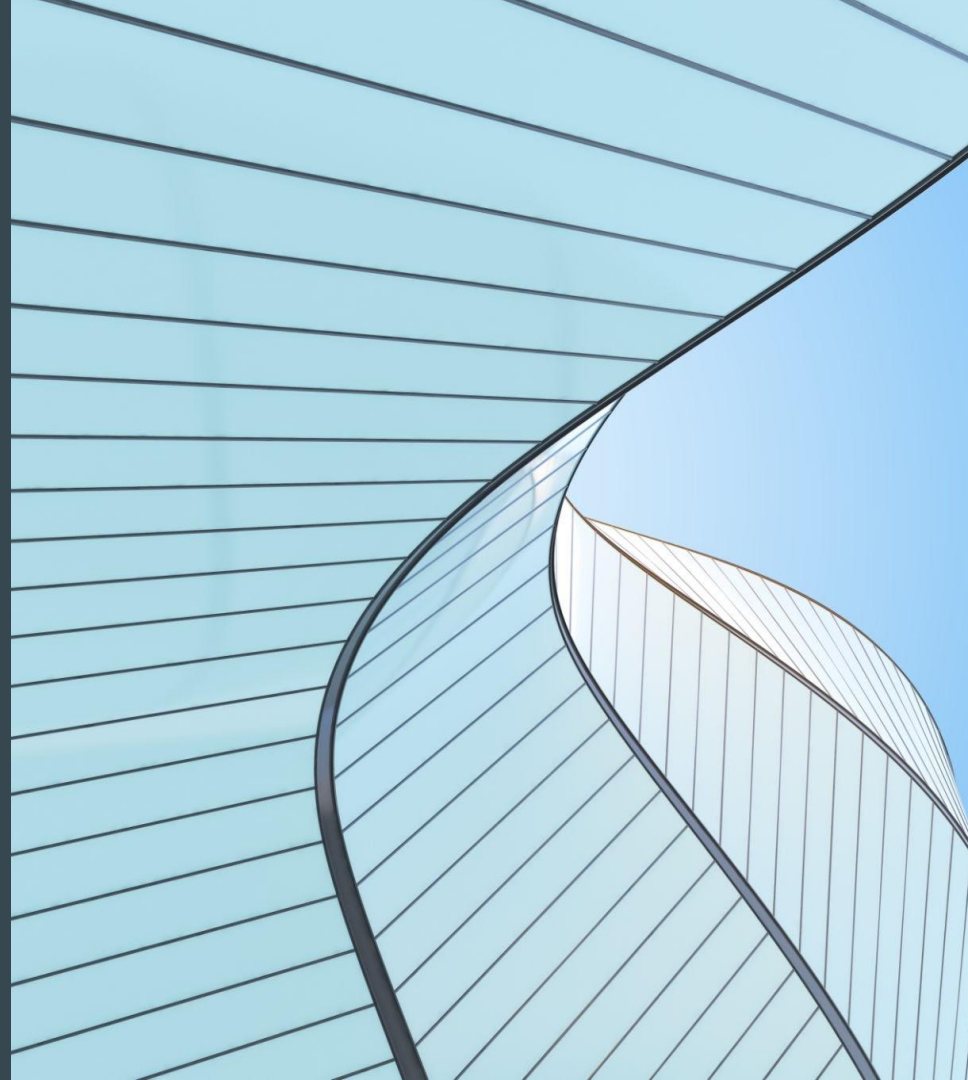


Comparing Original Medicare to Medicare Advantage

This section examines the differences between Original Medicare and Medicare Advantage, with a focus on claims submission, non-contracted providers, and when a provider may or may not collect payment directly from the patient.



A Brief History: *Medicare* → *Medicare Advantage*

*Medicare Advantage didn't *replace* Medicare. It created a **private-plan way to receive Medicare benefits.**

Medicare created with Part A (hospital) and Part B (medical)	Medicare expanded to people under 65 with certain disabilities and ESRD Chiropractic is added as a <i>limited</i> benefit to Medicare.	Private HMO/ risk-contracting model introduced, laying groundwork for Medicare managed care	Medicare+ Choice (Part C) created, allowing private plans to provide Medicare benefits	Medicare+ Choice renamed Medicare Advantage Part D added	Medicare Advantage has grown from a small alternative to more than half of eligible Medicare beneficiaries in many markets
1965	1972	1982	1997	2003	Today

Why was Medicare Part C created?

As Medicare costs continued to rise, Part C was developed to bring private health plans into Medicare, with the expectation that a capitated payment model and managed care would improve efficiency, control utilization, and reduce Medicare spending.

Did it save Medicare money?

Not as originally intended. Early managed-care programs did not produce meaningful savings. Later, Medicare Advantage had periods where Medicare paid private plans more than it would have spent under Original Medicare.

KFF's 2026 analysis:

- Medicare payments to MA plans are currently about **14% higher per beneficiary than what Medicare would spend for comparable beneficiaries in traditional Medicare.**
- This translates to approximately **\$76 billion in additional federal Medicare spending in 2026.**



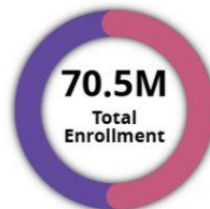


Medicare Enrollment for May 2026

Hospital/Medical

Prescription Drug

MA: 36.1M
(51% of total)



FFS: 34.4M
(49% of total)

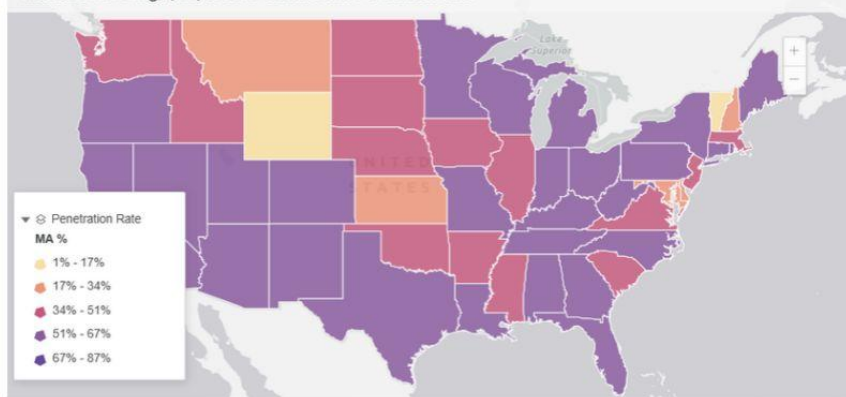
Map/Graphs

Grid

All Areas

Counties

Medicare Advantage (MA) & Other Health Plans Penetration Rate



Esri, TomTom, Garmin, FAO, NOAA, USGS, EPA, USFWS

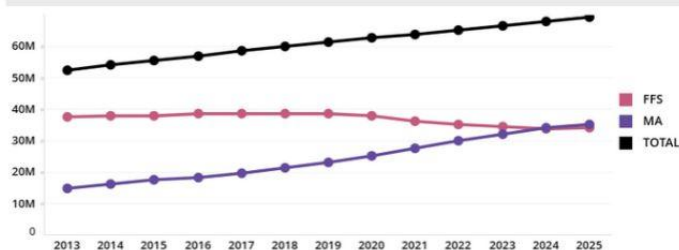
Powered by Esri

*Map includes data for all 50 United States plus Washington D.C. Click to view state level information. See "Grid" for additional US territories.

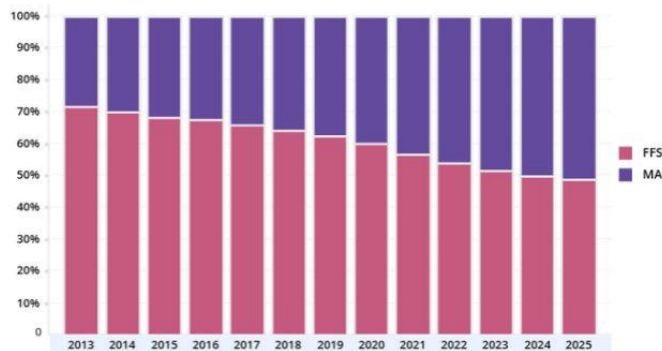
Yearly Trend

12-Month Trend

Enrollment Count Yearly Trend: All Areas



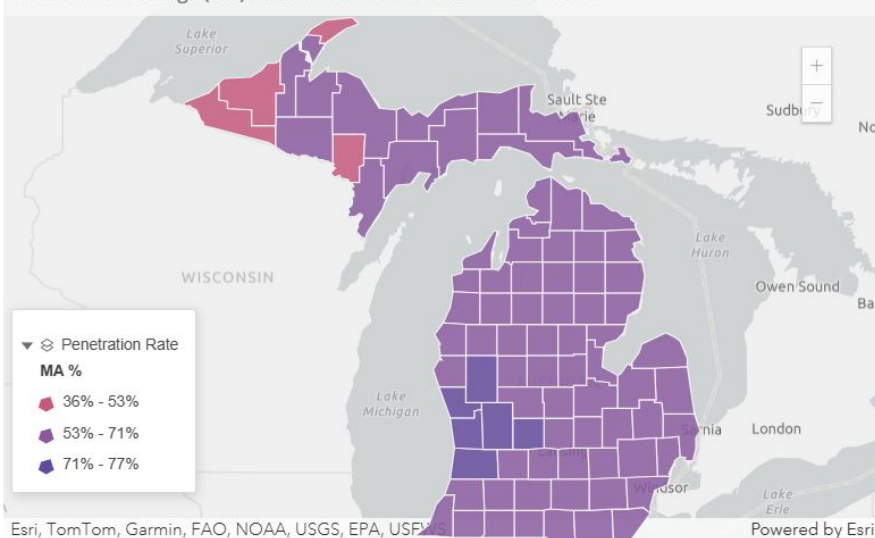
Percent of Total Enrollment Yearly Trend: All Areas



MICHIGAN (84 counties) | TOTAL: 2,320,424 | FFS: 846,083 (36% of total) | MA: 1,474,341 (64% of total)

Michigan

Medicare Advantage (MA) & Other Health Plans Penetration Rate

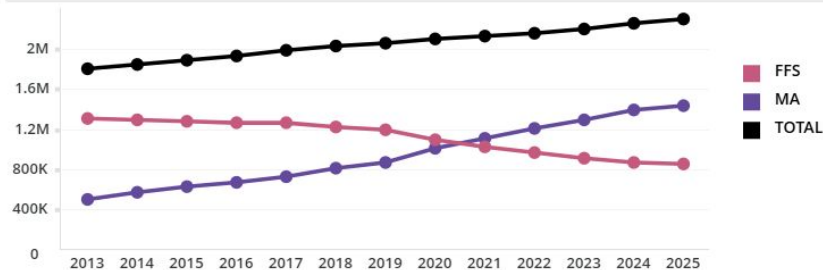


Yearly Trend

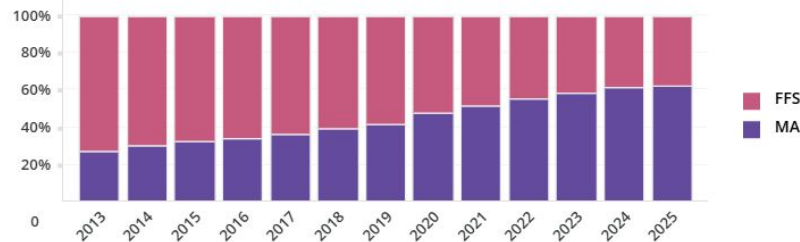
12-Month Trend

Grid

Enrollment Count Yearly Trend: State Total

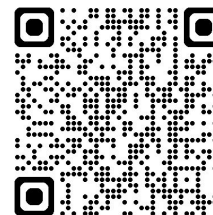


Percent of Total Enrollment Yearly Trend: State Total



Medicare Enrollment Dashboard

<https://data.cms.gov/tools/medicare-enrollment-dashboard>



What Is Medicare Advantage?

- Medicare Advantage = Medicare Part C
- Private Medicare Advantage Organizations (MAOs) contract with CMS to administer Medicare benefits
- The beneficiary still has Medicare, but receives Part A and Part B benefits through the MA plan.
- The plan **must cover** the Medicare Part A and Part B benefits.
- Must follow Original Medicare's *coverage rules*.
- The plan may also offer supplemental benefits beyond Original Medicare.

The Parts of Medicare

Part A	Part B	Part C	Part D	Medigap
Hospital Insurance • Covers inpatient hospital care, skilled nursing, hospice • <i>Not relevant to chiropractors directly</i>	Medical Insurance • Covers outpatient care • This is the part that applies to chiropractors • <i>For chiropractic, covers spinal manipulation when medically necessary</i> • <i>Does not cover exams, x-rays, or maintenance care</i>	Medicare Advantage (MA Plans) • Managed by private insurers • Required to cover at least the same services as Part A and Part B • Rules vary by plan, may cover additional services (always verify individually) • May require prior auth or set networks	Prescription Drug Coverage • Covers medications • <i>Not directly relevant to chiropractic, but helpful to know for patient context</i>	Medicare Supplement • Extra coverage purchased from private insurance companies • Helps to pay out-of-pocket costs of Original Medicare • There are 10 different types of Medigap plans offered in most states, which are named by letters: A-D, F, G, and K-N.
Original Medicare, Traditional Medicare, or Fee-for-Service (FFS)		Medicare Advantage	May be added to Original Medicare	May be added to Original Medicare

Key Drivers of Medicare Advantage Growth

- **Prescription Coverage:** Instead of buying a separate standalone Part D plan (as with Original Medicare), it is built into the all-in-one Medicare Advantage plan.
- **Supplemental Benefits:** Extra perks like vision, dental, hearing, and fitness classes attract enrollees.
- **Zero-Premium Options:** Many plans feature \$0 monthly premiums beyond the standard Part B premium.
- **Out-of-Pocket Limits:** Unlike Original Medicare, Advantage plans include mandatory annual caps on out-of-pocket spending.
- **Special Needs Growth:** Targeted plans for chronic conditions or dual-eligibility (Medicare/Medicaid) fuel a large share of net additions.
- **Marketing and Commissions:** Aggressive insurer advertising and high broker incentives drive higher sign-ups.

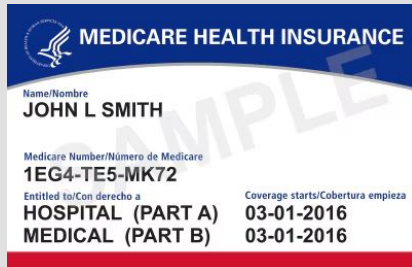
Original Medicare

Red, white and blue Medicare card

Part B claims go through the
Medicare Administrative
Contractor

Michigan: WPS GHA

Time Filing: 1 year



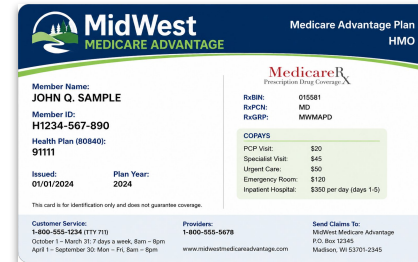
Medicare Advantage

The patient is still a Medicare
beneficiary.

The MA plan administers the Medicare
benefit.

Use the patient's current MA plan
information/card to identify the plan and
coverage.

Timely Filing: Plan specific, may vary



Example Part C card! Not a real plan!

What happens when **Original Medicare** is *billed* instead of the patient's private **Medicare Advantage Plan** (Part C)?

A Medicare claim form, likely a CMS-1500, is shown in the top right corner. It is a complex form with many fields for patient information, provider details, and claim data. The form is tilted and partially cut off on the right side.

Reason Codes on the RA

You will most commonly see one of the following Claim Adjustment Reason Codes (CARCs):

- **CO-109:** (*Claim/service not covered by this payer/insurer. You must send the claim/service to the correct payer/insurer*). This is the standard code triggered when traditional Medicare notes that a private Part C carrier is responsible for the patient's managed care.
- **CO-24:** (*Charges are covered under a capitation agreement/managed care plan*). This explicitly indicates that the patient's care falls under a managed care entity.
- **CO-22:** (*This care may be covered by another payer per coordination of benefits*). Sometimes utilized alongside specific remarks indicating an active Part C plan.

Medicare Advantage: What Kind of Plan Is It?

HMO (Health Maintenance Organization)

Requires a strict Primary Care Provider (PCP) gatekeeper model.

Out-of-network claims are universally denied except for emergency room stabilization.

PPO (Preferred Provider Organization)

Allows patients to self-refer to specialists without administrative intervention.

Providers are classified as **in-network** or **out-of-network**; out-of-network care requires patients to meet higher separate deductibles and pay greater coinsurance.

HMO-POS (HMO Point-of-Service)

Utilizes a standard HMO core where patients choose an in-network PCP to manage routine care.

Out-of-Network Allowance: Features an "escape hatch" permitting out-of-network utilization, though at a significantly higher cost-share to the patient.

PFFS (Private Fee-for-Service)

A private Medicare structure where the insurer establishes its own independent payment rates and provider terms.

Deemed Acceptance: Does not rely on a traditional network panel; any provider can treat a PFFS patient on a **case-by-case basis**, provided they review and accept the plan's terms of conditions before rendering care.

SNP (Special Needs Plan)

A specialized type of Medicare Advantage Plan tailored for people with specific chronic conditions, limited financial resources, or specialized care requirements.

How the Money Flows

Monthly capitated payments: CMS pays a set, fixed amount each month to private insurance companies for every person enrolled in their Medicare Advantage plan, regardless of how much or how little medical care that person uses.

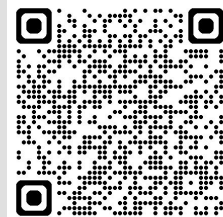
In-Network (Contracted) Providers: Payment rates are governed entirely by private, negotiated contracts between the Medicare Advantage organization and the medical provider or facility.

- Per the "Non-Interference Rule." ([Section 1854\(a\)\(6\)\(B\)\(iii\) of the Social Security Act](#)), Medicare Advantage plans *do not have to pay the standard CMS fee* schedule for contracted, in-network care.

CMS: MA Payment
Guide for Out of
Network Payments



Out-of-Network (Non-Contracted) Providers: Coordinated care plans, such as HMOs and PPOs, are generally required to reimburse *non-contracting providers* at least the original Medicare rate for Medicare covered services. ([42 CFR § 422.100\(b\)\(2\)](#))





Draw



Ask Copilot



1

of 111



Medicare Managed Care Manual

Chapter 4 - Benefits and Beneficiary Protections

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(Rev. 121, Issued: 04-22-16)

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10.3 – Types of Benefits

10.4 – Hospice Coverage

MA Plan Benefits

***Basic Benefits:** All MA plans must cover medically necessary Medicare Part A and Part B services.

Part D Benefits: Prescription drug coverage that an MA plan may include.

Mandatory Supplemental Benefits: Extra benefits not covered by Original Medicare that are provided to all enrollees. Funded through premiums, cost-sharing, and/or plan rebate dollars. No waiting period is permitted.

Optional Supplemental Benefits: Extra benefits offered to all enrollees, but the enrollee can choose whether to purchase them. The enrollee pays an additional premium and/or cost-sharing.

Medicare Advantage Coverage Documents

Evidence of Coverage

The Evidence of Coverage is the legal, detailed description of benefits and out of pocket costs. It also explains rights and rules regarding coverage for medical care.

What it includes:

- Detailed exclusions and limitations
- Definitions (e.g., *what's "medically necessary"*)
- Instructions on how to appeal a denial
- Rules prior authorizations, referrals, etc.
- Chiropractic-specific policy rules (*often buried deep*)

Annual Notice of Change

The Annual Notice of Change outlines the year-to-year changes to the plan, including basic benefits.

Tip: When searching an electronic PDF, use the *Ctrl* and *F* keys for a search window. Type common coverage terms (*i.e. chiropractic, maintenance, massage*)

Medicare Advantage Cost-Share Rules



MA plans can structure cost-sharing differently than Original Medicare.

A plan may charge more for one service and less for another, as long as the plan's overall cost-sharing remains actuarially equivalent to Original Medicare and meets CMS limits.

Original Medicare generally charges a flat 20% coinsurance for most outpatient services (Part B). Private MA plans tend to use flat copays (like a \$20 or \$40 specialist fee).

Medicare Advantage Can Add Administrative Requirements

Depending on the plan, requirements may include:

- Prior authorization
- Referral requirements
- Network requirements
- Plan-specific claims submission or documentation rules

Before Billing or Charging the Patient: *First Confirm the Patient's Current Coverage!*

Best practice: Have the patient enter or write down their current insurance information in your intake form or digital platform. This creates documentation of the coverage information that the patient provided.

Then take it one step further: Verify that the information is current and accurate.

If a coverage issue comes up later, you have documentation of the information the patient provided and your efforts to verify it.

Before deciding whether you can bill the patient directly, you must verify what coverage the patient actually has today.

Ask and Confirm:

- ☐ Is the patient enrolled in **Original Medicare (Part A/B)** or **Medicare Advantage (Part C)**?
- ☐ Has the patient changed plans following **Open Enrollment** or another enrollment period?
- ☐ Did the patient present all current insurance cards, including secondary coverage (*i.e. Medicaid*) ?
- ☐ Has the patient's new coverage actually become effective?
- ☐ **Use HETS or WPS Portal to help determine:**
 - ☐ Current Medicare Part A/B entitlement
 - ☐ Whether the patient is enrolled in Medicare Advantage
 - ☐ MA plan/contract information
 - ☐ Applicable enrollment dates
- ☐ Which Medicare Advantage plan is the patient enrolled in?

**** Do not assume that the patient's Medicare card or the card presented at the front desk tells you the entire story. Verify current eligibility and coverage first.***

Evidence of Coverage Documents

[BCBSM](#)

[Humana](#)

[Priority Health](#)

[UnitedHealthcare](#)

[Health Alliance Plan \(HAP\)](#)

Covered Service	What you pay			
	Secure	Vitality	Signature	Assure
Chiropractic services Covered services include: Manual manipulation of the spine to correct subluxation.	In-Network \$15 copayment for Medicare-covered services. Out-of-Network 50% of the approved amount for Medicare-	In-Network \$15 copayment for Medicare-covered services. Out-of-Network 40% of the approved amount for Medicare-	In-Network \$15 copayment for Medicare-covered services. Out-of-Network 40% of the approved amount for Medicare-	In-Network \$15 copayment for Medicare-covered services. Out-of-Network 30% of the approved amount for Medicare-
Chiropractic services (continued) ☆ Routine care covered for 1 visit per year for Vitality and Signature. Routine care covered up to 3 visits per year for Assure. This excludes Secure. ☆ Members have coverage for one set of X-rays (up to 3 views) per year performed by a chiropractor. This excludes Secure.	covered services. Routine care services and X-ray services Not covered.	covered services. In-Network routine care services* \$30 copayment Out-of-Network routine care services* 40% of the approved amount In-Network X-rays* \$35 copayment Out-of-Network X-rays* 40% of the approved amount *This does not count toward your maximum	covered services. In-Network routine care services* \$30 copayment Out-of-Network routine care services* 40% of the approved amount In-Network X-rays* \$35 copayment Out-of-Network X-rays* 40% of the approved amount *This does not count toward your maximum	covered services. In-Network routine care services* \$10 copayment Out-of-Network routine care services* 30% of the approved amount In-Network X-rays* \$35 copayment Out-of-Network X-rays* 30% of the approved amount *This does not count toward your maximum
Chiropractic services (continued)		out-of-pocket amount.	out-of-pocket amount.	out-of-pocket amount.
	Refer to the Exclusions Chart at the end of this Medical Benefits Chart for more information.			

Covered Service	What you pay	
	In-Network	Point-of-Service (POS)
Chiropractic services Medicare-covered services include: Manual manipulation of the spine to correct subluxation	\$15 copay for each Medicare-covered chiropractic service. Deductible does not apply.	50% of the total cost for each Medicare-covered chiropractic service. Deductible does apply.
Chiropractic services (continued) Office visits and x-rays related to a Medicare-covered service are not covered		
 Non-Medicare-covered routine chiropractic services Non-Medicare-covered routine visits can be used for conditions including, but not limited to, back pain, neck pain and headaches. Limited to 12 non-Medicare-covered routine visits and one non-Medicare-covered x-ray every year when done in-network.	\$15 copay for each routine chiropractic services visit, up to 12 every year. \$35 copay for a non-Medicare covered x-ray services performed once per year by a chiropractor (you would pay this in addition to your visit). Deductible does not apply.	Routine chiropractic services are not covered.

I am Contracted with the MA Plan.

What can/should I charge the patient for?

For Medicare-covered services:

- Verify eligibility, benefits and plan requirements before services are provided.
- **Collect the patient's applicable copay, coinsurance or deductible upfront**
 - *Note: there are prohibitions to charging QMB/D-SNP patients for Medicare-cost sharing.*
- Bill the MA plan.

Under the Chiropractic Benefit:

- Active-treatment CMT is a Medicare-covered benefit.
- The MA plan may also cover additional chiropractic services as supplemental benefits. Check the patient's EOC and benefits.

Don't assume "Medicare doesn't cover it." Verify the patient's MA benefits first.

I am Contracted with the MA Plan.

What can/should I charge the patient for?

Non-Covered Services: Medicare Advantage Rules are Not the Same as Original Medicare

50.1 - ABN Scope

(Rev. 10862; Issued: 07-14-21; Effective: 10-14-21; Implementation: 10-14-21)

The ABN is an Office of Management and Budget (OMB)-approved written notice issued by healthcare providers and suppliers for items and services provided under Medicare Part B. With the exception of DME suppliers, only healthcare providers and suppliers who are enrolled in Medicare can issue the ABN to beneficiaries.

The ABN is given to beneficiaries enrolled in the Medicare FFS program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D).

I am Contracted with the MA Plan.

What can/should I charge the patient for?

Non-Covered Services: Medicare Advantage Rules are Not the Same as Original Medicare

- If there is a question about whether an item or service is covered, the member or provider should request a **pre-service Organization Determination (OD)** from the Medicare Advantage plan.
- The MA plan makes the coverage determination, not the provider.
- If coverage is denied, the plan must issue the required written denial notice explaining the decision and appeal rights.
- The process for requesting an OD varies by plan. **Know the rules for each MA plan you participate with** -- often found in the payer's Provider Manual.

Priority Health

- CMS requires the plan, not the provider, to issue the written notice of non-coverage. Priority's process for this is the PSOD. A member can't be held liable for a non-covered service unless the EOC clearly excludes it or Priority has issued a Notice of Denial of Medicare Coverage.
- **EOC exclusion path:** You may provide the service if you tell the member the EOC specifically excludes it and that they'll pay 100%. Then bill with the **GY modifier**. No form is needed, and a documented verbal explanation is sufficient. That page also notes that routine chiropractic is included on several PriorityMedicare plans, so it isn't an exclusion there.
- **Not clearly excluded:** Request a PSOD. If it's denied, Priority sends the CMS-10003 notice, and you bill with **GA modifier** if the member proceeds, which routes the balance to member liability.
- Sources: [EOC exclusions](#), [Authorizations & PSODs](#)

BCBSM (Medicare Plus Blue PPO manual, revised July 1, 2026)

- You're responsible for determining what's covered. If you think a service won't be covered, you must tell the member before providing it. If the member still wants to proceed, you submit a **pre-service organization determination (BCBSM calls it an advance coverage determination)**.
- If you provide a non-covered service without that prior notice, you may not bill the patient.
- Decisions come within 14 days, or 72 hours if expedited.
- This section doesn't mention an EOC-exclusion shortcut like Priority's and UHC's.
- Source: [Provider manual \(PDF\)](#). It covers the PPO only, and I didn't check the BCN Advantage HMO manual.

I am Contracted with the MA Plan.

What can/should I charge the patient for?

What About Exams?

The service may not be covered, but the documentation may still be necessary.

- An **E/M service is often not covered as a chiropractic benefit**, but verify the individual MA plan. Some plans may provide additional coverage.
- An appropriate initial evaluation is still necessary to establish the patient's condition, medical necessity and treatment plan before CMT.
- Think of the initial evaluation as "**Chapter 1**" of the **patient's story**. Daily treatment notes alone may not establish the complete clinical picture.
- Medicare chiropractic documentation requirements include the patient's history, examination and other information supporting medical necessity.
- If the E/M is not covered, you can and should charge the patient for the service!

I'm not contracted with “*that*” Medicare Advantage plan.

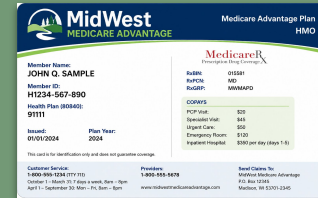


Can I treat the patient and charge them out-of-pocket?



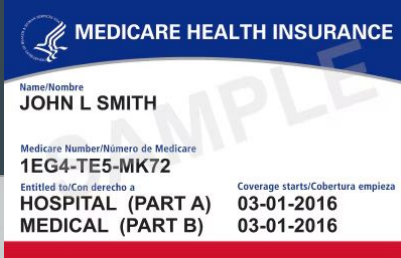
If I treat the MA patient, am I required to bill the MA plan??

I am NOT contracted with *that* Medicare Advantage Plan. Now What?



1. What type of MA plan is it: PPO, HMO, PFFS, SNP?
2. Does the plan provide an out-of-network benefit?
3. Is the service a Medicare-covered benefit, a supplemental benefit, or not covered?
4. What federal payment and balance-billing protections apply?

Original Medicare: *The Basic Rule*



Can an Chiropractor Treat a Medicare Part B Patient for Cash?

Generally, NO.

For Medicare-covered services, an enrolled physician is subject to Medicare's **mandatory claims submission requirement**.

Social Security Act §1848(g)(4)(A) requires physicians to submit claims to Medicare for covered services.

CMS explains that:

- Mandatory claims submission applies to enrolled providers.
- A provider does **not** have to be enrolled as *Participating* to be subject to the rule.
- *Non-Participating* status does **not** mean the provider can simply decline to bill Medicare.

PAR vs. Non-PAR has nothing to do with “opting out” of Medicare. Non-PAR does not mean “cash-pay.”

Legal authority: Social Security Act §1848(g)(4)(A); CMS Medicare Claims Processing Manual, Ch. 1, §70.8.6.1.

“But What If the Patient Signs a Waiver?”

A Signed “Agreement” Does Not Override Medicare Federal Laws.

CMS specifically addresses agreements between Medicare beneficiaries and providers that attempt to waive Medicare's claims-submission or charge limitations.

The general rule is: **A provider and beneficiary cannot simply negotiate away Medicare's requirements.**

CMS states that agreements that are not authorized under Medicare's rules and that purport to waive claims-filing or charge limitations have **no legal force and effect.**

***The ABN form can never be used to override Medicare rules and avoid claims submission.**

Legal authority: Medicare Benefit Policy Manual, Pub. 100-02, Ch. 15, §40.4 (beneficiary free-will exception to claims submission); 45 C.F.R. §164.522(a)(1)(vi) (HIPAA required restriction on disclosure to a health plan)

Why Can't a Chiropractor Just Opt Out?

Medicare Has an Formal, Legal Opt-Out Process

Certain physicians and practitioners can formally **opt out of Medicare**.

An eligible provider who opts out may:

- Enter private contracts with Medicare beneficiaries.
- Receive payment directly from the patient.
- Avoid submitting claims to Medicare, subject to the opt-out rules.

Chiropractors Are Not Eligible to Opt Out

The opt-out statute, **Social Security Act §1802(b)**, limits eligibility to specifically defined categories of physicians and practitioners.

Chiropractors are defined separately under §1861(r)(5) and are not included in the opt-out definition.

Legal authority: Social Security Act §§1802(b), 1861(r)(1)–(5), 1842(b)(18); CMS Medicare Provider Enrollment guidance.

Original Medicare: Put It All Together

A Chiropractor is Required to Follow:

Mandatory claims submission



§1848(g)(4)(A)

No general patient waiver of Medicare requirements



Medicare Benefit Policy Manual, Ch. 15, §40

No Medicare opt-out option for chiropractors



§1802(b)

Therefore: A chiropractor cannot establish a routine “cash-pay instead of Medicare” arrangement for Medicare-covered services.

An ABN, GFE, financial policy, waiver, or patient agreement does not create a Medicare opt-out.

PAR and Non-PAR are enrollment/participation statuses. They are not permission to bypass Medicare.

Non-Contracted Provider + Medicare Advantage

What Happens When You Are NOT Contracted With the MA Plan?

There are two important federal provisions to consider.

1. §1848(g)(4)(A)

The mandatory claims–submission statute requires submission to the Medicare **“carrier.”**

That is part of the Original Medicare Part B claims framework. (For Michigan, this is WPS–GHA.) A Medicare Advantage organization is not the Part B carrier administering Original Medicare. Therefore, the mandatory claims–submission rules does not apply to MA patients.

2. §1852(k)(1)

Medicare Advantage does, however, have its own statutory protection for beneficiaries who receive covered services from certain non–contracted providers. The statute establishes a limit on what the provider may collect for Medicare–covered services.

The image shows a sample Medicare Advantage Plan HMO member card from MidWest. The card includes the following information:

- Member Name:** JOHN Q. SAMPLE
- Member ID:** H234-567-890
- Health Plan (00040):** 0111
- Issued:** 01/01/2024
- Plan Year:** 2024
- COVERS:**
 - PCP visit: \$25
 - Specialist visit: \$40
 - Urgent Care: \$20
 - Emergency Room: \$100
 - Inpatient Hospital: \$200 per day (days 1-9)
- Customer Service:** 1-800-999-1234 (TDD) / 1-800-999-1234 (Voice)
- Provider:** 1-800-555-5678
- Address:** 12345 Main St., Suite 100, Detroit, MI 48201

Non-Contracted Provider + Medicare Advantage

- Federal Medicare Advantage rules establish specific **payment and balance-billing protections** when non-contracted providers furnish Medicare-covered services to MA enrollees.
- In situations where these rules apply, the MA plan generally must reimburse the non-contracted provider based on what the provider could collect under Original Medicare, and the provider must accept the permitted amount as **payment in full**, subject to the enrollee's applicable cost-sharing.
- These protections are part of the Medicare/Medicare Advantage framework and existed independently of the **No Surprises Act (NSA)**.
- The federal NSA generally **does not apply to individuals covered by Medicare, including Medicare Advantage**, because Medicare programs have their own statutory and regulatory protections against improper balance billing.

Federal Regulations Define the Fee Limits

Medicare Managed Care Manual **Chapter 6 - Relationships With Providers**

100 - Special Rules for Services Furnished by Non-Contract Providers **(Rev. 24, 06-06-03)**

Consistent with §1852(a)(2) and §1852(k)(1) of the Social Security Act, non-contract providers must accept as payment in full payment amounts applicable in Original Medicare. Thus, this provision of law imposes a cap on payment to non-contract providers of provider payment amounts plus beneficiary cost-sharing amounts applicable in Original Medicare, and ensures that non-contract providers not balance bill MA plan enrollees for other than MA plan cost-sharing amounts.

In addition, under Federal law, non-contract providers are subject to penalties if they accept more than Original Medicare amounts.

(Source: 42 CFR 422.214 and preamble to June 29, 2000, rule.)



So, What Are My Options as a Non-Contracted Provider?

1. Don't accept the MA patient

2. Accept the patient + collect only applicable MA cost-sharing

Choose not to pursue the plan for the remaining payment.

3. Accept the patient + collect applicable MA cost-sharing + bill the MA plan

For covered services for which the MA plan is responsible, federal rules govern OON payment and generally cap total provider payment at the applicable Original Medicare amount.

Important Notes:

- **HMO:** Verify OON coverage first. §422.214 does not create an OON benefit.
- **QMB/SLP:** Do NOT collect Medicare cost-sharing. QMB protections apply to Medicare Advantage patients and non-contracted providers.
- **PFFS:** Special rules apply. You may become a **“deemed” provider without signing a contract**. If you know the patient has PFFS coverage, and provide a covered service, treating the patient can constitute acceptance of those terms for that visit.