

UNDERSTANDING YOUR MEDICARE COVERAGE
AND
HOW IT WORKS IN OUR PRACTICE

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INTRODUCTION

The purpose of this pamphlet is to help you understand your Medicare coverage. We've heard your questions and hope that this information will help you to better understand the billing process.

Wake Internal Medicare Consultants, Inc. (WIMC) is a nonparticipating Medicare provider. This means that we do not accept Medicare assignment. We will file your claim for you, and Medicare will send payment directly to you. Therefore, we will ask you to pay your bill in full at time of your visit.

Exceptions

There are some exceptions to this rule, however. Medicare DOES require us to accept assignment on certain claims.

1. As required by law, any injections, hospital charges and lab work will be paid to us directly by Medicare. You will not be asked to pay WIMC at the time of your visit for these services.

Fees

Every Medicare patient who is seen in our office is charged according to a specific fee schedule. The fee schedule is generated each year by Medicare and issued in the fall for the following year. When your visit is completed, you will be asked to pay the Medicare fee for the services received, according to this fee schedule. Our office accepts cash, check and credit card (Visa, MasterCard, Discover and American Express). If you cannot pay your charges in full, you may speak with a patient account representative to make specific payment arrangements.

As stated previously, we do submit your claim to Medicare for you. You will be billed what is known as the "limiting charge." This is from Medicare's official fee schedule and represents 115% of Medicare's "allowable charge." When Medicare processes the claim, they will reimburse you at 80% of their allowable charge after you have met your yearly deductible. Medicare does not pay you 80% of the total charges – they pay you 80% of their allowable charges.

Claim process time

After your appointment with WIMC, you will need to allow Medicare two (2) to three (3) weeks to process and pay your claim. If you do not receive a response from Medicare after three weeks, call Medicare at 1-800-672-3071 to check the status of your claim. Please call Medicare before you call the WIMC office.

Our office makes every effort to file your claim using the correct codes. Sometimes claims are denied by Medicare based on their strict criteria for certain procedures. If you receive a Medicare Explanation of Benefits that shows a denied charge that you have already paid, please send us a copy of the explanation of benefits. We will review the claim for correct coding, and if a correction needs to be made, we will bill the corrected claim for you to Medicare. If the denial is upheld upon review, your account will be corrected and any refund due issued to you.

When a procedure is not covered

There may be a time when your doctor feels it is in your best interest to have a procedure or test done that may not be covered by Medicare. We will make you aware prior to the procedure/test that Medicare may not cover the service and give you the option to have it performed or not. You will be asked to sign a Medicare waiver that is kept on file in our office. When the claim is submitted to Medicare we do inform them that you have signed a waiver. Should Medicare deny payment, you are still responsible for the charges. If Medicare denies payment on a procedure for which you did not sign a waiver, and if that denial is upheld on appeal, you are not responsible for payment. We will issue you a refund for any overpayment in this circumstance.

When you receive your Medicare explanation of benefits, compare the “amount charged” to the “amount you may be billed.” If there is any discrepancy, please send a copy of the explanation of benefits to our office and we will review it and make the appropriate changes needed, which may include adjustment on your account.

MEDICARE ADVANTAGE PLANS

There are many different Medicare Advantage plans that patients can now select which replaces their traditional Medicare policy. **WIMC does not participate with any of the Medicare Advantage plans.** If you are enrolled in a Medicare Advantage Plan, you will be asked to pay the Medicare limiting fee schedule charge in full for the services you have received. Our office accepts cash, check and credit card (Visa, MasterCard, Discover and American Express). As a courtesy to you, we will file a claim to most Medicare Advantage plans on your behalf. Your Medicare Advantage plan should reimburse you according to the out-of-network benefits (if any) allowed under your policy.

The Medicare Advantage PPO products do offer reimbursement when seeing an out-of-network provider (nonparticipating); however, in most cases, the reimbursement is less than if you were treated by an in-network (participating) provider. You will need to check your plan benefits to determine the out of pocket cost to you when seeing an out-of-network provider such as WIMC.

Listed below are the current Medicare Advantage plans of which we are aware:

- UHC Medicare Complete (Plan doctors only)
- UHC Medicare Complete Choice (any doctor)
- UHC Medicare Complete Premium (any doctor)
- Humana Gold Choice PFFS (any doctor)
- Humana Gold Plus (Plan doctors only)
- Humana Choice PPO (any doctor)
- Partners Medicare Choice (Plan doctors only)
- Partners Medicare Options (any doctor)
- Unicare Security Choice Plus (any doctor)
- Unicare Security Choice Classic (any doctor)
- Sterling Option I (any doctor)
- Today's Options Basic (any doctor)
- Today's Options Premier (any doctor)
- *Secure Horizons Direct / PacifiCare*

*Due to Secure Horizons Direct's administrative policies, WIMC is unable to accept this plan in our office. Our office will charge you according to the Medicare limiting fee schedule. You will be asked to pay in full for all services received. When you check-out, you will be given a standard claim form that you can use to submit to Secure Horizons Direct. In the event that Secure Horizons Direct issues any payment to our office, it will be returned to them along with notice that we do not participate and that any payment should be sent directly to you.

SECONDARY INSURANCE

If you have provided our office with your secondary insurance coverage information, we will be happy to assist you in filing a claim to ONE secondary insurance. If you request that your secondary claim be filed immediately, you will need to provide our office with a copy of the Medicare explanation of benefits (EOB) that is sent to you by Medicare. You may mail us a copy of the explanation of benefits, along with a note asking us to file to your secondary insurance. If you have no way to make a copy, you can either bring your explanation of benefits to our office so that we can make a copy for you, or you can mail us the original (which will be returned to you). If you prefer to wait, Medicare does send our office a bulk EOB for non-assigned claims. However, we receive these bulk EOBS two (2) to three (3) weeks after patients have received their summaries, so this does delay the filing of your secondary claim.

Automatic claim forwarding

There are several insurance companies with which Medicare has an agreement to automatically forward your claim to a secondary insurance carrier. This results in you getting your reimbursement from the secondary insurance more rapidly because you don't have to wait to send in a paper claim. You must contact Medicare to see if your account is set up to automatically forward claims to your secondary insurer.

Complementary Crossover

The process of automatic transfer of claim described above is known as "complementary crossover." All claims processed by Medicare are eligible to cross over to the supplemental insurer. Claim type and/or participation are not factors with the complementary crossover process. The secondary insurance provides Medicare with an eligibility file containing the Medicare numbers of its insured. Medicare only sends claims that match the Medicare numbers on claims coming from our system. Medicare cannot add to or delete the beneficiary information that the secondary insurance sends them. The secondary insurance makes changes only from your instruction.

All complementary crossovers are done on a weekly basis. Medicare has a complementary arrangement with the following companies:

AAG Benefits Administrators
AARP Operations
AEGON
Aetna Healthcare
AFLAC
AFSA
Aid Association for Lutherans
Allied Benefits System

Alternative Professional Services Inc.
American Capitol
American Family
American General
American Insurance Admin Group
American Legion
American Medical Association
American National Ins. Co.

American Republic Ins. Co.
Amerihealth
Anthem FEP
APWU Health Plan
Assoc Doctors Health and Life
Atlantic American
AUSA
Bankers Fidelity Life and Casualty
BCBS of Alabama
BCBS of Arkansas
BCBS of Delaware
BCBS of Florida
BCBS of Illinois
BCBS of Iowa
BCBS of Kansas
BCBS of Massachusetts
BCBS of Michigan
BCBS of Minnesota
BCBS of Mississippi
BCBS of New Jersey
BCBS of New Mexico
BCBS of North Carolina
BCBS of North Dakota
BCBS of Oregon Regence
BCBS of Rhode Island
BCBS of Tennessee (State
Employees/Retirees)
BCBS of Texas
BCBS of Utah Regence
BCBS of West Virginia
BCBS of Wisconsin
Benefit Planners Limited
BeneSys Inc.
BS California
C&R Consulting
Capital Blue Cross
Carefirst BCBS (NC claims only)
Celtic Life Insurance
Central Benefits Life Ins.
Central States Health & Life of Omaha
Christian Fidelity Insurance
CIGNA
CAC/Mail Handlers
Comprehensive Benefits
Continental General Insurance Co.
Continental Life Ins. Co.
Coresource
Country Life Insurance
Empire HealthChoice Inc.
Epoch Group
Equitable
Federal Home Life Insurance
FRA
GE Capital Assurance
GE Life Assurance and Annuity
Gilsbar Ins.

GEHA
Great West
Group Health Inc.
Health Care Service Corporation
Health Scope Benefit
Highmark Life & Casualty
Highmark Services Insurance
Humana Inc.
ITT Hartford
Kanawha Ins. Co.
Kenyon College Retirees
KPS Health Plans
Life Insurance Co. of Georgia
Lincoln Heritage Life Insurance
Medico Life
Mennonite Mutual Aid
MOAA
Monumental Life
Mutual of Omaha (Group)
Mutual of Omaha (Individual)
Mutual Protective
National Assoc. of Letter Carriers
Nationwide Health Plans
NEA
New Era Life Enterprise
NGS American
North American Insurance
North American Health Plans
Olympic
Oxford Life Insurance
PacifiCare Health Plan Admin.
Pekin Life Insurance
Peoples Benefit Life Ins.
Physicians Mutual Ins. Co.
Pioneer
POMCO
Preferred Health Systems
Premera Blue Cross
Principal Financial Group
Principal Life Insurance
Pyramid
Regence BS
Regence BS ID Federal Employees
Regence BS of Idaho
Regence BS WA FEP
Retiree Medical Plans
ROA
SAMBA
Savers Life Insurance
State Farm Insurance Company
State Mutual Insurance
Stirling and Stirling
Trivent Financial
TMG Health
TRICARE
Unicare

Unified Life Insurance Co.
Union Bankers/PMSC
Union Fidelity
Union Fidelity Life Insurance
United American Ins. Co.
United Commercial Travelers
United Healthcare
United Medical Resources
United Methodist Church

United Teacher Associates Ins. Co.
USAA Life Insurance Co.
USABLE Life Insurance
Wakely and Associates
Wausau Company
Westport Benefits
World Insurance Company
Worldnet Services Corp

If you have the Medicare/Secondary crossover set up, when you receive the Medicare explanation of benefits, it will indicate on the EOB, “this claim has been forwarded to your private insurance.” If this does not appear on the EOB, a paper claim will need to be submitted.

Payments from a secondary insurance carrier

Most secondary insurance carriers send their payment directly to the insured as well. If, however, your secondary insurance pays our office when you have already paid your charges at the time of service, this will create a credit balance on your account. The credit may remain on your account for future visits or you can call our office to request a refund.

Another point to mention about your secondary insurance is that it does not always pay the total balance that was not paid by Medicare. There are many different policies available for people to choose from and your reimbursement will be made according to the guidelines of your particular policy. Some examples are:

- Your secondary insurance may pay only the remaining 20% of the Medicare allowable charge, which means that the patient will not receive any reimbursement from their secondary insurance for the amount that exceeds the Medicare allowable charge.
- Some secondary policies do not pick up the Medicare deductible or procedures that are not covered by Medicare.
- If your secondary insurance is not a Medicare supplement plan, but is a retired employee plan, there may be a clause in your benefit provision which states that if Medicare paid what the secondary insurance would have paid, then the secondary insurance will not make any additional payment. This is seen quite often with United Healthcare benefits.

If your secondary insurance does not pay as you think they should, call your company representative and have them explain the policy to you in detail.

Many of our patients have secondary insurance through one of the carriers with which our office is contracted. When these plans are the primary insurance, the

patient usually only pays a co-payment for office visits. A secondary insurance plan does not work the same. Your secondary insurance will only pay on the amount that Medicare has not already paid. However, your secondary insurance carrier may require a co-payment and a deductible from you. Please check your policy and call your insurance company to understand how they process your claim before calling WIMC with questions.

Third insurance carrier

WIMC does not routinely file to a third insurance, but we will be happy to provide you with a standard claim form that you can use to submit a claim to your third insurance carrier. Please contact our office to request a printed claim form. You will need to attach both the primary and secondary Explanation of Benefits (EOB) to the claim form prior to mailing it to your third insurance company.

MISCELLANEOUS INFORMATION

Separate billing

There may be cases when you receive a bill from a facility other than our office. You will receive a separate bill for any procedure that is performed by our physician at an ambulatory center or hospital. The bill you receive from us will be for the physician's services; the bill from the surgery center or hospital is for the use of their facility. This is also true for any lab studies which you have performed that cannot be done in our in-house lab.

Any questions you have about a bill from a facility other than WIMC must be directed to that office. Even though our office scheduled the procedure, we have nothing to do with another facility's billing and cannot help you with any questions.

CLOSING

We hope this information has been helpful to your understanding how your Medicare coverage works at WIMC. If you have additional questions, please call our business office and we will be happy to assist you.

Our goal is to be the most patient-friendly practice in Raleigh. We hope that this information helps make your interaction with us even more hassle-free. Unfortunately, Medicare's administrative policies have made it unfeasible for us to be participating providers. We strive to give you the best care possible and feel sure that this outweighs any inconvenience due to our non-participation.

GLOSSARY

allowable charge – The charge indicated according to the Medicare fee schedule

complimentary crossover - Automatic claim forwarding; Medicare has an agreement with some insurance companies to automatically forward your claim to a secondary insurance carrier.

explanation of benefits (EOB) – sometimes called “summary of benefits”; the statement you receive from your insurance company itemizing your charges and coverage

fee schedule – Medicare issues a new fee schedule for services every year; these are the charges that Medicare allows for specific procedures.

limiting charge – 115% of the Medicare allowable charge according to their fee schedule