Medicare Minute Teaching Materials – November 2018
Original Medicare and Medicare Advantage Providers

1. What should I consider when looking for an Original Medicare provider?

If you have Original Medicare, your Part B costs once you have met your deductible can vary depending on the provider you see. There are three kinds of billing agreements that Part B providers can have with Medicare. Beneficiary cost-sharing amounts are lower or higher depending on the type of agreement. Providers are designated as participating providers, non-participating providers, or opt-out providers depending on that agreement. A provider's relationship with Medicare determines how much you will pay for Part B-covered services you receive from them. The word provider often refers to a physician, but can also refer to other providers of care such as a hospital, dialysis facility, home health agency, or durable medical equipment (DME) supplier, among others.

A participating provider accepts Medicare and always takes assignment. Taking assignment means that the provider accepts Medicare's approved amount for health care services as full payment. To pay the least for services, see a participating provider when possible.

- These providers are required to submit a bill (file a claim) to Medicare for the services or items you receive from them. Medicare will process the bill and pay your provider directly. If your provider does not file a claim, there are steps you can take to help resolve the problem (see number 4).
- If you see a participating provider, you are responsible for a 20% coinsurance charge for Medicare-covered services.
- Certain providers, such as clinical social workers and physician assistants, must always take assignment if they accept Medicare.

A non-participating provider accepts Medicare but does not agree to take assignment in all cases (but they may take assignment on a case-by-case basis). This means that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare's approved amount for health care services and items as full payment.

- Non-participating providers can charge up to 15% more than Medicare's approved amount for the cost of the services you receive (known as the limiting charge). This means that you are responsible for up to 35% (20% coinsurance + 15% limiting charge) of Medicare's approved amount for covered services.
- Some states may restrict the limiting charge when you see non-participating providers. For example, New York State's limiting charge is set at 5%, instead of 15%, for most services. For more information, contact your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is on the last page of this document.
- If you pay the full cost of your care up front, your provider should still submit a bill to Medicare. Afterward, you should receive from Medicare a Medicare Summary Notice (MSN) and reimbursement for 80% of the Medicare-approved amount.
- The limiting charge rules do not apply to durable medical equipment (DME) suppliers. Call 1-800-MEDICARE or visit www.medicare.gov to find a DME supplier that accepts assignment.

An opt-out provider does not accept Medicare at all and has signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services but must follow certain rules to do so.

- Medicare will not pay for care you receive from an opt-out provider (except in emergencies). You are responsible for the entire cost of your care.
- The provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.
- Opt-out providers do not bill Medicare for services you receive.
- Medicare Supplement (Medigap) insurance policies will not reimburse you for services received from an opt-out provider.
- Many psychiatrists opt out of Medicare.

Providers who take assignment should submit a bill to a Medicare Administrative Contractor (MAC) within one calendar year of the date that you received care. If your provider misses the filing deadline, they cannot bill Medicare for the care they provided you. However, they can still charge you a 20% coinsurance and applicable deductible amount.

Be sure to ask your provider if they are participating, non-participating, or opt-out. You can also check by calling 1-800-MEDICARE or by using Medicare's Physician Compare tool on www.medicare.gov.

2. What kind of provider should I see if I have a Medicare Advantage Plan?

All Medicare Advantage Plans must cover at least the same health care services as Original Medicare, but they may do so with different costs and restrictions. For example, some Medicare Advantage plans require you to get prior authorization for certain services, or to get a referral from a primary care physician (PCP) before seeing a specialist.

There are several kinds of Medicare Advantage Plans. The most common types of plan are:

- Health Maintenance Organizations (HMOs)
- Preferred Provider Organizations (PPOs)
- Private Fee-for-Service (PFFS)

You may also see:

- Special Needs Plans (SNPs)
- Provider Sponsored Organizations (PSOs)
- Medical Savings Accounts (MSAs)

Each type of Medicare Advantage Plan has different network rules. A network consists of doctors, hospitals, and medical facilities that contract with a plan to provide services. There are various ways a plan may manage your access to specialists or out-of-network providers. Remember that your costs are typically lowest when you use in-network providers and facilities, regardless of your plan.

Your Medicare Advantage Plan is required to cover emergency and urgent care anywhere in the U.S. without imposing additional costs or coverage rules (such as prior authorization). This means that if you seek emergency care from an out-of-network provider, your Medicare Advantage Plan must cover the care as if you had gone to an in-network provider. Medicare Advantage Plans define an emergency by the prudent person standard. Prudent means acting with care or thought about the future. This standard ensures that even if your condition turns out not to be a medical emergency, it will still be covered as long as a prudent person would have assumed it was an emergency at the time you got care.

It is important to know that not all Medicare Advantage Plans—even plans of the same type—work the same way. Make sure you understand a plan's network and coverage rules before enrolling. If you have questions, contact your plan for more information.

This table provides a general overview of provider access rules for HMOs, PPOs, and PFFS plans:

	HMO	**PPO**	**PFFS**
Do I need to get a referral before I can see an in-network specialist?	Yes, usually	No	Yes
Will the plan pay for care from a doctor or hospital that is not in the plan's network?	No, unless you need urgent or emergency care or if you have a Point of Service (POS) option that allows you to use out-of-network providers	Yes, but you will pay more, unless it is an emergency	Yes, but you will usually pay more and the provider must agree to treat you, unless it is an emergency

Note: This chart does not include SNPs or Medicare MSA plans. A SNP is a managed care plan that serves people with special needs. In an MSA plan, you can go to any doctor or hospital willing to accept the plan's fees. If you are considering joining a SNP or an MSA, ask about that specific plan's network rules.

Your State Health Insurance Assistance Program (SHIP) can provide one-on-one counseling and assistance in helping you choose a plan option that meets your coverage needs. SHIP contact information is on the last page.

3. What kind of pharmacy should I go to for my Part D-covered drugs?

Medicare Part D is Medicare's prescription drug benefit. Part D is offered through private companies, either as a stand-alone plan for those enrolled in Original Medicare, or as a set of benefits included with your Medicare Advantage Plan.

Part D plans generally have networks of pharmacies that they contract with to provide you with covered medications. Use a preferred, in-network pharmacy to fill your prescriptions. Many pharmacy networks include both preferred and non-preferred pharmacies. You typically pay less for your prescriptions at

preferred pharmacies. If you need to find a preferred, in-network pharmacy or if you have any issues accessing your covered medications at the pharmacy, contact your Part D plan. Your State Health Insurance Assistance Program (SHIP) can also provide one-on-one counseling and assistance in helping you choose a plan option that meets your coverage needs. SHIP contact information is on the last page of this document.

4. What should I do if my provider is refusing to submit a claim to Medicare?

If you have Original Medicare: In certain situations, your health care provider may be unable or unwilling to submit a bill (file a claim) to Medicare. Listed below are a few reasons why your provider may refuse to file a Medicare claim, along with information about what to do in each situation.

- Your provider believes Medicare will deny coverage.
  - Your provider must ask you to sign an Advance Beneficiary Notice (ABN).
  - Before signing an ABN, ask additional questions to find out whether your provider considers the service to be medically necessary, and whether they will help you appeal.
  - Ask your provider to still file a claim with Medicare, even if they believe coverage will be denied. You can appeal if Medicare denies coverage.
- Your provider may ask that you pay in full for services.
  - If you are seeing a participating provider, your provider can collect your Part B deductible and coinsurance at the time of service, but they should not ask you to pay in full. Ask your provider to submit a claim to Medicare. Medicare should let you know what you owe after it has processed the claim. You may also find it useful to contact your state's medical licensing board to report the issue. Your State Health Insurance Assistance Program (SHIP) or Senior Medicare Patrol (SMP) can also bring these issues to Medicare's attention. Contact information for your SHIP and SMP are on the last page of this document.
  - Non-participating providers are allowed to request payment up front at the time of service. Your provider should file a claim with Medicare on your behalf so you can receive Medicare reimbursement (80% of the Medicare-approved amount).
  - To file a claim yourself, submit a Patient's Request for Medicare Payment form (also called the CMS-1490S form) to the Medicare Administrative Contractor (MAC) in your area. You must send bills or receipts for the service along with the form. After processing your request, Medicare should either send reimbursement or a coverage denial that you can appeal. To find the MAC in your area, call 1-800-MEDICARE.
- Your provider has opted out of Medicare.
  - Opt-out providers have signed an agreement to be excluded from the Medicare program. They do not bill Medicare for services you receive.
  - You should not submit a reimbursement request to Medicare for costs associated with services you received from an opt-out provider. You are responsible for the entire cost of care when seeing an opt-out provider.
- Your provider refuses to bill Medicare and does not specify why.
  - All Medicare-enrolled providers are required to submit claims. A refusal to bill Medicare at your expense may be Medicare fraud or abuse and should be reported. Contact 1-800-MEDICARE or your SMP (contact information for your SMP is on the last page of this document).

If you have a Medicare Advantage Plan or Part D prescription drug plan: If you are experiencing billing issues with providers or pharmacies in your Medicare Advantage Plan or Part D plan's network, you can ask your pharmacy or provider to contact your plan directly. If you continue to experience issues or if your pharmacy or provider is unresponsive, you can file a grievance with your Medicare Advantage or Part D plan. Contact your plan to find out how to file a grievance. You can also contact your State Health Insurance Assistance Program (SHIP) for help. See the last page for SHIP contact information.

5. How can I access covered care if I live in an area affected by a disaster or public health emergency?

Medicare Advantage Plans and Part D plans must work to maintain access to health care services and prescription drugs during emergencies for plan members living in affected areas. Plans must meet certain requirements following the declaration of a disaster, emergency, or public health emergency.

In these cases, Medicare Advantage Plans must:

- Allow you to receive health care services at out-of-network doctor's offices, hospitals, and other facilities
- Waive referral requirements
- Charge in-network cost-sharing amounts for services received out of network
- Suspend rules requiring you to tell plans before you get certain kinds of care or prescription drugs, if failing to contact the plan ahead of time could raise your costs or limit your access to care

In these cases, Part D plans must:

- Cover formulary Part D drugs filled at out-of-network pharmacies
  - Part D plans must do this when you cannot be expected to get covered Part D drugs at an in-network pharmacy
  - Remove restrictions that stop you from getting refills too soon
- Cover the maximum supply of your refill if you request it

After the disaster, emergency, or public health emergency ends, plans can stop following these requirements. The government will typically indicate when the emergency has ended.

6. How can I find a doctor or other health care provider?

Once you know that you should see a participating provider (see question 1) or an in-network provider (see question 2), you may want a list of providers in your area from which to choose. You may ask for referrals from friends, relatives, coworkers, and/or neighbors. You can also check with your insurance plan, medical societies, hospitals, and accreditation organizations. Be aware that while these sources can provide a list of doctors, they will not necessarily provide quality information.

The following sources can help you find lists of health care providers and learn more about their quality:

- **Medicare:** To find a provider who accepts Original Medicare, call 1-800-MEDICARE or use Medicare's physician and other provider compare tools (such as the hospital compare tool) available on www.medicare.gov. In general, these online compare tools show a provider's star rating in different categories. These tools also identify Medicare-participating providers. If you have a Medicare Advantage Plan, contact your plan for a list of in-network providers.

- **American Medicare Association (AMA):** The AMA offers a search engine on its website (www.ama-assn.org) where you can find doctors in your area by specialty. You can also check on their training and board certification.
- **American Board of Medical Specialties (ABMS):** ABMS is a nonprofit organization consisting of 24 medical specialty boards that oversee physician certification. You can look up a specific doctor's credentials or find doctors who are board-certified in a certain specialty. The service is free, but you must sign up before you can do a search. The ABMS also publishes a book, which is available at many hospitals, Social Security offices, Area Agencies on Aging, senior centers, and local libraries.
- **Administrators in Medicine (AIM):** If you know the name of a particular provider, you can look them up on AIM's website. AIM is a group of medical board directors. On their website (https://docboard.org/), you can see physicians' licensing background and whether or not they have had any disciplinary action taken against them.

These resources cannot ensure that a particular provider is the best one for you, but they do provide information on a doctor's knowledge and skills. Some of the resources tell you which doctors are board-certified which means they have completed a training program in a specialty and have passed a board exam on the subject. Keep in mind, though, that while board certification is a good measure of a doctor's knowledge, it does not guarantee a doctor's quality or that they will be a good fit for you.

You can also contact your SHIP for more assistance. See the final page of this document.

SHIP case example: Naima has a Medicare Advantage Plan. She has been experiencing knee pain and a friend recommended that she see a nearby orthopedic doctor. Naima is not sure if her plan will cover the care and wants to know how she can find out.

What should Naima do?

- Naima can call her State Health Insurance Assistance Program (SHIP) for help understanding her situation.
  - If Naima does not know how to reach her SHIP, she can call 877-839-2675 or visit www.shiptacenter.org.
- A SHIP counselor will tell Naima that before she schedules an appointment with this doctor (or with any doctor), she should make sure that she understands her Medicare Advantage Plan's network and coverage rules.
  - Naima likely has to see doctors who are in her plan's network to have services covered with the lowest costs. If she sees an out-of-network doctor, she may be responsible for paying a higher copay/coinsurance charge or for paying the entire cost of her visit out-of-pocket.
  - Naima's plan may also require her to get a referral before seeing a specialist. Specialists handle particular issues that require specific knowledge and training.
- The SHIP counselor will let Naima know that once she knows her plan's rules and whether this doctor is in the plan's network, she can make a decision about whether to get care from them.
  - If the doctor is in-network, and if Naima can see them without a referral, she can try to make an appointment with the doctor.
  - If the doctor is out-of-network, Naima can ask her plan for a list of in-network providers in her area who can provide the same services. If Naima decides to see the out-of-network

doctor anyway, she should be aware that she could be responsible for paying up to the full cost of the visit out-of-pocket.

SMP case example:
Tim has Original Medicare, and he went see a participating provider for outpatient physical therapy. Before going in for his appointment, Tim checked with the therapist's office to confirm that they accept Medicare. When he arrived, he presented his red, white, and blue Medicare card to the receptionist who checked him in. Tim just received a bill from the provider, and he suspects that he was billed for the full cost of the service rather than the 20% he thought he was supposed to owe for outpatient services. He checked his Medicare Summary Notice (MSN) for this quarter, and it indicates that the provider never billed Medicare for the physical therapy he received.

What should Tim do?

- Tim can contact his Senior Medicare Patrol (SMP) for assistance.
  - If Tim does not know how to contact his SMP, he can call 877-808-2468 or visit www.smpresource.org
- The SMP will let Tim know that he should contact his doctor's office to ask why they billed him for the full amount of the service and did not file a claim with Medicare.
  - The office may have made a mistake. Tim can request that they send the bill to Medicare. After Medicare processes the claim and if it is approved, Tim will be responsible for paying 20% of Medicare's approved amount for the service.
  - The SMP can tell Tim that since this is a participating provider, it is their responsibility to bill Medicare for their services directly.
- If the provider or their billing office continues to refuse to bill Medicare, the SMP can report it to the proper authorities on Tim's behalf for further investigation.

Local SHIP and SMP contact information

Senior LinkAge Line®
1-800-333-2433
LINK TO A LOCAL AGING EXPERT

- **To find a SHIP in another state:**
  Call 877-839-2675 or visit www.shiptacenter.org.
- **To find an SMP in another state:**
  Call 877-808-2468 or visit www.smpresource.org.

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