

Medicare Minute Teaching Materials – September 2015 Making Sense of Your Medicare Statements

1. What is an MSN?

If you have Original Medicare, you will receive an MSN in the mail every 3 months for your Medicare Part A and Part B covered services. If you do not receive any services or medical supplies during that 3-month period, you will not get an MSN for that particular 3-month period. Keep in mind that Medicare provides separate MSNs for Part A and Part B covered services. For example, inpatient hospital, Skilled Nursing Facility (SNF), and hospice care will have their own MSN separate from the MSNs for Part B outpatient services and durable medical equipment (DME). **An MSN is not a bill.** It is simply a summary to help you keep track of your health care services and ensure that you are paying the proper amounts for them. The MSN will list the services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and the maximum amount you may owe the provider.

The MSN is divided into four sections. The initial summary page lists your deductible status, the names of the providers you've used in the past three months, and the total amount you owe for care received during that time. Section 2, "Making the Most of Your Medicare," contains tips to understand the MSN and lists additional resources for more information. Section 3 details claims for care you've received during the last quarter, including how much the provider billed Medicare, what Medicare actually paid the provider and the amount you owe for the care. This section will also indicate if Medicare has denied coverage for any of your care. Finally, Section 4 provides instructions and deadlines for filing an appeal if Medicare failed to approve any of the claims submitted for your care. You can also create an account at www.mymedicare.gov and view your MSNs online at any time.

2. What is an EOB?

There are two types of Explanation of Benefits (EOB) summary notices. First, if you have a Medicare Part D prescription drug plan, you will receive a Part D EOB listing the medications you filled in the prior month and what you paid for them. You will receive a Part D EOB whether you have Original Medicare with a stand-alone Part D plan or you get your Part D coverage through a Medicare Advantage Plan. In addition to the drugs you have filled, the EOB will tell you which phase of drug coverage you are in so far this year—the deductible, initial coverage, coverage gap, or catastrophic phase—and your total out-of-pocket costs and drug costs to date. It will also indicate any mid-year formulary changes that may affect you.

The second kind of EOB applies if you get your Medicare health benefits through a Medicare Advantage Plan. *Some plans choose to send EOBs on a monthly basis (if you received services). Other plans send an EOB for each claim and then a quarterly summary of your health claims.* Your Medicare Advantage EOB tells you what your provider billed your plan, the approved amount that the plan will pay, and what you may have to pay. Like an MSN, **an EOB is not a bill.** It is simply a summary of the services you have received and how much you may owe for them. The Medicare Advantage EOB will also state the amount you have paid that counts toward your yearly out-of-pocket maximum. All Medicare Advantage Plans must have an annual limit on the amount you can pay out-of-pocket for health care. If you have a Medicare Advantage Plan that includes prescription drug coverage, you will get one EOB for the all health care services you have received, and a separate EOB for the Part D prescription drugs you have filled in the past month.

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SHIP National Technical Assistance Center: 877-839-2675, www.shiptacenter.org, info@shiptacenter.org

SMP National Resource Center 877-808-2468, www.smpresource.org, info@smpresource.org

3. My notice says that this is not a bill. What does that mean?

Both MSNs and EOBs say “THIS IS NOT A BILL” on the first page of the statement. This is true: these statements are meant only as a summary of charges and payments made by Medicare or your Medicare Advantage Plan or Part D plan. You will receive a separate bill from your doctor or other health provider for any amounts you owe to them. If you already paid the provider, make sure you paid the right amount by comparing your payment to the provider against your MSN or EOB. The provider must refund you if you overpaid. If you believe you overpaid your provider, first call your doctor or health provider directly to ask for refund.

The Part D EOB lists the amount your plan paid the pharmacy and the amount you have already paid for the prescription. If the charge you see on your EOB does not match what you paid your pharmacist, call your plan to see where the mistake has been made.

4. Why would my EOB or MSN say I am responsible for a charge?

Some reasons you may be responsible for a bill include:

- You owe a copayment, or copay, which is a set amount that you pay each time you receive a service. You may have already paid this when you were leaving the doctor’s office. You should always keep receipts and compare them to your EOB or MSN for accuracy.
- You are responsible for coinsurance, which is a set percentage of the cost each time you receive a service.
- You have not yet reached your deductible, the amount you must pay for health care expenses before your health insurance begins to pay. Once you reach your deductible, your plan will begin paying for part or all of the covered services.
- Medicare or your plan is denying your coverage. If you are denied coverage for a service that you believe should have been covered, you should appeal this decision. Your MSN or EOB will include instructions for appealing this decision.

5. Can I view my statements online?

If you have Original Medicare, you can access your MSNs online at www.mymedicare.gov. You will need to create an account. These electronic MSN statements do not replace the paper statements you receive in the mail. Some Medicare Advantage and Part D plans give you the option of accessing your EOB online using your secure account information. If you are interested in accessing your EOB online, either go to your plan’s website or call your plan using the number on the back of your insurance card.

6. Do all MSNs and EOBs apply a uniform format?

If you have Original Medicare, the general appearance and format of your MSN should look the same no matter where you live. You can find a sample MSN online at <https://www.medicare.gov/forms-help-and-resources/mail-about-medicare/medicare-summary-notice-msn.html>. However, if you have a Medicare Advantage or Part D plan, your EOB can look different than EOBs from other Medicare Advantage and Part D plans because each plan can use a unique EOB format; however, the Centers for Medicare & Medicaid Services (CMS) requires plans to include certain standard language and information in their EOBs.

7. I have supplemental or secondary insurance. Will my MSN statement show the amount I owe after my other insurer has paid?

The amount shown on your MSN is the amount you owe after Medicare or your Medicare Advantage Plan has made its payments. If you have secondary insurance, such as a Medigap or other insurance that pays after Medicare pays, Medicare or your doctor may have already submitted the remaining bill to your other insurance (especially if you have a Medigap plan). Check the notes in your MSN because they may indicate if a claim has already been sent to another insurer. If not, you may need to submit a claim yourself. Call your secondary insurance plan to learn what (if any) steps you need to take, and speak with your provider to ensure that they have your most up-to-date insurance information.

8. Why is there a difference between the amount my provider billed and the amount the provider is paid by Medicare?

If you have Original Medicare, Medicare decides the maximum amount that each service is worth. This Medicare-allowed amount is often less than the amount billed by your provider. Medicare will pay the provider a percentage of the Medicare-approved amount. When a provider accepts Medicare assignment, this means that they agree to accept the payment amount that Medicare decides is appropriate for a certain service, even if your provider bills for a higher amount. Medicare does not base its payment on the amount charged by the provider. The coinsurance or copay amount (20 percent for Part B services) is based on the Medicare-allowed amount, not the original amount your provider bills Medicare. Your MSN will state the maximum amount the provider can bill you in the column labeled “maximum you may be billed.”

If you have a Medicare Advantage Plan, your plan may have negotiated a lower rate with your provider for the services you received. That means that the plan will only pay your provider its share of the agreed-upon lower amount. Your EOB will show the amount the provider may bill you in the “What You Owe” column. If you follow your plan’s rules and use providers in the plan’s network, you will typically only owe a coinsurance (percentage of the plan’s rate) or a set copayment.

If you have a Part D plan, your EOB will only list what the plan has paid for a prescription and what you paid for that prescription at the pharmacy. It will also list your total out-of-pocket costs for prescription drugs for the year, as well as your Part D coverage phase (deductible, initial coverage, coverage gap, or catastrophic coverage). If you are unclear about any of these charges, or why your drug costs change from one month to the next, contact your plan. Your out-of-pocket costs for drugs may change depending on your coverage phase.

9. Why did I receive an MSN that contains a check made payable to me?

You would have received an MSN with a check if the claim is non-assigned. This means that the doctor has not accepted Medicare’s fee as the cost and may charge you more, up to certain limits. In these cases, you typically would have paid the full amount at the doctor’s office when you received the service. Your doctor must bill Medicare, but Medicare will directly pay you for its share. The check will be for a percentage of Medicare’s approved amount. You will be responsible for the remainder of the bill. Medicare mails the MSN and check once it processes the doctor’s claim.

10. What should I do if Medicare or my plan is not paying for a service I think should be covered?

If Medicare or your plan is not paying for a service you think should be covered, you should appeal. In order for your appeal to be considered, the Medicare claims office must receive your appeal within **120 days** of the date on your MSN. Look for the box on your statement containing the deadline for you to file your appeal.

If you have a Medicare Advantage Plan or Part D plan, there may be instructions on how to file an appeal on the last page or pages of your EOB, though you may also receive a separate notice with these instructions. In order for your appeal to be considered, you will need to file it within **60 days** of the date on your EOB. It is helpful to include relevant medical records and a doctor's letter of support in any appeal, whether you have Original Medicare, a Medicare Advantage Plan, or a Part D prescription drug plan.

Medicare, your plan, and/or your provider may be able to help you understand your appeals rights and the process. The State Health Insurance Assistance Program (SHIP) is also able to help you understand the appeals process and conduct an appeal (go to the last page for contact information).

11. What should I do if my Medicare Part D plan is not paying for a drug I think should be covered?

If your Medicare Part D prescription drug plan won't cover a drug you need, you should file an appeal. An appeal is when you ask your Part D plan to reconsider its coverage decision. Common reasons for appealing are:

- The drug you need is not on your plan's list of covered drugs (**formulary**).
- Your drug plan only covers a limited amount of the drug you need (**quantity limits**).
- Your plan wants you to try other drugs first (**step therapy**).
- You must get special permission from the plan in advance before it will cover your drug (**prior authorization**)
- Your plan is charging more for your drug than for similar drugs on its formulary.

The State Health Insurance Assistance Program (SHIP) is also able to help you understand the appeals process and conduct an appeal (go to the last page for contact information).

12) What is the difference between a denial, a billing error, and Medicare fraud?

Sometimes Medicare denials can be the result of a mistake or billing error rather than a decision not to cover a service, item, or medication. If you receive a health service denial from Original Medicare or your Medicare Advantage Plan, always call your doctor's office to ensure they did not make a billing mistake before proceeding with an appeal. If you receive a drug denial, call your plan to check for potential errors before requesting a formal denial notice. As always, if you need one-on-one assistance understanding denials and appeals, contact your SHIP (see last page).

If you do not recognize or remember receiving the service, item, or medication that was denied, call your provider or pharmacist to ensure a billing error did not take place. Help to protect yourself from Medicare fraud, errors, and abuse by keeping a record of all the medications you purchase and services you receive. You may detect fraud, errors, and abuse by comparing your records to your EOB or MSN. Call your provider if you discover charges or claims for medications or services you never received.

If you receive an unsatisfactory answer or you are uncomfortable talking to your provider, contact your Senior Medicare Patrol (SMP) to discuss potential fraud, errors, or abuse (go to the last page for contact information). The SMP will help determine if fraud or abuse are suspected and whether the issue needs to be referred to the proper authorities for further investigation.

SHIP Case Study: Shauna

Shauna, who is 82 years old and has a Medicare Advantage Plan, is confused by a statement that she received in the mail that listed medical services she had received in the past three months, including a regular doctor's visit and an x-ray. Medicare denied coverage of the x-ray. Shauna worries that she is overdue paying her medical bills and is upset that Medicare did not pay anything for her x-ray.

What should Shauna do?

- Shauna should contact her SHIP for help. A SHIP counselor will be able to help Shauna understand what an Explanation of Benefits (EOB) is and will remind Shauna that it is not a bill.
 - If Shauna doesn't know how to find her SHIP, she can go to www.shiptacenter.org or call 877-839-2675 for assistance.
- The SHIP counselor will discuss Shauna's Medicare coverage with her, including whether or not she signed a form called an Advance Beneficiary Notice prior to receiving the x-ray.
- The SHIP counselor will explain how to find the information on her EOB that explains the appeals process.
- Through this conversation, the SHIP counselor will help Shauna determine her possible next steps, including contacting her provider, contacting her plan, and/or conducting an appeal.

SMP Case Study: Phil

Phil, who is 67 years old and has Original Medicare, receives a quarterly Medicare Summary Notice (MSN). Phil's recent MSN listed claims for services that he hadn't received, including a visit to a doctor he had never heard of and services from a local home health care agency, even though Phil does not receive any home health care. Phil worries that he is the victim of fraud.

What should Phil do?

- Phil should contact his local Senior Medicare Patrol (SMP) to discuss his MSN.
 - If Phil doesn't know how to find his local SMP, he should contact the SMP National Resource Center at 877-808-2468 or use the online SMP locator at www.smpresource.org.
- The SMP will discuss Phil's MSN with him and can contact 1-800-Medicare on his behalf to determine whether or not there might have been error, such as in the Medicare number or name associated with Phil's claim.
 - If an innocent error is discovered, such as a typo in the claim, the SMP or 1-800-Medicare can assist in the process of correcting the error, depending upon who made the error – Medicare or the provider.
- If an innocent error is not discovered, the SMP will report Phil's case to the appropriate authorities, including the Office of Inspector General (OIG) and Medicare, as suspected fraud or abuse. The OIG and Medicare will make the final determination.



LOCAL HELP FOR PEOPLE WITH MEDICARE

- Meanwhile, the SMP will assist Phil in determining what to do if a bill arrives from the provider. The SMP will also explain what type of follow-up to expect as a result of the referral to the appropriate authorities.
- The SMP will also provide Phil with tips for identifying future incidents of billing fraud.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free:</p> <p>SHIP email:</p> <p>SHIP website:</p> <p>To find a SHIP in another state: Call 877-839-2675 or visit www.shiptacenter.org.</p>	<p>SMP toll-free:</p> <p>SMP email:</p> <p>SMP website:</p> <p>To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>

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