NEW YORK STATE OF OPPORTUNITY. Health Insurance Information, Counseling and Assistance Program

SHIP State Health Insurance Assistance Program
Technical Assistance Center

MODULE 4: MEDICARE PART B MEDICAL INSURANCE

TABLE OF CONTENTS

MODULE 4 LEARNING OBJECTIVES

1. Identify Part B-covered services
2. Know how Medicare pays for Part B-covered services

INTRODUCTION

Medicare Part B is known as the medical coverage component of Medicare. Medicare Part B helps pay for medically necessary outpatient care, including but not limited to physicians' services, outpatient hospital services, ambulance services, behavioral health services, preventive care, and durable medical equipment.

OUTPATIENT CARE

Medicare Part B covers outpatient care, which is care that beneficiaries receive when they have not been formally admitted to the hospital as an inpatient. Outpatient care is medical care provided by health care professionals in hospital outpatient clinics, outpatient surgical centers, doctors' offices, and emergency rooms, among other settings.

Covered services

This section highlights common Medicare-covered outpatient services, but it is not a comprehensive list.

- Services provided to beneficiaries on an outpatient basis, such as x-rays, lab tests, day surgery, and diagnostic services.
- Therapy, such as physical therapy, occupational therapy, and speech language pathology services. These types of therapy are covered if a doctor prescribes it and the beneficiary receives the care 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.

  - Prior to 2018, Medicare had a financial limitation on physical, speech and occupational therapy. Since January 2018, there is no longer a limit to the amount of therapy services covered, so long as they are medically necessary, with the same cost-sharing as most other Medicare Part B covered services, subject to the Part B deductible and the 20% coinsurance. In 2024, if an individual requires over $2,330 in physical and speech therapy services, or $2,330 in occupational therapy services, the provider must add additional information and a code to the claim. Should one require over $3,000 in physical and speech therapy services, or $3,000 in occupational therapy services, a Medicare contractor may also review the medical records to be sure the therapy services were medically necessary.
- Certain medically necessary medications, such as immunosuppressant drugs, oral cancer drugs, and drugs that must usually be administered by a doctor, such as drugs delivered intravenously.
- There are a few drugs that can be covered by either Part B or Part D depending on the circumstances. Generally, Part B coverage is usually—but not always—limited to medications that are infused or injected in a doctor's office or hospital outpatient setting. See this chart, Medicare Drug Coverage: Part B vs. Part D, from the Medicare Rights Center for more information.
- Mental health services, including individual and group therapy, substance use disorder treatment, activity therapies, training and education (such as training on how to inject a needed medication), and family counseling to help with treatment. Medicare covers mental health care services a beneficiary receives through an outpatient hospital program, at a doctor's or therapist's office, or at a clinic. Medicare covers services provided by general practitioners, nurse practitioners, physicians' assistants, psychiatrists, clinical psychologists, clinical social workers, and clinical nurse specialists, among other providers.
- Emergency ambulance services are covered if an ambulance is medically necessary, meaning it is the only safe way to transport someone; the reason for the beneficiary's trip is to receive a Medicare-covered service or return from receiving care; they are transported to and from certain locations, following Medicare's coverage guidelines; and the transportation supplier meets Medicare's ambulance requirements. The locations that are covered are from one's home to the nearest hospital or skilled nursing facility (SNF) or from the hospital or SNF to home.
- Home health care is covered under Part B if a beneficiary is not eligible for Part A-covered home care services. (See HIICAP Notebook Module 3: Medicare Part A for more information.)

Outpatient care costs

After a beneficiary meets their annual Part B deductible, Medicare pays for 80% of the cost of most outpatient services, and the beneficiary is responsible for a 20% coinsurance. Call 1-800-MEDICARE or visit www.medicare.gov/care-compare to find providers. Look for providers who take assignment. They will be marked as ones who charge the Medicare-approved amount. A beneficiary pays the least when they see these providers. A beneficiary may be responsible for a higher coinsurance if they see a provider who does not take assignment (see Medicare Provider Categories section for more information).

If a beneficiary has a Medicare Advantage Plan, they should contact their plan directly to learn about its costs and coverage rules.

If a beneficiary has secondary insurance, it may cover some or all of the costs after Medicare pays.

PHYSICIANS' SERVICES

Part B also covers physicians' services. This is care a beneficiary receives from a doctor in the doctor's office, hospital, skilled nursing facility (SNF), or in the patient's home. Medical, surgical and anesthesia services are covered under Part B. Types of providers covered under this section can include:

- Doctors of medicine (MD) or osteopathy (DO)
- And, in some circumstances:
- Doctors of dental surgery or dental medicine
- Chiropractors
- Optometrists
- Podiatrists
- Acupuncturists

Covered physicians' services

- 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 fourth pint)
- Second surgical opinions
- Acupuncture
    - Note: Acupuncture is covered only for chronic low back pain lasting 12 weeks or longer that has no identifiable systemic cause. Coverage is limited to 12 visits in 90 days and an additional eight sessions for those demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.

Non-covered services

- Routine physical examinations and tests related to such examinations (with limited exceptions)
- Chiropractic services
    - Exception: These services are covered for manipulative treatment to treat subluxation of the spine.
- Most routine foot care, such as corn and callus removal.
    - Exception: These services are covered when foot care is related to a serious medical condition, (e.g., diabetes with complications).

- Examinations for fitting of a hearing aid
- Vision services
    - Exception: Treatment/diagnosis of eye disease, cataract surgery, and lenses following cataract surgery.
- Most routine dental care and dentures
    - Exception: Medicare covers dental services only when they are intended to correct fractures of the jaw or facial bones or involve care for facial tumors or oral cancer.
- Cosmetic surgery
    - Exception: 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

Physicians' services costs

After a beneficiary meets their annual Part B deductible, Medicare pays for 80% of the cost of most outpatient services, and the beneficiary is responsible for a 20% coinsurance. Call 1-800-MEDICARE or visit www.medicare.gov/care-compare to find providers. Look for providers who take assignment. They will be marked as ones who charge the Medicare-approved amount. A beneficiary pays the least when they see these providers. A beneficiary may be responsible for a higher coinsurance if they see a provider who does not take assignment (see Medicare Provider Categories section for more information).

If a beneficiary has a Medicare Advantage Plan, they should contact their plan directly to learn about its costs and coverage rules.

If a beneficiary has secondary insurance, it may cover some or all of the costs after Medicare pays.

OUTPATIENT HOSPITAL CARE

Medicare Part B covers medically necessary outpatient hospital care, which is care a beneficiary receives when they have not been formally admitted to the hospital as an inpatient.

Covered services include but are not limited to:

- Observation services
- Emergency room and outpatient clinic services, including same-day surgery
- Mental health care
- Hospital-billed laboratory tests
- Blood transfusions
- Certain drugs
- Medical supplies, such as splints and casts
- X-rays and other radiation services

In some cases, a beneficiary may stay overnight in the hospital without being formally admitted as an inpatient by their doctor. For example, a beneficiary may be in the hospital receiving emergency room services or be under observation status. While someone may receive services similar to those they would receive as an inpatient, keep in mind that these services are covered by Part B when a beneficiary is an outpatient.

Costs

After a beneficiary meets their annual Part B deductible, Medicare pays for 80% of the cost of most outpatient services, and the beneficiary is responsible for a 20% coinsurance.

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 copayments for each service a beneficiary can have done in an outpatient hospital setting. For each service a person gets, the copayment 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.

In areas where the hospital charges are lower than the national average, the pre-set copayment (which is based on the national average) 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 copayment 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 copayment 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.

Call 1-800-MEDICARE or visit www.medicare.gov/care-compare to find providers. Look for providers who take assignment. They will be marked as ones who charge the Medicare-approved amount. A beneficiary pays the least when they see these providers. A beneficiary may be responsible for a higher coinsurance if they see a provider who does not take assignment (see Medicare Provider Categories section for more information).

If a beneficiary has a Medicare Advantage Plan, they should contact their plan directly to learn about its costs and coverage rules.

If a beneficiary has secondary insurance, it may cover some or all of the costs after Medicare pays.

PREVENTIVE SERVICES

Preventive care is care a beneficiary receives to prevent illness, detect medical conditions, and keep them healthy. Medicare Part B covers many preventive services, such as screenings, vaccines, and counseling. If a beneficiary meets the eligibility requirements and guidelines for a preventive service, they must be allowed to receive the service. This is true for Original Medicare and Medicare Advantage Plans. However, the Medicare Advantage Plan's coverage rules may apply.

Covered preventive services

If a beneficiary meets the eligibility requirements and guidelines, Medicare Part B covers the following services:

- Welcome to Medicare preventive visit
- Annual Wellness Visit
- Vaccines and immunizations
- Flu shots
- Pneumonia shots
- Hepatitis B shots
- Hepatitis C screenings
- Diabetes screenings and supplies
- Glaucoma screenings
- Depression screenings
- Cardiovascular disease risk reduction visits
- Heart disease screenings
- Abdominal aortic aneurysm (AAA) screening
- Pap smears, pelvic exams, and breast exams
- Mammogram screenings
- Colorectal cancer screenings
- Prostate cancer screenings
- Lung cancer screenings
- HIV screenings
- Sexually transmitted infection (STI) screening and counseling
- Smoking cessation counseling
- Bone mass measurements
- Body mass index screenings and behavioral counseling
- Medical nutrition therapy
- Alcohol misuse screening and counseling

For more details about these screenings, see Medicare Interactive: Preventive Services, from the Medicare Rights Center.

Preventive care costs

Original Medicare

- A beneficiary pays nothing (no deductible or coinsurance) for most preventive services when they see a participating provider (see Medicare Provider Categories section for more information).
- Preventive services recommended by the U.S. Preventive Services Task Force are covered at 100% of the Medicare-approved amount (zero cost-sharing), but for other services a beneficiary may be charged Original Medicare cost-sharing.
- A beneficiary may also be charged if they see a non-participating or opt-out provider.

Medicare Advantage

- When seeing an in-network provider, a beneficiary pays nothing for preventive services that are covered with zero cost-sharing by Original Medicare. This means that plans are required to cover a beneficiary's care without charging deductibles, copayments, or coinsurance, as long as they meet Medicare's eligibility requirements for the service.
- Medicare Advantage Plans may charge for preventive services that Original Medicare does not cover with zero cost-sharing.
- A beneficiary may be charged if they see an out-of-network provider.

Under certain circumstances, a beneficiary may be charged for services they receive related to their preventive service, even if the preventive service itself is covered at 100% of the cost. For example, during the course of a beneficiary's preventive care, their provider may discover and need to investigate or treat a new or existing problem. This additional care is considered diagnostic, meaning the beneficiary's provider is treating them because of certain symptoms or risk factors.

The beneficiary's provider may bill them for any diagnostic care they receive during a preventive visit. For example, if a beneficiary's doctor finds and removes a polyp during a colonoscopy, costs related to removing the polyp will apply.

A beneficiary may have to pay a facility fee depending on where they receive their preventive care. For example, certain hospitals charge separate facility fees when a beneficiary receives a preventive service. A beneficiary may be charged for a doctor's visit if they meet with a doctor before or after receiving their preventive care.

Keep in mind that each preventive service has its own eligibility requirements and guidelines. Medicare may only cover a service a certain amount of times each year or under specific circumstances.

Note: Medicare may cover certain preventive services more frequently than guidelines suggest if they are needed to diagnose or treat an illness or condition. The service must be medically necessary and would be covered in the same way as other Part B-covered services. For example, if a beneficiary required a follow-

up mammography due to a medical condition, that additional mammogram would not be preventive in nature; it would be diagnostic, and therefore covered as a regular Part B service.

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

Durable medical equipment (DME) is equipment that helps an individual complete their daily activities. It includes a variety of items, such as walkers, wheelchairs, and oxygen tanks.

Medicare usually covers DME if the equipment:

- Is durable, meaning it is able to withstand repeated use
- Serves a medical purpose
- Is appropriate for use in the home, although an individual can also use it outside the home
- And, is likely to last for three years or more

To be covered by Part B, DME must be prescribed by a beneficiary's primary care provider (PCP). If someone is in a skilled nursing facility (SNF) or is a hospital inpatient, DME is covered by Part A.

Covered items

Whether a beneficiary has Original Medicare or a Medicare Advantage Plan, the types of Medicare-covered equipment should be the same. Examples of DME include:

- Wheelchairs
- Walkers
- Hospital beds
- Power scooters
- Portable oxygen equipment

Under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) category, Medicare Part B also covers:

- Prosthetic devices that replace all or part of an internal bodily organ
- Prosthetics, like artificial legs, arms, and eyes
- Orthotics, like rigid or semi-rigid leg, arm, back, and neck braces
- Certain medical supplies

Medicare also covers certain prescription medications and supplies that a person uses with their DME, even if they are disposable or can only be used once. For example, Medicare covers medications used with nebulizers. Medicare also covers lancets and test strips used with diabetes self-testing equipment.

Non-covered items

- Equipment mainly intended to help an individual outside the home. For example, if someone can walk on their own for short distances—enough to get around their house—Medicare does not cover a motorized scooter that they only need outside the home.
- Most items intended only to make things more convenient or comfortable. This includes stairway elevators, grab bars, air conditioners, and bathtub and toilet seats.
- Items that get thrown away after use or that are not used with equipment. For example, Medicare does not cover incontinence pads, catheters, surgical facemasks, or compression leggings. However, if an individual receives home health care, Medicare pays for some disposable supplies–including intravenous supplies, gauze, and catheters–as part of their home health care benefit.
- Note: Catheters may be covered as prosthetics if a beneficiary has a permanent condition.
- Modifications to a person's home, such as ramps or widened doors for improving wheelchair access.
- Note: Some Medicare Advantage Plans may cover minor home modifications or other items as a supplemental benefit.
- Equipment that is not suitable for use in the home. This includes some types of DME used in hospitals or skilled nursing facilities (SNFs), like paraffin bath units and oscillating beds.

DMEPOS Competitive Bidding Program

Some people with Original Medicare may need to get their DME from what is called a contract supplier, depending on what DME they need and in what area they live. This is because of Medicare's Competitive Bidding Program, in which suppliers are awarded contracts to sell DME to Medicare beneficiaries in areas that participate in the program. Currently, only off-the-shelf knee and back braces in competitive bidding areas are part of the program. This means that if a beneficiary in a competitive bidding area needs an off-the-shelf knee or back brace, Original Medicare requires them to get it from a contract supplier, unless an exception applies. You can see if you are in a competitive bidding area by visiting www.medicare.gov/supplierdirectory.

DME costs

If a beneficiary has Original Medicare, it is important to use the right supplier. Call 1-800-MEDICARE or visit www.medicare.gov/supplier to find DME suppliers. Look for providers who are marked as ones who charge the Medicare-approved amount. A beneficiary pays the least when they see these providers.

Original Medicare normally pays 80% of the Medicare-approved amount after a beneficiary meets their Part B deductible, and the beneficiary is responsible for a 20% coinsurance. A beneficiary's costs will also depend on whether or not they are required to rent or buy the equipment they need. If a beneficiary uses insulin with Part B-covered DME, a one-month's supply of their insulin is capped at a $35 copay.

Be aware that many suppliers are Medicare-approved but do not take assignment (see the Medicare Provider Categories section for more information). These suppliers may charge more than Medicare's approved amount for the cost of services and they are not limited to a 15% limiting charge. Medicare will still only pay 80% of its approved amount for services, so the beneficiary will be responsible for any additional costs.

If a beneficiary has a Medicare Advantage Plan, their plan will have its own cost and coverage rules for DME. A beneficiary should contact their plan for more information.

MEDICARE PROVIDER CATEGORIES

If a beneficiary has Original Medicare, their Part B costs once they have met their deductible can vary depending on the type of provider they see. For cost purposes, there are three types of providers, meaning three different relationships a provider can have with Medicare. A provider's type determines how much a beneficiary will pay for Part B-covered services.

Participating providers accept Medicare and always take assignment. Taking assignment means that the provider accepts Medicare's approved amount for health care services as full payment.
These providers are required to submit a bill (file a claim) to Medicare for care a beneficiary receives. Medicare will process the bill and pay the provider directly for the beneficiary's care.
The provider usually receives 80% of the Medicare-approved amount, and the beneficiary is responsible for the remaining 20% of the approved amount.
Certain providers, such as clinical social workers, clinical psychologists, physician assistants, and ambulance providers must always take assignment if they accept Medicare. Laboratories must always accept assignment for clinical diagnostic tests.

Example:	
Doctor bills:	$110
Medicare approves:	$100
Medicare pays 80% of Medicare's approved amount (after the beneficiary has met their Part B annual deductible):	$80
Beneficiary pays 20% of Medicare's approved amount:	$20

Non-participating providers accept Medicare but do not agree to take assignment in all cases (they may on a case-by-case basis). This means that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare's approved amount for health care services as full payment. Non-participating providers can charge up to 15% more than Medicare's approved amount for the cost of services a beneficiary receives (known as the limiting charge). This means the beneficiary is responsible for a higher percentage of Medicare's approved amount for covered services.

New York State law limits the amount that Medicare non-participating providers may charge to 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, specifically 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).

Remember: the limiting charge rules do not apply to DME suppliers. Beneficiaries should be sure to use DME suppliers that take assignment in order to have the lowest out-of-pocket costs.

A non-participating provider usually charges the beneficiary for the full cost of care up front. Their provider should still submit a bill to Medicare. Afterward, the beneficiary should receive from Medicare a Medicare Summary Notice (MSN) and reimbursement for 80% of the Medicare-approved amount.
A beneficiary may want to ask their physician if they can pay their bill after they receive their MSN, allowing them to compare the provider's bill to the Medicare-approved amount to make sure they are being charged the right amount. If a beneficiary believes they have been overcharged, they should contact their provider. The law requires that the providers make an adjustment or refund the beneficiary. If a beneficiary's call to the physician does not resolve the bill, they should contact the New York State Department of Health is designated by law to investigate possible overcharges. The beneficiary can send their complaint, a brief description of the problem, and copies of the MSN, may be sent to

New York State Department of Health,
Corning Tower
Empire State Plaza
Albany, NY 12237

Non-participating providers can still accept assignment on a claim-by-claim basis. A beneficiary may want to ask their non-participating doctor if they are willing to accept Medicare's approved amount as the total due.

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 pays 20% of Medicare's approved amount:	$20
+ 5% excess charge allowed in New York State	$5

Opt-out providers do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services but must follow certain rules to do so.

Medicare will not pay for care a beneficiary receives from an opt-out provider (except in emergencies). The beneficiary is responsible for the entire cost of their care. Opt-out providers do not bill Medicare for services the beneficiary receives. (Exception: Medicare will cover services from an opt-out provider in an emergency.)

The following providers **can** opt out of Medicare:

- Doctor of medicine or osteopathy
- Optometrists
- Podiatrists
- Dentists
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical nurse midwives
- Clinical social workers
- Clinical psychologists (Many psychiatrists opt out of Medicare

The following providers **cannot** opt out of Medicare:

- Chiropractors
- Doctors of oral surgery
- Physical and occupational therapists in independent practice

Private contracts

The opt-out provider must give the beneficiary a private contract describing their charges and confirming that the beneficiary understands they are responsible for the full cost of their care and that Medicare will not reimburse them. A private contract is a contract between the beneficiary and their opt-out provider. Under the opt-out agreement that the provider signs with Medicare, the provider will not bill for any services or supplies to Medicare for a two-year period.

Providers who opt out must give patients with Medicare a private contract describing their relationship and the agreement. The private contract must:

- Be in writing and signed by the person with Medicare before the service is rendered
- Contract is not valid if signed during an emergency

- State that the 13beneficiary agrees that they will not submit a claim, even if the item or service would otherwise be covered
- State that a person with Medicare agrees to be responsible for payment and that no reimbursement will be made by Medicare
- Acknowledge that no limits would apply to amounts charged, and no Medicare, Medigap, or other supplemental policy reimbursement will be made.
- Be signed prior to a service being rendered under the contract agreement.

Provider opt out process

A provider who decides to enter into private contracts with their patients must send an affidavit to their Medicare Administrative Contractor (MAC) stating their 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.

Providers who opted out of Medicare on or after June 16, 2015 have their opt-out status automatically renewed every two years, unless the provider notifies all Medicare contractors with which they filed an affidavit in writing at least 30 days prior to the start of the next two year opt-out period.
For a listing of all physicians and practitioners that are currently opted out of Medicare, visit https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits

Sequestration

The Budget Control Act of 2011 requires mandatory across-the board reduction in Federal spending, also known as sequestration. Medicare Fee-for-Service (FFS) claims with dates-of-service or dates-of-discharge on/after April 1, 2013, incur a 2 percent reduction in Medicare payment.

The claims payment adjustments are applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction.

Beginning in 2022, there is no payment adjustment through March 31, 2022, a one percent payment adjustment April 1 through June 30, and a two percent payment adjustment beginning July 1.

FILING PART B CLAIMS

providers are required to submit a beneficiary's claims to the Medicare Administrative Contractor (MAC) for payment. The MAC will then send the payment directly to the provider. The beneficiary should not submitting their own Medicare claims.

- The Medicare Part A and Part B MAC for all of New York State is National Government Services.
- Palmetto GBA processes Part B claims for Railroad Retirees from all states.

Noridian Healthcare Solutions is the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for all of New York State.

Steps for filing assigned claims:

1. The provider sends the claim to the Medicare Administrative Contractor (MAC).
2. The MAC sends the beneficiary an MSN and usually pays 80% of the amount approved under Medicare Part B.
3. If your client has secondary insurance, such as a Medigap or retiree plan, they should let their doctor's office know. Most Medigap and other secondary insurers have an automatic crossover arrangement with Medicare, where once Medicare processes the claim, the information is forwarded electronically to the other insurer, eliminating the need to submit a separate claim. Check with the secondary insurer to see if this service is available. If it is not, then one of the following will occur:
4. The provider submits the claim directly to your client's secondary insurance. Your client's insurance company will send payment to the provider.
5. The provider submits the claim directly to your client's secondary insurance. Your client's insurance company will send payment to your client unless your client signed an agreement with the provider for them to be paid directly.
    - If the provider does not submit the claim to the secondary insurance, your client mails the following to their secondary insurer:
        - A copy of the Medicare Summary Notice
        - A copy of the itemized hospital bill (if required)
        - A completed claim form (if required)
    - Your client's secondary insurer may require one or more of these three forms (learn the insurer's claim requirements before your client sends their first claim)
6. After secondary insurance has paid, if applicable, your client's provider sends them a bill.
7. Your client pays the provider. Your client is responsible for the following:
    - Amounts paid to your client by your client's Medigap or retiree plan
    - Deductible and coinsurance amounts not paid by your client's insurance
    - Charges for items not covered by Medicare or your client's insurance

Steps for filing unassigned claims:

1. The beneficiary pays the doctor.
2. The provider sends the claim to the to the MAC.
3. The MAC sends the beneficiary an MSN and usually pays the person with Medicare 80 percent of the amount approved by Medicare (if deductible was met);

4. Either the provider or beneficiary sends the claim and MSN to the secondary insurer (if applicable), unless their insurer has a crossover contract with Medicare Part B.
5. The secondary insurer sends the beneficiary an Explanation of Benefits (EOB) detailing what benefits were paid or not and pays the beneficiary any secondary benefit amount.
6. Medicare Summary Notice (MSN)
7. An MSN is an explanation of benefits that informs the beneficiary how much Medicare pays for each health care service or item they receive. An MSN is sent by the MAC for the area or state in which they received a health care service. For example, if a beneficiary is a New York State resident who traveled to a Boston hospital for a surgical procedure, the MSN for the hospital stay will come from the Massachusetts MAC.

A beneficiary should receive their MSNs in the mail every quarter. If they did not receive any medical services during a particular quarter, they will not get an MSN. If a beneficiary needs a copy of an MSN, they can call 1-800-MEDICARE or make a www.medicare.gov account.

ADVANCE BENEFICIARY NOTICE (ABN)

An Advance Beneficiary Notice (ABN), also known as a waiver of liability, is a notice a provider should give a beneficiary before they receive a service if, based on Medicare coverage rules, their provider has reason to believe Medicare will not pay for the service. A beneficiary may receive an ABN if they have Original Medicare, but not if they have a Medicare Advantage Plan. The ABN may look different, depending on the type of provider.

The ABN allows a beneficiary to decide whether to get the care in question and to accept financial responsibility for the service (pay for the service out-of-pocket) if Medicare denies payment. The notice must list the reason why the provider believes Medicare will deny payment. For example, an ABN might say, “Medicare only pays for this test once every three years.” Providers are not required to give a beneficiary an ABN for services or items that are never covered by Medicare, such as hearing aids. Note that a beneficiary’s providers are not permitted to give an ABN all the time, or to have a blanket ABN policy.

While the ABN serves as a warning that Medicare may not pay for the care your provider recommends, it is possible that Medicare will pay for the service. To get an official decision from Medicare, a beneficiary must first sign the ABN, agreeing to pay if Medicare does not, and receive the care. They should make sure they request that their provider bills Medicare for the service before billing them (the ABN may have a place on the form where the beneficiary can elect this option). Otherwise, the beneficiary’s provider is not required to submit the claim, and Medicare will not provide coverage.

ABNs and appeals

Medicare has rules about when a beneficiary should receive an ABN and how it should look. If these rules are not followed, a beneficiary may not be responsible for the cost of the care. However, a beneficiary may have to file an appeal to prove this.

When a beneficiary's MSN shows that Medicare has denied payment for a service or item, they can choose to file an appeal (see HIICAP Notebook Module 12). Remember, receiving an ABN does not prevent a beneficiary from filing an appeal, as long as Medicare was billed.

A beneficiary may not be responsible for denied charges if the ABN:

- Is difficult to read or hard to understand
- Is given by the provider (except a lab) to every patient with no specific reason as to why a claim may be denied
- Does not list the actual service provided, or is signed after the date the service was provided
- Is given to the beneficiary during an emergency or is given to the beneficiary just prior to receiving a service (for instance, immediately before an MRI)

A beneficiary also may not be responsible for denied charges if an ABN was not provided when it should have been. A beneficiary may not need to pay for care if they meet all of the following requirements:

- They did not receive an ABN from their provider before they were given the service or item;
- Their provider had reason to believe their service or item would not be covered by Medicare;
- Their item or service is not specifically excluded from Medicare coverage; and
- Medicare has denied coverage for their item or service.

Sources of Assistance

NYSOFA HIICAP Hotline
1-800-701-0501

Medicare
1-800-MEDICARE (1-800-633-4227)
Call for questions about Medicare coverage, claims, or how Medicare works with your clients' other insurance.
http://www.medicare.gov

Social Security Administration
Hotline: 1-800-772-1213
Fax: 1-833-914-2016

Call for Medicare eligibility and enrollment information, lost Medicare card replacement and general Social Security issues. Visit www.ssa.gov/locator to find your local SSA office and contact information for that office.

Benefits Coordination & Recovery Center (BCRC)
1-855-798-2627 (TTY 1-855-797-2627)
Call the BCRC with any changes in insurance coverage or any questions about who pays first.

National Government Services
Part B Medicare Administrative Contractor
http://www.ngsmedicare.com

Noridians
Durable Medical Equipment Medicare Administrative Contractor
https://med.noridianmedicare.com/web/jadme

Additional Resources

Medicare Coverage of Therapy Services, CMS Publication #10988
https://www.medicare.gov/publications/10988-medicare-coverage-therapy-services.pdf

Medicare Coverage of Durable Medical Equipment & Other Devices, CMS Publication #11045
https://www.medicare.gov/media/publication/11045-medicare-coverage-of-dme-and-other-devices.pdf

Medicare Coverage of Diabetes Supplies, Services, & Prevention Programs, CMS Publication #11022
https://www.medicare.gov/publications/11022-medicare-coverage-of-diabetes-supplies.pdf

MODULE 4 APPENDIX

Medicare Part B costs in 2024

2024 Part B Monthly Premium			
Income			Part B Premium
Individual	Couple	Married, filing separately	
$103,000 or below	$206,000 or below	$103,000 or less	$174.90
$103,001 - $129,000	$206,001 - $258,000	N/A	$244.60
$129,001 - $161,000	$258,001 - $322,000	N/A	$349.40
$161,001 - $193,000	$322,001 - $386,000	N/A	$454.20
Above $193,000 and less than $500,000	Above $386,000 and less than $750,000	Above $103,000 and less than $397,000	$559
$500,000 or above	$750,000 and above	$397,000 and above	$594

Part B deductible: $240