



ADMINISTRATIVE RULES OF MONTANA



37.83.802 QUALIFIED MEDICARE BENEFICIARIES, DEFINITIONS

- (1) "Assignment" means an agreement between the medicare carrier and a medicare provider under which the carrier makes payment to the provider rather than the recipient, and the provider agrees to accept the medicare allowable rate as payment in full.
- (2) "Carrier" means the private insurance company contracted with by the United States health care financing administration to process medicare Part B claims and issue payments to physicians and other providers or to recipients.
- (3) "Chiropractic services" means the manipulation of the spine by a licensed chiropractor to correct a subluxation. Chiropractic services do not include x-rays or other diagnostic or therapeutic services provided by a licensed chiropractor.
- (4) "Coinsurance" means an amount of medical and other costs incurred by an eligible person that are the financial responsibility of that person rather than of the medicare Parts A or B insurance. The amount of coinsurance is the difference between the medicare allowable rate and the actual medicare payment.
- (5) "Copayment" means a cost sharing fee imposed upon a qualified medicare beneficiary recipient for a medical service paid for by medicaid.
- (6) "Customary charge" means the charge most frequently used by the provider for the service or item.
- (7) "Deductible" means a set amount of medical and other costs designated by medicare as the person's financial responsibility. Medicare coverage begins with costs in excess of the deductibles.
- (8) "Department" means the department of public health and human services as provided for at 2-15-2201 , MCA.
- (9) "Full medicaid" means medicaid coverage other than that provided to qualified medicare beneficiaries.
- (10) "Hospice care" are those services providing pain relief, symptom management, respite care, and support services to terminally ill persons.
- (11) "Intermediary" means the private insurance company contracted with by the United States health care financing administration to make coverage and payment decisions on services covered by medicare Part A insurance in hospitals, skilled nursing facilities, home health agencies and hospices.
- (12) "Medicare allowable rate" means the reasonable charge for the medical service reimbursable under medicare Part B.

- (13) "Medicare" means the health insurance programs under Title XVIII of the Social Security Act.
- (14) "Medicare Part A insurance" means the insurance program under medicare that covers inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care.
- (15) "Medicare Part B insurance" means the insurance program under medicare that covers outpatient hospital services, physician services, home health care services, and other medical services not covered by medicare Part A insurance.
- (16) "Premiums" means the monthly amounts that are charged for a person to receive medicare Part B insurance coverage and that may be charged for a person to receive medicare Part A coverage when the person is not eligible for premium-free coverage.
- (17) "Prevailing charge" means a level equal to at least three-fourths of the average of all the charges for the same service billed by all the physicians or suppliers in the state.
- (18) "Qualified medicare beneficiary" means a person eligible for the program provided for in Title 37, chapter 83.
- (19) "Respite care" is a short term inpatient hospital stay necessary to temporarily relieve the person who regularly provides hospice care to a person.

Authorizing statute(s): Sec. 53-2-201 and 53-6-113, MCA

Implementing statute(s): Sec. 53-6-101 and 53-6-131, MCA

History: NEW, 1989 MAR p. 835, Eff. 6/30/89; TRANS, from SRS, 2000 MAR p. 197; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.