

Dear SMP:

This year I switched from Original Medicare to a Medicare Advantage plan. What are some of the differences between the two and how can I avoid falling victim to scams involving my new plan?

Vera



Dear Vera,

It is necessary to understand the difference between Original Medicare and Medicare Advantage (MA) plans. Private Medicare Advantage plans contract with the federal government to cover all of a patient's healthcare needs, rather than charging the government for each individual service as does Original Medicare. MA plans also frequently cover the Part D benefit as well, so additional pharmacy coverage is not necessary.

All health insurance plans have rules about how much it will pay for services and how much you will pay yourself. The amount you pay yourself is called an out-of-pocket cost and includes deductible, co-pay, and coinsurance toward an annual out-of-pocket maximum. That means you, not your health plan, pay for these medical services or items. You are not reimbursed.

Both Original Medicare and MA plans issue statements that detail the charges for that time period, what was allowed, what was paid, and what your obligation was. Medicare's semi-annual notice is referred to as a Medicare Summary Notice (MSN). MA plans issue statements in months when services are provided and it is known as an Explanation of Benefits (EOB). An EOB is also issued for Part D and supplemental coverage as these are provided by private insurers.

Original Medicare users receive the "Medicare & You" handbook, which is mailed to all beneficiaries in September and outlines changes to premiums, deductibles, and benefits for the upcoming year. Since Original fee-for-service Medicare is paid by regional contractors, information about charges and how to dispute any possible errors is in the MSN.

MA plans are paid different and have an annual published Evidence of Coverage (EOC) for each service it provides together with co-pays. Many services are bundled together under a single co-pay but appear on the monthly EOB as separate charges. Since the separate charge is covered within the office visit itself, the plan now tries to collect on un-bundled service by charging the patient the full amount of what the plan contends is an uncovered service.

Services that are not covered are identified in the EOC. The EOC also identifies what services require prior authorization (PA) before the plan will pay. Failure to obtain PA can move the cost to the patient and relieve the MA plan of burden.



The Evidence of Coverage (EOC) is an annual, legal document for the MA plan (Part C) and Medicare prescription drug plan (Part D), detailing exactly what is covered, how much you will pay, and rules for services. Sent every Fall (by October 15), it outlines plan changes effective January 1, and acts as the legal contract between you and your Medicare plan provider and is specific to your locale. The EOC can be over 200 pages and you can often find the digital version by logging in to your plan's website, or via www.medicare.gov.

The EOC is an important document in dealing with billing abuse and fraud. You will find details on deductibles, co-pays, and coinsurance for different services. You can check which drugs are covered and cost-sharing tiers for your medications. Also, use the document to identify in-network providers, hospitals, and pharmacies to minimize costs. The EOC explains how to file a complaint (grievance) or appeal if the plan denies a service or payment.

Fraud and scams can occur with both Original Medicare and MA plans. Providers may bill for medical procedures, tests, or services that were never performed or bill for services, supplies, or treatments that are not medically necessary. Individuals should always review their MSNs and EOBs for accuracy. If you believe that you were billed in error, ask your plan's billing office to verify the charge is valid. You can also question physician orders for covered labs, medications, and DME that you believe are unnecessary. If you have contacted your provider and plan regarding the suspected errors and are unhappy with the results, contact your local SMP for help at 877-272-8720 or visit www.stopmedicarefraud.org for more information.

Senior Medicare Patrol (SMP) provides personal tools such as the [My Health Care Tracker \(MHCT\)](#), a personal health care journal, that is designed as a fraud-fighting tool to help Medicare beneficiaries record their doctors visits, services received, and medical equipment. Beneficiaries can use the MHCT to compare against their Medicare statements. You can request a copy by calling our toll-free hotline number, 877-272-8720. There is also a smartphone version called [SMP Medicare Tracker](#) that you can download to your cell phone or tablet from the Apple App Store or Google Play.

Remember, the burden to ensure the accuracy of your Medicare claims falls to an astute reckoning of the billing process for the specific Medicare plan you are enrolled in. It's up to you to report suspected Medicare fraud, errors, and abuse!

Lynn Rosenblatt, RN (retired) & SMP Volunteer



**Do you have a Medicare fraud or scam question for SMP?
If so, please email ASK SMP to smp@advisewell.org**



Webinar Wednesdays w/ SMP:

April 29th 10:30CT/11:30ET - Don't get Swabbed by Scammers
May 20th 10:30CT/11:30ET - Protecting Your Loved Ones from Scams

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