Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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NEW/REVISED MATERIAL--*EFFECTIVE DATE: October 11, 2000*
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Section 9051, Beneficiaries Previously Enrolled in Managed Care Who Return to Traditional Fee For Service (FFS), provides instruction for situations where a beneficiary returns to FFS after leaving a Managed Care plan.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

CHAPTER IX

CARRIER RELATIONSHIPS

C. Other Covered Services.--Other covered services are services which are determined by the Secretary not to have been made reasonably available by the HMO to its Medicare enrollees.

9050.2 Carrier Involvement With Reimbursement For HMO Services.--Part B services for HMO members who are Medicare beneficiaries are reimbursed either through the HMO itself or through the carrier. The HMO may select from a number of options the one method by which its bills will be handled. The jurisdiction of Part B bills is indicated in the R-trailer of the query reply.

The HMO options which will be shown in the R-trailer are:

A. For Restricted Beneficiaries.--Code A, B, or C - The HMO has jurisdiction over all Part B physician/supplier bills except bills from physicians for dialysis and related services provided through an approved dialysis facility which are the jurisdiction of the carrier. Carriers will transfer to the HMO all claims for Part B services for which the HMO has jurisdiction.

B. For Unrestricted Beneficiaries.--Code l or 2 - The HMO has jurisdiction over all bills for in-plan services (see §9050D) except:

l. All claims involving out-patient psychiatric services;

2. All claims for services by an independent physical therapist; and

3. All claims from physicians for dialysis and related services provided through an approved dialysis facility.

Carriers will process all claims for Part B services for unrestricted beneficiaries as though they were claims for out-of-plan services. (See §9050C.)

NOTE: For out-patient blood claims, the HMO will file claims with the carrier until the EOMB indicates the 3 pint deductible is met.

Carrier actions in relation to query responses and receipt of Part B bills are described in §§4267ff.

When the HMO has jurisdiction of its bills, SSA makes the interim capitation payments to the HMO and the periodic accounting and end-of-year adjustments.

When the carrier has jurisdiction for services to HMO members, the carrier processes the bills in the same manner as for non-HMO beneficiaries.

9051. BENEFICIARIES PREVIOUSLY ENROLLED IN MANAGED CARE WHO RETURN TO TRADITIONAL FEE FOR SERVICE (FFS)

When a beneficiary who was previously enrolled in a Medicare HMO/Managed Care program returns to traditional FFS, he or she is subject to all benefits, rules, requirements and coverage criteria as a beneficiary who has always been enrolled in FFS. When a beneficiary returns to FFS, it is as though he or she has become eligible for Medicare for the first time. Therefore, if a beneficiary received any items or services from their HMO or Managed Care plan, they may only continue to receive such items and services if they would be entitled to them under Medicare FFS coverage criteria and documentation requirements.

For example, if a beneficiary received a manual wheelchair under their HMO/Managed Care plan, he or she would need to meet Medicare coverage criteria and documentation requirements for

manual wheelchairs. He or she would have to obtain a Certificate of Medical Necessity (CMN), and would begin an entirely new rental period, just as a beneficiary enrolled in FFS would to obtain a manual wheelchair for the first time.

There is an exception to this rule if a beneficiary was previously enrolled in FFS and received a capped rental item, then enrolled in an HMO, stayed with the HMO for 60 or fewer days, then returned to FFS. For instructions on how to deal with this situation, refer to §5102.1(E)(3). For purposes of this instruction, HCFA has interpreted an end to medical necessity to include enrollment in an HMO for 60 or more days.

These instructions apply whether a beneficiary voluntarily returns to FFS, or if he or she involuntarily returns to FFS because their HMO or Managed Care plan no longer participates in the Medicare + Choice program.