

Medicare Advantage

In 2010 11.4 million Medicare beneficiaries were receiving their health care through enrollment in Medicare Advantage (MA) plans (also known as Medicare Part C). Payment issues for providers who see patients in Medicare Advantage plans are different from those for the standard fee-for-service Medicare (also known as Original Medicare). As more and more Medicare patients enroll in Advantage plans, it becomes important that psychiatrists understand how they work since there is greater and greater likelihood that they will see patients who are enrolled in one or another of them.

When you have a patient who has reached 65 or obtained Medicare for a disability, you should always check to be sure what kind of Medicare coverage they have. Ideally, at every visit you should check with the patient to make sure there have been no changes in their coverage. And a check should absolutely be done at the first visit of each new year for every patient. Some patients may have aged into Medicare or changed their insurance for some other reason. And a patient who already has Medicare may have switched from fee-for-service to a Medicare Advantage plan, or vice versa.

If you inadvertently bill the Medicare carrier or contractor for a patient who's enrolled in an Advantage plan, as you would for a fee-for-service Medicare enrollee, chances are the claim will bounce back and you'll be advised to refile it with the appropriate Advantage plan. If the Medicare carrier or contractor pays it by mistake, when the error is discovered you will have to return the money and then refile the claim.

There are several types of Medicare Advantage plans. The majority are HMO or PPO plans, but there are also Private Fee-for-Service Plans, Special Needs Plans, and Medical Savings Accounts (MSAs). It is important to find out what type of Medicare Advantage plan they are enrolled in because coverage and payment rules vary from plan to plan. Neither you nor your patient will be reimbursed by Medicare, but rather by the private Medicare Advantage plan that covers the patient.

Essentially, when a beneficiary enrolls in a Medicare Advantage plan, she is taking herself outside of standard Medicare. In fact, you can see a Medicare Advantage patient without being enrolled as a Medicare provider as long as you are eligible to be a Medicare provider (i.e., you haven't opted out of Medicare, unless you are providing emergency or urgently needed services, or you are not on the HHS Office of Inspectors General excluded and sanctioned provider list). In other words, you don't need the ability to bill Medicare to be able to see these patients.

If you are an in-network provider for the Medicare Advantage plan (that is, you have a signed a contract with the plan), you will receive whatever payment amount you negotiated with the plan for seeing its beneficiaries—be it higher or lower than the Original Medicare amount. If you are an out-of-network provider, the plan is obligated to pay you at least the amount you would have received under Original Medicare, unless for some bizarre reason, you charge less than the standard Medicare fee.

Some psychiatrists may find they are in-network providers without realizing it. If when you joined an insurer's network you signed an "all products" contract, then it means you are in-network for the insurer's Medicare Advantage plans as well as for any other plans the insurer maintains. In other cases, the contract should specify that it only covers the plans listed, or may state what the exclusions are.

A great deal of confusion may arise when you see a patient who's enrolled in a Medicare Advantage plan and you're a non-contracting, or out-of-network, provider. As when you see a patient with any private insurance, you'll want to check and make sure the visit will be covered by the MA plan. Some Medicare Advantage plans have prior authorization and/or referral requirements, so make sure you know the plan's rules for covering services before you accept a beneficiary enrolled in a Medicare Advantage plan.

You may request a written advance coverage determination (also known as an organization determination) from the plan before furnishing a service in order to confirm that the service is medically necessary and will be covered by the plan. In the absence of an advance coverage determination, the Medicare Advantage plan can retroactively deny payment for a service furnished to an enrollee if the plan determines that the service was not covered by the plan or was not medically necessary. In this case, the enrollee may be held responsible for paying all of the costs.

For a first visit, the MA plan may respond benevolently, paying you even though the visit was not preauthorized. Thereafter, however, they may refuse to pay if the patient does not obtain required prior authorization for the out-of-network visit. Here's the weird part: If the MA plan rejects your services, saying they're not covered, then, whether you're a Medicare provider or not, you're free to charge the patient your customary fee (rather than the Medicare fee) because the care is not considered to be covered by Medicare.

Documentation Requests from Medicare Advantage Plans

Because the Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage plans to submit detailed documentation on their enrollees, presumably to ensure that the enrollees are receiving appropriate treatment for their conditions, you may receive requests for post-payment review of patient medical records to aid the MA plan with this process. These requests are not compulsory unless they are accompanied with a letter from CMS, which oversees the entire Medicare program. If you receive a request for documentation and you're not comfortable complying, call the contact provided on the request letter and let them know your concerns. It may be the request really shouldn't have been sent to you in the first place, but was just part of a blanket mailing to all providers. That is what happened in a case the Practice Management HelpLine investigated for an APA member who was concerned about meeting the deadline to supply the documentation requested. If you have any questions, contact the HelpLine at 800-343-4671.