Technician Tutorial:
The ABCs of Medicare

Medicare, managed by the federal government, is the nation's largest health insurance program. Medicare provides coverage for around 40 million Americans.

What's the difference between Medicaid and Medicare?
While Medicare is administered by the federal government, Medicaid is a joint federal and state program that helps people with low income and limited resources pay for medical costs. Some people are referred to as "dual eligible." This means they're eligible for both Medicaid and Medicare, and will get government aid for their part of Medicare costs.

Who's eligible for Medicare?
Medicare provides health insurance coverage for people 65 years or older, for some disabled people under 65 years, and for people of all ages with kidney failure who are treated with dialysis or with a kidney transplant.

Adam Baum, a long-time patient at your pharmacy, has just turned 65 years old. He has diabetes and high blood pressure, and today he needs to get his Lantus *insulin filled. He was previously uninsured, and paid cash for most of his prescriptions. However, he tells you that he finally has Medicare, and is happy that he will spend less on prescriptions.*

Alphabet soup…what's the difference between Medicare Part A, Medicare Part B, Medicare Part C, and Medicare Part D?
Medicare Part A is **hospital insurance**. It helps pay for hospital visits, care in a skilled nursing facility, hospice care, and some home health care. Medicare Part A does not have a monthly premium. Medicare Part A does not cover prescription drugs for outpatients.

Medicare Part B is **medical insurance**. It helps pay for doctors' services, outpatient hospital care, physical therapy, and home health care. Most people who have Medicare Part B have to pay a monthly premium. Medicare Part B covers a limited number of prescription drugs for outpatients.

Medicare Part A plus Medicare Part B is considered "original Medicare." Patients with original Medicare will have a "red, white, and blue" insurance card. The card will contain the patient's ID number, which is usually their Social Security number with an additional letter. The card also indicates if the patient is eligible for Part A or Part B, or both.

Some people might get a Medigap policy, or supplemental coverage that helps pay deductibles, coinsurance, and other costs that are not covered by original Medicare. There is a monthly premium for the Medigap policy in addition to the monthly Part B premium. Medigap policies are offered by private insurance companies, not by the federal government.

Medicare Part D is a **prescription drug plan**. There are a lot of different choices, since these plans are administered by private insurance companies and approved by Medicare. There are, on average, almost 30 different plans per state. Part D coverage is optional, and can be added on to "original Medicare." Most people who have Medicare Part D plans will pay a monthly premium.

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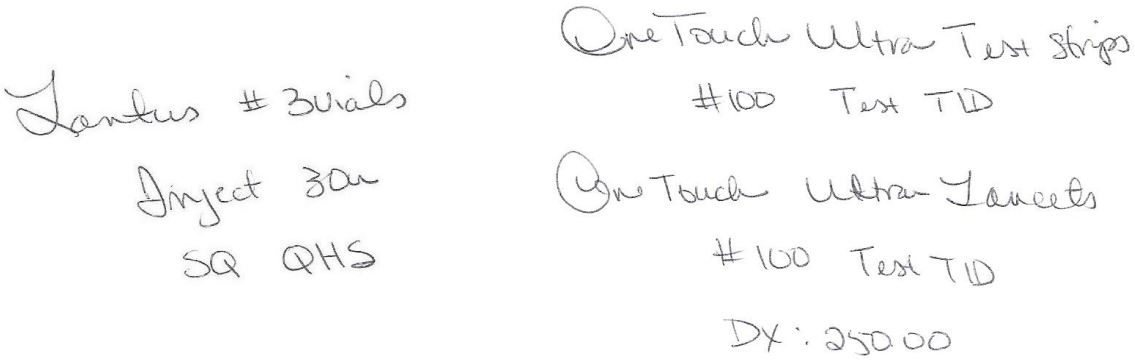
Prescriptions for patients with Part D plans are processed just like those for any other insurance company (e.g., Express Scripts, WellPoint, etc). Patients will have a separate insurance card indicating which insurance company you will use to process their Rx.

A Medicare Advantage Plan, also called a Medicare Health Plan, is an alternative to original Medicare (Medicare Part A and Medicare Part B) and possibly Medicare Part D. Medicare Advantage Plans are run by private companies such as health maintenance organizations (HMOs) or preferred provider organizations (PPOs), but they're approved by Medicare. Medicare Advantage Plans are sometimes referred to as Part C.

You ask Mr. Baum if he has his insurance card, and he hands his "red, white, and blue" card to you, along with some new scripts. He also enrolled in a Part D plan, and he has his insurance card for the Part D plan as well.



Pharmacy billing…what's covered by Part B and what's covered by Part D?

Part D prescription drug plans pay for most prescription drugs in the outpatient setting. This includes biological products; insulin; some vaccines; and medical supplies associated with the injection of insulin like syringes, needles, alcohol swabs, and gauze. Part D plans are not required to pay for the following in most cases:

- Drugs used for weight loss (e.g., orlistat [*Xenical*], etc) or for anorexia or weight gain (e.g., megestrol [*Megace*], etc);
- Drugs used to promote fertility (e.g., clomiphene [*Clomid*], chorionic gonadotropin [*Pregnyl*], etc);
- Drugs used for cosmetic purposes or hair growth (e.g., minoxidil [*Rogaine*], etc);
- Drugs used for the symptomatic relief of cough and colds (e.g., benzonatate [*Tessalon*], etc);
- Drugs used for erectile dysfunction;
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations;
- Nonprescription drugs;

Some vaccines are also covered under Part D. These include the vaccine for shingles, *Zostavax*, and any other vaccine not covered under Part B. Be sure to process the vaccine through the patient's Medicare plan to determine coverage rules.

Part D also covers Medication Therapy Management, known as MTM. These are patient-centered services provided by a pharmacist or another healthcare professional. MTM is a medication review that is used to help ensure patients are taking their medications properly and avoiding any medication problems. There are five core elements involved in this process:

- Medication therapy review – a meeting between the pharmacist and patient. This meeting is to gather specific information to help the pharmacist determine if the medication is working properly or if the prescriber needs to be consulted. This can be a comprehensive medication review, CMR, or a targeted medication review, TMR. A TMR is a review of a specific medication whereas a CMR encompasses the patient's whole medication profile.
- Personal medication list – a complete list of the patient's medications
- Medication action plan – a document containing a list of actions for the patient to use in tracking progress for self-management
- Intervention and/or referral – the pharmacist identifies a medication-related problem and works with the patient and the prescriber if needed to resolve the problem
- Documentation and follow-up – used to explain what services the pharmacist provided as well as any interventions that were performed.

Most of the billing for MTM will be done through a computer MTM platform that your pharmacy may use. Examples of the MTM platforms you may see are OutcomesMTM and Mirixa.

Medicare Part B pays for a limited set of drugs. Many of these drugs are injectables that aren't usually self-administered. However, in the retail pharmacy setting, Medicare Part B may also cover:

- Antigens, usually prepared in a physician's office and dispensed to a properly instructed person, who may be the patient;
- Injectable drugs for osteoporosis for women (e.g., zoledronic acid [*Reclast*], etc);
- Epoetin alfa (*Epogen*, *Procrit*) to treat anemia in patients with end-stage renal disease;
- Clotting factors for self-administration by patients with hemophilia;
- Immunosuppressive drug therapy (e.g., cyclosporine [*Neoral*, *Sandimmune*, others], etc) for Medicare-covered organ transplants;
- Oral cancer drugs prescribed for the treatment of cancer if the same drug is available in injectable form (e.g., capecitabine [*Xeloda*], etc);
- Oral anti-nausea drugs (e.g., granisetron [*Kytril*], ondansetron [*Zofran*], etc) for patients receiving Medicare-covered cancer drugs, for use within 48 hours of chemotherapy;
- Influenza and pneumococcal vaccines, and hepatitis B vaccine for intermediate to high-risk individuals, and vaccines like tetanus toxoid given for treatment of an injury or direct exposure to a disease;
- Parenteral nutrition for patients with permanent dysfunction of the digestive tract;
- Insulin pumps and the insulin used with the pump. (Insulin not used with a pump is covered by Part D);
- Intravenous immune globulin (e.g., IVIG [*Carimune, Gammagard*, others]), to be used in the patient's home.

- Part B also pays for durable medical equipment (DME) supply drugs when dispensed from a retail pharmacy. For example, solutions to be administered in a nebulizer (e.g., albuterol) or infused drugs.

Other supplies Part B covers are wheelchairs, enteral nutrition, undergarments, prosthetics, and orthotics.

You will need the patient's "red, white, and blue" card to process these prescriptions.

Part B covers supplies for patients with diabetes, including:

- blood glucose monitors;
- blood glucose test strips;
- lancet devices and lancets;
- glucose control solutions for checking the accuracy of testing equipment and test strips.

Note that the amount of test strips and lancets Medicare will cover depends on whether the patient is insulin-dependent or non-insulin dependent. For insulin-dependent beneficiaries, medicare will cover up to 100 test strips and lancets every month. For non-insulin dependent beneficiaries, Medicare will cover up to 100 test strips and lancets every three months.

In order to be paid by Medicare for these diabetes supplies, there must be a prescription written, with the following information:

- confirmation that the patient has diabetes (diagnosis code for type 1 or type 2 diabetes);
- whether or not the patient requires insulin;
- what kind of blood glucose monitor is needed;
- how often the patient is to test blood glucose. This cannot be "as needed" or "use as directed." If the prescriber writes either of those, the pharmacist will need to contact him or her for clarification.
- date the physician signs the prescription
- physician's signature

Not all pharmacies are set up to bill Medicare B electronically for diabetes testing supplies. Check with your pharmacist if you are unsure about procedures for billing for diabetes supplies. Policies and procedures vary in different practice settings.

Most pharmacies are required to have an accreditation to bill Medicare Part B for DME (but not DME drugs) and diabetes supplies. This accreditation is given to pharmacies that apply, pay the required fees, and meet the requirements for training.

You will need to bill Medicare Part B for Mr. Baum's strips and lancets. Notice Mr. Baum's prescriber included the required information (diagnosis code and instructions for using the strips and lancets) on the prescription, so that you won't have any problems with billing Part B. If this information had been missing, the pharmacist would have had to call the prescriber for clarification.

You can process Mr. Baum's Lantus *prescription through his Part D plan, using the same procedures you would use to process any prescription claim.*

For more general information about billing for prescription drugs, use our technician tutorial, *Billing for Rx Drugs*.

Medicare Part D…what does the lingo mean?

Star Ratings: Medicare Plans with high ratings get marketing advantages, such as year-round open enrollment, and possible bonus payments. These ratings are based on quality measures. Measures related to MED USE will account for half of a Medicare D plan's rating. Some of the key quality measures are adherence and optimizing med use with comprehensive medication reviews, or CMRs.

Donut hole or coverage gap: After a patient and his or her plan have spent a certain amount of money (i.e., the patient's yearly deductible plus co-pays plus what the insurance company pays for prescriptions), the patient must pay out-of-pocket for their cost of all prescription drugs. However, after a certain amount of money is spent out-of-pocket ($4950 total for 2017, but this changes from year to year), catastrophic coverage kicks in and starts paying for prescription drugs again. With catastrophic coverage, the patient will only have to pay a small co-pay.

Some Part D plans pay a certain amount toward prescription drug costs during the coverage gap. However, these plans typically cost more than those that don't pay during the coverage gap.

When a patient "falls into the donut hole," reducing prescription drug costs can help make sure that he or she can continue to get necessary prescription drugs. If a patient expresses concern about being in the coverage gap, let the pharmacist know. The pharmacist may be able to work with the prescriber to find generic or less expensive brand name drugs for their conditions. Drug manufacturers and national, state, and community-based programs offer assistance programs for these patients (see www.medicare.gov/pharmaceutical-assistance-program). Some counties contract with private companies to match patients with manufacturer patient assistance programs that offer medications similar to the patient's medications for free or at reduced cost.

Extra Help or low-income subsidy: For certain individuals who meet qualifications based on income, the government subsidizes the cost of prescription drug plans (i.e., Medicare Part D). Premiums, deductibles, and co-pays can be either cheaper, or completely paid for by the government subsidy. Plus, people who get Extra Help won't have a coverage gap.

For more information on the low-income subsidy, patients can call 800-772-1213 or go to www.socialsecurity.gov/i1020.

Medicare Part D…what are the important dates for patients to know?

Individuals first become eligible for Medicare in the three months before turning age 65, the month they turn 65, and through the three months after turning 65. They can sign up for a Medicare Part D plan during this seven-month period.

Those who are younger and get Medicare because of a disability can join a Part D plan during the three months before or the three months after the 25th month of their cash disability payments.

Individuals who qualify for Extra Help can enroll in a Part D program at any time.

Each year, open enrollment for Part D plans begins on October 15th and ends on December 7th. This is the period of time where folks can change plans, or enroll if they had not enrolled before. People who do not sign up for Medicare D or other prescription insurance coverage within the required timeframe are likely to end up paying more if they enroll later. A monthly penalty premium will be added to their monthly Part D premium. Changes made during open enrollment take effect on January 1st of the following year.

More information about Medicare is available at www.medicare.gov.

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