**Reimbursement and Coverage**

**Question 1:** What is TRICARE?

**Answer 1:**

TRICARE is the health insurance agency that covers active, reserve, or retired military personnel in the United States. Eligibility depends on enrollment in the Defense Enrollment Eligibility Reporting System (DEERS). The DEERS record will indicate the dates of eligibility. The Department of Veterans Affairs (VA) uses TRICARE as its provider agency for purposes of screening and processing claims.

The VA provides medical coverage for retired service people based on certain eligibility factors like service-connection and income. Medicare is not required for these folks; however, it seems to be encouraged as back-up coverage (VA, 2007).

TRICARE, the VA, and Medicare all apply similar benefits and payments. Reimbursement is based on billing that entails proper coding, using ICD-9-CM, CPT codes, and Medicare standards. Just as other third-party payers use the Medicare system as their reference point for documentation and payment, the VA and TRICARE utilize these standards.

**Question 2:** What are the Medicare plus Choice plans introduced in 1997 as health care options?

**Answer 2:**

Medicare + Choice plans are prepaid plans that include regular Part A and Part B benefits and other coverage including preventative care, prescription drugs, eyeglasses, dental care, and hearing aids. Known as Part C coverage, these Medicare + Choice plans may be one of the following (Medical Learning Network, 2007):

- health maintenance organization (HMO)
- preferred provider organization (PPO)
- point-of-service option (POS)
- provider-sponsored organization (PSO)
- private fee-for-service plan
- religious fraternal benefit society plan (RFP)

The HMOs are both insurers and care providers. For a prepaid fee, services are
covered and the focus is on prevention and assessment.

A PPO is a group of physicians, hospitals, and other health care providers who have joined together to provide services at a reduced cost for members (Medical Learning Network, 2007).

POS combines the services of the HMO and PPO, and members will choose which plan is applicable when the service is requested.

A PSO is a covered entity that will provide services under a contract with Medicare. The fee-for-service plan allows members to access care from any provider because they pay higher fees for the services provided.

An RFP is affiliated with a religious or fraternal organization that provides coverage to members at reduced fees.

**Question 3:** Who are Medicare Part A providers?

**Answer 3:**

Medicare Part A providers include entities like hospitals, nursing homes, and Skilled Nursing Facilities (SNFs). These institutions must be inspected and certified by Medicare generally through The Joint Commission (TJC) review process.

Medicare Part A also covers home health care including skilled nursing care, physical therapy, speech/occupational therapy, medical social services, medical supplies, and durable medical equipment (DME). The Home Health Agency (HHA) care must be ordered by the physician and be part of the plan of care directed by that MD (Medical Learning Network, 2007). There is no time limit on this care as long as medical necessity continues.

Home hospice care, or care for those who are terminally ill and have chosen not to pursue further treatment, is also covered. The physician must verify that life expectancy is less than 6 months. The benefits will continue for an unlimited time. Interestingly, this covered care also includes short-term inpatient care, including respite care (Medical Learning Network, 2007).

**Question 4:** Who are Medicare Part B providers?
Reimbursement and Coverage

Answer 4:

Medicare Providers for Part B services include physicians; certified registered nurse anesthetists (CRNA); certified nurse midwives (CNM); physician assistants (PA); clinical psychologists (CP); and other independent practitioners like physical, occupational, and speech therapists.

For Part B coverage, it is the local Medicare contractor that has the authority to designate services as covered or not. Diagnostic tests and procedures are covered, as are x-rays (including in-home), medical supplies, and durable medical equipment (DME). DME includes wheelchairs, oxygen equipment, walkers, hospital beds, canes, and orthotics but not personal convenience items or bathroom and safety equipment (Medicare Learning Network, 2007).

Diagnostic procedures may be performed in numerous places including independent laboratories, independent diagnostic testing facilities (IDTF), and outpatient x-ray among others (Medicare Learning Network, 2007).

DME regional contractors (DMERC) process claims for those medical devices and should be contacted for information about payment, duration of care, and equipment providers.

Question 5: What are intermediaries and carriers?

Answer 5:

The first step in the Medicare process is the Centers for Medicare and Medicaid Services (CMS). They assign contracts to regional or local organizations to review and process claims for Medicare Parts A and B. Intermediaries are contractors that process Part A claims. Carriers are private companies that contract with CMS to process claims for Part B services and equipment.

Tasks given to intermediaries include the following (Medicare Learning Network, 2007):

- determining costs and reimbursement amounts
- maintaining records
- establishing controls
- safeguarding against fraud and abuse or excess use
- conducting reviews and audits
- making payments to providers for services
Reimbursement and Coverage

- assisting both providers and beneficiaries as needed

Tasks given to carriers include the following (Medicare Learning Network, 2007):

- determining charges allowed by Medicare
- maintaining quality of performance records
- assisting in fraud and abuse investigations
- making payments to physicians and suppliers for services that are covered under Part B
- assisting both suppliers and beneficiaries as needed

Question 6: What guidelines can physician offices use to ensure correct coding?

Answer 6:

In 1994, coding and reporting requirements were published by the Centers for Medicare and Medicaid Services (CMS) to outline specific guidelines for diagnostic coding. Those steps include the following (Medicare Learning Network, 2007):

- Use the ICD-9-CM codes that describe the patient’s diagnosis, symptom, complaint, condition, or problem.
- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use fourth and fifth digits when necessary.
- Do not code suspected diagnoses. Code only the diagnosis symptom, complaint, and condition reported. Medical records, not claim forms, should reflect that the services were provided for rule out purposes.
- Code a chronic condition as often as applicable to the patient’s treatment.
- Code all documented conditions that coexist at the time of the visit and require patient care or treatment. Do not code conditions that no longer exist.

Question 7: What are some additional tips for coding provided by Medicare?

Answer 7:

Medicare offers the following tips for coding (Medicare Learning Network,
Reimbursement and Coverage

2007):

- In an emergency situation, the coder should identify the acute conditions or symptomology for outpatient services.
- For inpatient services, the principal diagnosis is the reason or reasons for a patient’s condition.
- For multiple injuries, always sequence the most severe injury first.
- Code causes and infections as secondary.
- Limit the use of unlisted diagnosis codes to situations where there is no definitive information available or there is no other specific code available.
- Distinguish between acute and chronic whenever the ICD-9-CM makes that distinction.
- For inpatient coding on a UB-92 (form), code each medical condition identified in the medical record.
- Revise billing charge tickets and forms periodically to include up-to-date ICD-9-CM codes.

Question 8: What is the billing/payment process for Medicare providers?

Answer 8:

Providers submit claims in either paper or electronic form. An Electronic Media Claim (EMC) using approved software from the American National Standards Institute (ANSI) may be submitted to the processing center (Medicare Learning Network, 2007).

When the claim reaches the center, either intermediary or carrier, it begins the process of edits and audits. First, editing verifies the accuracy and completeness of the claim, then the auditing system checks for overpricing and/or duplicate billing. During this inspection period, the claim is also reviewed to ensure it meets Medicare guidelines.

When the claim is determined to be valid and accurate, payment will be sent within 14 days for EMC and 27 days for paper claims. The intermediary or carrier will also send a Medicare Summary Notice (MSN) to the beneficiary notifying them of co-pays required and payments made to providers (Medicare Learning Network, 2007).

At this point, if the claim is denied, a provider or beneficiary has the right to appeal the decision and/or payment allowed.
Reimbursement and Coverage

**Question 9:** What advantages does a participating provider enjoy versus a nonparticipating provider?

**Answer 9:**

To begin, a participating provider is one who contracts with Medicare to provide services to covered members for the preset fees that Medicare assigns. In other words, their patients will not pay more than the Medicare assigned benefit. Conversely, nonparticipating providers may see Medicare patients and may bill above and beyond the Medicare allowances, billing the patient for those extra costs.

Special considerations are given to participating providers that include the following (Medicare Learning Network, 2007):

- Reimbursement is paid directly from Medicare.
- There is a 5% higher fee allowance for most physician procedures.
- The Medigap/Supplemental insurance crossover process is automatic.
- There is access to beneficiary eligibility information.

For nonparticipating providers, these options are not available, and they must still file all Medicare claims on behalf of Medicare patients.

**Question 10:** What is Medigap?

**Answer 10:**

Medicare is not a mandatory choice for those over 65 in the United States. In fact, everyone is entitled to choose another option and pay for health care insurance through another provider. Even with Medicare Parts A and B elected, the patient will be asked to contribute a deductible and co-pay for certain services and procedures, as well as the monthly premium that is collected from the citizens' Social Security benefits.

Medicaid, at the state level, also supplements the coverage for those determined to be poor or medically indigent (Medicare Learning Network, 2007). Recall that Medicaid dollars spent at the state level are matched by federal dollars from the Medicare system.

*Medigap* insurance is the name given to any coverage outside the Medicare/Medicaid system. It is supplemental insurance that will help cover out-of-pocket expenses and deductibles. This insurance may be provided
Reimbursement and Coverage

through a Medicare + Choice option or through any other insurer in the business. One example of a supplemental provider is the American Association of Retired Persons (AARP), which offers a supplemental plan for health care coverage to its members (AARP, 2007).

References

