Navigating Medicare & Medicare Advantage (Part C) Plans

MEDICARE IS A HEALTH INSURANCE PROGRAM FOR:

- People age 65 or older.
- People under age 65 with specific disabilities.
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

MEDICARE HAS DIFFERENT PARTS THAT HELP COVER SPECIFIC SERVICES:

Medicare Part A (Hospital Insurance) - Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits. Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Medicare Part B (Medical Insurance) - Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Most people pay a monthly premium for Part B.

Medicare Part D (Prescription Drug Coverage) - Medicare prescription drug coverage is available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a plan approved by Medicare that offers Medicare drug coverage. Most people pay a monthly premium for Part D.[1]

Visit Medicare.gov to find more information about Medicare.

Medicare Enrollment Application (Part B)

To provide covered dental services or to order or certify items and/or services for Medicare patients, you will enroll in Medicare as a Part B provider of covered services. To only order or certify, you can enroll using a much shorter form CMS Form 855o.

Medicare proposes to include as examples the following dental services for which payment is permitted under current policy: (1) dental or oral examination as part of a comprehensive workup prior to a renal organ transplant surgery; (2) reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor; (3) wiring or immobilization of teeth in connection with the reduction of a jaw fracture; (4) extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and (5) dental splints only when used in conjunction with medically necessary treatment of a medical condition. CMS further proposes that Medicare payment would be made for these dental services regardless of whether the services are furnished in an inpatient or outpatient setting. Payment can also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia and use of operating rooms, or other facility services.

[1] https://www.cms.gov/medicare/medicare-general-information/medicaregeninfo

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Effective January 1, 2023, Medicare will cover the dental or oral examination as part of a comprehensive workup prior to an organ transplant, cardiac valve replacement, or valvuloplasty procedure; and the necessary dental treatments and diagnostics to eliminate the oral or dental infections found during a dental or oral examination as part of a comprehensive workup prior to an organ transplant, cardiac valve replacement or valvuloplasty procedure. Furthermore, CMS proposes that payment under the applicable payment system could also be made for services that are ancillary to these dental services, such as x-rays, administration of anesthesia and use of the operating room.

Here's how to Enroll in Medicare to Provide Covered Services

STEP 1 – National Provider Identifier (NPI)

Skip to step 2 if you already have an NPI. Need an NPI? Visit the National Plan and Provider Enumeration System (NPPES) website. Not sure if you have an NPI? Visit the NPI Registry.

STEP 2 – Enroll via the Provider Enrollment Chain and Ownership System (PECOS) or by Completing the Paper Form

Complete the PECOS online application or complete CMS Form 855i. Need help? View this video. If you have trouble logging in, contact the External User Services Help Desk at **866-484-8049**.

STEP 3 – Locate your Medicare Administrative Contractor (MAC)

Locate your Medicare Administrative Contractor (MAC) (Part B contractor) based on your location. You can also contact your MAC for help in enrolling in Medicare.

Participating vs. Non-Participating

Medicare "participation" means you agree to accept claims assignment for all Medicare-covered services to your patients. By accepting assignment, you agree to accept Medicare-allowed amounts as payment in full. You may not collect more from the patient than the Medicare deductible and coinsurance or copayment.[2]

Participating Provider or Supplier	Non-Participating Provider or Supplier
• Medicare pays the full Medicare Physician Fee Schedule allowed amount • Medicare pays you directly • Medicare forwards claim information to Medigap (Medicare supplement coverage) insurers	• Medicare pays 5% less than the Medicare Physician Fee Schedule allowed amount • You can't charge the patient more than the limiting charge, 115% of the Medicare Physician Fee Schedule amount

[2] Annual Medicare Participation Announcement | CMS

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	• You may accept assignment on a case-by-case basis • You have limited appeal rights

Medicare Participating Physician or Supplier Agreement

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients. If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.[3] You will need to complete Form CMS-460 and send it to your MAC. Additional information can be found on the ADA's web portal.

Medicare Advantage (Part C) Plans

Medicare Advantage (Part C)

Medicare Advantage Plans are another way for patients to get Medicare Part A (hospital insurance) and Part B (medical insurance) coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. Many Medicare Advantage Plans include drug coverage (Part D). In some cases, patients will need to use health care providers who participate in the plan's network; however, many PPO plans provide coverage for out-of-network providers. These plans set a limit on what patients have to pay out-of-pocket each year for covered services. Patients must use the (red, white and blue) card from their Medicare Advantage Plan to get Medicare-covered services.[4] There is always coverage for emergency and urgent care.

Covered Services

Medicare Advantage plans may provide coverage for things original Medicare doesn't cover e.g., fitness programs (gym memberships or discounts), vision, hearing and dental services (routine check-ups or cleanings). Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote your health and wellness. Plans can also tailor their benefit packages to offer these benefits to certain chronically-ill enrollees.[5] Learn more about what Medicare Advantage Plans cover.

Types of Medicare Advantage Plans

[3] MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT FORM CMS-460
[4] Medicare Advantage Plans | Medicare
[5] Medicare Advantage Plans cover all Medicare services | Medicare

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There are several different types of Medicare Advantage plans on the market. The most popular plans include:

- Health maintenance organization (HMO) plans - These are typically closed panel plans meaning the patient needs to see a network provider in order to be eligible for a benefit, except in the event of an emergency. Dentists are paid a capitated rate.
- Health maintenance organization (HMO) plus point of service (POS) plans – These are HMO plans that typically allow out-of-network benefits for dental coverage (if provided).
- Preferred provider organization (PPO) plans – These are indemnity plans. The insurance company contracts with a network of dentists who have agreed to charge certain discounted fees for approved services. Benefits are available for patients to visit dentists that are not participating in the plan's network. In addition, some MA plans may offer allowance plans as the dental option under a PPO plan. These plans typically pay a set dollar amount for covered procedures and patients can save money by visiting network providers.

How do I know if my patient has a Medicare Advantage plan?

Check the patient's insurance identification card to determine if the patient has a Medicare Advantage plan. If this is not indicated on the ID card itself call the 800-telephone number listed on the card to verify whether or not the patient has an MA plan. Although not always 100% accurate, your staff can ask the patient if he or she has an MA plan. This way if there is any doubt, it would behoove your office to call the plan to verify. Lastly, if the patient is over 65 years of age there is a greater chance that the patient may have an MA plan and once again, a call to the plan to verify is suggested.

Commercial Dental Insurance Plans and Medicare Advantage

Many commercial PPO plans include participation with their Medicare Advantage products. Some plans may send an addendum to the contract for your signature or require you to opt-out of the MA program should you choose not to participate. Still other plans may offer an exclusive provider organization (EPO) plan which requires patients to visit a network dentist in order to receive a benefit. Many commercial plans use the same network fee schedule for their commercial business as for their MA business.

Allowance plans are gaining popularity with MA plan options. These plans provide patients with a set dollar amount that the patient can use on specific allowable or covered dental services. Out-of-network dentists can receive their full fees while network dentists are subject to the plan's allowable fees.

If the plan also offers a separate dental health maintenance organization (DHMO) plan and the dentist wishes to participate in the MA DHMO plan, the dentist will need to sign a separate agreement with the DHMO plan.

View the archived webinar titled, Medicare Advantage: What is Medicare Part C and how does it work with Dental Coverage?

The Appeals Process: Medicare Advantage (Part C)

There are multiple levels in the Medicare Advantage Part C appeals process. The levels are:

1. Level 1 Appeals: Medicare Advantage (Part C) | HHS.gov

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2. Level 2 Appeals: Medicare Advantage (Part C) | HHS.gov
3. Level 3 Appeals (OMHA) | HHS.gov
4. Level 4 Appeals | HHS.gov
5. Level 5 Appeals | HHS.gov[6]

Waiver of Liability for Non-Contracted Providers

If the MA plan approves a request for payment from a non-contracted provider, then the provider receives payment and a remittance advice/notice. If the MA plan denies a request for payment from a non-contracted provider, the MA plan must notify the non-contracted provider of the specific reason for the denial and provide a description of the appeals process. MA plans must deliver either a remittance advice/notice or other similar notification that states the non-contracted provider:

- Has the right to request a reconsideration of the MA plan's denial of payment
- Must submit a Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal. (MA plans must include the form as an enclosure or attachment and/or provide a direct link to the form)
- Has 60 calendar days from the remittance notification date to request a reconsideration
- Should include documentation, such as a copy of the original claim or remittance notification showing the denial, and must include any clinical records and other documentation that supports the provider's argument for reimbursement
- Return the request for reconsideration to the MA plan following the instructions provided by the plan on where to send the request[7]

Additional information on Medicare Advantage can be found on the ADA's web portal. General information to help you navigate the Medicare landscape, which includes FAQs and a Medicare Toolkit for Integral Care, can be found here.

[6] Level 1 Appeals: Medicare Advantage (Part C) | HHS.gov
[7] Medicare Managed Care and Part D Appeals Guidance (cms.gov)

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