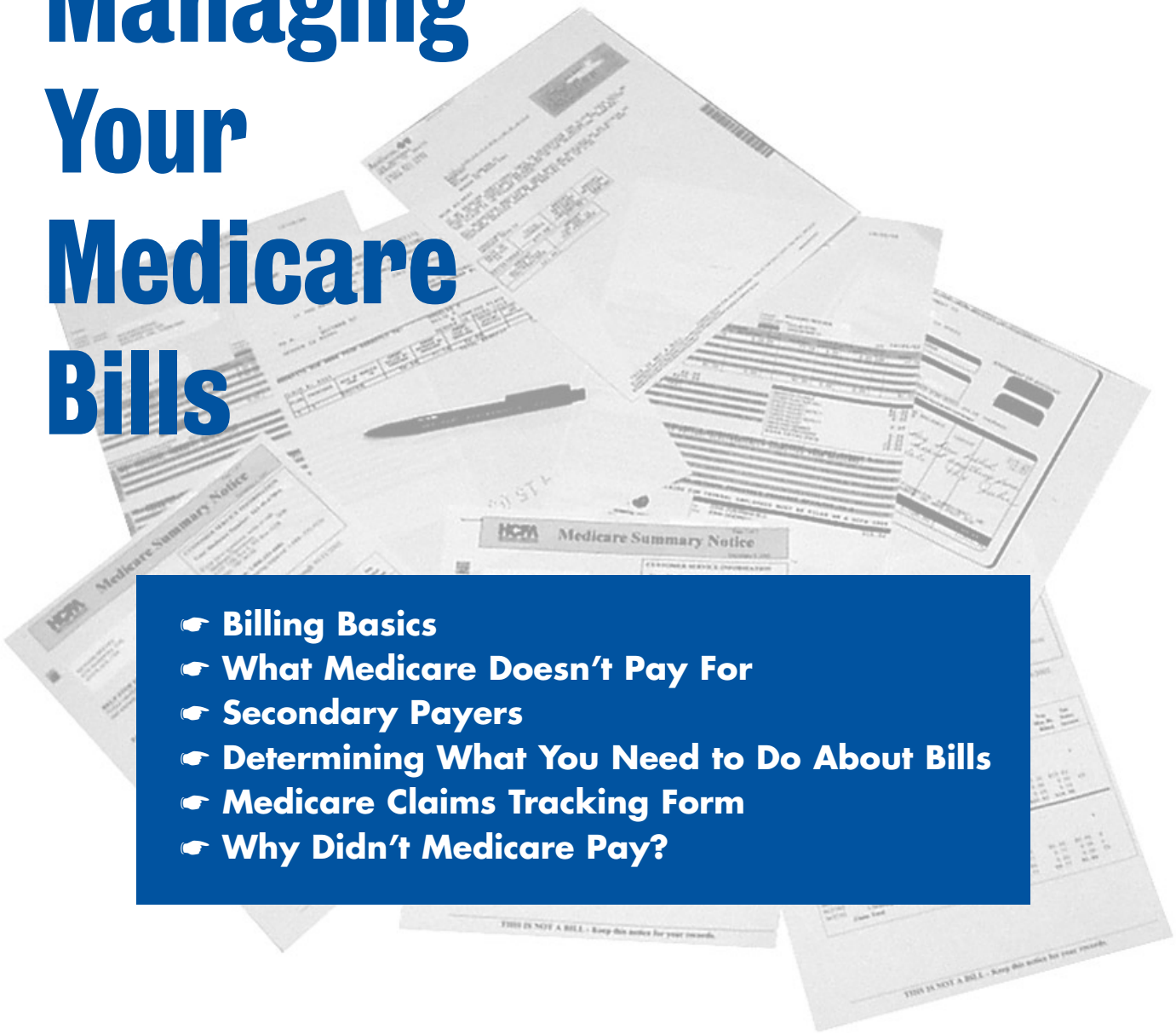
STATE OF COLORADO

Managing Your Medicare Bills



- Billing Basics
- What Medicare Doesn't Pay For
- Secondary Payers
- Determining What You Need to Do About Bills
- Medicare Claims Tracking Form
- Why Didn't Medicare Pay?

Senior Health Insurance Assistance Program
Colorado Division of Insurance

Regional affiliates,
call toll free 1-888-696-7213
or 1-800-544-9181
Metro Denver call 303-899-5151
En Espanol sin cargo 1-866-665-9668
www.coloradomedicare.com
E-mail: Robert.pierce@dora.state.co.us

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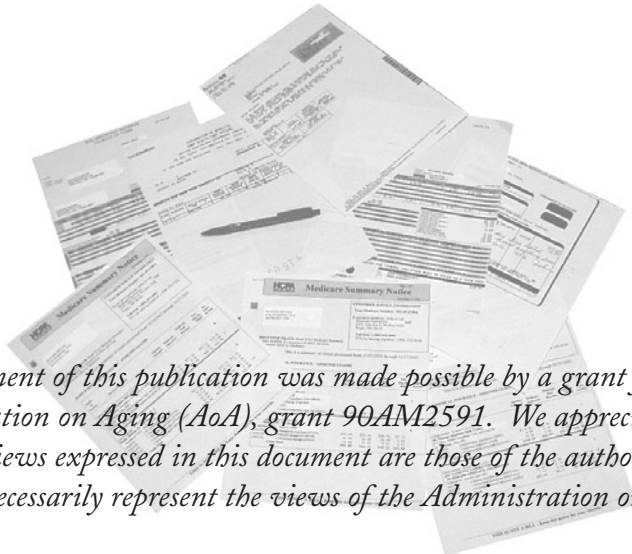

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Medical bills and resulting statements can result in a puzzling pile of paperwork! The process of organizing, submitting, and tracking hospital and medical bills can be intimidating. At worst, it can be so frustrating that many elders give up in disgust and use the simple "pay all bills as they arrive" method. **DON'T DO THIS!**

Organization is the key to putting you, not the paperwork, in control. This publication provides a simple tracking form, "Medicare Claims Tracking Form," and instructions on how to use it. If you do not currently use a tracking form, you'll find it a helpful tool for managing your health insurance paperwork. Your Medicare Claims Tracking Form shows both your progress and your next move for each individual claim.

This tool will allow you to track health services received, track Medicare and other insurance payments, determine whether your insurers have paid their share, and decide whether you still owe any payment to health care providers. You will be certain that Medicare and your second insurer have paid the costs for which they are responsible. More importantly, you will be certain that you are paying only the costs for which you are responsible.

We'll also explain the basics of Medicare and secondary insurance billing, what Medicare doesn't pay for, explain how to use your Medicare Summary Notices (MSN) and insurance statements with your Medicare Claims Tracking Forms, and to understand what, if anything, you owe a provider. In addition, we give more background about situations when payment isn't made by Medicare.

Billing Basics

All healthcare providers are required by federal law to submit their bills for Medicare-covered services to Medicare. A provider cannot require you to submit the bill to Medicare. If this happens to you, you should alert the Medicare contractor who pays the bills on behalf of Medicare to contact the provider, and you should refuse to pay any bills you receive.

Who pays Medicare bills?

Medicare pays private contractors to make payments on behalf of the program. Which contractor processes the payment for Medicare is dependent on the type of service provided, and the state in which the service was provided. So if you go outside Colorado for a service, there will probably be a different company that handles the payment. There are five different contractors who handle the billings for services received in Colorado:

- Doctor, lab, and ambulance services (Noridian);
- Hospital, most hospital outpatient services, and nursing home services (Trailblazer or Mutual of Omaha);
- Home health care and hospice services (CAHABA); and
- Durable medical equipment and oxygen (Palmetto GBA).

Medicare charge limits

Medicare limits how much providers can charge for most services. Hospitals, labs, nursing homes, home health, and ambulance providers must accept the Medicare approved charge as payment in full for covered services. Doctors are limited to extra charges no greater than 15% more than the Medicare approved charge. Durable Medical Equipment providers, however, have no limits on their prices.

Where the money goes—assigned and unassigned claims

Health care providers who submit their claims to Medicare as "assigned"—meaning the provider agrees not to charge more than the Medicare approved amount—will receive the Medicare portion of their payment directly from Medicare. Therefore, the consumer will only need to worry about payment of the balance of allowed charges, usually a 20% copayment.

There are many doctors who agree to always accept Medicare assignment for a calendar year. These doctors are referred to as "participating providers."

A few Medicare providers do not accept assignment. About 20% of Colorado doctor bills sent to Medicare are not assigned. In these situations, Medicare will send their payment to you, the patient, rather than to the doctor. So you will be responsible for paying the entire amount of the bill Medicare says is owed to the doctor or durable medical equipment supplier.

Medicare as secondary payer

There are a few occasions when Medicare isn't the primary payer, paying most of your health bills. Most often this occurs when someone is covered by an employer health plan because they or a spouse are still working. It also happens with automobile accident injuries and workers' compensation claims. In these circumstances, the other insurer is billed before Medicare. Medicare will usually pay the balance once they know how the other insurer handled the claim.

If You Belong to a Medicare HMO

If you have enrolled in a Medicare HMO, the entire billing process is different. If you are covered by Kaiser Senior Advantage or PacifiCare Secure Horizons you won't receive a Medicare Summary Notice, and your out-of-pocket expense for a service should only be the copayment listed in the plan policy, which most enrollees pay at the time of the visit.

Should a health care provider who is part of the HMO network ask for payment from you beyond the copayment, you should refer him or her to your HMO.

However, if you receive emergency or urgent care services outside the HMO service area, your HMO will pay the provider for each service based on the Original Medicare payment rate, and bill you for the copay. If you are asked by the emergency or urgent care provider to pay for the services at the time they are received, you will have to submit a claim to the HMO to be reimbursed. For tracking purposes you should keep a record, by provider, the date of service, service provided, and date copay was paid.

For those enrolled with Rocky Mountain Health Plans, that HMO will bill you for the copay that is due. However if you opt to receive services from a non-Rocky Mountain Health Plans provider, the non-network provider will bill original Medicare and you will be responsible for Medicare required copayments and deductibles yourself. You will receive a Medicare Summary Notice (MSN) that tells you how much you must pay.

In cases of emergency or urgent care, when an enrollee of Rocky Mountain Health Plans receives services from a provider who is not part of the HMO network, the claim is mailed directly to the Medicare carrier or intermediary, as appropriate. Medicare will pay for 80% of the approved amount and Rocky Mountain Health Plans will pay the 20% copayment. Rocky Mountain Health Plan will then bill you for their copay for emergency and urgent services.

Health Service	Medicare Pays	You or Secondary Insurance Pays
Doctor	80% of Medicare Approved Charges	•20% of Medicare Approved Charges for Assigned Claims •Up to Additional 15% for Unassigned Claims
Lab	100% of Medicare Approved Charges	Nothing
Ambulance	80% of Medicare Approved Charges	20% of Medicare Approved Charges
Durable Medical Equipment/Oxygen	80% of Medicare Approved Charges	•20% of Medicare Approved Charges for Assigned Claims •Balance of Billed Charges for Unassigned Claims
Outpatient Hospital	Fee Schedule Amount	Copayment-varies
Inpatient Hospital	Everything but deductible	$840 Deductible (2003)
Skilled Nursing Facility	100% for days 1-20 All but $105 for Days 21-100	Nothing $105 for Days 21-100 (2003)
Skilled Home Health Care	100% of Medicare Approved Charges	Nothing

What Medicare Doesn't Pay For

Medicare, like most health insurance policies, does not pay for all services and medical equipment related to healthcare. Here is a list of some of the more common items that are not paid for by Medicare.

Required cost sharing:
There are copayments and deductibles that consumers are required to pay that are set by federal Medicare law. For example, consumers must pay at least 20% of the Medicare approved charge for doctor services, and a deductible for inpatient hospital services ($840 in 2003) that increase each year.

Long-term Care Services:
Medicare, like private health insurance, does not pay for services such as custodial home health and nursing home care needed by people who are frail, disabled, or suffering from Alzheimer's Disease.

Long-term Care Equipment:
Medicare does not pay for items needed by frail or disabled individuals such as wheelchair ramps, grab bars, and other home modifications.

Acupuncture and Holistic Medicine:
Medicare does not pay for non-traditional and holistic health care.

Prescription Drugs:
Medicare does not pay for self-administered prescription drugs. There are a few exceptions for some cancer drugs. Drugs administered while admitted to a hospital are paid for by Medicare, as are injectible drugs that must be administered by a health professional.

Annual Physicals and Related Testing:
This is one of the few preventive services not covered by Medicare. Related blood tests, x-rays, and other services are also not covered. However, if covered preventive tests such as pap smears are received as part of the annual physical, Medicare should be billed for that test and the Medicare payment deducted from the physican's bill for the annual physical.

Eyeglasses and Routine Eye Exams:
Medicare does not pay for routine exams to determine if your eyesight has changed (refractions). Medicare only pays for eyeglasses following cataract surgery, but only for a single pair. Medicare does pay for eye exams related to suspected eye disease, such as cataracts, macular degeneration and glaucoma testing.

Dental Services:
Medicare does not pay for dental exams, fillings, crowns, dentures, etc. In unusual circumstances, Medicare may pay for repair of teeth following trauma due to an accident, such as wiring teeth for reduction of a jaw fracture.

Care Outside the United States:
Medicare does not pay for care outside the United States, including emergency care. There is an exception for people traveling through Canada on the way to Alaska, and for situations where a hospital just across the Canadian or Mexican border is the closest source of care in an emergency.

Hearing Aids and Exams:
Medicare does not pay for hearing aids or exams to test hearing.

Insulin and Syringes:
Medicare doesn't cover insulin and syringes for diabetics, although it does pay for a glucometer, test strips, lancets, and certain diabetic patient education.

Blood Deductibles:
Medicare doesn't pay for the first three pints of blood you receive in an inpatient or outpatient setting. Blood can be donated towards this deductible.

Oxygen and Durable Medical Equipment in a Nursing Home:
Medicare will not pay for oxygen and durable medical equipment for people confined to a nursing home. Medicare does pay for these items, when appropriate, for people living at home or in an assisted living facility.

Skilled Nursing Facility Services Beyond 100 Days:
Medicare payment for skilled nursing home care ends at 100 days, regardless of the circumstances.

Independent Therapist Services:
Medicare will approve no more than $1590 per year toward physical therapy and speech-language pathology, and $1590 toward occupational therapy services received in most settings outside a hospital, regardless of client need. Services received at a hospital outpatient department, however, are not subject to this limit.

Routine foot care:
Treatment of corns, calluses, bunions, etc. are not covered by Medicare. However, many people with diabetes can receive routine foot care.

50% of Psychiatric Services:
Medicare pays for individual psychiatric counseling by doctors and other professionals at 50% of the Medicare approved amount, rather than the usual 80%. Medicare will pay 80% of the cost for day treatment programs, however.

Experimental or Outdated Procedures: Medicare generally follows mainstream medical practice, and will not pay for experimental services still being evaluated, or for procedures that are considered outmoded. Medicare does, however, pays for some costs related to clinical trials.

Other:
Wigs and diapers are not covered.

Insurance that Supplements Medicare

Medigap as secondary payer

Medigap insurance, also referred to as Medicare supplement insurance, is designed specifically to coordinate benefits with Medicare coverage. Mostly, Medigap insurance pays certain copayment and deductible amounts for Medicare services. Medicare HMO's and employer retiree health plans are not the same as Medigap insurance.

Currently there are 10 standardized Medigap benefit packages sold in Colorado. Each standardized benefit package covers somewhat different benefits, except all pay 20% of Medicare approved doctor charges. All but one benefit package cover hospital deductibles. Eight of the ten standardized benefit packages pay the skilled nursing stay coinsurance for Medicare-covered stays of more than 20 days.

Only three benefit packages cover the $100 annual Medicare Part B deductible. Four benefit packages will pay additional charges physicians may receive on unassigned Medicare claims.

Some Medigap policies sold before 1992 are also considered Medigap products, but don't have the standardized benefit packages of current Medigap products. You will have to check the policy terms to see what it pays for.

There are a handful of non-Medicare services paid for by some standardized Medigap benefit packages. Best known are the limited prescription drug coverages in three standardized benefit packages. Emergency services outside the United States are covered by eight of the ten standardized products. Limited at-home recovery benefits and preventive care are covered by a handful of policies.

There are some variations on traditional Medigap plans called "high deductible" plans F and J, and Medicare Select Plans. High deductible plans will not pay benefits until consumers have paid a $1,650 (2003) annual deductible. A Medicare Select plan requires use of certain health providers in order to receive payment.

Employer Retiree Health Plan as secondary payer

Employer retiree health plans have no set requirements about what they must pay. You must read the policy language or contact the insurer administering the plan to find out about specific coverages. In general, many employer retiree plans offer very good coverage.

However, some employer retiree plans may not pay some important copayments and deductibles left by Medicare. "Carve out plans" have payment terms that mean they do not pay the 20% doctor copayment. Some employers have large annual deductibles that must be paid out-of-pocket before they will begin paying benefits. If your employer retiree health plan has one of these features, you will need to pay these expenses yourself, or purchase a basic Medigap product to make these payments.

Medicaid as a secondary payer

Some Medicare consumers qualify for the state-operated regular Medicaid program or Qualified Medicare Beneficiary (QMB) program, so Medicaid is responsible for their copayments and deductibles.

However, Medicaid payment rates are usually much lower than Medicare payment rates. Federal regulations allow state Medicaid programs to NOT pay Medicare copayment and deductible amounts above the state's own reimbursement rates. As a practical matter, people on Medicaid and QMB do not owe these amounts to providers, but doctors and other providers may decline to continue treatment and services due to the reduced payments they will receive.

Determining What You Need to Do About Bills

There are a few major items that consumers need to know to determine their next step. These items are included in the Medicare Summary Notices (MSNs) you receive from Medicare, or the explanation of benefits forms you receive from your Medigap or employer retiree health plan.

- What does Medicare say is owed?
- Has your other insurance coverage made their payment?
- Did the provider get paid directly by Medicare and the other insurance, or do you have to pay them?

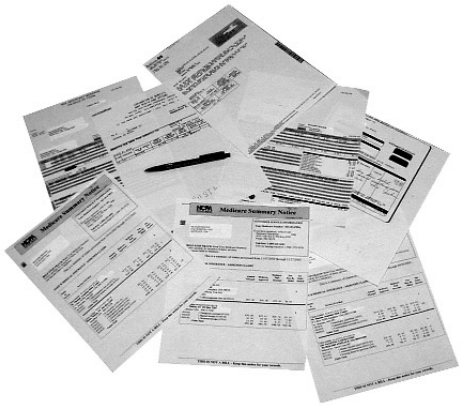
What Does Medicare Say is Owed?

Healthcare providers are required to bill Medicare when Medicare is supposed to pay most of the bill ("the primary payer"). Medicare examines the bill, determines whether to make a payment, determines what price Medicare has assigned for that type of service, and determines whether a particular provider is allowed to charge the patient more than the Medicare determined price.

Each of the private contractors who pay bills for Medicare sends each person a monthly statement, called the Medicare Summary Notice (MSN). The MSN's list all the bills each healthcare provider has submitted to Medicare for payment on that person's behalf. If no bills were submitted on your behalf, you won't receive an "MSN."

Each MSN contains several categories of information for each date a provider billed Medicare. This information includes the provider name, date of service, the service provided, the billed charge, etc.

The most important information on the MSN is in the second to last column, under the heading "You may be billed." This gives you the dollar figure for the total amount you are allowed to be billed by the provider. It considers whether the provider is allowed to bill more than the Medicare approved charge, the federal legal limit on how much more a doctor is allowed to bill a patient, and situations where there is no legal limit how much a provider may charge.



Has Your Secondary Insurance Coverage Made Their Payment?

Most people on Medicare have a second insurance to pay costs not covered by Original Medicare, such as copayments and deductibles. Ensuring these sources have made their payment is a key to ensuring you don't unnecessarily spend money out of pocket. These insurances are usually true Medigap policies or employer retiree health plans. Other secondary insurance includes "TriCare for Life" for military retirees and limited coverage plans such as cancer policies or hospital indemnity policies.

These secondary insurance plans have their own set of payment rules, and may not automatically pay all costs that are left after Medicare makes its payment. For example, some Medigap policies don't pay the Medicare Part B $100 calendar-year deductible, and some don't pay amounts providers are allowed to bill that are above the Medicare-approved payment amounts. Employer health plans may have annual deductible amounts that must be met before the policy begins making payments, or they may not be designed to pay most doctor copayments.

As a consumer, you will want to ensure that your secondary insurance receives a copy of your Medicare Summary Notice (MSN) for each service, along with your policy identification information. Even if they make no payment, they will track the amount applied towards your deductible.

Many claims will automatically be sent to your secondary insurance because the claim was assigned, or because your insurer pays Medicare to forward claims to them. Sometimes your provider will bill the secondary insurance, even though they are not required to do so. In other situations—or when the system fails to function properly—you may need to send the Medicare MSN and a claim form to your secondary insurer.

Did the provider get paid directly by Medicare, or do you have to pay them?

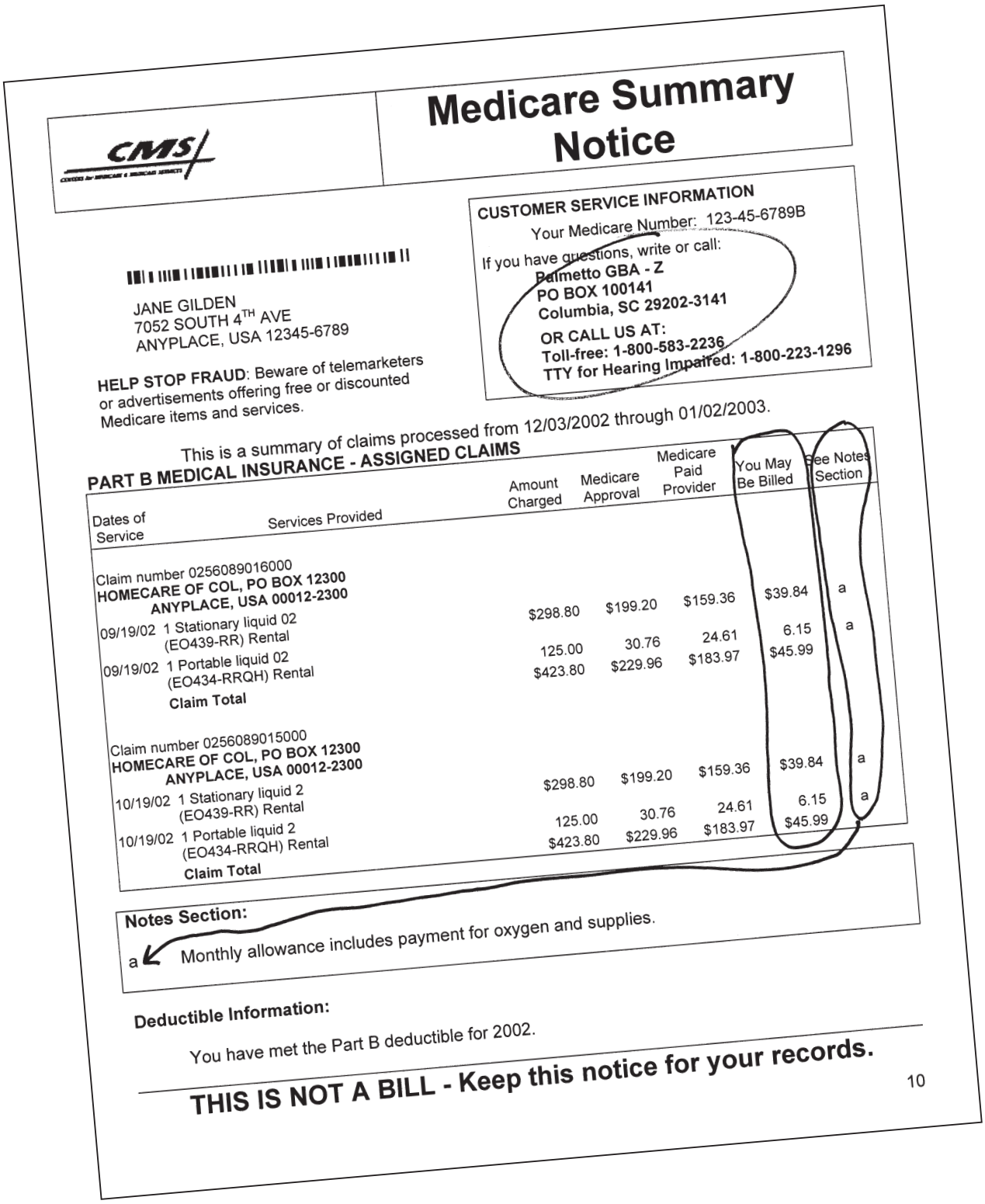
When Medicare receives an assigned claim, Medicare will send their payment directly to the provider, and they will automatically forward their MSN information to your secondary insurance. This assumes your provider fills out the secondary insurance information on the claim. So you need not forward MSNs and claim forms to your other insurance coverage (assuming the system works as designed).

When Medicare receives a claim that is not assigned, Medicare will send their payment to you, the patient. You are then responsible for making sure the provider is paid. Also, Medicare will not automatically forward your claim to your secondary insurance. Unless the second insurer has made separate arrangements to automatically receive information from Medicare, called automatic crossover, you will have to send the insurer a copy of your MSN and a claim form to receive their payment. And the second insurer will probably send the payment directly to you.

Many claims that are not assigned are likely to require extra payment. Remember that the MSN will tell you the total amount you are legally required to pay. So if payment from Medicare and your secondary insurer does not add up to that amount, you will have to pay the balance out of your pocket. For example, Medicare may say a doctor service has an approved charge of $100, and will then send you $80 of this amount. Your Medicare supplement plan may then pay another $20, for a total of $100. But the provider may be able to charge you $115, and you will have to pay the last $15 out of your own pocket.

Example of Medicare Summary Notice

Medicare Part B Claim



CMS

Medicare Summary Notice

JANE GILDEN
7052 SOUTH 4TH AVE
ANYPLACE, USA 12345-6789

CUSTOMER SERVICE INFORMATION
Your Medicare Number: 123-45-6789B
If you have questions, write or call:
Palmetto GBA - Z
PO BOX 100141
Columbia, SC 29202-3141
OR CALL US AT:
Toll-free: 1-800-583-2236
TTY for Hearing Impaired: 1-800-223-1296

HELP STOP FRAUD: Beware of telemarketers or advertisements offering free or discounted Medicare items and services.

This is a summary of claims processed from 12/03/2002 through 01/02/2003.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approval	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 0256089016000	**HOMECARE OF COL, PO BOX 12300 ANYPLACE, USA 00012-2300**					
09/19/02	1 Stationary liquid 02 (EO439-RR) Rental	$298.80	$199.20	$159.36	$39.84	a
09/19/02	1 Portable liquid 02 (EO434-RRQH) Rental	125.00	30.76	24.61	6.15	a
	Claim Total	$423.80	$229.96	$183.97	$45.99	
Claim number 0256089015000	**HOMECARE OF COL, PO BOX 12300 ANYPLACE, USA 00012-2300**					
10/19/02	1 Stationary liquid 2 (EO439-RR) Rental	$298.80	$199.20	$159.36	$39.84	a
10/19/02	1 Portable liquid 2 (EO434-RRQH) Rental	125.00	30.76	24.61	6.15	a
	Claim Total	$423.80	$229.96	$183.97	$45.99	

Notes Section:

a Monthly allowance includes payment for oxygen and supplies.

Deductible Information:

You have met the Part B deductible for 2002.

THIS IS NOT A BILL - Keep this notice for your records.

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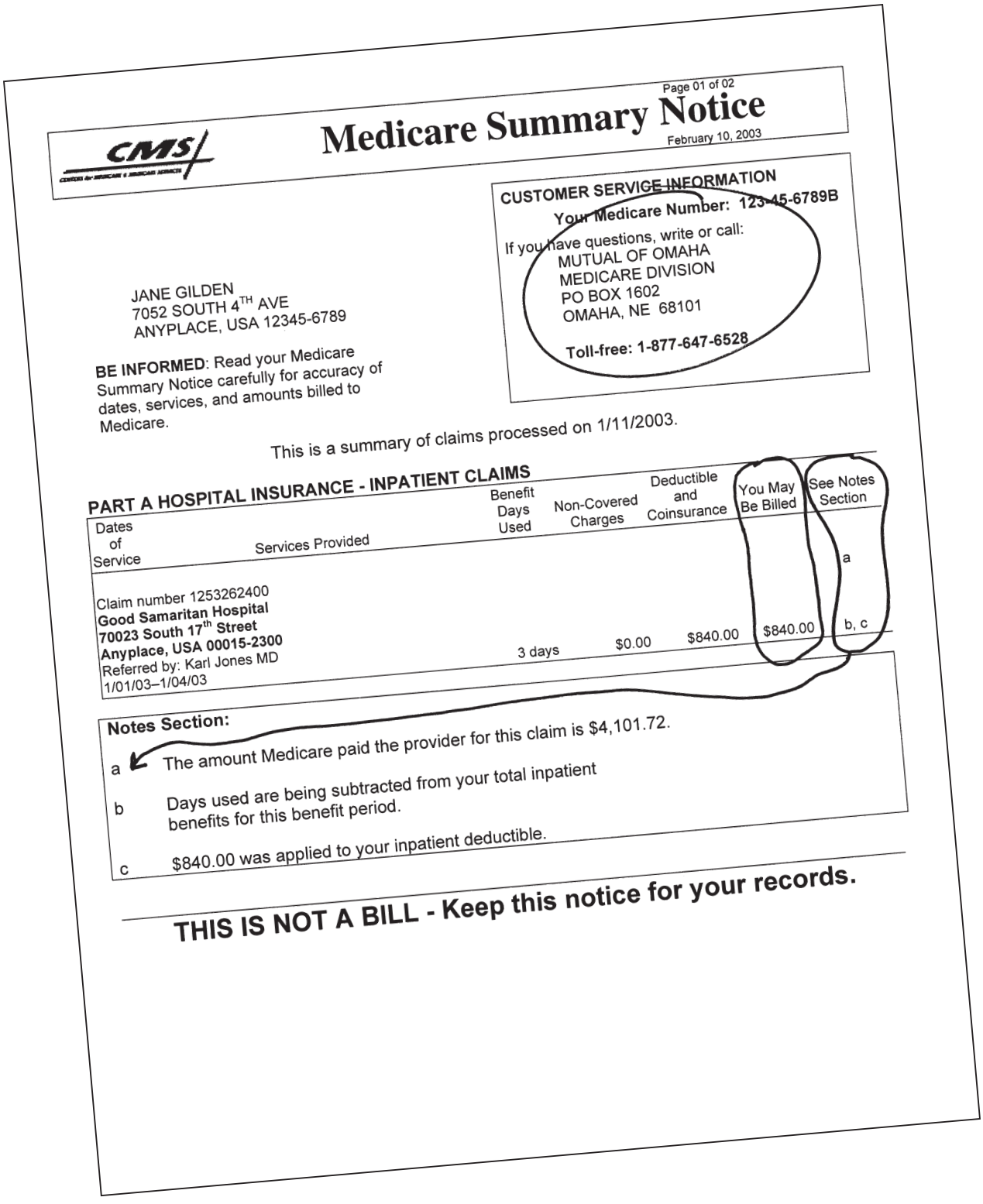
Example of Medicare Summary Notice

Medicare Part A Inpatient Hospital Claim, page 1



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Medicare Summary Notice

February 10, 2003

CMS

JANE GILDEN
7052 SOUTH 4TH AVE
ANYPLACE, USA 12345-6789

BE INFORMED: Read your Medicare Summary Notice carefully for accuracy of dates, services, and amounts billed to Medicare.

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 123-45-6789B

If you have questions, write or call:
MUTUAL OF OMAHA
MEDICARE DIVISION
PO BOX 1602
OMAHA, NE 68101

Toll-free: 1-877-647-6528

This is a summary of claims processed on 1/11/2003.

PART A HOSPITAL INSURANCE - INPATIENT CLAIMS

Dates of Service	Services Provided	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
1/01/03–1/04/03	Claim number 1253262400 **Good Samaritan Hospital** **70023 South 17th Street** **Anyplace, USA 00015-2300** Referred by: Karl Jones MD	3 days	$0.00	$840.00	$840.00	a b, c

Notes Section:

a The amount Medicare paid the provider for this claim is $4,101.72.

b Days used are being subtracted from your total inpatient benefits for this benefit period.

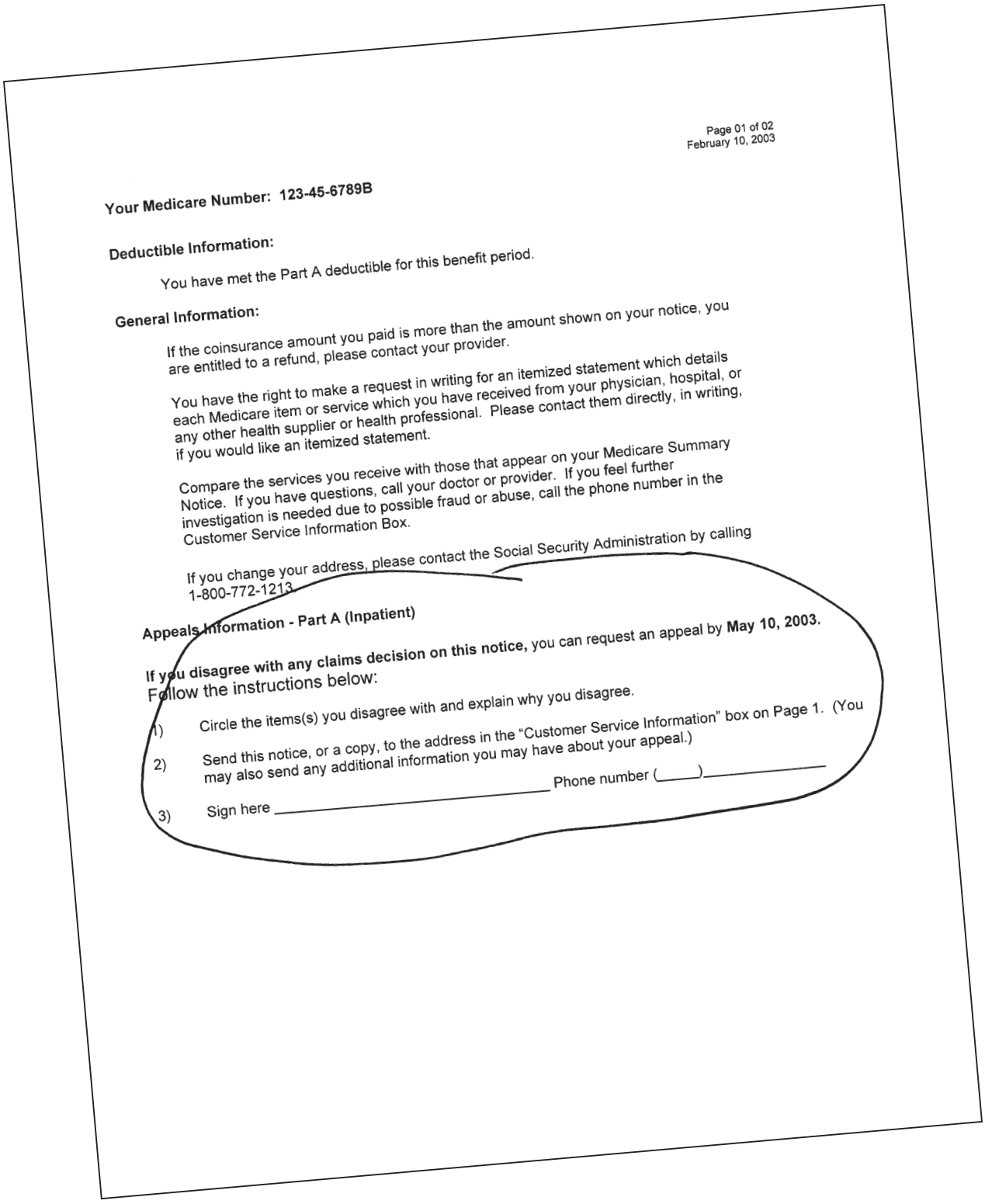
c $840.00 was applied to your inpatient deductible.

THIS IS NOT A BILL - Keep this notice for your records.

Example of Medicare Summary Notice

Inpatient Hosptial Claim, page 2

Appeal rights are explained on page 2



Page 01 of 02
February 10, 2003

Your Medicare Number: 123-45-6789B

Deductible Information:

You have met the Part A deductible for this benefit period.

General Information:

If the coinsurance amount you paid is more than the amount shown on your notice, you are entitled to a refund, please contact your provider.

You have the right to make a request in writing for an itemized statement which details each Medicare item or service which you have received from your physician, hospital, or any other health supplier or health professional. Please contact them directly, in writing, if you would like an itemized statement.

Compare the services you receive with those that appear on your Medicare Summary Notice. If you have questions, call your doctor or provider. If you feel further investigation is needed due to possible fraud or abuse, call the phone number in the Customer Service Information Box.

If you change your address, please contact the Social Security Administration by calling 1-800-772-1213.

Appeals Information - Part A (Inpatient)

If you disagree with any claims decision on this notice, you can request an appeal by **May 10, 2003.**
Follow the instructions below:

1) Circle the items(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here _____ Phone number (____)_____

Medicare Fraud and You

Medicare contractors pay millions of claims each year. Some of these claims are fraudulent. Keeping track of the health care services you received and comparing your records to the Medicare Summary Notice can help if you find that Medicare has paid for services that you did not receive. Your good record keeping can help Medicare when fraud or abuse is suspected.

While most providers and suppliers are honest, there are a few 'bad apples' who cheat Medicare and other insurers out of millions of dollars each year. Some possible benefits of successfully preventing fraud include lower Medicare and supplemental insurance premiums, reduced coinsurance payments, and preservation of Medicare funds for use in expanding Medicare coverage for items such as prescription drug coverage.

A few health care providers defraud the Medicare and Medicaid program by charging for services they did not provide, charging for a more expensive service than actually provided, or by filing false claims to receive payment for services not covered by Medicare.

You can help fight Medicare fraud by simply being a wise consumer.

Review your Medicare Summary Notices (MSNs). Did you receive the services listed on the MSN? Does the price charged seem appropriate for the service?

1. If a billing seems wrong, call the provider and ask for an explanation. In most cases, there will be a good explanation. An improper billing may be a result of a simple error, and the provider should correct the problem. Remember that simple errors are not fraud. Fraud requires a willful decision to get payment that is not deserved.

2. If you are not satisfied by the provider's explanation, call the Medicare contractor that processed the claim. Their phone number will be on the MSN. Tell them of your concern, and ask if they can provide more information or clarification about the billing.

3. If you are still not satified by the Medicare contractor's explanation, contact a Medicare counselor and ask them to review the bill. If you live outside the Denver Metro area, you may contact a counselor by calling toll-free 1-888-696-7213 or 1-800-544-9181. In Metro Denver you can call 303-899-5151. The counselor can examine the claim and forward it to the state office if they believe it may be fraud. The claim will be investigated and forwarded to Medicare if appropriate. Your counselor will advise you of their actions.

You can also report suspected fraud anonymously by calling the U.S. DHHS Office of the Inspector General at 1-800-447-8477.

Your Insurance Claims Record and Tracking Sheet

The Medicare Tracking Form is for your use in tracking your health care services as they are processed by Medicare and your private insurance. Below are guidelines for using this valuable tool.

- Use pencil for all entries.
- Use a separate form for each provider for the year.
- Copy additional forms as needed-keep a clean master copy.
- Remove forms and discard mailing envelopes, but keep return envelope.
  - o Sort the paperwork by provider.
  - o Arrange by date of service – (earliest on top.)
  - o Keep MSN's, Explanation of Benefits Forms, and recent bills and bills that give useful information, e.g., payments credited, new information on the account and reference to any activity.
  - o Discard duplicates.
  - o Remember that you can order missing MSN's from the Medicare contractor, and get information from missing Explanation of Benefits forms by contacting your secondary insurer.

1. Columns 1-2: Services: Record the date and brief description of each service and the amount billed. Begin with January bills and continue month by month. After you record the information regarding the bill on the log sheet, wait for the Medicare Summary Notice to record additional information

2. Columns 3 - 6: Medicare- (From MSN): From the Medicare Summary Notice, record in columns 3 through 6:

- Medicare's approved charge
- Amount Medicare paid to provider (assigned claims)
- Amount Medicare paid to patient (non-assigned claim)
- Amount that you may be billed

If needed, request missing Medicare Summary Notice forms (MSN's) from one of the following Medicare sources, depending on the type of service received:

- o Part A Hospital Claims: Request MSN's for outpatient or inpatient hospital services from Trailblazers Health Enterprise, 1-800-442-2620 or Mutual of Omaha, 1-877-647-6528
- o Colorado Part B Medical Claims: Noridan Government Services, 1-800-332-6681; Durable Medical Equipment, Palmetto GBA, 1-800-583-2236

3. Columns 7- 8: Other Insurance

- Enter the amount paid if check went to the provider
- Enter amount received if payment came to you directly
  - o If your provider accepted assignment, the remaining bill (after Medicare paid) automatically crosses over to your supplemental insurance company for payment of the Medicare gaps.
  - o If there is no crossover agreement with your insurance company, you will need to submit the information or a claim yourself. Call your insurer for guidance.

4. Columns 9-10: Patient Column 11: Notes

- Enter amounts, if any, you directly paid the provider at time of service
- Enter amount due after all insurance and personal payments are totaled
- Use Notes section as needed to record dates and details to remind yourself of actions taken or other information in the tracking process:
  - o Requested MSN & when
  - o Appealing to Medicare
  - o Called carrier regarding…

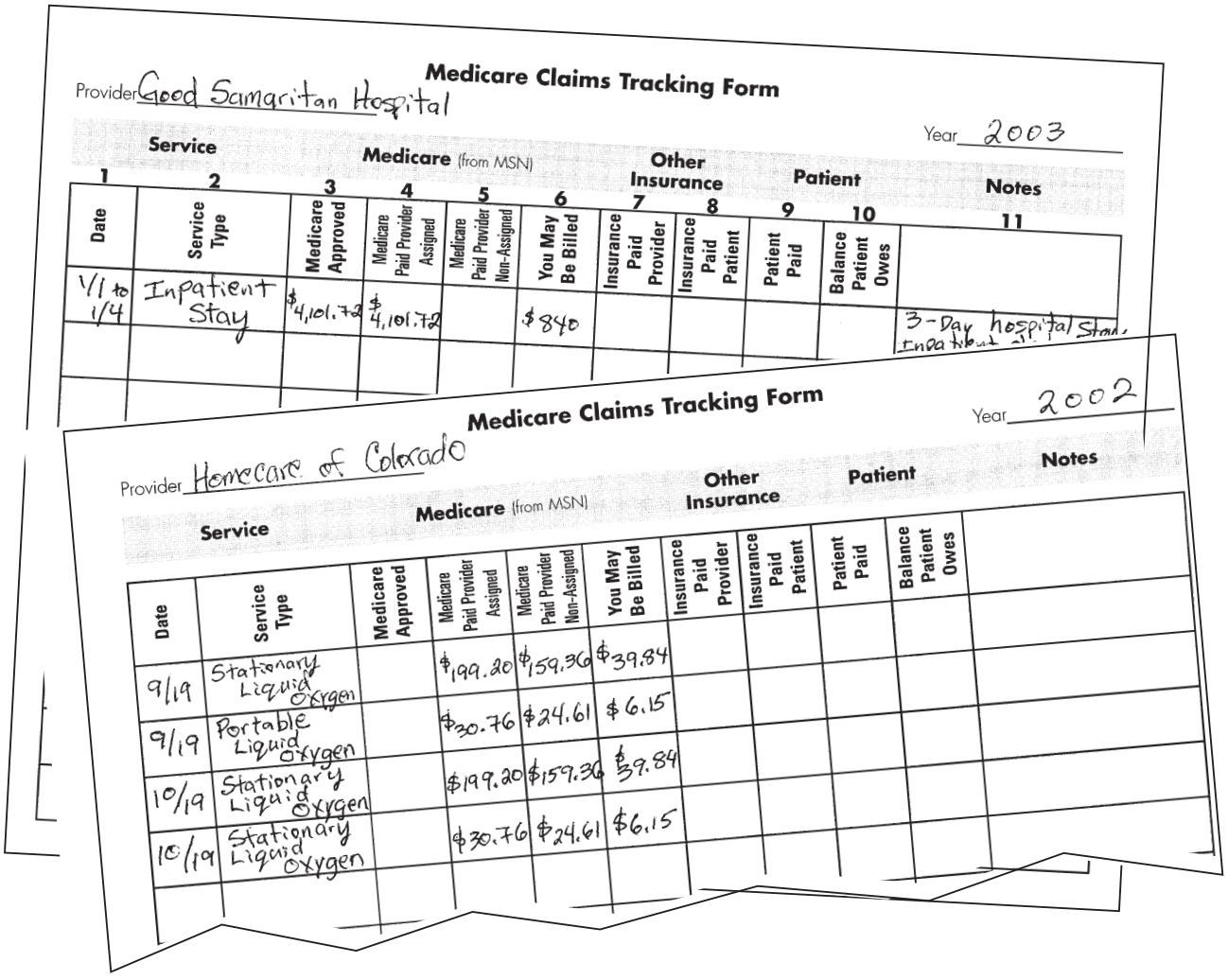
Reminders

- Store records of the year's medical expenses for reference at tax time.
- Remember that:
  - o At any point along the way, you may need to call the doctor's office for confirmation of a bill, or of its submission to Medicare or another insurer, etc.
  - o You may call the Medicare contractor for clarification or for a copy of your MSN.
  - o You may call your Medigap or Retiree Health Plan insurer for an Explanation Of Benefits form, or forms to file a claim.
  - o Provider bills may obtain references to "contractual adjustment" or "Medicare adjustment" when they reduce the amount you owe to comply with Medicare limits on their charges.
  - o You should feel free to call your local SHIP program for assistance when problems or obstacles arise.

Sample Tracking Forms

See pages 18-20 for full-size, blank forms

Using information from MSN's on pages 8–10



Medicare Claims Tracking Form

Provider Good Samaritan Hospital Year 2003

Service		Medicare (from MSN)				Other Insurance		Patient		Notes
1 Date	2 Service Type	3 Medicare Approved	4 Medicare Paid Provider Assigned	5 Medicare Paid Provider Non-Assigned	6 You May Be Billed	7 Insurance Paid Provider	8 Insurance Paid Patient	9 Patient Paid	10 Balance Patient Owes	11
1/1 to 1/4	Inpatient Stay	$4,101.72	$4,101.72		$840					3-Day hospital Stay Inpatient

Medicare Claims Tracking Form

Provider Homecare of Colorado Year 2002

Service		Medicare (from MSN)				Other Insurance		Patient		Notes
Date	Service Type	Medicare Approved	Medicare Paid Provider Assigned	Medicare Paid Provider Non-Assigned	You May Be Billed	Insurance Paid Provider	Insurance Paid Patient	Patient Paid	Balance Patient Owes	
9/19	Stationary Liquid Oxygen		$199.20	$159.36	$39.84					
9/19	Portable Liquid Oxygen		$30.76	$24.61	$6.15					
10/19	Stationary Liquid Oxygen		$199.20	$159.36	$39.84					
10/19	Stationary Liquid Oxygen		$30.76	$24.61	$6.15					

Why Didn't Medicare Pay?

There are many reasons why Medicare may not pay a bill submitted to them by a healthcare provider. Medicare will provide a somewhat cryptic explanation for this decision in the notes section of your Medicare Summary Notice (MSN). The notes section of the MSN is on the far right hand column on the line containing the date of service in question. There will be a letter listed (a, b) and an accompanying footnote at the end of the MSN saying what the letter code stands for. Medicare may provide multiple messages about the claim. Reviewing these brief explanations will often explain why a bill was not paid. It also will help you understand what action needs to be taken if the reason for Medicare non-payment is inaccurate.

Here are some of the more common MSN notes for denial of payment by Medicare:

▲This approved amount has been applied toward your deductible.

This is not really a denial of payment. Medicare approved the charge, but believes you still owe toward the $100 deductible for Medicare Part B services that people on the program must pay each year. Payment would have been made if the deductible had been met for that calendar year.

In some cases, your secondary insurance may pay this deductible charge once they receive the Medicare denial.

▲The information provided does not support the need for this many services or items.

▲The information provided does not support the need for this service or item.

▲The information we requested was not received.

Medicare makes payment only when they believe the service is "medically necessary." This gets into difficult issues such as how many services or visits are appropriate, or when is a treatment method justified. If you receive this type of MSN note, you will need to enlist the help of your provider to medically document why the service was appropriate. Often, the reason will have to do with unusual medical circumstances or multiple health care problems that must be explained to Medicare.

You may not owe the provider for this service, even if Medicare denies payment. The provider is responsible for alerting patients in writing before the specific service that Medicare may not pay. If this was not done, the provider may not be allowed to bill you for the charges.

▲Routine examinations and related services are not covered.

Medicare does not pay for annual routine physicals and related tests for healthy people. Bills coded for a routine physical, blood tests, x-rays, etc. will be legitimately denied by Medicare. However, if the exam or tests were not for preventive services, but for the diagnosis and treatment of a health problem, then the denial should be appealed and details about the health problem supplied to Medicare.

Many people on Medicare will have periodic exams paid for by Medicare because their doctor is monitoring health problems such as high blood pressure, arthritis, diabetes and other common problems that may lead to more serious health concerns.

▲This service is being denied because it has not been (12, 24) months since your last examination of this kind.

▲Screening pap smears are covered only once every 24 months unless high risk factors are present.

▲Medicare only covers this procedure for beneficiaries considered to be at high risk for colorectal cancer.

Medicare does pay for most common preventive tests such as mammography, pap smears, bone density scans, colonoscopy, PSA tests, glaucoma screening, etc. However, there are time limits as to how often Medicare will pay for preventive tests, and some tests are only available to people who have certain demonstrated risk factors. It is unlikely you can win an appeal where the appropriate time hasn't passed since the last preventive test. However, if you are in a high-risk category or the service was a diagnostic procedure mistakenly coded as a preventive test, your provider should be asked to correct the billing.

▲A separate charge is not allowed because this service is part of the major surgical procedure.

▲Payment is included in another service received on the same day.

▲Medicare does not pay separately for this service.

Most Medicare payments are designed to cover all the steps necessary to perform a certain service. Sometimes, the individual steps are billed separately to Medicare, and Medicare refuses to pay them using a message similar to those above. The process of billing the individual steps of a Medicare procedure is called "unbundling." And for some major services like surgery, the Medicare payment rate includes the pre and post-surgical office visits. Usually when you receive this type of MSN note, you do not have to pay the charge for the unbundled service.

▲Payment for transportation is allowed only to the closest facility that can provide the necessary care.

▲The information provided does not support the need for an air ambulance.

▲To receive Medicare payment, you must have a doctor's prescription before you rent or purchase this equipment.

▲Payment for this item is included in the monthly rental payment amount.

▲Skilled nursing facility benefits are only available after a hospital stay of at least 3 days.

▲Medicare does not pay for an assistant surgeon.

Many denials will have specific reasons such as those noted above. In these situations, specific and usually well-known Medicare payment rules have not been met. Some of these rules are contained in your Medicare handbook. Other rules are more technical, but your provider is expected to be familiar with them. An appeal of the payment decision is appropriate when you or your healthcare provider have additional information that can be submitted to show that Medicare payment is appropriate.

▲Our records show that you are enrolled in a health maintenance organization. Your provider must bill this service to them.

Medicare will not pay for services for people enrolled in a Medicare + Choice organization such as Kaiser Permanente or Pacificare Secure Horizons. If you disenrolled from this type of Medicare HMO very recently, Medicare records may not yet reflect your switch back to Original Medicare. It often takes 6 to 8 weeks for the records to be updated. The bills should automatically be paid after the update. If they have not been paid within 6-8 weeks, contact Medicare at the number listed on your MSN.

If you are enrolled in a Medicare + Choice organization and require emergency or urgent care from a non-HMO provider, your Medicare HMO should pay this bill at the Original Medicare rate. The provider should be instructed to submit their bill to the Medicare HMO. You should not pay any "additional charges" from the non-network provider beyond your HMO-established copayment for emergency services. Additional charges should be referred to your HMO customer service department for their handling.

▲**Our records show that Medicare is your secondary payer. This claim must be sent to your primary insurer first.**

▲**Medicare cannot pay for this service because it was furnished by a provider who is not a member of your employer prepaid health plan.**

▲**Secondary payment cannot be made because the primary insurer information was either missing or incomplete.**

In certain circumstances, Medicare does not pay most of your medical bills. People who are enrolled in an employer health plan because they or their spouse is still working should be paid mostly by the employer plan, unless it is a small employer plan. (Fewer than 20 employees for people 65+, fewer than 100 employees for people below age 65. ESRD patients have different payment rules)

Medicare also pays secondary to auto insurance coverage for injuries in an accident, liability insurance, worker's compensation, and other similar situations. However, if a person on Medicare is at fault in an auto accident and did not purchase optional medical coverage, Medicare will be the first payer for injuries. If another driver is at fault in an accident involving a person on Medicare, the at fault driver's auto liability insurance will be the first payer for injuries.

These payment situations are referred to as "Medicare secondary payer" or MSP situations, and the other insurer is called the primary insurer. Medicare will not pay bills in these circumstances until the other insurance has paid their share of the medical bill, and until Medicare sees the Explanation of Benefits statement from that insurer. If the primary insurer requires you to use a certain network of providers or receive preauthorization for services, you cannot ignore those rules in the expectation that Medicare will pay the bill.

Sometimes Medicare will not pay for a service following a trauma accident of some sort, or after a situation where auto insurance has been the primary payer. Medicare may assume incorrectly that this following treatment is related to the accident, and they are the secondary payer. In these circumstances you should call Medicare at the phone number listed on the MSN and correct the record.

Medicare may also refuse to pay if you recently quit working or dropped your employer health plan, thinking that the employer plan is still the primary payer. In this circumstance, you should inform Medicare of the change, and they may request that you provide them information about your former employer plan. A contractor hired by Medicare will send a questionnaire to the employer asking them to verify the change. You can also call the Medicare coordination of benefits contractor to inform them of the change in status at 1-800-999-1118. Remember that an employer health plan for retirees always pays secondary to Medicare

Demystifying Medicare Claims Jargon

You need to understand Health insurance claims-speak. Become familiar with the following terms:

Approved charge - The amount from the Medicare Fee Schedule on which Medicare bases its payment.

Assignment - An agreement between Medicare and the provider in which the provider agrees to accept the Medicare's approved charge as payment in full. The provider who accepts assignment will receive Medicare's share of the payment directly from Medicare. (Assigned claim)

Carrier - A health insurance company that contracts with Medicare to process Medicare Part B claims.

Claim – An itemized bill from a healthcare provider to Medicare or to a private insurance company for payment.

Copayment - A dollar amount or percentage of covered health expenses expenses that is your share of the cost of the care. You or your secondary insurer pay this amount.

Deductible - Amount of money you pay before Medicare or other insurance pays a benefit.

Denial – A decision by Medicare or other insurance not to pay a claim.

EOB - An "Explanation of Benefits" form from an insurer that describes what services were billed to a non-Medicare insurer and what payment that insurer made. EOBs are sent by Medicare supplement insurance (Medigap) and employer retiree health plans.

Health Care Provider - Someone who is authorized to provide health care services or products. Includes doctors, hospitals, therapists, nurses, and durable medical equipment suppliers.

Intermediary - A health insurance company that contracts with Medicare to process Medicare Part A claims.

Medicare Contractor – A private insurer hired by Medicare to process medical claims. Medicare Part A contractors are called "intermediaries," and Medicare Part B contractors are called "carriers."

Medigap – Medigap or Medicare Supplement Insurance are names describing private health insurance policies sold and designed to provide payment for service costs not paid by Medicare, primarily Medicare copayments and deductibles.

Medicare Summary Notice (MSN) - The monthly statement sent by a specific Medicare contractor explaining what services were billed to Medicare on your behalf and their payment decision.

Medicare Secondary Payer (MSP) – Situations where Medicare is not the first and major payer on a health care claim because another insurance is responsible for most of the cost.

Non-Participating Providers –Doctors and other providers who do not sign a contract with Medicare to accept the Medicare approved charge. These providers are not required to accept the Medicare approved charges as payment in full, although they may choose to do so. Doctors who opt to not accept the Medicare approved charge are allowed to collect up to 115% of the Medicare approved charge from their patients.

Participating providers – Doctors and other healthcare providers who sign a contract with Medicare to accept the Medicare approved charge on ALL Medicare claims. Participating providers cannot bill patients for amounts above what Medicare approves. Medicare pays the participating providers directly. You are responsible for deductibles, coinsurance amounts, and costs for noncovered items.

Primary (or First) Payer - The insurance coverage that pays first and most of the health care bill. Most people age 65 and older have Medicare as their primary, but those still working for a large employer and covered by their insurance or victims of an auto accident will find other insurances are primary.

Secondary (or Second) Payer - An insurance that pays costs not covered by the Medicare. Most often, these are Medicare supplement insurance (Medigap), or employer retiree health plans. Sometimes Medicare may be the secondary insurance, such as when a person on Medicare is still working and has health insurance coverage from a large employer.

Medicare Claims Tracking Form

Provider_____ Year_____

Service		Medicare (from MSN)				Other Insurance		Patient		Notes
Date	Service Type	Medicare Approved	Medicare Paid Provider Assigned	Medicare Paid Provider Non-Assigned	You May Be Billed	Insurance Paid Provider	Insurance Paid Patient	Patient Paid	Balance Patient Owes	

Medicare Claims Tracking Form

Provider_____ Year_____

Service		Medicare (from MSN)				Other Insurance		Patient		
Date	Service Type	Medicare Approved	Medicare Paid Provider Assigned	Medicare Paid Provider Non-Assigned	You May Be Billed	Insurance Paid Provider	Insurance Paid Patient	Patient Paid	Balance Patient Owes	

Medicare Claims Tracking Form

Provider_____ Year_____

Service		Medicare (from MSN)				Other Insurance		Patient		Notes
Date	Service Type	Medicare Approved	Medicare Paid Provider Assigned	Medicare Paid Provider Non-Assigned	You May Be Billed	Insurance Paid Provider	Insurance Paid Patient	Patient Paid	Balance Patient Owes	

Colorado Resources
Free Publications and Videos

The Senior Health Insurance Assistance Program provides the following publications to consumers at no cost. Publications can also be provided in quantity to organizations for distribution to their members. Please contact us at 303/894-7553 to place an order. You can also access this information via the Internet at www.dora.state.co.us/insurance Click on Senior Health/Medicare.

Medicare and Related Health Insurance: The Big Picture
An overview of Medicare and how it works with various other health insurance products.

Medicare Supplement Insurance Information for Consumers
A list of private insurers marketing these products, their contact information, and pricing.

Medicare Health Maintenance Organization (HMO) Information for Consumers
Comparisons of health benefits, copays, and other information on these private options.

Long Term Care Insurance Information for Consumers
Discussion of who should buy this coverage, how policies are structured, and the standardized Colorado products.

Prescription Manufacturer Consumer Assistance Programs
Drug companies provide deep discount cards for many people on Medicare.

Medicaid Assistance for Medicare Beneficiaries
State help program for low-income, low savings consumers on Medicare. Your house and car aren't counted as an asset.

Managing Your Medicare Bills
Help understanding the billing system, a tool to track bills including supplemental payers, and information for when Medicare doesn't make payment.

Primary Care Doctors Accepting New Medicare Patients in Metro Denver or Boulder

Personal Health Care Reference
Booklet containing information on preventive health services, help sources, a log for your health information, and a discussion of Medicare fraud.

Senior Security: Avoiding Scams and Fraud in Colorado
Video providing consumer information about Medicare fraud, identify theft, telephone scams, junk mail offers, home repair cons, and caregiver fraud. Available free for showing before senior organizations. Twenty-nine minutes long with accompanying handout.

Master of the Transaction: Senior Security II
Video providing consumer information about Medicare billing, charitable solicitations, planning for increased dependence, and investment fraud. Twenty-four minutes long with accompanying handout.

Publications have been produced by the Colorado Division of Insurance with financial assistance, in whole or in part, through grants from the Centers for Medicare & Medicaid Services (CMS), the Federal Medicare agency or from the federal Administration on Aging (AoA).

STATE OF COLORADO

The Colorado Senior Health Insurance Assistance Program is a counseling program for Medicare beneficiaries and their family's who wish assistance in understanding Medicare benefits, coverage gaps, billing concerns, Medigap, Medicare HMOs, long term care insurance, and other health insurance options.

Services are provided through a statewide network of organizations that recruit counselors, publicize services, and operate the local program. Counselors donate their time and expertise.

Counselors will not recommend or endorse specific insurance policies, but will assist consumers with information to make informed insurance choices.

All services are provided without charge.

Colorado Senior Health Insurance Assistance Program (SHIP) volunteers can help you:

- ➢ Organize, understand and process medical bills
- ➢ Assist with private health insurance claims
- ➢ Identify gaps in Medicare coverage and options to fill them
- ➢ Evaluate Medicare supplement insurance options
- ➢ File Medicare appeals
- ➢ Understand your hospital and Medicare rights
- ➢ Provide you with reference information and referral sources

Senior Health Insurance Assistance Program
Colorado Division of Insurance

Regional affiliates,
call toll free 1-888-696-7213
or 1-800-544-9181
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