Bid Reports 2027

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) nursing services and other related services, use of hospital facilities, medical social services, drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by hospitals for the care and treatment of inpatients; and (3) other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with 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. Medicare Advantage Organizations (MAOs) must ensure enrollees will have access to all of the specified tiers for services offered by the Medicare Advantage (MA) plan and the tiers are transparent to prospective and actively enrolled beneficiaries and plan providers. 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). 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. Medicare Advantage Organizations (MAOs) must ensure enrollees will have access to all of the specified tiers for services offered by the MA plan and the tiers are transparent to prospective and actively enrolled beneficiaries and plan providers. 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 skilled nursing facility (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: (1) 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 (2) 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: - Allowance of less than 3 day inpatient hospital stay prior to SNF admission - Additional Days beyond Medicare-covered 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 (CR) 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 - A coronary 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 National Coverage Determination (NCD). Eligible beneficiaries are covered for up to a maximum of 2 1-hour CR sessions per day for up to 36 sessions or 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, similar to 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. 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 ICR 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.

4a: Emergency Services	Emergency Services 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, 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; - 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. 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 should be included under Outpatient Hospital Services (9a). 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 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 the patient is temporarily outside of their plan's service area or if applicable, continuation area. Reference: 42 CFR 422.113, Medicare Managed Care Manual, Pub 100-16, Chapter 4.
4c: Worldwide Emergency/Urgent Coverage	A Medicare Advantage (MA) plan may offer Worldwide Emergency/Urgent Coverage as a supplemental benefit to its enrollees for services outside the US and its territories. "Worldwide Emergency/Urgent 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 worldwide emergency coverage, worldwide urgent coverage, and/or worldwide emergency transportation when they are temporarily outside of the United States and its territories. MA plans that offer a worldwide emergency/urgent/emergency transportation coverage 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 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/urgently needed had they been provided in the United States. Reference: The Medicare Managed Care Manual, Chapter 4.
5a: Partial Hospitalization	Partial hospitalization programs (PHPs) and Intensive Outpatient Programs (IOPs) 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: (1) individual and group therapy with physicians or psychologists or other mental health professionals to the extent authorized under State law. (2) Occupational therapy requiring the skills of a qualified occupational therapist. (3) Services of other staff including social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients. (4) Drugs and biological that are not self-administered and are furnished for therapeutic purposes, subject to the limitations specified in 410.29. (5) 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; (6) Family counseling, the primary purpose of which is treatment of the individual's condition. (7) 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 the diagnosed psychiatric condition. (8) Diagnostic services related to mental health treatment. References: 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.
5b: Intensive Outpatient Program Services	Section 4124 of Division FF of the 2023 Consolidated Appropriations Act establishes coverage and payment under Medicare for the Intensive Outpatient Program (IOP) benefit, effective January 1, 2024. Intensive outpatient programs (IOPs) are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in § 1861(ff) of the Social Security Act (the Act). An IOP furnishes treatment at a level more intense than outpatient day treatment or psychosocial rehabilitation, but less intense than a Partial Hospitalization Program, and a physician must certify that each patient participating in an IOP needs at least 9 hours per week of IOP services. IOP may be furnished by hospitals, Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Opioid Treatment Programs (OTPs). References: 42 CFR 410.44 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 6, section 70.4.

6: Home Health Services	Home health care services are provided in the patient's home for the purpose of promoting, maintaining, or restoring health or reducing the effects of illness and disability. Services are consistent with Original Medicare home health and may include medical, 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 Medicare Advantage (MA) plan may offer coverage of a supplemental benefit if it is medically necessary and additional to the benefit covered by Original Medicare. 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, Family Practice Services, or Geriatric Medicine 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 Medicare Advantage (MA) plan may offer Routine Care or Other 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 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's supplemental benefit as 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. Examples of physician specialist services include cardiology, gastroenterology, nephrology, and ENT (otolaryngology). 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	Medicare-covered mental health services provided by State-licensed clinical psychologists, clinical social workers, marriage and family therapists, mental health counselors, and other professionals 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: 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 Medicare Advantage (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 may include: Nurse Practitioners, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, and Physician Assistants. Note: Cost sharing for Medicare-covered acupuncture services for chronic low back pain provided by a provider not specifically identified elsewhere in PBP section 7 should be included under this service category. 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, Decision Memo for Acupuncture for Chronic Low Back Pain https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=295.
7h: Psychiatric Services	Services provided by a doctor of medicine who specializes in the diagnosis, prevention, and treatment of mental disorders (such as, psychiatrists). References: Medicare Benefit Policy Manual, Pub 100-02, Chapter 6, Section 70, "Outpatient Hospital Psychiatric Services."
7i: Physical Therapy and Speech-Language Pathology Services	Physical therapy (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, 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 speech-language pathology 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.
7j: Additional Telehealth Benefits	42 CFR 422.135 allows Medicare Advantage (MA) plans the ability to provide "additional telehealth benefits" to enrollees and treat them as basic benefits for purposes of bid submission and payment by CMS. Additional telehealth benefits are limited to services for which benefits are available under Medicare Part B but which are not payable under section 1834(m) of the Act, and that have been identified for the applicable year as clinically appropriate to furnish through electronic exchange when the physician or practitioner providing the service is not in the same location as the enrollee. An MA plan must meet the requirements of 42 CFR 422.135 in order to furnish additional telehealth benefits. If the MA plan fails to comply with the requirements of 42 CFR 422.135, then the MA plan may not treat the benefits provided through electronic exchange as additional telehealth benefits, but may treat them as supplemental benefits as described in 42 CFR 422.102, subject to CMS approval. MA plans must indicate in the PBP service category B7j if they are offering additional telehealth benefits through network providers for Part B services and should select in the PBP the Part B service categories where additional telehealth benefits may be offered. MA plans should enter the cost sharing for additional telehealth benefits as part of the cost-sharing range entered in the service category selected. References: 42 CFR 422.135; section 50323 of the Bipartisan Budget Act of 2018 (Public Law No. 115-123); section 1852(m) of the Social Security Act.
7k: Opioid Treatment Program Services	Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Public Law No. 115-271) establishes opioid use disorder treatment services furnished by Opioid Treatment Programs (OTPs) as a Medicare Part B service. Opioid use disorder treatment services include: Food and Drug Administration (FDA) approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use counseling; individual and group therapy; toxicology testing; and other items and services that CMS determines appropriate (excluding meals and transportation). Reference: Public Law No. 115-271 and the Medicare Benefit Policy Manual, Pub 100-2, Chapter 17.
8a: Outpatient Diagnostic Procedures, 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. References: 42 CFR 410.35 and the Medicare Benefit Policy Manual, Pub 100-02, Chapter 6, Section 20.4, "Outpatient Diagnostic Services."

9a: Outpatient Hospital Services	Outpatient hospital services are services that are furnished in a hospital outpatient department or provider-based department of a hospital to include the services that cannot be entered elsewhere in the PBP, such as outpatient surgical services (i.e. outpatient surgical services not provided in an Ambulatory Surgical Center as defined by Original Medicare), observation services, and outpatient palliative care. 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 in a hospital outpatient department or provider-based department of a hospital. Outpatient substance abuse services include the services that cannot be entered elsewhere in the PBP such as traditional counseling (one or a few hours per day, usually weekly or biweekly) in an outpatient hospital setting. References: The Medicare National Coverage Determinations Manual, Pub. 100-3, Chapter 2, Section 130.2 Outpatient Hospital Services for Treatment of Alcoholism and Section 130.6 Treatment of Drug Abuse (Chemical Dependency). The Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B," section §§20. The services must also be reasonable and necessary for treatment of the individual's condition.
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 Medicare Advantage (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 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	A Medicare Advantage (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 enrollees a supplemental benefit that provides transportation to locations where its enrollees can access their health benefits. 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 in the PBP the proposed transportation supplemental benefit. Reference: The Medicare Managed Care Manual, Chapter 4.
11a: Durable Medical Equipment (DME)	Equipment which (1) can withstand repeated use, and (2) is primarily and customarily used to serve a medical purpose, and (3) generally is not useful to a person in the absence of an illness or injury; and (4) 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. 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	The diabetic supplies (11c1) service category consists of items such as blood glucose test trips, lancets, supplies for external infusion pumps, supply allowance for continuous glucose monitors, and blood glucose control/calibration solutions. Diabetic therapeutic shoes/inserts (11c2) include items such as custom molded shoes, depth shoes, inserts and braces. Diabetic monitors (11c3) include items such as blood glucose monitors, continuous glucose monitors, and ambulatory infusion pumps. 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: Dialysis Services	Dialysis services for enrollees with End-Stage Renal Disease (ESRD) 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 Treatments	Plans may choose to offer acupuncture 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. Note: Medicare covers limited acupuncture services for chronic low back pain under the service categories in section 7: Healthcare Professional Services. Reference: The Medicare Managed Care Manual, Chapter 4.
13b: Over-the-Counter (OTC) Items	Plans may offer OTC items as a supplemental benefit under Part C. OTC items include both: - Non-prescription drugs, also known as OTC drugs; and - Primarily 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. The plan must describe the proposed benefit in its plan benefit package for CMS review. Note: Hearing aids available over-the-counter should only be included in service category 18c: OTC Hearing Aids. Reference: The Medicare Managed Care Manual, Chapter 4.
13c: Meal Benefit	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 types of circumstances: - 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: - Offered for temporary period, typically for two weeks, per enrollee per year; - Ordered by a physician or non-physician practitioner; - Part of a supervised program designed to prevent future exacerbation episodes and to help the enrollee to adopt life style modifications; - Social factors, by themselves, do not qualify an enrollee for supplemental meal services. - For a medical condition or potential medical condition that requires the enrollee to remain at home for a period of time. Note that all Medicare Advantage (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 MyPlate.Gov; - Provide nutritional tips in their plan newsletters and/or on their plan websites; and - Partner with social community services. However, the MA plan may not classify any of these community services as "plan benefits."
13d: Other 1	The Other service category is intended for data entry of those supplemental benefits that are offered by the Medicare Advantage (MA) plan but do not fit into the standard PBP service categories. A full description of the proposed 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 Medicare Advantage (MA) plan but do not fit into the standard PBP service categories. 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 Medicare Advantage (MA) plan but do not fit into the standard PBP service categories. 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 additional supplemental benefits that these D-SNPs may offer. 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 (Instrumental Activities of Daily Living (IADL) limitation) due to functional limitations with Activities of Daily Living (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.
13h: Additional Services	Not Applicable.
13i: Non-Primarily Health Related Benefits for the Chronically Ill	Non-Primarily health related benefits may only be offered as Special Supplemental Benefits for the Chronically Ill (SSBCI) in Section 19b. MA plans have the ability to offer a "non-primarily health related" item or service to eligible chronically ill enrollees if the SSBCI has a reasonable expectation of improving or maintaining the health or overall function of the enrollee as it relates to the chronic disease. Such items and services may include, but are not limited to, healthy food and produce, transportation for non-medical needs and home-delivered meals (beyond the limited basis described in B13c). A full description of the proposed non-primarily health related supplemental benefit must be included in the notes field for CMS review. Reference for SSBCI: The service category selections available within 13i are further described in the HPMS memorandum, "Implementing Supplemental Benefits for Chronically Ill Enrollees", issued April 24, 2019.
14a: Medicare-covered Zero Cost-Sharing Preventive Services	All Medicare Advantage (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. It is the plan's responsibility to monitor and stay up-to-date on which Medicare-covered preventive services must be offered without cost sharing.
14b: Annual Physical Exam	Medicare Advantage Organizations (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.
14c: Other Defined Supplemental Benefits	Following is a list of supplemental benefits that a MAO may choose to offer to enrollees: - Additional sessions of Smoking and Tobacco Cessation Counseling - Adult Day Health Services* - Alternative Therapies* - Home and Bathroom Safety Devices and Modifications* - Counseling Services - Enhanced Disease Management - Health Education - Home-Based Palliative Care* - In-Home Safety Assessment - In-Home Support Services* - Fitness Benefit* - Medical Nutrition Therapy (MNT) - Nutritional/Dietary Benefit - Personal Emergency Response System (PERS) - Post discharge In-home Medication Reconciliation - Re-admission Prevention - Support for Caregivers of Enrollees* - Telemonitoring Services* - Therapeutic Massage - Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline)** - Wigs for Hair Loss Related to Chemotherapy - Weight Management Programs* *Indicates a note is required for these benefits. ** A note is optional if a plan is only offering the Nursing Hotline benefit under Remote Access Technologies. A note is required for the Web/Phone based technologies benefit.
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: Other Medicare-Covered Preventive Services	The "Other Medicare-Covered Preventive Services" category includes cost-sharing fields for glaucoma screening, diabetes self-management training, digital rectal exams, and electrocardiogram (EKG) following welcome visit, for which cost sharing may apply. The service category allows the plans the ability to either apply or not apply cost sharing for these preventive services. Glaucoma screening tests may be administered to those individuals who are at high risk for developing glaucoma. Such services must be performed or supervised by an eye doctor who is legally allowed to do this test in the state. 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. It is the plan's responsibility to monitor and stay up-to-date on other Medicare-covered preventive services for which cost sharing may apply. 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 Part B drugs-Insulin, Part B drugs-Chemotherapy/Radiation, and Part B drugs-Other. Plans may also indicate step therapy (if applicable). Medicare Advantage Prescription Drug Plans (MA-PDs) 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 bundled service unless the cost sharing associated with the bundled service is $0. Given uniform benefits requirements, Medicare Advantage (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 long-term care (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: Medicare Dental Services	Original Medicare will pay for certain dental services that a beneficiary receives when they're in a hospital. Original Medicare can pay for hospital stays if a beneficiary has an emergent or complicated procedure that involves the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth because an underlying medical condition or if the severity of the dental procedure requires hospitalization. Under Section 1862(a)(12) of the Social Security Act, payment for dental services in connection with care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth is precluded. However, Original Medicare does pay for dental services that are inextricably linked to the clinical success of an otherwise covered medical service, because those dental services are so integral to other medically necessary services that they are not in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth (87 FR 69663, 42 CFR 411.15(i)). Original Medicare makes payment for these services performed in either the inpatient or outpatient setting (Medicare Benefit Policy Manual (IOM Pub 100-02, Chapter 15, section 150). These services include, but are not limited to: 1) Dental or oral examination performed as part of a comprehensive workup prior to, and medically necessary diagnostic and treatment services to eliminate an oral or dental infection prior to, or contemporaneously with, the following Medicare-covered services: organ transplant, hematopoietic stem cell transplant, bone marrow transplant, cardiac valve replacement, valvuloplasty procedures, chemotherapy when used in the treatment of cancer, chimeric antigen receptor (CAR) T-cell therapy when used in the treatment of cancer, and administration of high-dose bone-modifying agents (antiresorptive therapy) when used in the treatment of cancer. 2) The reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor. 3) The stabilization or immobilization of teeth in connection with the reduction of a jaw fracture, and dental splints only when used in conjunction with covered treatment of a covered medical condition such as dislocated jaw joints. 4) The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
16b: Diagnostic and Preventive Dental Services	Plans may offer non-Medicare covered diagnostic and preventive dental services as supplemental benefits. Diagnostic and preventive dental services are provided by or under the supervision of a dentist in the practice of the profession, including treatment of the teeth and associated structures of the oral cavity. Diagnostic and preventive dental services include oral exams, dental x-rays, other diagnostic services, prophylaxis (cleaning), fluoride treatment, and other preventive dental services. The non-Medicare covered Diagnostic and Preventive Dental service categories are defined by the following CDT code categories: 16b1: Oral Exams, 16b2: Dental X-Rays, 16b3: Other Diagnostic Services (I. Diagnostic D0100-D0999) 16b4: Prophylaxis (Cleaning), 16b5: Fluoride Treatment, 16b6: Other Preventive Dental Services (II. Preventive D1000-D1999) Reference: The Medicare Managed Care Manual, Chapter 4.
16c: Comprehensive Dental Services	Plans may offer non-Medicare covered comprehensive dental services as supplemental benefits. Comprehensive dental services are provided by or under the supervision of a dentist in the practice of the 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. Comprehensive dental supplemental benefits include restorative services, endodontics, periodontics, prosthodontics (removable and fixed), maxillofacial prosthetics, implant services, oral and maxillofacial surgery, orthodontics, and adjunctive general services. The non-Medicare covered Comprehensive Dental service categories are defined by the following CDT code categories: 16c1: Restorative Services (III. Restorative D2000-D2999) 16c2: Endodontics (IV. Endodontics D3000-D3999) 16c3: Periodontics (V. Periodontics D4000-D4999) 16c4: Prosthodontics, removable (VI. Prosthodontics, removable D5000-D5899) 16c5: Maxillofacial Prosthetics (VII. Maxillofacial Prosthetics D5900-D5999) 16c6: Implant Services (VIII. Implant Services D6000-D6199) 16c7: Prosthodontics, fixed (IX. Prosthodontics, fixed D6200-D6999) 16c8: Oral and Maxillofacial Surgery (X. Oral and Maxillofacial Surgery D7000-D7999) 16c9: Orthodontics (XI. Orthodontics D8000-D8999) 16c10: Adjunctive General Services (XII. Adjunctive General Services D9000-D9999) Reference: The Medicare Managed Care Manual, Chapter 4.

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, and includes limited coverage of eyewear and prosthetic lenses related to cataract surgery. Plans may offer routine eye exams or other services 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: Eyewear	Medical eyewear 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. Plans 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: Prescription Hearing Aids	Plans may offer prescription 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. Hearing aid assistance is either "monaural" (a hearing aid for one ear) or "binaural" (a hearing aid for each ear). Reference: The Medicare Managed Care Manual, Chapter 4.
18c: OTC Hearing Aids	Plans may offer hearing aids available over-the-counter (OTC) as a supplemental benefit. For more information about the FDA category of OTC hearing aids, please refer to the FDA final rule: https://www.federalregister.gov/documents/2022/08/17/2022-17230/medical-devices-ear-nose-and-throat-devices-establishing-over-the-counter-hearing-aids
19a: Reduced Cost Sharing for MA Uniformity and SSBCI	This service category collects information on reduced cost sharing offered for Medicare Advantage (MA) Uniformity Flexibility/Special Supplemental Benefits for the Chronically Ill (SSBCI) benefits. Up to 15 packages can be entered which will represent the reduced cost sharing. When entering MA Uniformity Flexibility benefit packages, create a separate package for each unique benefit offering, or combination of benefit offerings. MA Uniformity Flexibility packages may be targeted to single or multiple clinical condition groups. When entering an SSBCI benefit package, include all reduced cost sharing SSBCI benefits in a single package in section B19a. When entering the MA Uniformity Flexibility/SSBCI maximum and minimum cost sharing for a service category, list only the cost sharing that would apply to enrollees qualifying for the benefit package. Cost-sharing ranges should reflect only the services within the service category or specialty selected that are eligible for reduced cost sharing. If the reduced cost sharing is being offered through reimbursement, the cost-sharing range should represent what the enrollee pays after reimbursement, and the note should describe the benefit and any limitations. If there is a maximum aggregate amount of reduced cost sharing, the cost sharing entered should reflect only the costs paid by the enrollee prior to reaching the maximum aggregate amount of reduced cost sharing.
19b: Additional Benefits for MA Uniformity and SSBCI	This service category collects information on additional supplemental benefits offered under Medicare Advantage (MA) Uniformity Flexibility/Special Supplemental Benefits for the Chronically Ill (SSBCI). Up to 15 packages can be entered which will represent the additional benefits. When entering MA Uniformity Flexibility benefit packages, create a separate package for each unique benefit offering, or combination of benefit offerings. MA Uniformity Flexibility packages may be targeted to single or multiple clinical condition groups. When entering an SSBCI benefit package, include all additional SSBCI benefits in a single package in B19b.

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: 1) 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 Medicare Advantage Prescription Drug (MA-PD) or Medicare Advantage (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 2) 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, that are used to prevent or cure disease or otherwise enhance the physical or mental welfare of a patient. Only the Food and Drug Administration (FDA) 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 long-term care (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
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 Locations and Deductible information. For Non-Defined Standard plans, coinsurance and/or copayment data are required. Reference: 42 CFR 423.