

MODULE 4: MEDICARE PART B MEDICAL INSURANCE

Objectives

Below are the topics covered in Module 4, Medicare Part B Medical Insurance. This module will ensure that counselors will attain an understanding of this Medicare benefit and the tools needed to assist their clients with problems relating to Medicare Part B.

At the end of this module are the Study Guide Tests and Answer Keys.

Medicare Part B

Medicare Part B is coverage of medical services such as doctor visits, outpatient care, ambulance services and durable medical equipment and supplies.

What does Medicare Part B Cost-Sharing mean?

- Cost-sharing means that Medicare and the beneficiary will share the costs of health care.
- The person with Medicare is responsible for the monthly Medicare Part B premium, annual deductible and the 20% (or 40% for mental health) coinsurance.

What are excess charges?

- Difference between what Medicare approves for a service and what the provider of service bills.
- Only providers who do not accept Medicare assignment are able to bill for these excess charges.
- The excess charge is limited by law (Limiting Charge).

Note: The Limiting Charge only applies to Medicare providers (including doctors), not to suppliers (of medical equipment).

What are Medicare Part B covered services and supplies?

- Physician services
- Outpatient hospital services
- Outpatient treatment of mental illness
- Outpatient rehabilitation
- Ambulance services
- Durable medical equipment and supplies
- Diagnostic tests
- Certain preventive care services

What is Medicare Assignment?

An agreement between Medicare and a provider who agrees to accept the amount Medicare approves for a service or supply as payment in full (the person with Medicare is still responsible for the Part B deductible and 20% (or 40% for mental health coinsurance amount). Participating providers always accept Medicare assignment.

What does “non-assigned” mean?

When a provider does not accept the amount Medicare approves as payment in full. However, a provider cannot charge whatever he or she chooses to Medicare beneficiaries. (This same protection does not apply to suppliers.) Non-participating providers do not always accept Medicare assignment.

What is the Balance Billing Law?

New York State law limits the amount that Medicare non-participating providers (but not suppliers) may charge. Non-participating providers cannot charge beneficiaries more than 5% more than the Medicare approved amount for most services.

What is an Advance Beneficiary Notice of Noncoverage (ABN)?

This is a notice that a provider gives a person with Medicare if they do not think Medicare will pay for the service. If a beneficiary does not sign an ABN, they are not responsible for what Medicare will not pay for.

What is the Medicare Summary Notice?

- The notice is a form that explains Medicare payment and/or denial of services.
- The notice is also a tool that one can use to keep records, appeal denials of service or detect and report fraud.

MEDICARE PART B MEDICAL INSURANCE

Medicare Part B is the medical coverage component of Medicare. Medicare Part B medical insurance helps to pay for **medically necessary** physician services, outpatient hospital services, ambulance services, prosthetic devices, medical equipment, and a number of other health services and supplies not covered by Medicare Part A hospital insurance. Module 4 considers the components of Medicare Part B coverage—physician services, outpatient hospital care, and durable medical equipment and supplies—and addresses the requirements for coverage, the extent of coverage, the specific services that are and are not covered, and the payment process. It also considers what Medicare assignment means, and what a person with Medicare must know about balance billing, the Advance Beneficiary Notice of Noncoverage (ABN), and Medicare Summary Notice (MSN).

WHAT DOES MEDICARE PART B COST-SHARING MEAN?

Medicare Part B is the basis of payment, but Medicare will not pay all costs. It’s a cost-sharing program in which Medicare and the person with Medicare share the costs of health care. The person with Medicare will be responsible for five types of costs:

1. **Premium** - the monthly cost paid for the protection offered by Medicare Part B. The premium is deducted every month from one’s Social Security, Railroad Retirement or Civil Service Retirement check. If the person with Medicare is enrolled in Part B and does not receive a Social Security check, they will be billed every three months for their Medicare Part B premium. This premium represents only 25% of the actual cost of providing Medicare Part B benefits to older and disabled Americans. All Americans paying payroll and income taxes share the remaining 75% of the cost. This makes Medicare Part B a very reasonably priced health insurance.

Note: American citizens and lawfully admitted aliens who are not covered by Social Security and are not eligible for premium-free Part A of Medicare still pay the same Part B premium as those who are eligible.

Note: People with Medicare with higher incomes pay higher Part B premiums. See chart on page 4-31 for details.

2. **Part B deductible** - the initial amount of medical expense for which the person with Medicare is responsible before Medicare or other insurance plans will pay.
3. **Part B coinsurance** - Beneficiaries share, usually 20%, of the Medicare approved charge. Medicare Part B pays the remaining 80% for Medicare approved services and supplies.
4. **Excess charges** - the difference between what Medicare approves for the service and what the doctor or supplier actually bills. Only doctors or other providers who do not accept Medicare assignment may bill these charges. And state and federal law limit the excess charge.
5. **Services not covered by Medicare** - services that Medicare does not cover such as dental care and routine eye care. The person with Medicare is completely responsible for these costs.

Requirements

Medicare Part B approves payment for services when the care received is considered reasonable and necessary and when a Medicare-certified doctor, therapist, supplier, laboratory, or hospital outpatient unit provides the care.

WHAT'S COVERED?

Medicare Part B covers a long list of health care services and supplies—physician services, outpatient hospital services, outpatient treatment of mental illness, outpatient rehabilitation therapy, ambulance services, durable medical equipment and supplies, diagnostic tests, and a number of preventive care services. Part B coverage, however, has very specific limits on the amount and type of care covered. An individual is free to choose whatever services he or she wishes, but will be responsible to pay for any services that go beyond the coverage limits established by Medicare.

Physician Services - Care received from a doctor in his or her office, hospital, skilled nursing facility, or in the patient's home. Medical, surgical and anesthesia services are covered under Part B. Physician specialties include:

1. Doctors of medicine (M.D.) or osteopathy (D.O.)
2. Doctors of dental surgery or dental medicine
3. Chiropractors
4. Optometrists
5. Podiatrists

Please Note: Part B coverage of services by physicians in all but #1 is limited.

Doctors Services Covered

- Medical and surgical services including anesthesia
- Diagnostic tests and procedures that are part of treatment
- Radiology and pathology services (in or out of the hospital)
- Certain drugs administered at the doctor's office
- Transfusions of blood and blood components (beginning with 4th pint)
- Second opinions

Doctors Services, Which May Be Partially Covered

- Chiropractic Services - only for manipulative treatment to treat a subluxation of the spine demonstrated by X-ray or examination. Medicare will *not* pay for an X-ray taken by a chiropractor.
- Podiatric Services - but not for routine foot care such as corn and callus removal, except when foot care is related to a serious medical condition (e.g., diabetes with complications).
- Ophthalmologic Services - treatment/diagnosis of eye disease and lenses following cataract surgery.
- Dental Services - only when services are intended to correct fractures of the jaw or facial bones or involve care for facial tumors or oral cancer.

Doctors Services Not Covered

- Routine physical examinations and tests related to such examinations (with limited exceptions – see “Welcome to Medicare Visit” on page 4-21)
- Most routine foot care (with certain exceptions)
- Examinations for fitting of a hearing aid
- Examinations for eyeglasses except those required following cataract surgery
- Most routine dental care or false teeth
- Acupuncture
- Cosmetic surgery unless needed as a result of degenerative disease or damage from an accident
- Experimental medical procedures and other services that Medicare does not consider medically reasonable or necessary
- Services that are rendered by Christian Science practitioners

Other Services Covered

Outpatient Hospital Services - care received in a hospital without staying overnight. Outpatient hospital services include emergency room or outpatient clinic, lab tests and X-rays billed by the hospital, medical supplies such as splints and casts, drugs which cannot be self-administered, and blood transfusions, beginning with the fourth pint, that are given as an outpatient.

Claims for outpatient hospital services are processed alongside other Medicare Part A claims although they are paid as a Medicare Part B benefit under the Outpatient Prospective Payment System (OPPS).

- Under the OPPS, there are pre-set payments and pre-set co-payments for each service a person with Medicare can have done in an outpatient hospital setting. For each service a person gets, the co-payment cannot be more than the Medicare Part A inpatient hospital deductible for the current calendar year. These pre-set amounts are based on different factors, such as the national median average and the hospital wage index for a particular area. The national median average is based on what it costs, on average, to provide a certain service to a patient.
- The payment and co-payment amounts are subject to change annually
- In areas where the hospital charges are lower than the national average, the pre-set co-payment (which is based on the national average) may be higher than what the person paid before for the same service. In some cases, it may even be higher than what the hospital charged.

- If a person with Medicare has a Medigap insurance policy, the insurer is mandated by law to pay that co-payment amount, even if it is higher than the charges. However, if the person with Medicare has a retiree plan from a former employer, the insurer may or may not pay the full co-payment amount. It depends on how the retiree insurance plan policy is written. If there are questions about the retiree plan payments, the person should call their retiree plan insurer.
- See CMS publication entitled, “*Quick Facts About Payment for Outpatient Services for People with Medicare Part B*” (CMS 02118 – January 2010).

Outpatient Treatment of Mental Illness - covered under a special payment rule: Medicare pays only 60% of approved charges. A provider such as a psychiatrist, a clinical psychologist, or a clinical social worker can provide outpatient treatment for a mental illness.

Note: Starting in 2010, Medicare began phasing in a change to how it pays for mental health services, and by 2014, will pay for these services at 80% of the allowed amount, the same as for medical services today.

Calendar Year	Percentage Paid by Medicare
2010-2011	55%
2012	60%
2013	65%
2014	80%

Outpatient Rehabilitation Therapy - covered if a doctor prescribes therapy and it is received either in a doctor’s office or as an outpatient of a Medicare-approved hospital, home health agency, clinic, rehabilitation or public health agency, or from an independent Medicare-certified physical or occupational therapist in his or her office or in a person’s home.

Therapy Caps -unlike other covered services, Medicare has a financial limitation on physical, speech and occupational therapy. In 2012, there is a limit of \$1,880 for physical therapy (including speech therapy) and a separate limit of \$1,880 for occupational therapy. The \$1,880 limit applies to the Medicare allowance for the therapy services and is subject to the Part B deductible and 20% coinsurance. Therefore, the maximum benefit in 2012 would be 80% of \$1,880 or \$1,504. People with Medicare are responsible for 100% of the providers’ usual fees for therapy services above the \$1,880 limit, regardless of whether they had signed an Advance Beneficiary Notice of Noncoverage (ABN). But, for those that exhaust their physical therapy benefit in the therapist’s office, they can continue to receive therapy in the outpatient department of the hospital. The \$1,880 limit does not apply to therapy received in a hospital setting.

NEW: Effective October 1, 2012, the therapy cap will also start to apply for services done in the outpatient department of a hospital.

Note: People with Medicare may qualify for automatic exceptions to the cap based on their diagnosis or circumstances – such as a person who received two periods of physical therapy during the calendar year for two different conditions. This therapy cap exceptions process is currently available through December 2012.

Ambulance Services - covered only in a Medicare-certified ambulance, if transportation in another vehicle would endanger one’s health, and only ambulance service from one’s home to the nearest hospital or skilled nursing facility or from the hospital or skilled nursing facility to his or her home.

Home health care - Part A pays for home health care until the number of Part A days in a benefit period is exhausted. Part B commences coverage of Medicare-approved home health care after the patient no longer has any Part A covered days left. (See Module 3 (Medicare Part A Hospital Insurance) for details of Medicare coverage of home health care.)

Diagnostic tests by Medicare certified independent laboratories - The lab must always accept assignment for clinical diagnostic lab tests.

Portable diagnostic X-ray services - when received at home from a Medicare-certified supplier and when ordered by the beneficiary's physician.

Oral chemotherapy drugs

Drugs Not Usually Self-Administered

Medicare covers certain injectable drugs that are deemed to be not self-administered by the majority of the Medicare population that is using the drug. The drug must be administered "incident to" a physician's services. "Incident to" the service means that the physician or nurse practitioner be personally present for the administration of the drug. In addition, the physician must purchase the drug. If purchased by the person with Medicare and then administered by the physician, the drug will not be covered under Medicare Part B. You may check the web site (www.ngsmedicare.com) of the local Medicare Administrative Contractor (National Government Services in New York State) to see if a particular drug meets the Medicare coverage criteria for "not usually self-administered."

Note: Doctors are required to accept assignment for the cost of these drugs.

COVERAGE: HOW MUCH? HOW LONG?

Except for the services and supplies specifically limited in dollar amounts (physical, speech and occupational therapy) or specifically excluded from coverage, as long as the service is medically necessary, Medicare Part B has no payment cap or time limit for covered services. After a person with Medicare has satisfied a yearly Part B deductible, Medicare usually pays 80% of the total approved charge for the provided health care service or supply. The approved charge for a particular service or item is a fixed amount calculated on the basis of a national Medicare Fee Schedule, a price list for hundreds of different health care procedures. The person with Medicare is then responsible for the remaining 20% of the approved charge.

Payment

Medicare Administrative Contractors (MACs) make payments for covered services and supplies according to a national **Medicare Fee Schedule**. Reimbursements are based on a "relative value scale," which considers the time, and resources a doctor devotes to each procedure. The payment also considers the doctor's overhead according to the area of the country where the doctor practices. Providers and suppliers are required by law to send the person with Medicare's claims to the Medicare Administrative Contractor (MAC) who handles Medicare payments for a specific area. The Medicare Part A and Part B MAC for all of New York State is National Government Services.

Note: The MAC who handles the Medicare provider claims is determined by where the service is done, NOT where the person lives. So, if a person with Medicare who lives in New Jersey has a service in New York City, the claim would be handled by National Government Services.

Palmetto GBA in Augusta, Georgia processes Part B claims for Railroad Retirees from all states.

National Heritage Insurance Company (NHIC) is the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for all of New York State.

Payment from the Medicare Administrative Contractor (MAC) goes directly to a doctor who accepts **assignment**. The person with Medicare will receive a Medicare Summary Notice (MSN) explaining the payment made to his or her doctor. Payment from the MAC for a claim from a doctor who does not accept assignment is sent with the MSN to the person with Medicare. When a doctor does not accept assignment, they will usually expect payment from the person with Medicare at the time of service.



Caution: A doctor of a person with Medicare has a legal responsibility to submit claims to Medicare. The doctor is not permitted to charge for this service. (Refer to Module 10 for a detailed description of the Medicare Part A and Part B claims process).

MEDICARE ASSIGNMENT: WHAT DOES IT MEAN?

Doctors and other health care providers may choose either to accept the amount Medicare approves as the total they will charge for a service or to charge more. A provider who agrees to charge no more than Medicare’s approved amount is said to accept Medicare assignment. When a provider accepts assignment, Medicare Part B pays the doctor directly. The provider usually receives 80% of the Medicare-approved amount. The person with Medicare is then responsible for the remaining 20% of the approved amount.

Example:

Doctor Bills:	\$110
Medicare approves:	\$100
Medicare pays 80% of Medicare’s approved amount (<i>after the beneficiary has met their Part B annual deductible</i>):	\$80
Beneficiary (or their insurance) pays 20% of Medicare’s approved amount:	\$20

A nonparticipating provider, who does not accept Medicare assignment can, and usually will charge the person with Medicare more than the Medicare approved amount. When a provider does not accept assignment, the Medicare beneficiary will pay the doctor and Medicare will usually pay the beneficiary 80% of the approved amount.

The person with Medicare will also be responsible for an excess charge, an additional percentage above the approved amount. This excess charge is limited by federal law to 15% above the Medicare approved amount. This is referred to as the Federal Limiting Charge. In addition, some states, including New York State, further limit how much providers can charge. (Refer to section on balance billing laws that follows.)

Each year, Medicare asks doctors and suppliers to sign agreements to become Medicare participating physicians and suppliers. Incentives to participate include a 5% higher **fee schedule** allowed amount. Each year, more doctors and other providers choose to participate. **Becoming a participating provider means that the provider has agreed to accept Medicare assignment on all Medicare claims for all Medicare patients.**

Example:

Doctor bills:	\$110
Medicare approves:	\$100
Medicare pays 80% of Medicare's amount: (after the beneficiary has met their Part B annual deductible):	\$80
Beneficiary (or their insurance) pays 20% of Medicare's approved amount:	\$20
Plus, in New York State, the beneficiary pays a maximum of 5% over Medicare's approved amount	\$5

How can I find a doctor who participates in Medicare?

A person with Medicare can find a doctor who participates in Medicare by calling 1-800-MEDICARE. A participating provider directory can also be found on the Medicare Web site <http://www.medicare.gov/find-a-doctor/provider-search.aspx>. The search for a participating doctor can be narrowed down by ZIP code or county.



Consumer Tip: Remember, providers who have not signed a contract to participate—to accept assignment in all cases—are considered to be non-participating providers and may still choose to accept assignment on individual claims. A person with Medicare may ask a nonparticipating doctor to accept assignment for all bills or for a particularly large bill only.

NEW YORK STATE'S BALANCE BILLING LAW

The amount a person with Medicare owes their doctor may be less than they expect. A New York State law limits the amount that Medicare non-participating doctors (doctors who do not accept Medicare assignment) may charge - no more than 5% above Medicare's approved amount. This limit applies to all services except certain home and office visits for basic medical examinations, (those represented by procedure codes of 99201 to 99215 and 99341 to 99353). For services billed with these procedure code numbers, the federal limit of 15% above Medicare's approved amount applies. Medicare's approved amount for health care services and supplies is shown on the beneficiary's Medicare Summary Notice (MSN).

Medicare-participating doctors (who always accept Medicare assignment) have already agreed to collect no more than Medicare's approved amount.

The following refers to non-participating doctors only:

Ask a non-participating doctor if he or she will be willing to accept Medicare's approved amount as the total due. Non-participating doctors may accept assignment on a claim-by-claim basis.

If a beneficiary's doctor will not accept Medicare assignment:

A beneficiary should ask their doctor if they might pay their bill after they receive their Medicare Summary Notice (MSN). A person with Medicare will then be sure that their doctor's bill conforms to the New York State limit.

If a beneficiary's doctor charges more than 5% above Medicare's approved charge:

Contact the doctor. The law requires that the doctor make an adjustment or refund the person with Medicare if they are overcharged.

If a beneficiary’s call to the doctor does not resolve the bill:

The New York State Department of Health is designated by law to investigate possible overcharges. The person with Medicare’s complaint, a brief description of the problem, and photocopies, not originals, of the MSN, may be sent to:

Linda Gowdy
 New York State Department of Health
 Empire State Plaza
 Corning Tower - Room 2084
 Albany, NY 12237
 1-518-474-6965
llg07@health.state.ny.us

A person with Medicare may also call their local Health Insurance Information, Counseling and Assistance Program, or the HIICAP Hotline, 1-800-701-0501, for help with this and other health insurance concerns.

The Medicare Summary Notice (MSN) will tell the person with Medicare whether or not a doctor accepted assignment. If assignment was accepted, the person with Medicare generally owes 20% of the approved amount shown on the MSN. If the doctor did not accept assignment, the person with Medicare will be responsible for an additional 5% of the approved amount for most services in New York, or in the case of specific procedures not covered by New York state law, an additional 15%, the federal limiting charge.

Note: The limiting charge does not apply to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)



Caution: A person with Medicare will need to do his or her own computation for New York State services. The Medicare Administrative Contractor who processes claims is a federal contractor and therefore shows only the federal limiting charge of 15% above Medicare’s approved amount on the Medicare Summary Notice (MSN). The MSN will give the approved charge on which to calculate what is actually owed to the non-assigned doctor. If the procedure code number of the service the doctor provided is 99201 through 99215, or 99341 through 99353, the federal limit applies. Multiply the Medicare approved amount by 1.15 to determine the maximum the doctor may charge. For all other code numbers, the New York State limit applies. Multiply the Medicare-approved amount by 1.05 to determine the maximum the doctor may charge.

Opt-Out Providers

Opt-out providers are providers who have opted out of Medicare completely. They can charge their patient whatever they want. When a beneficiary sees an opt-out provider, they pay the entire cost of their care (except in emergencies). Opt-out providers are not subject to the 15% limiting charge. The opt-out provider should have the beneficiary sign a private contract acknowledging that they are responsible for the full cost of their care and that the doctor’s office will not bill Medicare at all. These providers must officially opt-out of Medicare in the process outlined below.

Private Contracts

A **private contract** is a contract between a person with Medicare and a doctor or other practitioner who has decided not to provide services through the Medicare program. Under a **private contract**, the provider will not bill for any services or supplies to Medicare for a two-year period.

Use of Private Contracts with People with Medicare

- Must be in writing and signed by the person with Medicare before the service is rendered
- Not valid if signed during an emergency
- Physician must file an affidavit with all affected Medicare Administrative Contractors within ten days of the first contract being signed and physicians will not be allowed to submit claims for two years

Private Contracts must state:

- Person with Medicare agrees they won't submit a claim even if the item or service would otherwise be covered
- Person with Medicare agrees to be responsible for payment and that no reimbursement will be made by Medicare
- Acknowledges that no limits would apply to amounts charged, and no Medicare reimbursement will be made
- Acknowledges that Medigap plans do not make payments, and other supplemental policies may choose not to
- Acknowledges that the person with Medicare has a right to have services rendered by someone else
- Must indicate if provider is excluded from participating in Medicare

Contracts must be signed prior to a service being rendered under the contract agreement.

AFFIDAVITS

A physician who decides to enter into private contracts with his or her patients must send an affidavit to Medicare stating his or her intention to “opt-out” of Medicare. Affidavits must be in writing, signed, identify the provider and state that no claims will be submitted in the next two years. The affidavit must be submitted within ten days of the first contract being signed. For a full list of providers who have opted out of Medicare Part B, please visit the National Government Services (NGS) website at <http://apps.ngsmedicare.com/applications/IndexPrivateContPartB.aspx?CatID=2> .

Affidavits must:

- Identify the physician or practitioner
- Provide that the physician or practitioner will not submit any claims to Medicare for any item or service provided to any beneficiary during the two-year period beginning on the later of the date the affidavit is signed or its effective date; in doing so, a physician/provider “opts out” of the Medicare program for this two-year period
- Provide that the physician or practitioner will not receive any Medicare payment for any services provided to Medicare beneficiaries, within that two-year “opt out” period
- Must be filed with all Medicare Administrative Contractors who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare
- Must be in writing and signed

Medicare will cover services from an opt-out provider in an emergency. For Medicare to cover these services, the beneficiary cannot have signed an Advance Beneficiary Notice prior to the service. The beneficiary must also provide proof to Medicare that the services were provided in an emergency.

The following providers *can* “opt out” of Medicare: doctors of medicine or osteopathy, optometrists, podiatrists, dentists, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, clinical nurse midwives, clinical social workers and clinical psychologists.

The following providers *cannot* “opt out” of Medicare: chiropractors, doctors of oral surgery, and physical and occupational therapists in independent practice.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

National Heritage Insurance Company (NHIC) is the Jurisdiction A **Durable Medical Equipment** Medicare Administrative Contractor (DME MAC), which processes claims for people with Medicare who reside in ten states in the Northeast including the state of New York.

Medicare Part B covers medically necessary **Durable Medical Equipment, Prosthetics, Orthotics and Supplies** that have been prescribed by a Medicare physician and are provided to them by a Medicare-approved supplier.

Note: Like services provided by doctors and most other healthcare professionals, DMEPOS is paid by Medicare at 80% of the allowed amount after the annual Part B deductible has been met.



Caution: Unlike services provided by doctors and other healthcare professionals, suppliers of DMEPOS who do not accept Medicare assignment are not subject to the Federal Limiting Charge and can bill the beneficiary for the entire difference between what Medicare allows and their usual charges.

Durable Medical Equipment (DME) is defined as that which;

- can withstand repeated use
- is ordered by a physician
- is primarily and customarily used to serve a medical purpose
- is generally not useful to a person in the absence of an illness or injury, and
- is appropriate for use in the home

Examples of **DME** include: canes, walkers, commode chairs, blood glucose monitors, traction equipment, ventilators, suction pumps, hospital beds and accessories, wheelchairs, home oxygen equipment and supplies. Examples of prosthetic and orthotic devices are: corrective lenses after cataract surgery, artificial limbs and eyes, leg, arm, and neck braces.

Medicare does not cover routine first-aid supplies and non-medical equipment like exercise cycles, home humidifiers and wheelchairs ramps.

Medical Policies for DMEPOS Coverage

Jurisdiction A DME MAC has local coverage determinations and articles regarding durable medical equipment, prosthetics, orthotics and supplies for Medicare suppliers, providers, and people with Medicare. Click on the below line for all of the DMEPOS polices and articles.

http://www.medicarenhic.com/dme/medical_review/mr_lcd_current.shtml

Advance Determination of DMEPOS Medicare Coverage

Advance Determination of Medicare Coverage (ADMC) is a voluntary program that allows Suppliers and Beneficiaries to request prior approval of "eligible" items before delivery of the items to the beneficiary. At this time, only customized wheelchairs (manual and power) are eligible for ADCM. Approval applies to the medical necessity of the item and does not guarantee that the claim will be paid. Other claim edits, such as Medicare eligibility, could cause the claim to deny even though ADCM approved the item.

Note: When a particular wheelchair base is eligible for ADCM, all wheelchair options and accessories ordered by the physician for that patient along with the base HCPCS code will be eligible for ADCM.

Upon receipt of a request, the DME MAC will make a determination within thirty (30) calendar days. The requestor will be sent a letter with a decision, either affirmative or negative, in writing. A beneficiary or supplier can resubmit an ADCM request if additional medical documentation is obtained that could affect the prior negative ADCM decision. However, requests may only be re-submitted once during a six-month period. An affirmative ADCM decision is only valid for a period of six (6) months from the date the decision is rendered.

Additional information on ADCM can be obtained on their Web site at http://www.medicarenhic.com/dme/dmemaca_sm_v005.pdf

Highlight on Medicare Coverage of Home Oxygen Equipment

Medicare covers the monthly rental of medically necessary oxygen equipment during a period of continuous use for up to 36 months. The monthly oxygen rental payments made to the supplier cover not only the oxygen equipment, but also the oxygen contents, any supplies and accessories such as tubing, maintenance, servicing and repairs and other services necessary for furnishing oxygen equipment. The Medicare Program prohibits separate payment allowances for the supplies, accessories and other services necessary for furnishing oxygen and oxygen equipment. The supplier may not bill the patient separately for these items.

Rental payments end after 36 months but the supplier continues to own the oxygen equipment. The supplier is required to provide the oxygen equipment and related supplies for up to an additional two years, if medically necessary. Medicare will continue to pay separately for the oxygen contents for the supplier owned equipment as needed. Medicare will pay for routine maintenance and servicing visits every six months starting six months after the end of the 36-month rental period.

Payment

There are several payment categories of DMEPOS that are divided into the following:

- Inexpensive or other routinely purchased DME (i.e., Diabetic Monitors and Supplies)
- Items requiring frequent and substantial servicing
- Customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Home Dialysis Supplies
- Oxygen and oxygen equipment

- Surgical dressings
- Parenteral and enteral nutrition (PEN)
- Therapeutic shoes and inserts

Some items of **DME** are approved for purchase while others must be rented. The supplier of service will know whether purchase or rental is the Medicare required method. If a person with Medicare purchases an item that is covered by Medicare, he or she may also be entitled to some repairs and/or replacement parts as long as the Medicare beneficiary still meets the medical necessity guidelines for the item can still be supported.

Capped Rental Guidelines

When items are needed for a period of continuous use, payment for items in this category may not exceed a period of continuous use longer than 13 months. After 13 months of rental have been paid, the beneficiary owns the DME item, and after that time Medicare pays for reasonable and necessary maintenance and servicing (i.e., parts and labor not covered by a supplier's or manufacturer's warranty) of the item.

Medicare Advance Beneficiary Notice of Noncoverage (ABN)

An Advance Beneficiary Notice of Noncoverage (ABN) is a written notice that health care providers give to Medicare beneficiaries when the provider believes Medicare will not pay for some or all of the items or services due to the items or services being deemed not reasonable and necessary under Medicare guidelines. The ABN allows the beneficiary to make an informed decision about whether to receive services for which he/she may be financially responsible for paying. The ABN serves as proof that the beneficiary knew, prior to receiving the service that Medicare might not pay. Even if a beneficiary signs an ABN, the DME supplier is required to bill Medicare.

Note: Medicare Durable Medical Home Equipment items under Medicare Part B may require the ABN be issued at times when the items may be medically necessary. The supplier is required to issue an ABN when the supplier expects a claim to be denied for one of the following reasons:

- Services are not medically reasonable and necessary
- The supplier made an unsolicited telephone contact
- Supplier number requirements not met
- Advance Determination of Medicare Coverage (ADMC) denial
- Suppliers not contacted with Medicare in a competitive bidding area (CBA)

DMEPOS Competitive Bidding Program

Currently, Medicare payment for most DMEPOS is based on fee schedules. However, recent amendments to the Social Security Act will alter the process for determining payment amounts for certain DMEPOS items. Specifically, competitive bidding payment amounts will replace the current DMEPOS fee schedule payment amounts for selected items in selected areas. The intent is to improve the effectiveness of the Medicare methodology for setting DMEPOS payment amounts, which will reduce beneficiary out-of-pocket expenses and save the Medicare program money while ensuring beneficiary access to quality items and services. The Medicare Modernization Act

(MMA) required the competitive bidding program to be phased in beginning in 2007, but the Medicare Improvements for Patients and Providers Act (MIPPA) delayed this until 2009.

The program, initially affects patients obtaining DMEPOS in 9 Competitive Bidding Areas (CBAs) that align with the 9 Metropolitan Statistical Areas (MSAs) affected by the first phase of this program and includes 9 product categories of DMEPOS. In general, if a beneficiary resides in one of the CBAs, they must use a Medicare contract supplier for competitive bid items, unless they are willing to be responsible for full payment of these items. This means that some beneficiaries may have to change from a non-contract supplier to a contract supplier. Also, certain suppliers that rent DMEPOS that were not awarded contracts may be “grandfathered” under this program and may be able to continue to supply certain DMEPOS items/services should the beneficiary choose to continue to receive these items from a grandfathered supplier.

Note: The nine CBAs that became effective beginning in January 2011 are all outside of New York State. However, the DME competitive bidding process is rolling out to many more areas in July 2013. The areas in New York State that will be affected by these changes are; Albany, Schenectady, Troy, Bronx, Manhattan, Nassau, Brooklyn, Queens, Richmond County, Buffalo, Niagara Falls, Poughkeepsie, Newburg, Middletown, Rochester, Suffolk County and Syracuse. For more information on the affected areas and the DMEPOS competitive bidding turnover, please visit <http://www.dmecompetitivebid.com>.

In addition, mail-order diabetic testing supplies (throughout the United States) will also be included in the next round of the DMEPOS Competitive Bidding Program.

For names of approved suppliers in a specific location, call 1-800-MEDICARE or go to www.medicare.gov. Further information on National Heritage Insurance Company (NHIC), the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC) can be obtained on their Web site at <http://www.medicarenhic.com/dme/index.shtml>.

MEDICARE COVERAGE FOR PREVENTIVE SERVICES

The charts on the following pages show what health screenings are provided as a Medicare benefit and the portion of the cost that a person with Medicare will pay.

Note: Eligibility is based on the date of the last screening test (paid by Medicare) not a calendar year.

For example, a woman who had her last mammography screening on September 15, 2011 is eligible for another screening mammogram beginning September 1, 2012.

NEW: As of January 2011, Medicare now covers nearly all preventive services at 100%, no longer subject to the Part B deductible and/or 20% coinsurance. In addition, Medicare added coverage for an annual wellness visit in 2011.

Five new services were added at the end of 2011, including alcohol misuse screening and counseling, depression screening, sexually transmitted infection (STI) screening and counseling, obesity counseling and cardiovascular disease behavioral therapy (see full descriptions below).

Starting in 2012, Medicare Advantage plans must cover preventive care the same way that Original Medicare does as long as you see in-network providers.

COVERED SERVICES	ELIGIBLE BENEFICIARIES	WHAT THE BENEFICIARY PAYS
<p>Screening Mammogram: Once every 12 months.</p>	<p>All female Medicare beneficiaries age 40 and older.</p> <p>For women between the ages of 35-39, only one baseline mammogram will be allowed.</p> <p>Medicare does not cover screening mammograms for women under the age of 35.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Pap Smear and Pelvic Exam: (includes a clinical breast exam).</p> <p>Pap smear and pelvic examinations are covered once every 24 months. Once every 12 months if at risk for cervical or vaginal cancer, or if of childbearing age and have had an abnormal Pap smear in the preceding 36 months.</p>	<p>All female Medicare Beneficiaries.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Diabetes Services: Coverage for Glucose monitors, test strips and lancets.</p> <p>Coverage for diabetes self-management training.</p>	<p>All people with Medicare who have diabetes (insulin users and non-users).</p> <p>If requested by the beneficiary's doctor or other provider and the beneficiary is at risk for complications from diabetes.</p>	<p>20% of the Medicare-approved amount after the annual Part B deductible.</p>
<p>Colorectal Cancer Screening: Fecal Occult Blood Test. Once every 12 months.</p> <p>Flexible Sigmoidoscopy. Once every 48 months.</p> <p>Colonoscopy Once every 24 months if at high risk for colon cancer.</p> <p>Once every 10 years but not within 48 months of a screening sigmoidoscopy if not at high risk for colon cancer.</p> <p>Barium Enema: Doctor can decide to use instead of sigmoidoscopy or colonoscopy.</p>	<p>All people with Medicare age 50 and older. However, there is no minimum age for having a colonoscopy.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p> <p>20% of the Medicare-approved amount. NOT subject to annual Part B deductible.</p>

COVERED SERVICES	ELIGIBLE BENEFICIARIES	WHAT THE BENEFICIARY PAYS
<p>Medical Nutrition Therapy (MNT): Three hours of one-on-one counseling the first year and two hours each year after that.</p> <p>Medical Nutrition Therapy Services are covered when provided by a qualifying registered dietitian or nutrition professional.</p>	<p>Beneficiaries with diabetes or renal disease, when their treating physician makes a referral.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Bone Mass Measurements Once every 24 months (more often if medically necessary)</p>	<p>Medicare beneficiaries at risk for losing bone mass.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Immunizations: Flu Shot</p> <p>Once each flu season.</p> <p>Pneumococcal Vaccination One may be all a person ever needs - ask a doctor.</p> <p>Hepatitis B Vaccination If the beneficiary is at medium to high risk for Hepatitis B.</p>	<p>All Medicare beneficiaries</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Prostate Cancer Screening: Prostate-Specific Antigen (PSA) test Once every 12 months.</p> <p>Digital Rectal Examination Once every 12 months.</p>	<p>All male Medicare beneficiaries age 50 or older.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p> <p>Generally, 20% of the Medicare-approved amount for the digital rectal exam after the annual Part B deductible.</p>
<p>Glaucoma Screening: Once every 12 months. Must be done or supervised by an eye doctor who is legally allowed to do this service in New York State.</p>	<p>People at risk for glaucoma, including people with diabetes, a history of glaucoma, and African Americans age 50 and older and Hispanic Americans age 65 and older</p>	<p>20% of the Medicare-approved amount after the annual Part B deductible.</p>
<p>Initial Preventive Physical Examination: (IPPE) “Welcome to Medicare Visit”</p>	<p>One time exam for all Medicare beneficiaries within the first 12 months they have Part B only.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Annual Wellness Visit</p>	<p>All Medicare beneficiaries who have had Medicare Part B for more than 12 months and who have not had an IPPE covered by Medicare within the last 12 months.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Ultrasound Screening for Abdominal Aortic Aneurysms (AAA)</p>	<p>Medicare beneficiaries at risk for AAA who get a referral at their IPPE for this one-time screening</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>

COVERED SERVICES	ELIGIBLE BENEFICIARIES	WHAT THE BENEFICIARY PAYS
Cardiovascular Screening Blood Tests Once every five years.	All Medicare beneficiaries.	Nothing if doctor accepts Medicare assignment as payment in full.
Diabetes Screening Blood Tests Once a year if at risk or twice a year for pre-diabetes.	Beneficiaries that are considered at risk or those having pre-diabetes.	Nothing if doctor accepts Medicare assignment as payment in full.
Smoking Cessation Counseling Eight face-to-face visits during a 12-month period	All beneficiaries who use tobacco	Nothing if doctor accepts Medicare assignment as payment in full. Those beneficiaries who are suffering from a tobacco related disease can have these services covered at 80% of Medicare's approved amount.
HIV Screening Test Once every 12 months	Any beneficiary who requests test	Nothing if doctor accepts Medicare assignment as payment in full.
Alcohol Misuse Screening and Counseling Screening once every 12 months.	Beneficiaries that are considered to misuse alcohol by their physicians. Misuse of alcohol does not mean alcohol abuse or alcoholism.	Nothing if doctor accepts Medicare assignment as payment in full.
Sexually Transmitted Infection (STI) Screening and Counseling	Pregnant beneficiaries and/or those considered high risk for an STI	Nothing if doctor accepts Medicare assignment as payment in full.
Depression Screening Once every 12 months.	All Medicare beneficiaries.	Nothing if doctor accepts Medicare assignment as payment in full.
Obesity Screening and Counseling	All Medicare beneficiaries who have a Body Mass Index (BMI) of 30 or more.	Nothing if doctor accepts Medicare assignment as payment in full.
Cardiovascular Disease (Behavioral Therapy) Once every 12 months.	All Medicare beneficiaries	Nothing if doctor accepts Medicare assignment as payment in full.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN) AND SPECIAL AGREEMENTS: ARE THEY LEGAL?

Right: A person with Medicare has the right to understand why Medicare will not pay for a service or supply in certain circumstances, and the reason why. The health care provider must give them, in writing, before the service is rendered, the reason why they believe Medicare will not pay for the service in a specific case. This is called an Advance Beneficiary Notice of Noncoverage (ABN).

It must contain four parts:

1. The service in question
2. The date of the service
3. A specific reason why they believe the coverable service may not be paid.
4. A person with Medicare's signature indicating they understand and agree to accept responsibility to pay for the service.

CMS has instructed providers to use the new version of the Advance Beneficiary Notice of Noncoverage (ABN) form (CMS-R-131) (3/11) as of January 1, 2012. (A sample copy of the ABN form can be found at the end of this module.)

“Blanket Waivers,” which are not specific, are not binding. These blanket coverage waivers are not legal and one is not bound by them.

Only when the doctor has informed the person with Medicare that Medicare does not cover a particular service and they had signed a statement agreeing to accept responsibility for a particular bill is a waiver legally binding. A small number of doctors attempt to avoid the limiting charge laws set by state and federal government. The Centers for Medicare & Medicaid Services (CMS) has released its position on such inappropriate physician tactics for collecting more than the law allows. A person with Medicare should be on guard if a doctor suggests any of the following:

- That they sign a blanket waiver (“pay for everything Medicare doesn’t”) like the one described above;
- that they pay the full charge in excess of Medicare’s approved amount;
- that they pay for services such as telephone calls or prescription refills that are; normally considered to be part of the charge of a visit.

This doctor may be attempting to avoid Medicare regulations. Doctors are legally obligated to charge no more than what federal and state laws permit. They are not permitted to bill separately for each individual part of a visit.

Responsibility: It is important for a person with Medicare to understand Medicare’s benefits. Advance Beneficiary Notices of Noncoverage (ABNs) are not required for services that are never covered by Medicare, for example, acupuncture. If a denial is received for a service they did not know was not covered, and it cannot be reasonably expected that they should have known, then the person with Medicare is not responsible to pay the charge. If a person with Medicare signs the ABN, which serves as proof that they did know the service may be denied, payment is their responsibility.

Limitation of Liability

If a person with Medicare did not know and could not be expected to know that Medicare would deny payment because the service was considered not reasonable and necessary, a person with Medicare is not liable for the charge. This special protection under Medicare law is called the *limitation of liability*. The Medicare Summary Notice (MSN) will alert them to the possibility that they may not be financially liable for the bill.

MEDICARE SUMMARY NOTICE (MSN)

A person with Medicare will receive Medicare Summary Notice (MSN) statements to inform them how much Medicare pays for each health care service or supply received. Learning how to read and understand the MSN is important for all people with Medicare. Medicare Part A and Part B Medicare Summary Notices are sent to the person with Medicare by the Medicare Administrative Contractor for the state where they received a specific health care service. For example, if a person with Medicare is a New York resident who travels to Baltimore to see a specific doctor, his or her MSN for that doctor’s service will come from the Medicare Administrative Contractor for the state of Maryland. Doctor services they receive in New York, however, will be processed by National Government Services, the Medicare Administrative Contractor for the State of New York.

Note: Medicare Summary Notices (MSN) are mailed to people with Medicare every 90 days (formerly it was every 30 days). If a person with Medicare cannot wait to receive an MSN, they may always call 1-800-MEDICARE to request an MSN or to verify claim information, or view their claims on-line at <http://www.mymedicare.gov>.

MYMEDICARE.GOV

People with Medicare are able to access their own recent personal claim information and to order Medicare Summary Notices on-line by signing up at www.mymedicare.gov. (www.mimedicare.gov for Spanish). They can also view their preventive service history to know when the last time Medicare paid for a preventive service and the next time they would be eligible for Medicare coverage of that service.

WILL ANOTHER ENTITY PAY BEFORE MEDICARE?

There are times when another type of coverage pays for a person with Medicare’s health care services before Medicare will pay. When a person with Medicare is covered by a governmental agency or program (e.g., worker’s compensation), covered by a **current** employer’s group health plan when the plan is the primary payer, or covered under liability or a no-fault insurance plan, Medicare becomes the secondary payer.

“Do I need to enroll in Medicare Part B?” is a common question from older Americans who continue to work after age 65. If a person with Medicare is **currently** working for a company of 20 or more employees, and retains their employer’s insurance plan as their primary insurer, Medicare is the secondary payer. If Medicare pays secondary to an employer health plan, would Medicare benefits be worth the dollars paid for Medicare Part B premiums? The answer depends on a person with Medicare’s specific company benefits and his or her expected health care costs. (Refer to Medicare Enrollment for Working Seniors in Module 2).

As a secondary payer, Medicare will consider any coinsurance, deductible or co-payment amounts that the primary insurance applies up to the amount Medicare would usually pay as the primary payer.

Medicare Part B may not be cost-effective if the employer group health plan usually pays its full approved amount without applying any coinsurance or deductible amounts and/or the person with Medicare does not expect to incur large health care costs.



Reference: *Medicare and Other Health Benefits: Your Guide to Who Pays First* CMS Publication #02179, November 2011)

WHAT ARE FEDERALLY-QUALIFIED HEALTH CENTERS?

Even with the protection of Medicare, low-income people with Medicare are often unable to find and afford health care services they need. Omnibus Budget Reconciliation Act of 1990 established Federally Qualified Health Centers (FQHCs) in federally-designated medically-underserved areas to provide comprehensive primary care to low-income elders. The FQHC can waive the annual Part B deductible, and if the person with Medicare qualifies for the sliding fee scale, the 20% coinsurance can be waived as well. People with Medicare can receive preventive primary services and services from physicians, nurse practitioners and physician assistants, clinical psychologists, clinical social workers, and visiting nurses. To find a FQHC, use this link at http://findahealthcenter.hrsa.gov/Search_HCC.aspx or call HRSA at 1-888-ASK-HRSA (275-4772)

Sources of Assistance

NYS OFA HIICAP Hotline **1-800-701-0501**

Medicare Hotline **1-800-MEDICAR(E)**
(1-800-633-4227)
TTY 1-877-486-2048

NYS Office for Aging Senior Hotline **1-800-342-9871**

Medicare Administrative Contractor (MAC)
National Government Services **1-800-MEDICARE**
Medicare Part B **(1-800-633-4227)**
Kathy Dunphy 1-718-989-0981

Railroad Retirees
Railroad Medicare/Palmetto GBA **1-800-833-4455**
P.O. Box 10066
Augusta, Georgia 30999-0001

Durable Medical Equipment
National Heritage Insurance Company (NHIC) **1-800-MEDICARE**
DME – Written Inquiries **(1-800-633-4227)**
P.O. Box 9146
Hingham, MA 02043-9146

Balance Billing Problems
Linda Gowdy **1-518-474-6965**
New York State Department of Health
Empire State Plaza
Corning Tower - Room 2084
Albany, NY 12237
llg07@health.state.ny.us

US Department of Health and Human Services **1-800-HHS-TIPS**
Fraud and Abuse Hotline **(1-800-447-8477)**

Additional Resources

- *Medicare and Other Health Benefits: Your Guide to Who Pays First*, CMS Publication #02179, November 2011
- *Medicare & You 2012*, CMS Publication #10050, September 2011
- *Medicare Coverage of Durable Medical Equipment and Other Devices*, CMS Publication #11045, December 2008
- *Your Guide to Medicare's Preventive Services*, CMS Publication #10110, May 2011
- *Your Medicare Benefits*, CMS Publication #10116, January 2011

MODULE 4 APPENDIX

Medicare Part B Covered Chart : Medicare Part B: Medical Insurance-Covered Services for 2012

Services	Benefit	Medicare Pays	Beneficiary Pays
Medical Expenses Doctors' services, inpatient, outpatient medical and surgical services and supplies, ambulance, diagnostic radiology, diabetes-testing supplies.	Unlimited if medically necessary	80% of approved amount (after \$140 deductible)	\$140 deductible plus 20% of approved amount
Physical, Speech and Occupational therapy	Up to \$1,880 in physical and speech therapy combined and a separate \$1,880 in occupational therapy	\$1,880 paid at 80%, or \$1,504 (after \$140 deductible)	\$140 deductible plus up to \$376 in coinsurance (20% of \$1,880) and 100% of provider charges in excess of \$1,880
Clinical Laboratory Services Blood tests, biopsies, urinalysis, and more	Unlimited if medically necessary	100% of approved amount	Nothing
Home Health Care Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies, other services	Unlimited as long as the beneficiary meets certain Medicare conditions.	100% of approved amount, 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment
Outpatient Hospital Treatment Services for the diagnosis or treatment of illness or injury	Unlimited if medically necessary	Payment is based on a payment rate. The rate is based on Part B \$140 deductible, coinsurance, actual payment to hospital.	\$140 deductible (if not met) and coinsurance or preset copay
Blood*	Unlimited if medically necessary	80% of approved amount (after \$140 deductible and starting with 4th pint)	First 3 pints, plus 20% of approved amount for additional pints (after \$140 deductible).

2012 Part B Monthly Premium		
Income		Part B Premium
Individual	Couple	
\$85,000 or below	\$170,000 or below	\$99.90
\$85,001 - \$107,000	\$170,001 - \$214,000	\$139.90
\$107,001 - \$160,000	\$214,001 - \$320,000	\$199.80
\$160,001 - \$214,000	\$320,001 - \$428,000	\$259.70
Above \$214,000	Above \$428,000	\$319.70

1. Once your client has met the \$140 Part B deductible for covered services in 2012, the Part B deductible will not apply to any further services during the year
2. Physicians who do not accept assignment on Medicare claims are limited by law as to the amount they can charge a person with Medicare for covered services. In New York State, the limiting charge is 5% above the approved amount (with certain exceptions)
3. Blood paid for or replaced under Part A of Medicare during the calendar year does not have to be paid for or replaced under Part B

** In New York State the American Red Cross replaces blood at no cost*

STUDY GUIDE MODULE 4: MEDICARE PART B MEDICAL INSURANCE

Medicare Part B - it's the medical coverage piece of Medicare. Medicare Part B helps to pay for medically necessary doctors' services, for outpatient hospital services, and for medical equipment. Medicare approves payment for care, and helps to pay for care, when care is considered "reasonable and necessary" and when the person with Medicare's care is provided by a doctor, therapist, supplier, laboratory, or hospital outpatient unit that is licensed to operate in their state.

MEDICARE PART B, PART 1



Read your *HIICAP Notebook*.

Medicare Part B, Part 1 focuses on these major topics:

- I. Medicare Part B Cost-sharing
- II. Medicare Part B Assignment
- III. Medicare Part B Payments
- IV. The Medicare Summary Notice (MSN)

Use the information from your *HIICAP Notebook* for the following lessons regarding Medicare Part B.

1. MEDICARE PART B COST-SHARING



Group Activity: Make a list of the Medicare Part B costs that a person with Medicare is responsible for. Explain each.

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____

2. MEDICARE ASSIGNMENT

Read "Medicare Assignment: What does it mean?" in your *HIICAP Notebook*.

With your group, use a chalkboard or flip chart to illustrate an example of how you can save money by seeing a doctor who accepts assignment. Use a \$150 billed charge, with a Medicare-approved amount of \$100 for an office visit.

A federal law, the Physician Payment Reform Act, limits the amount a non-participating doctor may charge to 15% above Medicare's approved amount. New York State's Balance Billing Law limits that amount even more - to 5% above Medicare's approved amount for most services. **Read "New York's Balance Billing Law" in your *HIICAP Notebook*.**



3. MEDICARE PART B PAYMENTS

Answer the following:

- How does Medicare determine the amount a doctor will be paid?
- Who sends Part B claims to the Medicare Administrative Contractor?
- When a doctor accepts Medicare assignment, who receives the Medicare payment?
- When a doctor does not accept Medicare assignment, who receives the Medicare payment?
- What form do beneficiaries receive to inform them of Medicare’s payment decision?

MEDICARE PART B, PART 2

Focuses on these major topics:

- Medicare Part B Benefits and Gaps
- Beneficiary Protection: Limits of Liability

Use the information from your HIICAP Notebook and the Medicare Handbook for the following lessons regarding Medicare Part B.



1. MEDICARE PART B BENEFITS AND GAPS

Are the following services covered by Medicare Part B? (circle “Yes” or “No”)

- | | | |
|--|-----|----|
| a. Services and supplies that Medicare does not regard as medically necessary? | Yes | No |
| b. Diagnostic tests? | Yes | No |
| c. Second opinions? | Yes | No |
| d. X-rays taken by a chiropractor? | Yes | No |
| e. Routine foot care? | Yes | No |
| f. Lenses following cataract surgery? | Yes | No |
| g. Outpatient hospital services? | Yes | No |
| h. Mammography screenings? | Yes | No |



Review your answers with the group.



2. LIMITATION OF LIABILITY

If Medicare denies payment because a service is not considered “reasonable and necessary,”

- When is your client not responsible for the cost of that service?

- When is your client responsible for the cost of that service?



3. SOURCES OF ASSISTANCE

- a. The Medicare Part B Medicare Administrative Contractor: _____
- b. The Medicare Part B carrier for railroad retirees: _____
- c. The Durable Medical Equipment Medicare Administrative Contractor (DME MAC): _____
- d. Federally-Qualified Health Center(s) in your client's area



In Summary: Review these Medicare Part B basic concepts.

Medicare Part B costs - my *responsibilities*. Medicare Part B benefits - my *rights*. It's *my responsibility* to learn about the Medicare Part B payment process and the Medicare assignment and balance billing issues.

ANSWER KEY MODULE 4: MEDICARE PART B MEDICAL INSURANCE

Medicare Part B – it’s the medical coverage piece of Medicare. Medicare Part B helps to pay for medically necessary doctors’ services, for outpatient hospital services, and for medical equipment. Medicare approves payment for care, and helps to pay for care, when care is considered “reasonable and necessary” and the person with Medicare’s care is provided by a doctor, therapist, supplier, laboratory, or hospital outpatient unit that is licensed to operate in their state.

MEDICARE PART B, PART 1



Read your *HIICAP Notebook*.

Medicare Part B, Part 1 focuses on these major topics:

- I. Medicare Part B Cost-sharing
- II. Medicare Part B Assignment
- III. Medicare Part B Payments
- IV. The Medicare Summary Notice (MSN)

Use the information from your *HIICAP Notebook* for the following lessons regarding Medicare Part B.



1. MEDICARE PART B COST-SHARING

Group Activity: Make a list of the Medicare Part B costs that a person with Medicare is responsible for. Explain each.

- a. monthly premiums
- b. annual deductible
- c. coinsurance
- d. excess charges
- e. noncovered services and supplies



2. MEDICARE ASSIGNMENT

Read “Medicare Assignment: What does it mean?”

With your group, use a chalkboard or flip chart to illustrate an example of how you can save money by seeing a doctor who accepts assignment. Use a \$150 billed charge, with a Medicare-approved amount of \$100 for an office visit.

With assignment, you are responsible for \$20

Without assignment, you are responsible for \$35

A federal law, the Physician Payment Reform Act, limits the amount a non-participating doctor may charge to 15% above Medicare’s approved amount. New York State’s Balance Billing Law limits that amount even more - to 5% above Medicare’s approved amount for most services



3. MEDICARE PART B PAYMENTS

Answer the following:

- a. How does Medicare determine the amount a doctor will be paid? *Medicare’s “approved” or “reasonable” charge is calculated on the basis of a fixed national Medicare schedule, and will be the lower of either (a) the actual charge, or (b) the Medicare fee schedule*
- b. Who sends Part B claims to the Medicare Administrative Contractor?
All doctors and suppliers
- c. When a doctor accepts Medicare assignment, who receives the Medicare payment? *The doctor*
- d. When a doctor does not accept Medicare assignment, who receives the Medicare payment? *The person with Medicare*
- e. What form do beneficiaries receive to inform them of Medicare’s payment decision? *The Medicare Summary Notice (MSN)*

MEDICARE PART B, PART 2

Use the information from your HIICAP Notebook and the Medicare Handbook for the following lessons regarding Medicare Part B.



1. MEDICARE PART B BENEFITS AND GAPS

Are the following services covered by Medicare Part B? (circle “Yes” or “No”)

Correct answers appear in **bold** type.

- | | | |
|--|------------|-----------|
| a. Services and supplies that Medicare does not regard as medically necessary? | Yes | No |
| b. Diagnostic tests? | Yes | No |
| c. Second opinions? | Yes | No |
| d. X-rays taken by a chiropractor? | Yes | No |
| e. Routine foot care? | Yes | No |
| f. Lenses following cataract surgery? | Yes | No |
| g. Outpatient hospital services? | Yes | No |
| h. Mammography screenings? | Yes | No |



Review your answers with the group.



2. LIMITATION OF LIABILITY

If Medicare denies payment because a service is not considered “reasonable and necessary”:

- a. When is your client not responsible for the cost of that service? *When your client did not know that Medicare would deny payment.*
- b. When is your client responsible for the cost of that service? *When the provider gave your client advance notice, in writing, of Medicare nonpayment, specifying the service in question; the date of the service, the reason he or she believes the service will not be paid by Medicare. Your client’s signature on this Advance Beneficiary Notice of Noncoverage (ABN) indicates that your client understood and agreed to accept responsibility to pay for the service.*

3. SOURCES OF ASSISTANCE

- a. The Medicare Part B Medicare Administrative Contractor: 1-800-MEDICAR(E)
- b. The Medicare Part B carrier for railroad retirees: 1-800-833-4455
- c. The Durable Medical Equipment Medicare Administrative Contractor (DME MAC): 1-800-MEDICAR(E)
- d. Federally-Qualified Health Center(s) in your client’s area



In Summary: Review these Medicare Part B basic concepts.

Medicare Part B costs - my **responsibilities**. Medicare Part B benefits - my **rights**. It’s **my responsibility** to learn about the Medicare Part B payment process and the Medicare assignment and balance billing issues.

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

Ask us any questions that you may have after you finish reading.

Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

OPTION 3. I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.