



3.1.1 Background

By the mid 1960's, it had become apparent to the Federal government that the medical needs of individuals over 65 were being met either inadequately or with great financial difficulty. This was attributable to the fact that income at this age is often reduced substantially, while at the same time medical expenses are likely to increase. Though insurance coverage through individual policies could partially meet the needs of our senior citizens, Congressional opinion was that some form of Government aid on a national level was necessary.

Therefore, by an act of Congress, in July 1966, legislation establishing a national health insurance program, the Medicare program, (Title XVIII of the Social Security (SS) Act) was enacted (the 1965 amendments to the SS Act), with most of its benefits taking effect as of July 1, 1966. The Medicare program has two parts. They are the hospital insurance (Part A) part and the medical insurance (Part B) part. Both parts of the program have been modified and liberalized several times since its enactment.

In May 1966, the Social Security Administration (SSA) delegated authority to the Railroad Retirement Board (RRB) for administering certain provisions of the Medicare program for qualified railroad retirement beneficiaries (QRRB's). These included enrolling, premium collection and selecting a carrier to process Medicare Part B claims.

In July 1966, RRB had a Medicare population of approximately 560,000 beneficiaries who were age 65 or older. From 1966 to 1972, QRRB's who were also eligible for SS benefits could have had their Medicare jurisdiction with either agency. Usually, the agency that processed the beneficiary's application first assumed Medicare jurisdiction.

This changed with the enactment of Public Law (PL) 92-603 in October 1972. The 1972 amendments to the SS Act brought about several changes. It provided that RRB would have jurisdiction of all QRRB's who were receiving both railroad retirement (RR) and SS Act benefits. This increased RRB's Medicare population by approximately 330,000. These amendments also gave RRB legislative authority to contract with a carrier(s) to process Part B claims, collect Part B premiums and allowed for reimbursement of administrative costs. In addition, PL 92-603 also expanded Medicare coverage, effective July 1, 1973, to certain disabled people and people of any age with chronic kidney disease. This legislation also provided equitable relief for individuals whose entitlement or reentitlement rights were prejudiced by error, misrepresentation or inaction of an employee or agent of the government.

Effective January 1, 1983, the "working aged provision" made employer group health plans (EGHP) the primary payer of benefits and Medicare secondary payer for individuals age 65 or over who were covered under an EGHP that covers 20 or more



employees by reason of their own or their spouses current employment. The "working age provision" was modified and liberalized several times since its enactment.

The Deficit Reduction Act of 1984 (PL 98-369) included a provision to provide special enrollment periods and premium surcharge relief to individuals covered by the "working aged provision." The "working aged provision" were further amended to make Medicare the secondary payer for disabled individuals who were covered as an active individual under a large employer group health plan (LGHP) or a plan that covers 100 or more employees and also provided special enrollment periods and premium surcharge relief to the disabled individuals who were covered as an active individual under a LGHP.

Currently, the special enrollment periods and premium surcharge relief provisions are the same for the aged and the disabled primary beneficiary and his/her spouse. However, any other disabled family member, e.g., a disabled child, must be covered on the basis of an LGHP to qualify for the special enrollment periods and premium surcharge relief.

The Medicare Catastrophic Coverage Act of 1988 mandated major changes in the coverage and payment of benefits. Effective January 1, 1989, the Act provided for increased coverage under Part A and mandated the collection of additional premiums to cover these expanded benefits.

The Medicare Catastrophic Coverage Repeal Act of 1989 eliminated major provisions of the Medicare Catastrophic Coverage Act and restored Medicare benefits to the levels available prior to January 1, 1989.

3.1.2 Characteristics Of RRB's Medicare Beneficiaries

As of August 1992, there were 779,486 beneficiaries enrolled for Medicare. Of this group, 15,501, or approximately two percent, are enrolled for Part A only.

A total of 793,985 beneficiaries are enrolled for Part A and Part B; 731,979 have their premiums deducted from their monthly payment, 23,056 have their premiums paid by State welfare agencies and 8,950 are paying their own premiums on a recurring basis every three months.

3.1.3 General Assignment Of Responsibility

The overall responsibility for the administration of the Medicare program rests with the Secretary of the U.S. Department of Health and Human Services (HHS). The Secretary has delegated certain administration functions to various components of the Department. In addition, as provided by the SS Act, a major role in the administration of the Medicare program has been given to public and private organizations.



Medicare was initially the responsibility of SSA and RRB coordinated their efforts with their Bureau of Health Insurance. However, as the program expanded, a decision was made to delegate responsibility for both Medicare and Medicaid to one agency.

In March 1977, the Centers for Medicare & Medicaid Services (CMS) was established. In 1977 and 1978, SSA delegated the authority to administer Title XVIII of the SS Act - "Health Insurance for the Aged and Disabled" to CMS. RRB now coordinates their efforts with CMS's Bureau of Programs Operations.

CMS's Regional Offices are responsible for a wide range of administrative activities. They include administrative coordination and operation appraisals as well as program interpretation and evaluation.

SSA has the responsibility for general management and operational aspects of the Medicare program.

3.1.4 Role Of CMS

Some of the functions of CMS are:

- maintains entitlement and utilization records;
- collects premiums from non-QRRB's;
- establishes, maintains and administers agreements and systems to meet the needs of State agencies, providers of services, intermediaries, carriers, RRB and other administrative agents involved in the program;
- formulates major policies involving technical issues; and
- oversees general financial management of the program.

3.1.5 Role Of RRB

Persons covered by the RR system participate in Medicare on the same basis as those under the SS system. RRB's authority to administer the Medicare program for RR beneficiaries is contained in the Railroad Retirement Act of 1974, Title XVIII of the Social Security Act and certain agreements entered into between CMS and RRB.

RRB certifies and enrolls QRRB's and deemed QRRB's for Part A and Part B and determines the beginning and ending dates of such coverage. RRB also:

- collects Part B premiums by deduction from monthly payments or direct billing;



- issues Medicare health insurance identification cards;
- selects and enters into contracts with a Part B carrier to process Part B claims for payment to QRRB's and deemed QRRB's and monitors the carrier's action (an RRB employee is on-site at Palmetto GBA);
- establishes and maintains Medicare Part A and Part B entitlement records;
- maintains identification and entitlement information;
- assists beneficiaries and providers in receiving Medicare-related services;
- assists intermediaries and carriers in resolving claims payment related problems as they pertain to QRRB's and deemed QRRB's; and
- investigates complaints of fraud and abused involving QRRB's and deemed QRRB's.

3.1.6 Role Of RRB's Retirement Medicare Section (RMS)

RMS within the Retirement Benefits Division of Operations (OPRNS), is the focal point for RRB's Medicare activities. Its major functions are enrollment and maintenance. Maintenance includes disenrollments, responding to inquiries, manual annuity adjustments, premium adjustments, payment of Part A Canadian claims, recovery of Medicare Part A and Part B benefit overpayments, maintenance of Medicare records and reviewing a sample of paid claims by the Medicare Part B carrier.

3.1.7 Role Of RRB's Field Offices

Field offices are responsible for furnishing information and assistance relative to the Medicare program to QRRB's before, during and after the enrollment process. In addition, field offices furnish information and assistance to any intermediary, carrier, provider or supplier relative to coverage or claims of RR beneficiaries. When field offices do not have requested information immediately available, they should contact MPS in writing or by telephone if expedited action is required for assistance.

3.1.8 Financing The Part A Program

- A. Taxes and Appropriations - The Part A program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected with regular RR or SS contributions from the wages and self-employment income earned during a



person's working years. Funds from general tax revenues are used to finance Part A benefits for people who are covered under the program but are not entitled to monthly SS or RR benefits. And, for individuals enrolled in premium Part A, the cost of Part A benefits is paid by the monthly premium paid.

NOTE: An employee or self-employed person who pays both social security and railroad retirement taxes may, as a result, pay excess taxes. Effective in 1968, excess HIB taxes may be claimed as a credit on federal income tax return. RR employers are required to notify employees who are also employed outside the RR industry that they may be entitled to a refund of excess taxes. The employee can ask the employer to furnish a breakdown of the amount of regular and Part A taxes deducted from RR compensation.

- B. Federal Hospital Insurance Trust Fund - The taxes collected, the amounts appropriated from general revenues and the premiums paid are put into the Federal Hospital Insurance Trust Fund. Payments are made from this fund for all services covered by Part A except services for RRB Canadian Part A claims, which are paid from the Railroad Retirement Trust Fund.

3.1.9 Financing The Part B Program

- A. Premiums - The Part B program is financed by a monthly premium paid by the Part B enrollee and subsidized by the Federal government from general revenues. During 1989, the monthly Part B premium consisted of two components; the basic monthly rate and the catastrophic coverage monthly premium. Effective January 1, 1990, the catastrophic coverage monthly premium component was dropped and the monthly premium was restored to a single amount.
- B. Medical Insurance Trust Fund - The premiums deducted by RRB from enrollees monthly payments are periodically transferred by the Secretary of Treasury from the SSEB to the appropriate portion of the Supplementary Medical Insurance Trust Fund. This fund is divided into the aged portion and the disability portion. Premiums collected by RRB from enrollees who pay by direct remittance are deposited directly into the aged portion of the fund and, if appropriate, they are later transferred to the disability portion of the fund.

3.1.10 What is Medicare

The Medicare program is a Federal health insurance program for people 65 or older and certain disabled people. It is run by CMS of the U.S. Department of Health and Human Services. RRB field offices across the country take application for Medicare and provide



general information about the program. Headquarters activities include establishing and maintaining the person's Medicare records.

3.1.11 The Two Parts Of Medicare

There are two parts to the Medicare program, there are:

- A. Part A - Medicare hospital insurance (Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care. Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A. Part A may also be referred to as hospital insurance benefits, HIB or HI.
- B. Part B - Medicare medical insurance (Part B) helps pay for doctors' services, outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Part A of Medicare. Part B of Medicare has premiums, deductibles and coinsurance amounts that the enrollee must pay. Participation is voluntary, that is, qualified persons must be enrolled in the plan and have the right to refuse or terminate their coverage. Part B may also be referred to as supplementary medical insurance benefits, SMIB or SMI.

Medicare premium, deductible and coinsurance amounts are set each year according to formulas established by law. New payment amounts begin each January 1. Exhibit 7 reflects the Part A deductible and coinsurance amounts. Exhibits 3 through 6 reflect the premium amounts.

3.1.12 Who Can Get Medicare Part A

Generally, people age 65 and over can get premium-free Medicare Part A benefits, based on their own or their spouse's employment. Premium-free means there are no monthly premiums. Most people do not pay premiums for Part A. A person can get premium-free Part A if they are 65 or over and any of the three statements are true:

- they receive benefits under the SS or RR system;
- they could receive benefits under the SS or RR system; or
- they or their spouse has Medicare-covered government employment.

If a person is under 65, they can get premium-free Part A benefits if they have been rated disabled under the SS Act and has received or be deemed entitled to receive payments from RRB or SSA for the prescribed period of time.



Certain government employees and certain members of their families can also get Medicare when they are disabled for more than 29 months. Others may be able to get premium-free Part A benefits if they receive continuing dialysis for permanent kidney failure or if they have had a kidney transplant. Both of these categories of beneficiaries have to file with SSA to obtain Medicare coverage.

If either the person or their spouse has 10 years of RR service or less than 10 years but has at least 5 years of service after 1995, they will be able to get premium-free Part A benefits. The Railroad Retirement and Survivors Improvement Act of 2001 (RRSIA) lowered the number of years of RR service required for RR benefits and RR Medicare. The earliest entitlement date based on RRSIA is January 1, 2002, see 3.2.20.

3.1.13 Who Can Get Medicare Part B

Any person who can get premium-free Part A benefits based on work can enroll for Part B, pay the monthly Part B premium and get Part B benefits.

3.1.14 Buying Medicare Part A And Part B

If a person does not have enough work credits to be able to get Part A benefits and they are 65 or over, they may be able to buy Part A and B or just Part B, by paying monthly premiums. These beneficiaries should file at SSA to obtain Medicare coverage.

Others may be able to buy Part A and B if they are disabled and lost their premium-free Part A solely because they are working.

3.1.15 Enrollment In Medicare

If a person is already getting SS or RR benefit payments when they turn 65, they will automatically get a Medicare card (G-41) in the mail. The card will show that they can get both Part A and Part B benefits. If they do not want Part B, they must follow the instructions that come with the card and return it to RRB.

The above process also applies when a person has been rated disabled under the SS Act and has received or be deemed to receive disability payments from RRB or SSA for the prescribed period of time. A Medicare card will automatically be sent to the person.

Some people do not automatically get a Medicare card. They must file an application to get Medicare benefits. If a person has not applied for SS or RR benefits, or if government employment is involved or they have kidney disease, they must file an application for Medicare.



If a person must file an application for Medicare, they should do so during their initial enrollment period (IEP), to avoid late enrollment penalties under Part B, unless they qualify for a special enrollment period (SEP). A person's IEP is a seven-month period that starts three months before the month the person first meets the requirements for Medicare. If they do not sign up for Medicare during the first three months of their IEP there will be a delay in starting their Part B coverage. Their coverage will be delayed from one to three months after enrollment.

If they do not enroll for Part B at any time during their IEP, they will not get another chance to enroll until the next general enrollment period (GEP). A GEP is held each year from January 1 through March 31. They may also be charged a premium penalty for late enrollment, unless they qualify for a SEP.

The enrollment period requirements and penalties for late enrollment described above for Part B also applies to people who buy Part A.

3.1.16 Medicare Card

The Medicare health insurance card is the person's proof of Medicare coverage. It shows the Medicare coverage a person has, Part A and Part B, Part A only, etc., and the date the protection started. The Medicare health insurance card also shows the person's Medicare health insurance claim number, name and sex. Headquarters initially issues Medicare cards when a beneficiary becomes entitled to Medicare. Any field office or headquarters can issue a duplicate Medicare card.

3.1.17 Intermediaries And Carriers

The Federal government contracts with private insurance organizations call intermediaries and carriers to process claims and make Medicare payments.

- A. Intermediaries - Intermediaries process claims submitted on a person's behalf by hospitals. They also handle inpatient and outpatient claims submitted by skilled nursing facilities, home health agencies, hospices and other providers of services.

Generally, a person does not need to get in touch with the intermediaries because the intermediaries pay most hospital, skilled nursing facilities, home health agencies, hospices and other providers of services directly. But, if a person has a question about a Part A bill, they should ask someone who works at the facility where the services were rendered for help. If they cannot answer the person's questions, they should then ask someone in the billing office at the facility where the services were rendered to help them get in touch with the Medicare intermediary that processes their Medicare Part A claims.



- B. **Carriers** - Carriers process claims for services by doctors and other suppliers covered under Part B. RRB is authorized by law to contract with a carrier to serve its beneficiaries enrolled in Part B. Accordingly, Palmetto GBA was selected to act as the sole Part B carrier for all QRRB's and deemed QRRB's. Part B claims are filed at the Railroad Medicare Claim Service Centers of Palmetto GBA. Palmetto GBA determines the amount payable and pays the claim for and on behalf of RRB in accordance with their agreement with RRB. If a person has any questions about a Part B claim, they should call or write Palmetto GBA.

Adequate provisions are made in the contract with Palmetto GBA for prompt, fair and equitable action on all claims. Palmetto GBA's performance under the contract is subject to supervision by RRB. RRB is responsible for evaluating the carriers performance and providing them with funds for administrative costs and benefits. The administrative costs paid to Palmetto GBA are charged to the Supplementary Medical Insurance Trust Fund. The Railroad Retirement Trust Fund is not used for this purposed.

In addition, Palmetto GBA also:

- determines benefit amounts and make benefit payments to beneficiaries and/or physicians, suppliers and others who furnish covered Part B services and supplies;
- maintains records of payments made to physicians, suppliers and beneficiaries;
- assists and supports RRB's Office of Inspector General (OIG) in areas concerning fraud and abuse; and
- provides RRB/CMS with various fiscal and claims-related reports required to administer the program.

For more information on Palmetto GBA, See RCM 3.1.107.

3.1.18 State Health Agencies

State health departments obtain the information used to determine whether facilities meet the conditions for participation in the Medicare program. As part of this process they advise the facilities of any necessary corrective actions. They also provide consultative services to assist facilities in meeting and maintaining Medicare program requirements.



3.1.19 Peer Review Organizations (PRO's)

PRO's are groups of practicing doctors and other health care professionals who are paid by the Federal government to review the care given to Medicare patients. Each State has a PRO that decides, for Medicare payment purposes, whether care is reasonable, necessary and provided in the most appropriate setting. PRO's also decide whether care meets the standards of quality generally accepted by the medical profession. PRO's have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting.

PRO's investigate individual patient complaints about the quality of care. PRO's also respond to requests for review of notices of noncoverage issued by hospitals to beneficiaries; and PRO's respond to beneficiary, physician and hospital requests for reconsideration of PRO decisions.

When a person is admitted to a Medicare participating hospital, they will receive An Important Message From Medicare which explains their rights as a hospital patient and provides the name, address and phone number of the PRO for their State. See Exhibit 11 for a sample of An Important Message From Medicare.

If a person feels that they were improperly refused admission to a hospital or that they were forced to leave the hospital too soon, they should ask for a written explanation of the decision. Such a written notice must fully explain how the person can appeal the decision and it must give the name, address and phone number of the PRO where the person's appeal or request for review can be submitted.

PRO's are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospital, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; ambulatory surgical center; and certain health maintenance organizations.

If a person believes that they received poor quality care provided by one of these facilities, they may complain to the PRO. The PRO will investigate written complaints. The complaint must be in writing. The PRO will help the person put their complaint in writing by taking the information from the person over the telephone and writing the complaint. If someone other than the PRO makes a complaint for a Medicare patient, the Medicare patient must give written permission for that person to represent them in the complaint.



3.1.20 A Medicare Beneficiary's Right To Decide About Their Medical Care

Under the Medicare law, when a person is admitted to a Medicare hospital or skilled nursing facility, gets Medicare home health care or enrolls in a Medicare-certified hospice or health maintenance organization, the person must be given information about their rights to make decisions about their medical care.

Generally, the person will be told about their rights to accept or refuse medical or surgical treatment. They will also be told about their right to make, if they choose, an "advance directive." An "advance directive" contains written instructions that states the person's choices for health care or names someone to make those choices for them. The instructions are to be used if the person is too sick or otherwise unable to talk. The paper giving the person's health care choices may be called a "living will" or "a durable power of attorney for health care."

A person does not have to have any "advance directive." But, if the person has one they can say "yes" in advance to treatment they want if they get too sick to talk to their health care provider. The person can also say "no" in advance to treatment they do not want.

Laws governing "advance directives" vary from State to State. The person's treatment choices will depend on what is legal in their State. The person can contact the health care professionals in their State about the State's rules for "living rules" or durable powers of attorney. They can also contact someone in their local State's attorney's office for this information.

3.1.21 Maintenance Of Program Integrity

- A. Fraud and Abuse - If a person has reason to believe that a doctor, hospital or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services that they did not receive, they should call RRB's Inspector General's toll-free Hotline. The toll-free number is 1-800-772-4258; in Illinois, they should call 1-312-751-4336. They may also send complaints in writing to RRB-OIG, Hotline Officer, 844 North Rush Street, Chicago, Illinois 60611-2092. They should not call the Hotline with questions about Medicare policy or delayed claims or payments.

Problems encountered with HMO's should also be reported to RRB's Inspector General's toll-free hotline.



- B. Carrier Performance Evaluation - A program to evaluate the carrier's performance has been established by HCFA. SSA is responsible for the evaluation of the area's carriers' performance and RRB is responsible for the evaluation of the Part B carrier's performance.

A quality review of the claims processed by the Part B carrier is conducted by RMS. Each month one tenth of one percent of the claims paid or denied are randomly selected by computer. The Part B carrier sends the selected claim folders to RMS. RMS reviews the folder and determines if the claim has been processed correctly.

RRB's contractor operations specialist at Palmetto GBA is Mr. Giansante. His mailing address is:

Mr. Joseph Giansante
Palmetto GBA
Augusta Corporate Center
Building 200
2743 Parameter Parkway
Post Office Box 1066
Augusta, Georgia 30999-0001

If you need to contact Mr. Giansante by phone, his telephone number is 706/855-3260.

3.1.22 Assistance For Low-Income Beneficiaries

By Federal law, State Medicaid programs must pay Medicare costs for certain elderly and disabled people who have low incomes and very limited resources. Each State still maintains their own eligibility requirements for a person to receive Public Assistance.

A person may qualify for this assistance even if they did not work long enough to be able to get premium-free Part A. If they did work long enough to be able to get premium-free Part A, and they qualify in all other ways, the State will pay the Part A premium.

A. To Qualify

- a person must be able to get Part A;
- the person's annual income level must be near the national poverty guidelines (poverty guidelines for 1992 are set at \$6,810 for one person and \$9,190 for a family of two); and



- the person cannot have resources such as bank accounts or stocks and bonds worth more than the established amounts (in 1992, they cannot be more than \$4,000 for an individual and \$6,000 for a couple).

B. Where the Person Should Apply - If a person thinks they may qualify for assistance and they already have Medicare Part A, they should file an application at their State or local welfare, social service or public health agency that serves people on Medicaid. All of these agencies are State, not Federal agencies.

If a person thinks they may qualify for assistance but they do not have Part A, they should first file an application for Part A.

C. What a Person Should Ask For - When the person contacts their State or local Medicaid office, they should ask about the Qualified Medicare Beneficiary (QMB) program or the Medicare Buy-In program. They should explain that they think they qualify for help in paying their Medicare costs and they want to know when and where they can file an application.

3.1.23 Medicare Beneficiary's Rights Under Data Matching

In 1988, Congress passed a law that allows computer matching of the information that a person gives to the government. They should be aware that when the government collects or uses information about them, it must act under specific guidelines to protect the person's privacy. The government must:

- tell the person, at the time the information is collected, why the information is needed and how it will be used;
- make sure personal information is used only for the reasons given, or seek the person's permission when another purpose for its use is considered necessary or desirable;
- allow the person to see the records kept on them; and
- provide the person with the opportunity to correct inaccuracies in the records kept about them.

3.1.30 Medicare Coordinated Care Plans

More and more Medicare beneficiaries are joining coordinated care plans. These coordinate care plans are prepaid, managed care plans, most of which are health



maintenance organizations (HMO's) or competitive medical plans (CMP's). Both HMO's and CMP's contract with Medicare and follow the same contracting rules.

Many beneficiaries find that coordinated care plans are a good way to get more health care for their dollar. HMO's and CMP's provide or arrange for all Medicare covered services, and generally charge a fixed monthly premium and only small copayments. This means that if a person joins a coordinated care plan and gets all of their services through the HMO or CMP, their out-of-pocket costs are usually more predictable. Also, depending on the person's health needs, those costs may be less than they would pay if they were liable for the regular Medicare deductible and coinsurance amounts.

Coordinated care plans may also offer benefits not covered by Medicare for little or no additional cost. Benefits may include preventive care, dental care, hearing aids and eyeglasses.

3.1.31 Who Can Enroll In Coordinated Care Plans?

Most Medicare beneficiaries are eligible to enroll in HMO's or CMP's. HMO's and CMP's cannot screen their applicants to find whether they are healthy, or delay coverage for preexisting conditions. The only enrollment criteria for Medicare HMO's and CMP's are:

- the person must be enrolled in Medicare Part B and continue to pay the Part B premium, they do not need to be able to get Part A;
- the person must live in the plan's service area;
- the person cannot be receiving care in a Medicare-certified hospice; and
- the person cannot have permanent kidney failure.

If the person develops permanent kidney failure or chooses hospice coverage after joining a coordinated care plan, the plan will provide, pay for or arrange for the person's care. If the person chooses to receive hospice care after joining a coordinated care plan, the plan must inform the person about hospice services available in the person's area. Staff at the coordinated care plans should explain how the hospice choice affects the person's plan membership.

3.1.32 Joining A Coordinated Care Plan

A person cannot enroll in a HMO or CMP through RRB's field office or headquarters. Enrollment must occur directly with the coordinated care plan. To join a coordinated care plan, the person must contact the plans in their area that have a contract with Medicare.



When a person joins a HMO or CMP, the Medicare records in Baltimore, Maryland are updated with an HMO indicator. It is not necessary that the person notify RRB regarding an HMO/CMP, since there is no change in RRB's Medicare record or in the collection of Medicare premiums. All HMO's and CMP's have an advertised open enrollment period at least once a year. Once a person joins, they may stay with the plan as long as they wish. And the person may return to regular Medicare at any time.

If the person enrolls in a coordinated care plan, they will usually be required to get all care from the plan. In most cases, if a person gets services that are not authorized by the HMO or CMP, unless they are emergency services, or services the person urgently needed when they were out of the plan's service area, neither the plan nor Medicare will pay for the services.

When a person joins a HMO or CMP, they should be sure to read the membership materials carefully to learn their rights and coverage.

3.1.33 Ending Enrollment In A Coordinated Care Plan

- A. Form HCFA-566, Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP) Disenrollment Form - To end enrollment in a coordinated care plan, the person must send a signed request and/or complete Form HCFA-566. See Exhibit 14 for instructions on how to complete the HCFA-566. Effective June 1, 1967, the HCFA-566 can be sent directly to the plan or the person's local RRB field office or headquarters. Prior to June 1, 1967, the person could only disenroll directly with the HMO or CMP.

If a person has already enrolled in another HMO or CMP, they do not have to complete a HCFA-566 for the previous HMO. An automatic transfer process is established for Medicare beneficiaries who change HMO's or CMP's. The person is automatically disenrolled from the previous HMO or CMP when they enroll in a subsequent HMO or CMP.

The person should be questioned regarding the possibility of enrollment in a different HMO or CMP before completing the HCFA-566. If a HCFA-566 is processed following the automatic transfer to a different HMO or CMP, it will result in a disenrollment from the new HMO or CMP.

When a HCFA-566 is completed, the person should be told to return their membership card to the HMO or CMP as soon as possible after the effective disenrollment date. They should also be reminded not to use the HMO or CMP beginning with the effective date of the disenrollment. If the HMO attached an identification (ID) to the person's Medicare health insurance card, the person should be advise to remove the ID on the effective date of disenrollment.



- B. Determination of HMO or CMP's Disenrollment Effective Date - The earliest effective date of disenrollment would be the 1st day of the month after the month that the disenrollment application was signed, dated and received in a RRB F/O or headquarters. For example, a person completing a disenrollment application on August 23, 1997, will be disenrolled from the HMO or CMP on September 1, 1997. If the person does not reenroll in another HMO or CMP, he/she will automatically be entitled to Medicare benefits through the regular Medicare fee-for-service program effective September 1, 1997.

Disenrollments can be made prospectively for up to two months. For example, a disenrollment application completed on July 3, 1997, may be effective either August 1,

September 1, or October 1, 1997. The disenrollment may not be made effective later than October 1, 1997. Since most beneficiaries will prefer the earliest possible disenrollment date, do not explain the 2-month disenrollment option unless the person inquires about alternative disenrollment dates.

If a request is based on a phone call, the effective date of the disenrollment is the last day of the month in which the HCFA-566 is signed, dated and received in a RRB F/O or headquarters. Therefore, the person should be informed of the importance of returning the HCFA-566 before the end of the month to assure the disenrollment will be the last day of the month.

- C. Field Office's Action - After the field office determines that the person is requesting to be disenrolled from an HMO or CMP and all questions are resolved, the contact representative will either complete or assist the beneficiary in completing the HCFA-566. This will depend on how the request to disenroll is made. It could be a personal, telephone or mail request.

After the person has signed and verified the information on the HCFA-566, the contact representative will detach and hand or mail the beneficiary copy to the person. The remaining 3 copies will then be mailed to headquarters in an envelope marked "DO NOT OPEN IN MAILROOM, ATTENTION: CHIEF OF MEDICARE SECTION (MS)." If the field office receives a written request, the beneficiary's signature is not necessary on the HCFA-566, however, a copy of the person's letter should be attached to each copy of the HCFA-566.

- D. Headquarters Action - When the 3 copies are received in headquarters, MS will first verify that there is an HMO indicator on the EDB by checking the CWF or BERT.



Retirement Claims Manual

October 9, 2007

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844 North Rush Street
Chicago Illinois, 60611-2092

Phone: (312) 751-7139
TTY: (312) 751-4701
Web: <http://www.rrb.gov>

If there is no HMO involvement, MS will take no action on the HCFA-566. And, if necessary, advise the field office accordingly.

If there is HMO involvement, MS will do the following actions:

- MS will verify that the information on the HCFA-566 is correct. Clarify any discrepant information with the field office. If the HMO disenrollment date is not the month after the month of completion of the form or receipt of the form, as shown in B above, MS will advise the field office of the correct HMO disenrollment date based on when the HCFA-566 was completed or received. If the individual wants an earlier HMO disenrollment date, the field office will have to obtain documentation of the earlier actions taken by the individual to request an HMO disenrollment date. The HCFA-566 will be forwarded to CMS's regional office and if necessary, further action as shown in E below will be taken to process a disenrollment form not processed timely.
- MS will distribute the HCFA-566 as follows:
 - White Copy - (Social Security Office Copy) - This copy will be retained in MS for any necessary follow-up action. The material will be kept in a pending file in MS. When the EDB is updated with the disenrollment, this copy will be sent to claim files as file only.
 - Yellow Copy - (HMO/CMP Copy) - Within 2 working days of receipt, MS will forward this copy to the HMO or CMP for their records. If necessary, MS will check the CWF or BERT to obtain the number of the HMO, then check the book that contains the addresses of the HMO's, which CMS has supplies to RRB.
 - Pink - (Regional Office Copy) - Within 2 working days of receipt, MS will send this copy to CMS's servicing Regional Office using the facsimile process. The fax number for CMS's Regional Offices and the State they serve are listed in Exhibit 17. Upon receipt of the facsimile copy, the Entitlement Database will be updated with the disenrollment request.

MS will check EDB to be sure the HMO disenrollment was processed. If after 45 days, the disenrollment is not processed, MS will call the appropriate regional office of CMS. MS will then take the necessary steps requested by CMS's regional office. It may be necessary to furnish CMS's regional office with another copy of the HCFA-566.



If the request comes directly to headquarters, MS will first resolve any questions and then complete a HCFA-566, original and three copies. In addition to the above actions, MS will send the beneficiary's copy (pink) to the person.

- E. Disenrollment Form Not Processed Timely - If CMS receives the HCFA-566 more than 90 days after it was filed, the HMO termination date will not be as requested. Therefore, special handling is required if there was a delay due to an inaction by headquarters or field office personnel.

MS will verify that the documentation allows the date requested. If the request lacks documentation, MS will contact the field office for additional information. The folder will also be requested from Claim Files.

After the necessary documentation is secured, MS will write a letter to CMS's regional office explaining the delay in handling. MS will send the letter and HCFA-566 to CMS's regional office. See Exhibit 15 for a sample of the letter. MS will also notify the individual, using the letter in Exhibit 16, with a carbon copy to CMS's regional office.

The material will be put in a pending file in MS. MS will periodically check the EDB and the CWF to be sure the disenrollment action was taken by CMS. If after 45 days, the disenrollment is not processed, MS will call the appropriate regional office of CMS. MS will then take the necessary steps requested by CMS's regional office. It may be necessary to furnish CMS's regional office with another copy of the HCFA-566.

3.1.34 If A Person Encounters Problems With A HMO Or CMP

If a person belongs to a Medicare HMO or CMP and they are unhappy with the quality of care, they can:

- follow the HMO or CMP's grievance procedure, or
- complain to their PRO.

If a person believes that the HMO made an incorrect decision on the coverage of benefits or payment of a claim, the person can exercise their appeal rights, rights that are similar to those provided under traditional Medicare. See RCM 3.1.115 for more information about appeals.

- A. POSSIBLE HMO/CMP PROBLEMS - Some of the problems that could develop because of a HMO involvement and are not HMO disenrollment requests are:



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- beneficiary should be enrolled in an HMO but the Entitlement Database (EDB) does not indicate HMO involvement;
- beneficiary should be disenrolled in an HMO but the EDB still indicates HMO involvement;
- beneficiary was never enrolled in an HMO but EDB indicates HMO involvement;
- beneficiary should not be disenrolled from an HMO but the EDB indicates he/she is;
- beneficiary complains about an incorrect HMO effective date on the EDB;
- beneficiary complains about an incorrect disenrollment date on the EDB.

B. Resolving HMO/CMP Problems - Problems with HMO's are generally resolved in CMS's Regional Offices. However, the following steps should be taken first to try to resolve the problem:

- MS or the field office should determine if the letter contains enough information to determine what the problem is. If not, secure a statement and whatever other proof the beneficiary may have.
- When enough information is obtained, it should be determined what is on the EDB. MS will check BERT to see what is on EDB. The field office should call MS. Based on what is on the EDB, take one of the following actions:
- If the EDB has now been updated, advise the beneficiary accordingly. No further action is necessary.
- If the EDB has not been updated, MS will call CMS's Regional Office about the problem. The field office should forward the letter to MS's expeditor. MS will discuss the problem with CMS. If it cannot be resolved over the phone, MS will refer the letter and other related material to CMS's Regional Office, Attention: HMO Section, to resolve. The beneficiary will be advised with a short letter, with a carbon copy to CMS's Regional Office, of the referral. In the letter, explain that CMS's Regional Office will contact them about the problem. A carbon copy of the letter should be included with the package being referred to CMS's Regional Office. A listing of CMS's Regional Offices and the States they service are shown in Exhibit 17. See Exhibit 16 for a sample letter.



If MS receives a manual payment/account correction from the Part B carrier when there is HMO involvement, a manual payment should not be authorized. The package should be returned to the Part B carrier to verify their records. The Part B carrier should process the claim in accordance with the instruction in their carriers manual. The Part B carrier should either pay, deny, or transfer the claim to the HMO.

If the beneficiary still protests or complains and the necessary information and proofs are submitted, MS will call CMS's Regional Office to see if the problem can be resolved.

3.1.38 Medicare+Choice Coverage Election Periods

The Balanced Budget Act of 1997 provided for Coverage Election Periods. During Coverage Election Periods, eligible beneficiaries may enroll in Medicare+Choice health plans.

Do not confuse Medicare+Choice Coverage Election Periods with the Initial Enrollment Period (IEP), General Enrollment Period (GEP), and Special Enrollment Period (SEP) of Medicare Part B.

IEPs, GEPs, and SEPs are still in effect for beneficiaries who enroll only in Medicare Part B.

There are several types of Medicare+Choice Coverage Election Periods.

- Initial Coverage Election Period (ICEP)

An ICEP begins three months before a beneficiary becomes entitled to coverage under Medicare Parts A and B. An ICEP ends the last day of the month proceeding the month of the beneficiary's entitlement.

During an ICEP, a Medicare health plan is required to accept the beneficiary's enrollment.

Coverage under the health plan starts the first day of the month in which the beneficiary is entitled to Medicare Parts A and B.

- Annual, Coordinated Election Period (ACEP)

Under the Balanced Budget Act of 1997, the ACEP is the month of November. However, that law was amended in June 2002 to change the ACEP from the month



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of November to November 15 through December 31 for the years 2002, 2003, and 2004.

During the ACEP, a Medicare health plan is required to accept the beneficiary's enrollment.

Coverage under the health plan starts January 1 of the following calendar year.

- Open Enrollment Period (OEP)

There are two OEPs, during which beneficiaries may enroll in Medicare health plans.

EXCEPTION: Special rules apply to enrollment in Medicare Medical Savings Account (MSA) Plans. A beneficiary may NOT enroll in an MSA during an OEP.

1. Continuous OEP through 2004.

At any time from November 1, 1998, through December 31, 2004, beneficiaries may change their Medicare health plans. As long as the health plan is open to new enrollees, beneficiaries may continue to change plans as many times as they wish.

Coverage under the health plan starts the first day of the month following the election.

Note: Under the Balanced Budget Act of 1997, the OEP was to end on December 31, 2001. However that law was amended in June 2002 to extend this continuous OEP to December 31, 2004.

2. Continuous OEP Beginning January 1 and Ending March 31 in Years Subsequent to 2004.

At any time from January 1 through March 31 in any calendar year after 2004, beneficiaries may change their Medicare health plans one time.

Beneficiaries who first become eligible for Medicare+Choice during a year after 2004 may also make a one time change in their elections of health plans. For these beneficiaries, the change may be made during the first three months in the year that they are eligible for Medicare+Choice.

The one time change limitation does not apply to changes made during an Annual, Coordinated Period or a Medicare+Choice Special Election Period.



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The Medicare health plan is not required to accept the beneficiary's enrollment. However, if the plan is open to new enrollees, the plan may then accept a beneficiary's enrollment.

Coverage under the health plan starts the first day of the month following the election.

- Medicare+Choice Special Election Period (M+C SEP)

Beginning January 1, 2002, a beneficiary may change to a new Medicare health plan during a M+C SEP.

A M+C SEP may occur at any time, other than an Annual, Coordinated Election Period, for the following reasons:

- The health plan terminates service in the area in which the beneficiary resides.
- The beneficiary moves out of the service area of the health plan.
- The beneficiary shows a provision of the Medicare+Choice contract was violated by the plan or the marketing of the plan materially misrepresented the provisions of the plan.
- The beneficiary meets other circumstances decided by the Secretary of Health and Human Services.

The Centers for Medicare & Medicaid Services will determine the beginning and ending dates of the M+C SEP on a case-by-case basis.

The Medicare health plan is not required to accept the beneficiary's enrollment. However, if a plan is open to new enrollees, the plan may then accept a beneficiary's enrollment.

Coverage under the new health plan starts at such a time so there is no disruption in benefits.

- Special Rules for Medicare Medical Savings Account Plans

There are special enrollment rules for a beneficiary who elects a Medicare Medical Savings Account (MSA) Plan.

1. A beneficiary may elect a MSA Plan ONLY during:

- an Initial Coverage Election Period (ICEP) or



- an Annual, Coordinated Election Period (ACEP).
- 2. A beneficiary who elects an MSA Plan during an ICEP MUST STAY in the plan through the last day of the calendar year in which the beneficiary made the election.
- 3. A beneficiary may disenroll from an MSA Plan ONLY during an ACEP.

EXCEPTION: A beneficiary who never previously elected an MSA Plan and who elects one during an ACEP may revoke the election no later than December 15 following the date of the election.

3.1.40 Buying Health Insurance To Supplement Medicare (MEDIGAP)

Medicare provides basic protection against the high cost of health care, but it will not pay all of the person's medical expenses, nor most long-term care expenses. For this reason, many private insurance companies sell insurance to supplement Medicare (Medigap insurance) as well as separate long-term care insurance. The Federal government does not sell or service such insurance.

- A. Shopping for Medigap Insurance - If a person is thinking about buying a new private insurance policy or replacing an old policy to supplement their Medicare protection or cover long-term care costs, they should shop carefully. The person can also secure a copy of the "Guide to Health Insurance for People with Medicare (507-X)," to help them make Medicare supplement decisions. They can obtain a copy by writing to the Consumer Information Center, Department 59, Pueblo, CO 81009 or refer them to the last page of Form RB-23, Your Medicare Handbook on how to secure a copy, see Exhibit 12.
- B. New Open Enrollment Period for Medigap Policies - A new open enrollment period for selecting Medigap policies guarantees that for six months immediately following enrollment in Medicare Part B, people age 65 or older cannot be denied Medigap insurance or be charged higher premiums because of health problems. Even if they buy a Medigap policy and switch to another within the six-month open enrollment period (they may switch as many times as they wish) they can still get the open enrollment guarantee. All Medigap policies becoming effective after November 5, 1991, are covered by this law.

No matter how the person enrolls in Part B, whether by automatic notification or through an IEP, SEP or GEP, they are covered by the new guarantees if both of the following are true:



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- the person is age 65 or older and is enrolled in Medicare based on age rather than disability; and
- the date the person gets by adding six months to the effective date for their Part B coverage, printed on their Medicare card, is in the future. The date arrived at is when the person's Medigap open enrollment ends.

Even though a person is guaranteed enrollment, their Medigap policy may not provide services for a preexisting condition until a six-month waiting period has passed.

- C. New Standardized Medigap Policies - During 1992, most States will adopt regulations limiting the sale of Medigap insurance to no more than 10 standard policies. One of the 10 will be a basic policy offering a "core package" of benefits. The other nine will each have a different combination of benefits, but they will all include the core package. The basic policy, offering the core package of benefits, will be available in all States.

A person can call their State insurance department to find out when the new standardized policies will be available in their State and how many of the 10 have been or are likely to be approved for sale. The telephone number of their State insurance department is listed under "State agencies" in their telephone book.

If a person already has a Medigap policy, they may want to keep it. They do not have to switch to one of the new standard policies. But, if they buy a new policy, they will probably be required to choose from one of the new standard plans.

- D. Medicare SELECT - In 1992, a new kind of Medigap insurance was introduced in 15 States. It is called Medicare SELECT. The difference between Medicare SELECT and standard Medigap insurance is that Medicare beneficiaries who buy a Medicare SELECT policy will be charged a lower premium in return for agreeing to use the services of certain designated health care professionals. These health care professionals, called "preferred providers," will be selected by the insurers.

Insurers, including some HMO's, offer Medicare SELECT in the same way standard Medigap insurance is offered. The policies are required to meet certain Federal standards and are regulated by the States in which they are approved.

The States in which Medicare SELECT policies were expected to be available are Alabama, Arizona, California, Florida, Indiana, Kentucky, Michigan, Minnesota, Missouri, North Dakota, Ohio, Oregon, Texas, Washington and Wisconsin. If a person lives in one of these States, they can ask their State



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insurance department about the Medicare SELECT policies that have been approved for sale in the State.

- E. Coordinated Care Plans Instead of Medigap - Coordinated care plans that contract with Medicare are not Medigap plans. But they can be an alternative to standard Medigap insurance. See RCM 3.1.30 for more information about coordinated care plans.
- F. Rules for Selling Medigap Insurance - Both State and Federal laws govern sales of Medigap insurance. Companies or agents selling Medigap insurance must avoid certain illegal practices. Federal criminal and civil penalties (fines) may be imposed against any insurance company or agent that knowingly:
- sells a policy that duplicates Medicare coverage, Medicaid coverage or a private health insurance coverage;
 - tells a person that they are employees or agents of the Medicare program or of any government agency;
 - makes a false statement that a policy meets legal standards for certification when it does not;
 - sells a policy that is not one of the approved standard policies, after the new standards have been put in place in their State;
 - denies a person a Medigap open enrollment period by refusing to issue a policy, placing conditions on the policy or discriminating in the price of a policy because of a person's health status, claims experience, receipt of health care or medical condition; or
 - uses the U.S. mail in a State for advertising or delivering health insurance policies to supplement Medicare if the policies have not been approved for sale in that State.
- G. When Illegal Sales Practices is Suspected - When a person suspects that they have been a victim of illegal sales practices, they should report these practices to their State insurance department. States are responsible for the regulation of insurance policies issued within their boundaries. Since there are also Federal laws governing Medigap sales practices, it should also be reported to the appropriate Federal officials.



The State insurance department should be listed in the telephone book. To talk to Federal officials about a suspected illegal sales practices, a person may call 1-800-638-6833.

A person may inquire about the necessity of securing additional insurance to supplement Medicare coverage. Detailed discussions of merits, recommendations, or endorsements of different overages or plans should not be made. Headquarters and field offices should not stock, display or distribute any material about private supplementary health insurance plans.

If a person seeks advice concerning a specific insurance plan, refer him to the insurance company for information or assistance. The responsibility for completion of claims for complementary insurance rests with the individual; if he requests your assistance, encourage him to seek other sources of help, if possible. There must be no indication on the complementary insurance claim or accompanying data that an RRB employee assisted the claimant, if the person is so assisted per their request. Any person making a complaint concerning a specific insurance plan should be referred to that company for explanation; if he has contacted the company and has not gained satisfaction, explain that his recourse is to contact the State agency responsible for regulating insurance activities.

3.1.41 When Other Insurance Pays Before Medicare

If any of the following insurance situations applies to a person, they should notify their doctor, hospital and all other providers of services.

- A. Person or Person's Spouse Continues to Work - Medicare has special rules that apply to beneficiaries who have employer group health plan (EGHP) coverage through their employment or the employment of a spouse.

Effective January 1, 1983, group health plans of employers with 20 or more employees are primary payers and Medicare is secondary payer for workers age 65 or over, and workers' spouses age 65 or over. Group health plans must offer these people the same health insurance benefits under the same conditions offered to younger workers and spouses. The worker and the spouse of the worker have the option to reject the plan offered by the employer. If they reject the employer's health plan, Medicare will remain the primary health insurance payer. In that case, the employer plan is not permitted to offer the person coverage that supplements Medicare covered services.



An individual has the right to take legal action against an EGHP which is primary to Medicare and fails to pay primary benefits. The authority for such legal action is under Section 1862 (b) of the Act.

Any problem regarding who is the primary payer will occur with the group health plan, not the employer. Inquiries should be referred to the appropriate CMS regional office. See Exhibit 17.

Under the law, the government recovers incorrect primary Medicare benefits from any EGHP which is primary payer. To recover Medicare payment, the government will take legal action against the EGHP and may collect double damages.

The person also has a recourse. Any claimant, including an individual who received services, and the provider or supplier, has the right to take legal action against an EGHP that fail to pay primary benefits for services covered by both the EGHP and Medicare and to collect double damages.

It is also in the employer's best interest to have the EGHP pay primary benefits since the employer is hit with a tax penalty for contributing to a nonconforming EGHP.

EGHPs do not have any appeal rights. The EGHP would advise the Medicare intermediary they will not pay primary benefits. The Medicare intermediary would then contact CMS who would check out if it is a EGHP that should pay primary benefits. If CMS determines it is, CMS would instruct the Medicare intermediary not to pay primary benefits.

A person covered by an EGHP should be encouraged to apply for Part A at age 65 since it is free and can help pay some of the expenses not paid by the EGHP.

If a person questions whether it is advantageous to apply and pay for Part B, advise of the following considerations so that the individual can decide what is best for his/her situation.

- He/she must consider how fully the EGHP covers the doctor's and other health services that Part B covers.
- He/she must also consider whether the secondary benefits that Part B would pay are worth the cost of paying the monthly premium.

The person's employer should provide him/her with an explanation of the options available under the EGHP and how Medicare coverage is affected. The employer should also give the person an opportunity to make a choice.



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If an employer plan denies a person coverage, offers a different type of coverage or pays benefits that are secondary to Medicare, the person should notify the Medicare Part B carrier.

- B. Disabled and Under Age 65 - Medicare is the secondary payer for certain disabled people who have premium-free Medicare Part A and are covered under an employer's health plan or the employer health plan of an employed family member. This secondary payer provision applies to group health plans of employers that employ 100 or more people.

Refer to A above for other information on EGHPs.

- C. Other Situations Where Medicare Is the Secondary Payer.

- If a person has a work-related illness or injury it should be covered by workers' compensation or Federal black lung benefits. It is important that the Medicare claim form note that the treatment is related to a work-related illness or injury, even if the injury or illness occurred in the past.
- Medicare is a secondary payer during a period, generally 18 months, for beneficiaries who have Medicare solely on the basis of permanent kidney failure, if they have employer group health plan coverage themselves or through a family member.
- Medicare also serves as the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, Medicare may make a conditional payment if it receives a claim for services covered by liability insurance. In those cases, Medicare may pay the claim; then, when a liability settlement is reached, Medicare recovers its conditional payment from the settlement amount.

- D. Medicare and Veterans Benefits - If a person has or can get both Medicare and veterans benefits, they may choose to get treatment under either program. But Medicare:

- cannot pay for services the person receives from Veterans Affairs (VA) hospitals or other VA facilities, except for certain emergency hospital services; and
- generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.



Since July 1986, the VA has been charging coinsurance payments to some veterans who have non-service connected conditions for treatment in a VA hospital or medical facility, or for VA-authorized treatment by non-VA sources. The VA charges coinsurance payments when the veteran's income exceeds a particular level. If VA charges a coinsurance payment for VA-authorized care by a non-VA physician or hospital, Medicare may be able to reimburse the person, in whole or in part, for the VA coinsurance payment obligation.

Medicare cannot reimburse a person for VA coinsurance payments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient hospital services. Then, the Medicare payment is subject to Medicare deductible and coinsurance amounts.

If questions arise about whether the VA or Medicare should pay the doctor or other services covered under Medicare Part B, the Medicare Part B carrier should be contacted. If questions arise about whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, the provider of services should check with the Medicare intermediary.

- E. Data Match - In 1989, Congress passed a law that will help Medicare get back an estimated \$1 billion in taxpayer money. The law will enable Medicare to get accurate information about beneficiaries' health insurance.

The law authorizes CMS, the agency that administers the Medicare program, the Internal Revenue Service, SSA and RRB to share information about whether Medicare beneficiaries or their spouses are working and whether they have employment-related health insurance.

The process for sharing information from other agencies is called the Data Match. The Data Match will help Medicare find cases where another insurer should have paid first on Medicare beneficiaries' health care claims. A designated Medicare contractor will contact employers to confirm health insurance coverage information. For more information about a person rights under the data match, see RCM 3.1.23.

3.1.50 What Medicare Does Not Pay

Medicare does not pay for custodial care when that is the only kind of care a person needs. Care is considered custodial when it is primarily for the purpose of helping the person with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered custodial care. For example, custodial care includes help in walking, getting in and out



of bed, bathing, dressing, eating and taking medicine. Even if the person is in a participating hospital or skilled nursing facility, Medicare does not cover the stay if all a person needs is custodial care.

3.1.51 Care Not Reasonable And Necessary Under Medicare Program Standards

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services include drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA; and services, including drugs or devices, not considered safe and effective because they are experimental or investigational. Some services are not covered by Medicare even when FDA has approved them.

If a doctor admits a person to a hospital or skilled nursing facility when the kind of care they need could be provided elsewhere, for example, at home or in an outpatient facility, that stay will not be considered reasonable and necessary, and Medicare will not pay for the stay. If a person stays in a hospital or skilled nursing facility longer than they need to be there, Medicare payments will end when inpatient care is no longer reasonable and necessary.

If a doctor, or the practitioner comes to treat a person, or the person visits the doctor or practitioner for treatment, more often than is medically necessary, Medicare will not pay for the "extra" visits. Medicare will not pay for more services than are reasonable and necessary for the treatment.

Medicare always bases decisions about what is reasonable and necessary on professional medical advice.

3.1.52 Services Medicare Does Not Pay For

Medicare, by law, cannot pay for certain services. These include services performed by immediate relatives or members of a person's household, and services paid for by another government program. If a person has questions about whether Medicare pays for a particular service, they should contact the Medicare Part B carrier.

3.1.53 Limitation Of Liability

Under the Medicare law, a person will not be held responsible for payment of the cost of certain health care services for which they were denied Medicare payment if they did not know or could not reasonably be expected to know, that is, the person had not



received a written notice, that the services were not covered by Medicare. This provision is called limitation of liability and is often referred to as a "waiver of liability". This protection from financial liability applies only when the care was denied because it was one of the following:

- custodial care;
- not "reasonable and necessary" under the Medicare program standards for diagnosis or treatment; or
- for home health services, the patient was not homebound or not receiving skilled nursing care on an intermittent basis.

This limitation of liability provision does not apply to Medicare Part B services provided by a non-participating supplier who did not accept assignment of the claim.

This limitation of liability provision does not apply under most circumstances to Part B services furnished by a non-participating physician who did not accept assignment of the claim. However, in certain situations the Medicare law will protect a person from paying for services provided by a non-participating physician on a non-assigned basis that are denied as "not reasonable and necessary". If the physician knows or should know that Medicare will not pay for a particular service as "not reasonable or necessary", the physician must give the patient a written notice, before performing the service, or the reasons why the physician believes Medicare will not pay. The physician must get a written agreement to pay for the services from the patient. If the patient did not receive this notice, the patient is not required to pay for the services. If the patient did pay, they may be entitled to a refund.

3.1.60 Scope of Part A Benefits

Medicare Part A helps pay for four kinds of medically necessary care:

- inpatient hospital care;
- inpatient care in a skilled nursing facility following a hospital stay;
- home health care; and
- hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare helps pay for in each benefit period. But a person's Part A protection is renewed every time they start a new benefit period, see RCM 3.1.61.



Skilled nursing facility care is the only type of nursing home care that Medicare covers. Medicare does not pay for care that is primarily custodial, see RCM 3.1.50 for more information about custodial care.

The following sections are applicable for Part A service provided prior to January 1, 1989 and after December 31, 1989. See Exhibit 10 for Part A services provided in 1989 and exceptions for Part A services provided in 1990.

3.1.61 Benefit Periods

A benefit period is a way of measuring the person's use of services under Medicare Part A. The person's first benefit period starts the first time they enter a hospital on or after their Part A effective date. A benefit period ends when the person has been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row, including the day of discharge. If the person remains in a facility, other than a hospital, that primarily provides skilled nursing or rehabilitation services, a benefit period ends when they have not received any skilled care there for 60 days in a row.

There is no limit to the number of benefit periods a person can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care, see RCM 3.1.72.

Here are two examples of how the benefit period works:

- Ms. Jones enters the hospital on January 5. She is discharged on January 15. She has used 10 days of her first benefit period. Ms Jones is not hospitalized again until July 20. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, her Part A coverage is completely renewed, and she will again pay the hospital deductible. The hospital deductible is explained in RCM 3.1.63.
- Mr. Smith enters the hospital on August 14. He is discharged on August 24. He also has used 10 days of his first benefit period. However, he is then readmitted to the hospital on September 20. Since fewer than 60 days elapsed between hospital stays, Mr. Smith is still in his first benefit period and will not be required to pay another hospital deductible. This means that the first day of his second admission is counted as the 11th day of hospital care in that benefit period. Mr. Smith will not begin a new benefit period until he has been out of the hospital, and has not received any skilled care in a skilled nursing facility, for 60 consecutive days.

3.1.62 How Medicare Pays For Part A Services

Medicare Part A helps pay for most but not all of the services rendered in a hospital or skilled nursing facility or from a home health agency or hospice program. There are



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covered services and noncovered services under each kind of care. Covered services are services and supplies that Medicare Part A will pay for.

Hospitals, skilled nursing facilities, home health agencies and hospices are called "providers" under the Medicare Part A program. Providers submit their claims directly to the Medicare intermediary. The person cannot submit claims for their Part A services. The provider will charge the person for any part of the Part A deductible they have not met and any coinsurance payment they may owe. Providers cannot require the person to make a deposit before being admitted for inpatient care that is or may be covered under Part A of Medicare.

EXCEPTION: If emergency inpatient services were provided by a nonparticipating hospital that does not bill for Medicare patients, the beneficiary will have to file a claim for payment. Such beneficiaries should be referred to the SSA district office for development and filing of a claim.

When a hospital, skilled nursing facility, home health facility or hospice sends the intermediary a Part A claim for payment, the person will get a Notice of Utilization that explains the decision Medicare made on the claim. This notice is not a bill. If the person has any questions about the notice, they should get in touch with the people (intermediary) who sent them the notice.

The intermediary also sends a notice when Part B benefits are performed by a Part A provider.

If the person is requesting information about, or requesting a duplicate notice, the person should contact the intermediary. However, if the person wishes to request this information directly from CMS, they can write to:

Centers for Medicare & Medicaid Services
Correspondence Branch, OMB. RM B3
1717 Equitable Building
6325 Security Boulevard
Baltimore, Maryland 20207

Any inquiry sent to CMS should contain the beneficiary's full name, address and Medicare claim number.

Although the intermediary issues the Notice of Utilization, the Entitlement Database (EDB) is maintained by CMS. Problems concerning utilization should be sent to:

Centers for Medicare & Medicaid Services
Division of Medicare Operations Support
Post Office Box 11981



Baltimore, Maryland 21207

- A. Claim for Payment - Before a payment can be made for Medicare service, a written request for payment must be signed by the patient. Each of the provider billing forms contains a patient's signature line incorporating the patient's request for payment of benefits and authorization to release information. If, because of his/her physical and mental condition, the patient is unable to transact business at the time of admission, another person qualified to act on his/her behalf may sign the form. If necessary, an authorized official of the provider may sign the claim.
- B. Filing Timely Claims - Claims for Medicare benefits must be filed on or before December 31 of the calendar year following the year in which the services were furnished.
- C. Late Filing Due to Administrative Error - When an error by RRB, SSA, CMS, an intermediary or a carrier caused the failure of the provider to file a timely request for payment, the time limit for filing is extended through the last day of the sixth calendar month following the month in which the error is corrected, but not beyond December 31 of the third calendar year after the year in which the services were furnished.

3.1.63 Inpatient Hospital Services

Medicare Part A helps pay for inpatient hospital care if all of the following four conditions are met:

- a doctor prescribes inpatient hospital care for treatment of a illness or injury;
- the kind of care that is required can be provided only in a hospital;
- the hospital is participating in Medicare; and
- the Utilization Review Committee of the hospital, a Peer Review Organization or an intermediary does not disapprove the stay.

If all of the four above conditions are met, Medicare will help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period. Medicare pays for only limited care in a psychiatric hospital, see RCM 3.1.66.

From the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the inpatient hospital deductible. The deductible is an amount the person owes before Medicare will begin to pay for services and supplies



covered by the Medicare program. The hospital may charge the person the deductible only for the first admission in each benefit period. If the person is discharged and then readmitted before the benefit period ends, they do not have to pay the deductible again. See Exhibit 7 for a list of the deductible amounts.

From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services except for the daily coinsurance amount. See Exhibit 7 for a list of the daily coinsurance amounts.

Hospital reserve days, explained in RCM 3.1.64, can help with the persons expenses if they need more than 90 days of inpatient hospital care in a benefit period.

Medicare Part A does not pay for the services of doctors and certain other practitioners, even though the person received these services in a hospital. Instead, those services are covered under Medicare Part B, see RCM 3.1.80.

- COVERED HOSPITAL INPATIENT SERVICES

- a semiprivate room, two to four beds in a room
- all meals, including special diets
- regular nursing services
- costs of special care units, such as intensive care or coronary care units
- drugs furnished by the hospital during the person's stay
- blood transfusions furnished by the hospital during the person's stay, see RCM 3.1.65 for information about coverage of blood
- lab tests included in the hospital bill
- X-rays and other radiology services, including radiation therapy, billed by the hospital
- medical supplies such as casts, surgical dressings and splints
- operating and recovery room costs
- rehabilitation services, such as physical therapy, occupational therapy and speech pathology services

- HOSPITAL INPATIENT SERVICES NOT COVERED



- personal convenience items that the person requests such as a telephone or television in their room
- a private duty nurse
- any extra charges for a private room unless it is determined to be medically necessary

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, they always have the right to appeal the decision, see RCM 3.1.110.

3.1.64 Hospital Inpatient Reserve Days

Medicare helps pay for a person's care in a hospital for up to 90 days in each benefit period. And Medicare Part A includes an extra 60 hospital days the person can use if they have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days. Once the person uses a reserve day they never get it back. Reserve days are not renewable.

Medicare Part A will pay for all covered services except for the coinsurance for each reserve day used. See Exhibit 7 for a list of the coinsurance amounts for reserve days. The person is responsible for paying the coinsurance.

The person has only 60 reserve days in their lifetime, and they can decide when they want to use them. After the person has been in the hospital 90 days, they can use all or some of their 60 reserve days right away if they do not want to.

If the person does not want to use their reserve days, they must tell the hospital in writing, either when they are admitted to the hospital or any time afterwards up to 90 days after they are discharged. If the person uses reserve days and then decides that they did not want to use them, they must request approval from the hospital to get them restored.

All Medigap plans pay some part of hospital bills after they person has used all of their reserve days. See RCM 3.1.40 for more information about Medigap insurance.

3.1.65 Coverage Of Blood Under Part A

Part A helps pay for blood, whole blood or units of packed red blood cells, blood components and the cost of blood processing and administration. If the person receives blood as an inpatient of a hospital or skilled nursing facility, Part A will pay for these blood costs, except for any nonreplacement fees charges for the first three pints of



whole blood or units of packed red cells per calendar year. The nonreplacement fee is the charge that some hospitals and skilled nursing facilities make for blood which is not replaced.

The person is responsible for the nonreplacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. When the person is charged nonreplacement fees, they have the option of either paying the fees or having the blood replaced. If the person chooses to have the blood replaced, they can either replace the blood personally or arrange to have another person or an organization replace it for them. A hospital or skilled nursing facility cannot charge the person for any of the first three pints of blood they replace or arrange to replace. If the person has already paid for or replaced blood under Medicare Part B during the calendar year, they do not have to meet those costs again under Medicare Part A. See RCM 3.1.81 for an explanation of coverage of blood under Medicare Part B.

3.1.66 Care In A Psychiatric Hospital

Part A helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in the person's lifetime. Once the person has used these 190 days, Part A does not pay for any more inpatient care in a psychiatric hospital.

3.1.67 Care Outside The United States

Medicare generally does not pay for hospital or medical services outside the U.S. Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the U.S. However, it can help pay for care in qualified Canadian or Mexican hospitals under certain conditions.

Payment can be made to a RR beneficiary for all covered hospital services furnished by a qualified Canadian hospital, regardless of where the beneficiary lives. RRB acts as the Medicare Part A intermediary and makes payment for Medicare Part A claims for covered Part A benefits.

In Mexico, Part A benefits for covered inpatient hospital services can be paid in two situations. They are:

- the person is in the U.S. when an emergency occurs and a Mexican hospital is closer than the nearest U.S. hospital which can provide the emergency services they need; or
- the person lives in the U.S. and a Mexican hospital is closer to their home than the nearest U.S. hospital which can provide the care the person needs, regardless of whether or not an emergency exists.



If the person is planning to travel outside the U.S., they may want to buy special short-term health insurance for foreign travel. If the person has other health insurance in addition to Medicare, they should check to see if health care in a foreign country is covered under their policy.

See RCM 3.8 for payment of Medicare services outside the U.S.

3.1.68 Care In A Christian Science Sanatorium

Medicare Part A helps pay for inpatient hospital and skilled nursing facility services a person receives in a participating Christian Science Sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston. However, Medicare Part B will not pay for the practitioner.

3.1.69 The Prospective Payment System

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid a predetermined rate per discharge for inpatient services furnished to Medicare beneficiaries. The predetermined rates are based on payment categories called Diagnosis Related Groups, or DRG's. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high or the length of stay is unusually long, the hospital receives additional payment. But even if Medicare pays the hospital less than the cost of the person's care, the person does not have to make up the difference.

It is important to remember that the PPS system does not change the person's Medicare Part A protection. PPS does not determine the length of the person's hospital stay or the extent of care they receive. The law requires participating hospitals to accept Medicare payments as payments in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible and coinsurance amounts, plus any amounts due for noncovered items or services, such as television, telephone or private duty nurses.

3.1.70 Skilled Nursing Facility Care

Medicare Part A can help pay for certain inpatient care in a

Medicare-participating skilled nursing facility following a hospital stay if the person's condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility, and the skilled care they receive must be based on a doctor's order.



- A. What is a Skilled Nursing Facility? - A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

Most nursing homes in the U.S. are not skilled nursing facilities that participate in Medicare. In some facilities, only certain portions participate in Medicare. If the person is not sure whether a facility participates in Medicare as a skilled nursing facility, they should ask someone in the facility's business office.

- B. When Can Medicare Pay For Care in a Skilled Nursing Facility? - Medicare Part A can help pay for care in a Medicare-participating skilled nursing facility if all of the following six conditions are met:

- the person's condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility;
- the person was in a hospital at least three days in a row, not counting the day of discharge, before they are admitted to a participating skilled nursing facility;
- the person is admitted to the facility within a short time, generally within 30 days after they leave the hospital;
- the care in the skilled nursing facility is for a condition that was treated in the hospital, or for a condition that arose while the person was receiving care in the skilled nursing facility for a condition which was treated in the hospital;
- a medical professional certifies that the person needs and received skilled nursing or skilled rehabilitation services on a daily basis; and
- the Medicare intermediary does not disapprove the person's stay.

All six conditions must be met. Remember, the person must need skilled nursing care or skilled rehabilitation services on a daily basis. Part A will not pay for a person's stay if they need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if they do not need to be in a skilled nursing facility to get skilled services. Also, Medicare will not pay for a person's stay if they are in a skilled nursing facility mainly because they need custodial care.



When a person's stay in a skilled nursing facility is covered by Medicare, Part A helps pay for a maximum of 100 days in each benefit period, but only if the person needs daily skilled nursing care or rehabilitation services for that long.

If the person leaves a skilled nursing facility and they are readmitted within 30 days, they do not have to have a new three day stay in the hospital for their care to be covered. If they have some of the 100 days left and they need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during their previous stay in the facility, Medicare will help pay.

In each benefit period, Part A pays for all covered services for the first 20 days a person is in a skilled nursing facility. For the 21st through 100th day, Part A pays for all covered services except the daily coinsurance amount. See Exhibit 7 for a list of the daily coinsurance amounts.

Medicare Part A does not cover the person's doctor's services while they are in a skilled nursing facility. Medicare Part B covers doctors' services, see RCM 3.1.80.

- COVERED SERVICES IN A SKILLED NURSING FACILITY

- a semiprivate room, two to four beds in a room
- all meals, including special diets
- regular nursing services
- physical, occupational and speech therapy
- drugs furnished by the facility during the person's stay
- blood transfusions furnished during the person's stay, see RCM 3.1.65 for information about coverage of blood
- medical supplies such as splints and casts furnished by the facility
- use of appliances such as a wheel chair furnished by the facility

- SERVICES NOT COVERED IN A SKILLED NURSING FACILITY

- personal convenience items that the person requests such as a television in their room
- a private duty nurse



- any extra charges for a private room, unless it is determined to be medically necessary

If a person wants to complain about a skilled nursing facility's treatment of patients or other conditions that concern them, they can contact the State survey agency. Each skilled nursing facility can give the person the telephone number and address of the State survey agency. The person can also look at a copy of the skilled nursing facility's latest certification survey report. The survey report will tell the person the results of the State survey agency's review of how well the agency thinks the facility followed the rules about the patient's rights, safety and quality of care.

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, the person always has the right to appeal the decision, see RCM 3.1.110.

3.1.71 Home Health Care

If a person needs skilled health care in their home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy in their home. A hospital or other facility that mainly provides skilled nursing or rehabilitation services cannot be considered the person's home.

Medicare pays for home health visits only if all of the following conditions are met:

- the care the person needs includes intermittent skilled nursing care, physical therapy or speech therapy;
- the person is confined to their home, homebound;
- the person is under the care of a physician who determines they need home health care and sets up a home health plan for them; and
- the home health agency providing services is participating in Medicare.

Once all four of the above conditions are met, either Medicare Part A or Medicare Part B will pay for all medically necessary home health services. When the person no longer needs intermittent skilled nursing care, physical therapy or speech therapy, Medicare will pay for home health services if the person continues to need occupational therapy.



Medicare home health services do not include coverage for general household services such as laundry, meal preparation, shopping or other home care services furnished mainly to assist people in meeting personal, family or domestic needs.

For a person to determine whether they can get services under the Medicare home health benefit, they should ask their physician to refer them to a Medicare participating home health agency. The home health agency will evaluate the person's case and advise them about whether they meet the requirement for Medicare coverage. Home health agencies do not charge for the evaluation.

- COVERED HOME HEALTH SERVICES
- part-time or intermittent skilled nursing care. This can include eight hours of reasonable and necessary care per day for up to 21 consecutive days - or longer in certain circumstances.
- physical therapy
- speech therapy
- if the person also needs intermittent skilled nursing care, or physical or speech therapy, Medicare will also pay for:
 - occupational therapy
 - part-time or intermittent services of home health aides
 - medical social services
 - medical supplies
 - durable medical equipment, 80 percent of approved amount
- HOME HEALTH SERVICES NOT COVERED
- 24-hour-a-day nursing care at home
- drugs and biologicals
- meals delivered to a person's home
- homemaker services
- blood transfusions



Medicare pays the full approved cost of all covered home health visits. The person may be charged only for any services or costs that Medicare does not cover. However, if the person needs durable medical equipment, they are responsible for a 20 percent coinsurance payment for the equipment.

The home health agency will submit the claim for payment. The person does not have to send in any bills.

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, they always have the right to appeal the decision, see RCM 3.1.110.

3.1.72 Hospice Care

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Medicare Part A helps pay for hospice care if all three of the following conditions are met:

- a doctor certifies that the patient is terminally ill;
- the patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness; and
- care is provided by a Medicare-participating hospice program.

Special benefit periods apply to hospice care. Part A pays for two 90-day periods, followed by a 30-day period, and when necessary, an extension period of indefinite duration. Hospice benefit periods may be consecutive. If a beneficiary cancels hospice care during one of the first three benefit periods, any days left in that period are lost, but the remaining benefit period(s) are still available. And, a beneficiary may disenroll from the hospice during any benefit period, return to regular Medicare coverage, then later re-elect the hospice benefit if another benefit period is available.

Two Hospice Benefit Period Examples:



- Mr. Jones canceled his hospice care at the end of 59 days during his first 90-day benefit period. He lost the 31 remaining days of the first 90-day period. But if he wants to, he can choose hospice care again. He still have a 90-day period, a 30-day period and the indefinite extension period.
- Ms. Smith canceled hospice care during her final extension period. She cannot use the Medicare hospice benefit again.

There are no deductibles under the hospice benefit. The person does not pay for Medicare-covered services for the terminal illness, except for small coinsurances amounts for outpatient drugs and inpatient respite care.

The patient is responsible for five percent of the cost of outpatient drugs or \$5 toward each prescription, whichever is less. For inpatient respite care, the patient pays five percent of the Medicare-allowed rate. The rate varies slightly depending on the area of the country.

Respite care under the hospice program is a short term inpatient stay in a facility. The Medicare beneficiary's inpatient stay gives temporary relief, a respite, to the person who regularly assists with home care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

- COVERED HOSPICE SERVICES
- nursing services
- doctor's services
- drugs, including outpatient drugs for pain relief and symptom management
- physical therapy, occupational therapy and speech language pathology
- home health aid and homemaker services
- medical social services
- medical supplies and appliances
- short-term inpatient care, including respite care



- counseling

The Medicare Part A hospice benefit does not pay for treatments other than for pain relief and symptom management of a terminal illness. Regular Medicare can usually help pay for treatments not related to the terminal illness.

If a person disagrees with a decision on the amount Medicare Part A paid on a claim or whether services they received are covered by Medicare Part A, they always have the right to appeal the decision, see RCM 3.1.110.

3.1.80 Scope of Part B Benefits

Medicare Part B helps pay for:

- doctors' services;
- outpatient hospital care;
- diagnostic tests;
- durable medical equipment;
- ambulance services; and
- many other health services and supplies which are not covered by Medicare Part A.

The following sections tell more about these different kinds of care, the services that are and are not covered by Medicare Part B and what part of the person's medical expenses Medicare will pay.

3.1.81 Deductible And Coinsurance Amounts Under Part B

- The Annual Deductible - The person must pay the first \$100 in approved charges for covered medical expenses. This is called the Medicare Part B annual deductible. The person needs to meet this \$100 deductible only once during the year, and the deductible can be met by any combination of covered expenses. The person does not have to meet a separate deductible for each different kind of covered service they receive.
- The Blood Deductible - The person must pay any nonreplacement fees charged for the first three pints or units of blood and blood components they use each year. The nonreplacement fee is the charge that some practitioners and facilities make for blood which is not replaced. This is called the Medicare Part B blood



deductible. After the person has replaced or paid for the first three pints of blood and they have met the \$100 annual deductible, Medicare will pay 80 percent of the approved amount for blood, starting with the fourth pint. If the person has already paid for or replaced some units of blood under Medicare Part A during the calendar year, they do not have to pay for or replace that number of units again under Medicare Part B.

- C. Coinsurance - After the person pays the annual deductible, they will owe a share of the Medicare-approved amount for services and supplies. This share is called coinsurance. Usually, the coinsurance share is 20 percent of the Medicare-approved amount.

Medicare determines the approved amount for each service covered under Part B. If the services were provided "on assignment," the person pays only the coinsurance, see RCM 3.1.100 for an explanation of assignment.

If the services were not provided "on assignment," and the charges for the services were more than the Medicare-approved amount, the person usually owes the Medicare coinsurance plus certain charges above the Medicare-approved amount. See Medicare-Approved Amounts in RCM 3.1.104. There are limits on the amount a doctor can charge a patient.

This explanation of the deductible and coinsurance amounts describes Medicare's payments system for most services covered by Medicare Part B. In cases where the payment for services is handled in a different way, the person will be given an explanation along with the description of services covered.

3.1.82 Doctors' Services Covered By Medicare Part B

Medicare Part B helps pay for covered services a person receives from their doctor in the doctor's office, in a hospital, in a skilled nursing facility, in the person's home or any other location.

A. Major Doctors' Services Covered by Medicare Part B

- medical and surgical services, including anesthesia
- diagnostic tests and procedures that are part of the person's treatment
- radiology and pathology services by doctors while the person is a hospital inpatient or outpatient



Retirement Claims Manual

October 9, 2007

U.S. Railroad Retirement Board
844 North Rush Street
Chicago Illinois, 60611-2092

Phone: (312) 751-7139
TTY: (312) 751-4701
Web: <http://www.rrb.gov>

- treatment of mental illness, see RCM 3.1.88 for Medicare payment for nonhospital treatment which are limited
- other services such as:
 - X-rays
 - services of a person's doctor's office nurse
 - drugs and biologicals that cannot be self-administered
 - transfusions of blood and blood components
 - medical supplies
 - physical/occupational therapy and speech pathology services

B. Some Doctors' Services Not Covered by Medicare Part B

- routine physical examinations, and tests directly related to such examinations, except some Pap smears and mammograms
- most routine foot care and dental care
- examinations for prescribing or fitting eyeglasses or hearing aids
- immunizations, except pneumococcal pneumonia vaccinations or immunizations required because of an injury or immediate risk of infection and Hepatitis B for certain persons at risk
- cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body

C. Types of Doctors - Most doctors' services are furnished by a doctor of medicine or a doctor of osteopathy. Other "physicians" that can furnish some covered services include chiropractors, doctors of podiatric medicine (podiatrists), doctors of dental surgery or of dental medicine (dentists) and doctors of optometry (optometrists).

D. Chiropractors' Services - Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct a subluxation that is demonstrated by X-ray. Medicare Part B does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.



- E. Podiatrists' Services - Medicare Part B helps pay for any covered services of a licensed podiatrist to treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities, bunion deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails, and other hygienic care. But, Medicare does help pay for some routine foot care if the person is being treated by a medical doctor for a medical condition affecting the person's legs or feet, such as diabetes or peripheral vascular disease, which requires that the routine care be performed by a podiatrist or by a doctor of medicine or osteopathy.

- F. Dentists' Service - Medicare Part B generally does not pay for care in connection with the treatment, filling, removal or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare does help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. If a person needs to be hospitalized because of the severity of a dental procedure, Medicare Part A will pay for their inpatient hospital stay even if the dental care itself is not covered by Medicare.
- G. Optometrists' Services - Medicare helps pay for Medicare-covered vision care, including the services of an optometrist if the optometrist is legally authorized to perform those services by the State in which he or she performs them. However, Medicare will not pay for routine eye exams, and it will usually not pay for eyeglasses. Medicare will pay for cataract spectacles, cataract contact lenses or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses or conventional contact lenses if necessary after insertion of an intraocular lens.

3.1.83 Second Opinion Before Surgery

Sometimes a doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, Medicare recommends that the person get an opinion from a second doctor to help the person decide about surgery. Medicare will help pay for a second opinion. Medicare will also help pay for a third opinion if the first and second opinions contradict each other.



The person's own doctor is the best source for referral to another doctor. But, if the person wishes, they can call the Medicare Part B carrier for the names and phone numbers of doctors in their area who provide second opinions.

3.1.84 Services Of Special Practitioners

Medicare Part B helps pay for covered services a person receives from certain specially qualified practitioners who are not physicians. The practitioners must be approved by Medicare. Medicare-approved practitioners are listed below:

- certified registered nurse anesthetist
- certified nurse midwife
- clinical psychologist
- clinical social worker, other than in a hospital or skilled nursing facility
- physician assistant, a physician assistant can furnish certain services in a hospital or certain other facilities; can serve as an assistant-at-surgery; and can furnish services in any location that is designated as a rural health professional shortage area
- nurse practitioner and clinical nurse specialist in collaboration with a physician, a nurse practitioner can furnish services in a skilled nursing facility or a Medicaid nursing facility in any area. In addition, a nurse practitioner or clinical nurse specialist can furnish services in a rural area.

3.1.85 Outpatient Hospital Services

Medicare Part B helps pay for covered services a person receives as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, Medicare helps pay for emergency outpatient care they receive from a non-participating hospital.

When a person receives outpatient hospital services, they are responsible for the annual Medicare Part B deductible. In addition to the deductible, they are responsible for a coinsurance of 20 percent of the hospital's charge above the deductible.

When a person goes to a hospital for outpatient services, they are sometimes asked how much of their Part B deductible has been met. One easy way to answer that question is for the person to look at their most recent Explanation of Your Medicare Part B Benefits notice. From this form, it can usually tell how much of the \$100 annual deductible the person has met.



If the hospital cannot tell how much of the \$100 deductible the person has met and the charge for the services they received is less than \$100, the hospital may ask the person to pay the entire bill. The amount they pay the hospital can be credited toward any part of the deductible they have not met. If the person pays the hospital for deductible amounts they do not owe, the hospital or the Medicare intermediary will refund the amount they overpaid.

- COVERED OUTPATIENT HOSPITAL SERVICES

- services in an emergency room or outpatient clinic, including same-day surgery
- laboratory tests billed by the hospital
- mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- medical supplies such as splints and casts
- drugs and biologicals that cannot be self-administered
- blood transfusions furnished a person as an outpatient

- OUTPATIENT HOSPITAL SERVICES NOT COVERED

- routine physical examinations, and tests directly related to such examination, except some Pap smears and mammograms
- eye or ear examinations to prescribe or fit eyeglasses or hearing aids
- immunization, except pneumococcal pneumonia and Hepatitis B vaccinations, or immunizations required because of an injury or immediate risk of infection
- most routine foot care

3.1.86 Other Services And Supplies Covered By Medicare

- A. Ambulatory Surgical Services - An ambulatory surgical center is a facility that provides surgical services that do not require a hospital stay. Medicare Part B will pay for the use of an ambulatory surgical center for certain approved surgical procedures. However, by law, Medicare can only pay centers that have an agreement with Medicare to participate in the Medicare program. If a person



does not know if an ambulatory surgical center participates in Medicare, they should ask someone in the center's business office. If that person does not know, they should call the Medicare Part B carrier.

In addition to helping pay for the use of the ambulatory surgical center, Medicare also helps pay for physician and anesthesia services that are provided in connection with the procedure.

- B. Home Health Services - If a person has both Medicare Part A and Part B, their Part A pays for home health services. However, if a person does not have Part A, Part B will pay for home health services as described in RCM 3.1.71.
- C. Outpatient Physical and Occupational Therapy and Speech Pathology Services - Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if all of the following three conditions are met:
- the person's doctor prescribes the service;
 - the person's doctor or therapist sets up the plan of treatment; and
 - the person's doctor periodically reviews that plan

The person can receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency or public health agency. The provider of services may charge the person only for any part of the \$100 annual deductible they have not met, 20 percent of the remaining approved amount and any noncovered services.

Also, the person can receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in the therapist's office or in the person's home if such treatment is prescribed by a doctor. But, the maximum amount Medicare pays for each of these services provided by an independently practicing physical or occupational therapist is \$600 a year. This is 80 percent of the maximum approved amount of up to \$750. The Medicare payment would be less than \$600 if charges for these services are used to meet part or all of the person's \$100 annual deductible.

- D. Comprehensive Outpatient Rehabilitation Facility Services - Under certain circumstances, Medicare helps pay for outpatient services a person receives from a Medicare-participating comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech,



occupational and respiratory therapies; counseling; and other related services. The person must be referred by a physician who certifies that they need skilled rehabilitation services. For most CORF services, the person is responsible only for the annual deductible and 20 percent of the Medicare approved-charges. Medicare helps pay for mental health treatment in a CORF, the Medicare payment limit for mental health treatment in a CORF is discussed in RCM 3.1.88.

- E. Partial Hospitalization for Mental Health - Partial hospitalization means an ambulatory program of active care that lasts less than 24 hours a day. Under certain conditions, Medicare Part B helps pay for partial hospitalization for mental health services furnished by hospital outpatient units and by qualified community mental health centers. If a person is considering mental health treatment, they should check with the program they have chosen to see if it meets the conditions for Medicare payment.
- F. Rural Health Clinic Services - Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, under certain conditions, clinical psychologists and clinical social workers furnished by a rural health clinic. The person is responsible only for the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the clinic.
- G. Federally Qualified Health Center Services - Federally qualified health centers are located in both rural and urban areas. As part of the "federally qualified health center benefit," Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses, under certain conditions, clinical psychologists and clinical social workers. Also, as part of the federally qualified health center benefit, Medicare helps pay for certain preventive health services. The person does not have to pay the Medicare Part B annual deductible for services provided under the federally qualified health center benefit. The person is responsible for 20 percent of the Medicare-approved charge for the clinic.

There are some specialized services that may be provided by a federally qualified health center that are not part of the federally qualified health center benefit. For these services, the person does have to meet the annual Part B deductible. As long as the center meets Medicare requirements to provide these specialized services, Medicare Part B can help pay for them. The center will tell the person if the service they need is a specialized service. For example, the center may provide screening mammograms. If the person gets a mammogram at the center, they are responsible for any unmet part of the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the mammogram.



- H. Independent Laboratory Services - Medicare Part B pays the full approved fee for covered clinical diagnostic tests provided by independent laboratories that are approved to perform them. The laboratory must accept assignment for these tests. See RCM 3.1.100 for an explanation of assignment. It may not bill the person for the tests.

Not all laboratories are approved by Medicare and some laboratories are approved only for certain kinds of tests. If a doctor orders tests which the laboratory is not approved to perform, Medicare does not pay for the tests, and the person can be required to pay for them. The person's doctor can usually tell them which laboratories are approved and whether the tests he or she is ordering from an approved laboratory are covered by Medicare. If the person's doctor can not tell, they should call the Medicare Part B carrier.

The person's doctor must accept assignment for covered clinical diagnostic laboratory tests which he or she furnishes. The doctor is not allowed to bill the person for the tests. See RCM 3.1.100 for an explanation of assignment.

- I. Portable Diagnostic X-ray Services - Medicare Part B helps pay for portable diagnostic X-ray services a person receives in their home or other location if they are ordered by a doctor and if they are provided by a Medicare-approved supplier. The person can ask the Part B carrier whether the supplier is Medicare-approved.
- J. Other Diagnostic Tests - Medicare Part B also helps pay for other diagnostic tests, including X-rays, that the person's doctor orders to evaluate the person's medical problems.
- K. Pap Smear Screening - Medicare Part B helps pay once every three years for Pap smears to screen for cervical cancer. Medicare helps pay more frequently for certain women at high risk. Medicare also pays for diagnostic Pap smears as needed when symptoms are present.
- L. Breast-Cancer Screening (Mammography) - Medicare Part B helps pay for X-ray screenings for the detection of breast cancer, if they are provided by a Medicare-approved supplier. Women 65 or older can use the benefit every other year. Younger, disabled women covered by Medicare can use the screening benefit more frequently. Medicare also pays for diagnostic mammograms as needed when symptoms are present.

For accurate up-to-date information on cancer prevention, detection, diagnosis, and treatment for patients, their families and the general public, a person can call the Cancer Information Service at 1-800-4-CANCER.



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- M. Radiation Therapy - Medicare Part B helps pay for outpatient radiation therapy given under the supervision of a person's doctor.
- N. Kidney Dialysis and Transplants - Medicare Part B helps pay for kidney dialysis and transplants. For detailed information on this coverage, a person can get a copy of Medicare Coverage of Kidney Dialysis and Kidney Transplant Services from the Consumer Information Center as explained on the last page of Form RB-23, Your Medicare Handbook, see Exhibit 12.
- O. Heart and Liver Transplants - Under certain limited conditions, Medicare Part B helps pay for heart and liver transplants in a Medicare-approved facility. If the person is considering a heart or liver transplant, the person and their physician can find out about Medicare coverage by contacting the Part B carrier. If they belong to an HMO, the HMO will give them the information they need about Medicare coverage.
- P. Ambulance Transportation - Medicare Part B helps pay for medically necessary ambulance transportation, but only if:

- the ambulance, equipment and personnel meet Medicare requirements; and
- transportation in any other vehicle could endanger the person health.

Under these conditions, Medicare helps pay for ambulance transportation but only to a hospital or skilled nursing facility, or from a hospital or skilled nursing facility to the person home. Medicare does not pay for ambulance use from the person's home to a doctor's office or to a dialysis facility.

Medicare usually helps pay only if the ambulance transportation is in the person's local area. But, if there are no local facilities equipped to provide the care the person needs, Medicare helps pay for necessary ambulance transportation to the closest facility outside the person's local area that can provide the necessary care. If there is a local facility equipped to provide the care the person needs but the person chooses to go to another institution that is farther away, Medicare payment is based on the charge for transportation to the closest facility that can provide the necessary care.

- Q. Durable Medical Equipment - Medicare Part B helps pay for durable medical equipment such as oxygen equipment, wheelchairs and other medically necessary equipment that the person's doctor prescribes for use in the person's home. A hospital or facility that mainly provides skilled nursing or rehabilitation services cannot be considered the person's home.



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To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to people who are not sick or injured and must be appropriate for use in the person's home. Not all types of equipment that a person might find useful can meet all four of these requirements.

Only the person's doctor should prescribe medical equipment for the person. An equipment supplier should not take any of the following actions:

- contact the person first, either by phone or by mail, and offer to get the person's doctor or Medicare to approve an item. It is all right for the supplier to contact the person in response to calls from the person's doctor or other health care workers;
- say he or she works for, or represents Medicare;
- deliver equipment to the person's home that neither the person nor the person's doctor ordered; or
- send the person used items, while billing Medicare for new ones.

Some of these actions may be against the law. If the person believes a supplier has taken any of these actions, the person should alert the Part B carrier. First, the person should ask their doctor whether he or she ordered the item. If the person's doctor did not order the item, the person should file a complaint with the Medicare Part B carrier. They can file the complaint by phone, in person or in writing. The Part B carrier will investigate the complaint.

It is also illegal for a supplier to offer the person items at no cost to the person or offer to pay the Medicare coinsurance on items. If a supplier makes one of these offers, the person should file a complaint with the Part B carrier as described above.

NOTE: The durable medical equipment supplier must have the person's doctor's prescription before delivering any of the following items: seat lift chairs, power-operated vehicles, equipment for care of pressure sores or transcutaneous electrical nerve stimulators. In the case of seat lift chairs, Medicare covers only the lift mechanism, not the chair itself.

Medicare uses three methods of payment for durable medical equipment: Lease-purchase, lump-sum payment for purchase or rental charges. The Part B carrier will be able to provide more specific guidance to the person on which method will be used for a particular item.



- R. Prosthetic Devices - Medicare Part B helps pay for prosthetic devices needed to substitute for an internal body organ. These include Medicare-approved corrective lenses needed after a cataract operation, ostomy bags and certain related supplies and breast prostheses including a surgical brassiere after a mastectomy. Medicare also helps pay for artificial limbs and eyes, and for arm, leg, back and neck braces. Medicare does not pay for orthopedic shoes unless they are an integral part of leg braces and the cost is included in the charge for the braces. Medicare does not pay for dental plates or other dental devices.
- S. Medical Supplies - Medicare Part B helps pay for surgical dressings, splints and casts ordered by a doctor in connection with a person's medical treatment. This does not include adhesive tape, antiseptics or other common first-aid supplies.

3.1.87 Drugs And Biologicals

- A. Pneumococcal Pneumonia Vaccine - Medicare Part B pays the full approved charges for pneumococcal pneumonia vaccine and its administration. Neither the \$100 annual deductible nor the 20 percent coinsurance applies to this service.
- B. Hepatitis B Vaccine - Medicare Part B helps pay for Hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.
- C. Hemophilia Clotting Factors - Medicare Part B helps pay for blood clotting factors and items related to their administration for hemophilia patients who are able to use them to control bleeding without medical or other supervision. The amount of clotting factors necessary to have on hand for a specific period is determined for each patient individually.
- D. Blood - Medicare Part B helps pay for blood and blood components that a person receives as a hospital outpatient or as part of other services. See RCM 3.1.81 for an explanation of the blood deductible.
- E. Antigens - Under certain circumstances, Medicare Part B helps pay for antigens prepare for the person by their doctor. They can check with the Part B carrier to see if Medicare will pay for their antigens.
- F. Immunosuppressive Drugs - Immunosuppressive drugs are often given to prevent rejection of transplanted organs. Medicare Part B helps pay for drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant was performed.



- G. Epogen - Medicare Part B helps pay for the drug epogen (EPO) when used to treat Medicare beneficiaries with anemia related to chronic kidney failure, or with AIDS. The kidney failure patients are not required to be on dialysis. The EPO must be administered incident to the services of a doctor in the office or in a hospital outpatient department. Part B also helps pay for EPO that is self-administered by home dialysis patients or administered by their caregivers.

3.1.88 Medicare Payments For Nonhospital Treatment Of Mental Illness

Medicare helps pay for services the person receives for nonhospital treatment of a mental illness. They may get the services from doctors, comprehensive outpatient rehabilitation facilities (CORFs), physician assistants, psychologists and clinical social workers.

These services for nonhospital treatment of a mental illness are subject to a special payment rule. In effect, once the annual deductible is met, Medicare Part B pays only 50 percent, not 80 percent, of approved charges for these services. On assigned claims, beneficiaries are responsible for paying the remaining 50 percent. For unassigned claims, beneficiaries may have to pay more. See RCM 3.1.100 for information about assignment.

Partial hospitalization services for treatment of mental illness are not subject to this special payment rule. Also, brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental illness are not subject to this special payment rule. See RCM 3.1.86 for more information about partial hospitalization services.

3.1.89 Services Rendered Outside The United States

Services received outside the U.S. are generally not payable. Medicare Part B can help pay for services rendered in Mexico and Canada if certain situations exist.

- FOR CANADA THEY ARE:
- the individual was in the U.S. when an emergency occurred and the Canadian hospital is closer than the nearest U.S. hospital which can provide the emergency services needed; or
- the individual lives in the U.S. and a Canadian hospital is closer to his or her home than the nearest U.S. hospital which could provide the care needed, regardless of whether or not an emergency existed; or



- the individual is in Canada traveling by the most direct route between Alaska and another State and an emergency occurs which requires an admission to a Canadian hospital (vacationing in Canada does not apply).
- FOR MEXICO THEY ARE:
- the individual is in the U.S. when an emergency occurs and a Mexican hospital is closer than the nearest U.S. hospital which could provide the emergency services needed; or
- the individual lives in the U.S. and a Mexican hospital is closer to his home than the nearest U.S. hospital which could provide the care needed regardless of whether or not an emergency existed.

NOTE: Medicare may not pay if the individual leaves the U.S. for a reason other than to obtain medical treatment (example: vocation), even though the medical emergency occurred within the U.S.

See RCM 3.8 for payment of Medicare services outside the U.S.

3.1.100 The Assignment Payment Method

Under the assignment method, a doctor or supplier agrees to accept the amount approved by the Medicare Part B carrier as total payment for covered services: the doctor or supplier agrees to "take assignment".

The assignment method can save a person money. The doctor or supplier sends the claim to Medicare. Medicare pays the doctor or supplier 80 percent of the Medicare-approved amount, after subtracting any part of the \$100 annual deductible not yet met. The doctor or supplier can charge only for the part of the \$100 annual deductible not met and for the coinsurance, which is the remaining 20 percent of the approved amount. Of course, the doctor or supplier also can charge for services that Medicare does not cover.

Doctors and certain other practitioners and suppliers must take assignment on all claims for services furnished to Medicare beneficiaries who are eligible for medical assistance through their State Medicaid program, including Qualified Medicare Beneficiaries. See RCM 3.1.22 for Assistance for Low-Income Beneficiaries.

3.1.101 Participating Doctors And Suppliers

Doctors and suppliers may sign agreements to become Medicare participating. Medicare-participating doctors and suppliers have agreed in advance to accept



assignment on all Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year. Medicare participating doctors and suppliers can display emblems or certificates which show that they accept assignment on all Medicare claims.

The name and addresses of Medicare-participating doctors and suppliers are listed, by geographic area, in the Medicare-Participating Physician/Supplier Directory. A person can get the directory for their area free of charge from the Medicare Part B carrier; or they can call the toll-free telephone number and ask for names of some participating doctors and suppliers in their area. Also, this directory is available to look at in any RRB field office, SS office, State and area offices of the Administration on Aging and in most hospitals.

3.1.102 When A Doctor Does Not Accept Assignment

If a doctor or supplier does not accept assignment, the patient must pay the doctor or supplier directly. The patient is responsible for the part of the bill that is more than the Medicare-approved amount, up to the limit explained below. The patient must pay this amount because the doctor or supplier did not agree to accept the Medicare-approved amount as payment in full. In this case, Medicare pays the patient 80 percent of the approved amount, after subtracting any part of the \$100 annual deductible the patient has not met.

Even though a doctor does not accept assignment, there are limits on the amount that they can actually charge a patient. In 1992, the most a doctor can charge a patient is 120 percent of the fee schedule amount for non-participating physicians. The fee schedule is explained under Medicare Approved Amounts, see RCM 3.1.104. Doctors who charge more than these limits may be fined. If a person thinks they have been charged more than the acceptable level, they should call or write the Medicare Part B carrier

Special rules for doctors performing elective surgery: In addition to the limit on charges, Medicare law requires doctors who do not take assignment for elective surgery to give the patient a written estimate of the patient's costs before the surgery, if the total charge for the surgical procedure is \$500 or more. If the doctor did not give a written estimate, the patient is entitled to a refund of any amount they paid the doctor over the Medicare approved-amount.

Many doctors and suppliers who do not take assignment on all claims may take assignment on some or most claims. The patient should ask the doctor or supplier whether they will take assignment on claims.



Examples of two payments for the same service are show below. Dr. A accepts assignment. Dr. B does not accept assignment. In both examples, the patient has already met the \$100 deductible.

TWO PAYMENTS EXAMPLES

THE ANNUAL PART B DEDUCTIBLE HAS BEEN MET

	ACTUAL AMOUNT	MEDICARE AMOUNT	BENEFICIARY PAYS	RESPONSIBLE FOR
DOCTOR A ACCEPTS ASSIGNMENT	\$480	\$400	\$320 (80% OF APPROVED AMOUNT)	\$80 (20% OF APPROVED AMOUNT)
DOCTOR B DOES NOT ACCEPT ASSIGNMENT	\$480	\$400	\$320 (80% OF APPROVED AMOUNT)	\$160 (DIFFERENCE BETWEEN CHARGE AND MEDICARE PAYMENT)

3.1.103 Participating Providers

Hospital, skilled nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities and providers of outpatient physical and occupational therapy and speech pathology services are all participating providers under Medicare Part B. They submit their claims to Medicare and must accept the Medicare-approved amount as payment in full for covered services. Medicare subtracts any deductible not met and any coinsurance amount and pays the provider. The provider then bills the patient for only those deductible and coinsurance amounts.

3.1.104 Medicare-Approved Amounts

Medicare Part B payments are based for the most part on Medicare fee schedule amounts. The fee schedule for physicians and certain suppliers lists payments for each Part B service and takes into account geographic variation in the cost of practice. The fee schedule amount is often less than the actual charges billed by doctors and suppliers. Part B usually pays 80 percent of the fee schedule amount, even if it is less than the actual charge.



When a Part B claim is submitted, the Medicare Part B carrier compares the actual charge shown on the claim with the fee schedule amount for that service. The Medicare-approved amount is the lower of the actual charge or the fee schedule amount.

3.1.105 Submitting Part B Claims

- A. Doctors, Suppliers and Other Providers Must Submit Claims For Medicare Patients - Since September 1, 1990, doctors, suppliers and other providers of Part B services have in most cases been required to submit Medicare claims for the patient, even if they do not take assignment. They must submit the claims within one year of providing the service or may be subject to certain penalties. If a person has other health insurance that should pay before Medicare, that person can submit their own claims. See Person Files Their Own Claim, below.

The person should contact the Medicare Part B carrier if their doctor or supplier refuses to submit a Part B Medicare claim for them if the person believes the services may be covered by Medicare.

- B. Doctor or Supplier Submission of Claim - A doctor or supplier must submit a form call a HCFA-1500, requesting that Medicare Part B payment be made for covered services, whether or not assignment is taken. The doctor or supplier should complete the HCFA-1500 and send it to the Medicare Part B carrier. The claim form should not be sent to RRB because it will delay the payment of the claim. When RRB receives a claim form, they forward it to the Part B carrier. The doctor or supplier orders and pays for a supply of the forms used for submission to Medicare. This is the same form that is used by SS beneficiaries.

- C. Enrollment in a Coordinated Care Plan - If a person is enrolled in a coordinated care plan, a prepaid health care organization such as an HMO, a claim will seldom need to be submitted on their behalf. Medicare pays the HMO a set amount and the HMO provides their medical care. In most cases, the person is required to receive all non-emergency care through their HMO, or through arrangements made before they receive care. However, if a person gets an out-of-plan service, the claim should be submitted directly to the HMO.

The person should consult their HMO membership handbook, or contact the HMO if their doctor or supplier needs an address.

- D. Person Files Their Own Claim - In some cases, a person may need to file their own Medicare Part B claims. They may file their own claims for:



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- services covered by Medicare for which a person has other health insurance that should pay first on their claims;
- services not covered by Medicare for which they want a formal Part B coverage determination;
- services provided that a doctor or supplier refuses to submit for a person, even though it is required by law;
- services provided outside the U.S.; and
- used durable medical equipment purchased from a private source.

The claim form, G-740s, should be sent to the Medicare Part B carrier.

This is a RRB stocked form and has the Medicare Part B carrier's address pre-printed on it.

- E. Time Limits - Under the law, there are time limits for a person submitting their own Medicare Part B claims. For Medicare to make payments on a claims, they must be sent within the time limits. The person has at least 15 months to submit the claim.
- F. Late Filing Due to Administrative Error - When an error by RRB, SSA, CMS, an intermediary or a carrier caused the failure of the provider to file a timely request for payment, the time limit for filing is extended through the last day of the sixth calendar month following the month in which the error is corrected, but not beyond December 31 of the third calendar year after the year in which the services were furnished.
- G. Claims for a Person Who Has Died - When a Medicare beneficiary dies, the way Medicare pays Part B claims depends on whether the doctor's or supplier's bill has been paid. Any Part A payments due to the hospital, skilled nursing facility, home health agency or hospice will be made directly to the provider of services.

If the physician or supplier had agreed to accept assignment before the person's death, payment will be made to the physician or supplier.

If the bill was paid by the patient or with funds from the patient's estate, Medicare's payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.



If the bill has not been paid and the doctor or supplier does not accept assignment, the Medicare payment can be made to the person who has or assumes legal obligation to pay the bill for the deceased person.

The Part B carrier can provide the person, who is trying to get a Part B claim paid, with additional information about how to claim a Medicare Part B payment after a patient dies.

3.1.106 Explanation Of Your Medicare Part B Benefits Notice

After a doctor, provider or supplier sends in a Part B claim, Medicare will send a notice called Explanation of Your Medicare Part B Benefits (EOMB) to tell the decision of the claim. If payment is being made to the person, the EOMB will accompany the check. In assignment cases, a copy of the EOMB is sent to the person.

For services of a physician, this notice shows what services were covered, what charges were approved, how much was credited toward the \$100 annual deductible, and the amount Medicare paid. For other Part B services the notice shows similar information. The person should examine the notice carefully. If they believe payment was made for a service or supply they did not receive, or the payment is otherwise questionable, they should call or write the Medicare Part B carrier.

Any person needing a duplicate EOMB should be referred to the Medicare Part B carrier. Written requests to the Part B carrier should contain the person's full name, address and Medicare claim number.

The address and toll-free telephone number of the Part B carrier is printed on the EOMB.

3.1.107 The Medicare Part B Carrier

- A. Background - The Travelers processed Part B claims for QRRB's from 1966 through 1992. For 26 years, the contract with the Travelers was not subject to competitive bidding. In December 1991, a majority of the Board approved publication of its intent to solicit bids for the contract for RRB's Part B carrier for Fiscal Year 1993. The RRB staff developed a Request for Proposals, which solicits bids, which are then evaluated by RRB staff. A recommendation is then made to the Board. Since 1991 The Travelers Insurance Company, Metra Healthcare and United Healthcare have held the contract.

The current Medicare Part B carrier is Palmetto GBA. RRB's arrangement with the Part B carrier is unique in that it is a nationwide operation. The Part B carrier can also process Part B claims for some SS beneficiaries with its agreements



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with CMS for some States. The Part B carrier can also be a Part A intermediary in several States.

- B. Calling The Part B Carrier - The Part B Carrier has an automated telephone answering system to help make their responses faster and more accurate. When a person calls, they will be connected to a special automated voice system. If the person has a touch-tone telephone, they should follow the instructions they receive over the phone to get information about the status of their claims.

If a person needs other information or wants to talk about a claim, they can ask the system to connect them with a customer service representative at any time.

If the person does not have a touch-tone telephone, they should stay on the line after they dial and they will be connected to a customer service representative.

The toll-free number is 1-800-833-4455.

If a person advises he is unable to contact the Part B carrier because the toll-free number is busy, suggest the call be made early in the morning or late in the afternoon because the volume of calls are lightest at those times. If repeated inquiries are received, contact the assistance manager or supervisor of beneficiary services.

Any inquiries you have on behalf of a person should be made to the assistant manager or supervisor of beneficiary services.

- C. General Processing Procedure by The Part B Carrier for Payment of Part B Claims

- Beneficiary Has Part B Coverage - The Part B carrier will determine the Medicare approved amount, subtracting any of the annual deductible that needs to be met, and issue the Medicare payment.

If payment is being made to the person, he/she receives an Explanation of Medicare Benefits (EOMB) with the Medicare benefit payment. In assignment cases, both the physician or supplier and the person are sent EOMB's. The physician or supplier receives a composite check covering payment of several claims on a periodic basis, usually once a week or once a month.

- Beneficiary Has No Part B Coverage - If the person is not entitled to Part B benefits, a denial notice will be released.

If the person advises he/she is entitled, the Part B carrier will check its records to determine if accurate data was used to process the claim the first



time. If so, the Part B carrier will contact MS for verification of coverage. If coverage is verified, MS will be asked to correct the records at CMS. The Part B carrier will then ask MS for authorization to make a payment manually if:

- The claim(s) submitted total \$100, and
- The claim is 90 days old.

If a physician or beneficiary does not cash a Part B benefit check for more than \$5 within approximately 90 days of issue, the Part B carrier will contact the payee to determine why it was not negotiated. If appropriate, a duplicate check will be issued based on the beneficiary's signed statement and the original check will be voided. The Part B carrier may request field office assistance if they are unable to contact the person. When the beneficiary cannot be reached, the Part B carrier will not void the check for at least 6 months.

3.1.108 Field Office Cooperation With Palmetto GBA

A. General - Field offices are responsible for seeing that QRRB's in their area promptly receive the full benefits they are entitled to under Medicare. In carrying out this responsibility, each field office works with Palmetto GBA to achieve two goals:

- The prompt payment of Part B claims and
- To reduce the number of claims and bills returned to beneficiaries.

Field offices will not instruct Palmetto GBA on the processing of Part B claims. Field offices are expected to keep their regional directors and/or Operations-RMS informed of the circumstances when it appears action taken or not taken by Palmetto GBA may not be conducive to the prompt payment of claims, and in keeping with RRB policies regarding the payment of Medicare benefits.

Field offices will not accept an overpayment case directly from Palmetto GBA. After Palmetto GBA has exhausted efforts to collect, the case will be referred directly to Operations-RMS for further action.

Some specific situations in which field offices may give assistance are:

- Helping to secure needed information in cases when Palmetto GBA is unable to obtain it by telephone.



- Assisting in obtaining information needed for the payment of claims where the beneficiary has died.

B. Processing Problems - Palmetto GBA may, at time, request field office assistance in clearing up problem cases. Palmetto GBA is instructed to contact the local RRB field office for any assistance on all cases involving QRRB's. There may be instances when the field office will have to contact the local SSA DO; do not encourage Palmetto GBA to by-pass the field office and directly contact the local SSA DO for assistance.

3.1.110 Appealing a Medicare Decision

If a person disagrees with a decision on the amount Medicare will pay on a claim or whether services they received are covered by Medicare, they have the right to appeal the decision. The notice the person receives from Medicare tells them the decision made on the claim and also tells them exactly what appeal steps they can take. Appealing decision by Part A providers, peer review organization, intermediaries, carriers and health maintenance organizations are discussed in the following sections.

3.1.111 Appealing Decisions Made By Providers Of Part A Services

In many cases the first written notice of noncoverage a person will receive will come from the provider of the services, for example, a hospital, skilled nursing facility, home health agency or hospice. This notice of noncoverage from the provider should explain why the provider believes Medicare will not pay for the services. This notice is not an official Medicare determination, but the person can ask the provider to get an official Medicare determination. If the person asks for an official Medicare determination, the provider must file a claim on their behalf to Medicare. Then, the person will receive a Notice of Utilization, which is the official Medicare determination. If the person still disagrees, they can appeal as shown in RCM 3.1.113.

3.1.112 Appealing Decisions Made By Peer Review Organizations (PRO's)

When a person is admitted to a Medicare-participating hospital, they will be given a notice called An Important Message From Medicare, see Exhibit 11 for a copy of this notice. The notice contains a brief description of PRO's, and the name, address and phone number of the PRO in the person's State. It also describes the person's appeal rights.

PRO's make determinations mainly about inpatient hospital care and ambulatory surgical center care. The PRO's decide whether care provided to Medicare patients is



medically necessary, provided in the most appropriate setting, and is of good quality. When a person disagrees with a PRO decision about their case, they can appeal by requesting a reconsideration. Then, if they disagree with the PRO's reconsideration decision, and the amount remaining in question is \$200 or more, they can request a hearing by an Administrative Law Judge. Cases involving \$2,000 or more can eventually be appealed to a Federal Court.

If a person belongs to a Medicare HMO, the HMO will usually make decisions about the medical necessity, the appropriateness of setting and the quality of the care received. In most cases, the person does not have the right to appeal to the PRO, but they always have the right to register complaints about the quality of their hospital care to the PRO. See RCM 3.1.115 for more information about a person's appeal rights for members of HMO's.

NOTE: In the case of elective, non-emergency, surgery, either the hospital or the PRO may be involved in pre-admission decisions. If the hospital believes that the person's proposed stay will not be covered by Medicare, it may recommend, without consulting the PRO, that the person not be admitted to the hospital. If this is the case, the hospital must give the person its decision in writing. If the person or their doctor disagree with the hospital's decision, they should make a request to the PRO for immediate review. If the person wants an immediate review, they must make their request, by telephone or in writing, within three calendar days after receipt of the notice.

3.1.113 Appealing Decisions Of Intermediaries On Part A Claims

The appeals procedures consists of three steps: reconsideration, hearing and a court review. The beneficiary must request each step within certain time limits and the amount in controversy must meet certain minimum dollar amount criteria.

- A. Services Furnished in U.S. or Mexico - Appeals of decisions on most other services covered under Medicare Part A (skilled nursing facility care, home health care, hospice services and a few inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries.
- Reconsiderations - After a person receives the official Medicare determination, the person should first seek assistance from the intermediary. If a beneficiary contacts a field office or headquarters regarding a Medicare payment after having contacted the intermediary, attempt to answer their questions. If necessary, contact the intermediary.

If the beneficiary is still dissatisfied he/she may request further consideration of his Medicare claim. If a person disagrees with the intermediary's initial



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decision, they have 60 days from the date they received the initial decision to request a reconsideration. The claim in question can be for any amount.

The request can be submitted directly to the intermediary or through any RRB office.

Any inquiry received in a field office or headquarters from a person must be stamped to show the receipt date to protect the filing date for the reconsideration. A request for reconsideration should include the beneficiary's Medicare claim number, name, address, a brief reason for dissatisfaction and a copy of the Notice of Utilization. It should be indicated on the statement whether it was prepared in the field office or in headquarters. Forward the request and a copy of the Notice of Utilization to the intermediary whose address is shown on the Notice of Utilization. If the intermediary cannot be determined, secure the information from the nearest SSA district office. Field offices should not forward the request to headquarters.

- Hearing - If the person disagrees with the intermediary's reconsideration decision and the amount remaining in question is \$100 or more, they have 60 days from the date they receive the reconsideration decision to request a hearing by an Administrative Law Judge.

If an inquiry is received by telephone or in person and an SSA office is conveniently located, advise the person to contact the SSA district office. If the person will contact the SSA district office in person, he/she should take the reconsideration notice along whenever possible.

If an SSA office is not conveniently located, or a written inquiry is received, accept the request for a hearing. The request must include the person's Medicare claim number, name, address, brief reason for dissatisfaction and a copy of the reconsideration notice. Send the material to the SSA district office. Advise the beneficiary that he/she will receive notification from SSA.

- Court Review - If the person is still dissatisfied after the hearing examiner's decision and the amount in controversy is at least \$1,000 or more, they can eventually be appealed to a Federal Court. The action must be initiated within 60 days after the receipt of the notice of the hearing decision.

- B. Services Furnished in Canada - Since Canadian claims under Part A are processed and paid by RRB using funds from the RR account, RR Act appeals procedures apply. To initiate the process, a written statement requesting reconsideration must be submitted within 60 days of the decision notice to the beneficiary on the Part A Canadian claim.



3.1.114 Appealing Decisions Made By Carriers On Part B Claims

A doctor must provide a person with a written notice if he or she knows or believes that Medicare will not consider a particular service reasonable and necessary and will not pay for it. This written notice must be given to the person before the service is performed and must clearly state the reasons the doctor believes Medicare will not pay. If the doctor does not give this written notice and the person did not know that Medicare would not pay for the services they received, they cannot be held liable to pay for them. However, if the person did receive written notice and signed an agreement to pay for the services so they could be treated, they will be held liable to pay.

This written notice is not an official Medicare determination. If the person disagrees with it, they may ask the doctor to submit a claim for payment to the Medicare Part B carrier to get an official Medicare determination, Explanation of Medicare Benefits (EOMB). The claim must be filed within the specific time periods shown in RCM 3.1.105. In some cases, the person can file the claim.

- **Informal Review** - When the person receives the EOMB and the person still disagrees, they have the right to appeal that decision. They have six months from the date of the initial decision to ask the Part B carrier to review it.

The person should first seek assistance from the Part B carrier. If a beneficiary contacts a field office or headquarters regarding a Medicare payment after having contacted the Part B carrier, attempt to answer their questions. If necessary, contact the Part B carrier. If the beneficiary is still dissatisfied he/she may request further consideration of his Medicare claim.

The person should complete Form G-790 (original only) or submit a statement with the same facts. If the beneficiary has additional evidence, it should be attached to the G-790 or the statement. Send the request to Palmetto GBA at the address shown on the EOMB. A review of the entire claim will be done by Palmetto GBA by someone who was not involved in the original decision. A letter will be sent to the person with an explanation and the results of the review.

- **Fair Hearing** - Then, if they disagree with Palmetto GBA's written explanation of its review decision and the amount remaining in question is \$100 or more, they have six months from the date of the review decision to request a hearing before Palmetto GBA's hearing officer. The request must be in writing. The person may combine claims that have been reviewed or reopened within the past six months, to meet the \$100 requirement.

The person should complete Form G-791 (original only) or submit a statement with the same facts. A copy of the informal review should be attached as should any



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additional evidence. Send the request to the Palmetto GBA office which conducted the informal review.

Palmetto GBA selects a person to act as a hearing officer. The person is usually an attorney, but does not have had any previous involvement in the case. The hearing officer notifies the beneficiary of the time and place of the hearing, the specific issues to be resolved, the person's right to counsel or other representation, the right to bring witnesses, the importance of bringing all evidence and the necessity of promptly notifying the hearing officer in writing if the person has any objections. After the hearing, the hearing officer will make a decision and a copy will be mailed to the person.

If the person does not wish to appear or have a representative appear at the hearing, he/she must waive this right in writing. The statement of waiver must be sent to the hearing officer. The hearing officer will then make a decision based on the evidence previously submitted. A copy of the decision will be mailed to the person.

- Administrative Law Judge (ALJ) Hearing - If the person disagrees with The Palmetto GBA hearing officer's decision and the amount remaining in question is \$500 or more, they have 60 days from the date they received the decision to request a hearing before an Administrative Law Judge. They may combine claims that have had a hearing decision within the past 60 days to meet the \$500 requirement. Cases involving \$1,000 or more can eventually be appealed to a Federal Court.

A request for an ALJ hearing can be made by submitting a written signed statement. Requests for Part B ALJ hearings should be forwarded to:

Centers for Medicare & Medicaid Services
Medicare Hearing Work Group
P. O. Box 26683
Baltimore, Maryland 21207

CMS controls requests and forwards them to a designated ALJ through SSA's Office of Hearing and Appeals. Any subsequent development will be handled by the ALJ assigned to the case.



3.1.115 Appealing Decisions Made By Health Maintenance Organizations (HMOs)

Reconsideration

If a person has Medicare coverage through an HMO, the HMO will make decisions about coverage and payment for services. A Notice of Initial Determination (NID) is given to a beneficiary when their HMO denies payment for Medicare-covered services or refuses to provide Medicare-covered supplies. In the NID the HMO is required to provide a full explanation of the person's appeal rights.

If a person believes that the decision their HMO made was not correct, they have the right to ask for reconsideration. Reconsideration of an HMO's decision is a two-stage process.

A. Stage 1

A request for reconsideration must be filed within 60 days of the date on the NID. The request must be in writing. The person may file the reconsideration request with the HMO, a Railroad Retirement Board (RRB) field office or RRB headquarters.

Take the following actions if a written request for reconsideration is received at a RRB office.

1. Make a copy of the request.
2. Forward the original request to the beneficiary's HMO. If the correspondence does not show the name and/or address of the HMO, this information can be obtained from the HMO Detail Screen in the Beneficiary Enrollment Retrieval System (BERT). If you need assistance in finding the HMO's name and address, contact the Medicare Section.
3. Forward the copy of the request Operations Programs Support Division to be imaged. In the upper right hand corner of the document write "Reconsideration Request".

The HMO is responsible for reconsidering their initial determination to deny payment or services. If the HMO upholds its original decision or does not rule fully in the person's favor, the HMO will send the person a notice explaining the decision. The notice will also advise the person that they have the right to ask for the decision to be reviewed. The HMO also sends a copy of the decision to the Center for Health Dispute Resolution (CHDR).



B. Stage 2

The CHDR is the contractor selected by the Center for Medicare and Medicaid Services (formerly the Health Care Financing Administration) to perform independent reviews of HMO reconsideration decisions. The CHDR will review the decision and the facts of the person's unpaid claim or denial of service that is in dispute. The CHDR will send the person a notice of its conclusion.

Although the HMO automatically forwards the individual's file and the original reconsideration request to the CHDR, the HMO must still advise an individual of their right to request further review. A person may file a second request for reconsideration with the CHDR, their HMO, or any office of the RRB. The request must be made in writing.

If a second request for reconsideration is received at a RRB office, take the same actions as prescribed for an initial request for reconsideration. The beneficiary's HMO will forward the request to the CHDR.

Appeals

If the person disagrees with a CHDR decision, and the amount in question is \$100 or more, the person has 60 days from receipt of the CHDR's decision to request a hearing before an Administrative Law Judge. Cases involving \$1,000 or more can eventually be appealed to a Federal Court.

A person may file an appeal of the CHDR decision. The appeal must be in writing and be received within 60 days of the date of the notice sent by the CHDR. A person may file an appeal with the CHDR, the HMO or a RRB office.

Take the following actions if a written request for an appeal is received at RRB headquarters or a field office:

1. Make a copy of the request.
2. Forward the original request to the beneficiary's HMO. If the correspondence does not show the name and/or address of the HMO, this information can be obtained from the HMO Detail Screen in the Beneficiary Enrollment Retrieval System (BERT). If you need assistance in finding the HMO's name and address, contact the Medicare Section in PSD. The HMO will forward the request to the administrative law judge.



3. Forward the copy of the request Operations Programs Support Division to be imaged. In the upper right hand corner of the document write "Reconsideration Request".

3.1.120 Medicare Related Systems

RRB's Medicare health insurance computer system is the Medicare Information Recorded, Transmitted, Edited and Logged (MIRTEL) system.

MIRTEL records and maintains Medicare health insurance information for all eligible QRRB's and deemed QRRB's, both aged and disabled. Records are accreted to the MIRTEL file by manual input, mechanical attainment selection, applications adjudicated by RASI and information transmitted from SSA about SS benefits that RRB pays. Information in the MIRTEL file is maintained by manual input, premium payment, validation with the CHICO file and information received from SSA in the screening process and information received from CMS for the State buy-in operation. MIRTEL generates screening records for jurisdictional clearance with SSA, records their reply, generates bills for the collection of Part B premiums or adjusts the monthly benefit to start, stop or change the deduction of the Part B premium and transmits record changes to the Entitlement Database (EDB) in Baltimore.

The MIRTEL file contains a record for all eligible aged and disabled beneficiaries regardless of enrollment or monthly payment status. The record contains information about the beneficiary's current and prior enrollment status, State buy-in information and activity. Addresses will be maintained on MIRTEL only for beneficiaries who pay their premiums by direct remittance. Those MIRTEL records not containing an address will pick up the address from CHICO when it is required for any activity.

The record remains on MIRTEL until the beneficiary dies or there is loss of QRRB status. The MIRTEL record is then dropped 18 months after the date of death or loss of QRRB status.

In addition to the record under the RRB claim number, pseudo numbers are set up as a special cross-reference type record. This cross-reference record will be set up mechanically whenever a record is established with a pseudo number. The record will be mechanically dropped whenever the primary record is dropped. The cross-reference record allows activity from SSA to come in under the pseudo number and be mechanically identified with the RR number and processed.

Information from the MIRTEL file may be obtained from two sources:

- CRT Terminal Display - MIRTEL On-Line Inquiry (MOLI) allows direct access to selected data in the MIRTEL file through CRT terminals. MOLI may be used



whenever there is a need for current Medicare status information. Any new data entered into MIRTEL during a night computer run will appear on MOLI.

Both the field office and headquarter's personnel have access to MOLI.

- Microfilm Records
- MIRF - MIRF (MIRTEL film) is a monthly film of all records on MIRTEL. Included are both active and inactive records. When the data on MOLI is questionable, verify the information on the MIRF.
- MMAC - MMAC (Microfilm of MIRTEL activity) is a weekly record of all activity processed in the MIRTEL file. In addition to the activity, the MIRTEL record is shown both before and after the MIRTEL record was updated with the activity.

Field offices do not have access to the microfilm records. Therefore, if the field office believes that the data on MOLI is questionable, they should call MS to have them verify the information on the microfilm records.

3.1.121 CMS's Systems

Field offices do not have access to CMS's systems. If certain information is needed which may be verified by checking one of CMS's systems, the field office should call MS.

- A. Enrollment DataBase (EDB) - In 1991, CMS resigned their Medicare Enrollment functional area. The EDB is the successor to the Health Insurance Master File, which was CMS's centralized source of beneficiary Medicare enrollment information before the EDB was created in 1991.
- B. BERT - BERT is an acronym for an on-line software tool called the Beneficiary Enrollment ReTrieval system. BERT provides authorized users with the on-line capability to search for, access, and review both current and historical Medicare enrollment and entitlement data for a specific beneficiary on EDB.

The beneficiary's information is retrieved by entering a RR claim number or a SS number (SSN) and, optionally, a Beneficiary Identification Code (BIC). The BIC is the symbol and prefix for the RR claim number or the BIC at the end of the SSN. When only a RR claim number or a SSN is entered, BERT displays limited identification information for all beneficiaries associated with the RR claim number or the SSN. When both a RR claim number or a SSN and BIC are entered, BERT retrieves the enrollment record for the individual claimant identified by that RR claim number or SSN and BIC combination. A RR claim



number or a SSN and BIC combination is also called the Medicare health insurance claim number.

- C. ERNIE - ERNIE is an extension of BERT and an acronym for an on-line software tool called the Enrollment Retrieval New Interactive Edit. ERNIE was designed to update beneficiary Medicare enrollment information.

Changes applied to ERNIE are immediately applied to the EDB. Updates, like changes to a beneficiary's Part A effective date, are applied to the EDB by ERNIE and forwarded to other systems where applicable. ERNIE shares changed information with the Common Working File (CWF), SSA, RRB and CMS's Group Health Plan (GHP) and Third Party Systems.

When ERNIE facilitates changes to beneficiary information found on EDB, ERNIE relies on BERT to retrieve information from EDB. BERT performs the retrievals of data that ERNIE acts upon. It is BERT that decides whether an accretion of a new beneficiary record will be allowed. ERNIE is only accessible from BERT because BERT must retrieve the beneficiary record.

MS can make limited changes to the EDB through ERNIE. These limited changes are changes that could be made using CMS's forms, such as to remove a date of death, change a date of birth, etc. The majority of changes to EDB are done through the MIRTEL system.

- C. Common Working File (CWF) - RRB is not directly involved in handling Medicare claims or the payment of Medicare claims for services performed within the U.S. The CWF is a Medicare Part A/Part B benefit coordination and pre-payment claims validation system which uses localized databases maintained by designated contractors (Host sites). The Host site provides Medicare intermediaries and carriers (also know as satellites) with beneficiary entitlement and utilization data.

Under the CWF, the country is divided into nine processing sectors. A Host site runs the system for each sector and maintains a database with information on all Medicare beneficiaries assigned to the sector. Each Medicare intermediary and carrier is a satellite in an assigned sector. Generally, the sectors were made on a geographic basis. However, there are some exceptions to this geographic alignment for processing considerations. All QRRB's are housed in the south sector.

When a beneficiary receives Part A/Part B services, the provider of services (e.g., hospital, skilled nursing facility, hospice, home health agency, doctor or various suppliers of services) starts the claim process by submitting a bill/claim



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to, for Part A claims, to its intermediary and for Part B claims, to the Part B carrier. The intermediary or the Part B carrier reviews the bill/claim and enters it into their system. The intermediary or the Part B carriers' history is updated and the bill/claim is also transmitted to the CWF Host site. This is usually done overnight. The CWF Host site edits the bill/claim for validity, entitlement, remaining benefits and deductible status.

The CWF Host site compares the data on the bill/claim to the beneficiary's utilization shown on the CWF Master File. The CWF Host site transmits a reply back to the intermediary or the Part B carrier within 24 hours of receipt of the bill/claim. If the bill/claim is correct, the Host site will advise the intermediary or the Part B carrier to make payment. If the bill/claim is incorrect, the Host site notifies the intermediary or the Part B carrier by correcting the bill (automatic adjustment) or reject (utilization reject).

The intermediary or the Part B carrier, upon notice from the CWF Host site, takes the indicated action to either pay the bill/claim as entered, pay the bill/claim but make an adjustment, deny the claim or wait because the CWF does not currently have the information needed to determine if the bill/claim can be paid.

The intermediary or the Part B carrier will also send the notification of payment, denial, etc. to the beneficiary.

The Host site is also in daily communication with CMS. It sends updated information to be added to CMS's EDB. It also receives updated beneficiary information from CMS which it uses to update its database.

The entitlement information on the CWF is established or updated when RRB establishes or changes a EDB record for a beneficiary.

Exhibits

Exhibit 1 - Legislative History Provisions

7-1-66	Established health insurance program (Medicare) for people age 65 or older and insured under the SS Act or the RR Act. Eligible insured individuals may enroll for Part A three months before age 65 and any time thereafter. No premium for Part A. Eligible individuals may enroll for Part B during their IEP or in a GEP within
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	<p>three years of their IEP. Part B is voluntary with a monthly premium.</p> <p>After Part A is terminated twice, an individual cannot re-enroll.</p> <p>Eligibility determinations and enrollment under both parts is the responsibility of both SSA and RRB.</p>
1-1-73	<p>Three year limitation for enrollment in Part B following the individual's IEP eliminated.</p>
2-1-73	<p>RRB received legislative authority to enroll and collect medical insurance premiums for all QRRB's entitled to annuities.</p>
7-1-73	<p>Coverage extended to disabled beneficiaries under age 65. Eligibility determinations and enrollment the responsibility of SSA and of RRB for all QRRB's.</p> <p>Coverage extended to individuals with chronic renal disease. Eligibility determinations and enrollment of all applicants the responsibility of SSA. EXCEPTION: When RRB is paying a social security benefit, RRB will enroll the individual for chronic renal disease (this is after SSA made eligibility, entitlement, etc. determinations) even though the individual may not be eligible based on the regular disability or aged provisions.</p> <p>Coverage extended to uninsured individuals on a voluntary basis. Eligibility determinations and enrollment of all applicants the responsibility of SSA. In addition to the premium for Part B, enrollees would pay a premium for Part A. Applicants for premium Part A must file in their IEP or GEP.</p> <p>Established automatic enrollment for Part B for U.S. residents receiving an SS benefit and RR annuity.</p>
1-1-81	<p>A survivor may be reimbursed for unpaid physician's bill.</p>
4-1-81	<p>The GEP (January through March) eliminated. An individual may enroll for Part B in his IEP and any time thereafter.</p>
10-1-81	<p>The GEP from January through March of each year was re-established.</p> <p>Only expenses in the current calendar year may be considered in meeting the Part B deductible.</p>
1-1-83	<p>Federal service after 12-31-82 can be used to qualify a person for Part A and Part B.</p>



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	<p>Passage of the Working Aged Provision requiring employer to provide the same group health insurance coverage to both age 65 working individuals and those younger, if the employer consists of 20 or more employees. Also, Medicare became secondary payer of benefits in these instances.</p> <p>The Deficit Reduction Act of 1984 provided premium surcharge relief, retroactive to 1-1-83, to those affected by the Working Aged Provision.</p>
5-1-86	<p>Changes affecting the SEP eliminated the requirement that the individual previously enroll for Part A to be eligible for a SEP. A retroactive adjustment was made to remove those months which could not previously be excluded from the premium penalty calculation because of non-enrollment for Part A. Also, the EGHP could be based on being the worker or the spouse of a worker any age, not under age 70.</p>
1-1-87	<p>Working Aged Provision extends coverage to disabled individuals, if certain requirements are met. This coverage is limited to the period between 1-1-87 and 12-31-91 as set by law. This period of coverage is commonly referred to as the "sunset provision."</p>
1-1-89	<p>First year of implementation of the Medicare Catastrophic Coverage Act of 1988 provided the following:</p> <ul style="list-style-type: none">• Annual Part A deductible imposes one time each year. Benefit periods eliminated.• Protection against back-to-back payment of the Part A deductible for December/January of any year beginning December 1988.• Part A provides expanded skilled nursing care and home health care.• Establishment of a supplemental catastrophic premium to be based on an individual's income tax liability and collected by the IRS.• Establishment of a Part B catastrophic component based on residency to be collected with the Part B Medicare premium. There were 3 categories of enrollees: residents of Puerto Rico (\$1.30), residents of other U.S. Commonwealth/Territories (\$2.10) and all others (\$4.00).• Out-of-pocket medical expenses covered under Part B limited to \$1370.00. The annual Part B deductible, 20% coinsurance of reasonable charges and the Part B blood deductible applied to this



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	<p>limit. Any amount that exceeded reasonable charges was excluded and had to be paid by the beneficiary.</p> <ul style="list-style-type: none">• Home health care coverage increased to allow up to seven days a week for 38 days under Part B.• Mammography screening provided for elderly and disabled beneficiary under Part B.• Coverage provided for home IV drugs (\$550.00 deductible and 20% coinsurance) and immunosuppressive drugs used in the second year after transplant (\$550.00 deductible and 50% coinsurance for immunosuppressives).• Part B covers drugs other than IV drugs and immunosuppressives (\$600.00 deductible and 50% coinsurance applied to these other drugs). <p>Coinsurance for drug coverage under Part B was reduced to 40%, and the deductible was \$652.00.</p> <p>Coinsurance for drug coverage under Part B was reduced to 20% and the deductible was later to be determined.</p>
1-1-90	Implementation of the Medicare Catastrophic Repeal Act of 1989, restored Medicare benefits to levels prior to January 1, 1989.
7-1-90	Starting 7-1-90, disabled employees and their spouses can qualify for an SEP based on coverage under either an EGHP or LGHP as an active individual. Disabled children are still required to be covered under a LGHP.
9-1-90	Doctors or the companies that furnish medical supplies and equipment are required to prepare and submit Part B claims for beneficiaries.
11-26-91	Sunset provision for SEP for the disabled was extended to 9-30-95.

Exhibit 2 - Medicare Premium Freeze

1973 MEDICARE PREMIUM FREEZE

- A. Premium Freeze - Premiums were increased for the period starting July 1, 1973, even though they were covered by the price freeze in effect at that time. It was later announced that the 7-1-73 rates would remain in effect through 8-12-73. It was also announced that rates that were erroneously put into effect on 7-1-73



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would actually be by the rates for the period beginning 8-13-73. From an operational standpoint, it was necessary to arrive at a single rate for August 1973 for computational purposes. This rate was \$6.10 and was referred to as a "simulated" rate. Effective 9-1-73, the monthly premium rates increased to \$6.30 and the comparable increases for late filing.

- B. Freeze Adjustment - The overcharge of premiums for July and August was refunded by increasing the December 1, 1973 annuity checks or by reducing bills for direct payees and third party payers. The following tables show the refunds for each month:

REFUNDS FOR JULY 1973

	CORRECT RATE	RATE CHARGED	REFUND
Basic	\$5.80	\$6.30	.50
10%	6.40	6.90	.50
20%	7.00	7.60	.60
30%	7.50	8.20	.70
40%	8.10	8.80	.70
50%	8.70	9.50	.80
60%	9.30	10.10	.80

REFUNDS FOR AUGUST 1973

	CORRECT RATE	RATE CHARGED	REFUND
Basic	\$6.10	\$6.30	.20
10%	6.70	6.90	.20
20%	7.30	7.60	.30



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30%	7.90	8.20	.30
40%	8.50	8.80	.30
50%	9.20	9.50	.30
60%	9.80	10.10	.30

The cases that were not mechanically adjusted in the mass premium rollback adjustment of December 1973, were identified in the claim folder by a pink 805 form, headed "Possible Rollback - Possible Refund."

Manual handling was taken if a refund was to be made. A refund was not made unless an annuity payment (recurring or lump sum) was being made to an eligible individual. In such cases, the pink 805 was noted "Refund Amt" was added to the award computation and the adjustment was explained in the award letter.

The folder was routed to the Medicare section for a transfer of the funds.

A manual refund of the "Refund Amt" was not made if an annuity payment was not being adjusted unless a specific claim for the refund was made. Then, a Form G-804 was prepared.

Exhibit 3 - Part B Premium Rates Prior To 1-1-89

TABLE USED FOR ALL ENROLLEES FROM 7/66 THROUGH 12/88

EFF DATE	7-66	4-68	7-68	7-69	7-70
BASIC	3.00	4.00	4.00	4.00	5.30
10%			4.40	4.40	5.80
20%				4.80	6.40
30%					6.90

EFF DATE	7-71	7-72	7-73	8-73	9-73
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BASIC	5.60	5.80	5.80	6.10	6.30
10%	6.20	6.40	6.40	6.70	6.90
20%	6.70	7.00	7.00	7.30	7.60
30%	7.30	7.50	7.50	7.90	8.20
40%	7.80	8.10	8.10	8.50	8.80
50%		8.70	8.70	9.20	9.50
60%			9.30	9.80	10.10

EFF DATE	7-74	7-75	7-76	7-77	7-78
BASIC	6.70	6.70	7.20	7.70	8.20
10%	7.40	7.40	7.90	8.50	9.00
20%	8.00	8.00	8.60	9.20	9.80
30%	8.70	8.70	9.40	10.00	10.70
40%	9.40	9.40	10.10	10.80	11.50
50%	10.10	10.10	10.80	11.60	12.30
60%	10.70	10.70	11.50	12.30	13.10
70%	11.40	11.40	12.20	13.10	13.90
80%		12.10	13.00	13.90	14.80
90%			13.70	14.60	15.60
100%				15.40	16.40
110%					17.20



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EFF DATE	7-79	7-80	7-81	7-82	7-83
BASIC	8.70	9.60	11.00	12.20	12.20
10%	9.60	10.60	12.10	13.40	13.40
20%	10.40	11.50	13.20	14.60	14.60
30%	11.30	12.50	14.50	15.90	15.90
40%	12.20	13.40	15.40	17.10	17.10
50%	13.10	14.40	16.50	18.30	18.30
60%	13.90	15.40	17.60	19.50	19.50
70%	14.80	16.30	18.70	20.70	20.70
80%	15.70	17.30	19.80	22.00	22.00
90%	16.50	18.20	20.90	23.20	23.20
100%	17.40	19.20	22.00	24.20	24.40
110%	18.30	20.20	23.10	25.60	25.60
120%	19.10	21.10	24.20	26.80	26.80
130%		22.10	25.30	28.10	28.10
140%			26.40	29.30	29.30
150%				30.50	30.50
160%					31.70

EFF DATE	1-84	7-84	1-85	7-85	7-86
BASIC	14.60	14.60	15.50	15.50	15.50
10%	16.10	16.10	17.10	17.10	17.10



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20%	17.50	17.50	18.60	18.60	18.60
30%	19.00	19.00	20.20	20.20	20.20
40%	20.40	20.40	21.70	21.70	21.70
50%	21.90	21.90	23.30	23.30	23.30
60%	23.40	23.40	24.80	24.80	24.80
70%	24.80	24.80	26.40	26.40	26.40
80%	26.30	26.30	27.90	27.90	27.90
90%	27.20	27.20	29.50	29.50	29.50
100%	29.20	29.20	31.00	31.00	31.00
110%	30.70	30.70	32.60	32.60	32.60
120%	32.10	32.10	34.10	34.10	34.10
130%	36.60	36.60	35.70	35.70	35.70
140%	35.00	35.00	37.20	37.20	37.20
150%	36.50	36.50	38.80	38.80	38.80
160%	38.00	38.00	40.30	40.30	40.30
170%	41.90	41.90	41.90	41.90	41.90
180%				43.40	43.40
190%					45.00

EFF DATE	1-87	7-87	1-88	7-88
BASIC	17.90	17.90	24.80	24.80
10%	19.70	19.70	27.30	27.30



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20%	21.50	21.50	29.80	29.80
30%	23.30	23.30	32.20	32.20
40%	25.10	25.10	34.70	34.70
50%	26.90	26.90	37.20	37.20
60%	28.60	28.60	39.70	39.70
70%	30.40	30.40	42.20	42.20
80%	32.20	32.20	44.60	44.60
90%	34.00	34.00	47.10	47.10
100%	35.80	35.80	49.60	49.60
110%	37.60	37.60	52.10	52.10
120%	39.40	39.40	54.60	54.60
130%	41.20	41.20	57.00	57.00
140%	43.00	43.00	59.50	59.50
150%	44.80	44.80	62.00	62.00
160%	46.50	46.50	64.50	64.50
170%	48.30	48.30	67.00	67.00
180%	50.10	50.10	69.40	69.40
190%	51.90	51.90	71.90	71.90
200%		53.70	74.40	74.40
210%				76.90

Exhibit 4 - Part B Premium Rates For 1989

PREMIUM RATES FOR THE THREE RESIDENCY TABLES FOR 1989



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	See 1 below	See 2 below	See 3 below
Basic Rate	\$31.90	\$29.20	\$30.00
10%	35.10	32.10	33.00
20%	38.30	35.00	36.00
30%	41.50	38.00	39.00
40%	44.70	40.90	42.00
50%	47.90	43.80	45.00
60%	51.00	46.70	48.00
70%	54.20	49.60	51.00
80%	57.40	52.60	54.00
90%	60.60	55.50	57.00
100%	63.80	58.40	60.00
110%	67.00	61.30	63.00
120%	70.20	64.20	66.00
130%	73.40	67.20	69.00
140%	76.60	70.10	72.00
150%	79.80	73.00	75.00
160%	82.90	75.90	78.00
170%	86.10	78.80	81.00
180%	89.30	81.80	84.00
190%	92.50	84.70	87.00
200%	95.70	87.60	90.00



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210%	98.90	90.50	93.00
220%	102.10	93.40	96.00

- 1) Rates used for all enrollees except residents of Puerto Rico and U.S. Commonwealth/Territories, the basic premium without penalty consisted of a \$27.90 age/disabled component and a \$4.00 catastrophic component.
- 2) Rates used for all enrollees who are residents of Puerto Rico, the basic premium without penalty consisted of a \$27.90 age/disabled component and a \$1.30 catastrophic component.
- 3) Rates used for all enrollees who are residents of American Samoa, Virgin Islands and Northern Mariana Islands, the basic premium without penalty consisted of a \$27.90 age/disabled component and a \$2.10 catastrophic component.

Exhibit 5 - Part B Premium Rates For 1-90 Thru Current

FOM, PART I, ARTICLE 8 - APPENDIX E RCM 3.1

RATES FOR ALL ENROLLEES

Eff. Date	1-2008
Basic	96.40
10%	106.00
20%	115.70
30%	125.30
40%	135.00
50%	144.60
60%	154.20
70%	163.90
80%	173.50
90%	183.20



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100%	192.80
110%	202.40
120%	212.10
130%	221.70
140%	231.40
150%	241.00
160%	250.60
170%	260.30
180%	269.90
190%	279.60
200%	289.20
210%	298.80
220%	308.50
230%	318.10
240%	327.80
250%	337.40
260%	347.00
270%	356.70
280%	366.30
290%	376.00
300%	385.60
310%	395.20



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320%	404.90
330%	414.50
340%	424.20
350%	433.80
360%	443.40
370%	453.10
380%	462.70
390%	472.40
400%	482.00
410%	491.60

Eff. Date	1-2007	1-2006	1-2005	1-2004	1-2003	1-2002
Basic	93.50	\$ 88.50	\$ 78.20	\$ 66.60	\$ 58.70	\$54.00
10%	102.90	97.40	86.00	73.30	\$ 64.60	\$59.40
20%	112.20	106.20	93.80	79.90	\$ 70.40	\$64.80
30%	121.60	115.10	101.70	86.60	\$ 76.30	\$70.20
40%	130.90	123.90	109.50	93.20	\$ 82.20	\$75.60
50%	140.30	132.80	117.30	99.90	\$ 88.10	\$81.00
60%	149.60	141.60	125.10	106.60	\$ 93.90	\$86.40
70%	159.00	150.50	132.90	113.20	\$ 99.80	\$91.80
80%	168.30	159.30	140.80	119.90	\$105.70	\$97.20
90%	177.70	168.20	148.60	126.50	\$111.50	\$102.60



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100%	187.00	177.00	156.40	133.20	\$117.40	\$108.00
110%	196.40	185.90	164.20	139.90	\$123.30	\$113.40
120%	205.70	194.70	172.00	146.50	\$129.10	\$118.80
130%	215.10	203.60	179.90	153.20	\$135.00	\$124.20
140%	224.40	212.40	187.70	159.80	\$140.90	\$129.60
150%	233.80	221.30	195.50	166.50	\$146.80	\$135.00
160%	243.10	230.10	203.30	173.20	\$152.60	\$140.40
170%	252.50	239.00	211.10	179.80	\$158.50	\$145.80
180%	261.80	247.80	219.00	186.50	\$164.40	\$151.20
190%	271.20	256.70	226.80	193.10	\$170.20	\$156.60
200%	280.50	265.50	234.60	199.80	\$176.10	\$162.00
210%	289.90	274.40	242.40	206.50	\$182.00	\$167.40
220%	299.20	283.20	250.20	213.10	\$187.80	\$172.80
230%	308.60	292.10	258.10	219.80	\$193.70	\$178.20
240%	317.90	300.90	265.90	226.40	\$199.60	\$183.60
250%	327.30	309.80	273.70	233.10	\$205.50	\$189.00
260%	336.60	318.60	281.50	239.80	\$211.30	\$194.40
270%	346.00	327.50	289.30	246.40	\$217.20	\$199.80
280%	355.30	336.30	297.20	253.10	\$223.10	\$205.20
290%	364.70	345.20	305.00	259.70	\$228.90	\$210.60
300%	374.00	354.00	312.80	266.40	\$234.80	\$216.00
310%	383.40	362.90	320.60	273.10	\$240.70	\$221.40



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320%	392.70	371.70	328.40	279.70	\$246.50	\$226.80
330%	402.10	380.60	336.30	286.40	\$252.40	\$232.20
340%	411.40	389.40	344.10	293.00	\$258.30	\$237.60
350%	420.80	398.30	351.90	299.70	\$264.20	\$243.00
360%	430.10	407.10	359.70	306.40	\$270.00	
370%	439.50	416.00	367.50	313.00		
380%	448.80	424.80	375.40			
390%	458.20	433.70				
400%	467.50					

Eff. Date	1-2001	1-2000	1-99	1-98	1-97	1-96
Basic	\$ 50.00	\$ 45.50	\$ 45.50	\$ 43.80	\$ 43.80	\$ 42.50
10%	\$ 55.00	\$ 50.10	\$ 50.10	\$ 48.20	\$ 48.20	\$ 46.80
20%	\$ 60.00	\$ 54.60	\$ 54.60	\$ 52.60	\$ 52.60	\$ 51.00
30%	\$ 65.00	\$ 59.20	\$ 59.20	\$ 56.90	\$ 56.90	\$ 55.30
40%	\$ 70.00	\$ 63.70	\$ 63.70	\$ 61.30	\$ 61.30	\$ 59.50
50%	\$ 75.00	\$ 68.30	\$ 68.30	\$ 65.70	\$ 65.70	\$ 63.80
60%	\$ 80.00	\$ 72.80	\$ 72.80	\$ 70.10	\$ 70.10	\$ 68.00
70%	\$ 85.00	\$ 77.40	\$ 77.40	\$ 74.50	\$ 74.50	\$ 72.30
80%	\$ 90.00	\$ 81.90	\$ 81.90	\$ 78.80	\$ 78.80	\$ 76.50
90%	\$ 95.00	\$ 86.50	\$ 86.50	\$ 83.20	\$ 83.20	\$ 80.80
100%	\$100.00	\$ 91.00	\$ 91.00	\$ 87.60	\$ 87.60	\$ 85.00



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110%	\$105.00	\$ 95.60	\$ 95.60	\$ 92.00	\$ 92.00	\$ 89.30
120%	\$110.00	\$100.10	\$100.10	\$ 96.40	\$ 96.40	\$ 93.50
130%	\$115.00	\$104.70	\$104.70	\$100.70	\$100.70	\$ 97.80
140%	\$120.00	\$109.20	\$109.20	\$105.10	\$105.10	\$102.00
150%	\$125.00	\$113.80	\$113.80	\$109.50	\$109.50	\$106.30
160%	\$130.00	\$118.30	\$118.30	\$113.90	\$113.90	\$110.50
170%	\$135.00	\$122.90	\$122.90	\$118.30	\$118.30	\$114.80
180%	\$140.00	\$127.40	\$127.40	\$122.60	\$122.60	\$119.00
190%	\$145.00	\$132.00	\$132.00	\$127.00	\$127.00	\$123.30
200%	\$150.00	\$136.50	\$136.50	\$131.40	\$131.40	\$127.50
210%	\$155.00	\$141.10	\$141.10	\$135.80	\$135.80	\$131.80
220%	\$160.00	\$145.60	\$145.60	\$140.20	\$140.20	\$136.00
230%	\$165.00	\$150.20	\$150.20	\$144.50	\$144.50	\$140.30
240%	\$170.00	\$154.70	\$154.70	\$148.90	\$148.90	\$144.50
250%	\$175.00	\$159.30	\$159.30	\$153.30	\$153.30	\$148.80
260%	\$180.00	\$163.80	\$163.80	\$157.70	\$157.70	\$153.00
270%	\$185.00	\$168.40	\$168.40	\$162.10	\$162.10	\$157.30
280%	\$190.00	\$172.90	\$172.90	\$166.40	\$166.40	\$161.50
290%	\$195.00	\$177.50	\$177.5	\$170.80	\$170.80	\$165.80
300%	\$200.00	\$182.00	\$182.00	\$175.20	\$175.20	
310%	\$205.00	\$186.60	\$186.60	\$179.60		
320%	\$210.00	\$191.10	\$191.10			



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330%	\$215.00	\$195.70				
340%	\$220.00					

Eff. Date	1-95	1-94	1-93	1-92	1-91	1-90
Basic	46.10	41.10	36.60	31.80	29.90	28.60
10%	50.70	45.20	40.30	35.00	32.90	31.50
20%	55.30	49.30	43.90	38.20	35.90	34.30
30%	59.90	53.40	47.60	41.30	38.90	37.20
40%	64.50	57.50	51.20	44.50	41.90	40.00
50%	69.20	61.70	54.90	47.70	44.90	42.90
60%	73.80	65.80	58.60	50.90	47.80	45.80
70%	78.40	69.90	62.20	54.10	50.80	48.60
80%	83.00	74.00	65.90	57.20	53.80	51.50
90%	87.60	78.10	69.50	60.40	56.80	54.30
100%	92.20	82.20	73.20	63.60	59.80	57.20
110%	96.80	86.30	76.90	66.80	62.80	60.10
120%	101.40	90.40	80.50	70.00	65.80	62.90
130%	106.00	94.50	84.20	73.10	68.80	65.80
140%	110.60	98.60	87.80	76.30	71.80	68.60
150%	115.30	102.80	91.50	79.50	74.80	71.50
160%	119.90	106.90	95.20	82.70	77.70	74.40
170%	124.50	111.00	98.80	85.90	80.70	77.20



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180%	129.10	115.10	102.50	89.00	83.70	80.10
190%	133.70	119.20	106.10	92.20	86.70	82.90
200%	138.30	123.30	109.80	95.40	89.70	85.80
210%	142.90	127.40	113.50	98.60	92.70	88.70
220%	147.50	131.50	117.10	101.80	95.70	91.50
230%	152.10	135.60	120.80	104.90	98.70	94.40
240%	156.70	139.70	124.40	108.10	101.70	
250%	161.40	143.90	128.10	111.30		
260%	166.00	148.00	131.80			
270%	170.60	152.10				
280%	175.20					

Effective 1-90, the basic premium without penalty was \$28.60. There is no catastrophic component due to the repeal of the Medicare Catastrophic Coverage Act of 1988. Repeal does not affect premium amounts for 1989. Rates for all three residency tables are the same effective 1-90.

Exhibit 5a – IRMAA (Income Related Monthly Adjustment Amount)

The 2008 income-related monthly adjustment amounts that are included in the Part B monthly premium rates paid by beneficiaries with modified adjusted gross incomes over prescribed thresholds are shown in the following tables. The monthly premium rates paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return are as follows:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$82,000	Less than or equal to \$164,000	\$0.00	\$96.40



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Greater than \$82,000 and less than or equal to \$102,000	Greater than \$164,000 and less than or equal to \$204,000	\$25.80	\$122.20
Greater than \$102,000 and less than or equal to \$153,000	Greater than \$204,000 and less than or equal to \$306,000	\$64.50	\$160.90
Greater than \$153,000 and less than or equal to \$205,000	Greater than \$306,000 and less than or equal to \$410,000	\$103.30	\$199.70
Greater than \$205,000	Greater than \$410,000	\$142.00	\$238.40

The 2008 monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are shown below:

	Income-related monthly adjustment amount	Total monthly premium amount
Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:		
Less than or equal to \$82,000	\$0.00	\$96.40
Greater than \$82,000 and less than or equal to \$123,000	\$103.30	\$199.70
Greater than \$123,000	\$142.00	\$238.40

The 2007 income-related monthly adjustment amounts that are included in the Part B monthly premium rates paid by beneficiaries with modified adjusted gross incomes over prescribed thresholds are shown in the following tables. The monthly premium rates paid by beneficiaries who file an individual tax return (including those who are single, head of household, qualifying widow(er) with dependent child, or married filing separately who lived apart from their spouse for the entire taxable year), or a joint tax return are as follows:

Beneficiaries who file an individual tax return with income:	Beneficiaries who file a joint tax return with income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$80,000	Less than or equal to \$160,000	\$0.00	\$93.50
Greater than \$80,000 and less than or equal to \$100,000	Greater than \$160,000 and less than or equal to \$200,000	\$12.30	\$105.80
Greater than \$100,000 and less than or equal to \$150,000	Greater than \$200,000 and less than or equal to \$300,000	\$30.90	\$124.40



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Greater than \$150,000 and less than or equal to \$200,000	Greater than \$300,000 and less than or equal to \$400,000	\$49.40	\$142.90
Greater than \$200,000	Greater than \$400,000	\$67.90	\$161.40

The 2007 monthly premium rates to be paid by beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate tax return from their spouse, are shown below:

Beneficiaries who are married and lived with their spouse at any time during the year, but file a separate tax return from their spouse:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to \$80,000	\$0.00	\$93.50
Greater than \$80,000 and less than or equal to \$120,000	\$49.40	\$142.90
Greater than \$120,000	\$67.90	\$161.40

Note: The premium rates shown in these tables do not reflect any penalty surcharges that a beneficiary may be required to pay, or any premium reductions that may be made because the beneficiary is enrolled in a Medicare Advantage plan that offers enrollees reduced Part B premiums.

Exhibit 6 - Part A Premium Rates

2008	\$423.00
2007	\$410.00
2006	\$393.00
2005	\$375.00
2004	\$343.00
2003	\$316.00
2002	\$319.00



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2001	\$300.00
2000	\$301.00
1999	\$309.00
1998	\$309.00
1997	\$311.00
1996	\$289.00
1995	\$261.00
1994	\$245.00
1993	\$221.00

Exhibit 7 - Deductible & Coinsurance Amounts – Part A and Part B

Note: SNF = Skilled Nursing Facility

	2008
Inpatient hospital deductible	\$1,024.00
Daily Coinsurance 61 st through 90 th day	256.00
Daily Coinsurance for each reserve day used	512.00
Daily Coinsurance 21 st through 100 th day in SNF	128.00

	2007	2006	2005	2004
Inpatient hospital deductible	\$992.00	\$952.00	\$912.00	\$876.00
Daily Coinsurance 61 st through 90 th day	248.00	238.00	228.00	219.00
Daily Coinsurance for each reserve day used	496.00	476.00	456.00	438.00
Daily Coinsurance 21 st through 100 th day in SNF	124.00	119.00	114.00	109.50



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	2003	2002	2001	2000
Inpatient hospital deductible	\$840.00	\$812.00	\$792.00	\$776.00
Daily Coinsurance 61st through 90th day	210.00	203.00	198.00	194.00
Daily Coinsurance for each reserve day used	420.00	406.00	396.00	388.00
Daily Coinsurance 21st through 100th day in SNF	105.00	101.50	99.00	97.00

	1999	1998	1997	1996
Inpatient hospital deductible	\$768.00	\$764.00	\$760.00	\$736.00
Daily Coinsurance 61st through 90th day	192.00	191.00	190.00	184.00
Daily Coinsurance for each reserve day used	384.00	382.00	380.00	368.00
Daily Coinsurance 21st through 100th day in SNF	96.00	95.50	95.00	92.00

	1995	1994	1993	1992
Inpatient hospital deductible	\$716.00	\$696.00	\$676.00	\$652.00
Daily Coinsurance 61st through 90th day	179.00	174.00	169.00	163.00
Daily Coinsurance for each reserve day used	358.00	348.00	338.00	326.00
Daily Coinsurance 1st through 100th day in SNF	89.50	87.00	84.50	81.50

	1991	1990	1989	1988
Inpatient hospital deductible	\$628.00	\$592.00	\$560.00	\$540.00



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Daily Coinsurance 61st through 90th day	157.00	148.00	N/A	135.00
Daily Coinsurance for each reserve day used	314.00	296.00	N/A	270.00
Daily Coinsurance 21st through 100th day in SNF	78.50	74.00	N/A	67.50
Daily Coinsurance 1st through 8th day in SNF (1989 ONLY)			25.50	

	1987	1986	1985	1984
Inpatient hospital deductible	\$520.00	\$492.00	\$400.00	\$356.00
Daily Coinsurance 61st through 90th day	130.00	123.00	100.00	89.00
Daily Coinsurance for each reserve day used	260.00	246.00	200.00	178.00
Daily Coinsurance 21st through 100th day in SNF	65.00	61.50	50.00	44.50

	1983	1982	1981	1980
Inpatient hospital deductible	\$304.00	\$260.00	\$204.00	\$180.00
Daily Coinsurance 61st through 90th day	76.00	65.00	51.00	45.00
Daily Coinsurance for each reserve day used	152.00	130.00	102.00	90.00
Daily Coinsurance 21st through 100th day in SNF	38.00	32.50	25.50	22.50

	1979	1978	1977	1976
Inpatient hospital deductible	\$160.00	\$144.00	\$124.00	\$104.00
Daily Coinsurance 61st through 90th day	40.00	36.00	31.00	26.00



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Daily Coinsurance for each reserve day used	80.00	72.00	62.00	52.00
Daily Coinsurance 21st through 100th day in SNF	20.00	18.00	15.50	13.00

	1975	1974	1973	1972
Inpatient hospital deductible	\$92.00	\$84.00	\$72.00	\$68.00
Daily Coinsurance 61st through 90th day	23.00	21.00	18.00	17.00
Daily Coinsurance for each reserve day used	46.00	24.00	36.00	34.00
Daily Coinsurance 21st through 100th day in SNF	11.50	10.50	9.00	8.50

	1971	1970	1969	7-66 thru 1968
Inpatient hospital deductible	\$60.00	\$52.00	\$44.00	\$40.00
Daily Coinsurance 61st through 90th day	15.00	13.00	11.00	10.00
Daily Coinsurance for each reserve day used	30.00	26.00	22.00	20.00
Daily Coinsurance 21st through 100th day in SNF	7.50	6.50	5.50	5.00

PART B DEDUCTIBLE

2008	\$135.00
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2007	\$131.00
2006	\$124.00
2005	\$110.00
1991 thru 2004	\$100.00
1982 thru 1990	\$ 75.00
1973 thru 1981	\$ 60.00
1966 thru 1972	\$ 50.00

Exhibit 10 - Hospital Benefits In 1989

Hospital Benefits - January 1, 1989 - December 31, 1989

- A. Inpatient Hospital Services - Under the provisions of the Medicare Catastrophic Coverage Act of 1988, the "benefit period" was eliminated as a way of measuring the use of services under Part B. Effective January 1, 1989, the "benefit period" was replaced with a single annual deductible. Medicare paid for unlimited medically necessary inpatient hospital care after the annual deductible was paid.

A "carry-over" rule prevented the payment of back-to-back deductible amounts in December and January. If an individual paid a hospital deductible in December 1988, no additional deductible was required if he was still a patient in or was readmitted to a hospital in January 1989.

Because of the Repeal of the Medicare Catastrophic Coverage Act of 1988, the following exceptions apply:

For hospital services provided in 1990 and later, no day before January 1, 1990 can be used in determining the beginning of a benefit period. For example, if an individual was hospitalized for 6 days in December of 1989 and still was in the hospital or was readmitted to a hospital in January of 1990, a new "benefit period" began the first day in 1990 that the person was in the hospital. A new 90 days of coverage was granted.

"Lifetime reserve days" used before January 1, 1989, are counted with "lifetime reserve days" used after December 31, 1989, in determining if the 60 day limit was used. No "lifetime reserve days" were charged for 1989.



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The hospital deductible did not apply for services provided January 1, 1990 or later, if:

- an individual was receiving inpatient hospital services during a continuous period beginning before and including January 1, 1990, and a deductible was imposed in 1989; or
- a "benefit period" began in January 1990 and a deductible was imposed for a period of hospitalization that began in December 1989; or
- a "benefit period" began before January 1, 1989, and did not end on January 1, 1990.

B. Skilled Nursing Facility (SNF) Services - Under the provisions of the Medicare Catastrophic Coverage Act of 1988, the post hospitalization requirements were eliminated. Effective January 1, 1989, Part A helped pay for inpatient care in a Medicare certified SNF if both of the following conditions were met:

- a doctor certified that the care was needed and the patient actually received skilled nursing or skilled rehabilitation services on a daily basis; and
- the Medicare intermediary or the facility's Utilization Review Committee did not disapprove the stay.

Part A helped pay for up to 150 days in a calendar year. For the first eight days of care during the year, Part A paid for all allowable expenses except the daily coinsurance amount. (See Exhibit 7 for a list of SNF coinsurance amounts.) Part A paid all other allowable charges for up to 150 days even if the patient is discharged and readmitted to a SNF more than once during the year.

NOTE: The requirements for post-hospitalization did not apply to an individual receiving extended care services from a SNF during a continuous period beginning before (and including) January 1, 1990, until the end of the 30 consecutive day period in which the individual is not provided inpatient hospital or extended care services.

Exhibit 11 - An Important Message From Medicare

YOUR RIGHTS WHILE YOU ARE A MEDICARE HOSPITAL PATIENT

You have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. According to Federal law, your



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discharge date must be determined solely by your medical needs, not by "DRGs" or Medicare payments.

You have the right to be fully informed about decisions affecting your Medicare coverage and payment for your hospital stay and for post-hospital services.

You have the right to request a review by a Peer Review Organization of any written Notice of Noncoverage that you receive from the hospital stating the Medicare will no longer pay for your hospital care. Peer Review Organizations (PRO's) are groups of doctors who are paid by the Federal Government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients. The phone number and address of the PRO for your area are:

TALK TO YOUR DOCTOR ABOUT YOUR STAY IN THE HOSPITAL

You and your doctor know more about your condition and your health needs than anyone else. Decisions about your medical treatment should be made between you and your doctor. If you have any questions about your medical treatment, your need for continued hospital care, your discharge, or your need for possible post-hospital care, don't hesitate to ask your doctor. The hospital's patient representative or social worker will also help you with your questions and concerns about hospital services.

IF YOU THINK YOU ARE BEING ASKED TO LEAVE THE HOSPITAL TOO SOON

Ask a hospital representative for a written notice of explanation immediately, if you have not already received one. This notice is called a "Notice of Noncoverage". You must have this Notice of Noncoverage if you wish to exercise your right to request a review by the PRO.

The Notice of Noncoverage will state either that your doctor or the PRO agrees with the hospital's decision that Medicare will no longer pay for your hospital care.

If the hospital and your doctor agree, the PRO does not review your case before a Notice of Noncoverage is issued. But the PRO will respond to your request for a review of your Notice of Noncoverage and seek your opinion. You cannot be made to pay for your hospital care until the PRO makes its decision, if you request the review by noon of the first work day after you receive the Notice of Noncoverage.

If the hospital and your doctor disagree, the hospital may request the PRO to review your case. If it does make such a request, the hospital is required to send you a notice to that effect. In this situation the PRO must agree with the hospital or the hospital cannot issue a Notice of Noncoverage. You may request that the PRO reconsider your case after you receive a Notice of Noncoverage but since the PRO has already



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reviewed your case once, you may have to pay for at least one day of hospital care before the PRO completes this reconsideration.

IF YOU DO NOT REQUEST A REVIEW, THE HOSPITAL MAY BILL YOU FOR ALL THE COSTS OF YOUR STAY BEGINNING WITH THE THIRD DAY AFTER YOU RECEIVE THE NOTICE OF NONCOVERAGE. THE HOSPITAL, HOWEVER, CANNOT CHARGE YOU FOR CARE UNLESS IT PROVIDED YOU WITH A NOTICE OF NONCOVERAGE.

HOW TO REQUEST A REVIEW OF THE NOTICE OF NONCOVERAGE

If the Notice of Noncoverage states that your physician agrees with the hospital's decision:

You must make your request for review to the PRO by noon of the first work day after you receive the Notice of Noncoverage by contacting the PRO by phone or in writing.

The PRO must ask for your views about your case before making its decision. The PRO will inform you by phone or in writing of its decision on the review.

If the PRO agrees with the Notice of Noncoverage, you may be billed for all costs of your stay beginning at noon of the day after you receive the PRO's decision.

Thus, you will not be responsible for the cost of hospital care before the you receive the PRO's decision.

If the Notice of Noncoverage states that the PRO agrees with the hospital's decision:

You should make your request for reconsideration to the PRO immediately upon receipt of the Notice of Noncoverage by contacting the PRO by phone or in writing.

The PRO can take up to three working days for receipt of your request to complete the review. The PRO will inform you in writing of its decision on the review.

Since the PRO has already reviewed your case once, prior to the issuance of the Notice of Noncoverage, the hospital is permitted to begin billing you for the cost of your stay beginning with the third calendar day after you receive your Notice of Noncoverage even if the PRO has not completed it review.

Thus, if the PRO continues to agree with the Notice of Noncoverage, you may have to pay for at least one day of hospital care.

NOTE: The process described above is called immediate review." If you miss the deadline for this immediate review while you are in the hospital, you may still request a



review of Medicare's decision to no longer pay for your care at any point during your hospital stay or after you have left the hospital. The Notice of Noncoverage will tell you how to request this review.

POST-HOSPITAL CARE

When your doctor determines that you no longer need all the specialized services provided in a hospital, but you still require medical care, he or she may discharge you to a skilled nursing facility or home care. The discharge planner at the hospital will help arrange for the services you may need after your discharge. Medicare and supplemental insurance policies have limited coverage for skilled nursing facility care and home health care. Therefore, you should find out which services will or will not be covered and how payment will be made. Consult with our doctor, hospital discharge planner, patient representative and your family in making preparations for care after you leave the hospital. Don't hesitate to ask question.

ACKNOWLEDGEMENT OF RECEIPT

My signature only acknowledges my receipt of this Message from (name of hospital) on (date) and does not waive any of my rights to request a review or make me liable for any payment.

Signature of beneficiary or (Date of receipt)
 person acting on behalf of beneficiary

Exhibit 12 - Other Publications About Medicare

Guide to Health Insurance for People with Medicare (507-X)	Getting a Second Opinion (536-X)
Discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare and give use hints on shopping for private health insurance. (HCFA-2110)	Explains the importance of getting a second opinion for non-emergency surgery, describes Medicare coverage of costs, and gives suggestions for specialist in your area. (HCFA-02114)



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Hospice Benefits Under Medicare (508-X)	Medicare and Employer Health Plans (586-X)
Describes the scope of medical and support services available to Medicare beneficiaries with terminal illnesses. (HCFA-02154)	Explains the special rules that apply to Medicare beneficiaries who have employer group health plan coverage. (HCFA-02150)
Medicare and Coordinated Care Plans (509-X)	Medicare Coverage of Kidney Dialysis and Kidney Transplant Services: A Supplement to Your Medicare Handbook. (587-X)
Describes the health services available to beneficiaries from HMOs and CMPs. (HCFA-02195)	Describes Medicare benefits for people with chronic kidney disease. (HCFA-10128)

To order a copy of one or more of these free publications, fill out and mail the order form at the bottom of the page to:

Consumer Information Center
Department 59
Pueblo, CO 81009

Supplies may be limited. Allow 6 to 8 weeks for delivery.

Please Cut Here and Mail

Check the booklets you want, fill in your name and address, and sent this order from to:
Consumer Information Center, Department 59, Pueblo, CO 81009

- Guide to Health Insurance for People with Medicare (507-X)
- Hospice Benefits Under Medicare (508-X)
- Medicare and Coordinated Care Plans (509-X)
- Getting a Second Opinion (536-X)



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- Medicare and Employer Health Plans (586-X)
- Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (587-X)

Name _____

Address _____

City _____ State _____ Zip _____

Exhibit 13 - Description Of The Health Maintenance Organization (HMO) / Competitive Medical Plan (CMP) Disenrollment Form HCFA-566

The HCFA-566 is completed by the beneficiary to disenroll from a HMO/CMP at their servicing RRB Field office or at Headquarters.

The form is completed as one original and three copies. A brief description of each copy of the form is listed below:

Original - WHITE COPY - SOCIAL SECURITY OFFICE COPY - This copy will be retained in MS until the HMO disenrollment is processed. Then, it will be matched with the claim folder.

2ND COPY - PINK COPY - REGIONAL OFFICE COPY - This copy is forwarded to CMS's servicing Regional Office.

3RD COPY - YELLOW COPY - HMO/CMP COPY - This copy will be sent to the HMO or CMP.

4TH COPY - GREEN COPY - BENEFICIARY COPY - This copy is to be given to the beneficiary.

Exhibit 14 - HCFA Forms

FOM PART I/ARTICLE 17/1730

HCFA-566(6-97), MEDICARE MANAGED CARE DISENROLLMENT FORM



Complete a Form HCFA-566 whenever a beneficiary wants to cancel coverage with a Health Maintenance Organization (HMO) or a Competitive Medical Plan (CMP) and resume fee-for-service Medicare coverage. Medicare beneficiaries were given an option under Public Law 97-248 to enroll with a prepaid health plan (i.e., HMO/CMP) to cover Medicare benefits. Medicare beneficiaries have the option of disenrolling at an RRB field office (F/O) or directly through the plan.

Form HCFA-566 should not be completed if the beneficiary is changing plans. When a beneficiary enrolls in the new plan, he or she is automatically disenrolled from the old plan. If Form HCFA-566 is completed in this situation, the beneficiary may be disenrolled from the new plan.

For more information about HMOs and CMPs, see FOM-I-805.30 and RCM 3.1.30. For more information about disenrollment, see FOM-I-805.30.4 and RCM 3.1.33.

COMPLETION OF FORM HCFA-566

Form HCFA-566 consists of a Social Security Office original and three copies: REGIONAL OFFICE COPY, HMO/CMP COPY, and BENEFICIARY COPY. All copies, except the beneficiary's copy, should be sent to headquarters for processing.

Contact representatives and headquarters staff who receive written requests should complete items 1-7 under the heading "MEDICARE MANAGED CARE DISENROLLMENT FORM" as shown below:

Item 1	BN	Beneficiary Name - Using the BEN NAME field from the MOLI GD screen, enter up to 12 letters of the beneficiary's last name and up to 12 letters of the beneficiary's first name in the boxes provided. Then enter the first initial of the beneficiary's middle name (if applicable) in the appropriate block.
Item 2	CN	HI Claim Number - Enter the beneficiary's RRB Medicare Health Insurance (HI) claim number (always use the MOLI GD screen to secure the HI claim number). The HI claim number must be converted to a 11-digit number. If the beneficiary was assigned a pseudo number for Medicare, enter the pseudo number in item 2. If you enter a pseudo number, show the RRB claim number in the blank space at the top of the form to enable headquarters to identify the beneficiary.



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	BIC	<p>The entry in the first box in item 2 should be the first digit of the numeric HI claim number converted as follows:</p> <p style="text-align: center;">+</p> <p style="text-align: center;">0 = 0 4 = D</p> <p style="text-align: center;">1 = A 5 = E</p> <p style="text-align: center;">2 = B 6 = F</p> <p style="text-align: center;">3 = C 7 = G</p> <p>If the HI claim number is a six-digit RRB claim number, the entry in the first box would be "0". Immediately above the "0," write a "+" sign.</p> <p>The RRB symbol(s) and prefix must be converted for the entry in these blocks. Convert the HI claim number symbol(s) and prefix to a numeric suffix after the HI claim number as follows:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">A = 10</td> <td style="width: 33%;">MA or XA = 14</td> <td style="width: 33%;">CA = 17</td> </tr> <tr> <td>WA, KA or TA = 16</td> <td>WD, KD or TD = 46</td> <td>PA = 15</td> </tr> <tr> <td>WCD, KCD or TCD = 43</td> <td>H = 80</td> <td>WH = 86</td> </tr> <tr> <td>WCA, KCA or TCA = 13</td> <td>MH = 84</td> <td>JA = 11</td> </tr> <tr> <td>WCH = 83</td> <td>PD = 45</td> <td>PH = 85</td> </tr> </table> <p>Examples of entries for item 2:</p> <p>A 713-01-6295 = G13 01 6295 10</p> <p style="text-align: center;">+</p> <p>MA 123645 = 000 12 3645 14</p>	A = 10	MA or XA = 14	CA = 17	WA, KA or TA = 16	WD, KD or TD = 46	PA = 15	WCD, KCD or TCD = 43	H = 80	WH = 86	WCA, KCA or TCA = 13	MH = 84	JA = 11	WCH = 83	PD = 45	PH = 85
A = 10	MA or XA = 14	CA = 17															
WA, KA or TA = 16	WD, KD or TD = 46	PA = 15															
WCD, KCD or TCD = 43	H = 80	WH = 86															
WCA, KCA or TCA = 13	MH = 84	JA = 11															
WCH = 83	PD = 45	PH = 85															
Item 3	SEX	Enter "M" for male or "F" for a female.															



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Item 4	ED	Effective Date - This item is the HMO/CMP disenrollment effective date. The day field will always be 01 and is prefilled. Enter the month and year the beneficiary will no longer be enrolled in the HMO/CMP. Use two positions for the month and two positions for the year. For example, if the beneficiary is completing the form on February 13, 1997, the entry in item 4 could be 03-01-97, 04-01-97, or 05-01-97, depending on when the beneficiary wants to return to fee-for-service Medicare coverage. Generally, the disenrollment date is the first day of the month following the month in which the form is completed and signed because most beneficiaries prefer the earliest possible disenrollment date.
Item 5	TC	Transaction Code - Enter "53" in this item.
Item 6	DC	Disenrollment Code - Select the appropriate code from the back of the form and enter it in this section. Use code "99" if there is not an appropriate reason code listed on the form or the reason for disenrollment is unknown.
Item 7	UN	Unit - Enter "RRB" in this item.

The beneficiary or the RRB employee receiving a written request should complete the middle section of the form under the heading "PLEASE COMPLETE THE FOLLOWING" as follows:

Blank 1	The beneficiary's first and last names.
Blank 2	The name of the Managed Care Plan from which the beneficiary intends to disenroll.
Blank 3	The month and year of the last month the beneficiary will be enrolled in the HMO/CMP.
Blank 4	The same date that is shown in item 4 at the top of the form. This date should be for the month following the month entered in blank 3.

The beneficiary should sign the form in the Beneficiary Signature box. If an RRB employee is completing the form based on a written request, enter, "Per the attached letter."



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The beneficiary should enter the date he or she completed and signed the form in the Date box.

The beneficiary, or the RRB employee completing the form, should enter the beneficiary's complete address in the Beneficiary Address box.

The beneficiary should enter a telephone number at which he or she wishes to be contacted in the Beneficiary Daytime Telephone No. box.

HANDLING REQUESTS TO DISENROLL BY PHONE OR MAIL

When a beneficiary requests to disenroll by telephone, the F/O should complete the entire Form HCFA-566 and mail it to the beneficiary for him or her to sign, date, and return all copies to the F/O. The contact representative will advise the beneficiary to return the form as soon as possible. The contact representative will also annotate field office records to reflect the date of the request. Once the forms are received in the F/O, review all entries for accuracy. Return the beneficiary copy of the form to the beneficiary and forward the remaining three copies to headquarters for processing.

Form HCFA-566 must be handled by CMS within 30 days from the date the beneficiary signs it to assure the effective date is the first day of the month following the month in which the beneficiary signed the form. Otherwise, CMS will process the form as a retroactive disenrollment.

Beneficiaries may request disenrollment by mail if the request clearly shows that disenrollment is desired and the date the beneficiary wishes the disenrollment to take effect. The contact representative will complete items 1-7 on Form HCFA-566. If it is not clear, contact the beneficiary to resolve any questions. The contact representative will make four photocopies of the written request and attach the original to the Social Security Office copy and a copy to each other copy of the completed Form HCFA-566 and retain a copy for their records. The beneficiary's written statement will satisfy the signature requirement.

DISPOSITION

The beneficiary should be given or mailed the Beneficiary Copy of the form. If a written request is processed, mail the beneficiary his or her copy of the form. Remove all carbons from the remaining copies and forward them to headquarters in an envelope marked "DO NOT OPEN IN MAILROOM, ATTENTION: MEDICARE SECTION."

HCFA-I500, SUPPLIER'S REQUEST FOR MEDICARE PAYMENT

Doctors, hospitals, and other suppliers use Form HCFA-I500 to claim reimbursement under Medicare Part B. The Railroad Retirement Board does not stock Form HCFA-



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I500; a provider must request it directly from the Centers for Medicare & Medicaid Services. The form is also numbered RRB-I500.

Forward requests for reimbursement to the appropriate Part B carrier. For regular claims, that is Palmetto GBA. For durable medical equipment or supplies, this is the regional DEMERC. Current addresses are shown in the Medicare Handbook (Form RB-23).

Exhibit 15 - Letter To CMS's R/O - Delayed HMO Disenrollment

CMS

ASSOCIATE REGIONAL ADMINISTRATOR

DIVISION OF MEDICARE

(ADDRESS FROM EXHIBIT 17)

In reply refer to

R.R.B. No.

Dear :

The enclosed HCFA-566, HMO/CMP Disenrollment Form, is being referred to you for special handling because more than 30 days have elapsed since the date the request was filed. The delay was caused by (enter the reason for the delay).

Based on the date the request was filed, the disenrollment effective date should be (enter the disenrollment date). The beneficiary has/has not received his/her copy of the disenrollment form.

Please advise us when your action to process the disenrollment effective date is completed.

Very truly yours,

Robert J. Duda

Director of Operations



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Enclosure

Exhibit 16 - Letter To Enrollee - Delayed HMO Disenrollment

Beneficiary's Name

Address

In reply refer to
R.R.B. No.

Dear :

The Centers for Medicare & Medicaid Services has direct supervision over Medicare and any involvement a Health Maintenance Organization may have with Medicare.

The responsibility of resolving problems that beneficiaries encounter with Health Maintenance Organization rests with one of the Centers for Medicare & Medicaid Services's Regional Offices. Therefore, your inquiry is being referred to the Centers for Medicare & Medicaid Services, Regional Office, Attention: HMO Section, (enter the address of the regional office).

They will evaluate the situation and respond directly to you. If you have any further questions or additional material, you should write to the Centers for Medicare & Medicaid Services Regional Office.

Very truly yours,

Robert J. Duda
Director of Operations

cc: CMS R/O

Exhibit 17 - CMS's Region/Addresses, Various Contacts And States Within CMS Regional Offices

I. Boston

Connecticut
Maine
Massachusetts
New Hampshire

CMS
Associate Regional Administrator
Division of Medicare
John F. Kennedy Federal Building



Retirement Claims Manual

October 9, 2007

U.S. Railroad Retirement Board
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