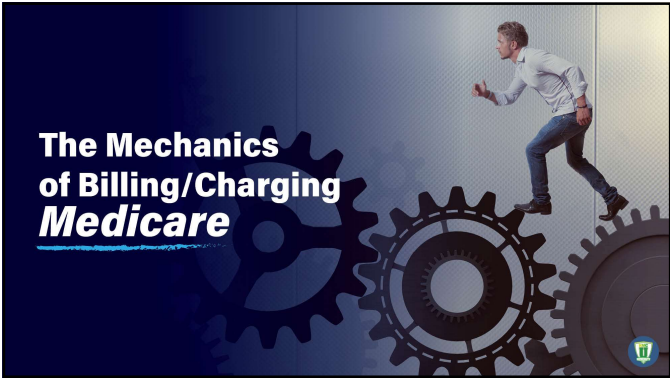




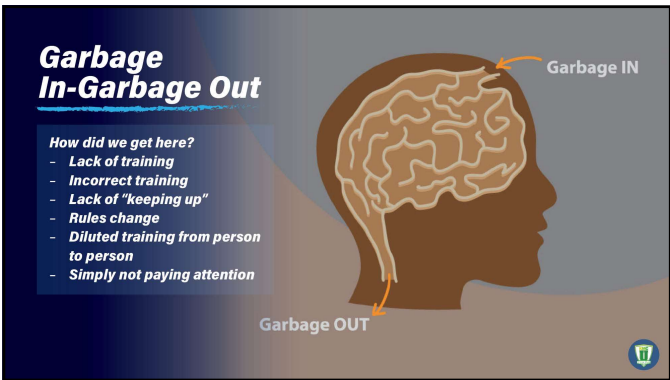
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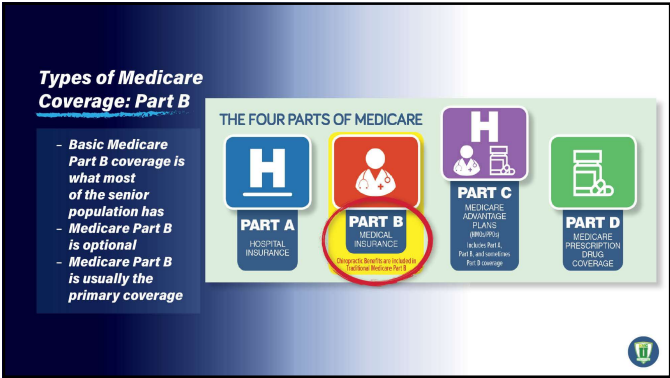
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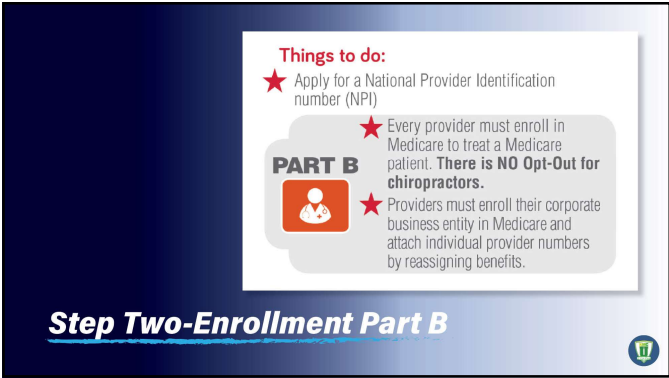
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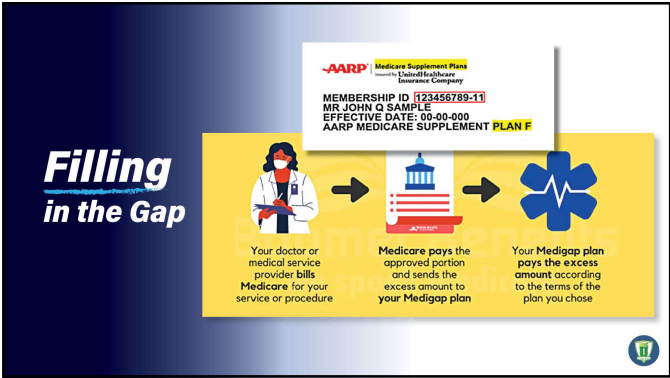
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12

	Medicare Supplement Insurance (Medigap) plans													
Benefits	A	B	C	D	F*	G	K	L	M	N				
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%				
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%				
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%				
Skilled nursing facility care coinsurance				100%	100%	100%	50%	75%	100%	100%				
Part A deductible	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%				
Part B deductible					100%									
Part B excess charges						100%	100%							
Foreign travel emergency (up to plan limits)			80%	80%	80%					80%	80%			
											Out-of-pocket limit in 2017			
											\$5,120	\$2,500		

Types of Medicare Coverage: Supplemental

13

PART C

H

★ Decide whether to enroll with Medicare Part C plans. Some Part C plans include additional benefits which may cover more than CMT.

NOTE: If you are out of network, do not treat Medicare Part C patients as cash patients. Plan type impacts billing requirements. PFFS plans require a provider to accept terms or refer the patient out. Other plan types, bill the limiting fee.

Step 3:
Enroll in Part C Plans if Desired

16

Types of Medicare Coverage: True Secondary

- Resembles eligible group health plans (GHP)
- Could be from retirement benefits
- Often behaves like a GHP rather than a supplemental

14

Let's Take a Poll!

17

Obligations of DCs When Agreeing to Accept and Treat Medicare Part B Patients

15

Types of Medicare Coverage: Part C

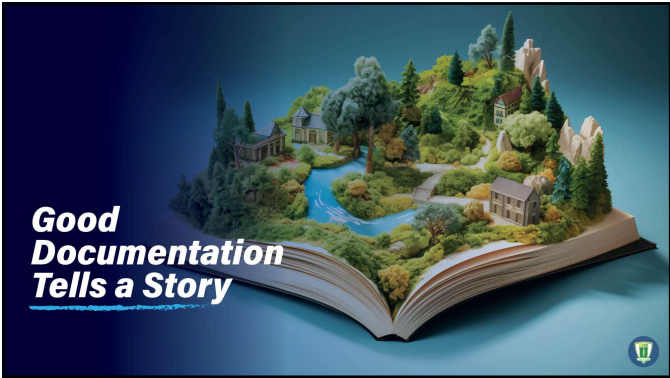
- Also known as Medicare Advantage Plans or Replacement Plans – “Managed Care Medicare”
- Redirects benefits to a private carrier
- No Part A or B

18





25



28

John Doe Chiropractic Office
1234 Any Street
Anytown, AS 12345
(555) 732-4498

Medicare Advantage (MA) Verification Form

Section A: Provider Info
Provider Name: PROVIDER NAME
Provider Tax ID or EIN: TAX ID/EIN

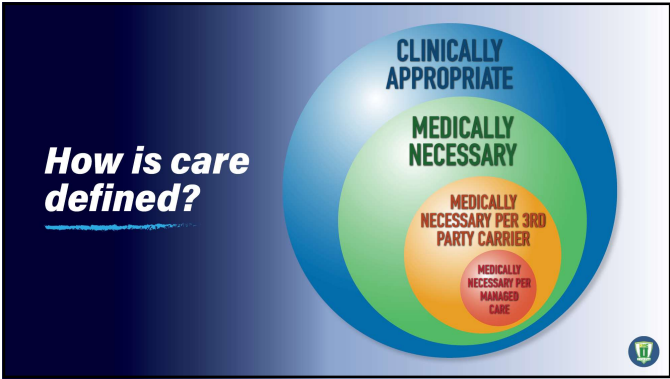
Section B: Patient Info
Patient Name on Card: _____ Patient's DOB: _____
Patient's Account #: _____ Patient's Medicare Part C Plan #: _____
Member ID #: _____ Group #: _____

Section C: Health Coverage
Auto Accident? ☐ Yes ☐ No Work Injury? ☐ Yes ☐ No Personal Injury? ☐ Yes ☐ No
Any other coverage? ☐ Yes ☐ No If yes, specify: _____
Patient is working aged? ☐ Yes ☐ No Patient's spouse is working aged? ☐ Yes ☐ No
Patient is a Medicare beneficiary? ☐ Yes ☐ No If yes, specify: _____
Type of Plan: ☐ CMO ☐ POS ☐ HMO ☐ PPO ☐ Other: _____
Patient is a QMSP? ☐ Yes ☐ No
Is the provider enrolled in Medicare? ☐ Yes ☐ No If yes, specify: _____
Is the provider enrolled in Medicare? ☐ Yes ☐ No If yes, specify: _____
Is the provider enrolled in Medicare? ☐ Yes ☐ No If yes, specify: _____

Section D: Health Insurance
Center Name: _____ Contact Person: _____
Phone Number: _____
Address: _____
City: _____ State: _____ Zip: _____
Does the patient have a designated primary care physician? ☐ Yes ☐ No
Does the patient have a designated specialist? ☐ Yes ☐ No
Does the patient have a designated mental health provider? ☐ Yes ☐ No
Does the patient have a designated durable medical equipment (DMEPOS) provider? ☐ Yes ☐ No
Does the patient have a designated durable medical equipment (DMEPOS) provider? ☐ Yes ☐ No
Does the patient have a designated durable medical equipment (DMEPOS) provider? ☐ Yes ☐ No

Section E: Notes
Notes: _____

26



29

KMC UNIVERSITY

NEXT-GEN MEDICARE

Practical and Updated Training for Billing & Risk Management

STEP INTO THE FUTURE OF MEDICARE BILLING & COMPLIANCE!

EARLY BIRD SPECIALS AVAILABLE

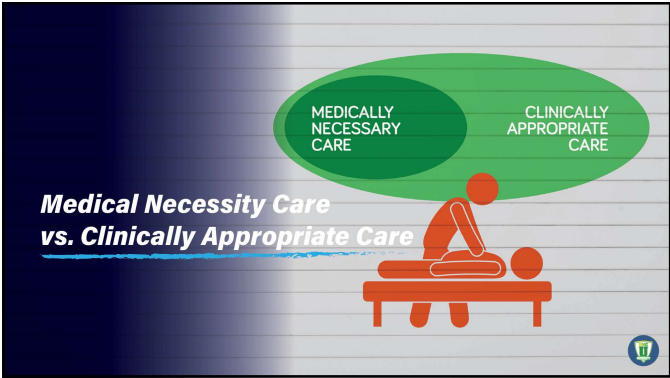
SCAN THE QR CODE LET'S GET STARTED!

<https://learn.kmcuniversity.com/next-gen>

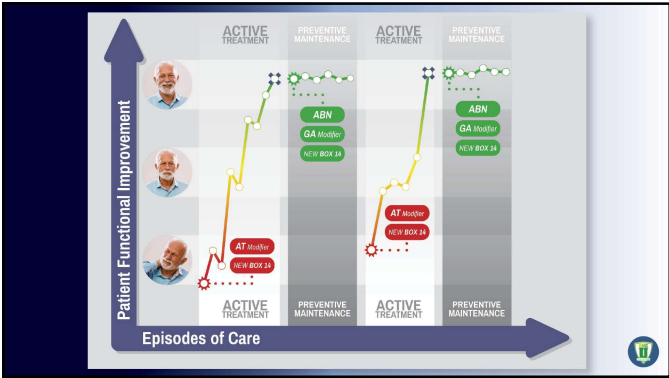
Virtual Hands-On LAB

KMCUniversity.com | (855) 832-6562

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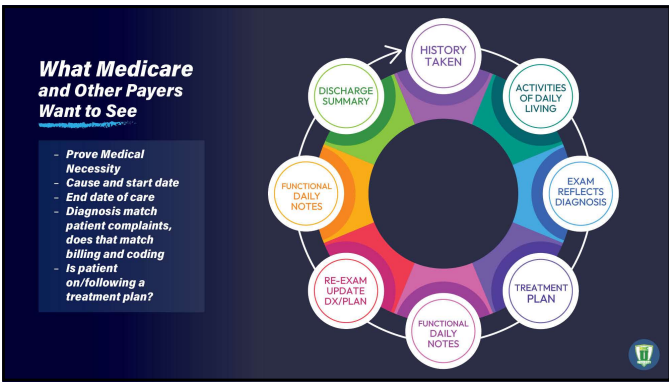
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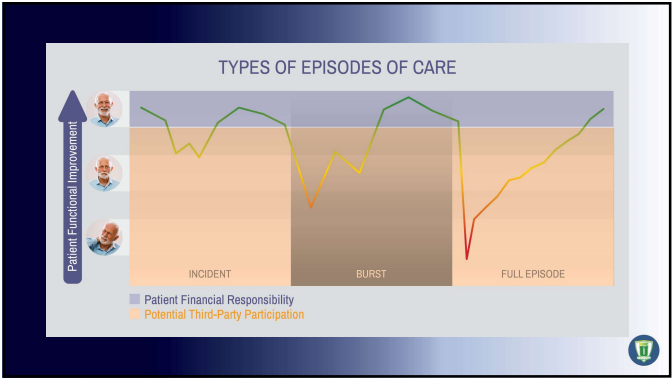
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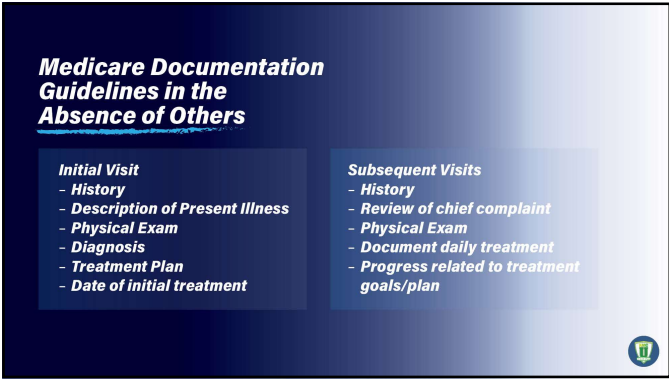
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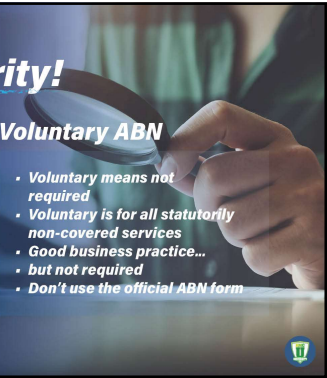
First, Some Clarity!

Mandatory ABN

- A must do... required
- Only for spinal CMT that may not be covered
- Usually only one or two reasons
- Again, no opt out

Voluntary ABN

- Voluntary means not required
- Voluntary is for all statutorily non-covered services
- Good business practice...
- but not required
- Don't use the official ABN form



49

Let's Revisit the ABN Process

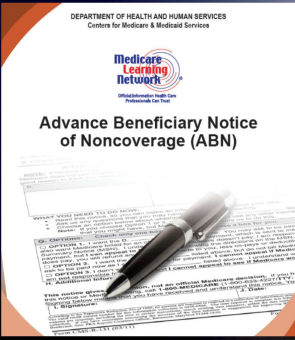
ISSUING AN ADVANCE WRITTEN NOTICE OF NONCOVERAGE

When You Must Issue an Advance Written Notice of Noncoverage

To transfer financial liability to the beneficiary, the provider must issue an advance written notice of noncoverage:

- When an item or service is not reasonable and necessary under Medicare Program standards. Common reasons Medicare denies an item or service as not medically reasonable and necessary include care that is:
 - Experimental and investigational or considered "research only"
 - Not indicated for diagnosis or treatment in this case
 - Not considered safe and effective
 - More than the number of services Medicare allows in a specific period for the corresponding diagnosis
- When custodial care is given
- Before caring for a beneficiary who is not terminally ill (hospice providers)
- Before caring for a beneficiary who is not confined to the home or does not need intermittent skilled nursing care (home health providers)

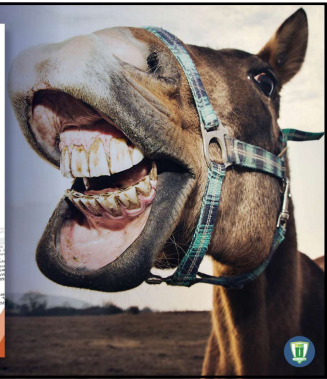
52



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
Official Medicare website: www.medicare.gov

Advance Beneficiary Notice of Noncoverage (ABN)



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Frequency Limits

Some Medicare-covered services have frequency limits. We pay only a certain amount of a specific item or service in each diagnosis period. If you believe an item or service may exceed frequency limits, issue the notice before providing it to the patient.


If you don't know the number of times the patient got a service within a specific period, get this information from them or other providers involved in their care. Find your MAC's website or check for eligibility to determine if a patient met the frequency limits from another provider during the calendar year.

Medicare Preventive Services educational tool has more information on Medicare-covered services that have frequency limits.

Extended Treatment

You may issue a single notice to cover extended treatment if it lists all items and services and the duration of treatment when you believe we won't pay. If the patient gets an item or service during the treatment that you didn't list on the notice and we may not cover it, you must issue a separate notice.

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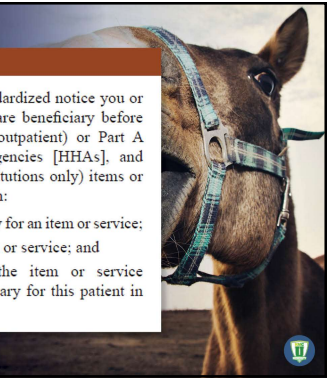


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WHAT IS AN ABN?

An ABN, Form CMS-R-131, is a standardized notice you or your designee must issue to a Medicare beneficiary before providing certain Medicare Part B (outpatient) or Part A (limited to hospice, home health agencies [HHAs], and Religious Nonmedical Healthcare Institutions only) items or services. You must issue the ABN when:

- You believe Medicare may not pay for an item or service;
- Medicare usually covers the item or service; and
- Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.



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Patient Name: **Buller, C. Christopher, Jr**
1234 Main Street, Boulder, CO 80501, 303.555.1234

Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **Chiropractic maintenance care** listed above, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **maintenance care** below.

Chiropractic Maintenance Care	Reason Medicare May Not Pay	Estimated Cost
19944 89042 89042	Medicare does not pay for Chiropractic maintenance care	\$24.71 \$22.54 \$47.25

WHAT YOU NEED TO DO NOW:

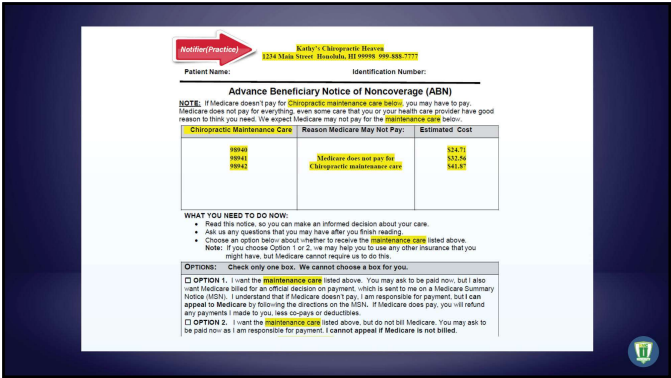
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **maintenance care** listed above. Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

Check only one box. We cannot choose a box for you.

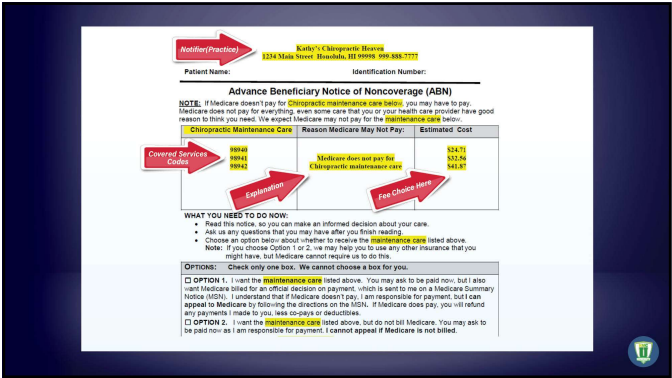
☐ **OPTION 1:** I want the **maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less copays or deductibles.

☐ **OPTION 2:** I want the **maintenance care** listed above, but do not tell Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

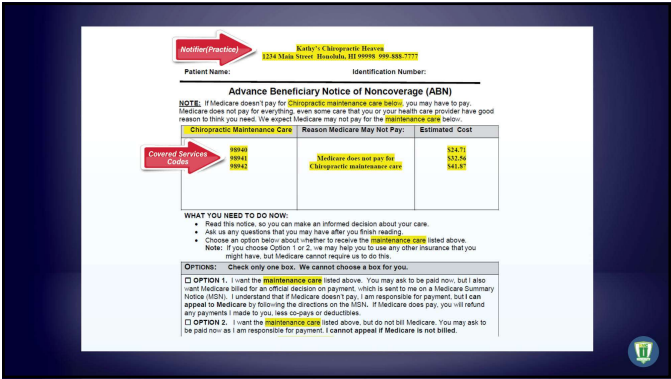
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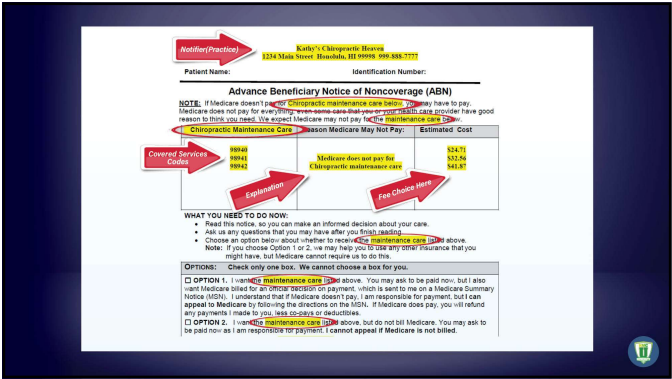
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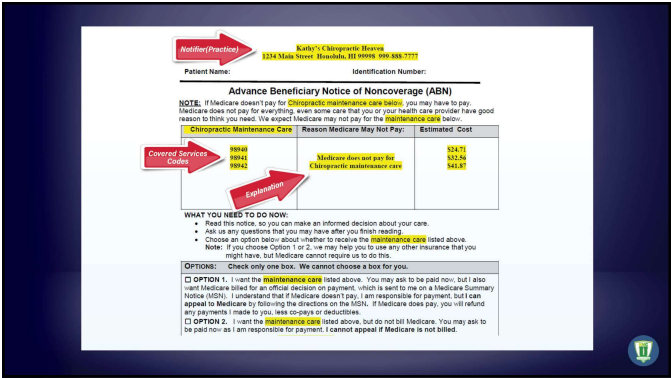
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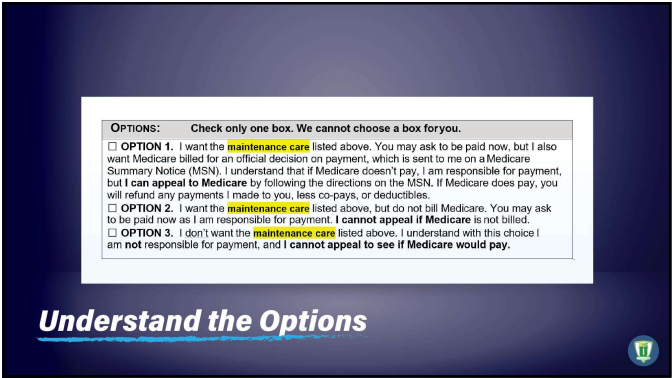
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OPTIONS: Check only one box. We cannot choose a box for you.

☒ **OPTION 1.** I want the **maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays, or deductibles.

☐ **OPTION 2.** I want the **maintenance care** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare** is not billed.

☐ **OPTION 3.** I don't want the **maintenance care** listed above. I understand with this choice I am not responsible for payment, and I **cannot appeal to see if Medicare would pay.**

Understand the Options

61

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy



64

OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays, or deductibles.

☒ **OPTION 2.** I want the **maintenance care** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare** is not billed.

☐ **OPTION 3.** I don't want the **maintenance care** listed above. I understand with this choice I am not responsible for payment, and I **cannot appeal to see if Medicare would pay.**

Understand the Options

62

Issuing a Voluntary Advance Written Notice of Noncoverage as a Courtesy

Medicare does not require you to notify the beneficiary before you furnish an item or service Medicare never covers or is not a Medicare benefit. However, as a courtesy, you may issue a voluntary notice to alert the beneficiary about their financial liability. Issuing the notice voluntarily has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice. For more information about noncovered services, refer to the [Items and Services Not Covered Under Medicare](#) booklet.

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OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **maintenance care** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays, or deductibles.

☒ **OPTION 2.** I want the **maintenance care** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare** is not billed.

☐ **OPTION 3.** I don't want the **maintenance care** listed above. I understand with this choice I am not responsible for payment, and I **cannot appeal to see if Medicare would pay.**

Understand the Options

63

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for the services that are not covered other than delivered by a chiropractor, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **services** listed below.

Services Not Covered When Delivered or Ordered by a Chiropractor	Reason Medicare May Not Pay:	Estimated Cost
Evaluation and Management services (examinations)	Medicare does not pay for these services when delivered or ordered by a chiropractor.	\$55 - \$150
X-rays	Medicare only covers spinal chiropractic adjustments, when medically necessary.	\$75 - \$175
Therapy services		\$55 - \$85
Chiropractic		\$55 - \$85

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **services** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

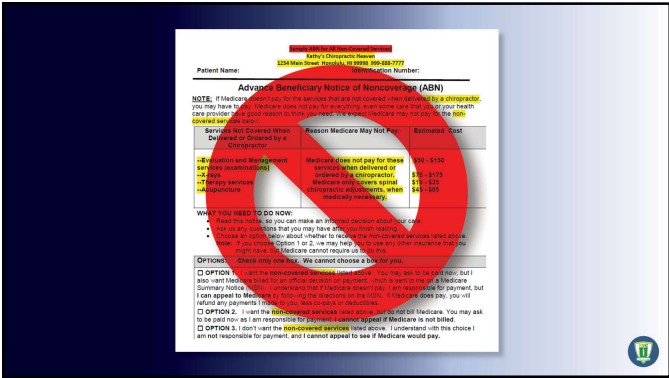
OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I **can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☒ **OPTION 2.** I want the **services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I **cannot appeal if Medicare** is not billed.

☐ **OPTION 3.** I don't want the **services** listed above. I understand with this choice I am not responsible for payment, and I **cannot appeal to see if Medicare would pay.**

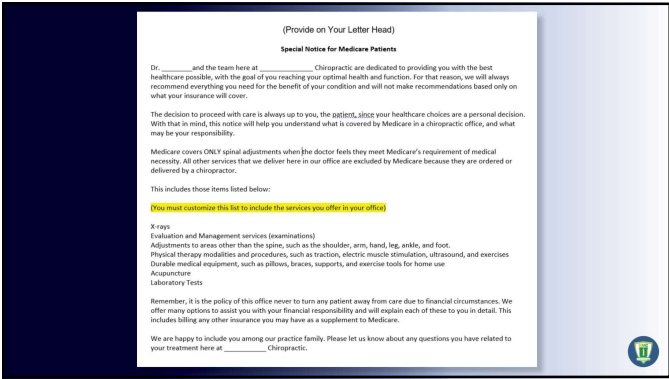
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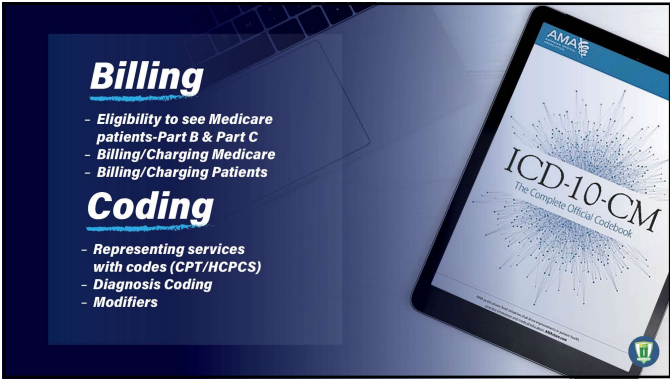
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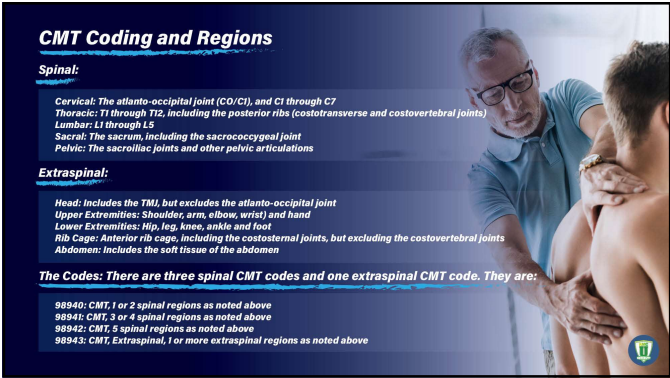
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AT = Active Treatment

- By definition meets medical necessity
- Billed and expected to be paid
- Follows MAC screens
- Should not be automatic



73


Never Charge 97010

HOT PACKS

- For chronic pain relating to muscle aches & joint stiffness
- Increases blood flow by dilating blood vessels
- Promotes muscle relaxation & tissue healing

COLD PACKS

- For injuries and acute pain relating to inflammations
- Reduces blood flow by constricting blood vessels
- Numbs pain & reduces the effects of inflammations (swelling & redness) & bruising



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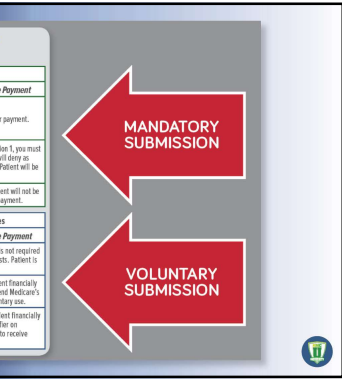
The KMC University's Guide to MEDICARE MODIFIERS

Code	Description/Instructions	Effect on Medicare Payment
AT	Reporting Active/Concurrent Treatment indicates service rendered was medically necessary per Medicare guidelines.	Medicare will consider for payment.
GA	Waiver of Liability (ABL) on file for monetary use. Indicates maintenance care or visit beyond current visit.	If patient selects ABL (option 1), you must bill Medicare. Medicare will deny as not medically necessary. Patient will be financially responsible.
GZ	Indicates you failed to collect ABL for maintenance care as required.	Claim will be denied. Patient will not be deemed responsible for payment.

Code	Description/Instructions	Effect on Medicare Payment
GY	Indicates statutorily non-repayable. Reimbursement is required by a DC.	Billing of these services is not required unless the patient requests. Patient is financially liable.
GX	ABL on file for voluntary use.	Claim will be denied/patient financially liable; we do not recommend Medicare's official ABL form for voluntary use.
GP	Used for certain therapy services as part of a treatment plan.	Claim will be denied/patient financially liable; use with GY modifier on certain therapy services to receive proper denial.

MANDATORY SUBMISSION

VOLUNTARY SUBMISSION




74

Group 1 Codes:

ICD-10 Codes	Description
M99.00	Segmental and somatic dysfunction of head region
M99.01	Segmental and somatic dysfunction of cervical region
M99.02	Segmental and somatic dysfunction of thoracic region
M99.03	Segmental and somatic dysfunction of lumbar region
M99.04	Segmental and somatic dysfunction of sacral region
M99.05	Segmental and somatic dysfunction of pelvic region

Primary DX Must Be Subluxation/ Segmental Dysfunction



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Coding Oddities

- Unattended electrical muscle stim
- Do not use 97014
- Use G0283



75

Group 2 Paragraph: Secondary Diagnostic Codes

Covered for:

Group 2 Codes:	ICD-10 Codes
G44.209	Tension-c
G55.20*	Pain in ul
H54.03	Pain in ul
H54.04	Pain in ul
H54.05	Pain in ul
H54.06	Pain in ul
H54.07	Pain in ul
H54.08	Pain in ul
H54.09	Pain in ul
H54.1	Pain in ul
H54.2	Pain in ul
H54.3	Pain in ul
H54.4	Pain in ul
H54.5	Pain in ul
H54.6	Pain in ul
H54.7	Pain in ul
H54.8	Pain in ul
H54.9	Pain in ul
H55.0	Pain in ul
H55.1	Pain in ul
H55.2	Pain in ul
H55.3	Pain in ul
H55.4	Pain in ul
H55.5	Pain in ul
H55.6	Pain in ul
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H55.8	Pain in ul
H55.9	Pain in ul
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H57.1	Pain in ul
H57.2	Pain in ul
H57.3	Pain in ul
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H57.5	Pain in ul
H57.6	Pain in ul
H57.7	Pain in ul
H57.8	Pain in ul
H57.9	Pain in ul
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H59.2	Pain in ul
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H59.6	Pain in ul
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H59.9	Pain in ul
H60.0	Pain in ul
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H60.8	Pain in ul
H60.9	Pain in ul
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H64.9	Pain in ul
H65.0	Pain in ul
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H65.3	Pain in ul
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H99.8	Pain in ul
H99.9	Pain in ul

Group 4 Paragraph: Group 4 Diagnostic Codes

Covered for:

Group 4 Codes:	ICD-10 Codes
G44.209	Tension-c
G55.20*	Pain in ul
H54.03	Pain in ul
H54.04	Pain in ul
H54.05	Pain in ul
H54.06	Pain in ul
H54.07	Pain in ul
H54.08	Pain in ul
H54.09	Pain in ul
H54.1	Pain in ul
H54.2	Pain in ul
H54.3	Pain in ul
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H56.9	Pain in ul
H57.0	Pain in ul
H57.1	Pain in ul
H57.2	Pain in ul
H57.3	Pain in ul
H57.4	

Diagnosis Hierarchy

Position 1:
Neurological/Injury: Examples of neurological diagnoses include Radiculitis and Sciatic Neuritis.

Position 2:
Structural/Subluxation: Examples of structural diagnoses for the spine include Degenerative Joint Disease, Spondylolisthesis, Scoliosis, etc.

Position 3:
Functional: Examples include Restricted Range of Motion, Deconditioning Syndrome, and muscle wasting.

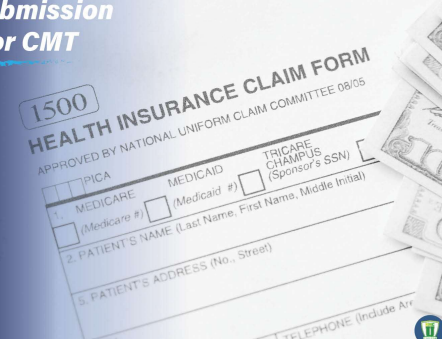
Position 4:
Soft Tissue/Extraspinal/Other: Fibromyalgia, myofascitis, and myalgia are excellent diagnoses to support manual therapy. Examples of extraspinal diagnoses include Frozen Shoulder, Carpal Tunnel Syndrome, Headache or Pain Syndromes.

Position 5:
Complicating Factors: Examples include obesity, high blood pressure, diabetes, cancer, and other forms of co-morbidities.

Position 6:
External cause, Activity, and Location Codes: Examples are related to mechanisms of injury, like slips, trips, falls and accidents, and activity codes show what the patient was doing when injured. These are not required, but helpful, and if reported are only reported on the first claim.

79

Mandatory Submission Rules Apply for CMT



82

Medicare DX Coding


- The preferred order is the same but use the **required coupling** of the primary segmental dysfunction diagnosis first, and the secondary neuromusculoskeletal diagnosis listed second in the pair. Then move on to the next condition and repeat that coupling for the next condition.

80

Statutorily Excluded Services Billing Optional... Kinda!

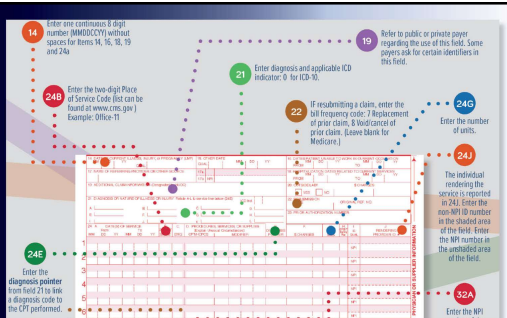
OPTIONAL

83



81

Common Billing Errors



84

Common Billing Errors

14 Enter one continuous 8 digit number (NPI/MDCCY) without spaces for Items 14, 16, 18, 19 and 24A

19 Refer to public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field.

21 Enter diagnosis and applicable ICD indicator: 0 for ICD-10.

22 If resubmitting a claim, enter the bill frequency code: 7 (Replacement of prior claim, & Void/cancel of prior claim. Leave blank for Medicare.)

24G Enter the number of units.

24I The individual rendering the service is reported in 24I. Enter the non-NPI ID number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

24E Enter the diagnosis pointer from field 21 to link a diagnosis code to the CPT performed.

52A Enter the NPI number of the

85

Common Billing Errors

14 Enter one continuous 8 digit number (NPI/MDCCY) without spaces for Items 14, 16, 18, 19 and 24A

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52A Enter the NPI number of the

88

Common Billing Errors

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52A Enter the NPI number of the

86

Common Billing Errors

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Common Billing Errors

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19 Refer to public or private payer regarding the use of this field. Some payers ask for certain identifiers in this field.

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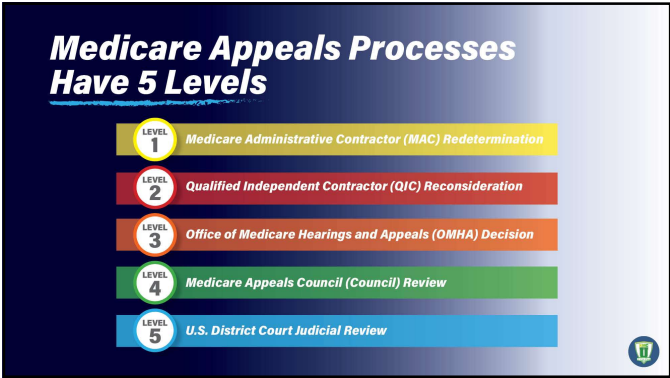
24E Enter the diagnosis pointer from field 21 to link a diagnosis code to the CPT performed.

52A Enter the NPI number of the

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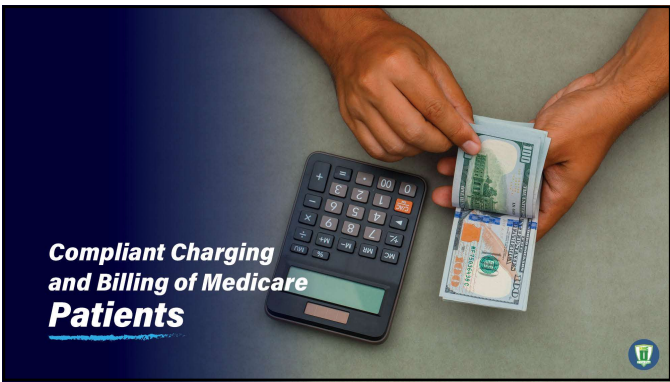
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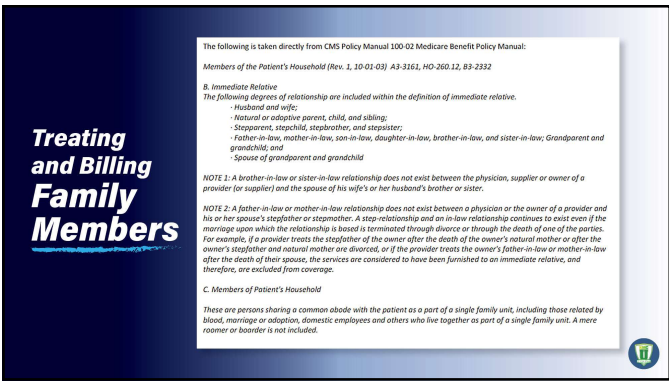
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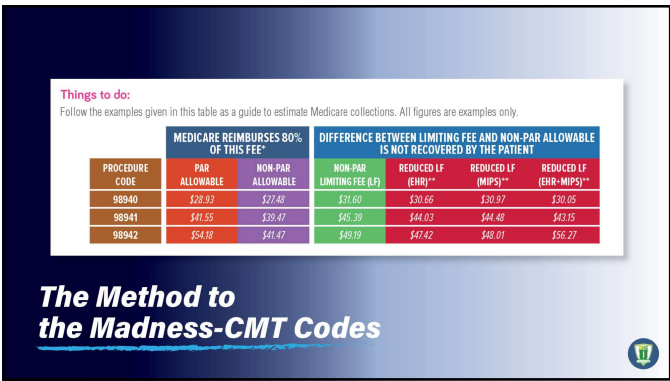
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96

Four Possible Fee Structures Pass Muster-Excluded Services

1. Charge your actual fee

2. Charge a reasonable time of service discounted fee (5-15%)

3. Use a network-based, legally discounted fee of choice

4. Allow for a legal hardship/indigence fee the patient qualifies for

97

Option Two: Charge Provider's Actual Fee for Maintenance Care

50.7.3 - Effects of Lack of Notification, Medicare Review and Claim Adjudication
(Rev. 2782, Issued: 09-06-13, Effective: 12-09-13, Implementation: 12-09-13)

A. Beneficiary Liability

A beneficiary who has been given a properly written and delivered ABN and agrees to pay may be held liable. The charge may be the supplier/provider's usual and customary fee for that item or service and is not limited to the Medicare fee schedule. If the beneficiary does not receive proper notice when required, s/he is relieved from liability.

Notifiers may not issue ABNs to shift financial liability to a beneficiary when full payment is made through bundled payments. In general, ABNs cannot be used where the beneficiary would otherwise not be financially liable for payment for the service because Medicare made full payment. See 50.13 for information on collection of funds.

100

Three Choices for Fees During Maintenance Care

1. Charge allowable fee or limiting fee

2. Charge your actual fee

3. Charge a discounted fee for maintenance if the patient qualifies and you offer this to ALL types of patients

4. Codify this in your compliance policy

98

Option Three: Publish a Maintenance Fee Schedule Anyone Can Access

The safest, and cleanest way to do this is to join a DIMPO network like ChiroHealthUSA

Within that fee schedule, post a fee for maintenance CMT, regardless of levels

Anyone that is a member can access that fee schedule

ChiroHealthUSA®

The Network That Works for Chiropractors

101

Option One: Payer's Allowable or Limiting Fee

Continue

- Continue to charge the allowable or limiting fee in maintenance care

Charge

- Charge that fee when billing for active treatment

Set

- Set policy that says THIS is your fee for all phases of care: acute, chronic, or maintenance

99

Medicare Advantage Plan Fees

- In-Network Participation: Agreed upon allowed fee

- Out-of-Network and Billing for the Patient: Must accept allowed fee

- Out of Network and Providing Superbill: No more than the allowed fee for your participation level in Part B

102

855-832-6562

17

Non-Contract Providers Limitation on Fees

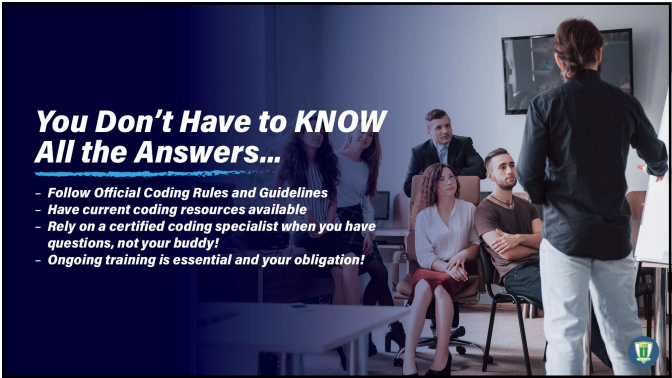
- **In-Network Participation:**
Agreed upon allowed fee
- **Out-of-Network and Billing for the Patient:**
Must accept allowed fee
- **Out of Network and Providing Superbill:**
No more than the allowed fee
for your participation level in Part B



103

You Don't Have to KNOW All the Answers...

- Follow Official Coding Rules and Guidelines
- Have current coding resources available
- Rely on a certified coding specialist when you have questions, not your buddy!
- Ongoing training is essential and your obligation!



106

Non-Contract Providers Limitation on Fees

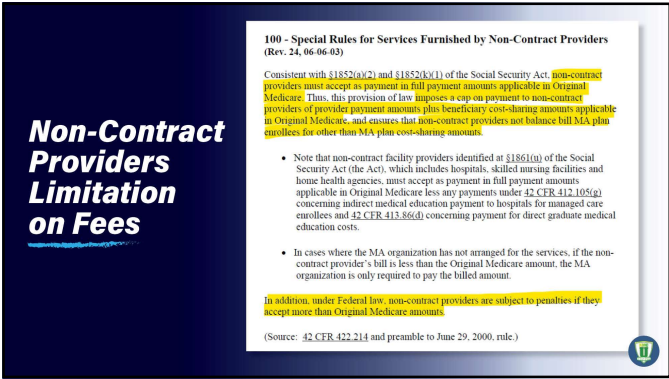
100 - Special Rules for Services Furnished by Non-Contract Providers
(Rev. 24, 06-06-03)

Consistent with §1852(a)(2) and §1852(b)(1) of the Social Security Act, non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.

- Note that non-contract facility providers identified at §1861(a) of the Social Security Act (the Act), which includes hospitals, skilled nursing facilities and home health agencies, must accept as payment in full payment amounts applicable in Original Medicare less any payments under 42 CFR 412.105(g) concerning indirect medical education payment to hospitals for managed care enrollees and 42 CFR 413.86(d) concerning payment for direct graduate medical education costs.
- In cases where the MA organization has not arranged for the services, if the non-contract provider's bill is less than the Original Medicare amount, the MA organization is only required to pay the billed amount.

In addition, under Federal law, non-contract providers are subject to penalties if they accept more than Original Medicare amounts.

(Source: 42 CFR 422.214 and preamble to June 29, 2000, rule.)



104



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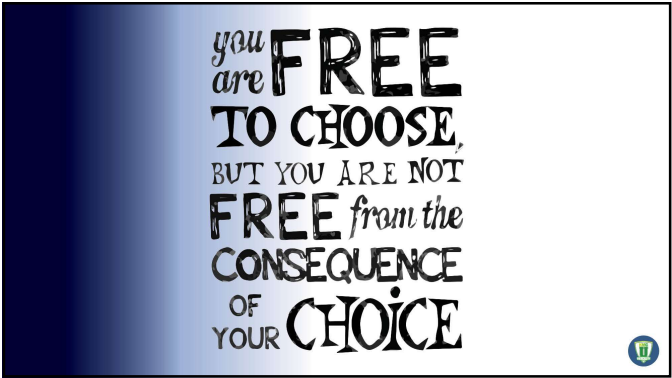
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Knowing the Rules Helps You Win the Game



105

you are **FREE**
TO CHOOSE,
BUT YOU ARE NOT
FREE from the
CONSEQUENCE
OF YOUR **CHOICE**



108



109



112



110



111