A POTPOURRI OF MEDICARE PART B ISSUES

This Issue Brief brings together a variety of topics related to items and services covered under Medicare Part B. It is designed as an update of certain key issues and concerns, some of them related to changes made by the recent health care reform legislation. It is not exhaustive. Please refer to our series of weekly electronic “Alerts,” that are archived on our website at www.medicareadvocacy.org, for additional updates about these and other Medicare topics.

PREVENTION AND WELLNESS

The Affordable Care Act (ACA) adds coverage for a new "Wellness Visit" and eliminates cost-sharing for almost all of the preventive services covered by Medicare, effective January 1, 2011.¹ These changes reflect a shift in policy to focus health care more on prevention and wellness than on treating acute illness, with the goal of reducing costs.

• Annual Wellness Visit

Starting in January 2011, Medicare will cover a new annual Wellness Visit and will provide payment for the creation of a personalized prevention plan. The Wellness Visit will include a health risk assessment to establish or update the individual's medical and family history; create a list of current providers and suppliers involved in providing medical care, including a list of prescriptions; take measurements of height, weight, body mass index, blood pressure and other routine measurements; and detect cognitive impairments.

During the Wellness Visit, the health professional will establish or update a screening schedule for the next 5-10 years, based on recommendations of the United States Preventive Services Task Force (USPSTF). The recommendations of USPSTF are based on an individual's age and health status. The visit may include health education or preventive counseling services designed to reduce risk factors that have been identified during the visit. Examples of such education and counseling services include those designed to promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention and nutrition.

¹ PPACA (or ACA) §§4103, 4104, amending 42 U.S.C. §§ 1395l(a)(1), 1395x.
The Wellness Visit may be conducted by a physician or another practitioner whose services are recognized by Medicare. Such practitioners include physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, clinical social workers, and clinical psychologists. Practitioners may also include health educators, registered dietitians, or nutrition professionals working under the supervision of a physician.

CMS listed "detection of any cognitive impairment" as one of the services to be included in the first and subsequent annual Wellness Visits. However, CMS did not recommend yearly screenings for depression or for functional impairments, based on the USPSTF finding that the optimal interval for screening for depression in older individuals is unknown. Based on comments to the proposed regulations, CMS added voluntary advance care planning as an element to the first and subsequent annual Wellness Visits.

The new annual Wellness Visit builds upon the current "Welcome to Medicare" check-up or "initial physical examination" that is available to beneficiaries within 12 months of their becoming covered under Medicare Part B. The initial preventive physical examination consists of a physical examination, including measurement of height, weight, and blood pressure and an electrocardiograph, with the goal of health promotion and disease detection. The initial preventive physical examination also includes education, counseling, and referral with respect to screening and other preventive services, although it does not include clinical laboratory tests. A beneficiary is only entitled to a "Welcome to Medicare" check-up, and not a Wellness Visit exam, during the 12-month period after coverage begins under Part B. However, a beneficiary is entitled to personalized prevention plan services once a year thereafter.

- **Elimination of Cost-sharing for Preventive Services**

The Affordable Care Act also eliminated cost-sharing for most of the preventive services covered under Medicare, effective January 1, 2011. The preventive services to which the provision applies are those that are appropriate for the individual and that are recommended with a grade of A or B by the USPSTF for any indication or population. The services for which no cost-sharing (deductible and/or co-payment) will be charged are:

1. Mammograms every 12 months for eligible beneficiaries age 40 and older;
2. Colorectal cancer screening, including flexible sigmoidoscopy or colonoscopy;
3. Cervical cancer screening, including a Pap smear test and pelvic exam;
4. Cholesterol and other cardiovascular screenings;
5. Diabetes screening;
6. Medical nutrition therapy to help people manage diabetes or kidney disease;
7. Prostate cancer screening (for most codes);
8. Annual flu shot, pneumonia vaccine, and the hepatitis B vaccine;

---

2 ACA § 4103 refers to practitioners described in 42 U.S.C. §1395u(b)(18)(C).
4 42 U.S.C. § 1395x(ww)
5 42 U.S.C. § 1395x(ww).
9. Bone mass measurement;
10. Abdominal aortic aneurysm screening to check for a bulging blood vessel;
11. HIV screening for people who are at increased risk or who ask for the test.
12. Smoking cessation counseling.⁶

Cost-sharing is also eliminated for the Wellness Visit and Personal Prevention Plan. CMS indicates that the following preventive services covered by Medicare are not recommended by USPSTF with a grade of A or B for any populations or indications, and will therefore continue to be subject to cost-sharing:

1. Digital rectal examination furnished as a prostate cancer screening service;
2. Glaucoma screening;
3. Diabetes self-management training services;
4. Barium enema furnished as a colorectal cancer screening.⁷

Note that, for all services, current coverage policies continue to apply. For example, Medicare only covers bone mass measurements once every two years for qualified high-risk individuals.⁸ Testing within that time frame for people who meet the eligibility criteria will not be subject to a deductible or co-payment. Bone mass measurement will not be covered for someone who is not a high risk individual, however, regardless of the change in cost-sharing requirements.

• Implications for Medicare Advantage Plans

With the exception of hospice care, Medicare Advantage plans are required to provide all items and services that are covered under Medicare Part A and Part B.⁹ Thus, Medicare Advantage plans will be required to offer the new Annual Wellness Visit to their enrollees, starting on January 1, 2011.

Medicare Advantage plans have more leeway with regard to elimination of cost-sharing for preventive services. Medicare Advantage plans have always been allowed to impose different cost-sharing than under Part A and Part B, as long as the cost-sharing is actuarially equivalent to cost-sharing under Traditional Medicare.¹⁰ In placing limits on Medicare Advantage cost-

---

⁶ On August 25, 2010, CMS announced that it was extending coverage for smoking cessation counseling. HHS Announces Medicare Expands Coverage Of Tobacco Cessation Counseling (Aug, 25, 2010); http://www.cms.gov/apps/media/press/release.asp?Counter=3830&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C2%2C13%2C4%2C5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date
⁷ 75 Fed. Reg. 73169 (November 29, 2010), amending 42 C.F.R. §§ 410.152; 410.160. Table 65 includes a chart of the complete list of codes for preventive services that indicates whether the services are subject to cost-sharing both currently and starting in 2011. 75 Fed. Reg. at 73420 – 73430.
⁸ 42 U.S.C.§ 1395x.
⁹ 42 U.S.C. § 1395w-22(a); 42 C.F.R. 422.101.
sharing for certain costly services, ACA expands that authority by allowing plans to impose cost-sharing for services for which Part A and Part B do not have cost-sharing.\textsuperscript{11}

While many Medicare Advantage plans have traditionally eliminated cost-sharing for preventive benefits under their authority to offer an actuarially equivalent benefit package, some did not. There are some plans that will still charge cost-sharing in 2011 for services for which there will be no beneficiary cost under Traditional Medicare. CMS issued proposed regulations on November 22, 2010, that would prohibit plans from charging deductibles, co-payments, or co-insurance for in-network Medicare-covered preventive services, as specified by CMS on an annual basis. If made final, the regulation would go into effect starting in 2012.\textsuperscript{12}

\textbf{PART B PREMIUMS}

- "Hold Harmless" Part B Premiums

The majority of Medicare beneficiaries will not see an increase in their Part B premium because there will be no Social Security cost-of-living adjustment for 2011.\textsuperscript{13} A hold harmless provision in the Social Security Act disallows an increase in the Medicare Part B premium for qualifying Social Security recipients if their COLA is not large enough to cover the increase in the Part B premium.

To be protected by the hold harmless provision, a beneficiary must:

- Be entitled to Social Security benefits for November and December of the preceding year. (For the 2011 cycle: November 2010 and December 2010)
- Have the Medicare Part B premium deducted from Social Security benefits in December of the preceding year and January of the current year. (For the 2011 cycle: December 2010 and January 2011) (The discrepancy between months of entitlement and months of check is due to the program design that has the beneficiary receiving the check for last month's benefits in the current month, e.g. December's benefits come in January.)
- Not receive a COLA that is greater than the Part B premium increase. (For the 2011 cycle, no one will receive a COLA.)
- Not have a modified adjusted gross income over a certain amount. ($85,000 for an individual and $170,000 for a couple in 2011.)\textsuperscript{14}

The Part B premium amount that protected beneficiaries will pay, however, will depend on whether they were protected by the hold harmless provision in 2010, or whether they first become eligible for hold harmless protection in 2011.

\textsuperscript{12} 75 Fed. Reg. 71189 (Nov. 22, 2010), amending 42 C.F.R. §422.100(k).
\textsuperscript{13} According to the Centers for Medicare & Medicaid Services (CMS), about 27% of beneficiaries will pay an increased Part B premium. Of these, 3% are new to Medicare, 5% pay an income-related Part B premium, and 19% (17% points of whom have their Part B premium paid by one of the Medicare Savings Programs) do not have their Part B premium deducted from their Social Security or Railroad Retirement check. CMS, Medicare Fact Sheet: Medicare Premiums, Deductibles for 2011 (Nov. 4, 2010).
\textsuperscript{14} 42 U.S.C. §1395t(f).
Assuming no change in their circumstances, people who were protected by the hold harmless clause in 2010 will be protected again in 2011. They will continue to pay the same Part B premium, $96.40, which they paid in 2009 and 2010. In addition, some beneficiaries who were not protected by the hold harmless clause in 2010 – primarily because they were new to Medicare in 2010 or because they did not have Part B premiums withheld from their Social Security or Railroad Retirement checks at the end of 2009 – will be protected by the hold harmless clause for 2011. These beneficiaries will continue to pay the same Part B premium, $110.50, which they paid in 2010.

- **Standard Part B Premium**

In addition to the two "hold harmless" Part B premium amounts, there will be a standard Part B premium amount of $115.40 for 2011. Individuals who are new to Medicare in 2011 or who did not have Medicare premiums withheld from their Social Security or their Railroad Retirement checks in 2010 will pay $115.40.

- **Implications for Beneficiaries Who Lose MSP Eligibility**

Individuals who currently have their Part B premiums paid for by the Qualified Individual (QI) program\(^\text{15}\) are in jeopardy of having to pay the $115.40 Part B premium in 2011 if Congress does not extend the QI program beyond the end of the year. That is because their Part B premiums were not withheld from their Social Security checks during the requisite time periods to be eligible for the hold harmless protection. Their Part B premiums were paid by their state under the QI program. People who lose eligibility for one of the other Medicare Savings Programs, Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB), will also have to pay the $115.40 Part B premium.

- **Income-Related Part B Premium**

As stated above, individuals who pay the income-related Part B premium are not protected by the hold harmless clause. The amount of the premium they will pay depends on their modified adjusted gross income and is indicated in the chart below.

\(^{15}\) The QI program is a block grant to states to pay the Part B premium for individuals with incomes between 120 and 135% of the federal poverty level and with countable resources of $4,000 (individual) and $6,000 (couple). The QI program is set to expire on December 31, 2010.
### Part B Income-Related Premium

<table>
<thead>
<tr>
<th>Beneficiaries who file an individual tax return with income:</th>
<th>Beneficiaries who file a joint tax return with income:</th>
<th>Beneficiaries who are married, but file a separate tax return with income:</th>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly Part B premium amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>Less than or equal to $170,000</td>
<td>Less than or equal to $85,000</td>
<td>$0.00</td>
<td>$115.40</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $107,000</td>
<td>Greater than $170,000 and less than or equal to $214,000</td>
<td></td>
<td>$46.10</td>
<td>$161.50</td>
</tr>
<tr>
<td>Greater than $107,000 and less than or equal to $160,000</td>
<td>Greater than $214,000 and less than or equal to $320,000</td>
<td></td>
<td>$115.30</td>
<td>$230.70</td>
</tr>
<tr>
<td>Greater than $160,000 and less than or equal to $214,000</td>
<td>Greater than $320,000 and less than or equal to $428,000</td>
<td>Greater than $85,000 and less than or equal to $129,000</td>
<td>$184.50</td>
<td>$299.90</td>
</tr>
<tr>
<td>Greater than $214,000</td>
<td>Greater than $428,000</td>
<td>Greater than $129,000</td>
<td>$253.70</td>
<td>$369.10</td>
</tr>
</tbody>
</table>

The Social Security Administration (SSA) modified and clarified its definition of major life-changing events that allow a beneficiary to request a review of a determination which states that she must pay an income-related premium. Under the new rules, a beneficiary may request that SSA use more recent tax information to make the calculation if:

1. A beneficiary receives a settlement payment from a former employer in lieu of periodic pension payments and/or health insurance coverage as a result of the former employer’s closure, bankruptcy or reorganization;
2. A beneficiary experiences a loss of investment property as a result of fraud or theft due to a criminal act by a third party;
3. A beneficiary experiences a reduction in or loss of income from an employer's pension plan due to termination or reorganization of the pension plan or a scheduled cessation of pension, regardless of whether the pension is insured.16

---

16 75 Fed. Reg. 41084 (July 15, 2010), amending 20 C.F.R. §§418.1205; 418.1210; 418.1230; 418.1255; 418.1265.
Summary of How the Hold Harmless Provision Applies

<table>
<thead>
<tr>
<th>Type of Beneficiary</th>
<th>Hold Harmless Applies?</th>
<th>Part B Premium Increase?</th>
<th>If Premium Increased, Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium Withheld from Social Security Check, Not Income-Related</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium Withheld, Pays Income-Related Premium</td>
<td>No</td>
<td>Yes</td>
<td>Specifically excluded from hold harmless provision.</td>
</tr>
<tr>
<td>New Beneficiaries</td>
<td>No</td>
<td>Yes</td>
<td>Have not been enrolled in Part B long enough</td>
</tr>
<tr>
<td>Enrolled in an MSP</td>
<td>No</td>
<td>Yes, but the state pays</td>
<td>Part B premiums are not withheld from their Social Security benefits</td>
</tr>
<tr>
<td>Lose MSP during 2010</td>
<td>No</td>
<td>Yes</td>
<td>Part B premium not withheld from their Social Security benefits</td>
</tr>
<tr>
<td>Direct Pay Status (Premium Not Withheld from Social Security Check)</td>
<td>No</td>
<td>Yes</td>
<td>Part B premiums are not withheld from their Social Security benefits (they don’t receive any)</td>
</tr>
<tr>
<td>SSDI Recipients Who Become Eligible for Medicare in 2011</td>
<td>No</td>
<td>Yes</td>
<td>Part B premium not previously withheld from their Social Security benefits</td>
</tr>
</tbody>
</table>

NEW MEDICARE HOME HEALTH REGULATIONS

The Centers for Medicare & Medicaid Services (CMS) clarified its regulations, effective January 1, 2011, for the coverage of services that constitute speech-language pathology services and physical or occupational therapy services in the home health care setting. The Center for Medicare Advocacy and other advocates were very involved in efforts to obtain these clarifications. Importantly, the rules specifically provide for coverage for maintenance physical therapy and prohibit denials on the basis of “rules of thumb” including lack of restoration potential or degree of “stability.” The regulations place emphasis on services that are in keeping with accepted standards of professional clinical practice and that must be provided by skilled personnel to be safe and effective treatment for the beneficiary’s condition.

17 75 Fed. Reg. 70461 (Nov. 17, 2010), 42 C.F. R. §409.44(c) (Nov. 2010). Effective January 1, 2011
18 Ibid.
19 §409.44(c)(2)(i). Note, the Center will have a detailed discussion of the clarifications during the February 2011 call.
FACE-TO-FACE PHYSICIAN/PRACTITIONER ENCOUNTER

• Durable Medical Equipment

Because of fraud and billing irregularities, the requirement of a face-to-face encounter with a physician for the receipt of certain specified durable medical equipment (DME) is long standing – specifically for a power mobility device (PMD) used as DME.\textsuperscript{20} Further, the law requires that a prescription for the PMD must be in the form of a written order completed by the physician or treating practitioner who performed the face-to-face examination and received by the PMD supplier within 45 days of the face-to-face encounter.\textsuperscript{21} In addition, the law provide that a physician has the same meaning as in section 1861(r)(1) of the Medicare Act. Note, however, for beneficiaries discharged from a hospital, a separate face-to-face encounter is not required 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, with supporting documentation, within 45 days after the date of discharge.\textsuperscript{22}

The Affordable Care Act (ACA) amends the Medicare statute to provide that the Secretary shall require that an order for specified DME must be written by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist who has had a face-to-face encounter with the patient (including tele-health) during the 6 month period preceding the written order or other reasonable time frame as determined by the Secretary.\textsuperscript{23}

• Home Health Care

Similar to the requirement for DME, with the enactment of the Affordable Care Act (ACA) of 2010, a face-to-face encounter with a physician and certification of the need for home health care is required before Home Health Care can be prescribed, although with a different time-line structure.\textsuperscript{24} For home health care, the certification, after the face-to-face encounter, must be related to the primary reason for which the beneficiary requires home health care. Further, the face-to-face encounter must have "occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter."\textsuperscript{25} The certification of the need for home health care must include an explanation why the physician’s clinical findings support the need for home health care, including that the patient is homebound and the need for either intermittent skilled nursing services or therapy

\textsuperscript{20} See 42 C.F.R. §410.38(c) (Aug. 2005). The Secretary’s authority to specify items of DME to be subject to the face-to-face requirement is found in §1834(a)(11)(B) of the Social Security Act, 42 U.S.C. §1395m(a)(11)(B). Further, the Secretary of Health and Human Services, (the Secretary), has been given the authority to apply the face-to-face requirement to other areas of Medicare to reduce waste, fraud, and abuse as she deems appropriate. ACA §6407(c). The Secretary has also been given the authority to apply the face-to-face requirement to Medicaid services if she deems it would reduce waste, fraud, and abuse. Id. §6407(d).
\textsuperscript{21} 42 C.F.R. §410.38(c).
\textsuperscript{22} Ibid.
\textsuperscript{23} See ACA §6407(b).
\textsuperscript{25} 42 C.F.R. § 424.22(a)(1)(v).
services as defined in 42 C.F.R. §409.42(a) and (c). Note, the regulations provide that a face-to-face encounter can be by tele-health as provided in §1834(m) of the Social Security Act.

In addition, the regulations provide that the face-to-face encounter must be performed by the certifying physician or by a nurse practitioner, a clinical nurse specialist who is working in collaboration with the physician or physician assistant under the supervision of the physician. Note, the documentation of the face-to-face patient encounter must be a separate and distinct section of, or an addendum to, the certification, and must be clearly titled, dated and signed by the certifying physician. When the face-to-face encounter is performed by a non-physician, he or she must document the clinical findings of the face-to-face encounter and communicate those findings to the certifying physician.

If the face-to-face encounter occurred within 90 days of the start of care but is not related to the primary reason that the patient requires home health services, or the patient has not seen the certifying physician or non-physician (as provided in the regulations) within 90 days of the start of the episode of home health care, the certifying physician or non-physician must have a face-to-face encounter with the patient within 30 days of the start of the home health care.

Recertification of the need for home health care must be provided at least every 60 days, with a preference for the recertification to occur at the time that the plan of care is revised, and must be signed and dated by the physician who reviewed the plan of care.

- **Hospice Care**

Hospice care is covered under Medicare Part A, not Medicare Part B. The new requirements for hospice care are included in this issue brief because of their similarity to the requirements for DME and home health. Beginning January 1, 2011, a hospice physician or hospice nurse practitioner must:

have a face-to-face encounter with each hospice patient, whose total stay across all hospices is anticipated to reach the 3rd benefit period, no more than 30 calendar days prior to the 3rd benefit period recertification, and must have a face-to-face encounter with that patient no more than 30 calendar days prior to every recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.

---

26 Ibid.
27 Ibid. C.F.R. §424.22(a)(1)(C).
28 Ibid. § 424.22(a)(1)(v).
29 Ibid.
30 Ibid. §424.22(a)(1)(v)(A).
31 Ibid. §424.22(a)(1)(v)(B).
32 Ibid. §424.22(b)(1).
33 Ibid. §418.22(a)(4).
The required narrative must include a statement, written directly above the physician’s signature, attesting that the physician confirms that the narrative is based on his or her examination of the patient. Moreover, the narrative for the 3rd benefit period and each subsequent benefit period must explain why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.

The certification of the physician or nurse practitioner who performs the face-to-face encounter must contain a written attestation that he or she had the face-to-face encounter with the patient. Further, the attestation of the nurse practitioner must state that his or her clinical findings from the face-to-face encounter were provided to the certifying physician; must be in writing; and must be a separate and distinct section or an addendum to the recertification form; and must be clearly titled. Moreover, all certifications and recertifications must be signed and dated by the physician(s), including the benefit periods to which the certification or recertification applies.

COMPETITIVE ACQUISITION OF DURABLE MEDICAL EQUIPMENT, ORTHOTICS AND SUPPLIES (DMEPOS) PROGRAM

Designated DMEPOS items furnished on or after January 1, 2011, are to be based on Medicare's competitive acquisition program. On November 3, 2010, CMS published its list of bid winners. As stated in our October issue brief, advocates should continue to monitor the DMEPOS program and its implementation to assure that beneficiary access to necessary items and services is not diminished. The DMEPOS Competitive Bidding website is a good reference point for information, including a list of the items currently subject to competitive bidding.

In addition, CMS has on its website, a variety of fact sheets and other information materials that describe the DMEPOS program, identify the Competitive Bidding Areas (CBAs), list the items of DMEPOS subject to the program as of January 1, 2011, and provide education materials for use in education activities for beneficiaries. Note, the DMEPOS program does not affect which

---

34 Ibid. §418.22(b)(3)(iii).
35 Ibid. §418.22(b)(3)(v).
36 Ibid. §418.22(b)(4).
37 Ibid.
38 Ibid. §418.22(b)(5).
39 See 1834a(1)(g) of the Social Security Act (Use of Information on Competitive Bid Rates), 42 U.S.C. §1395w-3b (Competitive Acquisition Program); see also 1871(a)(1) of the Social Security Act, 42 U.S.C. §1395w-3(a)(1); 72 Fed. Reg. 17,992 et seq. (April 10, 2007), 42 C.F.R. §414.400 et seq. On August 27, 2010, the Secretary of HHS published final regulations that clarify and expand enrollment requirements for DMEPOS suppliers, including billing privileges. See 75 Fed. Reg. 52629 (Aug. 27, 2010), effective September 27, 2010. The rule amends 42 C.F.R. §424.57 Special payment rules for items furnished by DMEPOS suppliers and issuance of DMEPOS supplier billing privileges.
40 See http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp. (Site visited December 2, 2010.).
41 See http://www.cms.gov/DMEPOSCompetitiveBid/01A2_Contract_Supplier_Lists.asp. (Site visited December 2, 2010.).
42 http://www.cms.gov/Partnerships/03_DMEPOS_Toolkit.asp. (Site visited December 2, 2010.).
doctors or hospitals a beneficiary may use. In addition, CMS has developed a brochure that will be helpful to beneficiaries and advocates.43

The geographic areas impacted in this phase of the program are: California—Riverside, San Bernardino, Ontario; Florida—Miami, Fort Lauderdale, Pompano Beach; Florida—Orlando, Kissimmee; Missouri and Kansas—Kansas City; North and South Carolina—Charlotte, Gastonia, Concord; Ohio—Cleveland, Elyria, Mentor; Ohio, Kentucky, and Indiana—Cincinnati, Middletown; Pennsylvania—Pittsburgh; and Texas—Dallas-Fort Worth, Arlington. If your clients live in or plan to visit certain ZIP codes in the areas identified above, they will almost always have to use a supplier that contracts with Medicare when they buy or rent certain equipment or supplies under the Medicare program.

AMBULANCE SERVICES

- Please review the Center for Medicare Advocacy’s Quick Screen for Ambulance Coverage and Appeals (Attached here as pages 12 - 13).

CONCLUSION

Part B of Medicare provides coverage for a host of items and services utilized by the majority of Medicare beneficiaries. The voluntary Part of Medicare, Medicare Part B is financed by premiums paid by those who choose to enroll. Advocates need to be aware of changes in Part B to ensure that beneficiaries receive all of the services to which they are entitled. They also need to be aware of the complexities of the new Part B premium structure, as that structure may discourage some beneficiaries from enrolling in Part B.

WHEN SHOULD MEDICARE COVERAGE BE AVAILABLE FOR
AMBULANCE SERVICES
A QUICK SCREEN TO AID IN IDENTIFYING COVERABLE CASES

Medicare ambulance claims are suitable for coverage, and appeal if they have been denied, if they meet the following criteria:

1. Travel by ambulance must be the only safe means of transportation available. It is not sufficient that alternative transportation cannot be arranged. It is necessary to show that your health would have been jeopardized had you been transported any other way.

2. Transportation by ambulance must be:
   
   • From your home to a "local" hospital or skilled nursing facility, or if you are not in the locality or "service area" of an institution which has appropriate facilities, to the nearest institution that does;

   • To your home from a local hospital or skilled nursing facility, or from the nearest institution with appropriate facilities;

   • From a skilled nursing facility to a hospital or from a hospital to a skilled nursing facility if the discharging institution is within the service area of the admitting institution; if the discharging institution is outside the service area of the admitting institution, the admitting institution must be the nearest one with appropriate facilities;

   • From a skilled nursing facility to a skilled nursing facility, or from a hospital to a hospital, if the discharging institution was not an appropriate facility and the admitting institution is the closest one with appropriate facilities.

   NOTE: Partial payment for ambulance services may be available even when the ambulance trip exceeds the distance limitations described above. For example, when a beneficiary is transported from a distant hospital or skilled nursing facility to his or her residence, payment may be based on the amount that would have been payable had the beneficiary been transported to his or her residence from the nearest institution with appropriate facilities.

3. The ambulance must be provided by a Medicare-certified provider.

4. Non-emergency transportation is covered only if the ambulance supplier obtains a physician’s written order certifying that the beneficiary must be transported in an ambulance because other means of transportation are contraindicated prior to the transportation or within 48 hours for unscheduled transportation.
OTHER IMPORTANT POINTS:

1. An "ambulance" is defined by Medicare as a vehicle specially designed for transporting the sick or injured, that contains a stretcher and other lifesaving equipment required by law, and is staffed with personnel trained to provide first aid treatment. Medicare does not consider a wheelchair van to be an "ambulance" and will therefore not cover transportation via wheelchair van or cover ambulance transportation for a patient who could have been safely transported by a wheelchair van.

2. The fact that a particular physician does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service out of your locality to a distant hospital solely to obtain the services of specific physician does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

3. Ordinarily, ambulance service to a physician's office is not covered. Coverage for transportation to a physician's office or other "outside supplier" may be allowed, however, when the ambulance must make an emergency stop at the physician's office on the way to the hospital.

4. Round trip ambulance transportation for an ESRD beneficiary living at home to the nearest treatment facility capable of furnishing the necessary dialysis service is covered regardless of whether the dialysis facility is located at a hospital.

5. Ambulance services are payable under Medicare Part B. You must therefore be enrolled in Part B, and Medicare payment is subject to the Part B deductible and co-insurance requirement.

IMPORTANT INFORMATION REGARDING PARAMEDICS: Medicare usually does not pay for Paramedic Services unless they are provided by a Medicare-certified ambulance company while providing coverable transportation services. This means that if a patient is transported by a volunteer ambulance and paramedic services are provided by a professional, Medicare-certified company, Medicare will not pay for the paramedic services even if the ambulance transportation is clearly medically necessary and reasonable.

There is an exception to this coverage limitation if the paramedic intercept services are provided in a rural area. However, a number of conditions have to be met. The paramedic intercept services have to be provided under a contract with one or more volunteer ambulance companies. The volunteer ambulance company must be certified and be prohibited by State law from billing for any service. The paramedic services company must be Medicare certified and must bill all recipients of their services regardless of whether or not those recipients are Medicare beneficiaries. The payment made will be the difference between basic life support services and advanced life support services or about $150.00.

12/2010