SHIBA

Senior Health Insurance Benefits Assistance

Section 2

Introduction to Medicare Part B

SHIBA Volunteer Training Program, July 2008

Section 2, Medicare Part B

Part B Costs, 2008

Premium

Part B (Medical Insurance) Monthly Premium		
If your yearly income is		**You pay**
File individual tax return	**File joint tax return**	
$82,000 or below	$164,000 or below	$96.40
$82,001-$102,000	$164,001-$204,000	$122.20
$102,001-$153,000	$204,001-$306,000	$160.90
$153,001-$205,000	$306,001-$410,000	$199.70
Above $205,000	Above $410,000	$238.40

Late enrollment penalty: Unless the beneficiary meets an exception, he or she plays an additional 10 percent on the monthly premium for each year that enrollment is delayed past the year of the 65th birthday. The penalty is paid as long as the person has Part B; in other words, someone may pay the penalty for life.

Example:
In 2004, Mr. Cheap was eligible for Part B but did not enroll because he thought it was too expensive. In 2008, 4 years past the year of his 65th birthday, he needs the coverage and decides to enroll during the General Enrollment Period. The 2008 premium is $96.40 per month, so his penalty will be 10% of $96.40 ($9.64) x 4 years ($38.56) for a total premium of $134.96. ***Premium amounts are adjusted annually. Mr. Cheap's premium will always be 40% higher than each year's new, adjusted premium.***

The Part B penalty is waived if:

1. The beneficiary is on Medicare because of a disability and paying a penalty for late enrollment, then becomes Medicare-eligible (for the second time) due to age 65. This creates a new open enrollment period and a chance to lose the penalty.
2. The beneficiary enrolls under a ***Special Enrollment Period.***

Limited income: If you have limited income and resources, your state may help you pay for Part B. For more information, contact your local office of Seniors and People with Disabilities for an application. This office is part of Oregon's Department of Human Services (DHS). Call DHS at: 800-282-8096.

Or, go to: www.oregon.gov/dhs/spwpid/offices.shtml.

Part B Cost Sharing	
Benefit	**Medicare patient pays**
Deductible	$135 yearly
Medical Services	20% of the Medicare-approved amount for most doctor services, most preventive services and durable medical equipment.

Example of Part B deductible:
Mrs. Jones' first medical expenses of the year arose from visits in January to two doctors. Dr. A charged $90 and Dr. B charged $65. Medicare approved $70 for Dr. A and $65 for Dr. B. Mrs. Jones is responsible for paying both bills, and meets her $135 deductible ($70 + $65) by doing so. This is the only deductible she pays for the entire year.

Outpatient physical therapy and speech pathology limits

Medicare limits how much it pays for outpatient therapy services per year. This is called an annual financial limitation, or cap. The Medicare benefit for outpatient physical therapy and speech-language pathology services (combined) is limited to $1,810 per year in 2008. There is a separate yearly benefit limit of $1,810 for outpatient occupational therapy.

Introduction to Medicare Part B

Learning objectives

Upon completion of this section, the SHIBA volunteer trainee will understand

- Medicare Part B eligibility, benefits, out-of-pocket costs, claims procedures, and Part B's relationship to Medicare Part A.
- how to be an advocate for beneficiaries within the Medicare Part B system.

What is Medicare Part B?

Medicare Part B pays for many medical services and supplies, but the most important coverage is for doctor's bills. Medically necessary services of a doctor are covered at home, in the doctor's office, in a clinic, in a Skilled Nursing Facility or in a hospital. Part B covers the following major services:

- Inpatient and outpatient services received from physicians
- Additional medical services such as outpatient and emergency hospital care
- Therapy services
- Ambulance transportation
- Equipment and supplies
- Home Health Care

Medicare Part B is overseen by two government agencies.

1. The Social Security Administration (SSA) determines eligibility.
2. Centers for Medicare & Medicaid Services (CMS) set operating regulations.

CMS contracts with a private insurance company to administer the Part B program in each state. The company, called the **carrier**, processes claims, applies CMS's regulations in approving or rejecting claims, and conducts appeals.

Important numbers for Oregon Part B beneficiaries:

- Medicare – 1-800-633-4227
- Centers for Medicare & Medicaid Services Regional Office – 206-615-2306
- Social Security Administration – 1-800-772-1213
- Railroad Retirement Board – 503-326-2143
- Palmetto (Railroad Part B Carrier) – 1-800-833-4455

Medicare Part B is funded primarily through monthly premiums paid by enrollees and through general tax revenues. By law, premiums must cover 25% of the Part B program costs. Thus, premiums rise as program costs rise.

Eligibility

Part B eligibility requirements are generally the same as those for Part A (see *Section 1, pages 5-6)*. Just like Medicare Part A, the SSA and the RRB determine eligibility for Part B**. Unlike Medicare Part A, however, Medicare Part B is not dependent on hours of employment.** For example, a person who has not worked, or who doesn't have a spouse's employment, may purchase Medicare Part B at the age of 65 *without having to pay more* than other beneficiaries.

Residency requirements

The United States is defined as the 50 states, the District of Columbia, the Commonwealth of Puerto Rico, Northern Mariana Islands, the Virgin Islands of the U.S., and Guam and American Samoa including Swain's Island. Individuals who establish residency in the U.S. with intent to continue living within the U.S. and have a 5-year period of residency may be entitled to Medicare. An absence of less than 6 months does not end residency. A non-citizen may be eligible to buy into the Medicare system. For specific situations, call the Social Security Administration, 1-800-772-1213.

Example: Mr. Newcomer is 65 years old, has been living in Oregon for two years. He has never worked in the U.S. and is not a citizen. He will be eligible for Medicare in three more years. **(Penalties start with *eligibility*, not with *age*.)**

Enrollment

Part B enrollment processes are the same as for Part A. Beneficiaries will receive a Medicare card by mail upon automatic enrollment status. If they do not want Part B medical insurance, they complete the card and return it to the Social Security office. If the card is not returned, the beneficiary is automatically enrolled in both Parts A and B. Those individuals who do not qualify for automatic enrollment must enroll with the SSA.

The Part B penalty is waived in two circumstances:

1. If the beneficiary is on Medicare by reason of disability, and is subject to a late-enrollment penalty, the penalty will drop off when the beneficiary becomes eligible due to age 65 and has a new open enrollment period.

2. The penalty is waived when the beneficiary enrolls under a ***Special Enrollment Period***.

Special enrollment period

Those who are eligible for Medicare and covered under an Employer Group Health Plan (EGHP) for two employees or more can enroll in Part B during a special eight-month enrollment period as follows:

- starting with the month the worker or working spouse is no longer working

or

- starting with the month the worker or working spouse is no longer covered by the EGHP

whichever occurs first.

If the beneficiary does not enroll in Part B when first eligible, the EGHP may pay **as if** she or he were enrolled, thus reducing the amount the EGHP would pay and creating a financial responsibility on the beneficiary. Medicare *would have been* primary with an 80% responsibility, the EGHP secondary and responsible for 20%. By not enrolling in Part B, the EGHP **may** pay their 20% and leave the 80% to the beneficiary. Contact the EGHP for specific information.

> **Note:** COBRA is NOT an Employer Group Health Plan for SEP eligibility. If a worker waits until the 18-month COBRA benefit is over to enroll in Part B, there is no SEP and the beneficiary may pay a late-enrollment penalty.

Beneficiary Costs

Premium

- For enrolled persons who receive Social Security payments, the Part B premium is automatically withheld from their checks.
- Federal retirees will have the premium withheld from monthly benefits when paying from annuity. If paying directly, premiums will be paid quarterly.
- Enrolled persons not receiving Social Security payments are billed every three months.

Deductible

Beneficiaries are responsible for the Part B deductible. This is an amount they pay every year before Medicare contributes to covered medical costs. After beneficiaries pay the Part B deductible Medicare pays its 80 percent share and beneficiaries pay 20 percent of the costs.

Expenses are allocated to the deductible in the order in which the bills were received. The Part B deductible increases each year by the estimated annual percentage increase in Part B expenditures.

- Non-covered expenses and any amount the beneficiary pays in excess of the approved charge cannot be counted toward the deductible.
- The beneficiary cannot apply expenses from an earlier year to the deductible for a later year.
- The costs of a combination of different services may be applied toward the deductible.

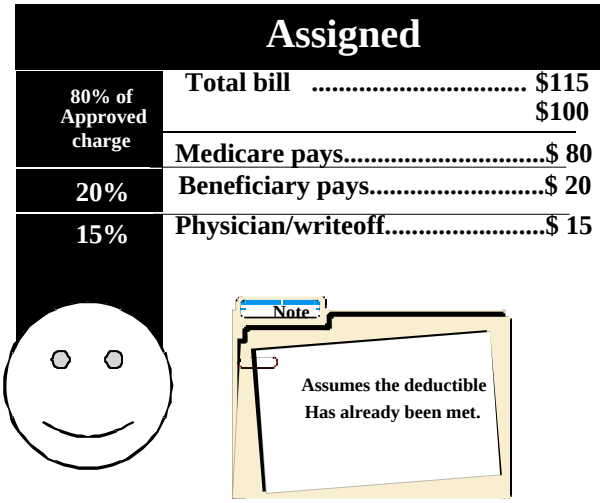
Coinsurance payment

After the deductible is met, the beneficiary is responsible for 20% of the Part B approved charge. Part B pays 80% of charges approved for coverage by Medicare.

What Doctors Can Charge

Assigned claims

Accepting assignment means that the provider accepts Medicare's approved charge as the total charge. This means the provider receives no payment for the excess over the approved charge. Under "assignment" Medicare pays 80% of the approved charge and the beneficiary pays the 20% coinsurance. The beneficiary is not responsible for any charges over that amount (excess charges).



Important: Providers choose whether or not to accept assignment. A provider may accept assignment in one case, but not do so in a similar case. *Beneficiaries should ask the provider about accepting assignment before receiving services.*

Exception: Ambulance providers are required to accept assignment. (See page 25.)

Assigned claims processing

The provider must file the claim to the Medicare carrier. The carrier sends a Medicare Summary Notice (MSN) form to the beneficiary detailing the charges of the assigned claim. The carrier pays the provider 80% of the approved charges, and then **may** send the remaining balance directly to the supplementary (Medigap) insurer. A beneficiary handles no checks from Medicare on an assigned claim. An MSN typically includes:

- total charges.
- a listing of covered and non-covered services.
- the approved charge for each covered service.
- the amount of the annual deductible paid or owed.
- the 80% of the approved charge Medicare pays and the 20% balance the beneficiary is responsible for.
- the portion of the total amount that the beneficiary owes.

Non-assigned claims

If a physician or other provider does not agree to accept Medicare's approved charge as the total charge, it is called a "non-assigned claim." In this case, the beneficiary may be responsible for an additional charge above and beyond the 20% coinsurance payment.

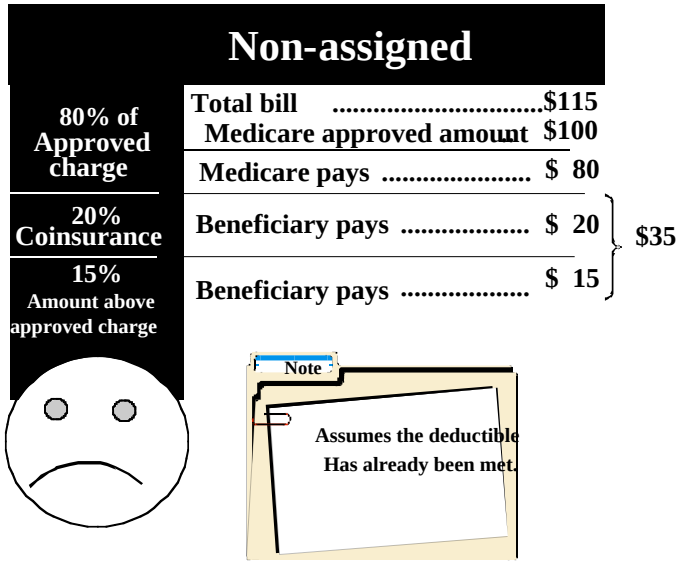
Note: Under federal law, providers cannot charge more than 15% over Medicare's approved amount. This limitation* applies to physician services, services and supplies in the physician's office, outpatient physical therapy, outpatient occupational therapy, diagnostic tests, and radiation therapy services including mammograms.

Durable medical equipment (DME) is **not subject to this limitation.*

Non-assigned claims processing

- Providers are required by law to submit claims to the carrier.
- The carrier sends a check to beneficiary for 80% of the approved charge.
- The carrier sends a Medicare Summary Notice (MSN) form to beneficiary, detailing the various charges. The MSN includes:
  - a listing of covered and non-covered services.
  - the amount of the annual deductible already paid or still owed.
  - the approved charge for each covered service.
  - the amount Part B pays at 80% of approved charge.
  - the amount beneficiary pays at 20% of approved charge.
  - the amount of charges exceeding the approved charge.
  - the portion of the total amount the beneficiary owes.
  - instructions for filing appeals to the carrier.

A nonparticipating provider must give the beneficiary an estimate before performing elective surgery costing more than $500. If the physician does not provide this information in writing before the procedure, he or she cannot charge for any amount above the Medicare-approved charge.



Private contracts

As provided in the Balanced Budget Act of 1997, a *private contract* is a contract between a Medicare beneficiary and a physician or other practitioner who has *opted out* of Medicare for two years for all covered items and services he or she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

In order for a private contract to be valid, a number of different requirements must be met. The private contract must

- be in writing.
- be signed by both the doctor and the beneficiary.
- advise the beneficiary in easy-to-understand language, all of the following:
  - The physician will not submit any Medicare claims for services that would otherwise be covered by Medicare.
  - The beneficiary will be personally responsible for payment for the physician's services.
  - The Medicare limiting charge will not apply to any of the physician's services.
  - Neither Medicare nor any Medicare supplemental insurance will pay for services rendered by the particular physician.
  - The beneficiary has the right to obtain such services from another physician.
  - The physician has been excluded from participating in the Medicare program.

Note: Physicians who may want to have private contracts might be clinical psychologists and psychiatrists, who normally do not treat Medicare beneficiaries.

Beneficiaries who have any doubts about a private contract they have signed should contact the Medicare carrier (through 1-800-Medicare) and ask if the doctor has filed an affidavit to opt out of Medicare. If the doctor has not done so, the beneficiary should report this to both the carrier and to the Medicare fraud and abuse hotline. Complaints of possible fraud, waste, and abuse may be reported to the Inspector General's Hotline in several ways.

- **Toll-free phone:** 1-800-HHS-TIPS (1-800-447-8477),
  8:00 am - 5:30 pm, Eastern Time, Monday-Friday
- **Fax:** 1-800-223-8164 (10 pages or less, please)
- **TTY:** 1-800-377-4950
- **Email:** hhstips@oig.hhs.gov
- **Mail:**

  HHS TIPS Hotline
  P.O. Box 23489
  Washington, DC 20026

(Please do not send any original documents.)

You can also access the OIG Hotline guide for filing a complaint by going to the OIG Website at **www.oig.hhs.gov/hotline.html**.

Medicare as Secondary Payer (MSP)

When Medicare is the secondary payer, there are situations in which the beneficiaries must submit a claim for payment themselves. This is rare, but it does happen. Medicare is the secondary payer to some employer group health plans (EGHPs) for services provided to the following groups of Medicare beneficiaries:

- **The working aged –** people older than 65 who are employed or who have employed spouses who have EGHP coverage with 20 or more employees
- **Younger working people** with permanent kidney failure. Medicare is secondary payer for 30 months for an employee or covered dependents that are covered under an Employer Group Health Plan (EGHP).
- **Certain disabled people –** Medicare is secondary payer for Medicare eligible disabled people who are covered by a large EGHP of over 100 employees and based on the employee's (or family member's) current employment status.

EGHPs cannot impose higher premiums or be more restrictive in benefits than for all plan enrollees.

Employer responsibilities

An employer must do the following:

- Identify employees who are eligible.
- Assure expedient claims payment.
- Not discriminate against eligible people.
- Complete data reports on eligible employees.

Employees have these options:

- Employees can elect to keep the EGHP as primary and take Medicare as secondary.
- Employees can elect to drop the group coverage, take Medicare as the primary insurer, and buy a Medigap. If an employee drops the EGHP, the employer is under no obligation to provide supplemental coverage to Medicare.

Tip: When an individual retires and takes Medicare as primary and the EGHP is continued as a supplement, sometimes there is confusion over which is primary. The beneficiary or a SHIBA volunteer should contact the carrier to clarify that Medicare is primary.

Benefits

Medicare Part B pays only for services determined to be **reasonable and necessary** in the diagnosis and treatment of a specific illness or injury. For example, Part B does not pay for excessive visits to a doctor or for services not generally accepted by the medical community as reasonable and necessary. Quality Improvement Organizations (QIOs) and carriers determine whether care is considered reasonable and necessary.

Coverage for physician services

Part B helps pay for covered services received from qualified providers at any location in the United States.

For Medicare purposes, qualified providers are:

- physicians, i.e., doctors of medicine (M.D.) or osteopaths (D.O.)
- dental surgeons
- chiropractors
- optometrists

- podiatrists
- The term "doctor" does not include Christian Science practitioners, naturopaths or acupuncturists.
- Other qualified, reimbursable health care professionals include clinical psychologists, social workers, physician assistants, certified nurse-midwives, and nurse practitioners.

Major physician services that <u>are</u> covered:

- medical and surgical services including anesthesia and the doctor's nurse
- diagnostic tests and preventive procedures:
  - X-rays (Part B pays 80% of the approved charge.)
  - pap smears and pelvic exams (including a breast exam) every two years or annually for women at high risk for cervical or vaginal cancer
  - routine annual mammography in Medicare-certified facilities
  - annual colorectal cancer screening
  - bone mass measurements for women at risk for osteoporosis
  - diabetes self-management training, including glucose monitor, testing strips
  - prostate cancer screening annually
  - annual glaucoma screenings for people who are at high risk for glaucoma
  - drugs and biologicals administered by professionals
  - certain oral cancer drugs
  - immunosuppressive drugs following an organ transplant covered by Medicare
  - nutrition therapy coinciding with a kidney transplant
  - medical equipment and supplies other than common first-aid needs
  - visit to physician for second opinion about recommended surgery
    - √ The second opinion program encourages Medicare beneficiaries to seek a second opinion about recommended non-emergency surgery. Beneficiaries may ask their physician for the name of another physician.

For additional information, contact:

Acumentra
2020 SW 4th Street, Suite 520
Portland, OR 97201
1-800-633-4227 or (503) 279-0100

Physician services that <u>may</u> be covered

- Clinical laboratory diagnostic services (e.g., blood tests and urinalysis)
  - The provider must accept assignment. Part B pays 100% of approved charge even if the deductible is not met for the year (except in rural health clinic labs where deductibles and coinsurance apply).
  - These Part B payments do not count toward meeting the yearly deductible.
  - Such laboratory diagnostic services must be in approved labs.
- Outpatient treatment of mental illness
  - Part B pays for the treatment of mental, psychoneurotic, or personality disorders for individuals who are outpatients. Medicare pays 50% (rather than 80%) of approved charges, subject to deductible and co-insurance.
  - Partial hospitalization services for treatment of mental illness are not subject to this payment limitation, nor are office visits for the purpose of monitoring or changing drug prescriptions.

Chiropractors' services

- Part B pays for only one kind of treatment furnished by a licensed chiropractor, i.e. manual manipulation of the spine to correct a subluxation (partial dislocation), verified by X-ray.
- Part B does not pay for X-ray services of a chiropractor.

Podiatrists' services

- Part B helps pay for covered services of a licensed podiatrist when medically necessary.
- Covered services may include treatment of mycotic (fungal infected) toenails, ingrown toenails, bunions, and heel spurs.

Physician services NOT covered

- routine physical examinations and tests directly related to such examinations — except the "Welcome to Medicare" exam, preventive screenings, and some examinations provided in Federally Qualified Health Centers

  Be aware of what the "Welcome to Medicare" exam *does* and *doesn't* include!

- routine foot care including hygienic care, treatment for flat feet or other structural misalignments of the feet, and removal of corns, warts (including plantar warts), and calluses (except when related to medical conditions such as diabetes or peripheral vascular disease)
- eye or hearing examinations specifically for prescribing or fitting hearing aids or eyeglasses (except those required by cataract surgery)
- immunizations (unless required because of an injury or immediate risk of infection or for administration of influenza, pneumococcal, or hepatitis-B vaccines)
- cosmetic surgery (unless needed because of accidental injury or to improve the functioning of a malformed part of the body)
- dental care (except for surgery of the jaw or related structures or setting fractures of the jaw or facial bones)
- services connected with treatment specifically for alcoholism or drug dependency
- acupuncture
- services connected with an experimental medical procedure
- Part B generally does not cover self-administered drugs.

Coverage of outpatient services

Outpatient hospital services covered

Part B covers services a beneficiary receives as an outpatient of a participating hospital for diagnosis and treatment of an illness or injury. **If diagnostic testing and treatment is within 72 hours of admission to the hospital, the expenses will be covered by Part A.** Under certain conditions, Part B also helps pay for emergency outpatient care received in a nonparticipating hospital.

- services in an emergency room or outpatient clinic
- laboratory tests billed by the hospital (Medicare will pay 100% of approved charge even if the deductible is not met.)
- X-rays and other radiology services billed by the hospital
- medical supplies, such as splints and casts
- drugs and biologicals that cannot be self-administered
- blood transfusions furnished to the beneficiary as an outpatient (The beneficiary is responsible for the first three pints of blood unless satisfied under Part A.)

Outpatient ambulatory surgical centers and reimbursements

- Part B covers certain specified outpatient surgical procedures performed in a Medicare-certified Ambulatory Surgical Center (ASC), based on the Prospective Payment System (PPS). The center can be hospital-affiliated or independent, but must provide only outpatient surgery services and must have an agreement with Medicare to do so.
- Part B pays 80% of the outpatient surgical center's approved charge for specified procedures. For the surgeon or anesthesiologists, Part B pays 80% of the approved charges for the service(s), and the beneficiary must meet the deductible.
- Beneficiaries can often save money by having outpatient services performed in an ASC where law sets reimbursements. Shop around and ask for price estimates.

Outpatient hospital & community mental health centers

Under the outpatient prospective payment system, hospitals and community mental health centers are paid a set amount of money (called the payment rate) to give some outpatient services to Medicare patients. The payment rate is the total payment that a hospital or community mental health center gets when it provides outpatient services to Medicare patients. The payment rate includes:

- Medicare's payment amount for these services.
- the beneficiary's yearly Medicare Part B deductible (if the beneficiary has not already paid it for the year).
- the beneficiary's coinsurance or fixed co-payment amount (depending on the service).

Outpatient physical therapy and speech pathology services

Medicare Part B pays for Occupational, Physical, and Speech therapy as long as it is medically necessary, but only up to the yearly cap. Before the limits, the beneficiary pays 20% of the Medicare-approved amount after they have met their yearly deductible. After the beneficiary has reached the cap, they will be responsible for 100% of the charge, unless they have other insurance coverage.

<u>There is no cap if the beneficiary goes to a hospital outpatient therapy department.</u> People who occupy a Medicare-certified bed in a skilled nursing facility are limited to the cap amounts and cannot receive additional covered outpatient hospital therapy while in the certified bed.

Therapy services can be received in one of three ways:

- As part of treatment in a physician's office.
- Directly from an independently practicing, Medicare-certified physical therapist in the therapist's office or in the home if a physician prescribes such treatment.

- As an outpatient of a participating hospital or SNF, or from a home health agency, clinic, rehabilitation agency, or public health agency approved by Medicare.

Other covered services

- Independent laboratory services — Part B covers 100% of diagnostic tests that Medicare-certified independent laboratories provide. Some labs are not certified or may perform tests they're not approved to perform, which may leave the beneficiary liable. Labs must accept assignment.
- Portable diagnostic X-ray services. Part B covers these services when services are received at home, a physician has ordered them, and a Medicare-certified supplier provides them.

Comprehensive Outpatient Rehabilitation Facility Services (CORF)

Part B caps payments on services provided by CORFs. Patient must be referred by a physician who certifies a need for skilled rehabilitation services. Covered services are

- physician services,
- physical, speech, occupational, and respiratory therapies,
- counseling, and
- other related services.

Part B will pay 80% of the facility's customary charges for covered services, and the beneficiary is responsible only for the remaining 20%. The charge is automatically assigned.

Home health care services

Major covered services for home health care are

- part-time skilled nursing care,
- physical therapy,
- speech therapy, and
- occupational therapy.

Other covered services

When a person requires part-time skilled nursing care, physical therapy, or speech therapy, Part B also covers

- part-time services of licensed and supervised home health aides,
- medical social services,
- medical supplies and equipment provided by the agency, and
- occupational therapy.

Conditions for home health care coverage

Part B covers services a home health agency provides **if** *all* of the following conditions are met:

- Care needed is part-time skilled nursing care, physical therapy, or speech therapy.
- Beneficiary requiring care is confined to the home.
- Physician determines that beneficiary needs home health care and sets up a plan for home health care.
- Home health agency participates in Medicare.

Covered days in a calendar year

- an almost unlimited number of days of *part-time or intermittent* (usually a few hours a day up to 28 hours a week) home health visits in a calendar year (Provider must re-certify every two months.)
- 21 days of daily *skilled* home health care.

Beneficiary costs for home health care

- Medicare covers 100% of the approved charges. Beneficiary has only 20% coinsurance for durable medical equipment.
- The home health agency submits the claim.
- The beneficiary is not responsible for submitting bills.

Services NOT covered by home health care (same as Part A):

- full-time nursing care at home
- drugs and biologicals
- meals delivered to a beneficiary's home
- homemaker services
- custodial care
- blood transfusions

Ambulance transportation

Part B covers ambulance service if the following two conditions are met:

1. The ambulance equipment and its personnel meet Medicare requirements.
2. Any other transportation would endanger the beneficiary's health.

Note: *Both* conditions must apply to receive Medicare ambulance approval and payment.

Generally, Part B covers ambulance service only to the closest treatment facility. Part B covers ambulance service

- from the scene of an emergency or accident to a hospital or skilled nursing facility.
- between a hospital and skilled nursing facility.
- from a hospital or skilled nursing facility to the home.

Ambulance providers must accept the Medicare approved fee as full payment, and beneficiaries will not pay more than 20% of the approved amount, once their annual deductible has been met.

Air ambulance

Contractors such as Noridian determine necessity of air ambulance by considering the following:

1. Was the point of pickup inaccessible to ground ambulance?
2. Did weather, traffic conditions, etc., make pickup by ground ambulance impractical, impossible, or overly time consuming?
3. Was the patient's condition such that the length of time required by the ground ambulance would have endangered the patient's life or health?

Equipment and supplies

Part B covers supplies and equipment under these two general conditions:

- A physician must order or prescribe the equipment.
- The equipment supplier is certified by Medicare to file claims.

Coverage categories are as follows:

Note: Suppliers are ***not*** required to accept assignment.

- **Inexpensive or routinely purchased items:** defined as paid in a lump sum or rental basis — items costing $150 or less, or purchased at least 75% of the time. Includes walkers, commodes, seat-lift chairs, and TENS units. Medicare will help pay for seat-lift chair mechanisms only, not the chairs themselves*. Medicare will also help pay to rent or purchase such equipment. If rented, reimbursement is capped at purchase price.

  * *The beneficiary may use their own chair or buy a new chair with a seat lift mechanism in it. Their doctor must fill out the proper paperwork, i.e., Certificate of Medical Necessity for Seat Lift. If the beneficiary purchases the mechanism or chair from a participating provider, it is much more likely that Medicare will pay for a portion of the cost. If not, they take their chances.*

- **Items requiring frequent or substantial servicing**, including ventilators and aspirators. Medicare will pay on a rental basis only, as long as the item is medically necessary.
- **Diabetic supplies:** blood glucose monitor (calibrating solution, replacement batteries, blood glucose monitor for visually impaired), test strip, lancets (spring-powered device), therapeutic shoes, insulin through external infusion pump.

- **Custom items** are defined as uniquely constructed or substantially modified. Medicare will pay for purchases of such custom equipment only.
- **Prosthetic:** a device needed to substitute for an internal body organ or a limb, e.g., heart pacemakers, corrective lenses needed after cataract surgery, and colostomy and ileostomy bags. Dental implants are not covered. Medicare will pay for purchase of such devices only, at 80% of the lesser of actual or approved amount.
- **Orthotic:** a brace or other device to support a weak body part or restrict motion.
- **Other durable medical equipment*, defined as items costing more than $150**, such as hospital beds and power-driven wheelchairs. Medicare will pay on a "capped rental" basis only for 15 months or as long as needed, whichever is less, up to the purchase price. After that, the supplier must repair and maintain the equipment — without a rental charge — as long as the equipment is needed. A small maintenance-servicing fee will be made every six months beginning in the twenty-second month.
- **Oxygen and oxygen equipment.** Medicare will pay on a rental basis only as long as medically necessary.
- **Refractive lenses,** after cataract surgery to correct for Aphakia, the absence of the crystalline lens of the eye. Additional prescribed options.

* To be defined as "durable medical equipment," the device

1. can withstand repeated use.
2. has a medical purpose.
3. is not useful if patient is not injured or ill.
4. can be used at home.

Update on power wheelchairs

Medicare has modified its conditions for obtaining power wheelchairs and other power mobility devices. **Effective June 5, 2006**, the Centers for Medicare and Medicaid Services (CMS) defines the term "power mobility devices" (PMDs) as power wheelchairs and power operated vehicles (POVs or scooters). CMS has revised the payment rules for PMDs and who may prescribe PMDs and clarifies the requirement of a face-to-face examination of the beneficiary in advance of obtaining a PMD.

In the new rule, CMS defines a power mobility device as a covered item of durable medical equipment that is in a class of wheelchairs including power wheelchairs (a 4-wheeled motorized vehicle whose steering is by an electronic device or joystick to control direction and turning), or a power operated vehicle (a 3 or 4-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.

The "uses in the home" requirement remains a contentious point for advocates who find it unduly restrictive. To this point of contention, CMS has responded that the use of a PMD outside the home is not prohibited, but the PMD must be *primarily* for use in the home in order to obtain Medicare coverage.

A PMD prescription must be an order written by the physician or treating practitioner who performed the face-to-face examination of the patient's need for the PMD.

The prescription must include

- the beneficiary's name,
- the date of the face-to-face examination,
- the diagnoses and conditions that the PMD is expected to modify,
- a narrative description of the item,
- the length of the beneficiary's need for the item,
- the physician's or treating practitioner's signature,
- the date on which the prescription was written.

CMS also clarifies in the new rule that a treating practitioner, for purposes of writing the prescription for a PMD, can be a physician assistant, a nurse practitioner, or a clinical nurse specialist. Any physician or treating practitioner who conducts a face-to-face examination of the patient can prescribe PMDs, including POVs.

A supplier is defined in the new rule as an entity with a valid Medicare supplier number, including a mail order supplier. The supplier must maintain the prescription and supporting documentation provided by the physician or treating practitioner and must make this information available to CMS and its agents upon request.

Suppliers may not dispense a PMD to a beneficiary until they have received the PMD prescription and the supporting documentation from the physician or treating practitioner. This documentation must be received by the supplier within 45 days after the face-to-face examination.

Medicare will pay for a PMD only if the physician or treating practitioner meets the following conditions:

- conducts a face-to-face examination of the beneficiary determining the medical necessity for the PMD as part of an overall treatment plan
- writes a prescription that is provided to the beneficiary or supplier
- provides supporting documentation that supports the medical necessity for the power mobility device

Beneficiaries discharged from a hospital do not need to receive a separate face-to-face examination as long as the physician or treating practitioner who performed the face-to-face examination of the beneficiary in the hospital issues a PMD prescription and supporting documentation that is received by the supplier within 45 days after the date of discharge.

In general, CMS's new rules on power mobility devices make the procedural process of obtaining a PMD less worrisome.

In Oregon, Medicare claims for equipment and supplies are processed by Noridian Administrative Services. Noridian will process claims for:

- oxygen (rental of equipment with oxygen cylinder only)
- parenteral (intravenous, subcutaneous, intra-muscular, and mucosal) and enteral (within or by way of the intestine) nutrition supplies such as feeder tubes, etc.
- durable medical equipment
- immunosuppressive drugs and oral cancer drugs
- prosthetics and orthotics
- home dialysis equipment and supplies and diabetic supplies

Coverage restrictions

Medicare does not pay for services that other insurers cover, including items or services which the Department of Veterans Affairs provides free of charge and items or services paid for by a governmental agency.

Medicare does not cover custodial services (i.e., services related to daily living needs) or personal comfort and convenience items.

Claims processing for Medicare beneficiaries

Even if providers do not accept assignment, most providers of Part B services must submit Medicare claims. If the provider or supplier refuses to submit a Part B Medicare claim, the beneficiary should notify the Medicare carrier if they feel the services may be covered. Hospitals file their outpatients' claims through intermediaries who process the claims as Part B expenses.

In some cases, beneficiaries may need to file their own Medicare Part B claims. If they do, send claims to the carrier responsible for processing Medicare claims in the area where services were received. Situations in which an individual might be required to file their own claims are:

- Foreign claims, such as emergencies in Canada or Mexico.
- Claims for non-covered benefits to obtain a denial.

Time limits for submitting claims

- Non-participating providers have up to 12 months to submit claims before facing possible penalties from CMS of up to $2,000 for willful and repeated non-compliance.
- Participating providers have up to 15 months to submit claims to the carrier, but will receive a 10% payment reduction if claims are not filed within one year.
- Beneficiaries have up to 15 months to submit claims to the carrier.

Railroad retirement system

If beneficiaries get Medicare under the Railroad Retirement System, the doctors and other providers must submit beneficiaries' claims as they do Medicare recipients' claims. Providers must file Part B claims to the Medicare carrier who handles railroad retirees' claims.

Medicare Record-Keeping

Beneficiaries should keep detailed records of Medicare transactions. This helps them determine the amount of benefits due and to understand Medicare payment decisions. The **SHIBA Medical Claims Payment Log** is helpful. What to record:

✔ **When the service was received, and from whom, including:**

- ♦ date of service
- ♦ name of provider
- ♦ description of service
- ♦ amount of charge

✔ **When the claim was submitted:**

- ♦ the date the claim was filed with the insurance company

✔ **When the service was paid for and to whom payment was made, including:**

- ♦ date and amount paid
- ♦ what service(s) the payment covered
- ♦ receipt for payment listing the above.

✔ **When correspondence was sent:**

- ♦ copies of written communications and a notebook of telephone calls showing date, time, person, and agency of each telephone inquiry

Exercises

Exercise #1 Medicare Part B – Non-assigned claims

After a recent hospital stay, Mrs. Jones received a MSN detailing the various charges for physicians' services. She brings the MSN to you and asks you to explain it to her.

Dr. Frank N. Stein charged $400 for visiting Mrs. Jones in the hospital. Dr. Ray D. Um, a radiologist, charged $380 for reading Mrs. Jones' X-rays. The MSN also lists charges of $170 for follow-up visits to Dr. Stein's office and $150 for diagnostic tests conducted at the office. Neither Dr. Stein nor Dr. Um accepts assignment.

Answer the questions below using the following information:

	Amount Billed	Medicare Approved Charge
Dr. Stein, hospital visit	$ 400	$ 350
Dr. Um, X-ray reading	380	350
Dr. Stein, office visits	170	150
Tests	150	150
TOTAL	$1,100	$1,000

1. Mrs. Jones has no supplemental insurance to cover the 20% coinsurance payment or the excess over the approved charge and she has already met her annual deductible. How much will Part B and Mrs. Jones pay toward her bills for this recent illness?

   a. Medicare pays

   b. coinsurance payment before excess amount

   c. excess over approved amount

   d. Mrs. Jones' total.

2. Who was responsible for submitting Mrs. Jones' claims to the Part B carrier?

3. Where will Medicare send payment?

1a. $800; 1b. $200; 1c. $100; 1d. $300 2. the Drs. 3. Mrs. Jones

Exercise #2

Medicare Part B - Assigned claims

Mr. Smith received a MSN detailing charges associated with his visit to Dr. Joan Good at a neighborhood clinic. Dr. Good is accepting assignment in Mr. Smith's case. The MSN shows Dr. Good charged $65 for the visit and $30 each for two injections.

1. Mr. Smith has already met his annual deductible and has no other insurance. How much will Mr. Smith and Medicare Part B pay toward these bills? Use the following information:

	Amount Billed	Medicare Approved Charge
Dr. Good, office visits	$ 65	$ 50
Injection 1	30	25
Injection 2	30	25
TOTAL	$125	$100

   a. Medicare pays

   b. Mr. Smith pays

2. Who was responsible for submitting Mr. Smith's claim to the Part B carrier?
3. Where will Medicare send the payment?

1a. $80; 1b. $20; 2. Dr. Good 3. Dr. Good