Medicare Advantage Frequently Asked Questions

What is Medicare Advantage?

Medicare Advantage Plans are another way for patients to get Medicare Part A (hospital insurance) and Part B (medical insurance) coverage. Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by Medicare-approved private companies that must follow rules set by Medicare. Many Medicare Advantage Plans include drug coverage (Part D). In addition, Medicare Advantage health plans may provide extra benefits, called supplemental benefits, which are not covered by traditional Medicare. It is the supplemental benefits that provide dental coverage. In some cases, patients will need to use health care providers who participate in the plan's network; however, many PPO plans provide coverage for out-of-network providers. These plans set a limit on what patients must pay out-of-pocket each year for covered services.[1] There is always coverage for emergency and urgent care.

How do I know if my patient has a Medicare Advantage plan?

You will need to check the patient's insurance identification (ID) card to determine if the patient has a Medicare Advantage plan. The ID card will typically look like the insurance company's commercial ID card (original Medicare ID cards are red, white and blue). If this is not indicated on the ID card itself, you will need to call the 800-telephone number listed on the card to verify whether the patient has an MA plan. Although not always 100% accurate, your staff can ask the patient if he or she has an MA plan. This way if there is any doubt, it would behoove your office to call the plan to verify. Lastly, if the patient is over 65 years of age there is a greater chance that the patient may have an MA plan and once again, a call to the plan to verify is recommended.

What coverage is provided under a Medicare Advantage plan?

Medicare Advantage plans may provide coverage for things original Medicare does not cover e.g., **dental services (routine check-ups, cleanings or restorative services)** fitness programs (gym memberships or discounts), vision and hearing. Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote health and wellness. Plans can also tailor their benefit packages to offer these benefits to certain chronically ill enrollees.[2]

What kind of Medicare Advantage plans are available for Medicare beneficiaries?

There are several different types of Medicare Advantage plans on the market including these most popular plans:

- Health maintenance organization (HMO) plans - These are typically closed panel plans meaning the patient needs to see a network provider to receive a benefit, except in the event of an emergency. Dentists are paid a capitated rate.
- Health maintenance organization (HMO) plus point of service (POS) plans – These are HMO plans that typically allow out-of-network benefits for dental coverage (if provided).
- Preferred provider organization (PPO) plans – These are indemnity plans where the insurance company has contracted with a network of dentists who have agreed to charge certain discounted fees for approved services. Benefits are typically available for patients to visit dentists not participating in the plan's network.

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[1] Medicare Advantage Plans | Medicare

[2] Medicare Advantage Plans cover all Medicare services | Medicare

- **Allowance plans** are gaining popularity with MA plan options. These plans provide patients with a set dollar amount that the patient can use on any covered dental service (except cosmetic services). Out-of-network dentists can receive their full fees while network dentists are subject to the plan's maximum allowable fees.

How do I contract to be in network for a Medicare Advantage plan?

Many commercial PPO plans include participation with their Medicare Advantage products while other plans may send an addendum to the contract for your signature or require you to opt-out of the MA program should you choose not to participate. Commercial plans may use the same network fee schedule for their commercial business as for their MA business.

If the plan also offers a separate dental health maintenance organization (DHMO) plan and the dentist wishes to participate in the MA DHMO plan, the dentist will need to sign a separate agreement with the DHMO plan.

What fee schedules are used for Medicare Advantage plans?

As noted above, many commercial PPO plans use the same network fee schedule for their commercial business as for their MA business. This can, however, vary by each different MA plan and it is recommended you ask the plans for a copy of their MA plan fee schedule before signing the agreement.

Are there out-of-network benefits for Medicare Advantage plans?

This will vary depending on the specific dental insurance plan. It is typical for PPO plans to provide out-of-network benefits to plan beneficiaries. However, some plans may offer an exclusive provider organization (EPO) plan which requires patients to visit a network dentist to receive a benefit. Also, if the patient presents with a DHMO plan, it is likely the patient will need to see a DHMO provider for the plan to receive a benefit, except in the case of emergency treatment.

How is coordination of benefits handled with Medicare Advantage plans?

If your patient has Medicare and other health insurance (from a group health plan, retiree coverage or Medicaid), each type of coverage is called a payer. When there's more than one payer, coordination of benefits rules decide who pays first. The primary payer pays what it owes first, and then the rest is sent to the secondary payer to pay. In some rare cases, there may also be a third payer.

If there are questions about who pays first, call the Benefits Coordination and Recovery Center at 855-798-2627. Representatives are available Monday through Friday, 8:00 a.m. – 8:00 p.m. Eastern Time.

Listed below are some of the most common COB scenarios for patients aged 65 and older that have group health plan coverage based on their current employment status and this link will take you to other multiple COB scenarios.

- If the employer has twenty or more employees, then the group health plan pays first and Medicare pays second.
- If the employer has less than twenty employees, the group health plan pays first, and Medicare pays second if both of these conditions apply:
    - the employer is part of a multi-employer or multiple employer group health plan
    - at least one of the other employers has twenty or more employees

- If the employer has less than twenty employees and is not part of a multi-employer or multiple employer group health plan, then Medicare pays first and the group health plan pays second.[3]

What happens when a Medicare Advantage claim for an out-of-network provider is denied due to lack of medical necessity?

If the MA plan denies a request for payment from a non-contracted provider, the MA plan must notify the non-contracted provider of the specific reason for the denial and provide a description of the appeals process. MA plans must deliver either a remittance advice/notice or other similar notification that states the non-contracted provider:

- Has the right to request a reconsideration of the MA plan's denial of payment
- **Must submit a Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal** (MA plans must include the form as an enclosure or attachment and/or provide a direct link to the form)
- Has sixty calendar days from the remittance notification date to request a reconsideration[4]

It may be a good idea to submit a pre-treatment estimate to the plan especially if the patient is receiving restorative treatment. Experience from dentists submitting Medicare Advantage claims suggests that use of ICD codes may aid in favorable claim adjudication. A list of ICD codes pertinent to dentistry can be found in Section 3 (page 105) of the CDT 2024 Current Dental Terminology manual.

How do I appeal a Medicare Advantage claim denial?

There are multiple levels in the Medicare Advantage (Part C) appeals process. The levels are:

1. Level 1 Appeals: Medicare Advantage (Part C) | HHS.gov
2. Level 2 Appeals: Medicare Advantage (Part C) | HHS.gov
3. Level 3 Appeals (OMHA) | HHS.gov
4. Level 4 Appeals | HHS.gov
5. Level 5 Appeals | HHS.gov[5]

Remember, if a claim submitted by an out-of-network provider is denied due to lack of medical necessity, the provider can request a reconsideration and **will have to submit a waiver of liability form, holding the enrollee harmless regardless of the outcome of the appeal** (see above).

Where can I find additional online resources on Medicare Advantage plans?

- View the archived webinar titled, Medicare Advantage: What is Medicare Part C and how does it work with Dental Coverage?
- Medicare Advantage (Part C) Plans PDF
- Navigating Medicare and Medicare Advantage (Part C) Plans PDF

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[3] https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance
[4] Medicare Managed Care and Part D Appeals Guidance (cms.gov)
[5] Level 1 Appeals: Medicare Advantage (Part C) | HHS.gov