Medicare Minute Teaching Materials – December 2018
Speaking with Your Providers

1. How can I communicate well with my health care providers?
Communication is key in building good relationships with your health care providers and getting the best possible care. To help you communicate effectively with your doctors and other providers, take the following steps:

Be prepared.
- Before making an appointment, make sure that the doctors you are interested in seeing accept your health insurance.
- Think about what you would like to ask the doctor before your visit. You may want to write down your questions and take them with you to your appointment.
- Make sure to bring all relevant health insurance cards (for example, Medicare, Medicaid, Medigap, and/or Medicare Advantage cards) and documents to your appointment.
- Bring a copy of your health history to your appointment, especially if it is your first visit to a particular doctor. Your health history may include a record of the dates and results of past tests, major illnesses, hospitalizations, medications, chronic illnesses, allergies, and a family history of any physical and mental illnesses.
- Bring a pen and paper to your appointment so you can write down what your doctor tells you. You can also ask your doctor if you can record your conversation.
- Decide if you want to bring another person, like a caregiver, to your appointment. It may be useful if you have extensive care needs or are used to someone managing your care.

Share information.
- Tell your doctor about any current symptoms or concerns during your visit. If there are several, consider ranking them in order of how much they are affecting/troubling you.
- Tell your doctor if you are having trouble with activities of daily living, such as bathing or dressing.
- Tell your doctor about other health care providers (like specialists or therapists) you have seen and any treatments they have prescribed or recommended.
- Health issues can be hard to talk about, but it is important that your doctor have as much relevant information from you as possible so they can recommend the best possible care.
- If your doctor does not specifically ask for information that you think is important, tell them.

Ask questions.
- If you do not understand something your doctor says, ask them to explain it.
- Ask the same question more than once, or ask if your doctor can explain something in a different way, if you need more time to process an answer. If you need further clarification, consider scheduling a phone conversation or speaking to a nurse or other provider.

Get it in writing.
- Ask your doctor to write down what you should do between now and your next visit. This may include instructions for how to take medications, specialists you should see, and/or lifestyle modifications.
Follow up.

- If you experience problems after your appointment, or if you have symptoms that get worse, call your doctor’s office to schedule a follow-up appointment. You may also need to make a lab/test appointment or find out how to access your lab/test results.
- Find out if your doctor uses any form of electronic communication, like email or an online portal. These can help you communicate questions and look up previous appointments and lab/test results without having to call the doctor’s office directly.

2. What if my Original Medicare provider doesn’t think the items or services I need will be covered?

If you have Original Medicare, your provider may ask you to sign an Advance Beneficiary Notice (ABN). An ABN, also known as a waiver of liability, is a notice a provider should give you before you receive a service if, based on Medicare coverage rules, your provider has reason to believe Medicare will not pay for the service. The ABN may look different, depending on the type of provider who gives it to you. An ABN is not an official Medicare coverage decision.

The ABN allows you to decide whether to get the care in question and to accept financial responsibility for the service (pay for the service out-of-pocket) if Medicare denies payment. The notice must explain why the provider believes Medicare will deny payment. For example, an ABN might say, “Medicare only pays for this test once every three years.” Providers are not required to give you an ABN for services or items that are never covered by Medicare, such as hearing aids. Note that your providers are not permitted to give an ABN all the time, or to have a blanket ABN policy.

If you receive an ABN from your provider, there are a few things you should ask before choosing whether to sign the ABN or refuse care:

- If your provider thinks the service is medically necessary, ask why you need to sign an ABN. Medicare should pay for most medical services you need, unless the service is specifically excluded from coverage, in which case an ABN is not required.
- Ask your provider if they are willing to help you appeal Medicare’s coverage decision, if the service is denied, by writing a letter justifying your medical need for the service. If your provider refuses to write a letter or help you appeal, you may want to find a different provider.

While the ABN serves as a warning that Medicare may not pay for the care your providers recommends, it is possible that Medicare will pay for the service. To get an official decision from Medicare, you must first sign the ABN, agreeing to pay if Medicare does not, and receive the care. Make sure you request that your provider submit a claim to Medicare for the service before billing you. The ABN may have a place on the form where you can elect this option. Otherwise, your provider is not required to submit the claim, and Medicare will not provide coverage. An ABN is not an official Medicare coverage decision.

Medicare has rules about when you should receive an ABN and how it should look. If these rules are not followed, you may not be responsible for the cost of the care. When your Medicare Summary Notice (MSN) shows that Medicare has denied payment for a service or item, you can choose to file an appeal. Remember, receiving an ABN does not prevent you from filing an appeal, as long as the provider submits a claim to
Medicare. You can contact your State Health Insurance Assistance Program (SHIP) for more information about the process. Contact information for your SHIP is on the last page of this document.

You may not be responsible for denied charges if the ABN:
- Is difficult to read or hard to understand
- Is given by the provider (except a lab) to every patient with no specific reason as to why a claim may be denied
- Does not list the actual service provided, or is signed after the date the service was provided
- Is given to you during an emergency or is given to you just prior to receiving a service (for instance, immediately before an MRI)

You also may not be responsible for denied charges if an ABN was not provided when it should have been. You may not need to pay for care if you meet all of the following requirements:
1. You did not receive an ABN from your provider before you were given the service or item;
2. Your provider had reason to believe your service or item would not be covered by Medicare;
3. Your item or service is not specifically excluded from Medicare coverage; and
4. Medicare has denied coverage for your item or service.

You can contact your Senior Medicare Patrol (SMP) for assistance if you are suspicious of a provider’s handling of the ABN or if you believe you were falsely billed for services. Contact information for your SMP is on the last page of this document.

3. **What if my Medicare Advantage provider thinks the items or services I need may not be covered?**

   If you have a Medicare Advantage Plan, your provider should be able to contact your plan and request a formal determination about whether a service will be covered. If your plan verbally tells you or your doctor that the service will not be covered, you can request an official written decision, called a Notice of Denial of Medical Coverage. You should receive this written notice in 14 days. You can request a fast (expedited) determination if you or your doctor believes your health could be seriously harmed by waiting the standard timeline for appeal decisions. If your plan approves your request to expedite, it should issue a decision within 72 hours.

Once your plan has issued a Notice of Denial of Medical coverage, you can appeal the denial to request coverage using the instructions on the notice. Ask your provider for assistance with the appeal and contact your State Health Insurance Assistance Program (SHIP) for more information about the process. Contact information for your SHIP is on the last page of this document.

Your Medicare Advantage Plan’s in-network providers are expected to know, or to follow plan procedures to find out, whether specific items and services are covered by your plan. This means that if your in-network provider provides you with or refers you to a health care service that your plan does not cover, you may not be responsible for the full cost of that service. In this situation, you should only be responsible for paying normal cost-sharing for this particular service. The same is true if your in-network provider refers you to receive healthcare services from a provider who is outside of your plan’s network. If you are denied coverage of a service that you reasonably believed would be covered, follow the appeal process on the
Explanation of Benefits (EOB) you receive from your plan. If you need help appealing, contact your SHIP for assistance.

Note that if the service is never covered by your Medicare Advantage Plan, and this is clear in your plan’s Evidence of Coverage (EOC), you can still be held responsible for the full cost of the item or service when your plan denies coverage.

4. **Does Medicare cover second and third opinions?**
A second opinion is when you ask a doctor other than your regular doctor for their view on symptoms, an injury, or an illness you are experiencing in order to better help you make an informed decision about treatment options.

Original Medicare covers second opinions if a doctor recommends that you have surgery or a major diagnostic or therapeutic procedure. Medicare does not cover second opinions for excluded services, such as cosmetic surgery. Medicare will also cover a third opinion if the first and second opinions differ. The second and third opinions will be covered even if Medicare will not ultimately cover your procedure (unless it is an excluded service).

If the first and second opinions were the same but you want a third opinion, you may be able to see a third doctor for a confirmatory consultation. Medicare may cover a confirmatory consultation if your doctor submits the claim correctly and the services are reasonable and necessary (even if Medicare will not ultimately cover them).

If you are in a Medicare Advantage Plan, your plan may have different cost and coverage rules for second and third opinions. Contact your plan for more information about costs and restrictions.

5. **How can I try to ensure that I get quality care?**
There are steps you can take to help ensure you get quality care from your health care providers. For instance, you can ask questions, do your own research, get second opinions, and keep in mind that you have the right to accept or refuse treatment. Below is a list of questions you can ask to help ensure you receive quality care.

**If your doctor gives you a diagnosis:**
- What are my treatment options, and the benefits and risks of each option?
- Is there information about the condition that I should read?
- Is there someone I could ask for a second/third opinion (see number 4)?
- Are there support groups for this condition that might help me gain additional insight?

**If your doctor prescribes a medication:**
- What is the medicine for (what is it intended to treat and how does it work)?
- Will my insurance cover the prescribed drug? If not, are there other drugs that will work for me?
- If it is a name-brand medication, is there a generic option? Is there a medical reason why I should not take the generic?
• Does the medication have any other effects (benefits, risks, side effects) that I should be aware of? Are any of them serious enough that I should ask for a second medical opinion?
• When should I start to feel the benefits of the medication?
• Could the medication interact poorly with other medications I take (including over-the-counter drugs)?
• Could a change in diet or special exercise have the same effect as the medication, or increase its effectiveness?
• Are there options other than taking this medication?
• What are the risks of not taking this medication and using alternative solutions?

If your doctor recommends surgery:
• Why is the surgical procedure necessary?
• What are the benefits and risks?
• What are the alternatives (such as a medication, a change in diet, or exercise)?
• Is there someone I could ask for a second and/or third opinion?
• What if I decide not to have surgery?

Other tips:
• Keep records of your doctors’ visits and notes on what you are told at each.
• Make sure your doctors have copies of your advance directive, power of attorney, and/or other documents you have related to your future health care needs.

Note: If you think a health care provider is trying to pressure you into receiving unnecessary services, charging an unusually high amount, or billing Medicare for services you never received, they may be committing fraud. Raise your concerns to your provider and/or their billing office to see if a mistake has been made. If you still believe they may be committing fraud, contact your Senior Medicare Patrol (SMP). Your SMP can help you understand what is happening and, if necessary, help you report fraud or abuse to the proper authorities. Contact information for your SMP is on the last page of this document.

6. What questions can I ask my provider if I am having trouble affording my health care costs?
Even when you have Medicare, the costs of drugs and health care services can be overwhelming. If you are having trouble affording these costs, you should contact your SHIP. Your SHIP will be able to provide you with information about cost-saving programs, Medicare plan options, and appealing drug or service denials. Contact information for your SHIP is on the last page of this document.

You may also want to ask your doctor if these options are available:
• If your doctor prescribes you a name-brand drug, you can ask about generics. Generic drugs are often less expensive than name-brand drugs, and might be more affordable for you. Check with your doctor to see if a generic drug will work for you.
• If your medication is prohibitively expensive, ask if your doctor can provide you with samples of the medication. This is a temporary solution, as your doctor may not be able to provide samples for very long. If you are using samples, be sure to explore other options for getting your drugs covered.
If your health care service or medication has been denied, ask your provider for assistance filing an appeal. Having the support of your doctor may increase the possibility that your plan will cover the drug or service.

If your costs are still very high, speak to your provider or their billing office about reducing the cost, accessing charity care, or setting up a payment plan.

Note that Federal law prohibits Medicare providers from billing people enrolled in the Qualified Medicare Beneficiary Program (QMB) for any Medicare cost-sharing (cost-sharing can include deductibles, coinsurance, and copayments). This means that if you have QMB, Medicare providers should not bill you for any Medicare-covered services you receive.

More specifically, if you have QMB and are enrolled in Original Medicare, you should not be billed when receiving a plan-covered service from either:

- A participating provider: a provider who has agreed to take assignment in all cases (taking assignment means accepting Medicare’s approved amount as full payment for a service).
- A non-participating provider: a provider who takes assignment in some cases.

If you have QMB and are enrolled in a Medicare Advantage Plan, you should not be billed when receiving a plan-covered service from:

- In-network providers, as long as you meet your plan’s coverage rules, such as getting prior authorization to see certain specialists.

To protect yourself from improper billing, be aware that:

- Original Medicare and Medicare Advantage providers who do not accept Medicaid must still comply with improper billing protections and cannot bill you.
- You keep your improper billing protection even when receiving care from Medicare providers in other states. (Note: You can be billed if you are enrolled in a Medicare Advantage Plan and see an out-of-network provider, or if you have Original Medicare and see an opt-out provider.)
- You cannot choose to waive these protections and pay Medicare cost-sharing, and a provider cannot ask you to do this.

Remember that if you have QMB, the Medicare providers you see must accept Medicare payment and any QMB payment as the full payment for any Medicare-covered services you received. Providers who violate improper billing protections may be subject to penalties. If you are having issues with a provider who continually attempts to bill you, or if you have unpaid cost-sharing bills that have been sent to collection agencies, call 1-800-MEDICARE or contact your Medicare Advantage Plan. You can also contact your Senior Medicare Patrol (SMP) or your State Health Insurance Assistance Program (SHIP) for assistance.

Note: Some states may impose Medicaid copays for certain Medicare-covered services. Medicare and Medicaid should pay the majority of the cost, leaving you a nominal, or small, copay. Contact your local Medicaid office or your SHIP to learn more about Medicaid copays in your state.
7. Who can I contact if I have questions?

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about how to access covered providers and services. You can also contact your SHIP for assistance appealing a denial of a health care service or item or applying for cost-saving programs. Contact information for your SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): Contact your SMP if you suspect that you have been a victim of Medicare fraud or attempted fraud. This might include if you think a health care provider is trying to pressure you into receiving unnecessary services or signing documents you don’t understand charging an unusually high amount, or billing Medicare for services you never received. SMP representatives can teach you how to identify and protect yourself from potential Medicare fraud, errors, and abuse. Contact information for your SMP is on the last page of this document.

1-800-MEDICARE: Contact Medicare if you have questions about what services are covered and at what cost under Original Medicare. You can also call to find providers who accept assignment in your area.

Medicare Advantage Plan/Part D plan: Contact your plan directly with questions about your prescription drug formulary, in-network providers, and your Medicare Advantage Plan’s costs and restrictions for accessing care.

SHIP case example
Chuck has Original Medicare and he is enrolled in the Qualified Medicare Beneficiary (QMB) program. His primary care physician recently told him that he should get surgery on his shoulder. Chuck is nervous about getting a major surgery based on just one medical opinion, but is not sure if Medicare would cover a visit to another doctor.

What should Chuck do?

- Chuck should call his State Health Insurance Assistance Program (SHIP) to ask for assistance.
  - If Chuck does not know how to contact his SHIP, he can call 877-839-2675 or visit www.shiptacenter.org.
  - A SHIP counselor can let Chuck know that Medicare covers second opinions when a doctor suggests surgery. As such, this second opinion should be covered by Medicare.
  - The counselor can also tell Chuck that if the second doctor makes a different recommendation than his primary care physician, Medicare will likely cover a third opinion.
  - If Chuck does not know how to find a doctor who accepts Medicare payment, the SHIP counselor can help him find a provider by calling 1-800-MEDICARE or using the Physician Compare tool on www.medicare.gov.
- Since Chuck has QMB, the SHIP counselor can also ensure he understands his rights.
  - The SHIP counselor can tell Chuck that as long as he sees providers who accept Medicare payment, he should not be charged for any cost sharing (with the possible exception of a nominal Medicaid copay).
Once Chuck has arranged to get a second opinion, he should prepare well for his visit.
  o Chuck should bring his insurance cards and health history to his visit. He should prepare to ask his provider in-depth questions. Chuck can also consider bringing someone with him to the appointment, like a caregiver, who might be able to help him understand what his provider tells him.

SMP case example
Aretta was referred to an orthopedic surgeon by a doctor at an urgent care center after she injured her knee. She went to the appointment prepared with copies of the x-rays taken at the emergency room. Because the orthopedic surgeon had these images, Aretta was not x-rayed again at the office. A month later, however, she received an Explanation of Benefits (EOB) from her Medicare Advantage Plan and saw that the orthopedic surgeon’s office submitted a claim to her plan for an x-ray.

What should Aretta do?
  • Aretta can call her Senior Medicare Patrol (SMP) to ask for assistance.
    o If she does not know how to contact her SMP, she can call 877-808-2468 or visit www.smpresource.org.
  • The SMP can tell Aretta that she should contact her doctor’s office.
    o It is possible that the orthopedic surgeon’s office made a billing error. Aretta can tell them that she did not get an x-ray during her visit and ask them to correct the error.
  • If Aretta is not satisfied with the answer she receives from the orthopedic surgeon’s office (for example, if they are unresponsive or do not correct the error), the SMP can help her take steps to report the problem.
    o Billing Medicare or a Medicare Advantage Plan for services that were not delivered is an example of Medicare fraud or abuse. The SMP can help Aretta understand what has happened and can refer her to report the problem to the proper authorities.
  • The SMP can also tell Aretta to continue checking her EOBs for signs of Medicare fraud and abuse.

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