

Advanced Issues in Medicare Part B

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we have focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Introduction

The Medicare Part B benefit covers a wide range of services and supplies. This paper looks at three areas in the Part B benefit where there is potential for confusion among beneficiaries and advocates: Advance Beneficiary Notices of Noncoverage (ABNs), Part B coverage of certain prescription drugs, and current changes in supplier rules for Durable Medical Equipment (DME).

Key Lessons

- Advance Beneficiary Notices of Noncoverage put Medicare beneficiaries on notice that they may be liable for specific Part A or Part B services that Medicare won't cover. If a provider believes that a service is not covered by Medicare and gives the beneficiary an ABN, the provider can charge the beneficiary before offering the service. Qualified Medicare Beneficiaries (QMBs) and people with Medicaid coverage, however, may not be charged until after the claim has run through both Medicare and Medicaid.
- ABNs can be challenged if insufficiently specific or if not properly explained. Whether or not an ABN was properly executed, beneficiaries can appeal a Medicare denial of coverage based on medical necessity.
- Different rules apply to payment for prescription drugs covered by Medicare Part B compared to those covered by Part D. Those differences particularly impact QMBs and those with the Part D Low Income Subsidy (LIS).
- For both 2019 and 2020, competitive bidding rules for Durable Medical Equipment covered by Part B have been suspended. During this period, Medicare beneficiaries have more choices in suppliers but may also be subject to aggressive marketing and disruptions with established suppliers.

Advance Beneficiary Notices of Noncoverage (ABNs)

An ABN is a standardized [notice](#) (CMS-R-131) used by suppliers and providers in Original fee-for-service Medicare.¹ The ABN informs a Medicare beneficiary that the provider or supplier believes that a requested service is unlikely to be covered by Medicare. An ABN has the effect of shifting payment liability to a beneficiary who accepts a service if Medicare, in fact, does not approve the charges. If an individual does not receive and sign an ABN for a Medicare service that was denied, the beneficiary has no liability to the provider for the charges. A [Justice in Aging Issue Brief](#) discusses in detail the statements in an ABN and the options presented to beneficiaries in the document.²

1 ABNs in English and Spanish are available at [cms.gov/Medicare/Medicare-General-Information/BNI/ABN](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN).

2 Justice in Aging, Advance Beneficiary Notices, Administrative Fees, and Dual Eligibles (Feb. 2018), available at [justiceinaging.org/wp-content/uploads/2018/02/Advance-Beneficiary-Notices-Administrative-Fees-and-Dual-Eligibles.pdf](https://www.justiceinaging.org/wp-content/uploads/2018/02/Advance-Beneficiary-Notices-Administrative-Fees-and-Dual-Eligibles.pdf).

ABNs are not used by Medicare Advantage plans. Instead, plans use prior authorization procedures to determine whether a service will be covered.

When is an ABN issued?

ABNs are required when a service that is usually or sometimes covered by Medicare is unlikely to be covered by Medicare in a particular case.³ ABNs are not required for services that are categorically excluded from Medicare coverage, for example, cosmetic surgery. CMS, however, encourages providers to give ABNs to Medicare beneficiaries for all uncovered services. ABNs are not required or permitted in emergency situations since CMS assumes that an individual in an emergency is not in a position to waive rights.

Ms. Chen's doctor gives her a lab slip for a number of tests. The lab presents her with an ABN for two of the tests, indicating that the diagnosis codes do not support the tests. She decides not to have the tests that day and to talk with her doctor about whether the tests are necessary and/or whether the doctor can provide information that justifies coverage.

What are the requirements for ABNs?

Providers may not issue blanket ABNs for all services. ABNs must identify the specific service the provider or supplier expects will be rejected by Medicare and identify the reason. For most beneficiaries, if the individual chooses to accept services after reviewing an ABN, the provider has the right to require payment before providing the service.

Special ABN procedures apply when a beneficiary is dually eligible for Medicare and Medicaid and/or is a Qualified Medicare Beneficiary (QMB).⁴ Providers must instruct the QMB or dual eligible beneficiary to check the option box in the ABN that asks for the claim to be submitted for Medicare adjudication. Providers may not bill a dual eligible or QMB before the claim is processed through both Medicare and Medicaid.⁵

In some cases, an individual who qualifies for Medicaid services may be able to get Medicaid coverage for a service denied by Medicare.

Those QMBs who do not also have full Medicaid (QMB-onlys), although protected from billing for Medicare-covered services, do not have billing protections for services that Medicare does not cover. If a QMB-only signs a properly presented ABN and receives services and Medicare ultimately denies payment, the QMB may be charged for those services.

What did the beneficiary sign?

It is important to distinguish between ABNs, in which a beneficiary agrees to be liable for payment for services not covered by Medicare, and contracts that providers sometimes require QMBs and dual eligible beneficiaries to sign agreeing to pay co-insurance for services that Medicare does cover. ABNs are legal and appropriate; provider contracts requiring QMBs to sign away their statutory rights are not legally binding and are unenforceable.

3 For an extensive discussion of when ABNs must be issued, see Center for Medicare Advocacy, CMS Clarifies When the Advance Beneficiary Notice of Non-Coverage Must be Issued (Aug. 2012), available at [medicareadvocacy.org/cms-clarifies-when-the-advance-beneficiary-notice-of-non-coverage-abn-must-be-issued/](https://www.medicareadvocacy.org/cms-clarifies-when-the-advance-beneficiary-notice-of-non-coverage-abn-must-be-issued/).

4 The steps a provider must follow are spelled out in a CMS Q&A (Question 16), available at [cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2018-06-06-QMB-Call-FAQs.pdf). CMS has proposed to revise the instructions accompanying the ABN to better ensure that providers are aware of their responsibilities. Note however that the revised instructions only reinforce current requirements, which are already in force. For more information on QMBs, go to NCOA, Medicare Savings Programs: Eligibility and Coverage (2018), available at [ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf](https://www.ncoa.org/wp-content/uploads/medicare-savings-programs-coverage-and-eligibility.pdf). For additional information on QMB protections see [justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/](https://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/) and [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/QMB.html).

5 CMS Q&A (Question 16) *supra* note 4.

Challenging charges when a beneficiary has signed an ABN

If a beneficiary signed an ABN and receives a bill from a provider because Medicare denied coverage for the service, there are several steps that can be taken and avenues that can be pursued.

Curing the deficiency

Often the ABN and the CMS denial of Medicare coverage are because a needed diagnosis code or other supporting information was not provided. Sometimes resubmittal with the required information can remedy the defect and the claim can be resubmitted. Beneficiaries may need to directly contact the prescriber or provider to ensure that, if a resubmission with needed information could solve the problem, there is follow through and the revised submission is made.

Appeal based on defects in the ABN

Did the beneficiary receive an ABN? If so, did it specifically identify the procedure/service that Medicare likely would not cover and why it likely would not be covered? Did the provider's office explain the ABN to the beneficiary? If for example, the beneficiary has limited English proficiency, did the provider make any effort to determine whether the individual could understand the document or offer interpreter services? Providers are required to present an ABN with sufficient time for the individual to make a choice. Presenting an ABN to a beneficiary right before being wheeled into surgery, for example, would not meet this standard. A [Medicare Learning Network booklet](#) for providers gives a good roadmap for determining if an ABN has met required standards.⁶

Appeal based on substantive issues

Whether or not an ABN was deficient, a beneficiary can appeal a Medicare denial on the substance of the claim, arguing the medical necessity of the service that Medicare has denied.

Part B and Prescription Drugs

A limited number of prescription drugs are covered by Medicare Part B, rather than by Part D. These drugs are primarily ones administered by a health professional in a physician's office or other outpatient setting, such as a same-day surgery unit in a hospital. Other drugs covered by Part B include drugs used with an infusion pump or a nebulizer, oral anti-cancer drugs, blood clotting factors for hemophilia, certain antigens that are self-administered, and some others.⁷ There also are some drugs that can be billed under either Part B or Part D, depending on the circumstances and diagnosis.⁸ In most situations, the provider, rather than a pharmacy, bills the beneficiary. When, however, the beneficiary picks up the drug at the pharmacy, the pharmacy will be the biller.

Paying for Part B drugs

Part B drugs are subject to the same payment regime as other Part B services. In Original Medicare, the standard co-insurance is 20% of the drug price, and Part B charges are subject to the Part B deductible; as with other Part B services, Medicare Advantage plans may have different deductibles and co-insurance amounts.

In both Original Medicare and Medicare Advantage, Qualified Medicare Beneficiaries (QMBs) may not be charged any deductibles or any co-insurance for Part B drugs.

6 CMS, Medicare Advance Written Notices of Noncoverage (Oct. 2018), available at [cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ABN_Booklet_ICN006266.pdf).

7 A fuller description of categories of Part B drugs is found on the medicare.gov website at [medicare.gov/coverage/prescription-drugs-outpatient#](https://www.medicare.gov/coverage/prescription-drugs-outpatient#).

8 For a chart of these drugs, see Medicare Rights Center, Medicare Drug Coverage: Part D vs. Part B (January 2019), available at [medicareinteractive.org/pdf/B-vs-D-chart.pdf](https://www.medicareinteractive.org/pdf/B-vs-D-chart.pdf).

QMB and LIS—Sorting it out

Part D drugs: The Low Income Subsidy (LIS or “Extra Help”) co-payments apply. Low income beneficiaries, including QMBs, are required to pay reduced co-pays at the appropriate LIS level for their Part D drugs.

Part B drugs: QMBs get complete protection from any charges for Part B-covered drugs. LIS beneficiaries who are not also QMBs have full co-insurance responsibility; LIS does not apply to their Part B drugs. But if they have Medicaid coverage, the charges should be sent to Medicaid as secondary insurance and Medicaid may cover the drugs.

These basic protections apply whether an individual is in Original Medicare or Medicare Advantage.

How payments look if everything works as it should

Last month, Mrs. Johnson, a dual eligible beneficiary and a QMB, started treatment with intravenous chemotherapy drugs at her oncologist’s office. At her pharmacy, she picked up prescriptions for oral anti-nausea drugs to help with her chemo side effects. She also picked up her usual prescription for a generic statin for her cholesterol. She paid nothing to her oncologist or to her pharmacy for the chemotherapy and anti-nausea drugs, both covered by Part B. She later receives a Medicare Summary Notice (MSN) showing that, because she is a QMB, she owes nothing more for either drug. At the pharmacy she paid \$1.25 for her cholesterol drug and later receives an Explanation of Benefits (EOB) from her Part D plan confirming the payment for the cholesterol drug, which is covered by her Part D plan.

Drug approvals and appeals

Although some process details for approvals and appeals of Part B drug coverage differ somewhat depending on whether an individual is in fee-for-service Medicare or in a Medicare Advantage plan, the substantive standards are identical. One step that advocates can take when considering an appeal of a Part B drug denial is to check whether there is any National Coverage Determination (NCD) or, in the absence of an NCD, a Local Coverage Determination (LCD) by a regional Medicare Administrative Contractor (MAC) concerning criteria for coverage of the particular drug.⁹ Medicare Advantage coverage determinations must comply with NCDs and with LCDs in the regions where the Medicare Advantage plans operate. If there is no NCD or LCD, Medicare makes a case-by-case determination based on medical necessity criteria.

Note: NCDs and LCDs are only applicable to Part B drugs and do not apply to prescription drugs covered by Part D.

Durable Medical Equipment (DME)—Update on Competitive Bidding

Over the last several years, increasing categories of durable medical equipment (DME) have been subject to competitive bidding. For beneficiaries, this has meant that they may only obtain DME from suppliers with competitive bidding contracts for the specific item.

CMS, however, has temporarily suspended competitive bidding for 2019 and 2020. The agency took this step to allow time to implement changes in bidding requirements required by the 2016 21st Century Cures Act.¹⁰ During this period, beneficiaries may use any Medicare-enrolled supplier for DME needs.

Until the end of 2020, this suspension offers beneficiaries more flexibility in choice of suppliers.¹¹ It also opens the door to aggressive marketing urging beneficiaries to switch suppliers. Further, some suppliers who had competitive bidding contracts may decide to drop some of the product categories they previously covered,

9 A searchable database of Medicare national and local coverage determinations is available at [cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

10 For a discussion of CMS’s actions see the CMS Fact Sheet (July 11, 2018) at [cms.gov/newsroom/fact-sheets/cms-proposed-updates-policies-and-payment-rates-esrd-pps-dmepos-competitive-bidding-program-dmepos](https://www.cms.gov/newsroom/fact-sheets/cms-proposed-updates-policies-and-payment-rates-esrd-pps-dmepos-competitive-bidding-program-dmepos).

11 A Medicare Supplier Directory, searchable by zip code and product category, is available at [medicare.gov/supplier](https://www.medicare.gov/supplier).

resulting in a need for beneficiaries to change suppliers.¹²

Complaints about inappropriate marketing can be filed at 1-800-Medicare, which also is available to provide assistance in finding local providers. Justice in Aging would also be interested in problems advocates are seeing during this gap period.

Competitive bidding and its current suspension do not affect beneficiaries in Medicare Advantage plans. Plan members must continue to use DME suppliers that are in the plan's supplier network.

Conclusion

ABNs, Part B prescription drug coverage, and durable medical equipment changes are among the many distinct issues within the world of Medicare Part B. In every instance it is particularly important to look at the way in which policies affect access and costs for low income beneficiaries.

Additional Resources

- Citations to key regulations and guidance on the topic:
 - » 42 U.S.C. § 1395m
 - » 42 C.F.R. § 411.404
 - » [Medicare Benefit Policy Manual, Chapter 15, part 50](#)
- Key federal agency overseeing the subject matter:
 - » [Centers for Medicare and Medicaid Services](#)
- National organizations providing additional resources:
 - » [Justice in Aging](#)
 - » [Medicare Rights Center](#)
 - » [Center for Medicare Advocacy](#)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

¹² See CMS, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program: Temporary Gap Period (Oct. 2018), available at [cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/DMEPOS-Temporary-Gap-Period-Fact-Sheet-Beneficiary.pdf](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/DMEPOS-Temporary-Gap-Period-Fact-Sheet-Beneficiary.pdf).