10.1 - Medicare Covered Services

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(From §4.10.9 of the Medicare Managed Care Manual, Pub. 100-16) *Medicare cost plans*, (that is, HMOs or CMPs) must generally provide coverage of, by furnishing, arranging for, or making payment for, all *medically necessary and appropriate* services, *including supplies and DME*, that are covered by Part A and Part B of original Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if the enrollee is entitled only to benefits under Part B) that are **available** to beneficiaries residing in the plan's **geographic area.**

The services are considered **available** if either the sources of services are located in the *Medicare cost plan's* approved geographic area or it is common practice to refer patients to sources outside that geographic area (42 CFR 417.414(b)(2)).

(42 CFR 417.401) The term **geographic area** refers to the area found by CMS to be the area within which the *Medicare cost plan* furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Administration of the Medicare program is governed by *title XVIII* of the Social Security Act (the Act). Under the Medicare program, the scope of benefits available to eligible beneficiaries is prescribed by law and divided into several main parts. Part A is the hospital insurance program and Part B is the voluntary supplementary medical insurance program.

The scope of the benefits under Part A and Part B is defined in the Act. The scopes of Part A and Part B are discussed in *§1812* and *§1832* of the Act respectively, while *§1861* of the Act lays out the definition of medical and other health services. Each Medicare cost plan must offer at least all Part A benefits (other than hospice care) and all Part B benefits (or all Part B benefits to those entitled to only Part B) to all individuals residing in the area served by the plan in all benefit packages in its authorized geographic area. Some benefit categories are defined more broadly than others. Specific health care services must fit into one of these benefit categories, and not be otherwise excluded for coverage under the Medicare program.

The Act does not contain a comprehensive list of specific items or services eligible for Medicare coverage. Rather, it lists categories of items and services, and vests in the Secretary the authority to make determinations about which specific items and services within these categories can be covered under the Medicare program. That is, the Act allows Medicare to cover medical devices, surgical procedures and diagnostic services, but generally does not identify specific covered or excluded items or services. Further guidance is presented in the Code of Federal Regulations and CMS interpretations. Medicare payment is contingent upon a determination that:

- A service meets a benefit category;

- Is not specifically excluded from coverage; and

- The item or service is “reasonable and necessary.”

Section *1862(a)(1)(A)* of the Act states that, subject to certain limited exceptions, no payment may be made for any expenses incurred for items or services that are not “reasonable and necessary” for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member. These authorities are exercised to make coverage determinations regarding whether a specific item or service meets one of the broadly defined benefit categories and can be covered under the Medicare program. National coverage decisions are published on the National Coverage Web site - for further information please see *§80* of this subchapter.

In the absence of a specific National Coverage Decision, coverage decisions are made at the discretion of local contractors. A Medicare cost plan is required to follow any local medical review policies (LMRP) issued by the fiscal intermediaries and carriers in its geographic area.