Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 1966

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents, Chapter 9	9-1 (1p.)	9-1 (1p.)
9051 – 9051 (Cont.)	9-53 – 9-54 (2 pp.)	9-53 – 9-54 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2002*
IMPLEMENTATION DATE: July 1, 2002

Section 9051, Beneficiaries Previously Enrolled In a Medicare HMO/Managed Care Program Who Transition To Traditional Fee for Service (FFS), is being updated to clarify requirements for oxygen patients who return to fee for service after disenrolling from an HMO.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER IX

CARRIER RELATIONSHIPS

Section

GPPPs

Health Maintenance Organizations

Rural Health Clinics

Comprehensive Outpatient Rehabilitation Facilities

C. Other Covered Services.--Other covered services are services which are determined by the Secretary not to have been made reasonably available by the HMO to its Medicare enrollees.

9050.2 Carrier Involvement With Reimbursement For HMO Services.--Part B services for HMO members who are Medicare beneficiaries are reimbursed either through the HMO itself or through the carrier. The HMO may select from a number of options the one method by which its bills will be handled. The jurisdiction of Part B bills is indicated in the R-trailer of the query reply.

The HMO options which will be shown in the R-trailer are:

A. For Restricted Beneficiaries.--Code A, B, or C - The HMO has jurisdiction over all Part B physician/supplier bills except bills from physicians for dialysis and related services provided through an approved dialysis facility which are the jurisdiction of the carrier. Carriers will transfer to the HMO all claims for Part B services for which the HMO has jurisdiction.

B. For Unrestricted Beneficiaries.--Code l or 2 - The HMO has jurisdiction over all bills for in-plan services (see §9050D) except:

l. All claims involving out-patient psychiatric services;

2. All claims for services by an independent physical therapist; and

3. All claims from physicians for dialysis and related services provided through an approved dialysis facility.

Carriers will process all claims for Part B services for unrestricted beneficiaries as though they were claims for out-of-plan services. (See §9050C.)

NOTE: For out-patient blood claims, the HMO will file claims with the carrier until the EOMB indicates the 3 pint deductible is met.

Carrier actions in relation to query responses and receipt of Part B bills are described in §§4267ff.

When the HMO has jurisdiction of its bills, SSA makes the interim capitation payments to the HMO and the periodic accounting and end-of-year adjustments.

When the carrier has jurisdiction for services to HMO members, the carrier processes the bills in the same manner as for non-HMO beneficiaries.

9051. BENEFICIARIES PREVIOUSLY ENROLLED IN A MEDICARE HMO/MANAGED CARE PROGRAM WHO TRANSITION TO TRADITIONAL FEE FOR SERVICE (FFS)

When a beneficiary who was previously enrolled in a Medicare HMO/managed care program transitions to traditional FFS, he or she is subject to all benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS. When a beneficiary transitions to FFS, it is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may only continue to receive such items and services if they would be entitled to them under Medicare FFS coverage criteria and documentation requirements.

For example, if a beneficiary received a manual wheelchair under their HMO/managed care plan, he or she would need to meet Medicare coverage criteria and documentation requirements for manual wheelchairs. He or she would have to obtain a Certificate of Medical Necessity (CMN), and would begin an entirely new rental period, just as a beneficiary enrolled in FFS would to obtain a manual wheelchair for the first time.

There is an exception to this rule if a beneficiary was previously enrolled in FFS and received a capped rental item, then enrolled in an HMO, stayed with the HMO for 60 or fewer days, then returned to FFS. For instructions on how to deal with this situation, refer to §5102.1(E)(3). For purposes of this instruction, CMS has interpreted an end to medical necessity to include enrollment in an HMO for 60 or more days.

Another partial exception to this rule involves home oxygen claims. If a beneficiary has been receiving oxygen while under a Medicare HMO, the supplier must obtain an initial CMN and submit it to the DMERC at the time that FFS coverage begins. However, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the Initial Certification date on the CMN, but the test must be the most recent study the patient obtained while in the HMO, under the guidelines specified in DMERC policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare HMO, it does not necessarily follow that he/she will qualify for oxygen under FFS.

The standard systems must make any changes necessary to accommodate the exception for oxygen patients, including any edits the systems perform on oxygen CMNs. DMERCs need not edit for dates of service prior to July 1, 2002, when implementing this initiative. Rather, when the standard systems implement changes on July 1, 2002, the DMERCs may apply this policy to all beneficiaries transitioning to FFS from a Medicare HMO, regardless of the date of service on the claim.

These instructions apply whether a beneficiary voluntarily returns to FFS, or if he or she involuntarily returns to FFS because their HMO or managed care plan no longer participates in the Medicare+Choice program.