



CALIFORNIA HEALTH ADVOCATES

Billing and Claims: How Medicare Parts A & B Claims Are Processed

Parts A and B claims for people on Medicare are submitted directly to Medicare by the providers of the services (doctors, hospitals, labs, suppliers, etc.) This fact sheet discusses claims in the Original fee-for-service Medicare program. Claims for Medicare Advantage plans (e.g. Medicare HMO, PPO, PFFS) and Medicare prescription drug benefit plans (Part D) work differently.

Part A Claims

Medicare pays Part A claims (such as inpatient hospital care, inpatient skilled nursing home care, skilled home health care, and hospice care) directly to the provider who submitted the claim. Providers include Medicare-certified hospitals, Medicare-certified skilled nursing facilities, Medicare-approved home health agencies and Medicare-approved hospice programs that provide Medicare-covered services and items. You are responsible for deductibles, co-payments, and any amounts for services or items that Medicare doesn't cover.

Part B Claims

Medicare pays Part B claims (such as doctor visits, outpatient hospital care, outpatient physical and speech therapy, some home health care, ambulance services, medical supplies and equipment) to either the provider or the beneficiary depending on whether the provider accepts assignment.

If the provider accepts assignment (agrees to accept Medicare's approved amount for a given service as full payment), the provider bills Medicare, and Medicare then pays the provider directly. For most Part B services, Medicare covers 80% of the Medicare-approved amount and you are responsible for the remaining 20% after you have paid the annual deductible of

\$135 (2008). Some Part B services have different cost-sharing. For example, beneficiaries have a 50% coinsurance for mental health services. For some preventive services, such as such as flu shots, Pap tests, and cardiovascular and diabetes screenings, beneficiaries have no coinsurance.

If the provider does NOT accept assignment (meaning s/he can charge more than the Medicare-approved amount for a given service, but not more than 115% of that approved amount), the provider still has to bill Medicare, but can ask the beneficiary to pay up front. The beneficiary can claim reimbursement from Medicare for the Medicare-approved amount. (**Note:** The 15% above the Medicare-approved amount is called the 'excess' or 'limiting charge.' It applies only to certain services, and does not apply to Durable Medical Equipment and some supplies.)

You often save money going to a provider who accepts assignment, so find out if your provider accepts assignment before your visit. For more information, see our fact sheet "Medicare Assignment and Costs" at cahealthadvocates.org.

Medicare takes about 30 days to process a claim. After the claim is processed, Medicare will send you a Medicare Summary Notice (MSN). The MSN states the amount the provider charged for the service, whether the provider accepted assignment, how much was approved and paid by Medicare, and how much you still owe. A MSN is mailed to you (usually every three months) if you had a Medicare-covered service during that period. To get personalized up-to-date information on your Medicare account (such as copies of your MSN, status of your claims and Part B deductible), you may register online at MyMedicare.gov.

Supplemental Insurance

Many Medicare beneficiaries have insurance that supplements Medicare. You may have a Medigap policy, retiree plan or individual health insurance policy that coordinates with Medicare. Your supplemental insurance company can receive a claim in one of the following three ways:

1. Medicare bills your insurance company directly through electronic claims processing. You need to have advised Medicare if you want your claims submitted to your supplemental insurance carrier.
2. Your provider who accepts assignment may submit the claim to your supplemental insurance company directly, if you provide the information.
3. If neither Medicare nor the provider submits the claim, you will need to:
 - Fill out the claim form provided by your insurance company, if required.
 - Attach copies of the bills you are submitting for payment, if required.
 - Attach copies of the MSN related to those bills when you receive it.
 - Mail your claim to the insurance company. Make sure to make copies of everything that you send and keep them with your personal records.

You should receive an Explanation of Benefits (EOB) from your insurance company which should state how much was paid. If you do not receive an EOB within 30 days after you receive the medical service(s), call the insurance company and ask about the status of your claim.

Calling About Claims

Follow these simple steps when you call Medicare (1-800 MEDICARE), your supplemental insurance company, or your health care provider to discuss your claims:

1. Identify yourself. If appropriate, give your Medicare number, your insurance policy number, or your account number from your latest bill. (DON'T leave this information on a phone message and DON'T give your Medicare claim number to anyone you do not know.)
2. Identify your claim. Give the date and type of service and the amount of the bill.

3. Find out about your claim. Ask when your claim will be processed and when you will find out how much has been paid by Medicare or your supplemental insurance company. Ask if your provider accepted assignment.
4. Find out how much is still owed. Ask your provider about making a payment plan if necessary.

Note: Be sure to take notes on the date and time of your call and the name of the person you talk to. Summarize everything discussed on the call.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.