

## **Eligibility and Benefit Verification for Beneficiaries enrolled in Medicare Health Plans and Medicaid**

### **Verifying Coverage Under Medicare Health Plans**

Through the Medicare Modernization Act (MMA) and recent enhancements to eMedNY, Medicare is providing Medicaid with updated eligibility information for beneficiaries enrolled in Medicare Health Plans (also known as Medicare Advantage, Medicare Part C and Medicare Managed Care Plans). Providers should expect to see this coverage more frequently on eligibility transactions.

Information available through the Medicaid Eligibility Verification System (MEVS) gives providers the eligibility status for a Medicaid beneficiary for a specific date (today or prior to today) and any Medicare, third party insurance or HMO coverage that a beneficiary may have for the date of service. If the beneficiary is enrolled in a **Medicare Health Plan**, the MEVS response is:

**ePACES:** Additional Payer Information – Carrier Code beginning with an “H”, “R”, or “E” followed by four numeric digits.

**Verifone:** Other Insurance – Plan Code beginning with an “H”, “R”, or “E” followed by four numeric digits.

For further information, see the MEVS manual:

<http://www.emedny.org/ProviderManuals/AllProviders/supplemental.html#MEVSPM>

### **Medicare Health Plan Benefits May Include Dental and Vision Services**

Some Medicare Health Plan benefit packages include certain dental and vision services not otherwise covered by traditional Medicare Part B. When a beneficiary is covered by a Medicare Health Plan, it is the provider’s responsibility to verify the benefit package with the Plan directly. For a listing of Medicare Health Plans, go to

<http://www.medicare.gov/MPPF/Include/DataSection/Questions/ListPlanByState.asp>. (Scroll to bottom left of the page, and click on “New York” from the dropdown menu under “*Learn More About Health Plans and Medigap Policies in Your Area*”.)

### **Medicaid As Secondary To A Medicare Health Plan**

Medicaid requires providers to exhaust all existing benefits prior to billing Medicaid. Medicaid will then pay the applicable Medicare Health Plan coinsurance, co-payment and deductible. Providers need to become network providers for Medicare Health Plans because Plans must be billed first for all services included in the benefit package. See the following Medicaid Updates regarding billing instructions for Medicaid beneficiaries with coverage under a Medicare Health Plan:

[http://www.health.state.ny.us/health\\_care/medicaid/program/update/2009/2009-11.htm#enr](http://www.health.state.ny.us/health_care/medicaid/program/update/2009/2009-11.htm#enr)

[http://www.health.state.ny.us/health\\_care/medicaid/program/update/2010/2010-01.htm#ben](http://www.health.state.ny.us/health_care/medicaid/program/update/2010/2010-01.htm#ben)

When required, providers must obtain prior authorization from the Medicare Health Plan and/or Medicaid.

- For further questions on eligibility and claims transactions, call CSC at 1-800-343-9000.
- For questions on Medicaid prior authorization, call the Division of Provider Relations and Utilization Management at 1-800-342-3005.