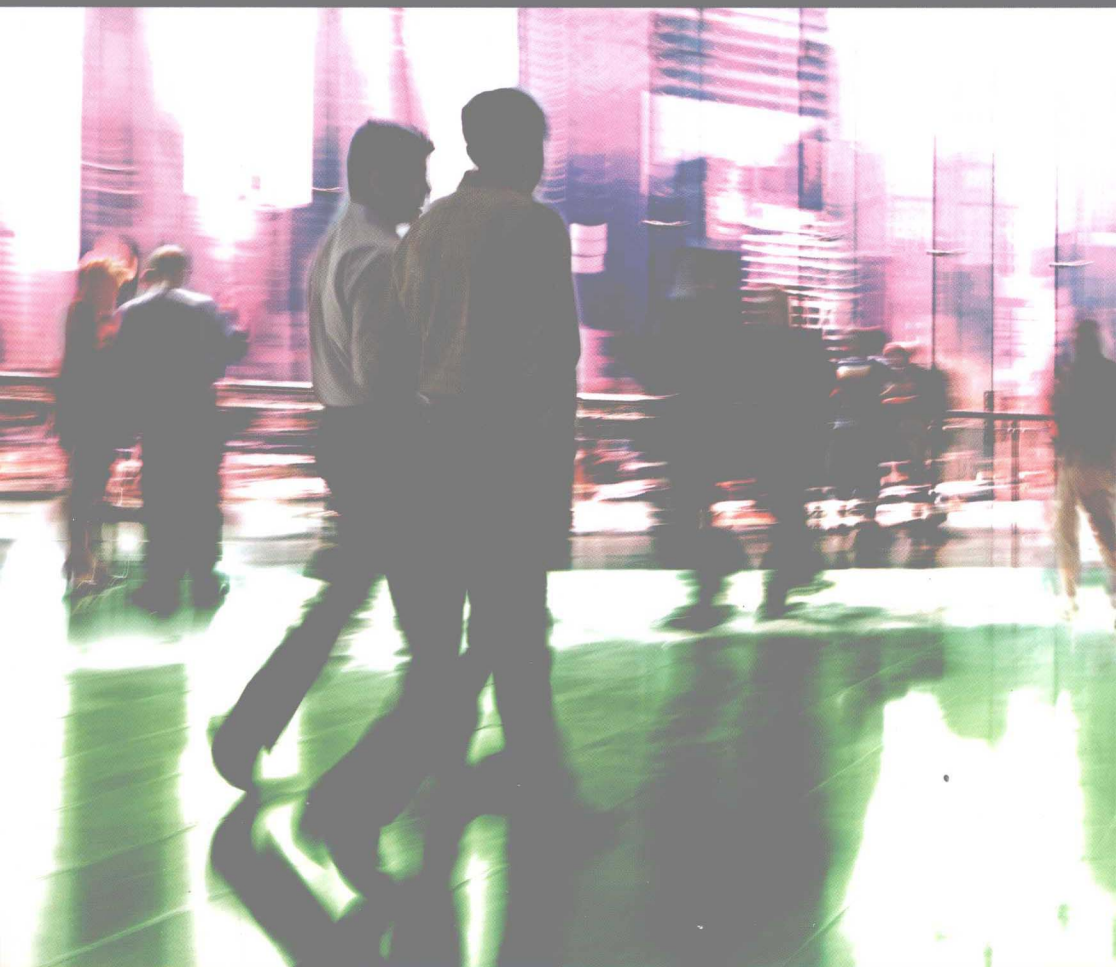


2014

# Medicare Explained

*Health Law Professional Series*



Wolters Kluwer  
Law & Business

# **2014 Medicare Explained**



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# Table of Contents

Chapter		Page
	Detailed Table of Contents . . . . .	9
1	Introduction . . . . .	15
2	Medicare Part A—Hospital Insurance . . . . .	17
3	Medicare Part B—Supplemental Insurance . . . . .	81
4	Medicare Part C—Medicare Advantage . . . . .	157
5	Medicare Part D—Prescription Drug Benefit . . . . .	203
6	Exclusions from Coverage . . . . .	273
7	Administrative Provisions . . . . .	297
8	Payment Rules . . . . .	343
9	Claims, Payments, and Appeals . . . . .	413
	Topical Index . . . . .	447

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## Foreword

This book has been prepared for Medicare beneficiaries and others who need a relatively thorough explanation of the Medicare program with particular emphasis on services covered in institutional settings and services provided by physicians and suppliers.

Published annually, this book includes changes made by law and regulation amendments and by updates to program manuals issued by the Centers for Medicare and Medicaid Services (CMS). This edition includes changes issued during 2013 that affect Medicare beneficiaries and providers in 2014.

The 2014 highlights are as follows:

*Medicare Part A (hospital insurance).* For 2014, the inpatient hospital deductible will be \$1,216 per each beneficiary “spell of illness,” an increase from the \$1,184 inpatient deductible in 2013. Patients are responsible for a coinsurance amount for each day after the 60th and through the 90th day per spell of illness, and in 2014 daily coinsurance amounts will be \$304 for the 61st through 90th day of hospitalization. When Medicare patients use their lifetime reserve days in 2014, their coinsurance will be \$608 per day. When Medicare patients are patients in skilled nursing facilities in 2014, their coinsurance will be \$152 for the 21st through 100th day of skilled nursing facility care (see ¶ 221, ¶ 222, ¶ 242).

*Medicare Part B (supplementary medical insurance).* The Part B premium for 2014 will be \$104.90, unless the Medicare beneficiary is subject to an income-adjusted premium. Income-adjusted premiums for 2014 are as follows: Individuals with modified adjusted gross income (MAGI) greater than \$85,000 but less than or equal to \$107,000 and couples with MAGI greater than \$170,000 but less than or equal to \$214,000 will pay a monthly premium of \$146.90. Individuals with MAGI greater than \$107,000 but less than or equal to \$160,000 and couples with MAGI greater than \$214,000 and less than or equal to \$320,000 will pay a monthly premium of \$209.80. Individuals with MAGI greater than \$160,000 but less than or equal to \$214,000 and couples with MAGI greater than \$320,000 and less than or equal to \$428,000 will pay a monthly premium of \$272.70. Individuals with MAGI greater than \$214,000 and couples with MAGI greater than \$428,000 will pay a monthly premium of \$335.70. The rates are modified slightly for beneficiaries who are married and lived with their spouse at any time during the taxable year but file a separate tax return from their spouse (see ¶ 320).

For 2014, the Part B deductible will remain at \$147 (see ¶ 335).

*Physician reimbursement.* In 2013, CMS began making a separate payment for transitional care management services furnished to a beneficiary making the transition from a facility stay back to the community. CMS continued to emphasize advanced primary care by establishing a separate payment for ongoing care management and continuous assessment that occurs outside of a face-to-face visit with a patient, beginning in calendar year (CY) 2015. Medicare will make this payment for non-face-to-face chronic care management services furnished to patients with multiple chronic conditions that are expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline (see ¶ 860).

*Inpatient hospital reimbursement.* To reduce the use of observation status, CMS implemented the “two midnight” rule. Under the “two midnight” rule, effective for admissions on or after October 1, 2013, if a physician expects a beneficiary’s surgical procedure, diagnostic test, or other treatment to require a stay in the hospital lasting at least two midnights and admits the beneficiary to the hospital based on that expectation, it is presumed to be appropriate that the hospital receive Medicare Part A payment (see ¶ 810).

*Outpatient services.* For CY 2014, CMS expanded the categories of related items and services packaged into a single payment for a primary service under the outpatient prospective payment system (OPPS) and finalized five new categories of supporting items and services to be included in payment for a primary service. It also replaced the five levels of outpatient clinic visit codes with a single code describing all clinic visits (see ¶ 874).

*Medicare Part C (managed care plans).* For 2012 and subsequent years, Medicare Advantage (MA) organizations must provide enrollees a monthly rebate equal to a specified percentage of their average per capita savings (if any). For 2012 and 2013, this percentage was based on a combination of the “rule of 75 percent” and the rules that set the percentage based on a plan’s quality rating under a 5-star rating system; however, for 2014 and subsequent years, this percentage will be determined based only on the final applicable rebate percentage (see ¶ 407).

The special needs plan (SNP) program, which covers managed care plans for individuals with special needs, has been extended through plan year 2016 (¶ 400).

*Medicare Part D (prescription drug plans).* For 2014, beneficiaries in standard prescription drug plans (PDPs) will be subject to a \$310 deductible. In 2014, beneficiaries in the coverage gap will continue to receive a 50 percent discount on brand-name drugs. PDPs also must pay another 2.5 percent, providing Part D beneficiaries with total coverage of 52.5 percent in the donut hole. Therefore, PDP beneficiaries will pay 47.5 percent of the costs for brand-name drugs in the donut hole. Also, PDP coverage of generic drugs in the coverage gap will increase to 21 to 28 percent in 2014 (see ¶ 510). The donut hole is gradually closing; by 2020, cost-sharing for both brand and generic prescription drugs will be the same during the donut hole as during the initial coverage period, i.e., beneficiaries will pay 25 percent of drug costs and PDPs will pay 75 percent (see ¶ 510).

For 2014, the national average monthly bid amount for a PDP will be \$75.88, down from \$79.64 in 2013. The 2014 base beneficiary premium will be \$32.42, up from \$31.17 in 2013. High-income beneficiaries will be subject to income-adjusted premiums for Part D, just as they will be for Part B. For 2014, the income-related monthly adjustment amount for a PDP premium will be \$12.10 for an individual with MAGI greater than \$85,000, but not more than \$107,000; \$31.10 for an individual with MAGI greater than \$107,000, but not more than \$160,000; \$50.20 for an individual with MAGI greater than \$160,000, but not more than \$214,000; and \$69.30 for an individual with MAGI greater than \$214,000. In the case of a joint tax return, the MAGI dollar amounts are doubled (see ¶ 508).

*Quality of care.* A number of quality of care initiatives will continue to be implemented by CMS in fiscal year (FY) 2014, many of which will affect provider and facility reimbursement.

Under the 10th Scope of Work, which began August 1, 2011, and runs through July 31, 2014, quality improvement organizations (QIOs) are responsible for completing the requirements for the following aims: (1) beneficiary- and family-centered care; (2) improved individual patient safety, focused on health care–associated infections, pressure sores, physical restraints, nursing home systemic improvement, adverse drug events, and quality reporting and improvement; (3) integrated care for people who transition from health care entities; and (4) improve health for populations and communities through prevention. Beginning in 2013, QIOs must make available a new, informal, alternative dispute resolution process, called “immediate advocacy,” for beneficiaries’ oral complaints about quality of care (see ¶ 710).

Inpatient hospitals that do not submit required quality data on specific quality indicators to the Medicare program each year will have their applicable hospital market basket



percentage increase reduced by 2 percent. To receive the full market basket update for FY 2016, in FY 2014 hospitals must report on 57 quality measures, including measures for: perinatal care, readmissions, surgical complications, and health care–associated infections. Similarly, Medicare payments to hospitals can be reduced under the Hospital Readmissions Reduction Program, and hospitals can earn incentives under the Hospital Inpatient Value-Based Purchasing Program (see ¶ 810).

Providers of outpatient services that fail to report quality of care data on 24 quality measures will receive a 2.0 percent reduction to their annual market basket payment for CY 2014 (see ¶ 874).

Under the Physician Quality Reporting System, physicians report on measures groups created for specific conditions. For 2012, 2013, and 2014, PQRS incentive payments are 0.5 percent of the total estimated Medicare Part B physician fee schedule allowed charges for covered professional services furnished for the reporting period; starting with CY 2015, a negative adjustment will apply for failure to satisfactorily report (see ¶ 860).

### ***Other Wolters Kluwer publications:***

Further details on the topics covered in this book, together with the texts of pertinent laws, regulations, policy guidelines, court decisions, etc., may be found in Wolters Kluwer's MEDICARE AND MEDICAID GUIDE. The GUIDE is available as a six-volume, loose-leaf print product as well as electronically on the Internet. Other electronic databases, including the full text of the CMS Program Manuals and the codes and complete descriptions contained in the Physician Fee Schedule, are offered as part of Wolters Kluwer's electronic Health Law Library. Wolters Kluwer also has an easy-to-read electronic reporter specializing in Part B issues entitled the PHYSICIANS' MEDICARE GUIDE. In print and electronic form, Wolters Kluwer also offers a comprehensive guide to the landmark health care reform legislation passed in 2010, entitled CCH'S LAW, EXPLANATION AND ANALYSIS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: INCLUDING RECONCILIATION ACT IMPACT, VOLUMES 1 AND 2.

Finally, Wolters Kluwer publishes the following related paperback books:

**2014 Master Medicare Guide**

**2014 Social Security Benefits (Including Medicare)**

**2014 Social Security Explained**

To find out more about these publications call 1-888-224-7377 or visit <http://health.wolterskluwerlb.com>.

### ***A note about the citations in the text:***

Throughout the text, statements are documented, when possible, by citations to the law, regulations, and program manuals issued by the federal government. In the interests of simplicity and conservation of space, citations generally have been made only to the highest authority available for the statement in the text, although, when appropriate, multiple citations (i.e., citations both to a law provision and its implementing regulation) are included. In some instances, when there is no clear ranking of authorities, only the most widely available source is cited.



# Table of Contents

Chapter		Page
	Detailed Table of Contents . . . . .	9
1	Introduction . . . . .	15
2	Medicare Part A—Hospital Insurance . . . . .	17
3	Medicare Part B—Supplemental Insurance . . . . .	81
4	Medicare Part C—Medicare Advantage . . . . .	157
5	Medicare Part D—Prescription Drug Benefit . . . . .	203
6	Exclusions from Coverage . . . . .	273
7	Administrative Provisions . . . . .	297
8	Payment Rules . . . . .	343
9	Claims, Payments, and Appeals . . . . .	413
	Topical Index . . . . .	447



# Detailed Table of Contents

## Chapter 1—Introduction

- ¶ 100 Introduction to Medicare

## Chapter 2—Medicare Part A—Hospital Insurance

### Eligibility and Enrollment

- ¶ 200 Entitlement to Part A Hospital Insurance Benefits
- ¶ 203 Voluntary Enrollment in the Hospital Insurance Program
- ¶ 204 Disability Beneficiaries
- ¶ 205 End-Stage Renal Disease Beneficiaries
- ¶ 206 Government Employees
- ¶ 209 Geographic Limits

### Inpatient Hospital Services

- ¶ 210 Inpatient Hospital Services: Coverage in General
  - ¶ 211 Accommodations
  - ¶ 212 Drugs and Biologicals
  - ¶ 213 Supplies, Appliances, and Equipment
  - ¶ 214 Diagnostic and Therapeutic Items and Services
  - ¶ 215 Services of Interns, Residents-in-Training, and Teaching Physicians
  - ¶ 217 Nursing and Related Services; Private-Duty Exclusion
  - ¶ 218 Inpatient Services Connected with Dental Services
- ¶ 220 Inpatient Hospital Services: Limitations on Coverage
  - ¶ 221 Inpatient Hospital Deductible
  - ¶ 222 Inpatient Hospital Coinsurance
  - ¶ 223 Whole Blood and Packed Red Blood Cells
  - ¶ 224 Use of Lifetime Reserve Days
  - ¶ 225 Psychiatric Hospital Restrictions
  - ¶ 226 Physicians' Professional Services
- ¶ 227 Emergency Services
- ¶ 228 Religious Nonmedical Health Care Institutions
- ¶ 229 "Hospital" Defined—Qualified Hospitals

### Nursing Home Services

- ¶ 230 Extended Care Services
  - ¶ 231 "Skilled Nursing Facility"—Conditions of Participation
  - ¶ 232 Accommodations
  - ¶ 233 Physical and Occupational Therapy and Speech-Language Pathology Services
  - ¶ 235 Drugs and Biologicals
  - ¶ 236 Supplies, Appliances, and Equipment
  - ¶ 237 Interns and Residents-in-Training
  - ¶ 238 Whole Blood and Packed Red Blood Cells
  - ¶ 239 Services Payable Under Part B
  - ¶ 242 Skilled Nursing Facility Coinsurance
  - ¶ 243 Duration of Covered SNF Services
  - ¶ 244 Noncovered Levels of Care

- ¶ 248 Rights of SNF Residents

### **Home Health Services**

- ¶ 250 Home Health Services: Qualifying Conditions for Coverage
- ¶ 251 Skilled Nursing Care
- ¶ 252 Physical and Occupational Therapy and Speech-Language Pathology Services
- ¶ 253 Medical Social Services
- ¶ 254 Home Health Aides
- ¶ 255 Medical Supplies and Durable Medical Equipment
- ¶ 256 Interns and Residents-in-Training
- ¶ 257 Outpatient Services
- ¶ 260 Care of a Physician
- ¶ 262 Establishment of a Plan of Care
- ¶ 264 Patient Confined to Home
- ¶ 266 Visits
- ¶ 267 Specific Exclusions from Coverage
- ¶ 268 "Home Health Agency" Defined—Qualified Home Health Agencies

### **Hospice Care**

- ¶ 270 Hospice Care

## **Chapter 3—Medicare Part B—Supplemental Insurance**

### **Eligibility and Enrollment**

- ¶ 300 Eligibility for Part B Benefits
- ¶ 310 Enrollment in Part B
- ¶ 311 Enrollment Periods
- ¶ 312 Automatic Enrollment
- ¶ 313 Coverage Period
- ¶ 320 Premiums

### **Benefits**

- ¶ 330 Part B Benefits: In General
- ¶ 335 Deductible and Coinsurance
- ¶ 340 Physicians' Services
- ¶ 350 Medical and Other Health Services
- ¶ 351 Services and Supplies Furnished Incident to Physicians' Services
- ¶ 352 Outpatient Hospital Services
- ¶ 353 Diagnostic X-Ray, Laboratory, and Other Diagnostic Tests
- ¶ 354 X-Ray, Radium, and Radioactive Isotope Therapy
- ¶ 355 Ambulance Services
- ¶ 356 Durable Medical Equipment
- ¶ 357 Prosthetic Devices
- ¶ 358 Braces, Artificial Limbs, Etc.
- ¶ 359 Surgical Dressings, Splints, Casts, Etc.
- ¶ 361 Inpatient Ancillary Services
- ¶ 362 Drugs and Biologicals
- ¶ 366 Other Health Care Practitioners
- ¶ 369 Prevention Services

- ¶ 370 Therapeutic Shoes
- ¶ 381 Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services
- ¶ 382 Rural Health Clinics and Federally Qualified Health Centers
- ¶ 383 Home Health Services
- ¶ 385 Comprehensive Outpatient Rehabilitation Facility Services
- ¶ 386 Ambulatory Surgical Services
- ¶ 387 Mental Health Services
- ¶ 388 Telehealth Services
- ¶ 389 E-Prescribing
- ¶ 390 National and Local Coverage Decisions

## **Chapter 4—Medicare Part C—Medicare Advantage**

- ¶ 400 Overview
- ¶ 401 Eligibility, Election, Enrollment, and Disenrollment
- ¶ 402 Benefits and Beneficiary Protections
- ¶ 403 Beneficiary Grievances, Organizational Determinations, and Appeals
- ¶ 404 MA Regional Plans
- ¶ 405 Contracts with Medicare Advantage Organizations
- ¶ 407 Bids, Benchmarks, Premiums, and Cost Sharing
- ¶ 408 Payments to Medicare Advantage Organizations
- ¶ 409 Marketing
- ¶ 410 Quality Improvement Programs
- ¶ 411 Relationships with Providers
- ¶ 412 Intermediate Sanctions and CMPs

## **Chapter 5—Medicare Part D—Prescription Drug Benefit**

- ¶ 500 Overview
- ¶ 505 Prescription Drug Benefit
- ¶ 506 Eligibility and Enrollment
- ¶ 508 Payment of Premiums
- ¶ 510 Benefits and Beneficiary Protections
- ¶ 515 Grievances, Coverage Determinations, Redeterminations, and Reconsiderations
- ¶ 516 Reopenings, ALJ Hearings, Medicare Appeals Council Review, and Judicial Review
- ¶ 520 Premium and Cost-Sharing Subsidies for Low-Income Individuals
- ¶ 525 Cost Control and Quality Improvement Requirements
- ¶ 530 Payments to Sponsors of Retiree Prescription Drug Plans
- ¶ 535 Marketing Requirements

## **Chapter 6—Exclusions from Coverage**

- ¶ 600 Exclusions Under Part A and Part B
- ¶ 601 Services Not Reasonable and Necessary
- ¶ 602 Experimental, Investigational, and Other Excluded Procedures
- ¶ 604 No Legal Obligation to Pay
- ¶ 607 Services Paid for by Governmental Entity
- ¶ 610 Services Outside the United States
- ¶ 613 War Claims
- ¶ 616 Personal Comfort Items
- ¶ 619 Glasses; Eye and Hearing Examinations

- ¶ 622 Foot Care and Orthopedic Shoes
- ¶ 625 Custodial Care
- ¶ 628 Cosmetic Surgery
- ¶ 631 Charges by Relatives
- ¶ 634 Dental Services
- ¶ 635 Services Not Provided In-House
- ¶ 636 Medicare as Secondary Payer
- ¶ 637 Workers' Compensation
- ¶ 638 Automobile and Liability Insurance Coverage
- ¶ 639 Employer Group Health Plans
- ¶ 644 Limitation on Payments for Certain Drugs
- ¶ 646 Individuals and Entities Guilty of Program Abuses
- ¶ 654 Surgery Assistants in Cataract Operations

### **Chapter 7—Administrative Provisions**

- ¶ 700 HHS and CMS Organizational Structure
- ¶ 703 Role of the State and Local Agencies
- ¶ 705 Role of Fiscal Intermediaries, Carriers, Medicare Administrative Contractors, and Recovery Audit Contractors
- ¶ 707 Role of Medicaid
- ¶ 710 Quality Improvement Organizations
- ¶ 711 Recovery Audit Contractors
- ¶ 715 Privacy of Health Data
- ¶ 717 Electronic Health Records
- ¶ 720 Fraud and Abuse Penalties
- ¶ 730 Provider Participation Agreements
- ¶ 740 "Medigap" Insurance

### **Chapter 8—Payment Rules**

- ¶ 800 Introduction
- ¶ 810 Inpatient Hospital Services
- ¶ 815 Long-Term Care Hospitals
- ¶ 820 Home Health Agencies
- ¶ 825 Skilled Nursing Facilities
- ¶ 827 Inpatient Rehabilitation Facilities
- ¶ 830 Psychiatric Hospitals and Units
- ¶ 832 End-Stage Renal Disease
- ¶ 840 Rural Health Facilities
- ¶ 842 Federally Qualified Health Centers
- ¶ 850 Accountable Care Organizations
- ¶ 860 Physician Fee Schedule
- ¶ 862 Actual Charge Restrictions
- ¶ 864 Nonphysician Practitioners
- ¶ 866 Clinical Diagnostic Laboratory Tests
- ¶ 868 Assignment
- ¶ 870 Participation Program for Physicians and Suppliers
- ¶ 872 Private Non-Medicare Contracts with Health Care Practitioners



- ¶ 874 Hospital Outpatient Services
- ¶ 876 Ambulatory Surgical Centers
- ¶ 877 Hospice Reimbursement

### **Chapter 9—Claims, Payments, and Appeals**

- ¶ 900 Claims and Payments
- ¶ 902 Certification and Recertification
- ¶ 904 Guarantee of Payment to Hospitals
- ¶ 905 Payments on Behalf of a Deceased Beneficiary
- ¶ 906 Overpayments and Underpayments
- ¶ 915 Limitation of Liability
- ¶ 920 Medicare Entitlement and Enrollment Appeals
- ¶ 924 Medicare Part A and B Claims Appeals
- ¶ 926 Expedited Appeals of Provider Service Terminations
- ¶ 928 NCD and LCD Appeals
- ¶ 930 RAC, Cost Report, Status, Exclusion, and Suspension Appeals

### **Topical Index**