

MEDICAL INSURANCE UNDER MEDICARE PART B

This section covers:

- Part B Introduction
- Part B Covered Services, Items, and Coverage Rules
- Excluded Services and Items
- Part B Costs and Claims
- Where to Learn More

MEDICARE PART B INTRODUCTION

Medicare Part B, officially called the Supplementary Medical Insurance (SMI) program (see the Medicare card), was designed to cover a wide range of medical services to complement Medicare's Part A hospital insurance benefits. Unlike Part A, which most beneficiaries receive automatically because they paid a Medicare tax through FICA payroll deductions, people must elect to enroll in Part B and pay a monthly premium.

The financing for Medicare Part B comes largely from federal general revenues, monthly premiums (\$96.40 in 2010, for most beneficiaries), and beneficiary cost-sharing charges that include the annual deductible and 20 percent coinsurance for most covered services and items. By law, the monthly premiums cover 25 percent of Part B program costs. FICA payroll taxes do not help finance Medicare Part B. The Part A and Part B trust funds are separate.



Don't confuse Medicare's Supplementary Medical Insurance (SMI) program with Medicare Supplement (Medigap) insurance policies.

You'll find that Medicare and insurers use the words supplemental and supplementary to describe various benefits and options related to Medicare. To keep things simple, most people simply refer to the SMI program as "Medicare Part B."

Some of the most common services that Medicare Part B covers are:

- Physician care
- Outpatient hospital treatment and surgery
- Home health care
- Durable medical equipment (DME) and supplies
- Ambulance services
- Prevention and screening services

The payment contractors for Medicare Part B services are the Carriers and A/B Medicare Administrative Contractors (A/B MAC) for physician, ambulance and many other covered services; the Regional Home Health Intermediaries (RHHI) for Part B covered home health care; and the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for medical equipment, prosthetics, and supplies. Providers submit claims to these contractors for Medicare payments.

PART B COVERED SERVICES, ITEMS, AND COVERAGE RULES

Generally, Medicare Part B covers medical services and items when they are medically necessary. This means that they must be reasonable and necessary in the diagnosis or treatment of an illness or injury. Since 1990, however, Congress has added many preventive and screening services to the list of Part B covered benefits. Part B covered services include physician, outpatient hospital, and ambulance services, along with durable medical equipment (DME) items. See the descriptions of these services, items, and coverage rules below.

Physician Services

Medicare Part B generally covers physician services, including diagnostic and surgical services. Medicare defines a “physician” as a licensed Medical doctor (MD), Osteopathic doctor (DO), Chiropractor (DC), Optometrist, Ophthalmologist, or Podiatrist (DPM).

Medicare also covers services from other providers who include:

- Certified registered nurse anesthetist (CRNA)
- Clinical psychologist
- Clinical social worker
- Physician assistant (PA)
- Nurse practitioner and clinical nurse specialist

Medicare covers a wide range of physician services that include:

- Office, hospital, and home visits
- Second opinions before surgery
- Surgical services
- Anesthesiology and radiology services
- Mental health services
- Chiropractic services under limited conditions
- Podiatric services under limited conditions
- Dental surgery under limited conditions

Medicare has limited coverage for some types of physician services, including chiropractic, podiatric, and dental care.

Chiropractic care: Medicare pays for the manual manipulation of a subluxation of the spine. It will cover chiropractic services for both acute and chronic subluxations with the short-term goal of improving the patient’s condition or function. Rules state that chiropractic maintenance treatments are not “reasonable and necessary.” Also, since 2000 Medicare has not required an x-ray to document the subluxation.

Podiatric services: Medicare pays for the debridement of mycotic toenails, ingrown toenails, bunions, and heel spurs. It pays for routine foot care only for patients with “systemic conditions” involving their circulation, nervous system, or metabolism, for example, diabetes.

Dental surgery: Medicare coverage is limited to paying dental surgeons to perform surgeries to set a fractured jaw, remove cancerous tissue, or to treat oral infections. It does not cover services in connection with the care, treatment, filling, removal, or replacement of teeth (although Part A pays for an inpatient hospital stay when a patient’s medical condition requires inpatient care for the safe removal of teeth).

Outpatient Hospital Services

Medicare covers many outpatient hospital services. They include but are not limited to:

- Medical treatments, such as chemotherapy administration for cancer patients
- Emergency room services
- Outpatient surgical services, including many common “day surgery” procedures
- Rehabilitation services, such as physical therapy and cardiac rehabilitation programs
- Diagnostic services, such as x-rays, CT scans, and Magnetic Resonance Imaging (MRI)

Since 1997, Medicare has been phasing in the Outpatient Prospective Payment System (OPPS) for many outpatient hospital services. Because of the OPPS, you may find that coinsurance charges for some outpatient hospital services, for example outpatient surgery, exceed 20 percent of the Medicare approved amount. You may also find that payment rates for the same outpatient service vary among hospitals. Note that the coinsurance charge for outpatient services in no case may exceed the Part A inpatient hospital deductible and that insurance rules require Medigap policies to cover the cost.



Some clients may wonder about the accuracy of their Medicare Summary Notices (MSN) when they see coinsurance charges of 30 percent or more for outpatient services. You can refer them to a Medicare publication called *Quick Facts about Paying for Outpatient Services for People with Part B* for more information about the OPPS and how it works.

The format for the Part B outpatient Medicare Summary Notice (MSN) differs from the format for the MSN for physician and other Part B services. These differences may cause confusion for some clients.

Durable Medical Equipment (DME), Prosthetics, and Supplies

Common examples of DME are wheelchairs, walkers, power operated vehicles, hospital beds, lift devices (e.g., Hoyer lift), and oxygen equipment. Medicare-covered DME includes customized equipment to meet a beneficiary's unique medical needs. DME suppliers include pharmacies, home health agencies, and companies that specialize in the sale and service of medical equipment and supplies. Some large suppliers have nationwide mail order operations and advertise extensively.

Medicare defines DME as equipment that is:

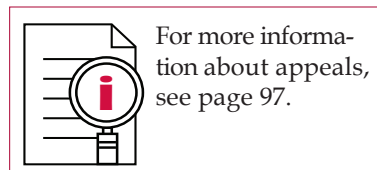
- Able to withstand repeated use
- Used primarily for a medical purpose
- Generally not useful in the absence of an illness or injury
- Appropriate for use in the home

To qualify for payment, Medicare requires that:

- The equipment is reasonable and necessary for the treatment of a person's illness or injury or to improve the functioning of his malformed body part.
- A physician order the DME and certifies the patient's need for DME through a prescription or, in some cases, a Certificate of Medical Necessity.
- The DME provider is Medicare enrolled and certified.

For purposes of Part B DME payments, a beneficiary's home may be her own house, apartment, a relative's home, a home for the aged, or some institutions. A home is not, however, a hospital or an institution (i.e., nursing home) that has a skilled nursing facility (SNF) unit. CMS assumes that Part A or Medicaid payments to hospitals and nursing facilities, or the private pay rates that residents pay to nursing facilities, should cover the cost of DME and supplies.

Even though an item serves a useful medical purpose and a physician has prescribed it, Medicare also considers if it is reasonable to pay for the DME. The Medicare Administrative Contractor (DME MAC) asks, for example, if the prescribed item is substantially more costly than other "appropriate and feasible alternatives." This analysis can result in coverage denials that may surprise some of your clients. DME denials usually are good cases to appeal.



Medicare excludes certain items from its list of covered DME. Because their purpose is not primarily medical, Medicare does not pay for:

- Air conditioners
- Humidifiers
- Stairway lifts
- Fitness equipment
- Safety grab bars
- Seat-lift chairs (but Medicare pays for the seat-lift device inside the chair)

Medicare has special coverage rules that CMS changed in 2005 for power-operated wheelchairs and scooters. In the past, Medicare required a patient to be “bed or chair confined” to show medical necessity. That is no longer the case. While coverage for such Mobility Assistive Equipment (MAE) is available only to meet a medical purpose in the home, Medicare has changed the rule to set up a function-based measure of medical necessity. Medicare now looks more broadly at the patient’s inability to safely accomplish activities of daily living such as toileting, feeding, and dressing when deciding to cover MAE.

Prosthetics

Prosthetic devices are designed to replace all or part of a missing body organ or an inoperative or malfunctioning body organ. They include:

- Breast prostheses and reconstruction following a mastectomy
- Pacemakers
- Cataract lenses and glasses
- Artificial limbs and eyes
- Braces and trusses
- Therapeutic shoes for people with diabetes
- Urinary collection and retention systems

Medicare does not cover these items as prosthetic devices:

- Eyeglasses or contact lenses (except for cataracts)
- Hearing aids
- Dentures or dental implants
- Orthopedic shoes

Medicare rules allow for the rental or purchase of DME and prosthetics. Generally, beneficiaries decide whether to purchase or rent equipment, but CMS decides how to pay for an item. The agency categorizes DME, prosthetics, and supplies into six categories. It groups items, for example, that are inexpensive or routinely purchased, or that require frequent

and substantial service, or that are customized. Based on the grouping, CMS decides whether to pay a monthly rental fee or a lump sum payment.

- For inexpensive items that cost less than \$150, like walkers, Medicare pays either a monthly rental fee or a lump sum.
- For expensive items, like hospital beds and wheelchairs, Medicare pays a monthly rental fee until payments reach the purchase price. Afterwards, Medicare pays the supplier a smaller monthly maintenance fee to cover repairs.
- For items that need frequent service, like ventilators and nebulizers, Medicare pays a monthly rental fee only.
- For customized equipment and prosthetics, Medicare pays a lump sum.
- For oxygen equipment, Medicare pays a monthly fee schedule amount only. It does not pay for the purchase of oxygen equipment.

With most rented DME, called “capped rental items,” Medicare gives beneficiaries the option to purchase the item in the tenth month of rental. If a beneficiary declines the purchase option, ownership of the DME stays with the equipment supplier after Medicare makes rental payments for 15 months. Afterwards, Medicare pays the supplier to service the equipment twice each year. If the beneficiary accepts the purchase option, she owns an item after 13 months of rental payments. Medicare covers servicing as needed. Different rules apply to oxygen equipment where Medicare now makes rental payments for 36 months after which the equipment supplier owns the equipment. After 2009, Medicare no longer will pay to maintain oxygen concentrators or transfilling equipment after the 36-month rental period.

Supplies

Medicare Part B pays for supplies that are furnished in connection with a physician’s services or that are needed to use DME effectively. Some examples of covered supplies are:

- Oxygen
- Ostomy bags and supplies
- Heparin when used with a home dialysis system
- Surgical dressings, limited to primary and secondary dressings to treat surgical wounds
- Splints

SHIP TIP Medicare covers both used and brand new equipment items. If a supplier has used DME items available, the lower cost can save your clients (and Medicare) some money

Medicare does not pay to repair equipment that the patient purchased prior to her eligibility for the Medicare program. In such cases, one approach is to work with the physician and supplier to establish the need for new equipment.

Medicare does not cover chucks, diapers, and rubber sheets for persons with urinary or bowel incontinence.

Competitive Bidding Program for DMEPOS

CMS will implement a competitive bidding program in 2010 for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Medicare will contract with a number of DME suppliers who submit winning bids to provide certain medical equipment and supply items to Medicare beneficiaries who live in nine designated metropolitan areas. A second round of bidding in 2011 will add 70 more metropolitan areas to the program. The Medicare Modernization Act (MMA) of 2003 authorized the DMEPOS Competitive Bidding program, and the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 postponed its implementation to late 2009 and 2010

Drugs and Biologicals

Medicare covers drugs that are given incident to a physician's services as long as the drugs are not usually self-administered by the patients who take them. Part B covered drugs and biologicals include:

- Erythropoetin for kidney failure
- Epoietin Alfa (Epoegen or Procrit) for severe anemia
- Blood clotting factors
- Immunosuppressive drugs, like cyclosporine, for transplant patients
- Certain oral medications for cancer patients, including anti-nausea drugs
- Osteoporosis medications for homebound patients
- Whole blood (except for the first three pints)

Medicare Part B uses the "self-administered drug rule" to determine medical necessity. Medicare looks at the usual method for taking a drug to decide if it is usually "self-administered." If the usual method for taking a drug is orally by tablet or capsule, or by self-administered injection, like insulin, Medicare Part B does not pay. Coverage for these drugs often is available through a Medicare Part D drug plan.

When Medicare Part D drug coverage took effect in 2006, Medicare coverage for the drugs and biologicals listed above continued under Medicare Part B for those who meet the Part B coverage rules. Two advantages for beneficiaries who receive coverage for drugs under Part B is that there is no coverage gap and the coinsurance is 20 percent of Medicare's approved amount.

SHIP TIP A patient's unique condition may sometimes require a physician to administer a drug that is normally self-administered. One example is vitamin injections for people with severe anemia. Without additional documentation, Medicare will deny coverage for a service that could be medically necessary.

Supplemental insurance policies normally cover the coinsurance cost, leaving the patient with no out-of-pocket costs. Note that out-of-pocket costs connected with the Part B drug coverage do not count toward as True Out-of-Pocket (TrOOP) costs in the Part D drug program.

Ambulance Services

Medicare pays for ambulance services when the ambulance provider and the patient's situation meet certain conditions of coverage. The ambulance service provider must be Medicare-certified, meaning that the equipment and personnel comply with federal standards. Medicare then considers such factors as the severity of the beneficiary's condition and the distance to the nearest emergency facilities. Generally, Medicare only covers ambulance services in a locality (with some exceptions) to/from a hospital, skilled nursing facility (SNF), some other treatment facilities (e.g., dialysis centers), and the beneficiary's home.

Medicare covers ambulance services when, given the patient's condition, other transportation modes are "contraindicated," meaning that the other transportation could endanger the person's health. If a patient could use some other means of transportation without danger (even if that transport is not available), Medicare rules say that the ambulance trip is not medically necessary and cannot be covered.

EXAMPLE *A beneficiary who fractures his collarbone in a fall may be able to travel safely to an emergency room in a car. But if he has other conditions or injuries that complicate the situation and endanger his health, Medicare may pay for an ambulance trip. Physician and ambulance service provider documentation is essential to Medicare payment.*

Medicare pays for ambulance trips to the "nearest appropriate facility," i.e., the nearest institution (for example, hospital or skilled nursing facility) that is generally equipped to provide the care for the illness or injury involved. It makes no difference if a patient's attending physician has staff privileges at the nearest hospital. If an institution has no bed available, however, it is not an appropriate facility and Medicare will pay for the trip to a more distant facility with an open bed. If an ambulance takes a patient to a facility beyond the nearest appropriate facility, Medicare limits its payment to the cost of transport to the nearer facility.

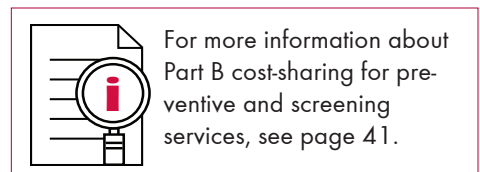
EXAMPLE *It may be more appropriate to transport a patient who is severely burned to a more distant hospital with a burn unit than to the nearest hospital with an emergency room.*

Medicare has special rules for non-emergency ambulance transportation. It only pays for non-emergency transport when the patient cannot get up from bed without assistance, or cannot walk or sit up in a chair or wheelchair. If the patient meets this condition, Medicare may pay for ambulance transport from a facility to the person's home.

Medicare also covers air ambulance services when ground transport is not medically appropriate. This occurs when the time or instability involved in transporting a patient by ground ambulance threatens her survival or seriously endangers her health. Some examples of these serious situations are intracranial bleeding that requires immediate neurosurgery, multiple serious injuries, and treatment in a hyperbaric oxygen unit. The nearest appropriate facility rule applies to claims for air ambulance payment.

Preventive and Screening Services

Medicare Part B covers a growing array screening and prevention services. Medicare began covering common screening procedures in 1991 after Congress added screening mammograms and other screening services to Medicare's covered benefits. In several cases, Medicare waives the Part B annual deductible, the 20 percent coinsurance charge, or both for these services.



Currently, Medicare's covered screening services are:

- One-time "Welcome to Medicare" physical exam for new Medicare beneficiaries (if received in the first 12 months of Medicare coverage, effective 1/1/2009)
- Cardiovascular screening for high-risk persons
- Annual screening mammograms for women over 40
- Cervical cancer screening (Pap smear screening and pelvic exams every two years; more often for high-risk women)
- Prostate cancer screening
- Colorectal cancer screening
- Diabetes screening tests (two per year)
- Glaucoma screening for persons at high risk (once every 12 months)
- Bone mass measure screening for high-risk persons
- Abdominal Aortic Aneurysm (AAA) screening for those at high risk

Medicare's covered preventive services include:

- Annual flu shots (paid at 100 percent of Medicare's approved amount)
- Pneumonia vaccine
- Hepatitis B vaccine
- Diabetes testing devices and supplies
- Diabetes self-management training
- Smoking cessation counseling
- Medical nutrition therapy for people with diabetes or kidney disease

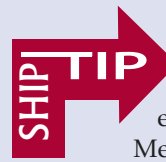
Mental Health Services

Covered mental health services include counseling and therapy services from doctors, clinical psychologists, and clinical social workers. Medicare currently limits its payments for outpatient mental health services to 50 percent of Medicare's approved amount. Starting on January 1, 2009, the coinsurance charge will decrease over six years from 50 percent to 20 percent to bring payment parity between Medicare coverage for medical and mental health services.

Other Covered Services

The list of other Part B covered services includes, but is not limited to:

- Physical, speech, and occupational therapy
- Laboratory, x-ray, and other diagnostic procedures
- X-ray, radium, and isotope therapy
- Devices for the reduction of fractures
- Comprehensive Outpatient Rehabilitation Facility (CORF) services
- Ambulatory surgical center services
- Rural health clinic outpatient mental health services
- Home health care
- Nutritional therapy for persons with diabetes or renal disease



One of the most important services you can provide to your clients is to tell them about Medicare's many covered services. Often people are unaware of Medicare's preventive and screening services. Medicare offers several free booklets and brief fact sheets that describe its covered services. Have a supply on hand to give or mail to your clients, or go to <http://www.medicare.gov> and click on "Find a Publication."

For more information on covered and non-covered services, see CMS's *Medicare Benefits Policy Manual* (Pub. 100-02) and the *Medicare National Coverage Determinations Manual* (Pub. 100-03) at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

EXCLUDED SERVICES AND ITEMS

Medicare excludes some services and items from its Part B benefits. These include:

- Acupuncture
- Routine physical examinations (except a one-time exam for new Medicare beneficiaries)
- Immunizations (except for flu, pneumonia, and hepatitis B vaccines)
- Routine eye exams
- Most dental care, such as cleaning, fillings, extractions, and dentures
- Routine foot care, except for those with systemic conditions like diabetes or neuropathy
- Cosmetic surgery
- Home maker services
- Meals on Wheels
- Private duty nursing
- Services that are not reasonable and necessary

PART B COSTS AND CLAIMS

Beneficiary Costs

Along with the monthly premium (\$96.40 in 2010 for most beneficiaries), Part B beneficiary cost-sharing charges generally are the:

- Annual deductible; the first \$155 (in 2010) in Medicare approved charges. The deductible will rise each year to adjust for inflation in Medicare spending.
- 20 percent coinsurance charge; 20 percent of Medicare’s approved amount
- Excess charge or balance bill
 - Physicians who do not “accept assignment” can bill for no more than 115 percent of Medicare’s approved amount. This is called the Limiting Charge.
 - The Limiting Charge does not apply to all Part B providers. DME suppliers who do not accept assignment, for example, can bill the patient for the entire difference between the approved amount and the actual charge for an item.

Starting in 2007, the law requires Medicare beneficiaries who have relatively high incomes to pay the monthly Part B premium (\$96.40 in 2010) along with an income-related adjustment to the premium. The income adjustment applies to beneficiaries who file individual tax returns and have modified adjusted gross annual income above \$85,000 (for 2010), and to beneficiaries who file a joint tax return with annual income above \$170,000 (for 2010). The monthly premium adjustment amounts reach up to \$257.20 for individuals with annual income greater than \$214,000 (for 2010). For more details, see HAP’s Medicare Premiums and Cost-Sharing chart at <http://www.hapnetwork.org/assets/pdfs/2010-aep-toolkit/medicare-costs.pdf>.

Medicare Part B Payments

After the beneficiary meets the annual Part B deductible, Medicare Part B typically pays 80 percent of the approved amount for physician, DME, ambulance and other covered services, and the beneficiary owes 20 percent of the approved amount (the Part B coinsurance charge). But there are some exceptions to the usual 20 percent coinsurance charge.

Medicare bases its payment for physicians and many other providers on national “fee schedules” that CMS adjusts for differences in costs among the nation’s geographic areas. CMS also adjusts its fee schedule payments to address cost increases.

Exceptions to Part B Cost-Sharing Norms

Outpatient hospital coinsurance charges and beneficiary costs for preventive and screening services often depart from the usual Part B cost-sharing rules. As Medicare phases in its Outpatient Prospective Payment System (OPPS), patient coinsurance charges often exceed 20 percent of Medicare’s approved charge. The law caps these coinsurance charges at 55 percent of Medicare’s approved amount and at \$1,100 annually (in 2010).

Medicare's incentive for beneficiaries to get some preventive and screening services is to waive the Part B deductible and/or the 20 percent coinsurance charge. Part B pays for:

- Flu and pneumonia shots at 100 percent of the approved amount; the 20 percent coinsurance does not apply.
- Fecal occult blood tests at 100 percent of the approved amount; the 20 percent coinsurance does not apply.
- Pap smears and lab tests at 100 percent of the approved amount; and for the Pap smear collection and pelvic and breast exams, Medicare pays 80 percent, but with no annual deductible.
- Screening mammograms at 80 percent with no annual deductible.
- "Welcome to Medicare" physical exam with no annual deductible (eff. 1/1/2009).
- Cardiovascular screening at 100 percent of the approved amount; the 20 percent coinsurance does not apply.
- Colonoscopy and sigmoidoscopy with no annual deductible.
- Prostate Specific Antigen (PSA) test at 100 percent of the approved amount; the 20 percent coinsurance does not apply.
- Diabetes screening tests at 100 percent of the approved amount; the 20 percent coinsurance does not apply.
- Abdominal aortic aneurysm screening at 80 percent of the approved amount but with no annual deductible.

Part B Billing and Claims

Most Part B providers, including physicians, must submit claims for services and items directly to the Carrier or A/B Medicare Administrative Contractor (A/B MAC).

Medical equipment, prosthetics, and supply providers send their claims to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC). Afterwards, the payment contractors send a Part B *Medicare Summary Notice* (see Appendix E) to the patient (normally every three months) that explains its coverage decision(s) and the patient's share of the costs. Keep in mind that providers have at least 15 months and as many as 27 months to submit



Your clients can find information about their claims and order copies of MSNs at <http://www.MyMedicare.gov>. This web-tool also allows beneficiaries to access online forms and information about their use of Medicare's preventive and screening services. Your clients will need their Medicare numbers available to register for MyMedicare.gov.

claims in Original Medicare.

Assignment

Providers who accept assignment agree to accept Medicare's approved amount as payment in full. The term itself means that a patient assigns her claim on Medicare's payment over to the provider. When that happens, Medicare pays the provider directly. Providers can only bill the patient for the annual deductible and the coinsurance charge. While physicians have the option to accept assignment, many agree to accept assignment in all cases. They are called "Medicare Participating Physicians." In recent years, physicians nationwide have accepted assignment on nearly 99 percent of their claims.

When providers do not accept assignment, they can bill the patient for more than the Medicare approved amount and ask for full payment at the time they give the service. Medicare then pays the patient, not the provider. Thus, the patient must take steps to pay the provider if she did not pay up front for the service.

EXAMPLE *Wayne's doctor billed \$1,500 for a procedure, and did not accept assignment. The doctor submitted the bill to Medicare. According to the fee schedule, Medicare approved \$1,000 and paid \$800, or 80 percent of the approved amount. What does Wayne owe? Assuming he has met the annual deductible, Wayne owes a coinsurance charge of \$200, or 20 percent of the approved amount. Because his doctor did not accept assignment, Wayne also owes an additional \$150. This is 15 percent of the approved amount. It is the most the doctor can charge under Medicare's "Limiting Charge" rule.*

Medicare requires some Part B providers to accept assignment in all cases. The mandatory assignment rule applies to:

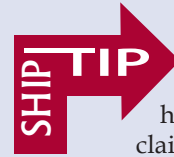
- Ambulance suppliers
- Outpatient hospital facilities
- Ambulatory Surgical Centers
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Outpatient physical, occupational, and speech therapy providers
- Clinical laboratories



Your clients will save money by using physicians and other Part B providers who accept assignment. Medicare lists participating physicians and equipment suppliers who always accept assignment on its website. Go to <http://www.medicare.gov> and click on "Find a Doctor or Other Health Care Professional," or "Find Suppliers of Medical Equipment in Your Area."

Providers who do not accept assignment for everyone may accept assignment on a case-by-case basis. It's a good idea to ask the provider if she or he will accept assignment, and under what conditions.

Since 1990 the law requires most Part B providers to submit claims on behalf of Medicare beneficiaries for both assigned and unassigned claims. Since October 2003, Medicare in most cases also requires doctors, suppliers, and other providers to submit claims electronically to the Carriers and MACs.



Because nearly all providers submit claims to Medicare, it is unlikely that you will ever help a client complete a Medicare claim form officially called the Beneficiary Request for Medicare Payment Form 1490S. But, it may come up in connection with covered care in Canada and Mexico, or when a provider refuses in rare cases to submit a claim to Medicare.

Beneficiary Financial Liability Protections: Waiver of Liability

When Medicare denies payment for services because they are not reasonable and necessary in an individual case, under certain conditions the patient is not liable for the bill. Under this “waiver of liability” rule, the provider cannot collect payment from the patient. The rule does not apply to services that Medicare excludes from coverage (for example, cosmetic surgery and personal comfort items), or to services that Medicare denies for technical reasons as when a claim does not meet all of the coverage requirements.

When does waiver of liability apply? It applies when the beneficiary did not know or could not be expected to know, that Medicare would deny coverage for the services because they are:

- Not reasonable and necessary
- Custodial
- Not intermittent skilled nursing care (for home health)
- Given to a non-homebound person (for home health)

When Medicare waives liability for a patient on a denied claim, the provider is liable for the bill unless he or she could not be expected to know that Medicare would deny coverage. Thus, providers have an incentive to notify patients in writing when there is any doubt that Medicare will cover a service or item. These notices are called *Notices of Medicare Provider Non-Coverage* and *Advance Beneficiary Notices* (ABNs) (see Appendices D and F). Note that if both patient and provider did not know that Medicare might deny payment, Medicare pays the provider for the service. (See the *Medicare Claims Processing Manual* (CMS Pub. 100-04), Chapter 30.)

Without a written notice, Medicare assumes that a beneficiary could not know about the chance of a claim denial, and it waives the beneficiary’s liability to pay the claim. But if a physician or other health care provider gave an ABN that properly explains why Medicare might deny coverage, Medicare assumes that the beneficiary has notice about the chance of a denial. The provider then is free to bill the beneficiary for the unpaid bill.

An *Advance Beneficiary Notice (ABN)* is a standard CMS form that, when a provider completes it properly, gives written notice to a patient that Medicare may not pay for a service or item. Medicare recently revised its ABN for use by physicians, suppliers, and other providers (see Appendix F). After March 1, 2009, the two ABN forms for general use (ABN-G) and laboratories (ABN-L) are no longer valid. Medicare guidelines instruct providers to use ABNs only when there is a legitimate doubt about the medical necessity of a service or item. Providers should not give them to everyone. Here are some key points about ABNs:

- Medicare considers a patient who receives a properly completed ABN to know that the service or item would not be covered if Medicare later denies payment on the claim.
- The practical effect of an ABN is to shift financial liability for a denied claim from the provider to the patient.
- After issuing an ABN, the provider must submit the bill to Medicare for an official coverage decision if the patient decides to receive the services or items and asks the provider to bill Medicare.



A patient generally is not liable for the charges on a denied claim if a provider does not give her proper written notice.

This means that providers must clearly describe the services or items in question and explain why they think the services are not reasonable and necessary in light of Medicare coverage rules. If a provider gives a blank ABN to your client and bills her for non-covered services, appeal the denial and send a copy of the improperly completed form along with the appeal request.

How do you find out if Medicare waived your client's liability for non-covered services? Look at the MSN. If Medicare's approved amount is \$0.00, a separate note will say, "It appears that you did not know that Medicare would not pay for this service, so Medicare does not hold you liable."

Laboratories may give ABNs to patients because Medicare often denies payment for tests when the diagnosis does not fit the procedure. The problem arises because physicians order tests when they are not yet sure of the patient's diagnosis, or when they want to rule out a condition. When your clients face coverage denials for lab tests, they can either ask the lab to resubmit the claim with additional information from the physician, or appeal the denial.

EXAMPLE *It is not appropriate for a laboratory to give an ABN to a patient who has a condition that clearly makes a lab test medically necessary. For example, a test for warfarin (Coumadin) levels in a patient's blood typically would be reasonable and necessary for someone who has a mitral heart valve replacement.*

Note:

If you find that a provider has a pattern of inappropriately issuing ABNs, report the problem to your Medicare Regional Office.

What happens if your client paid the provider before she realizes that Medicare waived her liability? Medicare will reimburse your client if she sends copies of the MSN, the provider's bill, and a receipt as proof of payment to the Carrier or A/B MAC. Medicare then settles accounts with the provider.

Ambulance Transportation and ABNs

CMS does not expect ambulance providers to issue Advance Beneficiary Notices (ABNs) to beneficiaries in some cases where Medicare is likely to deny payment. There are two main reasons for this. The first is that Medicare does not want providers to ask beneficiaries to sign ABNs when they are in an emergency situation or under great duress, that is, where someone would feel forced to sign the form. Medicare's concern is that a beneficiary will not be able to make an informed decision under such conditions.

The second reason why ambulance providers do not issue ABNs when Medicare is likely to deny payment, in both emergency and non-emergency situations, involves the "technical denial" problem. CMS views any denial where a patient could be transported safely by other means, or for mileage beyond the nearest appropriate facility, as technical denials instead of medical necessity denials. CMS guidance says that the waiver of liability and ABN rules (above) apply only to medical necessity denials where Medicare decides that a covered service is not reasonable and necessary in a particular case. But with technical denials for ambulance services, CMS reasons that the ABN rules do not apply because the law never allows transport to a facility other than the nearest appropriate facility. Thus, providers need not issue an ABN when there is no medical necessity determination to be made because Medicare excludes a service from coverage.


SHIP TIP

The result of CMS's interpretation of the rules for ambulance claims is that providers are free to collect on hefty bills for denied ambulance claims from beneficiaries who may be completely surprised by them. If you are helping clients with ambulance coverage denials, work with them and their physicians to appeal.

Private Contracts

The law allows Medicare beneficiaries and physicians to enter private written contracts in which the physician agrees to provide services and the beneficiary agrees to pay whatever the physician charges.

Providers who enter private contracts cannot receive Medicare payments for two years. Neither the provider nor the beneficiary can submit the claim to Medicare or to a Medicare supplement (Medigap) insurance plan, meaning that the beneficiary pays the entire bill out-of-pocket. Physicians, however, cannot require beneficiaries to enter a private contract in emergency situations. Because physicians who enter private contracts must forgo Medicare payments for all Medicare patients for two years, private contracts are rare.

WHERE TO LEARN MORE

Many information resources are available at <http://www.medicare.gov> on Medicare's Part B benefits through the "Find a Medicare Publication" link. They include:

- *Medicare Coverage of Ambulance Services*, a booklet that gives information on coverage, payments, and rights.
- *Medicare Coverage of Diabetes Supplies and Services*, a booklet that explains the supplies and services that Medicare helps pay for.
- *Medicare Coverage of Durable Medical Equipment and Other Devices*, a booklet that explains what DME is and which equipment is covered.
- *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*, a booklet with information about Medicare coverage for those with End-Stage Renal Disease (ESRD).
- *Your Medicare Benefits*, a CMS guide to Part A and Part B benefits.
- *Women with Medicare - Visiting Your Doctor for a Pap Test, Pelvic Exam and Clinical Breast Exam*, a CMS booklet that describes what is covered and what Medicare pays.
- *Pap Tests for Older Women*, a CMS fact sheet on the Medicare benefit for Pap test screening for cervical cancer.
- *Prostate Cancer Screening: A Decision Guide for Men with Medicare*, a CMS guide to Medicare coverage for prostate cancer screening and treatment.
- *Colorectal Cancer (CRC) Basic Facts on Screening*, a CMS fact sheet that explains Medicare coverage for the screening and types of tests that Medicare covers.

To learn more about Medicare Part B payment issues, see these CMS resources at <http://www.medicare.gov>:

- *Medicare Coverage Outside of the U.S.*, a pamphlet that explains Medicare's limited coverage for those who live near the Canadian and Mexican borders and those who have emergencies near the borders.
- *How to Read Your Medicare Summary Notice*, a booklet with examples and detailed instructions on how to decipher the MSN.
- *Getting a Second Opinion Before Surgery*, a guide to coverage for second opinions.
- *Quick Facts About Paying for Outpatient Services for People with Medicare Part B*, a fact sheet on how Medicare pays for outpatient services.

The Health Assistance Partnership's Original Medicare website, available at <http://www.hapnetwork.org>, has these resources:

- Guides to finding and appealing Medicare's National and Local Coverage Determinations
- *Accessing the Care in Medicare*, a booklet that uses case studies to explain Original Medicare's benefits and coverage rules.