31/2012

Figure 18 - Forward Health Eligibility Results screen

It is advisable to print the Enrollment Verification page using the Print function of their browser so that you have a permanent paper copy of the enrollment verification inquiry for LHD records.

Medicare coverage

You can access coverage information for Medicare through its online database located at:

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<http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=Wisconsin&KeyWord=chiropractic&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAAAAAAAAAAAAA%3d%3d&=&>

Figure 19 indicates how you can use the filter system to access any current coverage issues for Wisconsin regarding immunizations.

The screenshot shows the CMS.gov Medicare Coverage Database interface. The top navigation bar includes links for Home, About CMS, Newsroom Center, FAQs, Archive, Share, Help, Email, and Print. Below this is a search bar with the text "Learn about your healthcare options" and a "Search" button. A secondary navigation bar contains categories: Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations and Guidance, Research, Statistics, Data and Systems, and Outreach and Education. A third navigation bar includes buttons for OVERVIEW, ADVANCED SEARCH, INDEXES, REPORTS, DOWNLOADS, BASKET (0), and Contextual Help is Off | Page Help.

The main content area is titled "Welcome to the Medicare Coverage Database" and includes a "QUICK SEARCH" section. The search filters are highlighted with a red box and include:

- OR BY DOCUMENT TYPE (Currently in Effect Only):**
 - National and Local Coverage Documents
 - National Coverage Documents
 - Local Coverage Documents
- *Select Geographic Area/Region:**
 - Wisconsin
- *Select One or Both:**
 - immunization
- AND/OR**
 - Enter CPT/HCPCS Code

Additional text in the search section includes: "An asterisk (*) indicates a required field.", "YOU MAY SEARCH BY ID:", "*Document ID: Enter ID", "SEARCH BY ID", "View county listings for split states", "View region descriptions", and "Need more search power? Try Advanced Search".

Figure 19 - CMS Medicare Coverage Database filter options

Figure 20 is an example of the returned information. In this case only one coverage document exists, for tetanus, which you can access by clicking on the title hyperlink.

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The screenshot displays the CMS Medicare Coverage Database search results interface. At the top, there are navigation tabs for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations and Guidance, Research, Statistics, Data and Systems, and Outreach and Education. Below these are buttons for OVERVIEW, ADVANCED SEARCH, INDEXES, REPORTS, DOWNLOADS, and BASKET (0). The main content area is titled "Search Results" and includes a "MCD ARCHIVE" section with a document update schedule. The search results section shows "Your Search Results" with 1 record. Below this, there are buttons for "Modify Your Search", "New Search", "Print Selected", "Add to Basket", and "Select All Records". A table lists various document types, all showing "No records returned for this section". The "Articles" section shows 1 record, which is highlighted by a red box in the original image.

ARTICLE ID#	ARTICLE TITLE	CONTRACTOR TYPE	CONTRACTOR NAME	DATE INFO	SELECT ALL
A49710	Tetanus IMMUNIZATION - Medical Policy Article	FI	National Government Services, Inc. (00450)	Effective: 02/01/2010 Revision Eff: 01/01/2013 End: N/A Updated: 12/21/2012	<input type="checkbox"/>

Figure 20 - CMS Medicare Coverage Database query returns

Online Verification

As the use of technology continues to improve in the health insurance industry, it becomes more cost-effective to take advantage of these improvements.

As a result of the Patient Protection and Affordable Care Act (PPACA), December 31, 2013 is the certification date by which health plans must “file a statement with HHS certifying that their data and information systems are in compliance with the standards and operating rules,” including the federally mandated CAQH CORE Eligibility & Claim Status Operating Rules. This is defined in Section 1104(b)(2), requiring specific standards and associated operating rules to be implemented. This section states “To the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care.” Thus, the payers must

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provide automated eligibility and coverage verifications for providers. CMS will begin assessing penalties no later than April 1, 2014, against health plans that have failed to meet these standards. These standards include:

Meet certain content requirements for the eligibility transaction, including that:

- At a minimum, eligibility responses must include dates of eligibility for past and future dates at a benefit level if the benefit level is different from the contract level;
- The patient's financial responsibility is included for each benefit at the base contract amount for in- and out-of-network providers, as well as the patient's co-pay, deductible, and coinsurance amounts prior to the point of care; and
- The name of the health plan; and

Meet certain service and performance timeframes for eligibility and claim status transactions:

- Systems be operational 86 percent of the time per calendar week and regular system downtimes are published;
- Batch transactions, if received by 9:00 p.m. eastern standard time, must have a response sent by 7:00 a.m. eastern standard time the following day; and
- Real-time transactions must have a response sent within 20 seconds or less.

Coverage/Benefits

As the result of state and federal laws, most plans cover immunizations that are ACIP recommended. However, whether or not they are covered without any cost-sharing can be confusing due to exceptions in those same laws. Especially be aware of the grandfathered plans because:

1. Immunizations can be subject to deductibles and copay/coinsurance amounts, and,
2. There is no way to know if cost-sharing applies because the ID card isn't required to display the plan's grandfathered status.

Commercial Plans

Effective in 2010 with the passage of PPACA, immunizations are covered under preventive services in most instances.

PPACA Title I, Sec. 1001 — Coverage of preventive health services in private health plans
Insurance companies must cover preventive services recommended by the US Preventive Services Task Force (USPSTF) and the Advisory Committee on Immunizations Practices (ACIP); and *health plans cannot impose any cost-sharing requirements*. This includes those vaccines found in the recommended immunization schedule for children, adolescents, and adults.

This provision *does not apply to grandfathered plans* – which could include a majority of the existing plans (**Appendix 29**). The common understanding of a grandfathered plan is an individual or group health plan providing coverage on March 23, 2010 – the day the bill was enacted. There is no official definition of what those plans are so, at this time, it is difficult to determine the impact of this provision.

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PPACA Title I, Sec. 1001 — Extension of dependent coverage in private health plans

Requires health plans that offer dependent coverage to make it available for an adult child until that child turns 26 years old, with the exception of grandfathered plans.

Adult vaccines such as Meningococcal and Human Papillomavirus (HPV) may also be covered depending on HHS clarifying rules, as noted above.

Medicare

Immunizations are, for the most part, covered under Medicare Parts B and D. See **Appendix 30** for details.

Medicaid

Medicaid has a variety of programs under which immunizations are covered.

Vaccine for Children (VFC) Program Eligibility

Any child 18 years of age or younger who meets at least one of the following criteria is eligible for the VFC Program:

- Eligible for Medicaid or BadgerCare Plus.
- American Indian or Alaska Native, as defined by the Indian Health Services Act.
- Uninsured.
- Underinsured – includes those who are insured, but plan doesn't pay for the specific vaccine. Person's policies that have a high or unmet deductible, copay or coinsurance are not considered to be "underinsured".
 - LHDs – can administer state supplied vaccine and collect the administration fee, or waive based on family's ability to pay.

Note: Private VFC providers must refer underinsured patient to a LHD (in Wisconsin) or federally qualified health center (FQHC) or rural health clinic (RHC); underinsured children cannot receive immunizations from a private health care provider using VFC vaccine.

Vaccines for Children 18 Years of Age or Younger

Vaccines provided to members 18 years of age or younger are available through the federal VFC Program at no cost to the provider. ForwardHealth reimburses only the administration fee for vaccines supplied by the VFC Program.

For vaccines that are not supplied by the VFC Program, providers may use a vaccine from private stock. In these cases, ForwardHealth reimburses for the vaccine and the administration fee.

The Wisconsin Immunization Program website has more information about the VFC program. Providers may also call the VFC program at (608) 267-5148 if Internet access is not available.

Vaccines that are commonly combined are not separately reimbursable unless the medical necessity for separate administration of the vaccine is documented in the member's medical record.

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If a patient encounter occurs in addition to the administration of the injection, LHDs may receive reimbursement for the appropriate evaluation and management (E&M) procedure code that reflects the level of service provided at the time of the vaccination. If an immunization is the only service provided, the lowest level E&M office or other outpatient service procedure code may be reimbursed, in addition to the appropriate vaccine procedure code(s).

Cervarix[®] Coverage for Medicaid Members

Cervarix[®] is a covered vaccine for female members aged 9 to 26 years. Cervarix is available through the VFC program for VFC-eligible children aged 9 through 18 years; therefore, LHDs should submit claims with HCPCS procedure code 90650 (Human Papilloma virus [HPV] vaccine, types 16, 18 bivalent, 3 dose schedule, for intramuscular use) to be reimbursed for the administration of the vaccine for members aged 9 to 18 years.

For female members aged 19 through 26 years, private stock vaccine must be used.

Gardasil[®] Coverage for Medicaid Members

Gardasil[®] is covered for both male and female members aged 9-26 years. The vaccine is available through the VFC program for members aged 9 through 18 years. LHDs should submit claims for Gardasil[®] with the HCPCS procedure code 90649 (Human Papilloma virus [HPV] vaccine, types 6, 11, 16, 18 quadrivalent, 3 dose schedule, for intramuscular use) to be reimbursed for the administration of the state-supplied vaccine for members aged 9 through 18 years. For members aged 19 through 26 years, LHDs should bill 90649 to be reimbursed the administration fee and for the cost of the vaccine from their private stock.

HealthCheck Program

Providers are required to indicate the procedure code of the actual vaccine administered, not the administration code, on claims for all immunizations. Reimbursement for both the vaccine, when appropriate, and the administration are included in the reimbursement for the vaccine procedure code, so providers should not separately bill the administration code. Providers are required to indicate their usual and customary charge for the service with the procedure code.

The immunizations identified by CPT subsections "Immune Globulins" (procedure codes 90281-90399) and "Vaccines, Toxoids" (procedure codes 90476-90749) are covered.

Immune globulin procedure codes and the unlisted vaccine/toxoid procedure codes are manually priced by Forward Health's pharmacy consultant. To be reimbursed for these codes, physicians are required to attach the following information to a paper claim:

- Name of drug.
- NDC.
- Dosage.
- Quantity (e.g., vials, milliliters, milligrams).

Medicaid reimbursement for immune globulins, vaccines, toxoid immunizations, and the unlisted vaccine/toxoid procedure codes *includes* reimbursement for the administration

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component of the immunization, contrary to CPT's description of the procedure codes. Procedure codes for administration are *not* separately reimbursable.

Vaccines for Members 19 Years of Age or Older

Medicaid members aged 19 years and older are considered insured, and therefore cannot receive state-supplied vaccine. Thus, for vaccines from a provider's private stock that are administered to members 19 years of age or older, ForwardHealth reimburses for the vaccine and the administration. (Also see Gardasil[®] and Cervarix[®] above.)

SeniorCare Program

Immunizations and vaccines are not covered under the SeniorCare Program.

Medicaid immunizations were also affected by PPACA.

PPACA Title I, Sec. 2001 and 4106 — Medicaid

There are newly eligible persons for the Medicaid program, based on income, gender and family position. These changes will lead to more people receiving Medicaid benefits and potentially more people eligible for Medicaid-covered immunizations. One specific Medicaid section clarifies that the preventive services that could be offered to Medicaid eligible adults includes those services recommended by the USPSTF and those immunizations recommended by the ACIP. The impact will vary by state based on their current Medicaid eligibility and future required expansion.

