OREGON OFFICE of RURAL HEALTH

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Rural EMS Billing & Coding Webinar 1:
"VA and Other Nuanced Billing Situations"

Steve Johnson, PWW | AG, EMS/Mobile Healthcare Consultant

August 4, 2026

Joan Field, EMT-I, CP-C, CHW
OREGON OFFICE OF RURAL HEALTH, RURAL EMS

The mission of the Oregon Office of Rural Health is to improve the quality, availability and accessibility of health care for rural Oregonians.

The Oregon Office of Rural Health's vision is to serve as a state leader in providing resources, developing innovative strategies and cultivating collaborative partnerships to support Oregon rural communities in achieving optimal health and well-being.

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Webinar Logistics

- Audio will be muted for all attendees at the beginning of the webinar.
- **However**, this is meant to be an interactive session with discussion, so feel free to raise your hand and unmute, and you can also post your question or comment in the chat.
- Presentation slides and recordings will be posted shortly after the session at: https://www.ohsu.edu/oregon-office-of-rural-health/emergency-medical-services-programs.

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Steven M. Johnson

EMS/Mobile Healthcare Consultant

PWW | AG

Steve began his career in the EMS industry in 1985, gaining valuable experience while serving as an EMT and later as Director of a municipal ambulance service in Minnesota. As an ambulance service administrator, Steve established his expertise in areas of operations, billing and administration.
Steve also has significant EMS educational experience. He established and served as Training Coordinator and Lead Instructor for a State Certified EMS Training Institution for EMTs and First Responders.
Steve served on both the Rules Work Group and the EMS Advisory Council to the Minnesota State Department of Health.
He joined the staff of a large, national billing and software company, where he was a frequent lecturer at national events and user group programs. For over seven years, Steve served as Director of a national ambulance billing service and was responsible for all aspects of managing this company, including reimbursement, compliance and other activities for ambulance services throughout the nation.

Steve served as founding Executive Director of the National Academy of Ambulance Compliance (NAAC), overseeing all activities of the Academy, including the Certified Ambulance Coder program, the nation's only coding certification program specifically for ambulance billers and coders.
As the Director of Reimbursement Consulting with Page, Wolfberg & Wirth, Steve is involved in all facets of the firm's consulting practice. Steve works extensively on billing and reimbursement-related activities, performing billing audits and reviews, improving billing and collections processes, providing billing process assessments, billing and coding training, conducting documentation training programs, and performing many other services for the firm's clients across the United States.
Steve regularly presents at EMS conferences throughout the United States and has authored articles and columns for several EMS industry publications.
Steve is also a licensed private pilot and enjoys an active role in his church.

Professional Philosophy

"Having started my career in EMS out of a desire to help others in need within my community, I feel especially fortunate to have seen 'my community' expand to encompass the entire nation.

I count being given the opportunity to use my EMS experiences as a provider in the field, ambulance service administrator, billing service manager, educator and program developer to help others succeed in their EMS careers while maintaining a focus on compliance and integrity, among my greatest professional blessings."

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VA and Other Nuanced Billing Situations

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DISCLAIMERS

This information is presented for educational and general information purposes and should not be relied upon as legal advice or definitive statements of the law. Consult applicable laws, regulations and policies for official statements of the law. No attorney client relationship is created by attending this session.

Steve Johnson

Director of Reimbursement Consulting,
Page, Wolfberg, and Wirth, LLC

EMS/Mobile Healthcare Consultant,
PWW Advisory Group

sjohnson@pwwemslaw.com

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Oregon Office of Rural Health
Rural EMS workforce program

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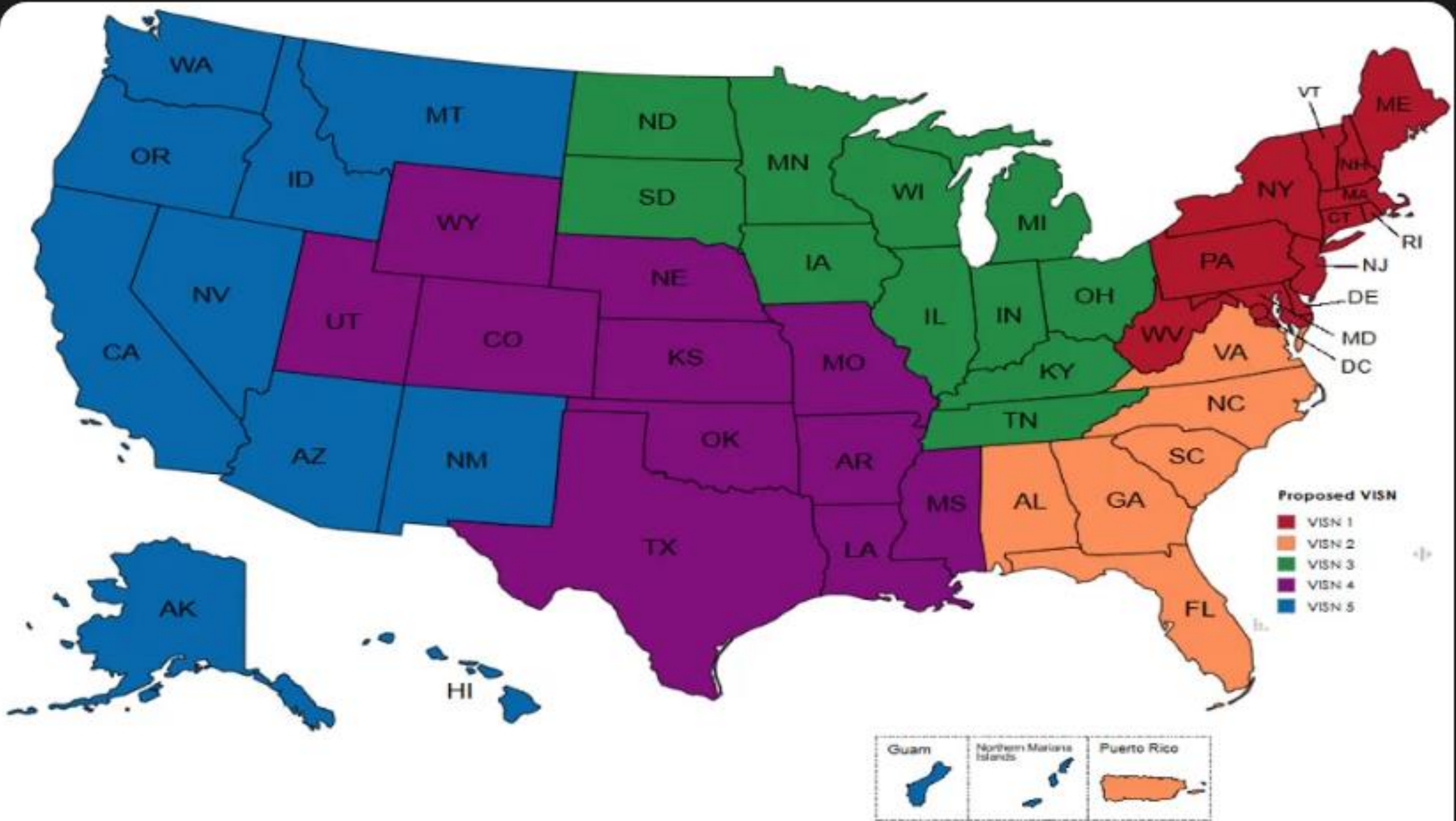
Understanding Some Special Payer Issues

- VA
- Medicare Advantage
- Hospice

Veterans Integrated Service Networks (VISNs)

- The Department of Veterans Affairs comprises 5 Veterans Integrated Service Networks or VISNs – regional care systems working together to meet local healthcare needs and provide greater access to care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DE
MD
DC
AK
HI
Proposed VISN
VISN 1
VISN 2
VISN 3
VISN 4
VISN 5
Guam
Northern Mariana Islands
Puerto Rico

There Is No "Coordination of Benefits" Between Government Programs

In Other Words . . .

- Two Government Programs do not both pay for the same service
  - It is **not** a question of which is primary and which is secondary
  - It is a question of which of the payers covers this particular service

Government Programs Include

- Medicare
- Federal Black Lung
- Veterans Administration (VA)
- Family Health Plan

Veterans Administration (VA)

- Veterans who have Medicare and VA benefits may choose Medicare or VA for covered benefits
  - Decision is made each time the beneficiary receives health care services
  - This is true for both Part B and Part C
  - The beneficiary may well not even be aware that they made the decision

In Other Words . . .

- For the same patient, Medicare can be primary one day, and the VA can be primary the next day, it all depends on the specifics of the services received, and choices the beneficiary makes

More Detail Found Here

https://www.doi.gov/sites/doi.gov/files/migrated/flert/training/upload/Medicare-Guide-to-Who-Pays-First.pdf

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Some VA Terminology

- **Community Care** partnerships work to ensure Veterans receive timely access to care
  - VA works with community providers to deliver care when VA can't provide the needed care directly. Community care may include care for Veterans, family members and dependents, depending on the program and eligibility requirements

Some VA Terminology

- VA-covered ambulance transportation for Veterans falls into two categories:
  - **Authorized ambulance transport** refers to **non-emergency** transportation that **must be preauthorized** by VA

Non-Emergencies

- To arrange preauthorized, non-emergency ambulance transportation, the Veteran should contact their local VA Beneficiary Travel Office. Contact information can be found at this link:

https://www.va.gov/resources/veterans-transportation-program-representatives/

Some VA Terminology

- **Unauthorized ambulance transport** refers to **emergency** transportation that **was not preauthorized**. In some cases, VA may reimburse these transports after the fact if the Veteran meets eligibility requirements and the transport is connected to a covered emergency. Whether VA can pay, and how much VA can pay is based on the Veteran's status and emergency treatment coverage

Authorized Transport (Non-Emergency)

Authorized Transport (Non-Emergency)

- **Pre-authorization required:** Routine or scheduled ambulance rides to a VA or community facility must be arranged and approved in advance
- **Medical necessity:** A VA health care provider must document that a special mode of transport like an ambulance is strictly required

Authorized Transport (Non-Emergency)

- **Administrative fit:** The Veteran generally must qualify for VA health care travel pay (such as having a service-connected rating of 30% or higher, meeting pension criteria, or traveling for a service-connected condition)

Authorized Transport (Non-Emergency)

- Pre-authorized ambulance transport for eligible Veterans to or from a VA facility or VA-authorized community care facility is approved and arranged in advance of care
- Veterans must meet the following administrative requirements to qualify for authorized transport:

Authorized Transport (Non-Emergency)

- Have a service-connected (SC) disability or combined rating of 30% or more (travel for care relating to any condition), *or*
- Be in receipt of a VA pension, *or*
- Travel is in connection with care for a SC disability, *or*
- Travel is for a Compensation and Pension exam, *or*
- Travel is to obtain a service dog, *or*

Authorized Transport (Non-Emergency)

- Previous calendar year income* does not exceed maximum VA pension rate, *or*
- Projected income in travel year* does not exceed maximum VA pension rate, *or*

*Note: Income related eligibility ("means score") must be verified and on file with VA **on or before the date of transport**

Authorized Transport (Non-Emergency)

- Travel relates to VA transplant care, *and*
- A VA clinician determines and documents that special mode transportation is medically required

To arrange non-emergent transportation, contact the local VA Beneficiary Travel Office

https://www.va.gov/resources/veterans-transportation-program-representatives/

Unauthorized Transport (Emergency)

Emergency Transportation

- During a medical emergency, Veterans should immediately seek care at the nearest medical facility without delay
- A medical emergency is an injury, illness or symptom so severe that without immediate treatment, an individual believes his or her life or health is in danger

Emergency Transportation

- If a Veteran believes his or her life or health is in danger, they should call 911 or report to the nearest emergency department right away
- Veterans do not need to check with VA before calling an ambulance or going to an emergency department
- **Notifying VA of the emergent transport within 30 days is required**

Unauthorized Treatment (Emergency)

- There are 2 different types of Unauthorized (Emergency) Treatment
  - Unauthorized Emergency Treatment (Service-Connected)
  - Unauthorized Emergency Treatment (Nonservice-connected)

Unauthorized ET (Service Connected)

- Approved under 38 USC §1728
  - Ambulance transports associated with emergent treatment approved under 38 USC §1728 will be assessed in accordance with Authorized Ambulance Transport eligibility. (See slides 19-22)

Unauthorized ET (Nonservice-Connected)

- Approved under 38 USC §1725
  - Ambulance transports associated with emergent treatment approved under 38 USC §1725 will be assessed in accordance with 38 CFR §17.1003 eligibility

Unauthorized ET (Nonservice-Connected)

- In accordance with 38 CFR §17.1003 VA must receive and adjudicate a claim for the emergency treatment received as part of the emergency transportation
- If no claim is received for the associated treatment, VA cannot pay for the emergency transportation unless one of the following two exceptions are met:

Unauthorized ET (Nonservice-Connected)

1. Other health insurance or a third party paid for the emergency treatment (leaving no liability for the treatment) excluding the emergency transportation itself; ***or***
2. Death occurred during transportation to receive emergency care

If VA cannot pay for emergency care outside of the above two exceptions, then it generally cannot pay for the associated emergency transportation

Community Care

Unauthorized Emergency Treatment

- If the Veteran thinks their life or health is in danger, they are instructed to call 911 or go to the nearest emergency department. They don't need prior authorization. **BUT . . .**
- If they go to a non-VA facility – even one that's in the VA community care network – they must follow certain rules so that VA can cover the cost of that care.

Must Be An Emergency Department

- The VA will only cover the cost of emergency care at an Emergency Department. An emergency department is a facility that has the staff and equipment to provide emergency care (like a hospital or free-standing emergency department).
- **Urgent Care Facilities don't qualify as Emergency Departments**

Mandatory Notification Within 72 Hours

- VA must be notified of the Veteran's care within 72 hours. The Veteran should ask the provider to notify VA right away in either of these ways:
  - Through the VA Emergency Care Reporting Portal
    - https://emergencycarereporting.communitycare.va.gov/compliance
  - By calling VA at 844-724-7842 (TTY: 711)

Mandatory Notification Within 72 Hours

- VA must get the notification **within 72 hours of when the emergency care starts**
- They prefer that the provider notify them, but if they don't, the Veteran or someone acting on their behalf can notify VA

Eligibility For Emergency Mental Health Care

- In most cases, VA will provide or cover the cost of emergency mental health care and up to 90 days of related services
- If a health care provider or a trained crisis responder determines the Veteran is at risk of immediate self-harm, VA can provide or cover the cost of necessary mental health care if the Veteran meets at least 1 of these requirements:

Eligibility For Emergency Mental Health Care

- The Veteran:
  - was sexually assaulted, battered, or harassed while serving in the Armed Forces, or
  - served on active duty for more than 24 months and didn't get a dishonorable discharge, or

Eligibility For Emergency Mental Health Care

- The Veteran:
  - served more than 100 days under a combat exclusion or in support of a contingency operation (including as a member of the Reserve) and didn't get a dishonorable discharge.
    - The Veteran meets this requirement if they served directly or if they operated an unmanned aerial vehicle from another location.

Eligibility For Emergency Mental Health Care

- If the Veteran goes to a non-VA emergency department for help, they are instructed to tell the staff they are a Veteran, and ask them to contact VA right away.

Eligibility For All Other Emergency Care

- By law, VA can only cover the cost of care at a non-VA emergency department if the Veteran meets all of these requirements:
  - The Veteran is enrolled in VA health care or has a qualifying exemption from enrollment, and

Eligibility For All Other Emergency Care

- By law, VA can only cover the cost of care at a non-VA emergency department if the Veteran meets all of these requirements:
  - A VA health care facility or other federal facility that could provide the needed care wasn't "feasibly available" (meaning it was too far away to get there fast enough for the Veteran to get the emergency care they needed), and

Eligibility For All Other Emergency Care

- By law, VA can only cover the cost of care at a non-VA emergency department if the Veteran meets all of these requirements:
  - A person with an average knowledge of health and medicine ("prudent layperson") would reasonably believe that a delay in seeking care would have put the Veteran's life or health in danger, and

Eligibility For All Other Emergency Care

- By law, VA can only cover the cost of care at a non-VA emergency department if the Veteran meets all of these requirements:
  - The Veteran meets VA's other requirements based on the specific situation – including the time limit for VA to receive the claim.

Eligibility For All Other Emergency Care

- **Note:** VA only covers non-VA emergency care until they can safely transfer the Veteran to a VA or other federal facility.
- The only time this rule doesn't apply is if the community provider contacts VA and VA can't accept the transfer.

Eligibility For All Other Emergency Care

- In addition to these general eligibility requirements, the Veteran must also meet other requirements based on their specific situation, found at:

https://www.va.gov/resources/getting-emergency-care-at-non-va-facilities/

Submitting Ambulance Claims

Submitting Ambulance Claims

- Submit only one ambulance trip per claim
- Include the pickup and drop-off locations using valid USPS addresses
- Include the ambulance trip report

Timely Filing Requirement

- We have heard several say that the VA has shortened the timely filing deadline for emergencies to 30 days, is this true?
- No

Timely Filing Requirement

- Under 38 CFR § 17.1230, providers have up to 180 calendar days from the date the service was furnished to submit the required standard billing form for emergency transportation to avoid a timely claim filing denial
- **BUT. . .** And here's where the answer starts to sound to some people like yes . . .

“Initial Notification” vs. “Claim Submission”

- The VA includes the following on their website at:

https://department.va.gov/vha/community-care/types-of-veteran-care/?target=Ambulance-transport

Ambulance transport claim submissions

Ambulance transport claims must be submitted directly to VA. For maximum benefit eligibility, submit claims within 30 days.

"Initial Notification" vs. "Claim Submission"

- While the formal **claim submission** window is up to 180 days, the VA emphasizes that they require **initial notification** of emergent transport within 30 calendar days
  - And the best way to notify is through claim submission
  - If a claim for transport is unable to be submitted to VA within 30 days, notification can be reported to the Centralized Notification Center by calling 844-724-7842

"Initial Notification" vs. "Claim Submission"

- Per Fact Sheet 20-44, this has been a requirement since 2022
- **HOWEVER,** they recently began enforcing it
- Recent denials we have been made aware of are not actually "timely filing" denials, they are denials due to failure to notify within 30 days, as required

More Details in This Fact Sheet

Fact Sheet

VHA Office of Integrated Veteran Care
Ambulance Transportation

VA | U.S. Department of Veterans Affairs, Veterans Health Administration, Office of Integrated Veteran Care

The Department of Veterans Affairs (VA) has the authority to provide or reimburse land or air ambulance transport of certain eligible Veterans in relation to VA care or VA community care.

Authorized Ambulance Transport

Pre-authorized ambulance transport for eligible Veterans to or from a VA facility or VA-authorized community care facility is approved and arranged in advance of care. Veterans must meet the following administrative requirements to qualify for authorized transport:

- Have a service-connected (SC) disability or combined rating of 30% or more (travel for care relating to any condition), or
- Be in receipt of a VA pension, or
- Previous calendar year income does not exceed maximum VA pension rate, or
- Projected income in travel year does not exceed maximum VA pension rate, or
- Travel is in connection with care for a SC disability, or
- Travel is for a Compensation and Pension exam, or
- Travel is to obtain a service dog, or
- Travel relates to VA transplant care, and
- A VA clinician determines and documents that special mode transportation is medically required.

Note: Income related eligibility must be verified and on file with VA on or before the date of transport.

To arrange non-emergent transportation, contact the local VA Beneficiary Travel Office.

Emergency Transportation

During a medical emergency, Veterans should immediately seek care at the nearest medical facility without delay. A medical emergency is an injury, illness or symptom so severe that without immediate treatment, an individual believes his or her life or health is in danger. If a Veteran believes his or her life or health is in danger, call 911 or report to the nearest emergency department right away. Veterans do not need to check with VA before calling an ambulance or going to an emergency department.

Notifying VA of the emergent transport within 30 days is required, and the best way to notify is through claim submission. If a claim for transport is unable to be submitted to VA within 30 days, notification can be reported to the Centralized Notification Center by calling 844-724-7842.

VA has three legal authorities under which emergency treatment in a community facility may be paid for, but specific requirements must be met. The legal authority under which the emergency treatment falls dictates eligibility requirements for associated emergent transportation.

Emergency Treatment	Associated Ambulance Transport	Eligibility Reference
Authorized Emergency Treatment - 38 CFR 17.4020(c)	Authorized Transport	Authorized Ambulance Transport
Unauthorized Emergency Treatment (Service-Connected) - 38 USC §1728	Unauthorized Transport (must meet authorized ambulance transport eligibility)	Authorized Ambulance Transport
Unauthorized Emergency Treatment (Nonservice-connected) - 38 USC §1725	Unauthorized Emergency Treatment (Nonservice-connected) - 38 USC §1725	Unauthorized Emergency Treatment (Nonservice-connected)

38-10-1 HEB—AMBULANCE TRANSPORTATION

Updated Date: May 02, 2022

Page 1 of 2

https://www.va.gov/COMMUNITYCARE/docs/pubfiles/factsheets/FactSheet_20-44.pdf

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Submitting Ambulance Claims

- **All** ambulance claims should be sent to the VA using one of the following:
  - Electronically (EDI): Payer ID is **12115**
    - Electronic 837 claim and EDI 275 supporting documentation submissions can be completed through the VA clearinghouse, PNT Data, or through another clearinghouse of your choice

Submitting Ambulance Claims

- **All** ambulance claims should be sent to the VA using one of the following:
  - Paper Claims:

VHA Office of Finance
P.O. Box 30780
Tampa, FL 33630-3780

Phone: (877) 881-7618 M-F
8:00 a.m. to 9:00 p.m. Eastern
Fax: (512) 460-5221

*Ambulance claims should **always** be submitted to VA and **never** to TriWest or Optum.

Submitting Ambulance Claims

- We have heard from a fair number of Ambulance Suppliers that they have stopped billing the VA electronically because they have to drop them to paper to send the VA a copy of the PCR, as the VA won't process them without the PCR
- VA does clearly state that the PCR is required, but depending on your clearinghouse you may be able to send that electronically with an EDI 275 transaction.

VA Electronic Claims Adjudication and Management System (eCAMS)

eCAMS

Paperless EOPs are here | Provider Advisor — May 2026

Veterans Health Administration sent this bulletin at 05/07/2026 11:00 AM EDT

MAY 2026 | Subscribe

Having trouble viewing this email? View it as a Web page.

Provider Advisor

Veterans Health Administration
Office of Integrated Veteran Care

Paperless EOPs are here

eCAMS Provider Portal

- VA now uses digital explanations of payment (EOPs) for providers who submit claims directly to VA. Digital EOPs offer faster access to payment details and reduce paperwork. They are available through the Electronic Claims Adjudication and Management System (eCAMS) Provider Portal (ePP).

eCAMS Provider Portal

- If you filed a claim with VA, check claims status through the VA Electronic Claims Administration and Management System (eCAMS) Provider Portal (ePP). ePP provides secure, web-based access to real-time claim details and payment information.

eCAMS Provider Portal

- ePP gives registered users access to:
  - Real-time claim status updates
  - Line-level adjudication details
  - Electronic remittance reports
  - Check or direct deposit information
  - Explanation of Payment (EOP) documents
  - Bill of collection and offset actions

eCAMS Provider Portal

- To access the Department of Veterans Affairs Electronic Claims Adjudication System (eCAMS) Provider Portal, users need an active SAM.gov account and an AccessVA – ID.Me account.

eCAMS Provider Portal

- Get started with digital EOPs by visiting the eCAMS Provider Portal at the link below, reviewing the registration prerequisites, and following the step-by-step guide located in the training documents section.

https://www.occepp.fsc.va.gov/

eCAMS Provider Portal Message

"We are aware that some users are experiencing login issues when accessing the eCAMS Provider Portal (ePP), including errors such as: "Hybrid Web Access Management Unknown host Status code: 400 The requested host: 'eauth.va.gov' is not being served by this Access Gateway." These problems are occurring when older or incorrect bookmarked URLs are used. To resolve the issue: Please delete any outdated ePP bookmarks and use the correct login URL: https://eauth.va.gov/ecams. Using the updated link will prevent redirects and erroneous login errors, ensuring stable access to the portal. If you continue to experience issues after updating the URL, please contact the service desk. ecamshdsupport@va.gov."

eCAMS Provider Portal

- You may still opt to receive paper EOPs after creating an ePP account. If you're unable to register, you can request paper EOPs by emailing eCAMSHDSupport@va.gov with your National Provider Identifier (NPI), a VA claim transaction control number (TCN), and contact information. Call 877-881-7618 if you need help.

Balance Billing

Balance Billing Prohibition

- 38 CFR § 17.1008 - VA reimbursements represent PAYMENT IN FULL - the Veteran CANNOT BE BALANCE BILLED, unless the provider rejects the payment and refunds it within 30 days.

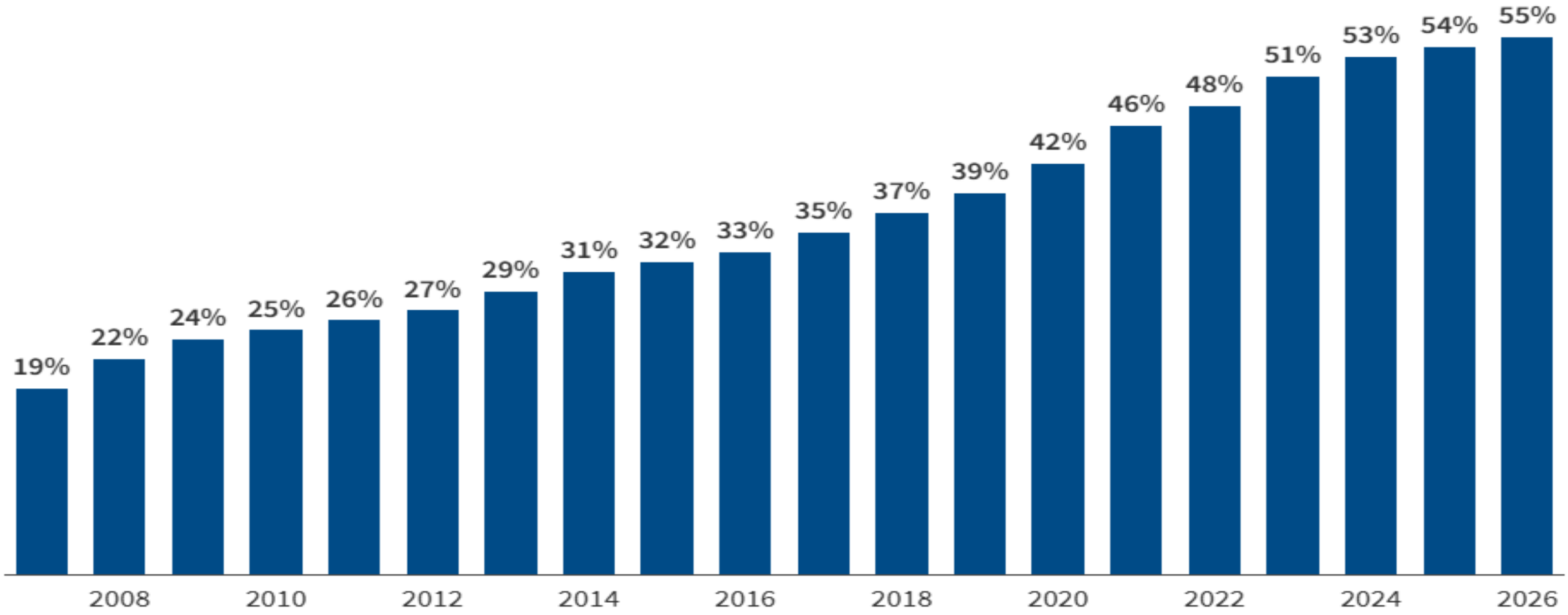
Medicare Advantage (MA)

Commonly Used Terminology

- Traditional Medicare
  - Fee for Service Medicare (FFS)
  - Part B
- Medicare Advantage
  - MA
  - Part C

Total Medicare Advantage Enrollment, 2007-2026

Medicare Advantage Penetration | Medicare Advantage Enrollment



Note: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 64.2 million people are enrolled in Medicare Parts A and B in 2026.

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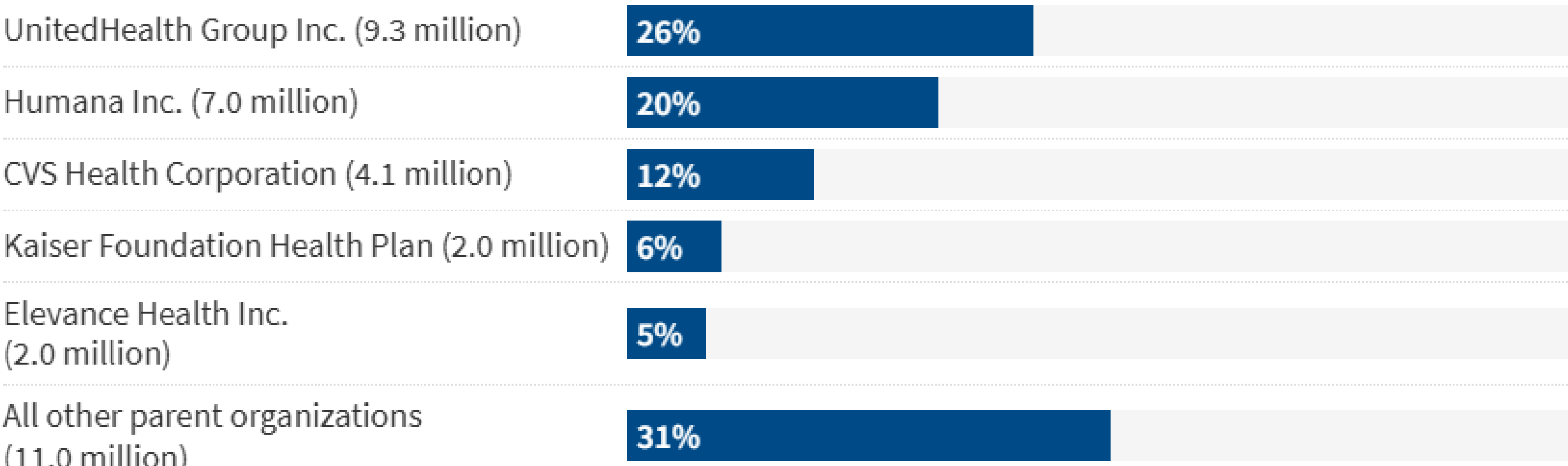
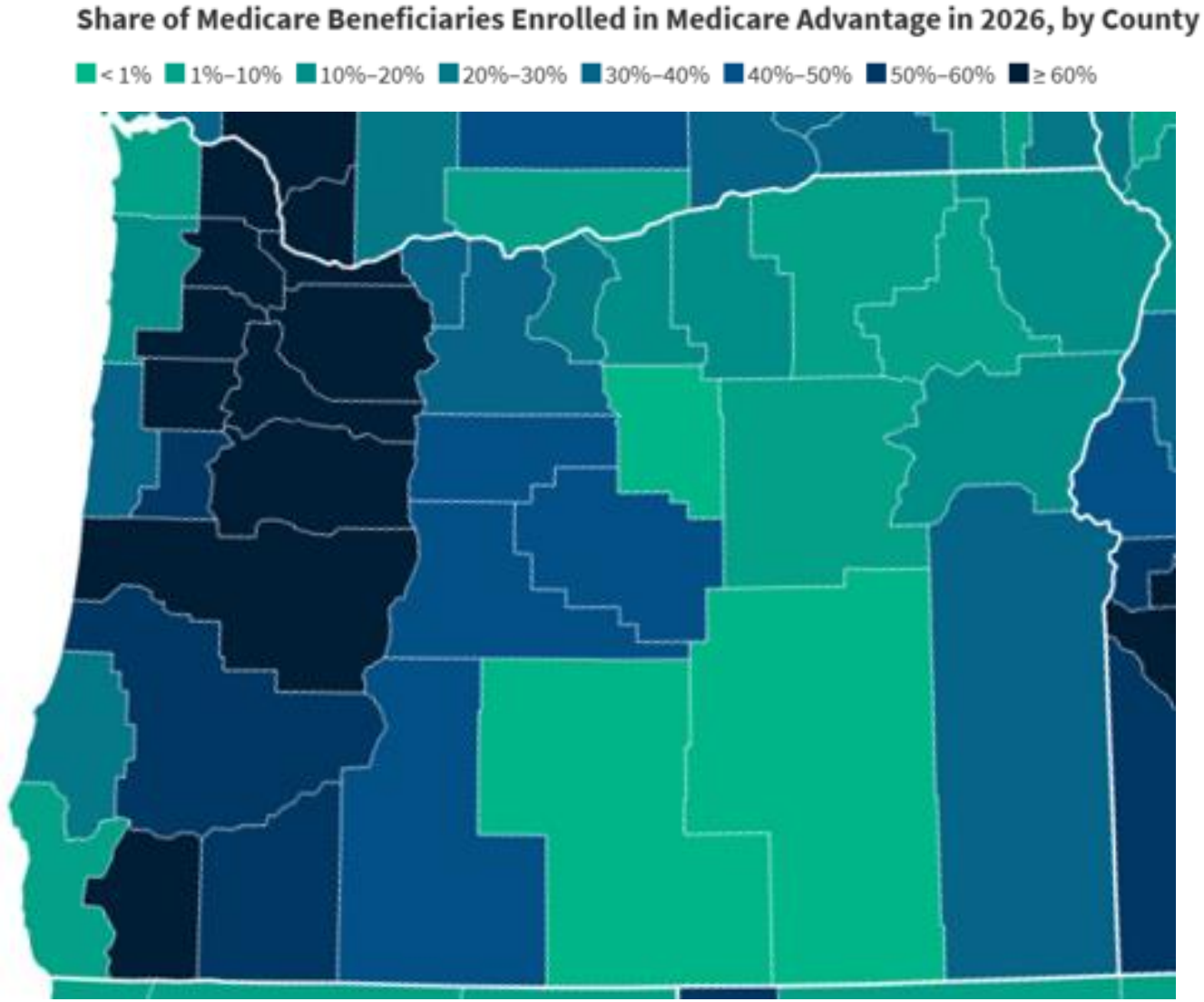
Medicare Advantage Enrollment by Parent Organization, 2026



Note: All other parent organizations include organizations with less than 5% of enrollment. Percentages may not sum to 100% due to rounding. Parent organizations are based on ownership in 2026. For example, CVS acquired Aetna in 2018.

Source: KFF analysis of CMS Medicare Advantage Enrollment Files, 2026. • Get the data • Download PNG

Oregon MA Penetration



https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/

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Oregon MA Penetration

fips	state_name	county	denom_eligibles	year	enrollment	MA penetration
41001	Oregon	Baker County	5162	2026	770	14.91669895
41003	Oregon	Benton County	18400	2026	9982	54.25
41005	Oregon	Clackamas County	90866	2026	65369	71.93999956
41007	Oregon	Clatsop County	11004	2026	417	3.78953108
41009	Oregon	Columbia County	12633	2026	8279	65.53471068
41011	Oregon	Coos County	20464	2026	5318	25.9870993
41013	Oregon	Crook County	7851	2026	3268	41.62527067
41015	Oregon	Curry County	9444	2026	395	4.182549767
41017	Oregon	Deschutes County	49912	2026	20624	41.32072448
41019	Oregon	Douglas County	33660	2026	18564	55.15151515
41021	Oregon	Gilliam County	579	2026	71	12.26252159
41023	Oregon	Grant County	2200	2026	25	1.136363636
41025	Oregon	Harney County	2025	2026	16	0.790123457
41027	Oregon	Hood River County	4840	2026	1718	35.49586777
41029	Oregon	Jackson County	57990	2026	30481	52.56251078
41031	Oregon	Jefferson County	6028	2026	2555	42.38553417
41033	Oregon	Josephine County	26970	2026	16586	61.4979607
41035	Oregon	Klamath County	17764	2026	7626	42.92952038
41037	Oregon	Lake County	2254	2026	0	0
41039	Oregon	Lane County	91203	2026	61315	67.22914816
41041	Oregon	Lincoln County	17270	2026	5552	32.14823393
41043	Oregon	Linn County	30705	2026	19846	64.63442436
41045	Oregon	Malheur County	6200	2026	2214	35.70967742
41047	Oregon	Marion County	66835	2026	46487	69.55487394
41049	Oregon	Morrow County	2185	2026	327	14.96567506
41051	Oregon	Multnomah County	126699	2026	90627	71.52937277
41053	Oregon	Polk County	19156	2026	13240	69.11672583
41055	Oregon	Sherman County	531	2026	117	22.03389831
41057	Oregon	Tillamook County	8356	2026	967	11.57252274
41059	Oregon	Umatilla County	14787	2026	479	3.239331846
41061	Oregon	Union County	6522	2026	294	4.507819687
41063	Oregon	Wallowa County	2524	2026	323	12.79714739
41065	Oregon	Wasco County	6260	2026	2080	33.22683706
41067	Oregon	Washington County	96249	2026	67647	70.28332762
41069	Oregon	Wheeler County	488	2026	0	0
41071	Oregon	Yamhill County	23156	2026	14640	63.22335464

https://www.kff.org/medicare/medicare-advantage-in-2026-enrollment-update-and-key-trends/

Duty for Part C to "Cover" the Same Things as Part B

It's the service, ***not*** the payment amount…

Allowed Amt. vs. Payment Amt.

- REMEMBER: Allowed Amount ≠ Payment Amount
- If you are non-contracted, the allowed amount should be the same for the same level of service (e.g. A0427)
- **BUT** . . .

Allowed Amt. vs. Payment Amt.

- . . . the portion of the allowed amount paid by the Plan vs. the patient is not the same
  - Deductible amounts vary
  - Co-payment amounts vary

Allowed Amt. vs. Payment Amt.

	BLS Base Rate	Mileage Rate $9.15 (Ex. 5 Miles)	Total	Medicare Payment	Patient Responsibility
Traditional Medicare	$438.00	$45.75	$483.75	$387.00	$96.75
Medicare Advantage	$438.00	$45.75	$483.75	$183.75	$300.00

Medicare Part C Coverage

- For contracted providers, an MA plan covers ambulance services (including ambulance services dispatched through 911 or its local equivalent), where other means of transportation would endanger the beneficiary's health
  - 42 CFR § 422.113(a)

Medicare Part C Coverage

- For noncontracted providers, MA plans cover ambulance services *dispatched through 911 or its local equivalent*, where other means of transportation would endanger the beneficiary's health
  - 42 CFR §§ 422.100(b)(i) and 422.113(a)

Medicare Part C Coverage

- Did you see the difference there?
- For ***noncontracted providers*** this means ***MA plans are not required to use noncontracted providers to provide coverage for nonemergency ambulance services***

What Definition of "Emergency" is Used?

Hint: It's not the same as for Medicare Part B…

Medicare Part C: Emergency

- MA covers emergencies
  - Though they define that differently
- No need for contract or prior authorization

Medicare Part C: Emergency

- If no contract, the **"Allowed Amount"** for emergencies should be the same as the Medicare Part B **"Allowed Amount"** for the same level of service

Medicare Part C: Emergency

- If no contract, the **"Medicare Paid Amount"** for emergencies should be:
  - The Medicare Part B allowed amount
  - **Minus** applicable MA Plan co-payments & deductibles

"Emergency"

- Problem: "Emergency" definition as it pertains to Medicare is not universal
- Result:
  - Confusion
  - Misunderstandings
  - Billing errors
  - Coverage issues

"Emergency"

- Cause:
  - MA plans use the prudent layperson definition of "emergency medical condition"
    - Based on the patient's actual condition on scene
  - Part B uses CMS' definition of "Emergency Response"
    - Based on medically necessary response to the patient's reported condition at the time of dispatch

Part B: "Emergency Response"

- Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Part B: "Emergency Response"

- . . . the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol.

Prudent Layperson Standard

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

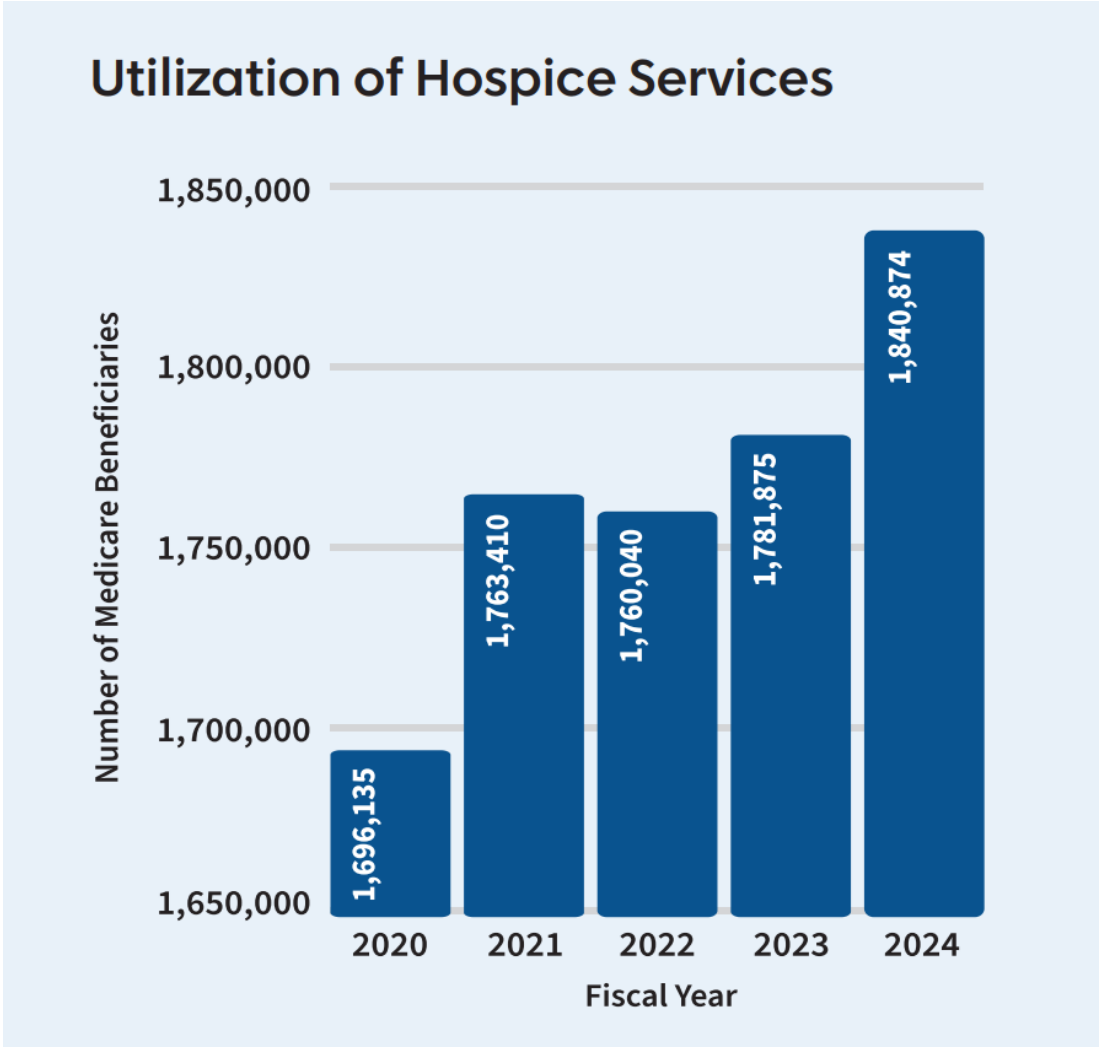
This definition is used by Medicare Part C Plans for emergency services

Remember – Regarding "Emergency"

- Medicare ≠ Medicare Advantage
- Be aware of each MA Plan's requirements

Hospice

Increasing Utilization



PWW|AG

CMS Is Cracking Down on Hospice Fraud!

July 25, 2025

HOSPICE | **CMS.GOV/FRAUD**

Fast Facts

Overview

Hospice is the comprehensive, holistic program of **palliative care for terminally ill patients** and support for their families. Once a beneficiary elects hospice, they waive curative treatment for their terminal illness. CMS pays for hospice care under Medicare Part A for beneficiaries enrolled in Medicare Fee-for-Service or Medicare Advantage. Hospice agencies are paid a per diem rate based on the level of care provided (e.g., routine home care or inpatient respite care).

Medicare hospice utilization has increased in recent years. In Fiscal Year 2024, **Medicare payments for hospice reached over $27 billion**, with approximately 1.8 million Medicare beneficiaries receiving hospice care.

CMS has taken significant action to address likely fraudulent behavior occurring in Medicare-enrolled hospices, including long lengths of stay, co-located hospices, and high rates of beneficiaries discharged alive.

N|AG

Hospice Basic Understandings

- When a Medicare beneficiary makes a Hospice election, the focus is now on comfort (palliative care), not curing an illness

Hospice Basic Understandings

- The intent is to care for them at home (which may now be a Hospice facility)
- They and their family agree that they will not call for ambulance transport without approval from Hospice

Hospice Basic Understandings

- Ambulance transports related to the terminal condition **and approved by Hospice** are billed to Hospice

Hospice Basic Understandings

- Ambulance transports that are unrelated to the terminal condition are billed to Medicare
  - The GW modifier is used to bypass the edits for Hospice when the transport is unrelated to the terminal condition

Hospice GW Modifier With MA Plan

- For a Medicare beneficiary with an MA Plan, claims that require the GW modifier should always be sent to the Part B MAC, not the MA Plan

Hospice Basic Understandings

- Ambulance transports related to the terminal condition that are **NOT** approved by Hospice are not Hospice's responsibility, and not Medicare's responsibility. They are billed to the patient or their estate

Date of Election

Date of Election

- The Hospice Interpretive Guidelines require that the initial assessment be conducted in the location where Hospice services will be provided
- The plan of care is developed from that initial assessment and from the comprehensive assessment

Date of Election

- Ambulance transports to a patient's home which occur on the effective date of the Hospice election (i.e., the date of admission), would occur prior to the initial assessment and therefore prior to the plan of care's development

Date of Election

- As such, **these transports are not the responsibility of the Hospice**

Date of Election

- Medicare will pay for ambulance transports of Hospice patients to their home, which occur on the effective date of Hospice election, through the ambulance benefit rather than through the Hospice benefit

Hospice and Medicare Advantage

Potential Scope

- Approximately 55% of Medicare Beneficiaries are enrolled in a Medicare Advantage Plan

What if the Patient Has MA

- Once a managed care enrollee has elected Hospice, all his or her Medicare benefits revert to traditional Medicare, even when the enrollee continues their Medicare Advantage plan for any additional benefits it may provide

What if the Patient Has MA

- CMS revised the CWF Medicare Hospice and MA enrollment edit(s) for claims submitted on or after July 6, 2010, to allow claims to be processed by FFS Medicare for services occurring on the date of the Hospice election, to prevent services provided on the date of the election from rejecting as MA Plan responsibility.

Transmittal 121, February 5, 2010

What if the Patient Has MA

- Submit the claim for the transport "home" on the date of election to FFS Medicare, not the MA Plan
- **Note:** In this case, "Home" means the place the patient is expected to live for the rest of their life
  - Not necessarily an "R" destination modifier

Revocation of Hospice Election

- Managed care enrollees who have elected Hospice may revoke Hospice election at any time

Revocation of Hospice Election

- When this happens, all Medicare claims will be paid by fee-for-service Medicare as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which Hospice was revoked

Common Errors With Hospice

Beneficiary End of Life

- While the family agreed that they would not call for an ambulance without Hospice approval, for a reason related to the terminal condition, when the patient's final day comes, they sometimes panic and forget that

Beneficiary End of Life

- When the ambulance service sends the bill to Hospice, they deny as "Not our responsibility"
- The ambulance service incorrectly assumes Hospice is saying the transport was unrelated to the terminal condition

Beneficiary End of Life

- The ambulance service submits the claim to Medicare with the GW modifier and Medicare pays the claim
- **HOWEVER . . .**

Beneficiary End of Life

- The reason for transport was not only **related to** the terminal condition, it was the expected result of the terminal condition

Beneficiary End of Life

- The payment from Medicare is an overpayment due to improper billing of the claim (using the GW modifier to bypass the edits when GW clearly did not apply)

Beneficiary End of Life

- The reason Hospice said that the claim was not their responsibility was that they did not authorize the transport.
- The family called for the ambulance when they had agreed they would not do that.
- **THEREFORE . . .**

Beneficiary End of Life

- Hospice is not responsible
- Medicare is not responsible
- The patient's family/estate is responsible for that transport for failing to abide by the agreement

Hospice Patient With An MA Plan

- Remember: The following claims go to the Part B MAC, not the MA Plan:
  - Date of enrollment trip to Hospice care
  - GW claims
  - All claims from date of Hospice revocation to the 1st of the next month

QUESTIONS?

THANK YOU FOR YOUR ATTENTION!

ORH Announcements

ORH Rural EMS Leadership series, and EMS Billing/Coding educational webinar series
(*More information here*)

Next ORH Community Conversation | September 17 | 12:00 p.m. Topic:
How CHWs at Rural Hospitals and Clinics Are Improving Health Outcomes
(*More information here*)

October 7-9, Bend, OR | 43rd Annual Oregon Rural Health Conference
(*More information here*)

Rural EMS Scholarship Program | Applications accepted on a rolling basis
(*More information here*)

Oregon Rural Health Excellence Award | Nomination application deadline August 31st
(*More information here*)

ORH's Rural Health Resource Hub | Search for resources, and share your resources
(*More information here*)

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Oregon Rural EMS and MIH SharePoint

A place to

post a question,
share a need,
find specific resources,
discover best practices,
seek equipment, and
collaborate.

See our new and upcoming ORH EMS and MIH grants and programs.

A site dedicated to addressing your workforce recruitment & retention needs.

It's a closed site. Request access here.
(Brief delay as your email must be added for login privileges.)


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❖ To be kept updated on specific ORH EMS offerings, complete this form and select your particular areas of interest.
❖ Please email any other topics or questions you would like to see addressed in future sessions to Joan at fieldj@ohsu.edu
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OREGON OFFICE of RURAL HEALTH

OPPORTUNITY Just knock.

Thank you!

Joan Field
Rural EMS Program Coordinator
fieldj@ohsu.edu

OHSU

CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare and Other Health Benefits: Your Guide to

Who Pays First

This official government booklet tells you

- How Medicare works with other types of insurance or coverage.
- Who should pay your bills first.
- Where to get more help.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Welcome to

Medicare and Other Health Benefits: Your Guide to Who Pays First!

How This Guide Can Help You

This Guide explains how Medicare works with other kinds of insurance or coverage, and who should pay your bills first. Some people who have Medicare have other insurance or coverage that must pay before Medicare pays its share of your bill. You may have more than one type of insurance or coverage that will pay before Medicare. This applies no matter how you get your Medicare benefits: through the Original Medicare Plan, a Medicare Advantage Plan, or an other Medicare Health Plan. Tell your doctor, hospital, and all other health providers about your other insurance or coverage. This is important to make sure that your bills are sent to the right payer to avoid delays.

"I used this Guide when I needed to know who paid first for my health care."

How To Use This Guide

This Guide has five sections. Each section is marked at the top of each page. The first section is a quick look at the Medicare insurance basics (see pages 1–4). The second section has basic information on who pays first in situations where you have Medicare and other insurance or coverage (see pages 5–8). The third section gives more detail on how Medicare works with other insurance or coverage (see pages 9–28). In this section, you will find important information about how Medicare works with a specific type of insurance or coverage. The fourth section includes definitions of important words (see pages 29–32). Use the index in the fifth section to look up a specific topic (see pages 33–34).

Table of Contents

"Medicare and Other Health Benefits: Your Guide to Who Pays First" isn't a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

The information in this Guide was correct when it was printed. Changes may occur after printing. For the most up-to-date version, visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

“We keep this booklet on our shelf so we know where to find it if we have a question.”

Section 1: Medicare Insurance Basics

What is Medicare?

Medicare is a health insurance program for

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

Medicare has

- **Medicare Part A**, Hospital Insurance, see page 4.
  Most people don't have to pay for Part A.
- **Medicare Part B**, Medical Insurance, see page 4.
  Most people pay a monthly premium for Part B.
- **Medicare prescription drug coverage** (starting January 1, 2006), see page 3. Most people will pay a premium for this coverage.

Medicare Plan Choices

The Original Medicare Plan—This a fee-for-service plan. This means you are usually charged a fee for each health care service or supply you get. This plan, managed by the Federal Government, is available nationwide. You will stay in the Original Medicare Plan unless you choose to join a Medicare Advantage Plan.

Words in red are defined on pages 29–32.

Medicare Plan Choices (continued)

Medicare Advantage Plans and Other Medicare Health Plans—These plans, which include HMOs, PPOs, and PFFS plans, may cover more services and have lower out-of-pocket costs than the Original Medicare Plan. However, in some plans, like HMOs, you may only be able to see certain doctors or go to certain hospitals.

Medicare Advantage Plans include

- Medicare Health Maintenance Organization (HMO) Plans
- Medicare Preferred Provider Organization (PPO) Plans
- Medicare Special Needs Plans
- Medicare Private Fee-for-Service (PFFS) Plans

Other Medicare Health Plans (that aren't Medicare Advantage Plans) include

- Medicare Cost Plans
- Demonstrations
- PACE (Programs of All-inclusive Care for the Elderly)

Words in red are defined on pages 29–32.

Medicare Plan Choices (continued)

Medicare Prescription Drug Coverage—Medicare prescription drug coverage starts January 1, 2006. You can get prescription drug coverage no matter how you get your Medicare health care.

You can first enroll in a Medicare Prescription Drug Plan starting November 15, 2005 through May 15, 2006, or until three months after the month your Medicare coverage starts, whichever is later.

For most people, joining now means you will pay your lowest possible monthly premium. If you don't join a plan by May 15, 2006, and you don't currently have a drug plan that, on average, covers at least as much as standard Medicare prescription drug coverage, you will have to wait until November 15, 2006 to join. When you do join, **your premium cost will go up at least 1% per month for every month that you wait to join**. Like other insurance, you will have to pay this penalty as long as you have Medicare prescription drug coverage. If you join by December 31, 2006, your coverage will begin January 1, 2007.

Note: If you have other insurance that pays for your prescriptions and you join a Medicare Prescription Drug Plan, you **must** let your Medicare Prescription Drug Plan know about your other coverage.

For more information about Medicare Prescription Drug Plans, get a free copy of "Your Guide to Medicare Prescription Drug Coverage" (CMS Pub. No. 11109) by visiting www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Section 1: Medicare Insurance Basics

Medicare Part A

Medicare Part A—Hospital Insurance, helps pay for inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not non-skilled or long-term care). It also covers hospice care and some home health care. You must meet certain conditions. To learn more about these conditions, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Cost: Most people don't have to pay a monthly payment, called a premium, for Medicare Part A. This is because they or a spouse paid Medicare taxes while they were working.

Medicare Part B

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

Cost: You pay the Medicare Part B premium of $78.20 per month in 2005. This amount may change January 1, 2006. Premiums can change every year. In some cases, this amount may be higher if you didn't sign up for Medicare Part B when you first became eligible.

Need More Information?

For information about signing up for Medicare Part A and Part B, call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. If you get benefits from the Railroad Retirement Board (RRB), call your local RRB office or 1-800-808-0772. You can also get a free copy of "Enrolling in Medicare" (CMS Pub. No. 11036) by visiting www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, call 1-800-MEDICARE (1-800-633-4227).

Words in red are defined on pages 29–32.

Section 2: Basic Information

A Quick Look: Know Who Pays First If You Have Other Health Insurance or Coverage

If you have Medicare and other health insurance or coverage, be sure to tell your doctor and other providers. This will help them send your bills to the correct payer to avoid delays. Whether Medicare pays first or second depends on a number of things. You should consider those listed in the chart below and on page 6 to help find who pays first. However, this chart doesn't cover every situation. If you have questions about who pays first or if your insurance changes, call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor.

If you...	Condition	Pays first	Pays second	See page(s)
Are age 65 or older and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	Entitled to Medicare			
	The employer has 20 or more employees	Group Health Plan	Medicare	10
	The employer has less than 20 employees*	Medicare	Group Health Plan	11
Have an employer group health plan after you retire and are age 65 or older	Entitled to Medicare	Medicare	Retiree Coverage	12–13
Are disabled and covered by a large group health plan from your work, or from a family member who is working	Entitled to Medicare			
	The employer has 100 or more employees	Large Group Health Plan	Medicare	13–14
	The employer has less than 100 employees**	Medicare	Group Health Plan	13

* (or, if it is part of a multi-employer plan where one employer has 20 or more employees, if the plan has requested an exception that is approved by Medicare)

** (and isn't part of a multi-employer plan where any employer has 100 or more employees)

If you...	Condition	Pays first	Pays second	See page(s)
Have End-Stage Renal Disease (permanent kidney failure) and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group Health Plan	Medicare	14
	After 30 months	Medicare	Group Health Plan	14
Have End-Stage Renal Disease (permanent kidney failure) and COBRA coverage	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare	25–28
	After 30 months	Medicare	COBRA	14
Have been in an accident where no-fault or liability insurance is involved	Entitled to Medicare	No-fault or Liability insurance, for services related to accident claim	Medicare	15–17
Are covered under workers' compensation because of a job-related illness or injury	Entitled to Medicare	Workers' compensation, for workers' compensation claim related services	Usually doesn't apply. However, Medicare may make a conditional payment.	17–21
Are a Veteran and have Veterans' benefits	Entitled to Medicare and Veterans' benefits	Medicare pays for Medicare-covered services	Usually doesn't apply.	21–23
		Veterans' Affairs pays for VA authorized services		
		Note: Generally, Medicare and VA can't pay for the same service.		
Are covered under TRICARE	Entitled to Medicare and TRICARE	Medicare pays for Medicare-covered services	TRICARE may pay second.	23–24
		TRICARE pays for services from a military hospital or any other federal provider.		
Have black lung disease and covered under the Federal Black Lung Program	Entitled to Medicare and Federal Black Lung Program	Federal Black Lung Program, for black lung related services	Medicare	24–25
Are age 65 or over OR disabled and covered by Medicare and COBRA coverage	Entitled to Medicare	Medicare	COBRA	25–28

General Information on Medicare and Other Insurance or Coverage

I'm not yet 65. How will Medicare know that I have other insurance or coverage?

Medicare doesn't automatically know if you have other insurance or coverage. Medicare sends you a questionnaire called the "Initial Enrollment Questionnaire" about three months before you are entitled to Medicare. This questionnaire will ask you if you have group health plan insurance through your work or that of a family member and if you plan to keep it. Your answers to this questionnaire are used to help Medicare set up your file, and make sure that your claims are paid by the right insurance.

Example
Harry is almost 65 and is getting ready to retire and enroll in Medicare. Harry's wife, Jane, is 63, and works for a large company. Both Harry and Jane have health insurance coverage through Jane's employer's group health plan. When Harry gets the Initial Enrollment Questionnaire in the mail from Medicare, he fills it out and reports that he has insurance through his wife's employment. His wife's employer employs more than 20 people. This insurance is Harry's primary (first) payer. In this situation, Medicare will pay claims second.

What happens if my health insurance or coverage changes after I fill out the Initial Enrollment Questionnaire?

If your health insurance or coverage changes, you will need to:

- Call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.
- Give the Medicare Coordination of Benefits Contractor the name and address of your health plan, your policy number, the date coverage changed or stopped, and why.
- Tell your doctor and other providers about the change in your insurance or coverage when you get care.

Words in red are defined on pages 29–32.

General Information on Medicare and Other Insurance or Coverage (continued)

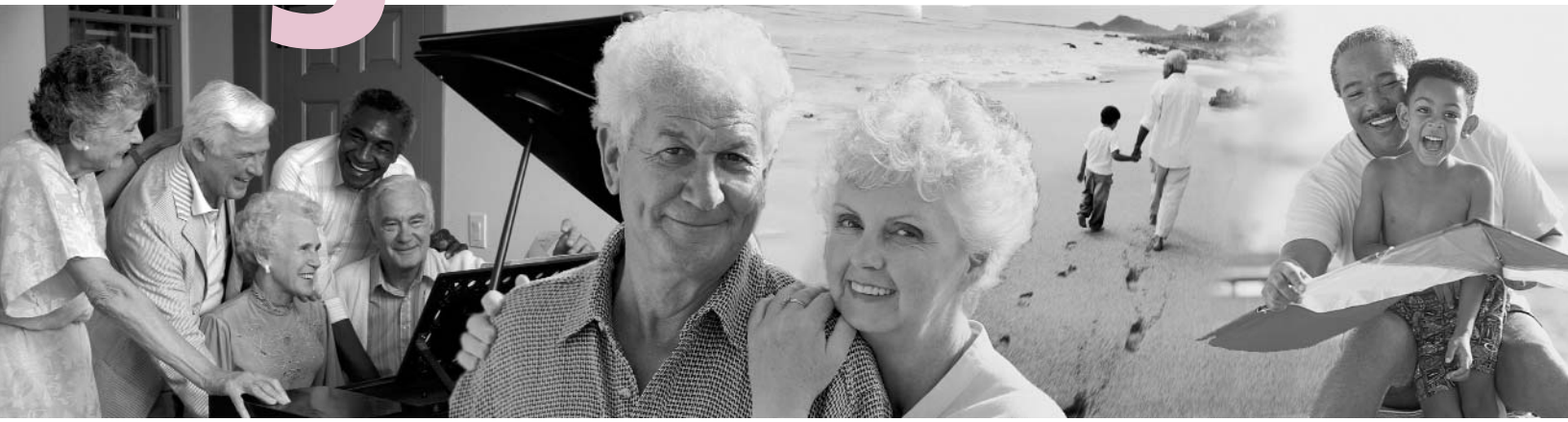
What if I have more than one type of insurance or coverage, as well as Medicare?

You may have more than one type of insurance or coverage that will pay before, or along with, Medicare. If you have a question about who should pay, or who should pay first, check your insurance policy or coverage. It may include a coordination-of-benefits clause. You should call 1-800-MEDICARE (1-800-633-4227) with questions about Medicare, who pays first, or how your insurance or coverage works with Medicare. They will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.

Whom can I call if I have a general question about who pays first?

You should call the benefits administrator at your health insurance plan. Or, you can call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.

Section 3: Medicare and Other Types of Insurance or Coverage



This section has more detailed information about the different types of insurance or coverage that you might have, and how these types of insurance or coverage work with Medicare.

Section 3 includes:

Medicare and Group Health Plan Coverage

When you turn age 65, there are a number of important decisions you must make, like whether to enroll in Medicare Part B, buy a Medigap policy, and/or keep employer or retiree coverage. To make sure you understand how to avoid paying more for Medicare Part B and other insurance, as well as get the coverage that is best for you, call 1-800-MEDICARE (1-800-633-4227). Ask for a free copy of "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare" (CMS Pub. No. 02110). TTY users should call 1-877-486-2048. Or, you can visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. You can also call your State Health Insurance Assistance Program. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

What is group health plan coverage?

Group health plan coverage is coverage offered by many employers and unions for current employees or retirees. You may also get group health plan coverage through a spouse or family member's employer.

If you can get Medicare and you are offered coverage under a group health plan, you can choose to accept or reject the plan. The group health plan may be a fee-for-service plan or a managed care plan, like an HMO or PPO.

I have Medicare and group health plan coverage. Who pays first?

Generally, if you are age 65 or older and covered by a group health plan because of your **current** employment or the **current** employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees, and covers any of the same services as Medicare. This means that the group health plan is the primary payer (see example below). The group health plan pays first on your hospital and medical bills. If the group health plan didn't pay all of your bill, the doctor or other provider should send the bill to Medicare for secondary payment. Medicare will review what your group health plan paid for Medicare-covered health care services, and pay any additional Medicare-approved amounts. You will have to pay the costs of services that Medicare or the group health plan doesn't cover.

Words in red are defined on pages 29–32.

Example

Marge is 72 years old and works full time for the ABC Company with 75 employees. She has group health plan coverage through her employer. Therefore, her group health plan will be the primary payer and Medicare will be the secondary payer.

Medicare and Group Health Plan Coverage (continued)

I work for a small company and have Medicare. Who pays first?

If your employer has fewer than 20 employees, Medicare is generally the primary payer. But, if your employer is part of a multi-employer plan and if any of the employers have 20 or more employees, the plan must file a request for exception for employers with less than 20 employees. Medicare must approve this exception before Medicare can be your primary payer. The plan must submit an exception request to the Medicare Coordination of Benefits Contractor at the below address:

Medicare Coordination of Benefits Contractor
P.O. Box 5041
New York, NY 10274-5041

I decided not to take group health plan coverage from my employer. Who is my primary payer?

If you don't take group health plan coverage from your employer and you don't have coverage through an employed spouse, then Medicare will be your primary payer. Medicare will pay its share for any Medicare-covered health care service you get.

I decided not to take group health plan coverage from my employer. What type of health insurance can my employer offer?

If you don't take group health plan coverage from your employer, then your employer can offer you a plan that will pay for services Medicare doesn't cover such as hearing aids, routine dental care, and routine physical check-ups. However, the employer can't offer you a plan that pays supplemental benefits for Medicare-covered services or pays for these benefits in any other way.

What happens if I drop my employer-based coverage?

Medicare is your primary payer unless you have employer-based coverage through an employed spouse and your spouse's employer has at least 20 employees.

Note: If you don't take or you drop your employer-based group health coverage, you may not be able to get it later or get it back. You may also be denied coverage after you retire, if you or your spouse's employer offers this type of coverage, because you weren't enrolled in the plan while you or your spouse were working. Call your benefits administrator for more information before you make a decision.

Medicare and Group Health Plan Coverage (continued)

What health benefits must my employer provide if I am age 65 or older and still working?

Generally, employers with 20 or more employees must offer the same health benefits, under the same conditions, to current employees age 65 and older as they offer to younger employees. If the employer offers coverage to spouses, they must offer the same coverage to spouses age 65 and older that they offer to spouses under age 65.

Medicare and Group Health Plan Coverage After You Retire

How does my group health plan coverage work after I retire?

Group health plan coverage after you retire (known as Retiree Coverage) provided by your or your spouse's former employer or union isn't a Medigap policy. However, like a Medigap policy, it usually offers benefits that fill in some of Medicare's gaps in coverage and sometimes includes extra benefits, like extra days in the hospital. Retiree coverage might not pay your medical costs during any period in which you were eligible for Medicare but didn't sign up for it. Find out if your employer coverage can be continued after you retire. Check the price and the benefits, including coverage for your spouse. Make sure you know what effect your continued coverage as a retiree will have on both your and your spouse's insurance coverage. Retiree coverage provided by your employer or union may have limits on how much it will pay. It may also provide "stop loss" coverage, or a limit on your out-of-pocket costs. When you become eligible for Medicare, you may need to enroll in both Medicare Part A and Part B to receive full benefits from your retiree coverage.

If you aren't sure how your retiree coverage works with Medicare, get a copy of your plan's benefits booklet, or look at the summary plan description provided by your employer or union. You can also call your benefits administrator and ask how the plan pays when you have Medicare.

Note: Generally, when you have retiree coverage from an employer or union, they control this coverage. They may change the benefits or the premiums and can also cancel the coverage if they choose.

Words in red are defined on pages 29–32.

Medicare and Group Health Plan Coverage After You Retire (continued)

I'm retired and have Medicare. I also have group health plan coverage from my former employer. Who pays first?

Generally, Medicare will pay first for your health care bills and your group health plan (retiree) coverage will pay second.

What happens if I have group health plan coverage after I retire and my former employer goes bankrupt or goes out of business?

If your former employer goes bankrupt or goes out of business, you may be protected under Federal COBRA rules. These rules require any other company within the same corporate organization that still offers a group health plan to its employees to offer you COBRA continuation coverage through that plan (see pages 25–28).

Medicare and Group Health Plan Coverage for People Who are Disabled

I'm under age 65, disabled and have Medicare and group health plan coverage based on current employment. Who pays first?

It depends. Generally, if your employer has less than 100 employees, Medicare is the primary payer if

- you are under age 65, and
- have Medicare because of a disability.

If the employer has 100 employees or more, the health plan is called a large group health plan. If you are covered by a large group health plan because of your current employment or the current employment of a family member, Medicare is the secondary payer (see example on page 14).

Sometimes employers with fewer than 100 employees join other employers in a multi-employer plan. If at least one employer in the multi-employer plan has 100 employees or more, then Medicare is the secondary payer for disabled people with Medicare who are enrolled in the plan, including those covered by small employers. Some large group health plans let others join the plan, such as a self-employed person, a business associate of an employer, or a family member of one of these people. A large group health plan can't treat any of its plan members differently because they are disabled and have Medicare.

Medicare and Group Health Plan Coverage for People Who are Disabled (continued)

Example
Mary works full-time for XYZ Company, which has 120 employees. She has large group health plan coverage for herself and her husband. Her husband has Medicare because of a disability. Therefore, Mary's group health plan coverage pays first for Mary's husband, and Medicare is his secondary payer.

Medicare and Group Health Plan Coverage for People with End-Stage Renal Disease (ESRD) (permanent kidney failure)

I have ESRD and group health plan coverage. Who pays first?

If you are eligible to enroll in Medicare because of End-Stage Renal Disease, your group health plan will pay first on your hospital and medical bills for 30 months, whether or not you are enrolled in Medicare and have a Medicare card. During this time, Medicare is the secondary payer. The group health plan pays first during this period no matter how many employees work for your employer, or whether you or a family member are currently employed. At the end of the 30 months, Medicare becomes the primary payer. This rule applies to most people with ESRD, whether you have your own group health plan coverage or you are covered as a family member.

Example
Bill has Medicare coverage because of permanent kidney failure. He also has group health plan coverage through his company. Bill's group health plan coverage will be the primary payer for the first 30 months after he becomes eligible for Medicare. After 30 months, Medicare becomes the primary payer.

Medicare and No-fault or Liability Insurance

Medicare is the secondary payer when no-fault insurance or liability insurance is available as the primary payer.

What is no-fault insurance?

No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Words in red are defined on pages 29–32.

Some types of no-fault insurance include, but aren't limited to

- Automobile insurance
- Homeowners' insurance
- Commercial insurance plans

What is liability insurance?

Liability insurance is coverage that protects against claims for negligence, inappropriate action, or inaction which results in injury to someone or damage to property.

Liability insurance includes, but isn't limited to

- Homeowners' liability insurance
- Automobile liability insurance
- Product liability insurance
- Malpractice liability insurance
- Uninsured motorist liability insurance
- Underinsured motorist liability insurance

Example
Nancy, 68 years old, falls while visiting her daughter's house and injures herself. While at the hospital emergency room, Nancy is asked whether her daughter has homeowner's insurance. Since she does, the hospital will supply Medicare with the information that another insurer (in this case, homeowner's liability insurance) may pay first.

Medicare and No-fault or Liability Insurance (continued)

If I expect to get money from no-fault or liability insurance, and I also have Medicare, which one should pay first?

No-fault or liability insurance should be the primary payer. If doctors or other providers decide that the services you received can be paid for by a no-fault or liability insurance company, they must try to get payments from the insurance company before billing Medicare. However, this may take a long time. If the insurance company doesn't pay the claim within 120 days, your doctor or other provider may bill Medicare. Medicare may make a conditional payment to pay the bill.

What is a conditional payment?

A conditional payment is a payment that Medicare makes for services for which another payer is responsible. This conditional payment is made so you won't have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a settlement, judgment, or award is reached.

Note: If Medicare makes a conditional payment, and later you get a settlement from an insurance company, Medicare will recover the conditional payment from your settlement, judgment, or award. You are responsible for making sure that Medicare gets repaid for the conditional payment.

Example

Joan is driving her car when someone in another car hits her. Joan has to go to the hospital. The hospital tries to bill the other driver's liability insurer. The insurance company disputes who was at fault, and won't pay the claim right away. The hospital bills Medicare, and Medicare makes a conditional payment to the hospital for health care services that Joan received. Later, when a settlement is reached with the liability insurer, Joan must make sure that Medicare gets its money back for the conditional payment.

Medicare and No-fault or Liability Insurance (continued)

How does Medicare get its money back for the conditional payment?

If Medicare makes a conditional payment, and you or your attorney haven't reported your no-fault or liability claim to Medicare, then you should call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor (COBC). If your attorney contacts Medicare, your attorney should call the COBC at 1-800-999-1118. The COBC will assign a Medicare contractor to work on your case. This contractor will use the information that you gave to the COBC to start gathering information about any conditional payments Medicare made which relate to your pending settlement, judgment, or award. Once a settlement, judgment, or award is final, you or your attorney should call the Medicare contractor assigned to your case. This contractor will get the final repayment amount (if any) on your case, and issue a demand letter requesting repayment.

Who pays if the no-fault or liability insurance doesn't pay, or denies my medical bill?

In this case, Medicare will pay first. However, Medicare will only pay for Medicare-covered services. You will be responsible for your share of the bill (for example, coinsurance, copayment, or deductible), and bills for services that Medicare doesn't cover.

Who should I call if I have questions?

If you have questions about a no-fault or liability insurance claim, call the insurance company. If you have questions about who pays first call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.

Words in red are defined on pages 29–32.

Medicare and Workers' Compensation

What is workers' compensation?

Workers' compensation is insurance that employers are required to have to cover employees who get sick or injured on the job. Most employees are covered under workers' compensation plans. If you don't know whether you are covered, ask your employer.

Medicare and Workers' Compensation (continued)

I have Medicare and filed a workers' compensation claim. Who pays first?

If you think you have a work-related illness or injury, you have to tell your employer, and file a workers' compensation claim.

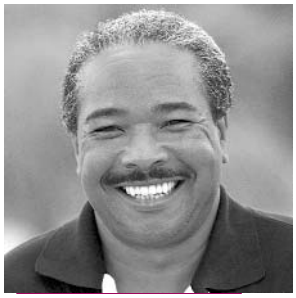
You also need to call 1-800-MEDICARE (1-800-633-4227) as soon as you file your workers' compensation claim and they will connect you to the Medicare Coordination of Benefits Contractor (COBC). If you have an attorney working on your behalf, your attorney should call the COBC at 1-800-999-1118.

Workers' compensation pays first on the bills for health care items or services you got because of your work-related illness or injury. There can be a delay between when a bill is filed for the work-related illness or injury and when the state workers' compensation insurance decides if they should pay the bill. Medicare can't pay for items or services that workers' compensation will pay for within 120 days. If workers' compensation doesn't pay your bill within 120 days, Medicare may then make a conditional payment.

What is a conditional payment?

A conditional payment is a payment that Medicare makes for services for which another payer is responsible. This conditional payment is made so you won't have to use your own money to pay the bill. The payment is "conditional" because it must be repaid to Medicare when a workers' compensation settlement is reached.

Note: If Medicare makes a conditional payment, and later you get a settlement from the workers' compensation agency, Medicare will recover the conditional payment from your settlement, judgment, or award. You are responsible for making sure that Medicare gets repaid for the conditional payment.



Example

Tom was injured at work. He filed a claim for workers' compensation insurance and his doctor billed the state workers' compensation insurance for payment. After 120 days passed, and the state workers' compensation insurance didn't pay the bill, Tom's doctor billed Medicare and sent a copy of the workers' compensation claim with the claim for Medicare payment. Medicare can make a conditional payment to the doctor for the health care services that Tom received. Later, when a settlement is reached with the state workers' compensation agency, Tom must make sure that Medicare gets its money back for the conditional payment.

Medicare and Workers' Compensation (continued)

How does Medicare get its money back for the conditional payment?

If Medicare makes a conditional payment, and you or your attorney haven't reported your worker's compensation claim to Medicare, then you should call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor (COBC). If your attorney contacts Medicare, your attorney should call the COBC at 1-800-999-1118. The COBC will assign a Medicare contractor to work on your case. This contractor will use the information that you gave to the COBC to start gathering information about any conditional payments Medicare made which relate to your pending settlement, judgment, or award. Once a settlement, judgment, or award is final, you or your attorney should call the Medicare contractor assigned to your case. This contractor will identify the final repayment amount (if any) on your case, and issue a demand letter requesting repayment.

What if I want to settle my workers' compensation claim?

As part of settling your workers' compensation claim, Medicare's interest must be considered. This means, if your proposed settlement includes funds for any future medical expenses, then you or your attorney should send your proposed settlement to the Medicare Coordination of Benefits Contractor.

The proposed settlement should be mailed to the Medicare Coordination of Benefits Contractor at the below address:

- CMS
  c/o Coordination of Benefits Contractor
  P.O. Box 660
  New York, NY 10274-0660
  Attention: WCMSA Proposal

You can also get more information about the requirements that are needed to send your proposed settlement at www.cms.hhs.gov/medicare/cob/PDF/wcchecklist.pdf on the web.

The information listed above is about settling your workers' compensation claim. To learn about Medicare set aside arrangements, see page 20.

Words in red are defined on pages 29–32.

Medicare and Workers' Compensation (continued)

I received a lump sum of money as part of my workers' compensation settlement. How can I use the money that was specifically set aside for Medicare if I manage (self-administer) my Medicare set aside arrangement?

If you received a lump sum of money as part of your workers' compensation settlement, then you must be careful how you spend the money that was specifically set aside for Medicare. The money that was placed in your Medicare set aside arrangement is to pay for future medical expenses related to your work injury or illness that would have otherwise been covered (payable) by Medicare. This means you can't use the Medicare set aside arrangement to pay for any work injury or illness services that Medicare doesn't cover (for example, dental services). If you aren't sure what type of services Medicare covers, then you should call Medicare for more information before you use any of the money that was placed in your Medicare set aside arrangement. You can call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

You created this set aside arrangement because you agreed to get all of your money at one time, instead of getting ongoing medical coverage from your workers' compensation carrier. Since you are self-administering your Medicare set aside arrangement, Medicare won't pay for any workers' compensation medical expenses until after you have used all of your set aside money appropriately.

Note: Workers' compensation claims can be resolved by settlements, judgments, or awards. The information listed here only applies to Medicare set aside arrangements.

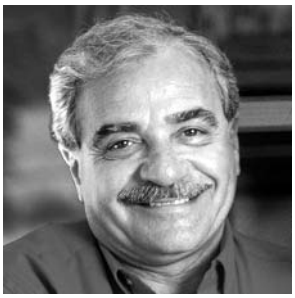
Be sure to keep records of your workers' compensation medical expenses. These records show what services you received and how much money you spent on your work injury or illness. You will need these records in the future to prove that you used your set aside money to pay your workers' compensation medical expenses. After you use all of your set aside money appropriately, Medicare can start paying for Medicare-covered (payable) services related to your work injury or illness.

Remember, as part of settling your workers' compensation claim, Medicare's interests must be considered (see page 19).

Medicare and Workers' Compensation (continued)

What if workers' compensation denies payment?

If payment is denied by the state workers' compensation insurance, Medicare will only pay for Medicare-covered items and services.



Example
Mike was injured at work. He filed a claim for workers' compensation. The workers' compensation agency denied payment for Mike's medical bills. Mike's doctor billed Medicare and sent a copy of the workers' compensation denial with the claim for Medicare payment. Medicare will pay Mike's doctor for the Medicare-covered items and services Mike received as part of his treatment. Mike will have to pay for anything Medicare doesn't cover.

Can workers' compensation decide not to pay my entire bill?

In some cases, workers' compensation insurance may not pay your entire bill. If you have a pre-existing condition that gets worse because of your job, your entire bill may not be paid. In this case, a pre-existing condition is any health problem that you had before you started your job. For example, you may have a problem with your back that gets worse because of your job. In this case, workers' compensation insurance may agree to pay only a part of your doctor or hospital bills. You and workers' compensation insurance may agree to share the cost of your bill. If the treatment for your pre-existing condition is covered by Medicare, Medicare may pay its share for part of the doctor or hospital bills that workers' compensation doesn't cover.

Medicare and Veterans' Benefits

Words in red are defined on pages 29–32.

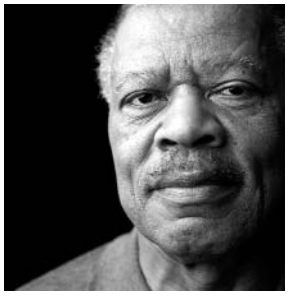
I have Medicare and Veterans' benefits. Who pays first?

If you have or can get both Medicare and Veterans' benefits, you can get treatment under either program. When you get health care, you must choose which benefits you are going to use. You must make this choice each time you see a doctor or get health care, like in a hospital. Medicare can't pay for the same service that was covered by Veterans' benefits, and your Veterans' benefits can't pay for the same service that was covered by Medicare. You don't always have to go to a Department of Veterans' Affairs (VA) hospital or to a doctor who works with the VA for the VA to pay for the service. To get services under VA, you must go to a VA facility or have the VA authorize services in a non-VA facility.

Medicare and Veterans' Benefits (continued)

Are there any situations when both Medicare and VA can pay?

Yes. If the VA authorizes services in a non-VA hospital, but doesn't pay for all of the services you get during your hospital stay, then Medicare may pay for the Medicare-covered part of the services that the VA doesn't pay for.



Example
Bob, a veteran, goes to a non-VA hospital for a service that is authorized by the VA. While at the non-VA hospital, Bob gets other non-VA authorized services that the VA refuses to pay for. Some of these services are Medicare-covered services. Medicare may pay for some of the non-VA authorized services that Bob received. Bob will have to pay for services that aren't covered by Medicare or the VA.

Can Medicare help pay my VA copayment?

Sometimes. The VA charges a copayment to some veterans. The copayment is your share of the cost of your treatment, and is based on income. Medicare may be able to pay all or part of your copayment if you are billed for VA-authorized care by a doctor or hospital who isn't part of the VA.

I have a VA fee basis identification (ID) card. Who pays first?

The VA gives "fee basis ID cards" to certain veterans. You may be given a fee basis ID card if

- you have a service-connected disability,
- you will need medical services for an extended period of time, or
- there are no VA hospitals in your area.

If you have a fee basis ID card, you may choose any doctor who is listed on your card to treat you for the condition.

If the doctor accepts you as a patient and bills the VA for services, the doctor must accept the VA's payment as payment in full. The doctor may not bill either you or Medicare for these services.

If your doctor doesn't accept the fee basis ID card, you will need to file a claim with the VA yourself. The VA will pay the approved amount to either you or your doctor.

Words in red are defined on pages 29–32.

Medicare and Veterans' Benefits (continued)

Need More Information?

You can get more information on Veterans' benefits by calling your local VA office, or the national VA information number at 1-800-827-1000. Or, you can visit www.va.gov on the web.

Medicare and TRICARE

What is TRICARE?

TRICARE is a health care program for active duty and retired uniformed services members and their families. TRICARE includes the following:

- TRICARE Prime,
- TRICARE Extra,
- TRICARE Standard, and
- TRICARE for Life (TFL).

What is TRICARE for Life?

TRICARE for Life (TFL) was created to provide expanded medical coverage to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses. To get TFL benefits, you **must** have Medicare Part A and Part B.

Can I have both Medicare and TRICARE?

Certain groups of people can have both Medicare and TRICARE. They are:

- Dependents of active duty service members who are entitled to Medicare for any reason,
- People under age 65 who are entitled to Medicare Part A because of a disability or End-Stage Renal Disease (ESRD) **and** enrolled in Medicare Part B, or
- People age 65 or older who are entitled to Medicare Part A **and** are enrolled in Medicare Part B.

Medicare and TRICARE (continued)

Who pays first, Medicare or TRICARE?

In general, Medicare pays first for Medicare-covered services. TRICARE will pay the Medicare deductible and coinsurance amounts, and for any service not covered by Medicare that TRICARE covers. You will have to pay the costs of services that Medicare or TRICARE doesn't cover.

Who pays if I get services from a military hospital?

If you get services from a military hospital or any other federal provider, TRICARE will pay the bills. Medicare doesn't usually pay for services you get from a federal provider or other federal agency.

Need More Information?

You can get more information on TRICARE by calling the health benefits advisor at a military hospital or clinic. You can also call 1-888-363-5433. Or, visit www.TRICARE.osd.mil on the web.

Medicare and the Federal Black Lung Program

I have Medicare and coverage under the Federal Black Lung Program. Who pays first?

Health care for black lung disease is covered under workers' compensation. For all other health care not related to black lung, your bills should be sent directly to Medicare. Medicare won't pay for doctor or hospital services that are covered under the Federal Black Lung Program. Your doctor or other provider should send all bills for the diagnosis or treatment of black lung to the following address:

Federal Black Lung Program
P.O. Box 828
Lanham-Seabrook, MD 20703-0828

If the Federal Black Lung Program won't pay your bill, your doctor or other provider can send the bill to Medicare. Your doctor or other provider should send your bill and a copy of the letter from the Federal Black Lung Program that says why they won't pay your bill.

Medicare and the Federal Black Lung Program (continued)

Who should I call if I have questions?

If you have questions about the Federal Black Lung Program, call 1-800-638-7072. If you have questions about who pays first, call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.

Medicare and COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985)

What is COBRA?

COBRA is a law that may let you keep your employer group health plan coverage for a limited period of time after your employment ends or after you lose coverage as a dependent of the covered employee. This is called "continuation coverage."

Generally, you may have this right if you lose your job, have your working hours reduced, leave your job voluntarily, or your employer goes bankrupt. You may also have this right if you are covered under your spouse's plan and your spouse dies or you get divorced.

COBRA generally lets you and your dependents keep the group health plan coverage for 18 months (or 36 months or sometimes even for a lifetime if you are a retiree and your former employer goes bankrupt as discussed on page 27). You usually have to pay both your share and the employer's share of the premium, plus an administrative fee.

This law only applies to employers with 20 or more employees. Some state laws require insurers covering employers with fewer than 20 employees to let you keep your coverage for a period of time. In most situations that give you COBRA rights, other than a divorce, you should get a notice from your employer's benefits administrator or the group health plan. If you don't get a notice, or if you get divorced, you should call the employer's benefits administrator or the group health plan as soon as possible.

Medicare and COBRA (The Consolidated Omnibus Budget Reconciliation Act of 1985) (continued)

What happens if I have COBRA and enroll in Medicare?

If you already have continuation coverage under COBRA when you enroll in Medicare, your COBRA coverage may end. This is because the employer has the option of canceling the continuation coverage at this time. The length of time your spouse may get coverage under COBRA may change when you enroll in Medicare.

What happens if I have Medicare and choose to get COBRA coverage?

If you are already enrolled in Medicare, you can elect COBRA coverage during the COBRA election period. If you have only Medicare Part A when your group health plan coverage ends (based on **current** employment), you can enroll in Medicare Part B during a Special Enrollment Period (SEP) without having to pay a higher Medicare Part B premium. You have to sign up for Medicare Part B within eight months after your group health plan coverage ends or when the employment ends, whichever is first.

Note: Before you elect COBRA coverage, it may be helpful to talk with your State Health Insurance Assistance Program. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

If you don't sign up for Medicare Part B during the eight-month period (SEP) or when your employment ends or you lose coverage, you will only be able to sign up during the General Enrollment Period and the cost of Medicare Part B may go up.

If you are covered under COBRA, your employer group health plan may require you to sign up for Medicare Part B. In that case, the best time to sign up for Medicare Part B is **before** your employment ends or you lose coverage. If you wait to sign up for Medicare Part B during the last part of your SEP (the eight months **after** your employment or coverage ends), your employer could make you pay for services that Medicare would have paid for if you had signed up earlier.

State law may give you the right to continue your coverage beyond the point COBRA coverage would ordinarily end. Your rights will depend on what is allowed under the state law.

Remember, once you are age 65 or older and you enroll in Medicare Part B, the Medigap open enrollment period starts and can't be changed.

Medicare and COBRA (continued)

What happens if I have group health plan coverage after I retire and my former employer goes bankrupt?

In this situation you may be able to get "COBRA-for-life." This means you can keep COBRA for the rest of your life or until the company ceases to exist, if earlier. Like any other employer plan, benefits under the plan can change and the cost of the coverage can go up in the future.

The notice you get from your former employer may only tell you about your COBRA options. However, because you are losing all coverage under your former employer's plan that supplemented your Medicare benefits, you now also have the choice of buying a Medigap policy. Under Federal law, you have a guaranteed issue right to buy certain Medigap policies.

Important: There are certain timeframes that you must know about COBRA and Medigap policies when your employer goes bankrupt. The COBRA election period is 60 days after the later of the date coverage is lost due to a COBRA qualifying event or the date of the notice of the right to elect COBRA coverage. You also have a 63-day Medigap guaranteed issue period to buy a Medigap policy. The 63-day guaranteed issue period generally begins when you receive a notice that coverage will be terminated and ends 63 days after the notice. If you don't receive a notice, the guaranteed issue period begins when you receive notice that a claim has been denied and ends 63 days after such notice. The Medigap guaranteed issue timeframe may be different depending on the law in your state. In most cases, the COBRA timeframe and the Medigap guaranteed issue timeframe will overlap. To learn how these timeframes will affect you, call your State Health Insurance Assistance Program. To get their telephone number, call 1-800-MEDICARE (1-800-633-4227).

For more information about Medigap policies and your Medigap rights and protections, you can call your State Health Insurance Assistance Program. You can also get a free copy of "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare" (CMS Pub. No. 02110). You can visit www.medicare.gov on the web. Select "Search Tools" at the top of the page. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Words in red are defined on pages 29–32.

Medicare and COBRA (continued)

Who pays first, Medicare or my COBRA continuation coverage?

If you or your spouse are age 65 or older and have COBRA continuation coverage, Medicare is the primary payer. If you or a family member have Medicare based on a disability and COBRA continuation coverage, Medicare is the primary payer.

However, if you or a family member have Medicare based on ESRD, COBRA continuation coverage is the primary payer and Medicare is the secondary payer to the extent COBRA coverage overlaps the first 30 months of Medicare eligibility or entitlement based on ESRD.

Where should I call if I have questions?

You should call your benefits administrator for questions about COBRA coverage and payments. If you have questions about Medicare and COBRA, call 1-800-MEDICARE (1-800-633-4227) and they will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.

Need More Information?

- For more information about how COBRA works for private sector (non-government) employees, you can visit the Department of Labor's (DoL) website at www.dol.gov on the web. Or, you can call 1-866-444-3272.
- For more information about how COBRA works for state and local government employees, you can visit www.cms.hhs.gov/hipaa/hipaa1/cobra on the web. Or, you can call 1-877-267-2323 extension 61565.
- For more information about how COBRA works for federal government employees, you can visit the Office of Personnel Management's website at www.opm.gov on the web.

Words in red are defined on pages 29–32.

Section 4: Words to Know

Claim—A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physicians/supplies services billed through the Medicare Carrier.

Coinsurance—The amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the deductible for Part A and/or Part B. In a Medicare Prescription Drug Plan, the coinsurance will vary depending on how much you have spent.

Conditional Payment—A payment made by Medicare for services for which another payer is responsible.

Consolidated Omnibus Budget Reconciliation Act (COBRA)—A law that may let you keep your employer group health plan coverage for a limited period of time after: the death of your spouse, losing your job, having your working hours reduced, leaving your job voluntarily, having your employer go bankrupt, or getting a divorce. You usually have to pay both your share and the employer's share of the premium, plus an administrative fee.

Copayment—In some Medicare health and prescription drug plans, the amount you pay for each medical service, like a doctor's visit, or prescription. A copayment is usually a set amount you pay. For example, this could be $10 or $20 for a doctor's visit or prescription. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan or other insurance begins to pay. For example, in Original Medicare, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

End-Stage Renal Disease—Permanent kidney failure requiring dialysis or a kidney transplant.

Group Health Plan—A health plan that provides health coverage to employees, former employees, and their families, and is supported by an employer or employee organization.

Guaranteed Issue Rights (also called "Medigap Protections")—Rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you insurance coverage or place conditions on a policy, must cover you for all pre-existing conditions, and can't charge you more for a policy because of past or present health problems.

Health Maintenance Organization Plan—A type of Medicare Advantage Plan that is available in some areas of the country. Plans must cover all Medicare Part A and Part B health care. Some HMOs cover extra benefits, like extra days in the hospital. In most HMOs, you can only go to doctors, specialists, or hospitals on the plan's list except in an emergency. Your costs may be lower than in the Original Medicare Plan.

Section 4: Words to Know

Initial Enrollment Questionnaire—This questionnaire is sent to you by Medicare, three months prior to your Medicare entitlement. The questionnaire asks if you have group health plan insurance or other insurance primary to Medicare.

Large Group Health Plan—A group health plan that covers employees of either an employer or employee organization that has 100 or more employees.

Liability Insurance—Liability insurance is insurance that protects against claims for negligence or inappropriate action, or inaction, which results in injury to someone or damage to property.

Medicare—The Federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare Advantage Plan—A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

Medicare Coordination of Benefits Contractor—A Medicare contractor that collects and manages information on other types of insurance or coverage that pay before or after Medicare. Some examples of other types of insurance or coverage are: Group Health Coverage, Retiree Coverage, Workers' Compensation, No-fault or Liability insurance, Veterans' benefits, TRICARE, Federal Black Lung Program, and COBRA.

Medicare Cost Plan—A Medicare Cost Plan is a type of HMO. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under the Original Medicare Plan, except your plan pays for emergency services, or urgently needed services outside the service area.

Medicare Part A (Hospital Insurance)—Hospital insurance that helps pay for inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Medical insurance that helps pay for doctors' services, outpatient hospital care, and many other medical services that aren't covered by Part A.

Medicare Secondary Payer—Any situation where another payer or insurer pays your medical bills before Medicare.

Medigap—A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

Section 4: Words to Know

Multi-Employer Plan—A group health plan that is sponsored jointly by two or more employers or by employers and unions.

No-Fault Insurance—No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.

Original Medicare Plan—A fee-for-service health plan that lets you go to any doctor, hospital, or other health care supplier who accepts Medicare and is accepting new Medicare patients. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). In some cases you may be charged more than the Medicare-approved amount. The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Pre-Existing Condition—A health problem you had before the date that new insurance coverage starts.

Preferred Provider Organization (PPO) Plan—A type of Medicare Advantage Plan in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

Primary Payer—An insurance policy, plan, or program that pays first on a claim for medical care. This could be Medicare or other health coverage.

Private Fee-for-Service Plan—A type of Medicare Advantage Plan in which you may go to any Medicare-approved doctor or hospital that accepts the plan's payment. The insurance plan, rather than the Medicare Program, decides how much it will pay and what you pay for the services you get. You may pay more or less for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan doesn't cover.

Provider—A doctor, hospital, health care professional, or health care facility.

Special Needs Plan—A special type of plan that provides more focused health care for some people, such as those who have both Medicare and Medicaid, or those who reside in a nursing home.

Section 4: Words to Know

State Health Insurance Assistance Program—A State program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Insurance Department—A State agency that regulates insurance and can provide information about Medigap policies and any insurance-related problem.

TRICARE—A health care program for active duty and retired uniformed services members and their families.

TRICARE for Life (TFL)—Expanded medical coverage available to Medicare-eligible uniformed services retirees age 65 or older, their eligible family members and survivors, and certain former spouses.

Workers' Compensation—Insurance that employers are required to have to cover employees who get sick or injured on the job.

Section 5: Index

Section 5: Index

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use, $300

CMS Pub. No. 02179
Revised September 2005

- Call 1-800-MEDICARE (1-800-633-4227) with any changes in your insurance, or any questions about who pays first and they will connect you to the Medicare Coordination of Benefits Contractor. TTY users should call 1-877-486-2048.

- ¿Necesita usted una copia en español? Llame gratis al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deberán llamar al 1-877-486-2048.

Fact Sheet

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Integrated Veteran Care

VHA Office of Integrated Veteran Care
Ambulance Transportation

The Department of Veterans Affairs (VA) has the authority to provide or reimburse land or air ambulance transport of certain eligible Veterans in relation to VA care or VA community care.

Authorized Ambulance Transport

Pre-authorized ambulance transport for eligible Veterans to or from a VA facility or VA-authorized community care facility is approved and arranged in advance of care. Veterans must meet the following administrative requirements to qualify for authorized transport:

- Have a service-connected (SC) disability or combined rating of 30% or more (travel for care relating to any condition), *or*
- Be in receipt of a VA pension, *or*
- Previous calendar year income does not exceed maximum VA pension rate, *or*
- Projected income in travel year does not exceed maximum VA pension rate, *or*
- Travel is in connection with care for a SC disability, *or*
- Travel is for a Compensation and Pension exam, *or*
- Travel is to obtain a service dog, *or*
- Travel relates to VA transplant care, *and*
- A VA clinician determines and documents that special mode transportation is medically required.

Note: Income related eligibility must be verified and on file with VA on or before the date of transport.

To arrange non-emergent transportation, contact the local VA Beneficiary Travel Office.

Emergency Transportation

During a medical emergency, Veterans should immediately seek care at the nearest medical facility without delay. A medical emergency is an injury, illness or symptom so severe that without immediate treatment, an individual believes his or her life or health is in danger. If a Veteran believes his or her life or health is in danger, call 911 or report to the nearest emergency department right away. Veterans do not need to check with VA before calling an ambulance or going to an emergency department.

Notifying VA of the emergent transport within 30 days is required, and the best way to notify is through claim submission. If a claim for transport is unable to be submitted to VA within 30 days, notification can be reported to the Centralized Notification Center by calling 844-724-7842.

VA has three legal authorities under which emergency treatment in a community facility may be paid for, but specific requirements must be met. The legal authority under which the emergency treatment falls dictates eligibility requirements for associated emergent transportation.

Emergency Treatment	Associated Ambulance Transport	Eligiblity Reference
Authorized Emergency Treatment - 38 CFR 17.4020(c)	Authorized Transport	Authorized Ambulance Transport
Unauthorized Emergency Treatment (Service-Connected) - 38 USC §1728	Unauthorized Transport (must meet authorized ambulance transport eligibility)	Authorized Ambulance Transport
Unauthorized Emergency Treatment (Nonservice-connected) - 38 USC §1725	Unauthorized Emergency Treatment (Nonservice-connected) - 38 USC §1725	Unauthorized Emergency Treatment (Nonservice-connected)

Unauthorized Emergency Treatment (Service-Connected) - 38 USC §1728

Ambulance transports associated with emergent treatment approved under 38 USC §1728 will be assessed in accordance with Authorized Ambulance Transport eligibility.

Unauthorized Emergency Treatment (Nonservice-connected) - 38 USC §1725

Ambulance transports associated with emergent treatment approved under 38 USC §1725 will be assessed in accordance with Code of Federal Regulations (CFR) 17.1003 eligibility.

In accordance with 38 CFR 17.1003 VA must receive and adjudicate a claim for the emergency treatment received as part of the emergency transportation. If no claim is received for the associated treatment, VA cannot pay for the emergency transportation unless one of the following two exceptions are met:

1. Other health insurance or a third party paid for the emergency treatment (leaving no liability for the treatment) excluding the emergency transportation itself; **or**
2. Death occurred during transportation to receive emergency care.

If VA cannot pay for emergency care outside of the above two exceptions, then it generally cannot pay for the associated emergency transportation.

To learn more about how emergency treatment eligibility determinations are made, visit https://www.va.gov/COMMUNITYCARE/providers/info-EmergencyCare.asp

Reimbursement Payment Rates

Ambulance Transport	Eligibility Reference	Payment Rate
Authorized Transport & Unauthorized Emergency Transport tied to 38 USC §1728 (Service-Connected)	Authorized Ambulance Transport	Generally billed charges
Unauthorized Emergency Transport tied to 38 USC §1725 episode of care (Nonservice-connected)	Unauthorized Emergent Transport 38 USC §1725 (Nonservice-connected)	Generally, 70% Medicare

To be considered for payment, all ambulance claims should be sent to VA using one of the following options:

Electronic Data Interchange (EDI): Payer ID is **12115**

Mail paper claims to:
VHA Office of Integrated Veteran Care
P.O. Box 30780
Tampa, FL 33630-3780

Ambulance claims should **always be submitted to VA and **never** to TriWest or Optum.*