Reference Guide for Medicare Physician & Supplier Billers

Helping Front Office Personnel Navigate Medicare Rules for Part B Claims Processing

Second Edition - October 2006

REFERENCE GUIDE FOR MEDICARE PHYSICIAN & SUPPLIER BILLERS

HELPING FRONT OFFICE PERSONNEL NAVIGATE MEDICARE RULES FOR PART B CLAIMS PROCESSING

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This guide was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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FOREWORD

The Centers for Medicare & Medicaid Services (CMS) is focused along three primary lines of service:

The Center for Medicare Management - manages traditional fee-for-service Medicare to include development of payment policy and management of the Medicare fee-for-service contractors;

The Center for Beneficiary Choices - provides beneficiaries with information on Medicare, Medicare Select, Medicare Advantage, and Medigap options to include management of the Medicare Advantage Plans, consumer research and demonstrations, and grievance and appeals functions; and

The Center for Medicaid and State Operations - manages programs administered by states to include Medicaid, the State Children's Health Insurance Programs (SCHIP), insurance regulation functions, survey and certification, and the Clinical Laboratory Improvement Amendments (CLIA).

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), was signed into law on December 8, 2003. This law and other proposed regulations provides a new voluntary drug benefit and enhanced health plan choices within Medicare Advantage. As a result of these new benefits, beneficiaries can obtain voluntary drug coverage and new support for their existing drug coverage through Medicare, and they can gain access to Preferred Provider Organizations (PPOs).

Through the MMA benefit, beneficiaries can choose how they want to get their outpatient drug coverage. Prescription drug plans and Medicare Advantage Plans are required to provide basic coverage, but may also offer additional plans with supplemental coverage. Such "high option" plans with enhanced coverage (for example, covering 75% of drug spending without any gap in coverage) allow beneficiaries to add to the Medicare-subsidized coverage using some of the contributions that beneficiaries, health plans, employers, unions, and others are making today. Charitable organizations, other individuals, and states will also be able to contribute to beneficiary out-of-pocket costs while still having their contributions count as "true out-of-pocket" spending for purposes of the Medicare subsidy for high drug expenses.

Where Is CMS Located?

The CMS Central Office is located in Baltimore, Maryland. The following ten Regional Offices, shown with their associated region codes, provide policy guidance to several Medicare Contractors:

Boston [I]

New York [II]

Philadelphia [III]

Atlanta [IV]

Chicago [V]

Dallas [VI]

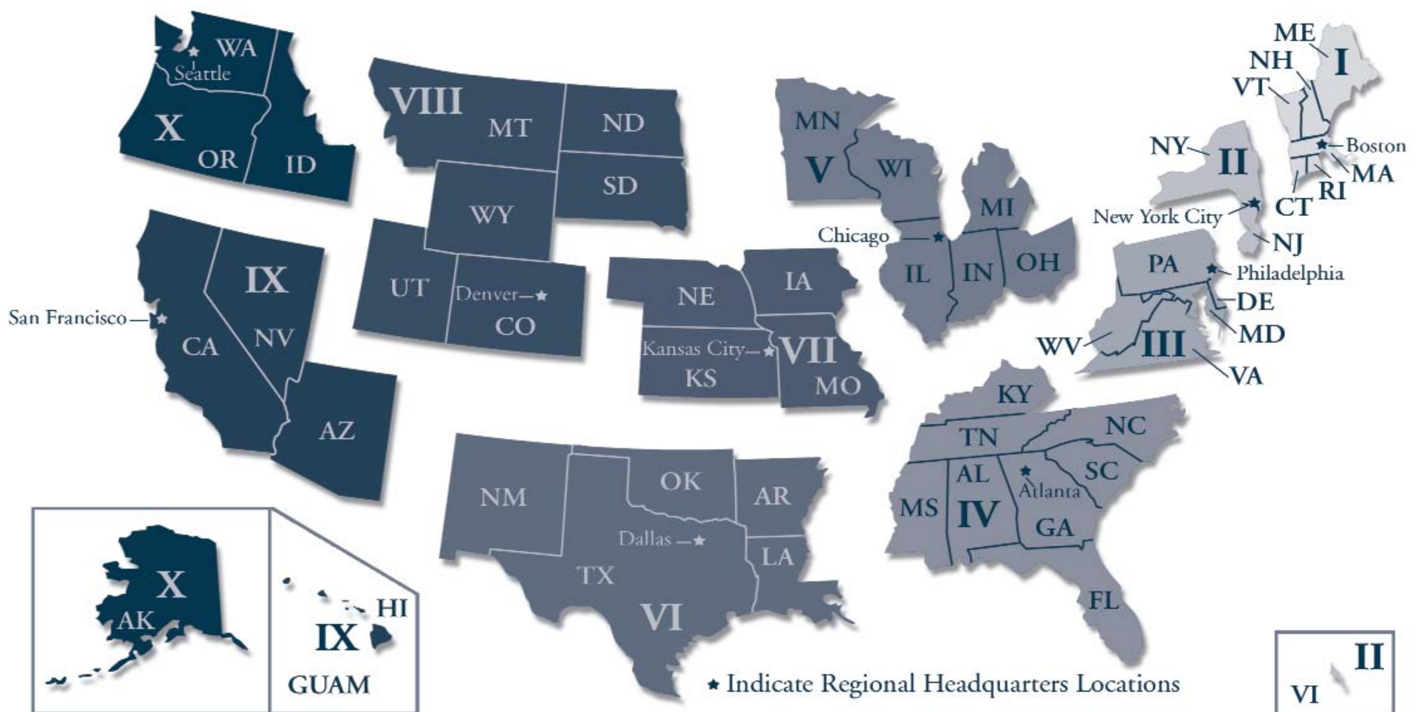
Kansas City [VII]

Denver [VIII]

San Francisco [IX]

Seattle [X]

The figure below shows how each CMS region is defined by state and/or territory:



Regional Office Contact Information

To access contact information for each Regional Office, please visit the CMS Regional Offices website at *www.cms.hhs.gov/RegionalOffices* on the CMS website.

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PREFACE

DISCLAIMER

This guide addresses the submission of Medicare Part B claims by physicians and suppliers. For the purposes of this guide, references to the term "provider" generally apply to all physicians or suppliers, unless otherwise specified.

What Is a Medicare Provider?

Medicare defines Part B providers as physicians and suppliers. Part A institutional providers are institutions that furnish inpatient and/or medical services to Medicare beneficiaries. These include: hospitals; Skilled Nursing Facilities (SNFs); Home Health Agencies (HHAs); Comprehensive Outpatient Rehabilitation Facilities (CORFs); End Stage Renal Disease (ESRD) facilities; hospice agencies; Outpatient Therapy Facilities (OTFs); and other facilities. Although Part A providers bill for Part B services in some situations, their specific billing procedures differ from those of physicians and suppliers, and therefore will not be discussed within this guide. Guidance for Part A providers who bill for Part B services is available within the companion *Reference Guide for Medicare Institutional Providers Who Submit Part B Claims* publication, available at *www.cms.hhs.gov/MLNProducts* on the CMS website.

What Information Is Included within this Guide?

This guide contains a variety of information to help providers submit accurate and timely Medicare claims. While providing historical information on Medicare Part A, Medicare Advantage, and Medicare Part D drug and coverage benefits, this guide is focused on providing information and procedures for physicians and suppliers that provide Part B services. This guide is divided into the following sections and contains reference sections at the end of the guide:

Section 1 - Introduction to Medicare

Provides an overview of the Medicare Program, describing what it is, who manages and administers the program, eligibility requirements, and coverage provisions.

Section 2 - Becoming a Medicare Provider

Provides an introduction to the general rules for participating as a Medicare provider, and explains the types of providers, instructions for enrollment and updating provider information, common enrollment questions and answers, and information regarding reimbursement.

Section 3 - Submitting Medicare Claims

Provides an overview of how to submit an electronic or paper Medicare claim, how provider claim assignment works, how to submit assigned and non-assigned claims, and Medicare Secondary Payer (MSP) submission regulations.

Section 4 - Introduction to the Medical Review (MR) Process

Provides an overview of the MR process and the effects of Medicare policy development.

Section 5 - Protecting Medicare from Fraud and Abuse

Provides an overview of the Progressive Corrective Action (PCA) process and ways to identify and prevent Medicare fraud and abuse.

Section 6 - Troubleshooting Denials and Claim Rejections
Explains numerous billing and data entry errors and provides methods for a provider to avoid such errors and submit Medicare claims accurately to avoid denied claims.

Section 7 - Appealing Medicare Claim Denials
Provides an overview of the Medicare claim appeals process.

Section 8 - Introduction to HIPAA
Provides an overview of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that protects health insurance coverage for workers and their families, establishes national standards for electronic health care transactions, and protects security and privacy of health data.

Reference A - Provider Specialty Codes
Contains a list of physician and supplier specialty codes.

Reference B - Form CMS-1500 Claim Form Instructions
Contains examples of the Form CMS-1500 claim forms submitted to Medicare Contractors and instructions for completing the forms.

Reference C - Form CMS-1500 Electronic Claim Format Crosswalk
Contains a crosswalk that matches Form CMS-1500 paper claim blocks to the corresponding electronic claim Field Locator (FL).

Reference D - Glossary
Contains a list of terms used throughout this document.

Reference E - Acronyms
Contains a list of acronyms used throughout this document.

Reference F - Websites and Phone Numbers
Contains a list of websites and phone numbers that are referenced throughout this document.

Section 1
Introduction to Medicare

The Medicare Program is currently the world's largest health insurance program. When Medicare began on July 1, 1966, approximately 19 million individuals enrolled. By 2006, over 43 million individuals will be enrolled in one or both parts of the Medicare Program (known as Part A and Part B), and 5 million of them chose to participate in a Medicare Advantage Plan, commonly referred to as Part C. Medicare also establishes guidelines for Medigap plans that help pay for deductibles, coinsurance amounts, copayments, and other costs not covered by Medicare. Beginning January 2006, Medicare offered a new prescription drug benefit (Part D) through private insurance companies. Congress has established specific rules regarding how various beneficiary health insurance plans are coordinated so that Medicare payments are issued fairly and equitably.

WHAT IS MEDICARE?

Title XVIII of the Social Security Act, designated "Health Insurance for the Aged and Disabled", is more commonly known as Medicare. As part of the Social Security Amendments of 1965, Medicare legislation established a health insurance program for aged individuals to complement the retirement, survivor, and disability insurance benefits under Title II of the Social Security Act. When first implemented in 1966, Medicare covered most individuals age 65 or over. In 1973, the following groups also became eligible for Medicare benefits:

- Individuals entitled to Social Security or Railroad Retirement disability cash benefits for at least 24 months
- Individuals with End Stage Renal Disease (ESRD)
- Certain otherwise non-covered aged individuals who elect to pay a premium for Medicare coverage

Medicare has traditionally consisted of two parts: Part A and Part B. A third part of Medicare, sometimes known as Part C, is the Medicare Advantage Plan. This plan is available to individuals who qualify for Medicare. Medicare Advantage was established by the Balanced Budget Act of 1997 (BBA) (Public Law 105-33) and expanded beneficiaries' options for participation in private-sector health care plans.

RECENT MEDICARE LEGISLATION

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) legislation provides seniors and individuals living with disabilities with a prescription drug benefit, additional choices, and enhanced benefits under Medicare (including new preventive services under Part B). Most notably, the MMA provided Medicare beneficiaries with opportunities for discounts on their prescription drugs during 2004 and 2005, as well as voluntary comprehensive Medicare prescription drug coverage, effective on January 1, 2006. This drug coverage, known as Medicare Part D, is provided by private health plans. This coverage can be a stand-alone drug benefit for individuals eligible for Medicare, or can be provided through a Medicare Advantage Plan that offers comprehensive benefits.

On February 8, 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law. A number of the DRA's provisions were effective on January 1, 2006. Most notable, the DRA prevents payments for physicians' services from being reduced by a negative update of 4.4%. Also, as of May 30, 2006, new payment rules went into effect for capped rental Durable Medical Equipment (DME) items. After 13 months, the beneficiary owns the capped rental DME item. Once the beneficiary owns the item, Medicare will pay 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.

In accordance with Section 303(d) of MMA, the Competitive Acquisition Program (CAP) for Part B drugs was implemented on July 1, 2006. The CAP is an alternative to the Average Sales Price (ASP) system for buying and billing drugs that are commonly administered incident to a physician's service. Under the CAP, physicians obtain certain Part B drugs and biologicals from a vendor selected by a competitive bidding process. The approved CAP vendor is responsible for shipping CAP drugs to physicians in response to a prescription order. The approved CAP vendor also submits drug payment claims to Medicare and collects applicable coinsurance from the beneficiary. Drug administration claims are still paid by the physicians' regular local carrier. Physician participation in the Medicare Part B drug CAP is voluntary.

Medicare Law and Drug Benefit Information

Current details about the 2003 Medicare legislation and related policies may be found at *www.cms.hhs.gov/MMAupdate* on the Centers for Medicare & Medicaid Services (CMS) website. If a Medicare beneficiary has questions about the Medicare Drug Benefit, he or she should call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-800-486-2048. The beneficiary could also visit *www.medicare.gov* on the Web and select "Prescription Drug Plan", or visit *www.cms.hhs.gov/PrescriptionDrugCovGenIn/03_Resources.asp* on the CMS website.

Deficit Reduction Act (DRA) of 2005

Current details about the 2005 Medicare legislation and related policies may be found at *www.cms.hhs.gov/apps/media/press/release.asp?Counter=1779* on the CMS website.

Competitive Acquisition Program (CAP)

Current physician, bidder, vendor, enrollment, and regulation information regarding the CAP for Medicare Part B drugs and biologicals is available at *www.cms.hhs.gov/CompetitiveAcquisforBios/* on the CMS website. Physicians who wish to participate in the program can obtain the CAP physician election form at *www.cms.hhs.gov/CompetitiveAcquisforBios/02_infophys.asp* on the CMS website. The drug CAP is separate from the Medicare Prescription Drug Benefit (Part D) that went into effect January 1, 2006.

Claims for Railroad Retirement Board (RRB) Beneficiaries

As claims for RRB beneficiaries cannot be paid under the CAP, physicians should not order drugs for RRB beneficiaries under the program. However, should this occur, and the claim is sent to the Carrier that processes claims for RRB beneficiaries, that Medicare Contractor will treat the claim as unprocessable.

UNDERSTANDING THE MEDICARE PART A BENEFIT

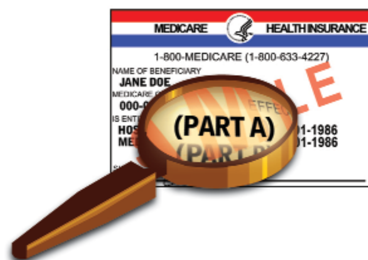
Medicare Part A, referred to as "Hospital Insurance", helps cover services and supplies related to inpatient hospital stays, Skilled Nursing Facility (SNF) care following a related, covered three-day hospital stay, some home health care, and hospice care for the terminally ill. The Social Security Administration (SSA) will determine if an individual must pay a premium for Medicare Part A, but most beneficiaries do not pay a premium because they (or a spouse) paid Medicare taxes while they were working.

A provider can determine if a beneficiary has Medicare Part A benefits by looking at the beneficiary's red, white, and blue Medicare Health Insurance card (see Figure 1-1). *Earlier versions of this card may appear differently than the card shown in Figure 1-1; however, these earlier versions are still valid.*

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)
NAME OF BENEFICIARY
JANE DOE
MEDICARE CLAIM NUMBER SEX
000-00-0000-A FEMALE
IS ENTITLED TO EFFECTIVE DATE
HOSPITAL (PART A) 07-01-1986
MEDICAL (PART B) 07-01-1986
SIGN HERE
SAMPLE

Figure 1-1. Medicare Health Insurance Card

If the beneficiary's Medicare card says "Hospital (Part A)", he or she is entitled to Part A benefits.



If a beneficiary qualifies for inpatient hospital care, services covered by Medicare Part A include the following:

- A semiprivate room
- Meals
- Blood transfusions
- General nursing
- Medications administered during the inpatient stay
- Special care units, such as intensive or coronary care
- Other hospital services and supplies

This includes care in Critical Access Hospitals (CAHs) and inpatient mental health care in an independent psychiatric facility. Coverage does **NOT** include private-duty nursing, an in-room television or telephone, or a private room (unless a private room is deemed medically necessary).

If a beneficiary qualifies for SNF care, services covered by Medicare Part A include the following:

- A semiprivate room
- Meals
- Blood transfusions
- Skilled nursing and rehabilitative services
- Medical social services
- Medications and medical supplies and equipment used in the facility
- Some ambulance transportation (when other transportation would endanger health) to the nearest provider of needed services not available at the SNF
- Dietary counseling
- Other services that SNFs generally furnish such as laboratory tests and X-rays

To be eligible for home health care, a beneficiary must meet all of the following four conditions:

- A doctor must decide that the beneficiary needs medical care in his or her home and must create a plan for home health care for that beneficiary.
- The beneficiary must need at least one of the following:
  - Intermittent (not full-time) skilled nursing care
  - Physical therapy
  - Speech-language pathology services
  - Continuing occupational therapy
- The beneficiary must be homebound (unable to leave home or leaving home is a major effort). If the beneficiary does leave the house, he or she may continue to be considered homebound if the absences are infrequent or for periods of short duration, or are to receive health care treatment. This may include regular absences to participate in therapeutic, psychological, or medical treatment in an adult day-care program that is approved by the state.
- The Home Health Agency (HHA) that provides the care must be Medicare-approved.

Occupational Therapy at Home

Services provided by an occupational therapist under the home health benefit must be started by another discipline (e.g., intermittent skilled nursing, physical therapy, speech-language pathology). Once established, occupational therapy becomes a qualifying discipline and may remain in the home as long as occupational therapy services are required and the patient meets all the eligibility criteria.

If a beneficiary qualifies for home health care, the following services are covered by Medicare Part A for each 60-day episode of care:

- Intermittent (not full-time) skilled nursing care
- Physical therapy
- Occupational therapy
- Speech-language pathology
- Home health aide services
- Medical supplies such as wound dressings (but NOT prescription drugs)
- Durable Medical Equipment (DME) such as wheelchairs, hospital beds, oxygen, and walkers
- Medical social services

If a beneficiary qualifies for hospice care, the following services are covered by Medicare Part A in “periods of care” (i.e., two-90-day periods followed by 60-day periods as needed) include the following:

- Doctor services [Nurse Practitioners (NPs) and hospice facilities should note that NPs have been added to the definition of an attending physician for beneficiaries who have elected the hospice benefit]
- Nursing care
- Durable Medical Equipment (DME) such as wheelchairs and walkers
- Medical supplies such as bandages and catheters
- Drugs for symptom control and pain relief
- Short-term hospital and inpatient respite care
- Home health aide and homemaker services
- Physical therapy
- Occupational therapy
- Speech-language pathology
- Medical social services

- Dietary counseling
- Counseling to help beneficiaries and their families deal with grief and loss

Hospice services must be provided by a Medicare-approved hospice and are usually provided in the beneficiary's home. However, inpatient SNF, short-term hospital, and inpatient respite care (care given to a hospice patient so that the usual caregiver can rest) are covered when needed.

Hospice Information

For additional information regarding hospice coverage and services, refer to the Medicare Hospice Benefits guide available at *www.medicare.gov/publications/pubs/pdf/02154.pdf* on the Web.

UNDERSTANDING THE MEDICARE PART B BENEFIT

Medicare Part B, referred to as "Medical Insurance", helps cover doctors' services, certain medical items, and outpatient care. Part B also covers medical services such as "therapy services" and some home health care furnished by hospitals, SNFs, and other institutional providers when the beneficiary does not qualify for Part A benefits.

In most cases, a provider can determine if a beneficiary has Part B benefits by looking at the beneficiary's red, white, and blue Medicare Health Insurance card (see Figure 1-1). If the beneficiary's Medicare Health Insurance card says "Medical (Part B)", he or she is entitled to Part B benefits.

The following services and supplies are covered under Part B, when medically necessary:

- Medical services
- Clinical laboratory services
- Some home health care
- Outpatient hospital services
- Blood transfusions (after the first 3 pints)
- Some preventive services
- Some ambulance services (when other transportation would endanger health)
- Some medical equipment

Part B Coverage and Payment Criteria

Providers who submit Part B claims should always refer to their Medicare Contractor's Local Coverage Decisions (LCDs [formerly known as Local Medical Review Policies (LMRPs)] and other billing guidance for specific coverage and payment criteria. Refer to Section 4, Local Coverage Determinations (LCDs), for detailed information regarding LCDs and LMRPs.

Part B requires payment of a monthly premium that is usually taken out of the beneficiary's Social Security, Railroad Retirement Board (RRB), or Office of Personnel Management Retirement payment. If the beneficiary does not receive one of these payments, Medicare will bill for the premium every 3 months. In addition to the premium, the beneficiary must meet an annual deductible and pay all coinsurance amounts unless he or she has other supplemental insurance.

If a beneficiary is entitled to Medicare Part B, covered services for medical care and other services include the following:

- Doctors' services
- Outpatient medical and surgical services and supplies
- Diagnostic examinations and tests
- Ambulatory Surgical Center (ASC) facility fees for approved procedures

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) such as wheelchairs, hospital beds, oxygen, walkers, prosthetics, orthotics, and supplies

Second surgical opinions

Outpatient mental health care

Outpatient physical therapy, occupational therapy, and speech-language pathology

If a beneficiary is entitled to Medicare Part B, the covered services for clinical laboratory services include the following:

Blood tests

Urinalysis

Other tests requested by a provider

If a beneficiary is entitled to Medicare Part B and does not have Medicare Part A coverage, the covered services for home health care include the following:

Intermittent skilled nursing care

Physical therapy

Occupational therapy

Speech-language pathology

Home health aide services

Medical social services

Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) such as wheelchairs, hospital beds, oxygen, walkers, prosthetics, orthotics, and supplies

Medical supplies and other services

Part B helps cover hospital services and supplies that a beneficiary receives as an outpatient, such as physical therapy, when under a doctor's care. Medicare Part B also covers blood transfusions that a beneficiary may receive as an outpatient or as part of a service covered under Part B.

Therapy Services

Financial limitations on therapy services were implemented on January 1, 2006. Detailed information regarding the therapy caps and exceptions process may be found at *www.cms.hhs.gov/TherapyServices/* on the CMS website.

Medicare Part B also helps to cover:

Some ambulance services when other transportation would endanger the patient's health

Artificial eyes

Braces - arm, leg, back, and neck

Chiropractic services (limited), for manipulation of the spine to correct a subluxation

Emergency care

Eyeglasses - one pair of standard frames after each cataract surgery with an intraocular lens

Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by private insurance that paid as a primary payer to Medicare Part A coverage, in a Medicare-certified facility

Kidney dialysis

Medical Nutrition Therapy (MNT) services for individuals who have diabetes or kidney disease (unless currently on dialysis) with a doctor's referral; the MNT services will be covered for 3 years after the kidney transplant

Medical supplies - items such as ostomy bags, surgical dressings, splints, casts, and some diabetic supplies

Very limited outpatient prescription drugs (e.g., some oral drugs for cancer)

Preventive services:

- Initial Preventive Physical Examination (IPPE) - the "Welcome to Medicare Visit" (WMV) Physical Exam
- Cardiovascular screening blood tests
- Screening mammography
- Screening Papanicolaou (Pap) tests
- Pelvic screening examination (includes a clinical breast exam)
- Colorectal cancer screening
- Prostate cancer screening
- Influenza, Pneumococcal, and Hepatitis B vaccinations
- Bone mass measurements
- Glaucoma screening
- Diabetes screening tests, supplies, and diabetes self-management training (DSMT)
- Smoking and tobacco use cessation counseling
- Ultrasound screening for abdominal aortic aneurysms (AAA) (as of January 1, 2007)

Prosthetic devices, including:

- Artificial limbs and their replacement parts
- Breast prosthesis after mastectomy
- Osseointegrated auditory and brainstem auditory devices (only under certain conditions)

Services of practitioners such as clinical social workers, Physician Assistants (PAs), and NPs who provide attending physician services and are not employed by or under contract to a hospice agency

Telemedicine services in some rural areas

Therapeutic shoes for individuals with diabetes (in some cases)

- Transplants - heart, lung, kidney, pancreas, intestine, bone marrow, cornea, and liver (under certain conditions and when performed at Medicare-certified facilities)
- X-rays, Magnetic Resonance Imaging (MRI) scans, Computed Tomography (CT) scans, Electrocardiograms (EKGs), and some other purchased diagnostic tests

As of January 1, 2005, Indian Health Services (IHS) can submit claims to Medicare for other Part B services such as DME, prosthetics, orthotics, surgical dressings, splits and casts, therapeutic shoes, clinical laboratory services, and ambulance services in addition to services paid on the Medicare Physician Fee Schedule.

Preventive Services Information

Detailed information regarding new preventive services covered under Medicare is available on the Preventive Services Educational Products for Health Care Professionals Web Guide available at *www.cms.hhs.gov/PrevntionGenInfo/* on the CMS website.

WHAT IS NOT COVERED BY MEDICARE

The following general medical services are not covered under Medicare Part A or B:

- Acupuncture
- Ambulance transportation to a doctor's office
- Blood transfusions for the first 3 pints of blood per year
- Cosmetic surgery except when required for the repair of accidental injury or for the improvement of the functionality of a malformed part of the body (or breast reconstruction following surgery for breast cancer)

Custodial care at a nursing home whenever this is the only kind of care required by the patient

Routine dental care or most dental procedures such as cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices

Emergency inpatient services in foreign countries **except for** some instances in Canada and Mexico to include:

When the beneficiary is traveling within the United States, a medical emergency occurs, and the closest hospital that can provide adequate treatment is in either Canada or Mexico

When the beneficiary is traveling through Canada without unreasonable delay by the most direct route between Alaska and another state and a medical emergency occurs and the Canadian hospital is closer than the nearest United States hospital that can treat the emergency

The beneficiary lives in the United States and the Canadian or Mexican hospital is closer to the beneficiary's home than the nearest United States hospital that can treat the medical condition, regardless of whether an emergency exists

Private duty nursing, television, or telephone in a beneficiary's inpatient hospital or Skilled Nursing Facility (SNF) room

A private room in a hospital or SNF unless it is deemed medically necessary

Custodial care

Medical Nutritional Therapy (MNT) services if the beneficiary has kidney disease but is on dialysis

Transportation to receive routine health care

Workers' Compensation (WC) claims

The following general items are not covered under Medicare Part B:

Bathroom supplies such as tub railings

Blood pressure monitors (unless the patient is receiving home dialysis)

White canes for the blind

Hearing aids

Experimental items during a clinical trial providing and testing new types of medical care

Diabetic supplies not ordered by the physician

Diabetic supply refills sent automatically by a supplier to the beneficiary

Diabetic supplies such as insulin (unless used with an insulin pump), insulin pens, syringes, or needles

Adult diapers

Common medical supplies such as alcohol swabs, bandages, and gauze

Supplies and/or DME provided by a supplier that is not currently enrolled in Medicare and does not have a current Medicare supplier number, even if the supplier is a large chain or department store that sells more than just DME

DME that is used in a Skilled Nursing Facility (SNF)

Eyeglasses (except for one pair of standard frames, intraocular lenses, or contact lenses after cataract surgery)

Portable oxygen when provided as a backup to a stationary oxygen system or used in an SNF

Most outpatient prescription drugs **except for** some antigens, osteoporosis drugs (covered while receiving home health care), Epoetin alfa (Epogen®), hemophilia clotting factors, immunosuppressive drugs, oral cancer drugs (if available in injectable form), and oral anti-nausea drugs

Orthopedic shoes and shoe inserts unless they are a necessary part of a leg brace and the cost is included in the charge for the brace

Outpatient substance abuse treatment if the treatment center does not participate in Medicare

Surgical stockings

Wheelchairs or Power Operated Vehicles (POVs) unless beneficiary meets Medicare requirements for Mobility Assistive Equipment (MAE)

Wheelchair ramps, elevators, stair glides, or some other lift devices

Note: Some lift chairs and chair lift mechanisms are covered.

Wigs

UNDERSTANDING THE MEDICARE ADVANTAGE PLAN

The Medicare Advantage Plan was established by the BBA as the Medicare + Choice Plan. This plan introduced a set of health care options that an organization can provide under contract to Medicare, possibly reducing beneficiaries' out-of-pocket expenses, and offering beneficiaries more health care and contractor choices. Beneficiaries who qualify for Part A and Part B Medicare benefits have the option to be covered under a Medicare Advantage Plan if a Medicare Advantage Plan organization is available in their area.

Medicare Advantage

Since MMA was signed into law in 2003, the Medicare Advantage Plan has undergone some significant changes. Effective March 1, 2004, increased payments for services went into effect for Medicare Advantage organizations. Additional information regarding the MMA is available at *www.cms.hhs.gov/HealthPlansGenInfo/* on the CMS website. The latest posted Medicare Advantage Plan payment rates are available at *www.cms.hhs.gov/MedicareAdvtgSpecRateStats/* on the CMS website.

To participate in the Medicare Program, a Medicare Advantage Plan organization must have a contract with the Secretary of the Department of Health and Human Services (HHS). The organization must provide the same services a beneficiary would be eligible to receive from Medicare if he or she were enrolled in Medicare Parts A and B. In other words, the beneficiary is still technically in the Medicare Program, but has selected a Medicare Advantage Plan that is required to provide services that have been accredited to meet CMS standards, rather than have claims processed through the traditional fee-for-service Medicare Contractor. The Medicare Quality Improvement Program sets requirements for the Medicare Advantage organizations.

Medicare Advantage Plans may include the following:

Medicare Managed Care Plan

Health Maintenance Organization (HMO) with a Point of Service (POS) option

Provider Sponsored Organization (PSO)

Preferred Provider Organization (PPO)

Medical Savings Account (MSA)

Private fee-for-service plan

Religious fraternal benefit society plan

Medicare Specialty Plans

The Medicare Advantage Plan places special limitations and requirements on beneficiaries with ESRD. Individuals entitled to Medicare because they have ESRD are limited to the Medicare Plan, except in special circumstances. A beneficiary with ESRD cannot join a Medicare Advantage Plan; however, if he or she developed ESRD after having enrolled in a Medicare Advantage Plan, he or she can remain enrolled. He or she may also join a different plan offered by the same company in the same state.

If a beneficiary who has ESRD is enrolled in a Medicare Advantage Plan and the plan stops offering service in the beneficiary's service area, he or she may join another Medicare Advantage Plan if one is available. This regulation applies to anyone whose provider left the plan after December 31, 1998.

If a beneficiary leaves a Medicare Advantage Plan for other reasons after developing ESRD, he or she can only choose the traditional Medicare Plan.

Individuals who have had a successful kidney transplant and no longer require regular dialysis are not considered to have ESRD. This means that the beneficiary is eligible to join a Medicare Advantage Plan as long as he or she has met all other eligibility requirements.

PROVIDING SERVICES TO BENEFICIARIES ENROLLED IN MEDICARE ADVANTAGE PLANS

Physicians and suppliers and their billing personnel must be aware that Medicare Advantage Plans do not operate under the same coverage and payment policy for claims processing as Original Medicare. ***If a beneficiary is a member of a Medicare Advantage Plan, the local Medicare Part B claims processor cannot process claims for that beneficiary.***

If a provider submits a Medicare claim in error to the local Medicare Part B claims processor for a beneficiary enrolled in a Medicare Advantage Plan, the claims processor will deny payment (except dialysis and related services provided in a dialysis facility). After denial, the claims processor will automatically transfer the claim to the appropriate Medicare Advantage Plan.

Providers and billing personnel must be aware that a Medicare managed care plan is **NOT** responsible for paying Medicare Advantage Plan claims submitted by a physician or supplier, **EXCEPT** under the following situations:

- The physician or supplier is affiliated with the Medicare Advantage Plan.
- The physician or supplier furnishes emergency services, urgently needed services, or other covered services not reasonably available through the Medicare Advantage Plan.

FILING CLAIMS WITH A MEDICARE ADVANTAGE PLAN

A provider may be reimbursed when filing a claim with a Medicare Advantage Plan if they are an in-network provider, or an out-of-network provider that furnished services that are identified in Section 1, Understanding the Medicare Advantage Plan. However, if the plan denies the claim, the provider has the right to appeal the claim to the plan or CMS. An out-of-plan provider may also collect the full physician or supplier charges from the beneficiary for services rendered if the beneficiary did not receive prior authorization to see the out-of-plan provider.

PROVIDERS WHO ARE NOT MEDICARE ADVANTAGE PLAN PROVIDERS

BEFORE rendering service, providers who are affiliated with a Medicare Advantage Plan should emphasize to their patient what their financial liability will be if the patient did not receive prior authorization to see the out-of-plan provider. If the patient chooses to see a provider not affiliated with their Medicare Advantage Plan for health care services, he or she should clearly understand that he or she may be responsible for the full physician or supplier charges for services rendered.

WHAT IS MEDICAID?

Title XIX of the Social Security Act is a federal/state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy individuals. Medicaid is the largest source of funding for medical and health-related services for America's poorest individuals. Within broad national guidelines established by federal statutes, regulations, and policies, each state:

- Establishes its own eligibility standards
- Determines the type, amount, duration, and scope of services
- Sets the rate of payment for services
- Administers its own program

Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, an individual who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and/or services within a state can change during the year.

THE MEDICARE-MEDICAID RELATIONSHIP

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid Program. For individuals who are eligible for full Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their state's Medicaid Program, according to eligibility category. These additional services may include nursing facility care beyond the 100-day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. **For individuals enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare Program before any payments are made by the Medicaid Program, since Medicaid is always the "payer of last resort".**

Certain other Medicare beneficiaries may receive help with Medicare premium and cost-sharing payments through their state Medicaid Program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the two best-known and largest categories of these types of beneficiaries. For QMBs, Medicaid pays the Medicare Part A and Medicare Part B premiums and the Medicare coinsurance amounts and deductibles, subject to limits that states may impose on payment rates. For SLMBs, the Medicaid Program pays only the Medicare Part B premiums.

A third category of Medicare beneficiaries who may receive help consists of disabled-and-working individuals. According to Medicare law, disabled-and-working individuals who previously qualified for Medicare because of disability, but who lost entitlement because they returned to work (despite the disability), are allowed to purchase Medicare Part A and Medicare Part B coverage. If these individuals meet certain requirements, they may qualify to have Medicaid pay their Medicare Part A premiums as Qualified Disabled and Working Individuals (QDWIs). According to the Centers for Medicare & Medicaid Services (CMS) estimates, Medicaid currently provides some level of supplemental health coverage for 6.5 million Medicare beneficiaries within the above three categories.

States vary in their participation in these programs. Some programs also pay Medicare deductibles and coinsurance amounts.

Availability of “Medicare Savings” Programs

Providers may recommend that low-income patients call 1-800-MEDICARE (1-800-633-4227) to see if such “Medicare Savings” programs are available locally. TTY/TDD users should call 1-877-486-2048.

HOW IS MEDICARE ADMINISTERED?

As a federal health insurance benefit program, Medicare represents the cooperative efforts and organization of numerous government and non-governmental organizations. The following section identifies the major organizations that work with Medicare.

CONGRESS

Congress passes laws that affect Medicare reimbursement of providers and beneficiaries.

SOCIAL SECURITY ADMINISTRATION (SSA)

The SSA, a federal agency, has special responsibilities in five major benefit areas: retirement; disability; family benefits; survivors; and Medicare. The SSA assures that beneficiaries are eligible for Medicare benefits and enrolls them in Parts A and/or B, the Federal Black Lung Program, or a Medicare Advantage Plan. When a patient enrolls in Medicare, CMS issues an initial enrollment package and a Medicare Health Insurance card.

The SSA is also responsible for the following:

- Handling requests for replacements for lost or stolen Medicare cards
- Maintaining and establishing beneficiary enrollment
- Maintaining and updating beneficiary information such as a change of address
- Collecting premiums from beneficiaries who receive retirement or disability benefits
- Educating beneficiaries regarding coverage and insurance choices

DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

HHS is the United States government’s principal agency for protecting the health of all Americans and providing essential health services, especially for those who are least able to help themselves. HHS includes more than 300 programs, including Medicare.

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare Program and works in partnership with the states to administer Medicaid, the State Children’s Health Insurance Program (SCHIP), and health insurance portability standards. CMS is also responsible for the administrative simplification standards from the Health Insurance Portability Act of 1996 (HIPAA), quality standards in health care facilities through its survey and certification activity, and clinical laboratory quality standards.

WHO PROCESSES MEDICARE CLAIMS?

Medicare’s Part A and Part B fee-for-service claims are processed by non-governmental organizations or agencies that contract to serve as the fiscal agent between providers and suppliers and the federal government. These Medicare Contractors who process claims have been traditionally known as *Fiscal Intermediaries (FIs) and Carriers*. These Medicare Contractors apply the Medicare coverage rules to determine the appropriateness of claims. Starting October 1, 2005, as part of the Medicare Contracting Reform (MCR) update, the Centers for Medicare & Medicaid Services (CMS) began replacing Medicare claims payment contractors with new contract entities called Medicare Administrative Contractors (MACs).

Medicare FIs process Part A claims for institutional services, including inpatient hospital claims, SNFs, HHAs, and hospice services. FIs also process Part B claims submitted by institutional providers, including hospital outpatient services. Examples of FIs include the Blue Cross Blue Shield Association (BCBSA), which utilizes its plans in various states, and other commercial insurance companies. An FI's responsibilities include the following:

- Determining costs and reimbursement amounts
- Maintaining records
- Establishing controls
- Safeguarding against fraud and abuse or excess use
- Conducting reviews and audits
- Making payments to providers for services
- Assisting both providers and beneficiaries as needed

Medicare Carriers handle Part B claims for services by physicians and medical suppliers. Examples of Carriers are the BCBSA plans in a state, and various commercial insurance companies. Carriers' responsibilities include the following:

- Determining charges allowed by Medicare
- Maintaining quality-of-performance records
- Assisting in fraud and abuse investigations

Directory of Current FIs and Carriers

To view a current directory of Fiscal Intermediaries (FIs) and Carriers, please visit the Intermediary-Carrier Directory at *www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

Medicare Contracting Reform (MCR) Information

MCR has been enacted per Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Effective July 1, 2006, Medicare will implement the integration of DME Carriers into MACs in Jurisdictions A and B only. Once all Jurisdictions have been integrated, each Jurisdiction will include multiple states as listed below:

Jurisdiction A: Connecticut; Delaware; District of Columbia; Maine; Maryland; Massachusetts; New Hampshire; New Jersey; New York; Pennsylvania; Rhode Island; and Vermont

Jurisdiction B: Illinois; Indiana; Michigan; Minnesota; Ohio; Wisconsin; Kentucky

Jurisdiction C: Alabama; Arkansas; Colorado; Florida; Georgia; Kentucky; Louisiana; Mississippi; New Mexico; North Carolina; Oklahoma; Puerto Rico; South Carolina; Tennessee; Texas; Virginia; Virgin Islands; and West Virginia

Jurisdiction D: Alaska; Arizona; California; Guam; Hawaii; Idaho; Iowa; Kansas; Missouri; Montana; Nebraska; Nevada; North Dakota; Oregon; South Dakota; Utah; Washington; Wyoming; Mariana Islands; and American Samoa

The transition process for all Medicare Contractors will occur through October 2011 using competitive procedures. Providers may access the most current MCR information to determine the impact of these changes at www.cms.hhs.gov/MedicareContractingReform on the CMS website.

- Assisting physicians, suppliers, and beneficiaries as needed
- Making payments to physicians and suppliers for services that are covered under the Part B benefit

Physicians and suppliers that have claims processed by Carriers are considered Part B providers. Carriers may only process Part B claims. Conversely, Part A providers that have claims processed by FIs are considered institutional providers. This situation sometimes creates confusion since FIs process Medicare claims for both Part A and Part B benefits. When a provider is called an institutional provider, it simply means that the provider has claims processed by an FI. For example, an Outpatient Rehabilitation Facility (ORF), commonly known as a rehabilitation agency, can only submit claims for Part B services. However, once a rehabilitation agency submits a claim to an FI, the rehabilitation agency is considered an institutional provider. Institutional providers can submit claims for services under the Part A benefit, the Part B benefit, or both (see Figure 1-2). Part B providers (physicians and suppliers) can only submit claims for services under the Part B benefit.

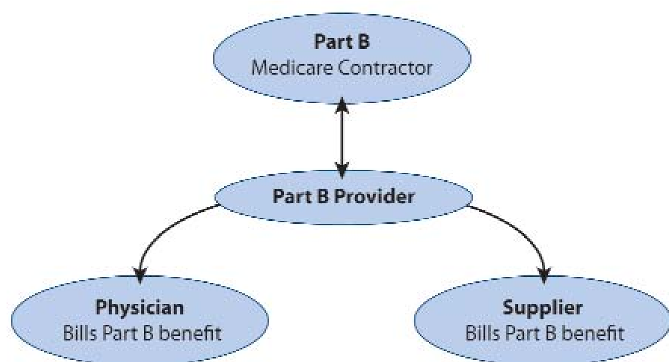


Figure 1-2. Part B Billing Benefits

WHO ARE MEDICARE BENEFICIARIES?

Medicare Part A eligibility is based on one's earnings, or on the earnings of a spouse, parent, or child. A specified number of "quarters of coverage" (QCs) must be earned through payment of payroll taxes. The exact number of QCs required for insured status depends on the basic group to which the individual belongs. If an individual has paid taxes for 40 QCs, he or she is eligible for "premium-free" Part A. Those who work for shorter periods would need to pay premiums depending on the length of taxpaying employment.

The basic types of individuals eligible for Medicare include:

- The aged
- The disabled
- Those with ESRD

Medicare Part B is a voluntary program for which the insured pays a monthly premium. All individuals who are entitled to premium-free Part A are eligible to enroll in Part B. Individuals who are not eligible for premium-free Part A can enroll in Part B if they are:

- Age 65
- A resident of the United States
- A United States citizen or an alien lawfully admitted for permanent residence who has continuously resided in the United States for the 5-year period immediately preceding the month he or she files for Part B

The cost of this premium is normally deducted from Social Security checks automatically and represents 25% of the cost of coverage. The remainder is financed from general tax revenues.

As described earlier, an individual eligible for Medicare (Part A and Part B) has the option to enroll in a Medicare Advantage Plan at any time. Since the enrollee has the option to enroll in Part B or Medicare Advantage at different times than when he or she enrolled in Part A, the effective dates on their Medicare Health Insurance cards may vary, depending on the month/year in which enrollment takes place. As described in Section 1, The Medicare-Medicaid Relationship, certain low-income individuals may also qualify through Medicare Savings Programs.

Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

Under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), Section 1011, eligible physicians, hospitals, and ambulance services that provide emergency health services to undocumented aliens can seek reimbursement from a $250 million fund available during Fiscal Years (FYs) 2005-2008. Additional information about eligibility is available at *www.cms.hhs.gov/UndocAliens/01_overview.asp* and *www.cms.hhs.gov/MLNMattersArticles/downloads/SE0633.pdf* on the CMS website.

AGED INSURED

An "aged insured" individual is age 65 or older and eligible for monthly Social Security or Railroad Retirement cash benefits, or equivalent federal benefits. Medicare enrollment typically occurs simultaneously upon application for Social Security benefits. Therefore, individuals that receive SSA benefits "early" will be automatically enrolled in Medicare Part A the month they turn age 65.

Medicare Part B is voluntary and becomes effective based on the enrollment period in which the individual enrolls. The earliest an individual may enroll in Part B is 3 months before and 3 months after an individual turns age 65. If a beneficiary chooses *not* to enroll in Medicare Part B during the initial enrollment period, he or she may enroll during other specified times. However, the cost of Part B may go up 10% for each 12-month period the beneficiary was eligible for Part B, except in special cases pertaining to the Special Enrollment Period (SEP). The beneficiary will have to pay this extra amount for the rest of his or her life.

Medicare Eligibility Tool

Information about and resources for enrolling in Medicare and a tool to help an individual determine eligibility for enrollment are available at *www.medicare.gov/MedicareEligibility/home.asp?version=alternate&browser=IE%7C6%7CWinXP&language=English* on the Web.

Medicare Eligibility and Enrollment Information

Questions about Medicare eligibility and enrollment should be referred to the beneficiary's local Social Security Field Office or the SSA's toll-free number at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778.

DISABLED INSURED

An insured individual entitled to Social Security, Railroad Retirement, or equivalent federal benefits, based on disability, is automatically entitled to Part A hospital insurance and is considered enrolled for Part B unless coverage was refused by Medicare because the individual does not meet the guidelines provided earlier in this section of the guide. This type of entitlement is also available to a disabled widow or widower, or the disabled child of a deceased, disabled, or retired worker. Generally, entitlement begins after the individual has been entitled to receive benefits for 24 months, not the date he or she became disabled. However, individuals whose disability is Amyotrophic Lateral Sclerosis (ALS) do not have to wait 24 months for Medicare. These beneficiaries are entitled to Medicare the first month they are entitled to disability benefits.

If it is determined that an individual is no longer disabled by the Social Security Administration (SSA), a notification of disability termination is sent, and Medicare Part A and Part B entitlement ends the following month.

Special Enrollment Period (SEP)

The SEP is for individuals who did not enroll in premium Medicare Part A during the initial enrollment period because they or their spouse currently worked and had Group Health Plan (GHP) coverage through their current employer or union. An individual can sign up for premium Medicare Part A at any time he or she is covered under the GHP based on current employment. If the employment or GHP coverage ends, the individual has 8 months to enroll in Medicare Part A starting the month after employment or GHP coverage ends, whichever comes first.

END STAGE RENAL DISEASE (ESRD) INSURED

Individuals of any age who require regular dialysis or a kidney transplant are eligible for Medicare if they:

- Worked the required amount of time under Social Security, the Railroad Retirement Board (RRB), or as a federal, state, or local government employee
- Are receiving, or are eligible to receive, Social Security or Railroad Retirement benefits
- Are the spouses or dependent children of such insured or entitled individuals

Entitlement to Medicare usually begins after a 3-month waiting period (e.g., the first day of the third month after the course of renal dialysis begins). Entitlement can begin at an earlier date if certain requirements are met. For example, Medicare coverage can start the month the beneficiary is admitted to a Medicare-approved hospital for a kidney transplant, or for health care services that are needed before the transplant if the transplant takes place in the same month or within the following 2 months. Medicare coverage can start 2 months before the month of the transplant if the transplant is delayed more than 2 months after the beneficiary is admitted to the hospital for that transplant or for health care service that are needed before the transplant.

Medicare is the secondary payer for claims during the 30-month coordination period for ESRD beneficiaries who are covered by a Group Health Plan (GHP). This 30-month coordination period begins with the first day of Medicare eligibility. The exception is an aged or disabled beneficiary who had GHP coverage that was secondary to Medicare when ESRD occurred.

For patients eligible for Medicare solely based on ESRD, coverage ends on the earliest of the following dates:

- The patient's date of death
- The last day of the 12th month after the month in which the course of dialysis is discontinued, unless the patient receives a kidney transplant during that period or begins another course of dialysis
- The last day of the 36th month after an individual receives a kidney transplant:
  - If the transplant fails and a regular course of dialysis is initiated or another transplant is performed within the 36 months, entitlement continues
  - If a patient whose entitlement based on ESRD has ended begins a new course of dialysis or has a kidney transplant, re-entitlement begins without a waiting period

WHAT ARE MEDICARE BENEFICIARY RIGHTS?

Provider staff should be familiar with the Medicare beneficiary rights that apply to the type of service(s) furnished and the type of Medicare insurance plan for which claims are being submitted. The Medicare beneficiary handbook, *Medicare & You*, is published by the Centers for Medicare & Medicaid Services (CMS) and sent to all Medicare beneficiaries. The handbook discusses the guaranteed rights of Medicare beneficiaries, which include the following:

- Protection when they get health care services
- Assured access to needed health care services
- Protection against unethical practices
- The right to receive emergency care without prior approval
- The right to appeal Medicare Plan's decision about payment/services provided
- The right to information about all treatment options
- The right to know how their Medicare health plan pays its doctors
- The right of the beneficiary to submit a written request to a physician or supplier for an itemized statement for any Medicare item or service received [the physician or supplier must furnish the itemized statement within 30 days of the request; failure to provide the statement on time can result in a Civil Monetary Penalty (CMP) of up to $100.00 for each failure]

Beneficiary Rights Information

CMS has also developed an additional publication, *Your Medicare Rights and Protections*, which provides details about beneficiary rights that are specific to the Original Medicare Plan, Medicare Managed Care Plans, and Medicare Private Fee-for-Service Plans. This document is available at *www.medicare.gov/Publications/Pubs/pdf/10112.pdf* on the Web.

HOW DOES A PROVIDER IDENTIFY A QUALIFIED MEDICARE BENEFICIARY?

When an individual becomes entitled to Medicare coverage, he or she receives a Medicare Health Insurance card. This card contains the following important information that must be included on all claims submitted by providers:

- Name
- Sex
- Health Insurance Claim Number (HICN)
- Effective date of entitlement to Part A insurance
- Effective date of entitlement to Part B insurance

Most Medicare beneficiaries receive Medicare Health Insurance cards issued by the Centers for Medicare & Medicaid Services (CMS) that includes a Medicare number issued by the Social Security Administration (SSA); however, the Railroad Retirement Board (RRB) issues a Medicare Health Insurance card to individuals eligible for Medicare Railroad Retirement benefits. CMS is also the agency in charge of the Medicare Program. The RRB, however, enrolls railroad retirement beneficiaries in the program, deducts Medicare medical insurance premiums from monthly benefit payments, and assists in certain other ways.

SOCIAL SECURITY ADMINISTRATION (SSA)-ISSUED MEDICARE NUMBERS

Medicare numbers issued by the SSA typically reflect the Social Security Number (SSN) of either the insured or a spouse (divorced from the beneficiary or deceased), depending on the wage earner upon whose earnings eligibility is based.

RAILROAD RETIREMENT BOARD (RRB)-ISSUED MEDICARE NUMBERS

Medicare numbers issued by the RRB may be the insured's SSN or a 6-digit number (zeros may be added at the beginning to bring it to 9 digits). Regardless of the length of the number, the insured's number will always have an alpha *prefix* (with one or more characters). For example, A000-000 or A000-000-000 would be a railroad pensioner (by age or disability).

VERIFYING BENEFICIARY ELIGIBILITY

Social Security benefits are the basis for eligibility for most Medicare beneficiaries. The eligibility source can be determined by asking to see the patient's Medicare Health Insurance card. Maintaining a photocopy of the card in the patient's file may prevent errors. The provider's office should develop a process to regularly verify Medicare insurance information and update patients' records to reflect current information. Providers may submit claims to Medicare without a copy of the patient's Medicare Health Insurance card, but they should confirm that the patient has coverage prior to billing. Due to an increase in lost and stolen Medicare Health Insurance cards, checking and copying a beneficiary's picture identification is suggested to ensure that the patient is eligible to receive benefits. *If Medicare has paid a claim for services rendered to a non-Medicare-eligible beneficiary, a refund request may be generated.*

WHAT IS MEDIGAP?

A Medigap policy is a health insurance policy sold by private insurance companies to fill "gaps" in the Medicare Plan coverage. Medigap policies must follow federal and state laws that protect the beneficiary. The front of the Medigap policy must clearly identify it as "Medicare Supplemental Insurance". In all states except Massachusetts, Minnesota, and Wisconsin (Medigap "waiver" states), a Medigap policy must be one of 12 standardized policies that can be compared easily. Each policy has a different set of benefits. Two of the standardized policies may have a high deductible option. In addition, any standardized policy may be sold as a "Medicare SELECT" policy. Medicare SELECT is a Medigap plan that requires the beneficiary to use a network of providers. All of the standardized Medicare Plans may be offered as Medicare SELECT policies, however not all plans are available in all states. A Medicare SELECT plan may lower the cost of a Medigap policy through the use of a network of providers. If a beneficiary is enrolled in a Medicare SELECT plan, he or she must use a provider in the network to get full insurance benefits (except in an emergency).

Medicare SELECT policies usually cost less because the beneficiary must use specific hospitals and, in some cases, specific doctors to get full insurance benefits from the policy. In an emergency, beneficiaries may use any doctor or hospital. Certain changes to Medigap policies will occur with the implementation of Medicare Modernization Act of 2003 (MMA).

Updated MMA Information

Updated information and assistance with selecting the health plan that best meets the needs of a beneficiary may be obtained using the Medicare Personal Plan Finder Help tool available at *www.medicare.gov/Help/mppf.asp* and at *www.medicare.gov/MPPF/include/DataSection/Questions/Welcome.asp* on the Web.

HOW DO THE MEDICARE SECONDARY PAYER (MSP) PROVISIONS AND COORDINATION OF BENEFITS (COB) PROGRAM WORK?

MSP is the term used when Medicare is the second insurer responsible for making payment on beneficiary health care claims. All health care providers are required to determine, prior to billing, whether Medicare is the primary or secondary payer. Medicare becomes the secondary payer when other primary insurance exists. The MSP provisions protect Medicare funds and ensure that Medicare does not pay for services reimbursable under private insurance plans or other government programs. Medicare may not pay if payment has been made, or can be reasonably expected to be made, with respect to an item or service that is covered under other health insurance or coverage. For example, if a Medicare beneficiary is covered by a Group Health Plan (GHP) as a result of his or her current employment or the current employment of his or her spouse, charges for medical services must first be submitted to his or her GHP for payment.

MSP PROVISIONS

Until 1980, the Medicare Program was the primary payer for all beneficiaries, except for those who received benefits from Workers' Compensation (WC), and those that receive all covered health care services through the Veterans Health Administration (VHA) programs. Beginning in 1980, changes to Medicare laws increased the number of coverage and benefit programs that are primary to Medicare. Examples include when a beneficiary is covered by a GHP through a current employer or a spouse's current employer (and the employer has 20 or more employees or at least one employer is a multi-employer group that employs 20 or more individuals) or when the beneficiary has been in an accident where no-fault or liability insurance is involved.

MEDICARE COORDINATION OF BENEFITS (COB)

The purpose of the COB Program is to identify health care coverage that beneficiaries may have that pays primary to Medicare and coordinate the payment process to prevent erroneous Medicare primary payments. The Medicare COB contract consolidated activities that support the collection, management, and reporting of other insurance coverage that Medicare beneficiaries have. This is one of many initiatives under the Medicare Integrity Program designed to further expand the Centers for Medicare & Medicaid Services (CMS') campaign against Medicare waste, fraud, and abuse. Please see Section 3, Submitting Medicare Secondary Payer (MSP) Claims, for more information regarding submission of MSP claims.

WHAT PROVIDER AND BENEFICIARY RESOURCES ARE AVAILABLE?

In addition to the materials presented in this section, the following resources are available to provider staff and beneficiaries who need information regarding Medicare:

<u>Provider Resources:</u>

Access information and resources specific to each Medicare fee-for-service provider type to include new program highlights, Medicare Learning Network (MLN) Matters articles, specialized links to federal regulations, Program Transmittals, Part D Tools for Health Care Professionals, and ListServs at *www.cms.hhs.gov/center/provider.asp* on the CMS website.

Access provider practice administration information regarding payment/claims, education, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), provider education, Medicare Secondary Payer (MSP), coverage, coding, policies and regulations, enrollment, manuals, provider specialty-specific

resources, participation, Health Insurance Portability Act of 1996 (HIPAA), compliance and Medical Review (MR), rural and urban resources, and contacts at *www.cms.hhs.gov/center/provider.asp* on the CMS website.

Access information and resources specific to Medicare demonstrations projects to test and measure the effect of potential program changes at *www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp* on the CMS website.

Access information regarding the Medicare Contractor Provider Satisfaction Survey at *www.cms.hhs.gov/MCPSS/* on the CMS website.

Access updated information regarding coverage and payment policy, claims, contacts, and Frequently Asked Questions available at *www.cms.hhs.gov* and *www.cms.hhs.gov/home/medicare.asp* on the CMS website.

Access helpful provider-friendly MLN Matters articles that relay information about revisions to Medicare claims processing at *www.cms.hhs.gov/MLNMattersArticles* on the CMS website.

Obtain local policy and claims processing information from the Medicare Coordination of Benefits (COB) Contractor's website at *www.cms.hhs.gov/COBGeneralInformation/#v4_2* on the CMS website, or by calling 1-800-999-1118 (TTY/TDD users should call 1-800-318-8782).

Access information on the new quality standards for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) at *www.cms.hhs.gov/CompetitiveAcqforDMEPOS/04_new_quality_standards.asp* on the CMS website.

Beneficiary Resources:

Providers should share the following resources of information with beneficiaries.

Access answers to common Medicare questions by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users may call 1-877-486-2048.

Access *www.medicare.gov* on the Web to obtain basic Medicare information and resources such as:

Find available Medicare-approved prescription drug plans, and compare prices for prescriptions - used by beneficiaries to find an available drug plan that meets their specific needs, as well as compare prescription prices

Information about the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 - provides access to the most current information regarding the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) that will help beneficiaries to make the best Medicare coverage decisions

Medicare premiums and coinsurance rates - provides the latest premiums and coinsurance rates

Search Tools - provides access to search tools that the beneficiary can use to:

Contact specific organizations to answer Medicare-related questions

Find prescription drug and other assistance programs

Compare nursing homes

Find a personal Medicare plan

Access publications such as the *Medicare & You* handbook

Determine Medicare eligibility

Find a participating physician

- Determine Medicare coverage
- Compare home health services
- Find a participating supplier
- Access helpful contacts
- Compare dialysis facilities
- Plan long-term care needs

Access to a State Health Insurance Assistance Program (SHIP) where specially trained staff and volunteer counselors provide personal health insurance counseling. Services are free, unbiased, and confidential. Local phone numbers are available by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

NOTES