July 2021 Medicare Minute: Troubleshooting Medicare Coverage Problems
Question and Answers

Question: Please explain how Medicare calculates the "12-month" period for Annual Wellness Visits. Assume past visit was Oct 15, 2020. Exactly when can the next visit be scheduled?
Answer: The Medicare wellness visit may be performed in the same calendar month (but different year) as the previous wellness visit. For example, if you have an annual wellness visit on Oct 15, 2020, you will be eligible for your next wellness visit on Oct 1, 2021, or after.

Question: Isn't it true that Medicare Advantage Plans must cover everything that Original Medicare covers?
Answer: Yes, that is true! If you are enrolled in a Medicare Advantage Plan, you should receive the same benefits offered by Original Medicare (but perhaps with different rules, costs, and restrictions, which can affect how and when you receive care). Medicare Advantage Plans may also offer certain benefits that Original Medicare does not, like dental and vision.

Question: Are there time limitations as to when a provider can submit a claim or re-submit a claim to Medicare? What happens if the provider does not submit a claim?
Answer: Medicare claims must be filed no later than 12 months (or 1 full calendar year) after the date when the services were provided. If a claim isn't filed within that time limit, Medicare cannot pay its share and the beneficiary is responsible. If your doctor is refusing to submit a claim to Medicare, they may be doing so for various reasons. If your doctor believes Medicare will deny coverage, you should still ask them to file a claim; you may be able to appeal if Medicare denies coverage. If your provider is asking you to pay in full for services, and they are a participating provider, ask your provider to submit the 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. If your provider is asking you to pay in full for services, and they are a non-participating provider, ask your provider to file a claim with Medicare on your behalf, so you can receive Medicare reimbursement (80% of the Medicare-approved amount). Non-participating providers are allowed to request payment up front at the time of service. If your provider has opted out of Medicare, they do not bill Medicare for services you receive and you should not submit a reimbursement request form to Medicare for costs associated with services you received from an opt-out provider. You are responsible for the entire cost of care. If your provider refuses to bill Medicare and does not specify why, this is often considered

Medicare fraud and should be reported. To report fraud, contact 1-800-MEDICARE, the Senior Medicare Patrol (SMP) Resource Center (877-808-2468) or the Inspector General's fraud hotline at 800-HHS-TIPS. You may also want to try filing the claim yourself. Submit a Patient's Request for Medicare Payment form (also called CMS-1490S) to the Medicare Administrative Contractor (MAC) in your area. To find the MAC in your area, call 1-800-MEDICARE. 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.

Question: Should I receive two documents for each claim? An EOB as well as a summary?
Answer: The Explanation of Benefits (also called EOB) is a summary of services you received. This is one document that is sent each month, unless you did not receive any services that month. Depending on your plan, your EOB may be multiple pages.

Question: Are there any guides to understanding the terms and phrases used in coverage statements?
Answer: The Senior Medicare Patrol (SMP) has a very comprehensive walkthrough video of how to read and understand your Medicare Summary Notice: https://www.smpresource.org/Video/46/How-to-Read-Your-Medicare-Summary-Notice-MSN.aspx.

Question: My insurance agent was able to switch me from a Medicare Advantage Plan to regular Medicare outside of Fall Open Enrollment. How were they able to do that?
Answer: Besides the Fall Open Enrollment Period and Medicare Advantage Open Enrollment Period, there are also Special Enrollment Periods (SEPs) that you may have been able to use. These SEPs are triggered by specific circumstances, such as moving to a different state or losing another form of insurance. You can view this table for a list of SEPs to learn if one may have been applicable to you.

Question: Does Medicare use the National Correct Coding Initiative (NCCI)? How can I gain access to the NCCI Policy Manual for Medicare?
Answer: Yes, the Centers for Medicare & Medicaid Services (CMS) developed the NCCI and is responsible for all decisions regarding its contents. You can access the NCCI Policy Manuals for Medicare here: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Manual-Archive

Question: Can I get a glaucoma test more frequently than once per year?
Answer: Medicare Part B covers glaucoma tests once every 12 months if you're at high risk for the year disease glaucoma. Medicare defines you as being high risk if you have diabetes, have a family history of glaucoma, are African American and age 50 or older, or are Hispanic and age 65 and older. Your doctor may recommend you get services

more often than Medicare covers, so speak to your doctor more about this. If this happens, you may have to pay some or all the costs.

Question: How often can I get checked for hypothyroidism? If I have hypothyroidism, can I get bloodwork covered more frequently?
Answer: Thyroid function tests may be covered up to two times a year in clinically stable patients. More frequent testing may be reasonable and necessary for patients whose thyroid therapy has been altered or in whom symptoms or signs of hypothyroidism or hyperthyroidism are notes.

Question: What is a private Medicare plan?
Answer: Medicare Advantage Plans are sometimes also called private Medicare plans.

Question: How can I learn if a service will be covered in advance? Medicare asks for codes and my doctors are not familiar with them.
Answer: For most services, Original Medicare does not make coverage decisions before you receive a service. If you have a Medicare Advantage Plan, you may be able to ask for your plan to make a coverage decision before you receive a service: contact your plan for more information. Even though Original Medicare does not make pre-service coverage determinations, you can still learn if a service is covered by Medicare in general. You can speak with Medicare, your private plan, your doctor, and/or your provider's billing department. If you need more clarification, there are other resources that can help. On Medicare.gov's website, you can type in the name of a service to see if it is covered or not. To access this, click here. Additionally, Medicare.gov offers a list of tests, items, and services covered, on which you can click on an item in the list to learn more. To access the list, click here. You can also view your most recent *Medicare & You* handbook (or request Medicare send it to you if you do not have it) or your Medicare Advantage Plan's handbook.

Question: Can a Medigap plan increase its premiums mid-year?
Answer: Yes, Medigap premiums can change throughout the year. Most plans have a rate increase once per year, usually on your policy anniversary, your birthday, or in some instances both. This will depend on the state you live in and the way in which your premiums are set. Some Medigap premiums are attained-age-rated, meaning that premiums are initially based on your age when you purchase a policy, and they increase as you get older. This means you pay a different price at age 65 than you do at age 70. These premiums may be the lowest when you first buy them, but they are generally the most expensive over your lifetime. Sometimes Medigap premiums are community-rated, meaning that premiums are the same for everyone living in a specific area, regardless of age. These are generally the least expensive over your lifetime, but premiums will still increase over time with inflation. Finally, Medigap premiums may be issue-age-rated, meaning that premiums are based on the age you were when you first

bought the policy. The younger you are when you purchase a Medigap, the cheaper your premium. Premiums will still increase in these instances, too, due to inflation.

Question: How can I get a replacement Medicare card?
Answer: There are multiple ways to get a replacement Medicare card, including:

- Log into (or create) your secure Medicare account to print an official copy of your Medicare card
- Log into (or create) your *my Social Security* account. Select the "Replacement Documents" tab. Then select "Mail my replacement Medicare card." Your Medicare card will arrive in the mail in about 30 days at the address on file with Social Security.
- Call 1-800-MEDICARE.

Question: Where do I ask questions about costs at the pharmacy? I was surprised that my pharmacy charged a copay for my prescription.
Answer: You can first check your plan's formulary. A formulary is a Medicare Advantage or Part D plan's list of covered drugs, and each plan has its own formulary. Many plans place drugs into different levels, called "tiers," on their formularies. Drugs in each tier have a different cost. Your formulary should be sent to you each fall, either in the mail or electronically. You can also check your plan's website for its formulary or call your plan directly. You should also check your plan's network to see which pharmacies are in-network. Even within a network, some pharmacies may be "preferred" while others are "non-preferred." Preferred in-network pharmacies will have the lowest costs.

Question: I successfully appealed Medicare's denial of a service that I already paid my doctor for. How do I get reimbursed by Medicare and my Medigap plan?
Answer: You should contact your doctor's billing department. If you won your appeal, Medicare and your Medigap will pay them, and then the doctor's office has been paid twice. They should reimburse you for the amount you paid prior to Medicare's payment and the Medigap's payment.

Question: Is counseling from the Medicare Rights Center free?
Answer: Yes.

Question: What is the number to call the Social Security Administration?
Answer: You can call Social Security at 800-772-1213.

Question: What is your recommended starting point to determine which Medicare plan is the best for you?
Answer: One great tool to begin comparing plans is Medicare.gov's Plan Finder tool. You can compare costs and coverage between different Medicare Advantage and Part D plans available in your area. You should always confirm what you read on Plan Finder

with the plan itself, though. Here are some things to consider when comparing Part D plans:

- Drug coverage (Are your prescriptions on the formulary? Are there are restrictions, such as step therapy or prior authorization?)
- Costs (What is the monthly premium and yearly deductible? How much will you pay at the pharmacy for your drugs?)
- Pharmacy network (Can you fill your prescriptions at the pharmacies you use? Can you fill your prescriptions when you travel? What will your options and costs be if you fill a prescription at an out-of-network pharmacy?)
- Coordination with other insurance (Do you need to have Part D coverage if you have other drug coverage?)

If you are comparing Medicare Advantage Plans, you should additionally consider the following factors:

- Providers, hospitals, and other facilities (Will you be able to use your doctors? Are they in the plan's network? If your providers are not in the plan's network, will the plan still cover your visits?)
- Access to health care (What is the service area for the plan? Will you need a referral from your primary care doctor to see a specialist? Will you have any coverage for care outside the plan's network?)
- Costs (What costs, like deductibles, copayments, and premiums, should you expect? What is the annual maximum out-of-pocket cost?)
- Benefits (Does the plan offer any additional benefits that Original Medicare does not? Are there any rules or restriction when you access these benefits?)
- Coordination of benefits (How does this plan work with your current coverage? If you join, will you lose your retiree coverage or job-based insurance?)

Question: What is the incentive for doctors to accept the Medicare-approved rate and not charge the additional 15%?
Answer: Medicare does provide several incentives for physicians to participate in Medicare. First, the Medicare payment amount for participating physicians is 5% higher than the rate for non-participating physicians. Second, their contact information will be more widely shared with senior citizen groups and individuals who request lists of participating providers in their area. Third, Medicare administrative contractors (MACs) process claims from participating providers more quickly and provide toll-free lines to participating providers.

Question: Can you have a Medicare account if you have a Medicare Advantage Plan?
Answer: Yes, you can, since all individuals with Medicare Advantage still have Medicare, someone with Medicare Advantage can create a Medicare.gov account. Note, though, that the online Medicare account at Medicare.gov only shows claims processed by Medicare. Your Medicare Advantage plan should have its own portal and account you can set up to see claims processed by your plan.

Question: How can I know if I will be charged facility fees by hospitals for services performed in hospital-based clinics?
Answer: Hospital-owned outpatient practices must notify you of your potential financial liability for the use of the facilities. If they do not, you should be sure to file a grievance with your plan or a complaint with Medicare. You may also wish to consider visiting a different provider in the future to avoid these costs.

For context, Medicare allows physician's practices and outpatient clinics owned by hospital to bill separately for the use of a facility as well as for the medical services provided. These providers must meet specific federal guidelines governing their organizational and financial structure, as well as their location with respect to the hospital. Facility fees are meant to reimburse providers for the overhead of maintaining expensive facilities. Under Original Medicare, facility fees are a covered service, and the beneficiary is responsible for the coinsurance. Therefore, Medicare Advantage Plans are also obligated to cover facility fees, though there is not requirement as to how much of the fees are paid by the plan. As a result, copays could be substantial.

Question: Is Medicare always the primary coverage if you have other coverage?
Answer: No, Medicare will not always be your primary coverage if you have other forms of coverage. For example, Medicare will always be secondary when you have liability-related claims. It will also be secondary if you are 65 or older and have job-based insurance from a company with 20 or more employees. On the other hand, Medicare will always be primary to COBRA coverage. For a full chart of when Medicare is primary and when it is secondary, click here.

Question: It's important to watch out for EOBs and MSNs to make sure they show the services you actually received, right?
Answer: Yes, that is correct! One important reason to read your Medicare notices carefully is to ensure they are correct. If you notice an error (for example, you see a service listed that you never received or a service for a greater number of hours than you received), you should contact your provider to see if they made a billing error. If they refuse to correct the error or claim no error, it may be Medicare billing fraud. If you suspect you are experiencing Medicare fraud, error, or abuse, you should contact your Senior Medicare Patrol (SMP) for assistance in reporting the issue. You can find your local SMP by going to www.smpresource.org or calling 877-808-2468.