Welcome to First Coast’s
Secure Provider Online Tool (SPOT)
Eligibility and Benefits Tutorial

Welcome to First Coast’s
Secure Provider Online Tool (SPOT)
Eligibility and Benefits Tutorial
The information you have available as a SPOT account holder will help you streamline your billing operations and reduce denied claims.

You may use the SPOT to analyze your claim history, your unique billing trends, as well as make comparisons with your peers’ billing practices. The SPOT also allows you to reopen claims to make clerical corrections on multiple lines, view remittances, submit redeterminations and respond to additional development requests.

Even with those useful tools, the eligibility and benefit information may be the most popular feature on the SPOT. Many providers use the eligibility data ahead of appointments to verify the Medicare beneficiary is eligible for the service scheduled. Using an eligibility and benefits report can benefit the health of your practice and your patients:

- Reduces the number of denied claims by conducting proactive verification of benefits
- Helps beneficiaries stay current with preventive screenings

One provider had this to say about their SPOT experience:

“The SPOT has improved our operations in tangible ways. With the SPOT, we are able to make eligibility determinations right then and there. The system is live.”

What can the SPOT do for you?

In the next series of slides, we will show you how to create a benefits and eligibility report as well as the depth of information contained in each report.
Click the 'Check Eligibility' tab at the top of the SPOT home page or the 'Check Eligibility & Benefits' window at the center of the home page. After clicking either of these links, you will be brought to the main search page.
Enter a specific date(s) of service. You may limit your query to the specific date(s) of service or you may specify any time period up to four months in the future and 12 months in the past.

Enter the beneficiary's Medicare ID, first name, last name, date of birth, and click Search.
Under the eligibility tab, you will find Beneficiary information including the Name, Medicare Number and Date of Birth or Death if applicable. You will also see the current address along with Part A and Part B eligibility information.

Once you click the search button, the returned data will present a series of tabs corresponding to each of these benefit categories:

- Eligibility and Benefits
- Deductibles/Caps
- Preventive
- Medicare secondary payer (MSP)
- Plan coverage
- Hospice/Home Health
- Inpatient
- Qualified Medicare beneficiary (QMB)

**Notes**

No date in any of the termination fields means the beneficiary remains eligible for those Medicare benefits.

The ‘Export Report’ link at the top and bottom of the page saves the report electronically or prints a copy to place in the patient’s file for easy reference.

The ‘Previous Queries’ link is used to resubmit a previously submitted eligibility query. This table will only display previously submitted queries in the same session.

If you receive an error message after submitting an eligibility query, check to make sure that you have no spaces before or after data entered in required fields. During high volume periods, the system may return an error message erroneously, or your query may “time out” due to slower than normal response times. To resolve this, try resetting your query.
Under the Deductibles/Caps tab, you will find information related to:

- Part A and Part B deductibles for the plan year plus any amounts remaining
- Therapy cap amounts

This will be helpful to you in managing your billing if you serve the occupational, physical or speech therapy needs of Medicare beneficiaries.

The SPOT will display the “used amount” instead of “remaining amount” for Medicare beneficiaries covered by these services.

The “used amount” listed under each category will continue to increase even after the cap has been reached to allow you to determine when therapy usage has exceeded the cap and has reached therapy thresholds in accordance with Medicare policy.
Knowing what preventive services your patient is eligible to receive is of benefit to them and you. Preventive services data includes both professional and technical services along with the next eligible dates. The SPOT eligibility reports show preventive services that are gender-specific to each beneficiary.

Both the ‘Next Professional Date’ and the ‘Next Technical Date’ represent the date the Medicare beneficiary is next eligible to receive that particular screening or test.

Many providers review this information in the SPOT prior to scheduling an appointment with a Medicare beneficiary.
In fact, one provider says this information was critical to reducing the number of denied claims their practice experienced:

“Most, if not all, of the denial codes we had were related to routine ultrasound tests and preventive exams. One procedure with an extraordinary high number of denials was DXA, a bone density test for measuring bone mineral density that is only covered by Medicare once every two years. We worked with our scheduling department to make sure we were only performing the DXA test according to Medicare guidelines.”
For each Medicare secondary payer (MSP), the SPOT will display the following information:

- Insurer name
- Effective date of coverage
- Termination date, if any
- Policy number
- Type of primary insurance

The beneficiary’s MSP information results will include only active MSP data per the date(s) requested and will not be accessible if there is no MSP data or if notification of coverage primary to Medicare has not been received by Centers for Medicare & Medicaid Services (CMS).
The Plan Coverage submenu displays data regarding the beneficiary's enrollment, as applicable, in one or more of the following plans:

- Medicare Advantage (MA)
- Medicare Part D prescription drug coverage plans
- MA Managed Care Plans (i.e., Part C contracts) that provide Part A and B benefits for beneficiaries enrolled under a contract

For each identified Medical Plan, the SPOT will display enrollment date, disenrollment date, the contract number or plan benefit package ID, a code identifying the type of managed care plan, the website address for the plan provider, the plan name and the address and phone number.

**Note:** If no active data is available, the Planned Coverage option will not be displayed.

It is the responsibility of the insurer or medical plan to notify the Social Security Administration of any information associated with the beneficiary and the coverage plan.
Medicare Plan Coverage

“With our snowbirds, we have to stay on top of their eligibility status. Many beneficiaries aren’t aware they enrolled in a Medicare plan different from the traditional plan. They know they have Medicare and that’s it. Having fast access to Medicare eligibility and secondary payer information helps us file clean, accurate claims and get reimbursed sooner.”

Medicare Plan Coverage

If you are receiving claim adjustment reason code (CARC) CO24 frequently on denied claims, becoming familiar with SPOT’s Plan Coverage data will be helpful to you as it is to this Medicare billing manager.

CO24 - Charges are covered under a capitation agreement/managed care plan

“With our snowbirds, we have to stay on top of their eligibility status. Many beneficiaries aren’t aware they enrolled in a Medicare plan different from the traditional plan. They know they have Medicare and that’s it. Having fast access to Medicare eligibility and secondary payer information helps us file clean, accurate claims and get reimbursed sooner.”
In addition to other plan coverage, another frequent cause of claim denials occurs when services are provided Medicare beneficiaries in the middle of a hospice or home health episode.

For hospice patients, Medicare services related to the terminal condition are covered only if billed by the hospice facility to the appropriate fiscal intermediary (Part A). Medicare Part B pays for physician services not related to the hospice condition and not paid under arrangement with the hospice entity.

The Hospice/Home Health results page in the SPOT will include the following beneficiary’s home health or hospice information:

- Hospice/Home Health episode start date and end date, the name of the hospice or home health contractor and their National Provider Identifier (NPI).

If other claims’ dates of service fall within the patient’s home health episode’s start and end dates the claim may deny.

Before providing services to a Medicare beneficiary, determine if a home health episode or hospice stay exists.

Also, the SPOT will supply you with the hospice provider NPI for purposes of billing the facility for services provided. You may search the CMS database by NPI for contact information regarding each home health or hospice provider.
The Inpatient tab provides access to the following:

- Part A Deductible
- Lifetime Reserve Days
- Lifetime Psychiatric Limitation Days
- Inpatient Spell
- Hospital
- Skilled Nursing Facility (SNF)
Each section of your SPOT eligibility report will focus on a different benefit category and list the dates of service queried as well as the date the report was generated.

Your report will include beneficiary personally identifiable information (PII), Medicare Part A and Part B eligibility status, and all active data available from HIPAA Eligibility Transaction System (HETS) at the time your query was submitted, which may include:

- Preventive services
- Deductibles/Caps
- Inpatient
- Hospice/Home health
- Medicare secondary payer (MSP)
- Plan coverage
The SPOT Eligibility Report represents a snapshot of the beneficiary's eligibility profile based on the dates of service queried and active data in HETS at the time the query was submitted.

It has proven to be a useful tool for thousands of providers in reducing their denied claims and streamlining their business.

The SPOT Eligibility Report represents a snapshot of the beneficiary's eligibility profile based on the dates of service queried and active data in HETS at the time the query was submitted.

It has proven to be a useful tool for thousands of providers in reducing their denied claims and streamlining their business.
Also in the SPOT eligibility section is a tool called MBI Lookup. This tool allows providers to instantly look up a beneficiary’s Medicare Beneficiary Identifier, or MBI, by providing some simple data.
MBIs have replaced the Social Security number-based Health Insurance Claim Numbers, or HICNs, on beneficiaries’ Medicare cards.

Providers can simply enter information on a beneficiary and receive that beneficiary’s MBI. This is very useful because SPOT users can use either a HICN or an MBI to exchange and retrieve data in SPOT through 2019. Providers can use the MBI Lookup to find an MBI if a beneficiary does not know it or have their card with them.
Besides eligibility and benefits information, and the MBI lookup functionality, the SPOT gives you the ability to view claims status, conduct detailed analysis at the claim and provider levels, reopen claims to make clerical corrections on multiple lines, and submit redeterminations and additional development responses (ADRs). First Coast offers the SPOT to providers at no charge.
First Coast would love to know how this information helps you improve your Medicare billing. When you begin to implement the use of eligibility and benefit reports, send us a note using the SPOT’s Feedback form under ‘Secure Messaging.’ Tell us what changes you have made in your Medicare billing and how these changes have improved the health of your patients and the bottom line of your medical practice.

Thank you for joining us today.