apter 10-Medicare Key Words

orm used to inform a patient that a service to be provided is not likely to be paid. The patient would be liable. Must be signed before tests are performed

Additional Documentation Request ADR-Medical review contractor wants more information and you must respond back within 30 days. These are sometimes called 30 day letters

Carriers-Process claims sent by physicians, providers, and suppliers

Clinical Laboratory Improvement Amendments CLIA-Federal law that establishes a standard for laboratory testing. Administered by CMS

Common Working File CWF-Medicare master patient/procedural data base

Fiscal Intermediary FI-Company that is paid to process claims for the government. Medical insurance programs

Health Professional Shortage Area HPSA-Providers in these areas receive an additional 10% bonus payment from Medicare

Incident to Billing Rules-Services supervised by the physician but provided by non-physician practitioners

Initial Preventative Physical Exam IPPE-One in a lifetime benefit that must be received within the first 6 months after date of enrollment

Local Coverage Determination LCD-Sent to physicians by Medicare program to explain new services or procedures

Limiting Charge-Apply only to non-par providers submitting non-assigned claims 115%

Medicare Advantage Plan (Medicare Part C + Choice)-Extends basic Medicare coverage by offering other options to beneficiaries, such as enrollment in a mange care plan, may also offer benefits that are excluded from the Original Plan

Medicare Part A-Inpatient hospital care, SNF, Home health care, Hospice, Administered by CMS

Medicare Part B-Supplementary medical insurance SMI, physician services, Outpatient hospital services, medical equipment, other supplies and services, Outpatient surgeries, Roster billings, Administered by CMS

Medicare Part C-Medicare Advantage (see Advantage Plan)-Managed care plan that extends basic Medicare coverage by offering other options to beneficiaries

Medicare Part D-Prescriptions

Medicare Summary Notice MSN-Explanation of Benefits

Medigap Insurance-Supplements the Medicare original plan. Under par provider can file claim before receiving MSN

e billing

n-covered Medicare service when item is expected to be denied

GY-Append to procedure code for non-covered Medicare service when item is excluded and ABN is not signed. It is not required

GZ-Append to procedure code for non-covered Medicare service when item is expected to be denied as non-reasonable but there is no ABN signed

Medical Savings Account MSA-Similar to private MSA tied to CDHP

Medicare Modernization Act 2003 MMA-Increased number of private health carriers who can offer Medicare benefits under Medicare Advantage Plans

National Coverage Determination NCD-Medicare policy stating whether and under what circumstances or services are covered under Medicare

Non-Participating Provider-Decide whether to accept assignment on a claim by claim basis. 5% less

Original Medical Plan-Fee for service

Participating Provider-Must accept assignment and file claims for beneficiaries

Quality Improvement Organization QIO-Employed by CMS, state based group of physicians who are paid by government to review aspects of the Medicare plan and advise on fees that are charged

Roster Billing-Under Medicare Part B-simplified billing for Pneumococcal, Influenza and Hepatitis B vaccines

Supplement Insurance-Designed to provide additional coverage for individuals receiving benefits under Medicare Part B

Urgently Needed Care-Emergency treatment

Waived Tests-Easy way to perform low risk laboratory tests performed by CLIA

To receive benefits individuals must be eligible under one of six beneficiary categories:

1. Age 65 or older who have paid FICA taxes or railroad taxes for at least 40 calendar quarters
2. Disabled adult who have been receiving Social Security Disability benefits or Railroad Retirement Board disability benefits for more than two (2) years. Coverage begins 5 months after the two year entitlement
3. Disabled before age 18 who meet the disability criteria of the Social Security Act
4. Spouses of entitled individuals as in deceased, disabled or retired who are (or were) entitled to Medicare benefits
5. Retired Federal Employees enrolled in the Civil Service Retirement System (CSRS); and their spouses
6. ESRD-any age who receive dialysis or renal transplant from ESRD. Coverage typically begins on the first day of the month following the start of dialysis treatment. In the case of Transplant, entitlement begins the day the individual is hospitalized. Transplant must take place within 2 months