

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% coinsurance.

What are excess charges?

- The difference between what Medicare approves for a service and what the provider of a 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
- Acupuncture (limited)
- Home care
- Ambulance services
- Durable medical equipment and supplies
- Diagnostic tests
- Certain preventive care services

Expansion of Part B-covered Services Due to COVID-19

Due to the COVID-19 health emergency, CMS has expanded coverage of Part B services. The coverage of services listed below is current as of the publication date. For updated information on changes to Medicare due to COVID-19, visit www.medicare.gov/medicare-coronavirus.

- **The lab test for COVID-19** is covered in full by Medicare with no cost-sharing.
- **COVID-19 Vaccine:** The federal government has paid for the cost of the vaccine for all people, and Original Medicare Part B covers the administration of the vaccine for all Medicare beneficiaries, regardless of whether the beneficiary has Original Medicare or a Medicare Advantage plan. The beneficiary owes no cost-sharing.
- **Telehealth Services-** doctors and other health care providers can use telehealth services to treat COVID-19 and provide other medically necessary services from offices, hospitals, and places of residence (like homes, nursing homes, and assisted living facilities) as of March 6, 2020. Coinsurance and deductibles apply. For a description of telehealth services see: <https://www.medicare.gov/coverage/telehealth>

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% coinsurance. 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 physicians may charge. Non-participating physicians cannot charge beneficiaries more than 5% over 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 to pay for services that Medicare may deny as not medically necessary.

What is the Medicare Summary Notice (MSN)?

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. MSNs are mailed to beneficiaries every 90 days for assigned claims. Claims for non-assigned services are mailed as those claims are processed. In addition, beneficiaries can log in to their medicare.gov accounts to view MSNs.

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, and the specific services that are and are not covered. 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 the 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 or they can elect to have the premium deducted monthly from a bank account. For most beneficiaries, this premium represents 25% of the actual cost of providing Medicare Part B benefits to older and disabled beneficiaries. All people paying payroll and income taxes share the remaining 75% of the cost.

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 in Appendix at end of this Module for details.
2. **Part B deductible** - the initial amount of Medicare-approved medical expense for which the person with Medicare is responsible to pay in a calendar year before Medicare 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 provider actually bills. Only doctors or other providers who do not accept Medicare assignment may bill for these charges, subject to state and federal limits.
5. **Services not covered by Medicare** - services that Medicare does not cover such as routine 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—doctor 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.

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

Doctors 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
6. Acupuncturists

Please Note: Part B coverage of services by doctors 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 fourth pint)
- Second surgical 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.
- **NEW** – Effective January 21, 2020: Acupuncture – 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.

Doctors Services Not Covered

- Routine physical examinations and tests related to such examinations (with limited exceptions)
- 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 and dentures
- 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 being formally admitted to the hospital. Outpatient hospital services include emergency room or outpatient clinic, “observation” services, 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 copayments for each service a person with Medicare 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.
- The payment and copayment amounts are subject to change annually.
- 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.
- See CMS publication entitled, “*Quick Facts About Payment for Outpatient Services for People with Medicare Part B*” (CMS 02118)
 - <https://www.medicare.gov/Pubs/pdf/02118-Part-B-Outpatient-Services.pdf>

Outpatient Treatment of Mental Illness - Medicare pays 80% of approved charges for mental health services, the same as for medical services, after meeting the Part B deductible. A provider such as a psychiatrist (MD), a clinical psychologist (PhD), or a clinical social worker (LCSW) can provide outpatient treatment for a mental illness.

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 – 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 2021, if an individual requires over \$2,110 in physical and speech therapy services, or \$2,110 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.

Part B-covered therapy can be provided in a provider's office, in the patient's home (if they do not receive Medicare-covered home health care) and can be provided in the outpatient department of a hospital.

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 (SNF) or from the hospital or SNF to his or her home. Ambulance providers must always accept assignment.

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, HIICAP Notebook; *Medicare Part A Hospital Insurance*, for details of Medicare coverage of home health care.

<https://aging.ny.gov/hiicap-notebook>

If one is not eligible for Part A-covered home care services, Part B has a home care benefit. Part B-covered home care must be ordered by a doctor. There is no cost-sharing for Part A or B home health care; it is covered in full by Medicare.

Diagnostic Tests by Medicare-Certified Independent Laboratories - The lab must always accept assignment for clinical diagnostic lab tests, which are covered at 100%, not subject to the Part B deductible or 20% coinsurance.

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

Oral Cancer Drugs – covers some cancer drugs you take by mouth if the same drug is available in injectable form. As new oral cancer drugs become available, Part B may cover them.

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 would be covered under Medicare Part D, not Part B.

Drugs NOT Usually Self-administered include drugs delivered intravenously and drugs delivered intramuscularly.

Drugs Usually Self-administered include drugs delivered subcutaneously or by other routes of administration such as oral, suppositories, and topical medications.

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

Prior Authorization for certain Outpatient Department (OPD) procedures

CMS established a nationwide prior authorization process and requirements for certain hospital outpatient department (OPD) services as a way of controlling increases in the volume of certain services. For more information and for a listing of procedures to which this applies, visit www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/prior-authorization-certain-hospital-outpatient-department-opd-services

COVERAGE: HOW MUCH? HOW LONG?

Except for services 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 an annual Part B deductible, Medicare usually pays 80% of the total approved charge for the provided health care service or item. 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 are required by law to send the Medicare beneficiary’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 provided/performed, 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 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.

Payment from the MAC goes directly to a doctor who accepts **assignment**. The Medicare beneficiary 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 in full 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, HIICAP Notebook; *Medicare Claims and Appeals*, for a detailed description of the Medicare Part A and Part B claims process.) <https://aging.ny.gov/hiicap-notebook>

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 (after the beneficiary has met their Part B annual deductible):	\$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 physicians can charge for certain services. (Refer to section on balance billing laws that follows.)

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 (for most physician services)	\$5

Medicare asks providers to sign agreements to participate in Medicare. (Incentives to participate include a 5% higher fee schedule allowed amount.) Becoming a participating provider means that the provider has agreed to accept Medicare assignment on all Medicare claims for all Medicare patients.

Note: Certain types of non-physician providers are mandated to accept Medicare assignment on all claims. These include clinical psychologists (PhDs) and clinical social workers (LCSW/LMSW) who provide mental health care.

How can I find a doctor who takes Medicare?

A person with Medicare can find a doctor (or other provider) in the Medicare program by calling 1-800-MEDICARE. A provider directory can also be found on the Medicare web site <http://www.medicare.gov/find-a-doctor/provider-search.aspx>. Searching for a provider can be done by location and by specialty.



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 but may still choose to accept assignment on individual claims. A person with Medicare should ask a non-participating doctor if he/she would be willing to accept assignment on claims for services they receive.

NEW YORK STATE'S BALANCE BILLING LAW

New York State law limits the amount that Medicare nonparticipating physicians (physicians who do not accept Medicare assignment) 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).

Medicare-participating providers (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 physician will not accept Medicare assignment:

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

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

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

If a beneficiary's call to the physician 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 copies of the MSN, may be sent to:

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

The 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 physician 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 protection does not apply to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS).



Caution: A person with Medicare may need to do his or her own computation to determine the correct limiting charge amount. 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 physician provided is NOT 99201 through 99215, or 99341 through 99353, then the lesser New York State limit applies. Multiply the Medicare-approved amount by 1.05 to determine the maximum the physician may charge.

OPT-OUT PROVIDERS

Opt-out providers are providers who are not part of the Medicare program. 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 limiting charge. The opt-out provider must 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. 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
- Provider must file an affidavit with all affected Medicare Administrative Contractors within ten days of the first contract being signed and providers will not be allowed to submit claims for two years

Private Contracts must:

- State that a person with Medicare agrees that they won't 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 reimbursement will be made
- Acknowledge that Medigap plans do not make payments, and other supplemental policies may also choose not to make payment

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. Providers who opted out of Medicare on or after June 16, 2015 will 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.

Exception: Medicare will cover services from an opt-out provider 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.


For a listing of all physicians and practitioners that are currently opted out of Medicare, visit <https://data.cms.gov/dataset/Opt-Out-Affidavits/7yuw-754z>

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

Noridian is the Jurisdiction A **Durable Medical Equipment Medicare Administrative Contractor** (DME MAC), which processes claims for people with Medicare who reside in the state of New York.

Medicare Part B covers medically necessary DMEPOS 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.

DMEPOS Competitive Bidding Program

Historically, Medicare payment for most DMEPOS is based on fee schedules. However, recent amendments to the Social Security Act alter the process for determining payment amounts for certain DMEPOS items. Specifically, competitive bidding payment amounts replace the 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.

NEW: CMS suspended the Competitive Bidding Program for 2019 and 2020. For 2021, CMS has implemented a Competitive Bidding Program for two supplies—Off-The-Shelf (OTS) Back Braces and OTS Knee Braces. While only in certain areas of New York, people who live in (or are visiting) affected areas will need to use contracted suppliers in order for Medicare to cover OTS back or knee braces. To view Competitive Bidding areas, visit www.medicare.gov/what-medicare-covers/what-part-b-covers/competitive-bidding-program-areas-items.

For other DME supplies, one can locate participating suppliers at <https://www.medicare.gov/medical-equipment-suppliers/> or by calling 1-800-Medicare.

Tip: when searching for suppliers, use the filter tool to view suppliers who “charge only the Medicare-approved amount” to view suppliers who always accept Medicare assignment.

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, grab bars and wheelchair 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 policies and articles.

<https://med.noridianmedicare.com/web/jadme/policies/lcd/active>

Advance Determination of DMEPOS Medicare Coverage

Advance Determination of Medicare Coverage (ADMC) is a 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 ADMC. 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 ADMC approved the item.

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

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

The Medicare Fee-for-Service Prior Authorization of Power Mobility Device (PMD) demonstration implemented a Prior Authorization process for scooters and power wheelchairs for people with Medicare who reside in a number of states with high incidences of fraud and improper payments including New York State. While the demonstration ended on August 31, 2018, any prior authorization decisions made before September 1, 2018 will continue to be valid.

Beginning nationwide on September 1, 2018, CMS added 31 items included in the PMD demonstration to the [Required Prior Authorization List](#). All new rental series claims for these items with a date of service on or after September 1, 2018, must be associated with a prior authorization request as a condition of payment.

In late April, 2019, the Centers for Medicare & Medicaid Services (CMS) expanded the list of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that require pre-authorization as a condition of payment. Currently, the list includes 51 procedure codes that require prior authorization. The codes are detailed in this CMS Announcement:

<https://www.federalregister.gov/documents/2020/02/11/2020-02644/medicare-program-update-to-the-required-prior-authorization-list-of-durable-medical-equipment>) and the full list of all prior authorization codes are found at:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf?eType=EmailBlastContent&eId=248f21b0-0581-4deb-b242-3c1f5cf01d01).

NOTE: For details about prior authorization for certain DMEPOS items use the following link; <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.html>

beneficiary or supplier can resubmit an ADMC request if additional medical documentation is obtained that could affect the prior negative ADMC decision. However, requests may only be re-submitted once during a six-month period. An affirmative ADMC decision is only valid for a period of six (6) months from the date the decision is rendered.

Advance Beneficiary Notice of Noncoverage (ABN)

An 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

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, such as glucose monitors, test strips and lancets)
- 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 DME 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 person with Medicare still meets the medical necessity guidelines for the item.

Capped Rental Guidelines

Other than oxygen, 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.

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.

Under the Coronavirus Aid Relief, and Economic Security (CARES) Act, there is a temporary suspension of the 2 percent payment adjustment currently applied to all Medicare FFS claims due to Sequestration, from May 1, 2020 to December 31, 2020. The Consolidated Appropriations Act, 2021, extended the suspension period to March 31, 2021. An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, signed into law on April 14, 2021, extends the suspension period to December 31, 2021.

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 of a given year is eligible for another screening mammogram beginning September 1 of the following year.

Medicare covers nearly all preventive services at 100%, not subject to the Part B deductible and/or 20% coinsurance. As long as the provider accepts assignment on the claim, the preventive service would then be covered in full by Medicare.

Note: Should someone require a service that falls under the “preventive benefits” listing more frequently than listed below, due to a medical condition, Medicare may cover that service. The service must be medically necessary, and would be covered in the same way as other Part B-covered services. For example, if a woman 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-covered service.

Note: Medicare Advantage plans must cover preventive services the same way that Original Medicare does as long as someone sees in-network providers.

COVERED SERVICES	ELIGIBLE BENEFICIARIES	WHAT THE BENEFICIARY PAYS
Abdominal Aortic Aneurysm Screening (AAA)	Medicare beneficiaries at risk for AAA who get a referral for this one-time screening.	Nothing if doctor accepts Medicare assignment as payment in full.
Alcohol Misuse Screening and Counseling Screening once every 12 months. Four (4) brief counseling sessions per year if misusing alcohol.	All beneficiaries for screening. For counseling, beneficiaries whose primary care providers determine they are misusing alcohol but do not meet criteria for alcohol dependence.	Nothing if doctor accepts Medicare assignment as payment in full.
Bone Mass Measurements Once every 24 months (more often if medically necessary)	Medicare Beneficiaries at risk for osteoporosis.	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.
Cardiovascular Screening Blood Tests Once every five years.	All Medicare beneficiaries.	Nothing if doctor accepts Medicare assignment as payment in full.
Colorectal Cancer Screening Fecal Occult Blood Test. Once every 12 months. Flexible Sigmoidoscopy. Once every 48 months if 50+ and high risk, or once every 10 years after colonoscopy if age 50+ and not high risk. Colonoscopy Once every 24 months if at high risk for colon cancer. Once every 10 years (but not within 48 months of a screening	All people with Medicare age 50 and older. However, there is no minimum age for having a colonoscopy.	Nothing if doctor accepts Medicare assignment as payment in full.

MEDICARE PART B MEDICAL INSURANCE

<p>sigmoidoscopy) if not at high risk for colon cancer.</p> <p>Multi-target stool DNA test (Cologuard) Once every 3 years</p> <p>Barium Enema Doctor can decide to use instead of sigmoidoscopy or colonoscopy.</p>	<p>Cologuard: Must meet certain conditions including being between 50 and 85 years of age.</p>	<p>20% of the Medicare-approved amount. Not subject to the Part B deductible.</p>
<p>Depression Screening Once every 12 months.</p>	<p>All Medicare beneficiaries.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Diabetes Screening Blood Tests Once a year if at risk or twice a year for pre-diabetes.</p>	<p>Beneficiaries that are considered at risk or those having pre-diabetes.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Diabetes Services Coverage for diabetes self-management training.</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>Flu Shot Once each flu season.</p>	<p>All Medicare beneficiaries</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Glaucoma Screening Once every 12 months.</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>Hepatitis B Vaccination</p>	<p>If the beneficiary is at medium to high risk for Hepatitis B.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Hepatitis B Virus (HBV) infection screening</p>	<p>Medicare beneficiaries at risk for infection or pregnant.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Hepatitis C Screening Test</p>	<p>Medicare beneficiaries born between 1945 and 1965, those who had a blood transfusion before 1992, and those at risk for Hep C.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>HIV Screening Test Once every 12 months.</p>	<p>All beneficiaries age 15-65. Beneficiaries younger than 15 or older than 65 if they are at increased risk for HIV. Pregnant people can get screening up to three times during pregnancy.</p> <p>Any beneficiary who requests test.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>

<p>Lung Cancer Screening Once every 12 months.</p>	<p>Medicare beneficiaries age 55-77 with history of tobacco smoking.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Mammogram Screening: Once every 12 months.</p>	<p>All female Medicare beneficiaries age 40 and older. For women between the ages of 35-39, only one baseline mammogram will be allowed. 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>Medical Nutrition Therapy (MNT) Three hours of one-on-one counseling the first year and two hours each year after that. 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>Medicare Diabetes Prevention Program: The program begins with 16 core sessions offered in a group setting over a 6-month period. Once you complete the core sessions, you'll get 6 more months of less intensive monthly follow-up sessions to help you maintain healthy habits. You'll also get an additional 12 months of ongoing maintenance sessions if you meet certain weight loss and attendance goals.</p>	<p>Beneficiary must have: A hemoglobin A1c test result between 5.7 and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test) within 12 months of attending the first core session. • A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian). • Never been diagnosed with type 1 or type 2 diabetes or End-Stage Renal Disease (ESRD). • Never participated in the Medicare Diabetes Prevention Program.</p>	<p>You pay nothing for these services if eligible.</p>
<p>Obesity Screening and Counseling</p>	<p>All Medicare beneficiaries who have a Body Mass Index (BMI) of 30 or more.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Pap Smear and Pelvic Exam (includes a clinical breast exam). Once every 24 months, or once every 12 months if at high risk, 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>Pneumococcal Vaccination An initial vaccination and a different, second, Pneumococcal shot at least 1 year after first shot</p>	<p>All Medicare beneficiaries</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>

<p>Preventive Visits: Initial Preventive Physical Examination: (IPPE) “Welcome to Medicare Visit” Includes EKG*</p> <p>Annual Wellness Visit (AWV)</p>	<p>One-time exam for all Medicare beneficiaries within the first 12 months they have Part B only.</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. *EKG subject to 20% of the Medicare-approved amount after the annual Part B deductible.</p> <p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Prostate Cancer Screenings: 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. Generally, 20% of the Medicare-approved amount for the digital rectal exam after the annual Part B deductible.</p>
<p>Sexually Transmitted Infection (STI) Screening Tests Once every 12 months</p> <p>STI Counseling Up to two individual 20-30 minute, face-to-face counseling sessions annually.</p>	<p>Beneficiaries who are considered at high risk for an STI or who are pregnant and have a referral from primary care provider.</p> <p>With primary care provider referral, beneficiaries who are sexually active adolescents and adults at increased risk.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>
<p>Smoking Cessation Counseling Two cessation attempts of up to 4 face-to-face visits each per year.</p>	<p>All beneficiaries who use tobacco.</p>	<p>Nothing if doctor accepts Medicare assignment as payment in full.</p>

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

Right: A person with Medicare has the right to understand when 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).

The ABN form includes:

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. An estimated cost
5. A person with Medicare’s signature indicating they understand and agree to accept responsibility to pay for the service.

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

Providers **MUST** use the current version of the ABN form (CMS-R-131). (A sample copy of the ABN form can be found at the end of this module.)

Responsibility: It is important for a person with Medicare to understand Medicare’s benefits. If a denial is received for a service they did not know would not be covered, and it cannot be reasonably expected that they should have known, then the person with Medicare is not responsible to pay the charge. However, 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.

Note: Advance Beneficiary Notice of Noncoverage (ABN) is not required for services that are never covered by Medicare, for example, hearing aids or dentures. The beneficiary is always liable for the provider charge for services that are excluded from Medicare coverage.

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 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 MSN statements to inform them how much Medicare paid 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 MSNs are sent to the person with Medicare by the Medicare Administrative Contractor (MAC) 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 MAC for the state of Maryland. Doctor services they receive in New York, however, will be processed by National Government Services, the MAC for New York State.

Note: Medicare Summary Notices (MSNs) are mailed to people with Medicare quarterly for services from providers who accept assignment. 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 online at <http://www.medicare.gov>.

MEDICARE.GOV ACCOUNT

People with Medicare are able to access their own recent personal claim information and to order Medicare Summary Notices online by signing up for an account at <https://www.medicare.gov>. (<https://es.medicare.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.

As an alternative to paper MSNs, beneficiaries can choose to receive Electronic Medicare Summary Notices (eMSNs) once they have established a medicare.gov account.

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 over 65 with Medicare is covered through their own or their spouse's active/current employment for a company of 20 or more employees (or disabled under 65 with Medicare for an employer of 100 or more employees), and retains the 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 Module 2, HIICAP Notebook; Medicare Eligibility and Enrollment) <https://aging.ny.gov/hiicap-notebook>

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 has limited cost-sharing and/or the person with Medicare does not expect to incur large health care costs.



Reference: *Medicare & Other Health Benefits: Your Guide to Who Pays First*, CMS Publication #02179 <https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf>

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. Federally Qualified Health Centers (FQHCs) provide health care services 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>

Note: FQHCs are also an option for people not yet eligible for Medicare who need to receive health care services but cannot afford to purchase health insurance. They can receive care at an FQHC and pay on a sliding scale based on their income.

Sources of Assistance

NYS Office for the Aging HIICAP Hotline **1-800-701-0501**

Medicare Hotline **1-800-MEDICAR(E)**
<https://www.medicare.gov/> **(1-800-633-4227)**
TTY 1-877-486-2048

NY CONNECTS **1-800-342-9871**
<https://www.nyconnects.ny.gov>

Medicare Administrative Contractor (MAC) **1-800-MEDICARE**
 National Government Services **(1-800-633-4227)**
 Medicare Part B
<https://www.ngsmedicare.com>

Railroad Retirees **1-800-833-4455**
<https://rrb.gov>

Durable Medical Equipment **1-800-MEDICARE**
<https://med.noridianmedicare.com/web/jadme> **(1-800-633-4227)**

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

Additional Resources

Medicare & Other Health Benefits: Your Guide to Who Pays First, CMS Publication #02179
<https://www.medicare.gov/Pubs/pdf/02179-Medicare-Coordination-Benefits-Payer.pdf>

Medicare & You 2021, CMS Publication #10050
<https://www.medicare.gov/Pubs/pdf/10050-Medicare-and-You.pdf>

Medicare Coverage of Durable Medical Equipment and Other Devices, CMS Publication #11045
<https://www.medicare.gov/Pubs/pdf/11045-Medicare-Coverage-of-DME.PDF>

Your Guide to Medicare's Preventive Services, CMS Publication #10110
<https://www.medicare.gov/Pubs/pdf/10110-Medicare-Preventive-Services.pdf>

Your Medicare Benefits, CMS Publication #10116
<https://www.medicare.gov/Pubs/pdf/10116-Your-Medicare-Benefits.pdf>

Medicare Coverage of Therapy Services, CMS Publication # 10988
<https://www.medicare.gov/Pubs/pdf/10988-Medicare-Limits-Therapy-Services.pdf>

Medicare's Wheelchair & Scooter Benefit, CMS Publication # 11046
<https://www.medicare.gov/Pubs/pdf/11046-Medicare-Wheelchair-Scooter.pdf>

MODULE 4 APPENDIX

Medicare Part B Covered Chart: Medicare Part B: Medical Insurance-Covered Services for 2021

Services	Benefit	Medicare Pays	Beneficiary Pays
Medical Expenses Doctors' services, inpatient, outpatient medical and surgical services and supplies, physical, speech and occupational therapy, ambulance, diagnostic radiology, diabetes-testing supplies.	Unlimited if medically necessary	80% of approved amount (after \$203 deductible)	\$203 deductible plus 20% of approved amount
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 the Part B \$203 deductible, coinsurance, actual payment to hospital.	\$203 deductible (if not met) and coinsurance or preset copay
Blood*	Unlimited if medically necessary	80% of approved amount (after \$203 deductible and starting with 4th pint)	First 3 pints, plus 20% of approved amount for additional pints (after \$203 deductible).

1. Once your client has met the \$203 Part B deductible for covered services in 2021, 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*

2021 Part B Monthly Premium			
Income			Part B Premium
Individual	Couple	Married, filing separately	
\$88,000 or below	\$176,000 or below	\$88,000 or less	\$148.50
\$88,001 - \$111,000	\$176,001 - \$222,000	N/A	\$207.90
\$111,001 - \$138,000	\$222,001 - \$276,000	N/A	\$297.00
\$138,001 - \$165,000	\$276,001 - \$330,000	N/A	\$386.10
Above \$165,000 and less than \$500,000	Above \$330,000 and less than \$750,000	Above \$88,000 and less than \$412,000	\$475.20
\$500,000 or above	\$750,000 and above	\$412,000 and above	\$504.90

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, outpatient hospital services, and medical equipment. Medicare approves payment for care, helps to pay for care, when considered "reasonable and necessary," and when the person with Medicare's care is provided by a doctor, therapist, supplier, laboratory, or hospital outpatient unit.

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 physician services. **Read "New York's Balance Billing Law" in your *HIICAP Notebook*.**



3. MEDICARE PART B PAYMENTS

Answer the following:

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

MEDICARE PART B, PART 2

Focuses on these major topics:

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

Use the information from your HIICAP Notebook and the Medicare & You 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 surgical 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?

- b. 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, outpatient hospital services, and medical equipment. Medicare approves payment for care, helps to pay for care, when considered "reasonable and necessary," and when the person with Medicare's care is provided by a doctor, therapist, supplier, laboratory, or hospital outpatient unit.

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 nonparticipating 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 physician services

3. MEDICARE PART B PAYMENTS

Answer the following:

- 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 Medicare fee schedule, and will be the lower of either (a) the actual charge, or (b) the Medicare fee schedule*
- Who sends Part B claims to the Medicare Administrative Contractor?
All doctors and suppliers
- When a doctor accepts Medicare assignment, who receives the Medicare payment? *The doctor*
- When a doctor does not accept Medicare assignment, who receives the Medicare payment? *The person with Medicare*
- 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 & You 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 surgical 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 Non-coverage
(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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