Replacement Plans In

MEDICARE

HALF

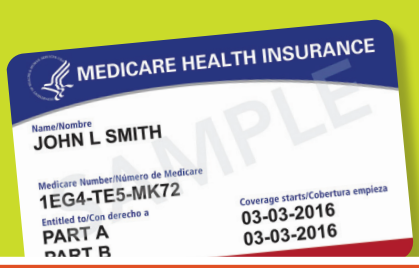
of offices surveyed admitted to not knowing the difference between Original (Traditional) Medicare and Medicare Advantage (MA) Plans

53%

of offices said they follow Medicare guidelines when billing MA plans and not the payer's Medical Review Policy or Provider Reimbursement manual

THE MAJORITY

of DCs and CAs surveyed didn't understand that Medicare Advantage plans require you to implement their ABN form and not Medicare's ABN form



Original Medicare vs Medicare Advantage

ORIGINAL MEDICARE

1. Includes Part A and B
2. Provides coverage for beneficiaries nationwide
3. Patient has a deductible and 20 % which applies to all covered services
4. Benefits are directly from the Federal Government
5. Requires you to use CMS' Mandatory ABN when rendering non-covered services
6. Details on diagnoses, covered conditions and documentation are usually located in the Local Coverage Determinations(LCD) by the MAC
7. The appeals process is unique to original Medicare
8. For DCs, spinal adjustment is the only covered service
9. Medicare does not pay for statutorily non-covered services (e.g., exams and therapies)

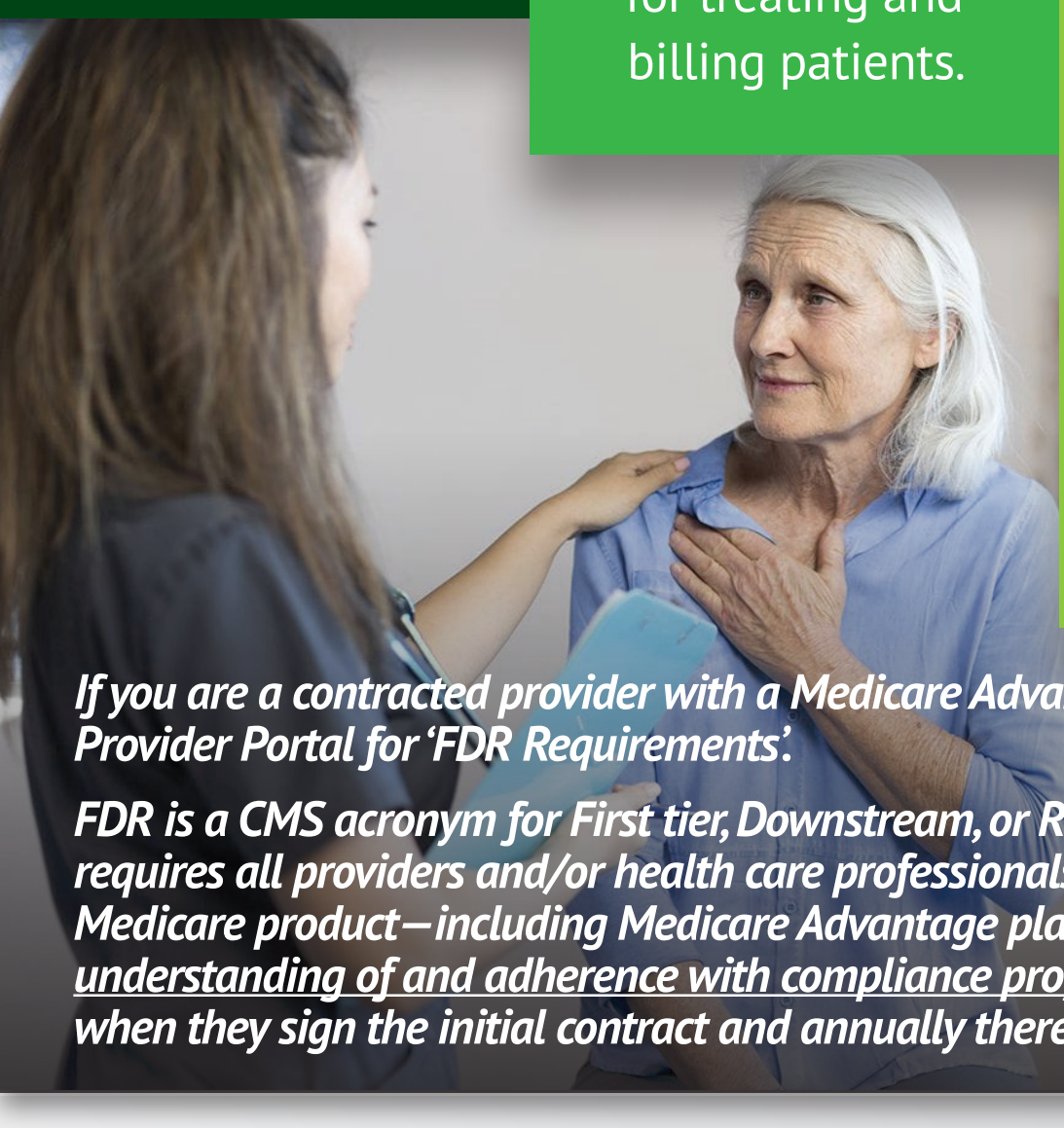
MEDICARE ADVANTAGE

1. Includes Part A, Part B and usually Part D
2. An alternative to original Medicare whose carrier limits coverage to providers in a certain geographic area
3. Patient has a copay and sometimes deductible; often lower out of pocket costs than original Medicare
4. Benefits are administered by a private plan such as Humana or Aetna
5. May require you to use their ABN when rendering non-covered or excluded services
6. Coverage and benefits are located in the Payer's reimbursement policy or Medical Review Policy.
7. MA appeals process is different than original Medicare
8. Chiropractic coverage is dependent on the payer and may or may not be included in the plan.
9. These plans may pay for otherwise statutorily non-covered services (e.g., exams and therapies)

MA plans **replace** traditional Medicare Part B. They are NOT supplemental insurance plans.

Medicare Part C (aka Advantage Plans or Replacement Plans) are similar to HMOs. They have their own specific rules for treating and billing patients.

Most Medicare Advantage plans require you to be enrolled in the individual product in order to be considered in-network. A payer does not automatically enroll a provider in their MA plans when they enroll for their commercial plans.



If you are a contracted provider with a Medicare Advantage Plan, research the Provider Portal for 'FDR Requirements'.

FDR is a CMS acronym for First tier, Downstream, or Related entity. CMS requires all providers and/or health care professionals contracted with a Medicare product—including Medicare Advantage plans—<u>to attest to their understanding of and adherence with compliance program requirements</u> when they sign the initial contract and annually thereafter.

KMC UNIVERSITY

Chiropractic Infographics

You don't need to know all the answers when you know the people who do.

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