Eligibility myCGS

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Hello! My name is Nykesha Scales. I am a member of the Provider Outreach and Education team with CGS, your Medicare Administrative Contractor.

Question….what do you find to be most frustrating when it comes to submitting claims? I can almost guarantee that most of you find it frustrating to have claims returned to you either rejected as unprocessable or denied. We, here at CGS, feel that frustration. Claims that are Returned-to-Provider or denied for avoidable reasons benefit no one. They are a waste of your time and a burden on us from a claims processing perspective.

Believe it or not, issues involving patient eligibility are always among the top reasons Part B claims are rejected and denied. Issues such as the patient name and identifier ; patient enrolled in a Medicare Advantage plan; Medicare is the secondary payer; the patient is enrolled in Hospice. All of those issues generate a TON of rejections and denials. This results in additional work for you because you then have to figure out which payer is responsible for paying the service. Touching a claim more than once is, again, a waste of time for you.

Well - Not anymore.

myCGS, our secure, Internet-based provider self-service web portal, is THE solution that allows you immediate access to everything you need to avoid these time-wasters…and MORE! Using myCGS to verify patient eligibility BEFORE submitting your claims helps to avoid the need to for to touch the same claim more than once, and allows us to process it and make a payment determination upon initial submission.

Accessing this information is easy! Once you are logged into myCGS, select the ELIGIBILITY tab. There you will find the various sub-tabs that provide everything you need to know about your patient. Today, I would like to review each one.

To query myCGS and receive the most accurate results, enter all identifying information for your patient.

- The patient's last name
- The patient's first name OR date of birth
- If the patient's Medicare card shows a suffix, such as Jr. Sr., etc., enter it in the SUFFIX field
- Enter the patient's identifier, either the Health Insurance Claim Number, also referred to as the HICN, or the new Medicare Beneficiary Identifier, or MBI, if one has been assigned.
- Patient sex is not a required field but may be entered. If you enter something in this field please be sure that the value is correct.

There is also a field to enter a date range. This field will ensure the response to your eligibility inquiry is based upon the specific date range entered. For example, if you need to know if the

patient was enrolled in traditional Medicare for a specific date, enter the date range so that the response is isolated to that specific timeframe.

The information available after submitting the request is populated in each applicable sub-tab which includes:

- The Eligibility sub-tab. Here you will find an overall view of the patient's Part A and Part B status including effective and termination dates; dates associated with any periods the patient's coverage was inactive; the address on file for the patient; as well as information regarding End Stage Renal Disease, if applicable.
- The next sub-tab is Deductible/Caps. Here, you will have access to the current and previous year's deductibles and coinsurance. If you render outpatient therapy services and want to know where the patient falls within the therapy cap, those totals are available to you as well.
- The next sub-tab is for Preventive services. This will help you determine when a patient is next eligible to receive one of the Medicare-covered preventive services. Not only will you know whether or not the service falls outside of our frequency limitations, but It will also help you with determining if a patient should be presented with an

Advance Beneficiary Notice of Non-Coverage, or ABN, should the patient still want the service. Having a signed ABN on file will allow you to bill the patient should we deny it for frequency.

- The next sub-tab is Plan Coverage. The Plan Coverage sub-tab provides information regarding the patient's enrollment under a Medicare Advantage (MA) plan, also known as Medicare Part C, in addition to Part D coverage. When a patient elects an MA plan, that plan processes claims for the patient in place of CGS, since we are a traditional Medicare contractor. Keep in mind…Patients may elect one or the other – not both.
- The next sub-tab is MSP. MSP stands for Medicare Secondary Payer. When a patient has a payer primary to Medicare, the MSP sub-tab will be populated with information specific to that payer. This includes effective dates, the name and contact information for the primary payer, as well as policy numbers. To generate the most accurate inquiry response, be sure to enter a date range on the initial Eligibility Inquiry screen.
- The next sub-tab is Hospice/Home Health. This sub-tab is populated when a hospice or home health claim has been submitted and processed through our system. Home health start and end dates, as well as information identifying the home health agency are displayed. Under the hospice section, effective and termination dates are available, in addition to identifying information for the hospice.
- The next sub-tab is Inpatient. This sub-tab provides hospital stays and skilled nursing facility (SNF) benefit and billing information. Like the previous sub-tab, the data returned is compiled from claims that have been processed by the Common Working File (CWF). To ensure you obtain accurate information, please be sure to enter a date range on the Eligibility Inquiry screen.
- The last sub-tab is QMB, which stands for Qualified Medicare Beneficiary. The QMB program is a State Medicaid benefit that assists low-income Medicare patients with Medicare Part A and Part B premiums and cost-sharing, including deductible, coinsurance, and copays. Patient enrolled in the QMB program may not be billed for these, as they have no legal obligation to pay. The QMB sub-tab is populated if the patient is a QMB patient.

So, that is a summary of the Eligibility tab and its sub-tabs. For more information, please refer to the *myCGS User Manual* located on our website:

- Go to https://www.cgsmedicare.com
- Select your line of business, either J15 Part A, J15 Part B, or J15 HHH
- From the left-navigation section, select the myCGS Portal tab

Eligibility functions are detailed in Chapter 4 of the manual.

Take advantage of this and other functions available to you through myCGS.

If you're not already, register for myCGS TODAY at https://www.cgsmedicare.com/mycgs/index.html!

Again, this is Nykesha Scales. I truly appreciate your time. THANK YOU.

