CY 2015 Service Category Report

Service Category	Service Category Description
1a:Inpatient Hospital - Acute	The following items and services are furnished to an inpatient of a hospital and by the hospital: (1) bed and board; (2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and (3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements. If inpatient cost sharing varies based on hospital tier, enter that cost sharing in the data entry fields provided. MAO's must continue to ensure that the tiered cost sharing in their plans' benefit packages provide to enrollees equal access to the hospitals in the network and is not otherwise discriminatory. The following benefits are eligible to be offered as supplemental benefits; Additional Days Non-Medicare-covered Stays Upgrades References: 42 CFR Part 409 Subparts A, B, E and F and the Medicare Benefit Policy Manual, Pub 100-2, Chapters 1, 3, 5, and 6.
1b:Inpatient Hospital Psychiatric	Inpatient psychiatric hospital services are inpatient hospital services furnished to a patient of an inpatient psychiatric facility that are provided under the direction of a physician for the care and treatment of mental disease. This benefit includes only mental health services furnished in psychiatric hospitals, and distinct part psychiatric units of acute care hospitals and critical access hospitals (CAHs). Inpatient mental health services furnished to an inpatient of an acute care hospital are included in 1a Inpatient Hospital. Institution for psychiatric diseases means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with mental diseases, including medical care, nursing care, and related services. If inpatient cost sharing varies based on hospital tier, enter that cost sharing in the data entry fields provided. MAO's must continue to ensure that the tiered cost sharing in their plans' benefit packages provide to enrollees equal access to the hospitals in the network and is not otherwise discriminatory.

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	The following benefits are eligible to be offered as supplemental benefits; Additional Days Non-Medicare-covered Stays References: 42 CFR Part 409 Subparts A, B, E and F and the Medicare Benefit Policy Manual, Pub 100-2, Chapters 2 and 4.
2:Skilled Nursing Facility (SNF)	A SNF is an institution or a distinct part of an institution which has a transfer agreement in effect with one or more participating hospitals and which: (A) Is primarily engaged in providing skilled nursing care and related services for patients who require medical and nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and (B) Meets the requirements for participation in section l8l9 of the Social Security Act and in regulations in 42 CFR part 483, subpart B. The following benefits are eligible to be offered as supplemental benefits; Additional Days Non-Medicare-covered Stays Waive the 3 day hospital stay prior to admission References: 42 CFR 409 Subparts C and D as well as the Medicare Benefit Policy Manual, Chapter 8.
3:Cardiac and Pulmonary Rehabilitation Services	Cardiac rehabilitation programs are comprehensive programs that include exercise, education, and counseling for patients whose doctor referred them and who had any of the following: - A heart attack in the last 12 months - Coronary artery bypass surgery - Current stable angina pectoris (chest pain) - A heart valve repair or replacement - An angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a device used to keep an artery open) - A heart or heart-lung transplant -For cardiac rehabilitation only, other cardiac conditions as specified through NCD. Eligible beneficiaries are covered for up to a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 36 weeks with the option for an additional 36 sessions for an extended period of time if approved by the Medicare contractor under section 1862(a)(1)(A) of the Act. Intensive cardiac rehabilitation (ICR) programs, like cardiac rehabilitation (CR) programs, include exercise, education, and counseling for patients whose doctor referred them and who had any of the conditions listed above. ICR programs are more rigorous or more intense than CR programs.

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	Both CR and ICR programs may be provided in a hospital outpatient setting (including a critical access hospital) or in a doctor's office. Eligible beneficiaries are covered for up to a maximum of 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks. Pulmonary rehabilitation programs are comprehensive programs that include exercise, education and counseling for people with moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease. These services may be provided in doctors' offices or a hospital outpatient setting that offers pulmonary rehabilitation programs. Eligible beneficiaries are covered for up to 36 sessions, no more than two sessions per day. Up to an additional 36 sessions may be approved by the Medicare contractor. A Plan may offer additional Cardiac/Intensive Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit. References: For complete standards for cardiac and intensive cardiac rehabilitation programs, see 42 CFR 410.49 and coverage and benefit guidance for CR and ICR contained in the Medicare benefit Policy Manual, Pub 100-2, Chapter 15, section 232, as well as, the Claims Processing Manual, Pub 100-4, Chapter 32, section 140.1 through 140.3. For complete standards for pulmonary rehabilitation programs, see 42 CFR 410.47 and coverage and benefit guidance contained in both the Medicare Benefit Policy Manual, Chapter 15, section 231, as well as the Medicare Claims Processing Manual, Pub 100-4, Chapter 32, section 140.4.
4a:Emergency Care	Emergency care refers to services: · furnished by a provider qualified to furnish emergency services and · needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that, independent of final diagnosis, a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: · Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

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	· Serious impairment to bodily functions; or · Serious dysfunction of any bodily organ or part. In general, items and services which are provided outside the U.S. and its territories (which include Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa and the Northern Mariana Islands) are not covered. "Post-stabilization care" (also referred to in the Act as "maintenance care") means medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from the M+C organization until: the enrollee is discharged; a plan physician arrives and assumes responsibility for the enrollee's care; or the treating physician and plan agree to another arrangement. A plan may not charge a separate cost share for observation services. Observation services are among the many services that a patient may receive in the outpatient department of a hospital and as such, the cost sharing for observation services is included in the cost sharing for hospital outpatient services. References: 42 CFR 422.113, Medicare Managed Care Manual, Pub 100-16, Chapter 4
4b:Urgently Needed Services	Covered urgently needed services are services provided to diagnose and treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services are provided in-network or by out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g. when you are temporarily outside of the plan's service area or if applicable, continuation area. Reference: Medicare Managed Care Manual, Pub 100-16, Chapter 4.
4c:Worldwide Emergency Coverage	A MA plan may offer Worldwide Emergency Coverage as a supplemental benefit to its enrollees for services outside the US and its territories. “Worldwide Emergency Coverage,” refers to any coverage of services outside the United States and its territories, whether worldwide or in areas specified by the plan as either a mandatory or optional supplemental benefit. Under the benefit, enrolled beneficiaries may obtain emergency or urgently-needed care when they are temporarily outside of the United States and its territories. MA plans that offer a worldwide emergency coverage benefit may retain enrollees who are covered by the benefit but temporarily outside of the United States or its territories for up to six months. The specific requirements for the Worldwide Coverage benefit are as follows:

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	- The nature of the services covered must be clearly stated, for example, an MA plan may limit such coverage to services that would be classified as emergency or urgently needed had they been provided in the United States; and - A plan benefit design may not discriminate based on health status. In particular, the cost of a mandatory supplemental Worldwide Coverage benefit should be nominal within the bid or CMS may determine that the benefit discriminates against enrollees who are unable to travel due to health status. Reference: The Medicare Managed Care Manual, Chapter 4.
5:Partial Hospitalization	Partial hospitalization programs (PHPs) are structured to provide intensive outpatient psychiatric care through active treatment that utilizes a combination of clinically recognized items and services. PHPs are covered by Medicare only when furnished in a hospital outpatient setting or a Community Mental Health Center. The treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program. It is treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation. Programs providing primarily social, recreational, or diversionary activities are not considered partial hospitalization. PHP programs include any of the following: (i) individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law. (ii) Occupational therapy requiring the skills of a qualified occupational therapist. (iii) Services of other staff including social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients. (iv) Drugs and biological that are not self-administered and are furnished for therapeutic purposes, subject to the limitations specified in 410.29. (v) Individualized activity therapies that are not primarily recreational or diversionary. These activities must be individualized and essential for the treatment of the patient's diagnosed condition and for progress toward treatment goals; (vi) Family counseling, the primary purpose of which is treatment of the individual's condition. (vii) Patient training and education, to the extent the training and educational activities are closely and clearly related to the individual's care and treatment of his/her diagnosed psychiatric condition. (viii) Diagnostic services related to mental health treatment. Reference: For more information, including patient eligibility criteria, benefit category description, covered services, reasonable and necessary services and limitations, see 42 CFR 410.43 and 424.24(e), 410.100 and the Medicare benefit Policy Manual, Pub 100-2, Chapter 6, section 70.3.
6:Home Health Services	Home health care services are provided in the patient's home

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	for the purpose of promoting, maintaining, or restoring health or reducing the effects of illness and disability. Service may include medical, dental, or nursing care, speech language pathology, occupational therapy or physical therapy, or transportation service. Skilled nursing may be provided by a registered nurse or licensed practical nurse. Medicare-covered home health services must be medically necessary, be provided only to eligible beneficiaries and satisfy the criteria in Chapter 7, "Home Health Services" of the "Medicare Benefit Policy Manual", Publication 100-02, on the CMS website. A MA plan may offer as a supplemental benefit items or services not covered by Medicare. Covering specific in-home services for enrollees who do not meet the Medicare criteria to qualify for Medicare-covered home health care. References: 42 CFR 409, Subpart E, Home Health Services Under Hospital Insurance (409.40 through 409.50) and the Medicare Benefit Policy Manual, CMS Internet only manuals, Publication 100-02, Chapter 7, "Home Health Services," Chapter 4..
7a:Primary Care Physician Services	Internal Medicine, General Practice, or Family Practice Services provided by a medical doctor or a doctor of osteopathy: General--Physicians' services are the professional services performed by a physician for a patient including diagnosis, therapy, surgery, consultation, and care plan oversight. The services must be rendered by the physician or incident to physician's services. A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of X-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc. References: 42 CFR 410.10 and 410.26 and the Medicare Benefit Policy Manual, Chapter 15.
7b:Chiropractic Services	Medicare coverage is limited to a chiropractor's manual manipulation of the spine to correct a subluxation if the subluxation has resulted in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment. A MA plan may offer Routine Care as a supplemental benefit. Routine chiropractic services may be offered by a plan as a supplemental benefit so long as the services are provided by a State-licensed chiropractor who provides services within the States' licensure and practice guidelines. The routine services may include conservative management of

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	neuromusculoskeletal disorders and related functional clinical conditions including, but not limited to, back pain, neck pain and headaches, and the provision of spinal and other therapeutic manipulation/adjustments. X-rays or other diagnostic or therapeutic services furnished or ordered by a chiropractor may be covered by the plan in the supplemental benefit so long as the chiropractor is State-licensed and is practicing within the States' licensure and practice guidelines. References: 42 CFR 410.21 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 30.5.
7c:Occupational Therapy Services	Occupational therapy is medically prescribed treatment to improve or restore functions which have been impaired by illness or injury to improve the individual's ability to perform those tasks required for independent functioning. References: For conditions of coverage of outpatient occupational therapy services, see 42 CFR 410.59 and 410.61 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 220 et al. See also coverage and benefit conditions for services furnished in a Comprehensive Outpatient Rehabilitation Facility (CORF), 42 CFR 410.100-105 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 12.
7d:Physician Specialist Services excluding Psychiatric Services	Physician specialist services are provided by a doctor of medicine or a doctor of osteopathy, a doctor of optometry or a doctor of dental medicine or dental surgery. Physician specialist services are the professional services performed by a physician or physicians for a patient including diagnosis, therapy, surgery, consultation, and care plan oversight. The services must be rendered by the physician or incident to physician's services. A service may be considered to be a physician specialist's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of X-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc. References: 42 CFR 410.20, 410.22, 410.24, 410.26, 410.32 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15.
7e:Mental Health Specialty Services - Non-Physician	Medicare-covered mental health services provided by State-licensed clinical psychologists and clinical social workers and other professional authorized by the State to furnish mental health services. Services are for enrollees only. Family members may accompany the enrollee but may not participate. References:

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	42 CFR 410.71 and 410.73 and applicable sections of the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15.
7f:Podiatry Services	Medicare-covered Podiatry services include the diagnosis and/or the medical, mechanical or surgical treatment of the ailments of the human foot provided by a State-licensed podiatrist. It may include the fitting or the recommending of appliances, devices or shoes for the correction or relief of minor foot ailments, but does not include the amputation of the foot or toes, or the administration of anesthetics other than local. Some of the conditions treated are corns, calluses, ingrown toenails, plantar warts, fungus infections of the skin and nails, bunion deformities, hammertoes, heel spurs, bursitis, arthritis, flat feet, pronating feet, gait problems, diabetic and avascular ulcers, fractured bones of the feet and sprains and strains of the foot. A doctor of podiatric medicine is included within the definition of physician, but only with respect to those functions that he/she is legally authorized to perform in the State in which he/she performs them and for the services that are covered by Medicare. A MA plan may offer routine podiatry services as a supplemental benefit. Reference: 42 CFR 410.25
7g:Other Health Care Professional Services	Cost sharing for professionals not specifically identified elsewhere in PBP section 7, who are engaged in the delivery of health care who are licensed, practice under an institutional license, are supervised by a licensed health care provider, or have a certificate to practice, and for whom Medicare Part B will make payment for their professional services. These professionals include only: Nurse Practitioners, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, and Physician Assistants. References: 42 CFR 410.69, 410.74, 410.75, 410.76, 410.77, and all applicable sections of the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, pertaining to non-physician practitioners.
7h:Psychiatric Services	Services provided by a doctor of medicine who specializes in the diagnosis, prevention, and treatment of mental disorders.
7i:Physical Therapy and Speech-language Pathology Services	Physical therapy, or PT, is evaluating and treating people with musculoskeletal injury or disease; assessing joint motion, muscle strength and endurance, function of heart and lungs, and performance of activities required in daily living, among other responsibilities. Treatment includes therapeutic exercise, cardiovascular endurance training, and training in activities of daily living. Speech-language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities,

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	and for the diagnosis, and treatment of swallowing disorders (dysphagia), regardless of the presence of a communication disability. References: For conditions of Medicare coverage of outpatient physical therapy services, see 42 CFR 410.60 and 410.61 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 220 et al. For conditions of Medicare coverage of outpatient physical therapy services, see 42 CFR 410.61 and 410.62 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 220 et al. See also coverage and benefit conditions for services furnished in a Comprehensive Outpatient Rehabilitation Facility (CORF), 42 CFR 410.100-105 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 12.
8a:Outpatient Diagnostic Procedures and Tests and Lab Services	Diagnostic procedures, tests, and lab services furnished in an outpatient setting includes: blood tests, diagnostic procedures and tests such as basal metabolism readings, electroencephalograms, electrocardiograms, respiratory function tests, cardiac evaluations, allergy tests, and psychological tests; and other diagnostic lab services. Note: The reading and interpretation of test results is considered to be one service, therefore there should be one cost share amount. References: 42 CFR 410.28, 410.32, 410.33 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 80 as well as the Medicare benefit Policy manual, Chapter 6, section 20.4 (outpatient hospital diagnostic services).
8b:Outpatient Diagnostic and Therapeutic Radiological Services	Diagnostic and therapeutic radiological services furnished in an outpatient setting. Includes: x-rays, nuclear medicine with SPECT; computerized tomography, magnetic resonance imaging, position emission tomography, ultrasound, interventional radiology, and radiation therapy. Note: The reading and interpretation of test results is considered to be one service, therefore there should be one cost share amount. Reference: 42 CFR 410.35 and the Medicare Benefit Policy Manual, CMS Internet only manuals, Publication 100-02, Chapter 6, Section 20.4, "Outpatient Diagnostic Services".
9a:Outpatient Hospital Services	Outpatient hospital services are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished in a hospital outpatient department or provider-based department of a hospital to include the services furnished at a clinic or hospital by or under the direction of a physician. A plan may not charge a separate cost share for observation services. Observation services are among the many services that a patient may receive in the outpatient department of a

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	hospital and as such, the cost sharing for observation services is included in the cost sharing for hospital outpatient services. References: 42 CFR 410.27 and 410.28 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 6, et al.
9b:Ambulatory Surgical Center (ASC) Services	An ambulatory surgical center (ASC) is a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours. Some examples of types of surgeries done in these centers are cataract removal, hernia repair, and some knee surgeries. References: For conditions of coverage and scope of benefits, see 42 CFR Part 416 Subparts A through F and the Medicare benefit Policy Manual, Pub 100-2, Chapter 15, section 260 et al.
9c:Outpatient Substance Abuse Services	Non-residential ambulatory services provided for the treatment of drug or alcohol dependence, without the use of pharmacotherapies. Services may include intensive outpatient services (all- day care for several days) as well as traditional counseling (one or a few hours per day, usually weekly or biweekly).
9d:Outpatient Blood Services	Medicare does not pay for the first 3 units of whole blood or units of packed red cells that a beneficiary receives, during a calendar year; on an inpatient or an outpatient basis. In most cases, the provider gets blood from a blood bank at no charge, and the beneficiary does not have to pay for it or replace it. However, the beneficiary will pay a copayment for the blood processing and handling services for every unit of blood the beneficiary receives and the Part B deductible applies. A MA Plan may offer to waive the 3 pint deductible as a supplemental benefit. Reference: 42 CFR 409.87
10a:Ambulance Services	Medicare Part B covers ground ambulance transportation when a beneficiary needs to be transported (one-way trip) to a hospital or skilled nursing facility for emergency services or for other medically-necessary services when transportation in any other vehicle could endanger the beneficiary's health. Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give the beneficiary the care they need. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if a beneficiary needs immediate and rapid ambulance transportation that ground

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	transportation can't provide. In some cases, Medicare may pay for limited non-emergency ambulance transportation if a beneficiary has orders from the doctor saying that ambulance transportation is medically necessary. References: 42 CFR 410.40 and the Medicare Benefit Policy Manual, Chapter 10.
10b:Transportation Services	An MA plan may create either a mandatory or optional supplemental transportation benefit to provide transportation not covered by Original Medicare. For example, the plan may offer to enrollees a supplemental benefit that provides transportation to locations where its enrollees can access their health benefits. The plan must arrange transportation exclusively to these places. Transportation should not consist of items and services that can be used for other non-medical transportation (such as a free train or bus pass). The plan must describe the proposed supplemental benefit in its submitted plan benefit package. Reference: The Medicare Managed Care Manual, Chapter 4.
11a:Durable Medical Equipment (DME)	Equipment which (a) can withstand repeated use, and (b) is primarily and customarily used to serve a medical purpose, and (c) generally is not useful to a person in the absence of an illness or injury; and (d) is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be durable medical equipment. References: 42 CFR 410.38 and the Benefit Policy Manual, Pub 100-2, Chapter 15, section 110; the Medicare Claims Processing Manual, Chapter 20
11b:Prosthetics/Medical Supplies	Medicare Part B pays for the following medical supplies, appliances and devices: (1) Surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations. (2) Prosthetic devices, other than dental, that replace all or part of an internal body organ, including colostomy bags and supplies directly related to colostomy care, including—(i) Replacement of prosthetic devices; and (ii) One pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery during which an intraocular lens is inserted. (3) Leg, arm, back, and neck braces and artificial legs, arms, and eyes, including replacements if required because of a change in the individual's physical condition.

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	References: 42 CFR 410.36 and the Medicare benefit Policy Manual, Pub 100-2, Chapter 15, sections 100, 120-140.
11c:Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	Diabetes Monitoring Supplies: Medical supplies which help monitor how much glucose (sugar) is in the blood. Some examples of diabetes monitoring supplies include blood glucose meters, lancets and reagents. Coverage of diabetic shoes includes custom molded shoes, depth shoes, inserts and braces. References: For more information and limitations on Medicare coverage, see the Medicare Benefit Policy Manual, Pub 100-2, and Chapter 15, section 140 and the Medicare Claims Processing Manual, Chapter 20.
12:End-Stage Renal Disease	Dialysis for patients with End-Stage Renal Disease is the process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. There are two types of renal dialysis in common clinical usage, hemodialysis and peritoneal dialysis. Both hemodialysis and peritoneal dialysis are acceptable modes of treatment of chronic renal disease. References: 42 CFR 410.50-55 and the Medicare benefit Policy Manual, Pub 100-2, Chapter 11.
13a:Acupuncture and Other Alternative Therapies	Plans may choose to offer acupuncture or a number of other alternative therapies as a supplemental benefit. For the benefit to qualify as a supplemental benefit the plan must ensure that the therapy will be provided by state-licensed or state-certified practitioners. The plan is required to describe the proposed benefit, the scope of the services to be provided, and the qualifications of the providers in its plan benefit package for CMS review. Reference: The Medicare Managed Care Manual, Chapter 4.
13b:OTC Items	Plans may offer OTC items as a supplemental benefit under Part C that are consistent with CMS guidance in Chapter 4 of the Medicare Managed Care Manual (MMCM). OTC items include both: · Non-prescription drugs, also known as OTC drugs; and · Health-related items (such as bandages in situations where Original Medicare does not cover them as surgical supplies). Plans must notify enrollees that OTC items may only be purchased for the enrollee. Purchases for anyone other than the enrollee are not allowed. CMS strongly encourages enrollees to purchase items only after having appropriate conversations with their providers who orally recommend the OTC item for a specific condition.

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	The plan must describe the proposed benefit in its plan benefit package for CMS review. Reference: The Medicare Managed Care Manual, Chapter 4.
13c:Meal Benefits	Note that all MA coordinated care plans are required to "coordinate MA benefits with community and social services generally available in the area served by the MA plan" (422.112(b)(3)). Therefore, plans are to: Provide information and links to websites with nutritious diet planning information, such as ChooseMyPlate.Gov; Provide nutritional tips in their plan newsletters and/or on their plan websites; and Partner with social community services such as "Meals on Wheels". However, the MA plan may not classify any of these community services as "plan benefits." Meals may be offered as a supplemental benefit if the service is: 1) Needed due to an illness; 2) Consistent with the normal pattern of delivery of care for the illness, and 3) Offered for a short duration. Meals may be offered as a supplemental benefit to address the following two types of circumstance: · Immediately following an inpatient hospital stay or outpatient surgery. Meals may be offered for a temporary duration, typically a two-week or four-week period, per enrollee per year, provided they are ordered by a physician or non-physician practitioner. As discussed in 42 CFR 422.112(b)(3), after the temporary duration, the provider should refer the enrollee to community and social services for further meals, if needed. · For exacerbation of a chronic condition if the meals are: o Offered for temporary period, typically for two weeks, per enrollee per year; o Ordered by a physician or non-physician practitioner; o Part of a supervised program designed to prevent future exacerbation episodes and to help the enrollee to adopt life style modifications; o Social factors, by themselves, do not qualify an enrollee for supplemental meal services. Reference: The Medicare Managed Care Manual, Chapter 4.
13d:Other 1	The Other service category is intended for data entry of those supplemental benefits that are offered by the MA Plan but do not fit into the standard PBP service categories. If the benefit offered aligns with the guidance in Chapter 4 for the particular benefit, no additional notes are required outside of the benefit description. If however, the benefit offered is different than Chapter 4 definitions a full description of the proposed

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	supplemental benefit must be included in the notes field for this PBP item for CMS review.
13e:Other 2	The Other service category is intended for data entry of those supplemental benefits that are offered by the MA Plan but do not fit into the standard PBP service categories. If the benefit offered aligns with the guidance in Chapter 4 for the particular benefit, no additional notes are required outside of the benefit description. If however, the benefit offered is different than Chapter 4 definitions a full description of the proposed supplemental benefit must be included in the notes field for this PBP item for CMS review.
13f:Other 3	The Other service category is intended for data entry of those supplemental benefits that are offered by the MA Plan but do not fit into the standard PBP service categories. If the benefit offered aligns with the guidance in Chapter 4 for the particular benefit, no additional notes are required outside of the benefit description. If however, the benefit offered is different than Chapter 4 definitions a full description of the proposed supplemental benefit must be included in the notes field for this PBP item for CMS review.
13g:Dual Eligible SNPs with Highly Integrated Services	If CMS has notified you that your D-SNP qualifies to offer additional supplemental benefits under the benefit flexibility initiative described by CMS and at 42 CFR 422.102, please use this service category to describe any additional supplemental benefits that your D-SNP is offering. CMS will evaluate these supplemental benefits according CMS requirements. Below, we provide a description of the categories of additional supplemental benefits that these D-SNPs may offer. Non-Skilled In-home Support Services: Non-skilled services and support services performed by a personal care attendant to assist individuals with disabilities and/or chronic conditions with performing ADLs and IADLs as necessary to support recovery, to prevent decline following an acute illness, prevent exacerbation of a chronic condition, or to aid with functional limitations. This benefit category would also include non-medical transportation that assists in the performance of IADLs. In-Home Food Delivery: Meal delivery service (beyond the limited coverage described in Chapter 4, Section 30.5, of the Medicare Managed Care Manual (MMCM) for individuals who cannot prepare their own food (IADL limitation) due to functional limitations with ADLs or short-term functional disability, or for individuals who, based on a physician's recommendation, require nutritional supplementation following an acute illness or as a result of a chronic condition. Supports for Caregivers: Provision of respite care – either through a personal care attendant or provision of short-term institutional-based care – for beneficiary caregivers. Coverage

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	may include benefits such as counseling and training courses (related to the provision of plan-covered benefits) for caregivers. Home Assessments, Modifications, and Assistive Devices for Home Safety: Coverage of home safety/assistive devices, and home assessments and modifications beyond those permitted in Chapter 4, Section 30.3, of the MMCM. Coverage may include items/services such as rails in settings beyond the beneficiary's bathroom. Adult Day Care Services: Services such as recreational/ social activities, meals, assistance with ADLs/IADLs, education to support performance of ADLs/IADLs, physical maintenance/rehabilitation activities, and social work service.
13h:Additional Services	Include only benefits covered by Medicaid or as demonstration-specific additional benefits. The Additional Services category is intended for data entry of Medicaid and demonstration-specific additional benefits that are offered by the Medicare/Medicaid plans under their integrated plan benefit package. Benefits include vision, dental, or long-term care or other benefits covered only under Medicaid.
14a:Medicare-covered Zero Cost-Sharing Preventive Services	All MA and 1876 cost plan contractors must provide, without cost sharing, all preventive services that are covered under Original Medicare without cost sharing. For a list of such services please consult 42 CFR 410.2, 410.64, 410.152(l). See also 410.15-19, 410.31, 410.34,410.37, 410.39, 410.56- 57, 410.63 410.132 and the Medicare Claims Processing Manual, Pub 100-4, Chapter 18 Preventive and Screening Services and the NCD Manual for preventive services added by NCD, Pub 100.3 Because the list may change during the year, we will include in guidance a more current list, but it is the plan's responsibility to monitor the Medicare coverage webpage to stay up-to-date about covered services http://www.cms.gov/center/coverage.asp
14b:Annual Physical Exam	MAOs may offer an Annual Physical Exam as a supplemental benefit, an exam that complements and in no way, duplicates, the services and activities included in the required Annual Wellness Visit. A full description of the proposed physical exam supplemental benefit must be included in the notes field for this PBP item for CMS review. Plans should refer to relevant HPMS memos that address guidance related to supplemental benefits.
14c:Eligible Supplemental Benefits as defined in Chapter 4	Following is a list of supplemental benefits that a MAO may choose to offer to enrollees: · Additional Smoking and Tobacco Cessation · Additional Sessions of Medical Nutrition Therapy (MNT)

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	· Bathroom Safety Devices · Counseling Services · Enhanced Disease Management · Health Education · In-home Safety Assessment · Membership in Health Club/Fitness Classes · Nurse Hotline · Nutritional/Dietary Benefit · Personal Emergency Response System (PERS) · Post discharge In-home Medication Reconciliation · Re-admission Prevention · Tele-Monitoring · Web/Phone-Based Technology · Wigs for Hair Loss Related to Chemotherapy If the benefit is offered as described in Chapter 4 for the particular benefit, a note is not required. If the benefit goes above and beyond the description in Chapter 4 benefit, a note is necessary to describe the benefit. Plans should refer to the Medicare Managed Care Manual, Chapter 4 and relevant HPMS memos that address guidance related to supplemental benefits.
14d:Kidney Disease Education Services	Kidney disease patient education services means face-to-face educational services provided to patients with Stage IV chronic kidney disease. It includes services such as patient education and management of comorbidities including for the purpose of delaying the need for dialysis. References: 42 CFR 410.48 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 310.
14e:Diabetes Self-Management Training	The term "diabetes outpatient self-management training services" means educational and training services furnished to an individual with diabetes. Such services must be ordered by a physician and provided under a comprehensive plan of care established by the physician (or qualified non-physician practitioner) treating the beneficiary for diabetes. References: 42 CFR 410 Subpart H, sections 410.140-146 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 300 et al.
15:Medicare Part B Rx Drugs and Home Infusion Drugs	This section allows the user to specify cost sharing for required Medicare Part B Drug benefit information for the current plan. MA-PD or cost plans may choose to provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit under Part C, provided the MA-PD or cost plan consistently applies the option (i.e., in a given contract year, either always covers a particular home infusion drug as part of a bundled service as a supplemental benefit under Part C, or always covers a particular home infusion drug under Part D). MA-PD or cost plans may not offer this

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	bundled service unless the cost-sharing associated with the bundled service is $0. Given uniform benefits requirements, MA organizations must also ensure that the bundled service is available to all enrollees of any MA-PD or cost plan (including those residing in LTC facilities) in which it chooses to provide Part D home infusion drugs as part of a supplemental benefit under Part C. Interested MA organizations must appropriately apportion costs between Part D and C components of their bid to account for these drugs. The bundle of home infusion services offered under a mandatory Part C supplemental benefit must include both the home infusion drugs that would otherwise be covered under their Part D benefit and supplies and services associated with their infusion. References: 42 CFR Part 410 and the Medicare Benefit Policy Manual, Pub 100-2, Chapters 6, section 10 and Chapter 15, section 50.
16a:Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)	Plans may offer Preventive Dental as a supplemental benefit. Preventive dental procedures are provided by or under the supervision of a dentist in the practice of his/her profession, including treatment of the teeth and associated structures of the oral cavity. Common preventive dental services include prophylaxis (cleaning), fluoride treatment, dental x-rays, and oral exams and office visits. Reference: The Medicare Managed Care Manual, Chapter 4.
16b:Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics/Periodontics/Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)	Medicare Part A will pay for certain dental services that a beneficiary receives when they're in a hospital. Medicare can pay for hospital stays if a beneficiary needs to have an emergency or complicated dental procedure. Comprehensive dental diagnostic or corrective procedures are provided by or under the supervision of a dentist in the practice of his/her profession, including treatment of the teeth and associated structures of the oral cavity; and disease, injury, or impairment that may affect the oral or general health of the recipient. Common comprehensive procedures may include non-routine dental care, diagnostic services, restorative procedures, endodontics, periodontics, extractions, and prosthodontics. Reference: 42 CFR 410. 24 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 15, section 120 (C) and 150.
17a:Eye Exams	An eye exam is the testing of the condition of the eye and the prescribing of corrective measures such as glasses or contact lenses. Medicare covers vision services related to the diagnosis and treatment of illness and injury of the eye, includes limited coverage of eyewear and prosthetic lenses related to cataract

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	surgery. Plan may offer routine eye exams as a supplemental benefit. Reference: 42 CFR 410.22 and the Medicare Benefit Policy Manual, Chapter 15, sections 30.4, 120(B) and (D)
17b:Eye Wear	Medical eye wear is defined as ophthalmic lenses, frames and other specially fabricated optical devices and/or contact lenses prescribed, normally by an optician, to the intended wearer. Medicare includes limited coverage of eyewear and prosthetic lenses related to cataract surgery. Plan may offer non-Medicare-covered eyewear as a supplemental benefit. Reference: Medicare Benefit Policy Manual, Chapter 15, sections 30.4, 120(B) and (D).
18a:Hearing Exams	If ordered by a physician as a diagnostic test, some exams are covered by Original Medicare. Plans may offer routine hearing exams, fitting and evaluation for hearing aids as a supplemental benefit. Best results are obtained by a trained audiologist in a special soundproof testing booth. Simple tests may be useful for screening but a careful audiogram is necessary for accurate diagnosis of most hearing problems. A complete audiogram will test both the bone conduction (the ability to hear a sound when it is transmitted through bone) and the air conduction (the ability to hear a sound when it is transmitted through air). A comparison between these two types of conduction can be very useful in localizing which part of the hearing mechanism is responsible for the loss. In particular, the test is useful in determining if the loss is due to problems with the portion of the middle ear that conducts sound from the ear canal to the inner ear (in which case it would be called a "conductive" hearing loss) or if it is due to the inner ear or the nerve that conducts the sound signals to the brain (in which case it would be called a "sensorineural" hearing loss). Reference: Medicare Benefit Policy Manual, chapter 15, sections 80.3 and 230.3.
18b:Hearing Aids	Plans may offer hearing aids as a supplemental benefit. All hearing aids include a microphone (to pick up the sound), an amplifier (to increase the strength of the sound), a receiver or speaker (to deliver the sound to the ear), and a battery. Some tiny batteries can provide hundreds of hours of

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	power. Hearing aid assistance is either "monaural" (a hearing aid for one ear) or "binaural" (a hearing aid for each ear), and well over half (65 percent) of all hearing aid users are fitted with binaurals to help maximize speech discrimination. Reference: The Medicare Managed Care Manual, Chapter 4.
20:Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	This service category is only enabled for Cost Plans not offering the Medicare Part D benefit. This category collects information on Medicare-covered and Non-Medicare-covered prescription drugs offered by Cost Plans. Rules for cost plans: a) If a Cost Plan organization states it offers Part D in the Health Plan Management System (HPMS), then the Cost Plan may only create plans that offer prescription drugs using Section Rx in the PBP. That is, Cost Plans with Part D designation in the HPMS, may only offer MA-PD or MA-Only plans. The PBP B-20 Outpatient Prescription Drugs Service Category in Section B of the PBP should be disabled for all plans in this scenario. OR b) If a Cost Plan organization states it does NOT offer Part D in the HPMS, then the Cost Plan may only define drug benefits using the PBP B-20 Prescription Drug Category in Section B of the PBP. PBP Section Rx in the PBP should be disabled for all plans in this case. Note: Cost Plan organizations without Part D are not required to complete service category PBP B-20 in the PBP if they choose to offer Part C benefits only for all plans. Prescribed chemical substances, usually in writing by a physician to the pharmacist, are used to prevent or cure disease or otherwise enhance the physical or mental welfare of a patient. Only the Food and Drug Administration can classify a drug as a prescription drug. MA-PD or cost plans may choose to provide Part D home infusion drugs as part of a bundled service as a supplemental benefit under Part C, provided the MA-PD or cost plan consistently applies the option (i.e., in a given contract year, either always covers a particular home infusion drug as part of a bundled service as a supplemental benefit under Part C, or always covers a particular home infusion drug under Part D). Given uniform benefits requirements, MA organizations must also ensure that the bundled service is available to all enrollees of any MA-PD or cost plan (including those residing in LTC facilities) in which it chooses to provide Part D home infusion drugs as part of a supplemental benefit under Part C. Interested MA organizations must appropriately apportion costs between Part D and C components of their bid to account for these drugs. The bundle of home infusion services offered under a mandatory Part C supplemental benefit must include both the home infusion drugs that would otherwise be

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	covered under their Part D benefit and supplies and services associated with their infusion. MA-PD or cost plans may not offer this bundled service unless the cost-sharing associated with the bundled service is $0. Reference: 43 CFR 417
Rx:Medicare Rx	The Medicare Rx section allows the user to define the prescription drug benefit type offered by the plan - Defined Standard, Actuarially Equivalent, Basic Alternative or Enhanced Alternative. Depending on the benefit type, the user may be required to enter Initial Coverage Limits, Locations, Out-of-Pocket Thresholds, and Deductible information. For cost sharing groups, Coinsurance and Copayment data are required. Authorization and additional costs data are required, regardless of benefit type. Reference: 43 CFR 417