

Accessing the Care in Medicare:

A Guide for Caregivers

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Health Assistance Partnership

In Cooperation with
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About Westport Cooperative Services

Westport Cooperative Services (WCS) is a non-profit social services agency with offices located in the Westport neighborhood of Kansas City, Missouri. WCS sponsors several programs that help Kansas City's older citizens. They are the Senior Companions Program, Meals on Wheels, Westport housing for the elderly, and the Medicare Assistance Project which incorporates the CLAIM program (Missouri's SHIP), the Caregiver Training & Support Program, and the Integrated Senior Care program. WCS also sponsors a program that annually equips children in the central city with school supplies, and a city-wide Christmas dinner. For more information on WCS and its services, call 816-753-7039 or visit its website at www.westportcooperative.org. WCS is located at 201 Westport Road, Kansas City, Missouri 64111.

About the Health Assistance Partnership

The Health Assistance Partnership is a non-profit organization that partners with State Health Insurance Assistance Programs (SHIP) to enhance their capacity to inform, counsel, and assist Medicare beneficiaries. It does this by engaging in capacity-building initiatives in the areas of program development and Medicare education. Through our work in these two areas, HAP is able to develop and share information and tools that allow SHIPs to better serve Medicare beneficiaries. Our services and tools include: a monthly e-newsletter, monthly conference calls, training and program development resources, web-based management tools (SHIPTools), advocacy for increased SHIP funding, and Collaborative State Projects. HAP is located at 1201 New York Avenue, N.W., Washington, DC, 20005 and its website is www.hapnetwork.org.

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I. INTRODUCTION

This booklet for caregivers focuses on Medicare coverage issues. If you are helping an older person with some of life's daily activities, this booklet is for you. As a caregiver, you may be helping your mother research her insurance options. You may be helping your husband organize his medical billing and payment statements. You may be going with a friend to doctor visits.

Caregivers are spouses, daughters, sons, nieces, nephews, friends and neighbors who provide unpaid care to someone. To identify the person who receives care, we use the term "family member" because it identifies the typical caregiving relationship. We do not intend, however, to ignore the fact that many caregivers are not directly related to the people they help. We also use the pronouns "he" and "she" to remind us that both men and women may need help with Medicare. Whatever your relationship with that older person, there are important things to know about Medicare's coverage and operations. As the nation's main health insurance program for people 65 and older and for those with disabilities, the program is vital to your family member's access to health care. Medicare covers some 45 million people in the United States.

As a caregiver, it is important to know about:

- Medicare's coverage rules for important benefits like home health care and medical equipment. We detail and discuss some of the rules.
- Potential coverage problems that may require your special attention. This booklet gives some practical tips for resolving problems and describes Medicare's new appeals procedures.
- Common Medicare forms and what they mean for your family member.
- Resources. This booklet lists national resources that may be helpful to you.

To illustrate some of Medicare's coverage issues, we've included several stories. They are drawn from actual cases, though we've changed names and combined some details to protect privacy. We hope they help you gain a better understanding of Medicare. We also hope that you will find inspiration in them. Thousands of people have walked, or are walking, in the shoes of a caregiver. Many have responded creatively and effectively to the challenges that Medicare and health care crises sometimes present. You can too.

This booklet tends to focus on the Original Medicare program, also called fee-for-service and traditional Medicare. Note however that the booklet's discussion of Medicare coverage rules applies equally to Original Medicare and to the various Medicare Advantage plans, including Medicare HMOs.

With all that said about what this booklet is, you should also understand what it is not. It is not:

- A guide to Medicare Supplement (Medigap), employer group plan, or long term care insurance. The Centers for Medicare & Medicaid Services (CMS, the federal Medicare agency) and the Insurance Departments for most states offer helpful booklets and fact sheets on these topics. In addition, the SHIP programs in each of the states offer free, objective, one-on-one help for those who want to understand and compare insurance options (see Helpful Resources, page 39).
- A guide to Medicaid eligibility and nursing home coverage. CMS and the state Medicaid agencies have useful information resources on these subjects.
- A comprehensive Medicare handbook. The place to find information on Medicare eligibility, enrollment periods, insurance plan enrollment rights, prevention and screening services, and much more is in the *Medicare and You* handbook, updated annually by CMS and available for free by calling Medicare's toll-free help line at 1-800-MEDICARE, or on its web-site, www.medicare.gov.
- A guide to Medicare's Part D prescription drug program, or the extra help to pay for prescriptions that is available for people with limited income. You can learn more about Medicare's drug coverage on Medicare's website, www.medicare.gov. People can apply for extra help (also known as the Low-Income Subsidy) to pay for prescription drugs through the Social Security Administration, www.ssa.gov. HAP's Medicare Part D Training Manual may also be a helpful resource, <http://www.hapnetwork.org/medicare-drug-coverage/training-manual.html>. The SHIP programs give objective plan comparison information and enrollment guidance. Another helpful website is www.benefitscheckup.org, sponsored by the National Council on Aging.

Despite its narrowed focus, we hope that you find this booklet useful. The time you take now to learn about some key Medicare coverage rules and procedures can help you save time, avoid confusion, and perhaps spare you some heartache in the future.

II. MEDICARE OVERVIEW

A. What is Medicare?

Medicare is a federal health insurance program that serves three main groups of eligible people: those who are 65 and older; younger people with a disability who receive Social Security Disability benefits for 24 months; and people of any age with end-stage renal disease (kidney disease that requires dialysis). While most people are entitled to benefits because they or a spouse or parent paid into Medicare trust funds while working, the program is open to anyone age 65 and older with permanent resident status who has lived in the United States for at least five years.

People with Lou Gehrig's Disease (ALS) are eligible for Medicare in the 6th month of disability.

Orlando's 68 year old brother, Juan, moved to the United States from Peru four years ago. The two brothers now live together. Juan has never worked in the United States under Social Security covered employment. Can he sign up for Medicare?

Juan can enroll in the Medicare program after he has lived here continuously for five years. He should go to a local Social Security office sometime between January and March to enroll. His coverage will take effect on July 1 of that year. Note that he would owe monthly premiums for both Part A hospital and Part B medical coverage (\$443.00 and \$96.40 respectively in 2009).

Medicare has two ways in which people can receive their benefits. One is through the "Original Medicare" program. Original Medicare has two parts, Part A Hospital Insurance and Part B Medical Insurance. A second way is through the "Medicare Advantage" program. In this program, private insurance companies offer Medicare-approved Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private-Fee-for-service (PFFS) plans, and more. For those who enroll, these private plans in effect become Medicare. The majority of Medicare's 45 million beneficiaries are enrolled in Original Medicare. About 23 percent of the total, however, are enrolled in Medicare Advantage plans.

How can you tell if your family member is enrolled in Original Medicare or a Medicare Advantage plan? Take a look at her insurance cards. The red, white and blue Medicare card shows the effective dates

of both Part A and Part B coverage. If you find a separate health insurance card issued by Humana, United Health Care, Coventry, or another company with the words “Medicare Advantage plan” and a current enrollment date, it probably means that she has opted out of Original Medicare and that the private company is managing her Medicare coverage.

Medicare is sometimes confused with Medicaid because the two names are similar. But the programs are very different. The main difference is that Medicaid is tied to financial need. A person must show that her monthly income and financial resources or assets are low enough to qualify. Another difference is that the states run the Medicaid programs under federal guidelines. Some eligibility rules and covered services vary state to state.

People of limited means can have both Medicare and Medicaid. Medicare pays first and Medicaid second. People with Medicaid must also find doctors who participate in the Medicaid program. Only doctors who participate in Medicaid accept the combined Medicare and Medicaid payments as payment in full. While the vast majority of physicians nationwide work with Medicare, fewer tend to participate in Medicaid. The best way to learn if a health care provider accepts both Medicare and Medicaid payments is to ask directly.

B. Who Runs Medicare?

In the big picture, two federal agencies—the Social Security Administration (SSA) and the Centers for Medicare and Medicaid Services (CMS)—are involved in Medicare’s operations. Be aware that Social Security’s role is fairly limited. The SSA has always handled eligibility and enrollment for Medicare. Generally, after your family member has signed up for Medicare you would call Social Security to replace a lost Medicare card or to apply for extra financial help in paying for prescription drugs. In 2005, the SSA began to handle applications for Medicare’s Extra Help Program to help people with limited income and resources pay for Part D prescription drugs.

CMS is the agency directly responsible for Medicare’s overall operations. It writes the coverage rules and sets payment policy. But when a billing or coverage problem arises, more often than not a Medicare contractor is involved. That’s because CMS hires private insurance companies to process claims for Original Medicare, to handle the early stages in the appeal process, and to determine if an insurance plan other than Medicare should pay first on a claim (see Helpful Resources, page 39).

The contractors that handle claims in the Original Medicare program have for many years been called Fiscal Intermediaries (FI, for Medicare Part A hospital and skilled nursing facility claims) and Carriers (for Medicare Part B physician, ambulance, and other claims). CMS, however, is phasing out FIs and Carriers. Regional “Medicare Administrative Contractors,” or MACs, are replacing them and will process both Part A and Part B claims. Medicare also has separate contractors that handle home health and durable medical equipment (DME) claims.

This means that, depending on the type of service your family member receives, a different contractor may be involved. If you have questions about a payment or coverage problem with Original Medicare, first call 1-800-MEDICARE. If your father belongs to a Medicare Advantage plan, you would call that private plan instead. All Original Medicare payment notices (called Medicare Summary Notices, or MSN) give a toll-free contact number.

On a recent visit to her mother’s apartment, Jane learned that Medicare had not paid for several of her mother’s doctor visits. Her mother reported her intention to pay the bills herself to avoid a collection action. The notes on the Medicare Summary Notices said that Medicare denied payment because her mother has benefits through another plan.

“This is odd,” Jane remarked. “Haven’t you been in Medicare for ten years? Why would Medicare say you’re in another plan?”

A likely cause for this problem is that the doctor’s office was unaware that Jane’s mother had joined a Medicare HMO plan. The doctor, unaware of the switch from Original Medicare to a Medicare Advantage plan, may have sent the claim to the Medicare Administrative Contractor (MAC) by mistake. What can Jane do? She can call 1-800-MEDICARE or use the Medicare website to verify her mother’s enrollment status. Next, after she learns which Medicare Advantage plan her mother joined, ask the doctor to resubmit the claim to the plan. If the doctor belongs to the plan’s provider network, the plan should pay. If the doctor is not a network provider, Jane’s mother probably is liable for the bill (see page 34 for more on Medicare Advantage plans).

C. Medicare's Exclusions

There are some things that the Original Medicare program does not cover. Simply put, Medicare does not pay for some services, even if you or a doctor thinks they are necessary. In addition, if Medicare excludes a service from coverage, most supplement insurance policies won't cover it either.

What are the exclusions from Original Medicare's coverage? They include:

- Routine eye examinations and eyeglasses
- Routine dental care and dentures
- Hearing aids and related examinations
- Routine foot care
- Routine physical examinations (except for a one-time, "Welcome to Medicare exam," within the first twelve months of Medicare eligibility, effective January 1, 2009.)
- Cosmetic surgery
- Private-duty nurses
- Acupuncture and homeopathic medicine
- Most immunizations (except for pneumonia, flu and hepatitis B)
- Personal comfort and convenience items
- First three pints of blood in blood transfusions
- Custodial care
- Services received outside the United States and its territories (with limited exceptions for those who live or travel along the borders with Canada and Mexico)
- Services or items that are not medically necessary

Note, however, that Medicare Advantage plans may cover some services that Original Medicare does not cover, such as hearing aids (see page 34).

D. Medical Necessity

The first rule of Medicare coverage is that Medicare pays for care that is "reasonable and necessary in the diagnosis or treatment of an illness or injury." In practical terms, this means that a patient must meet certain coverage rules in order to justify Medicare payment. These rules are set forth in federal regulations, several manuals and policy guidelines available online at the CMS website (see Helpful Resources, page 39). It also means that to be considered medically necessary, the care must be given in the most appropriate setting. Medicare won't pay for care that could be given safely in a less expensive or lower level care setting.

How do you find out if a service or ongoing care is no longer medically necessary? Medicare expects the providers to inform your family member in writing when they think that, in light of Medicare coverage rules, services are not medically necessary. They do so through “Advance Beneficiary Notices” (ABN), Service Termination Notices, or “Notices of Non-Coverage” (NONC) (see page 30 for details).

E. Payments to Providers

Generally, the Original Medicare program pays hospitals, skilled nursing facilities (SNF) and home health agencies (HHA) a fixed amount of money based on a patient’s condition. This is called “prospective payment,” meaning that the providers know in advance how much Medicare will pay them for medically necessary services. For hospitals, the payments are based on the patient’s diagnosis at the time of admission. For SNFs and HHAs, the payments are based largely on the complexity of the patient’s condition and the intensity and number of services needed to treat the patient’s medical condition.

What are the financial incentives in this kind of system? Providers make money if they keep their costs below Medicare’s payment. They lose money if their costs exceed it.

F. A System in Dynamic Tension

What does this mean for you as a caregiver? It means that Medicare law, state law, and health care ethics require care providers to give your family member all the care that is medically necessary to treat his or her condition. At the same time, the financial incentives in Medicare’s payment systems put pressure on providers to discharge, or move patients to the next lower level of care, as quickly as possible. Many people who will care for your family member will feel some of the tension that comes when legal, moral and financial forces push and pull at one another in a system that is constantly trying to balance the delivery of good health care with the need to contain costs.

This is why it is so important for you to know something about Medicare’s coverage rules. With this information, you will be in a better position to discuss your family member’s situation with providers, and assure yourself that they are basing their judgments about medical necessity on the patient’s total condition rather than concerns about the financial bottom line.

III. PART A HOSPITAL INSURANCE IN ORIGINAL MEDICARE

Medicare Part A covers medical care in four settings. These are:

- Inpatient hospitals (including rehabilitation hospitals)
- Skilled nursing facilities (SNF)
- Home health agencies
- Hospices

We'll look below at the coverage rules and other important information for each of these benefits in turn.

A. Inpatient Hospital Acute Care

For those who are admitted as inpatients to hospitals, Medicare payments typically cover the entire hospital bill except for a deductible, the first three pints of blood when the patient needs transfusions, and costs connected with TV and phone service. Medicare Part A covers charges for the room, nursing care, intensive care, therapies, medications, and much more. It does not pay for most physician services, including surgeons and other specialists. Medicare Part B does that.

To qualify for Medicare payments, the care must be reasonable and necessary and involve “services that can only be covered in a hospital.” What does this mean for your family member?

It means, for example, that if she has chronic obstructive pulmonary disease (COPD), she may be treated as an outpatient in an emergency room and stabilized under “observation status” without being admitted as an inpatient. In another case, for example following surgery, it could mean that someone encourages your family member to recover at home or in a skilled nursing facility. How would you respond to the following situation?

Your aunt Alicia had a mastectomy two days ago at a local hospital. Alicia is 72 years old and lives alone. Her only son lives in Seattle. When you arrive for a visit at three o'clock in the afternoon, Alicia announces, "They want me to go home tomorrow morning." Alicia has been nauseous all day and has a low grade fever. While she is in the bathroom, you learn that she's vomited several times since the surgery. Alicia reports, "When the surgeon stopped in this morning, he said that there was nothing the hospital could do for me that a visiting nurse couldn't do at home." Alicia's son will arrive the day after tomorrow to stay with her for several days. "I'm afraid to go home alone," Alicia says, "because I don't think I'm ready."

What can Alicia do? Should she accept the surgeon's assessment of the situation and go home? How long can she stay in the hospital before Medicare stops payments? Who can help? There are a number of informal and formal steps that Alicia or her caregiver can take. First, Alicia could ask her family physician to assess her situation and intervene if need be. Her family physician may look at her symptoms a little differently than the surgeon does, and could push for more time in the hospital to identify the cause of her nausea and fever. Second, Alicia could talk with one of the hospital's discharge planners. Discharge planners help smooth the transition from hospital to home by coordinating a care plan with doctors and home health nurses. Medicare rules require hospitals to set up discharge plans before a patient leaves. Alicia is under no obligation to leave the hospital until this is done.

If all else fails, Alicia can take a third step. She can appeal the hospital's discharge decision. The steps to request an independent review of the discharge are set forth on the "Important Message from Medicare," a two-page document that all Medicare patients must receive when a hospital admits them as inpatients. To appeal, Alicia must contact the Quality Improvement Organization (QIO) for her state no later than her discharge date and before she leaves the hospital. The QIO will review Alicia's medical records and seek her input. The QIO will notify Alicia of its decision within one day after it receives all the information it needs.

What is a **Quality Improvement Organization (QIO)**? Medicare contracts with QIOs for each state. Their job is to make sure that Medicare patients receive good quality of care in hospitals, including all the care that is medically necessary. Alicia or her caregiver could call the QIO and ask it to review the hospital's discharge decision. If the QIO

disagrees with the hospital, it will direct Medicare to continue covering Alicia's stay for a number of days (see Helpful Resources, page 39).

As long as a hospital stay is medically necessary, Original Medicare covers up to 150 days of inpatient hospital care during a benefit period. After a patient meets a **\$1,068 deductible** (in 2009) at the start of a benefit period, Medicare covers the first sixty days of hospitalization in full. For the vast majority of inpatient hospital stays, this means that Medicare payments cover the entire bill except for the deductible. If a patient continues to need hospitalization for more than 60 days in a benefit period, he owes:

- \$267 per day for days 61-90 (in 2009)
- \$534 per day for days 91-150 (in 2009)
- All costs beyond the 150th day

What is a benefit period? Original Medicare's coverage for hospital and skilled nursing facility (SNF) stays is tied to a benefit period or "spell of illness." A benefit period starts on the first day that a person enters the hospital. It ends after a person has been out of a hospital or SNF for at least 60 days in a row. After those 60 days in a row, a new benefit period starts with a new inpatient hospital stay. Benefit periods are renewable, and there is no limit on the number of benefit periods a person can have in a lifetime.

But this also means that a benefit period continues during repeated hospital stays if the patient does not go home or to a lower level of nursing home care for at least 60 days in a row. In this way, a person could use up her 150 days of inpatient hospital coverage. It happens rarely. It also means that someone who is hospitalized twice in a year, with at least 60 days at home separating the hospital stays, will owe two Part A deductibles. The Part A deductible is not an annual deductible.

Medicare limits coverage for inpatient psychiatric hospital stays to 190 days in a lifetime.

Don't panic about these high Part A costs! Most people have insurance that will cover the hospital deductible and coinsurance costs (see page 29).

B. Inpatient Rehabilitation Hospital Care

Inpatient rehabilitation hospital facilities exist as both stand-alone specialty hospitals, and as part of a larger inpatient hospital complex. Other hospitals, called long term stay hospitals, also provide inpatient rehabilitation.

All provide intense, multidisciplinary rehabilitation programs for patients following strokes, joint replacements, amputations, debilitating accidents, and the like. “Intense” and “multidisciplinary” mean that patients generally receive physical therapy, occupational therapy and rehabilitation nursing services several hours each day. As a caregiver, keep in mind that if your family member can tolerate and benefit from these intense services, she is likely to receive a higher degree of care at a rehabilitation hospital than in a skilled nursing facility, outpatient rehabilitation center, or from a home health agency. It could make a big difference in the degree of recovery and the extent to which she is able to live independently later on.

Medicare covers inpatient stays in both acute care and rehabilitation hospitals under the same Part A hospital benefit. This means, for example, that following a stroke your family member could spend the first 10 days of a benefit period in an acute care hospital and still have 140 days of Medicare coverage available for inpatient rehabilitation hospital care remaining in a benefit period. The length of stay in a rehabilitation hospital depends, of course, on whether or not the stay meets Medicare’s coverage rules.

Coverage Rules - To qualify for Medicare coverage in a rehabilitation hospital:

- A physician must certify that the patient needs an inpatient hospital level of care for rehabilitation.
- The patient must need a relatively intense, multidisciplinary rehabilitation program.
- A multidisciplinary team must coordinate and deliver the rehabilitation services (typically the team includes a physician and nursing staff who specialize in rehabilitation medicine, along with physical, occupational, and speech therapists).
- The rehabilitation program’s goal must be to improve the patient’s ability to function as independently as possible.
- The patient must show significant practical improvement.
- The facility must be Medicare-certified.

You will find that nearly all of Medicare’s coverage rules for specific benefits include at least one that requires a “judgment call,” or interpretation. In this

context, the judgment call involves “significant practical improvement.” What does this mean?

Medicare rules say that it is not necessary to expect “complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his condition at the start of the rehabilitation program.” The key to coverage is the rehabilitation hospital staff’s ability to show Medicare that your family member continues to make progress toward goals that will have some practical value in terms of strength, balance, mobility, and the ability to perform tasks like bathing, dressing and personal hygiene care. Medicare coverage for a rehabilitation hospital stay ends when it is unlikely that a patient will make more progress toward the rehabilitation goal, or when he could achieve the goal through a transfer to a less costly setting like a SNF.

What can you do to ensure that your family member receives all the care that is medically necessary? Ask the hospital staff to describe the goals they have set. Participate in setting these goals as much as you can. Note all evidence of progress toward those goals. Join the staff for their regular care planning meetings, and make sure that they see the same evidence of progress that you see. Finally, ask them how they interpret Medicare’s “significant practical improvement” rule in light of your family member’s overall condition.

Here’s one last note on rehabilitation hospital coverage. You might hear that Medicare has a “three hour” guideline that hospitals use to evaluate a patient’s ability to benefit from a “relatively intense rehabilitation program.” But Medicare rules state that providers should not use “rules of thumb” when assessing patients for Medicare coverage. There should be flexibility in their decisions about medical need, based on individual circumstances.

C. Skilled Nursing Facility (SNF) Care

There are more than 15,000 Medicare-certified skilled nursing facilities in the United States. Most exist within larger nursing facilities as a specific unit with a certain number of “skilled beds.” Others are part of a larger hospital complex. You can find lists and information about SNFs on Medicare’s “Nursing Home Compare” tool available at www.medicare.gov.

Generally, SNFs provide nursing and rehabilitation services. What is a skilled service? Medicare defines it as a service that is “so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.”

Examples of skilled nursing services include intravenous feedings, intramuscular injections, tube feedings, care for skin breakdown and bed sores, insertion and irrigation of Foley catheters, applying dressings that involve prescription medications or the need for sterile procedures, administering oxygen and other medical gases, patient education, overall management and evaluation of a patient’s care plan, and observation and assessment of a patient’s changing condition.

Examples of skilled rehabilitation services include ongoing assessment of a patient’s rehabilitation needs and potential. This includes tests to measure range of motion, strength, endurance and the like. They also include therapeutic exercises and activities which must be performed by or under the supervision of a physical therapist in order to ensure the patient’s safety and the treatment’s effectiveness, as well as gait evaluation and training and range of motion exercises.

Many Medicare HMOs and PPOs cover SNF stays from day one. They waive the 3 day prior hospital stay rule as an extra coverage benefit.

Coverage rules - Original Medicare covers SNF stays when:

- The patient was hospitalized as an inpatient for at least three days (the “three day prior hospital stay rule”).
- The patient was admitted to the SNF within 30 days of discharge from a hospital (some exceptions apply).
- A physician certifies that the patient needs care in a SNF.
- The patient receives skilled nursing or skilled rehabilitation services, or both, each day (the “daily basis rule”).
- The SNF must be Medicare-certified.

One of the most important issues for Medicare SNF coverage is whether or not the patient receives skilled care in the SNF on a daily basis. If the only skilled care your family member receives is physical therapy three days per week, Medicare won’t pay. But, if she receives

physical therapy three days per week and skilled nursing services on the other days, Medicare should pay. Medicare is satisfied if the patient receives combined skilled nursing and rehabilitation services on a daily basis. Also note that a patient who receives physical therapy five days per week meets the daily basis test.

Some nursing facilities, however, may hedge their bets and only admit patients whose skilled care needs are clearly defined and easy to document. This increases the chance that Medicare will pay, but it also may leave some patients without access to care. What would you do in the following situation?

Irma visited a nearby skilled nursing facility, hoping to arrange a direct transfer for her father Joseph, from a hospital.

Ninety-year old Joseph was hospitalized for eight days to treat congestive heart failure, chronic obstructive pulmonary disease and a bladder problem. Four years earlier doctors implanted a pacemaker after he had a heart attack. Joseph was seriously weakened by his recent illness. At the end of the hospital stay, he required total assistance to transfer from bed to a wheelchair and from the wheelchair to a toilet. He could not walk without help. He required oxygen and multiple medications to remove fluid from his lungs.

When Irma arrived for her meeting with the SNF's admissions director, she expected her father to qualify for Medicare coverage. Joseph had been in the hospital for at least three days. His attending physician ordered daily physical therapy to help rebuild strength in his legs and trunk with the goal of restoring his ability to walk and make transfers from bed to walker on his own.

After a thirty minute meeting during which the admissions director reviewed Joseph's medical records, the director told Irma that her father would not qualify for Medicare coverage. "Your father does not meet our Medicare coverage profile, " she said. "He doesn't have an open wound that needs dressing. He has no open bed sores. And he doesn't need I-V fluids. So, he doesn't meet the requirements for Medicare SNF coverage."

What are Joseph's options? There are at least two steps that Joseph and Irma can take to get Medicare to cover the care he needs. One is to enter the SNF, agree to pay privately and then ask the facility to bill Medicare even if the admissions director doesn't expect Medicare to pay. Joseph has a right to have a Medicare-certified SNF submit a claim on his behalf. It is called a "demand bill." If the nursing and therapy staff fully documents the daily skilled services they provide, Medicare should pay for the bill.

A second step Irma can take is to ask a different SNF to admit Joseph. In fact, that's what she did. The admissions director looked at Medicare's coverage rules more broadly. She reviewed the medical record and sent a nurse to visit Joseph and assess his condition in person. The SNF provided a combination of nursing and therapy services on a daily basis for 21 days. Medicare covered the entire stay. At the end of his SNF stay, Joseph was walking well enough to return to his apartment where he lived on his own.

Why was the admissions director at the first facility reluctant to admit Joseph? The answer probably has less to do with Joseph's condition than it does with her lack of knowledge of Medicare coverage rules and the facility's claims experiences. If a SNF submits too many claims that Medicare later denies for lack of medical necessity, the SNF may face financial penalties.

Bob wants to bring his mother home from the SNF to join the family for a weekend dinner. Will this disqualify her for Medicare coverage? No. Medicare rules permit short absences from the SNF.

As a caregiver, keep in mind the list of skilled services above. If your family member receives one or more of them on a daily basis, arguably Medicare should cover the SNF stay. Also, know that Medicare expects these coverage decisions to be based on an assessment of the individual's overall medical condition, not on arbitrary guidelines. The rules say, "Do not notify patients that services are not covered by Medicare because of 'rules of thumb' such as lack of restoration potential, ability to walk a certain number of feet, degree of stability, or because of general inferences about patients with similar diagnosis or general data related to utilization. A decision as to whether care is covered by Medicare must be made based on thorough analysis of the patient's total condition and individual need for care."

Medicare covers up to 100 days of SNF care in a benefit period. Medicare payments cover the first 20 days in full. For days 21 to 100, the patient owes a **\$133.50 per day coinsurance charge** (in 2009). The patient is liable for the cost of SNF care beyond the 100th day in a benefit period. Most Medicare Supplement insurance policies, however, cover the SNF coinsurance charges.

D. Home Health Care

There are more than 8,000 Medicare-certified home health agencies nationwide. They provide part time or intermittent nursing, rehabilitation care, and some home health aide services, to homebound patients who have skilled care needs. You can find lists and information about Home Health Agencies on Medicare's "Home Health Compare" tool available at www.medicare.gov.

For those who qualify, Medicare's home health coverage can be a long-term care benefit. There is no annual or benefit period limit on the number of covered visits. If a patient continues to need skilled services on a part-time or intermittent basis, Medicare will pay for home health care indefinitely.

Also be aware that a patient who needs skilled care can also receive non-skilled home health aide services. Home health aides can help with some of the activities of daily living, like bathing and dressing. Aides can visit the home in addition to, and at different times of the day than, nurse or therapist visits. Medicare does not pay for aide services only. It covers them if a patient receives skilled services in the first place. Medicare's definition of a skilled service for home health care is the same as it is for SNFs (see page 13, above).

Original Medicare covers 100 percent of the cost for covered home health services. There are no deductibles or coinsurance costs as with inpatient hospital and SNF services.

Coverage Rules - Medicare covers home health care when:

- A physician orders the home health care services and signs a care plan.
- The patient is "homebound," meaning that leaving home requires "a considerable and taxing effort." Someone who needs personal assistance, or the help of a walker or wheelchair, qualifies. A patient who has "short or infrequent absences" from home may still be homebound. Additionally, a person can leave home regularly for medical treatment and still be considered homebound.
- The patient needs skilled nursing, physical, or speech therapy on a "part-time or intermittent basis." Generally, this means that the person needs the skilled home health services as often as daily for short periods of time (up to 21 days), or as infrequently as once every 60 days.

- A Medicare-certified home health agency provides the care.

Consider the following story. Do you think that Helen qualifies for Medicare home health care coverage?

Your friend lives alone in her own home. She was widowed five years ago and for the most part has gotten along pretty well until now. Last week, she fell on the stairs leading to the basement. She was hospitalized four days to treat a rib fracture and bruises, and for tests. The physicians think that Helen is in the early stage of a chronic nervous system disease and that it probably led to her fall. When she left the hospital, Helen's doctor ordered outpatient physical therapy sessions three days a week starting the very next day.

When you visited Helen at her home two days after her discharge, she disclosed, "I've not be able to go to my outpatient physical therapy appointments. I can't drive and I'm still in pain." Helen also recalled that her doctor said that he didn't think she qualifies for Medicare home health therapy services because she can leave home for her regular physical therapy sessions.

It is not uncommon for misinformation about Medicare's coverage rules to spread through good intentions. Helen is having difficulty leaving home. She can't drive, and if her pain and weakness make it difficult for her to get from her house to a car alone, this is a "considerable and taxing effort." That means she is "homebound." Moreover, Medicare does not count absences from the home to receive medical care—even frequent absences—against her.

While Medicare does require other absences to be short or infrequent, recent rule changes permit attendance at family reunions, weddings, funerals and other unique events because they are "infrequent absences." Similarly, walks around the block, attending worship services and visits to a barber or beauty parlor are allowed because they are "short absences." Medicare rules also state that a patient is homebound if it is "contraindicated" for her to leave home. This means, for example, that if it is dangerous for someone with dementia to leave home, she is considered homebound even though she may have no other physical or mobility constraints that make it difficult for her to leave home.

E. Medicare and Chronic Conditions

Helen's story also raises an issue about Medicare's SNF and home health coverage for people with chronic conditions, like Parkinson's disease, Multiple Sclerosis and diabetes. Many people think that a patient must be "making progress" or otherwise showing improvement to qualify for Medicare coverage. That's not true! Medicare's rules say,

the determination of whether skilled nursing care is reasonable and necessary must be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time.

Similarly, many have heard that Medicare won't pay for rehabilitation therapy when a patient reaches a "plateau," or is no longer making progress. It's not necessarily so. While Medicare's rules expect material improvement in the patient's condition within a reasonable time, the rules also say,

When rehabilitation services are the primary services ... the deciding factor is not the patient's potential for recovery, but whether the services needed require the skills of a therapist or whether they can be carried out by non-skilled personnel.

Another section states,

Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capacities.

In other words, the decision about whether or not Medicare covers your family member's SNF or in-home therapy services should depend on her overall medical condition and need for professional services. This will vary from person to person.

Here is one more note about home health coverage and chronic conditions. Until 2000, a diagnosis of Alzheimer's disease or other dementia resulted in an automatic finding that a patient's medical needs are custodial. Thus, patients with dementia received little, if any, Medicare coverage for home health care. Medicare has since changed its policy, recognizing that people with dementia may have

skilled care needs that include skilled nursing and physical therapy services for conditions aside from their dementia diagnosis.

F. Hospice Care

Medicare covers hospice care for people who are terminally ill. There are hundreds of Medicare-certified hospice agencies nationwide. Check the Yellow Pages under “Hospice” for their names and contact information. Hospice agencies provide “palliative care,” that is, care designed to reduce pain and provide comfort for people who are dying. Hospices deliver most of their care in the patient’s home or nursing home. Medicare payments cover hospice physician, nursing, therapy, social worker, and homemaker services. The benefit also includes limited “respite services” for the patient’s caregiver. For many reasons, Medicare’s hospice benefit is under-used.

Medicare payments cover most of the cost of hospice care except small co-payments for pain medications.

Coverage Rules - Medicare covers hospice services when:

- The patient or her representative elect the hospice benefit by signing an election form, meaning that the patient has elected the “palliative care” hospice benefit as an alternative to Medicare’s regular acute care benefits.
- A physician certifies that the patient has six months or less to live.
- The patient’s attending physician and the hospice physician certify the patient for her initial hospice benefit period.
- The patient receives care according to a hospice care plan signed by the attending physician.
- The care is provided by a Medicare-certified hospice.

G. Billing for Part A Hospital Insurance Benefits

Who sends in the bill to Medicare for hospital, SNF, home health and hospice services? The provider does. Medicare rules require them to submit claims on behalf of Medicare patients. They have at least 15 months to do it. After the Medicare Administrative Contractor or Fiscal Intermediary makes a payment decision, it sends a Medicare Summary Notice (MSN) to the beneficiary. The notice contains important information including the financial liability for any deductible or coinsurance charges that apply.

As a caregiver, this news should come as a relief. Your family member is not responsible for submitting Part A claims to Medicare. If your family member feels pressure to pay a provider’s bill after receiving a “balance due” statement, try gently to resist it! Wait until you see the MSN. It explains if Medicare paid the provider, and what is still owed, if anything.

H. Quality of Care in Nursing Homes and Home Health Agencies

Where can you get information to help you compare the quality of services among different nursing homes and home health agencies? Medicare's website contains a wealth of information about local providers on its "Nursing Home Compare" and "Home Health Compare" web pages. It also has another page for dialysis facilities. Each has tools that allow you to see how well the Medicare-certified providers performed on different "quality indicators." You can find out, for example, how local nursing homes compare to state and local averages for "low risk long-stay residents who have pressure sores." Similarly, you can see how local home health agencies compare to one another as to "percentage of patients who get better at getting in and out of bed."

The "Compare" pages also give provider contact information. At the very least, Medicare's "Compare" web pages are a good place to start to educate yourself about the options. Go to www.medicare.gov.

IV. PART B MEDICAL INSURANCE IN ORIGINAL MEDICARE

Medicare Part B covers a host of medical services and items. The main ones are physician services, outpatient hospital services, diagnostic laboratory and x-ray services, ambulance services and durable medical equipment items. On the pages below we will look at the coverage rules for some key Part B benefits. Along with that, here is a short list of some other Part B benefits, including some of its screening and prevention services:

- Prosthetic devices, including breast prosthesis following mastectomy
- Glasses and lens implants following cataract surgery
- Braces, artificial limbs and eyes
- Surgical dressings, splints and casts
- Reconstructive surgery after an accident or injury
- Supplies, including drugs and biologicals that cannot be “self-administered,” along with some oral chemo-therapy medications
- Physical and occupational therapy services
- Some outpatient speech therapy services
- Psychologist’s services
- Limited chiropractic services (for an acute condition)
- Limited podiatry services
- Comprehensive Outpatient Rehabilitation Facility (CORF) services
- Antigens and blood clotting factors
- Institutional and home dialysis services
- Flu, pneumonia, and hepatitis B vaccines
- Screening mammograms
- Pap screening and pelvic exams
- Bone density screening
- Prostate cancer screening
- Colorectal cancer screening
- Diabetes self-care training
- Diabetes testing equipment and supplies
- Initial physical exam for those new to Medicare
- Cardiovascular disease screening for those at high risk
- Diabetes screening for those at risk
- BMI assessment
- End-of-life planning

A. Billing for Part B Medical Insurance Benefits and “Assignment”

Who sends the bill to Medicare for physician, medical equipment, ambulance, lab and other covered services? In nearly all cases, the provider does. Medicare rules require physicians, ambulance companies, outpatient facilities, and most equipment providers to submit claims on behalf of Medicare patients.

What does your family member owe for these services? Medicare Part B's costs work differently than those for Medicare Part A. There is an *annual* deductible of \$135 (in 2009) of Medicare approved charges. After your family member meets the deductible, Medicare usually pays 80 percent of the “approved amount.” The patient owes 20 percent of the approved amount as a “coinsurance charge.” There are, however, some exceptions to this 80/20 payment rule (see page 28).

One way to limit out-of-pocket costs for Part B services is to find providers who accept assignment. What does this mean? It means that a patient “assigns” his right to receive Medicare’s payment over to the provider. In return, the provider agrees to take Medicare’s approved amount as full payment. Even though the provider’s actual charge for a service may be higher than Medicare’s approved amount, the patient owes no more than the 20 percent coinsurance charge after Medicare pays its 80 percent share.

Most physicians in the United States “accept assignment.” Those who do not accept assignment are limited to charging no more than 15 percent above Medicare’s approved amount. Medicare’s “Participating Provider Directory” web tool lists physicians who accept assignment all the time. Go to “Find a Doctor” at www.medicare.gov. Medicare also requires all ambulance providers and outpatient hospital facilities to accept assignment.

B. Durable Medical Equipment and Supplies

Medicare covers durable medical equipment (DME) and supplies among its Part B benefits. Durable medical equipment includes wheelchairs, walkers, oxygen equipment, hospital beds, and much more. Supplies include things like tube feeding supplies, blood sugar testing strips, and more. Medicare specifically does not cover comfort and convenience items along with self-help devices. This means that Medicare won't pay for common equipment like air filters, bathtub grab bars, toilet seat lifts and stairway elevators. Medicare also does not cover things like incontinence pads for home use because they are "non-reusable" supplies.

For many covered DME items, Medicare pays a monthly rental fee for 10-15 months at 80 percent of the approved amount. At 13 months of rental, your family member will receive a letter that explains the option to purchase or continuing to rent the equipment. Medicare also pays for regular maintenance on items like wheelchairs. For relatively inexpensive DME items costing \$150 or less, the program normally pays a lump-sum purchase price at 80 percent of the approved amount. Many companies provide DME and supplies. They include national providers that advertise on TV, pharmacies, local DME stores and home health agencies.

Ask medical equipment suppliers if they accept assignment. You'll save a lot of money by finding one who does. Unlike physician bills, there's no "limiting charge" for DME and supplies.

Coverage Rules - Medicare covers DME when:

- A physician certifies that the DME is medically necessary (Medicare requires the physician to sign a "Certificate of Medical Necessity" to justify the need for the item).
- The equipment is able to withstand repeated use.
- The equipment is primarily and customarily used for medical purposes, and is generally not useful in the absence of an illness or injury.
- The equipment is appropriate for use in the home.
- The supplier is Medicare-certified.

With these rules in mind, what explains a Medicare coverage denial like the one below?

Dorothy is 92 and lives with her daughter Sylvia and her son-in-law. In the past three years, Dorothy has become increasingly frail. She has severe osteoarthritis and kyphosis, a condition that makes it difficult to straighten her spine. She is hunched over and needs help getting out of bed and with toileting. Dorothy can walk about fifteen feet at a time, but only with a walker.

Recently the pain in Dorothy's upper back has become severe. She awakens every couple hours at night screaming in pain. The whole family is exhausted.

Dorothy's doctor prescribed a hospital bed for her. He said he thinks it will take some of the pressure off her spine when she's lying down and thus reduce her pain. Medicare, however, denied coverage for the bed saying that it is not "medically necessary."

A hospital bed is a costly piece of medical equipment. Without Medicare coverage, the entire cost for rental or purchase would fall to Dorothy and her financial resources. What can Sylvia do to help Dorothy avoid this drain on her pocketbook?

She can appeal Medicare's coverage denial. Would it be worth the trouble? Absolutely! Medicare is very likely to approve coverage for a hospital bed in a situation like Dorothy's with additional information.

Medicare says that, even though a piece of equipment may serve a useful medical purpose, it must also consider the extent to which it is reasonable to pay for the equipment. To decide if coverage is reasonable, Medicare asks:

- 1) Would the item's cost clearly outweigh its medical benefits?*
- 2) Is the item much more costly than other medically appropriate care options?*
- 3) Does the item serve essentially the same purpose as equipment that is already available to the beneficiary?*

Sylvia can help by asking the physician for a letter that explains some of the other care options he has thought about and ruled out, or that he has already tried without success, like pain medications or physical therapy. In economic terms, Medicare uses a "cost-benefit analysis" to make its DME coverage decisions. The doctor should also explain how Dorothy's condition requires positioning on a hospital bed, instead of a regular bed, to treat the

pain. Any other information that Sylvia can provide about the severity or frequency of her mother's symptoms should tip the scales in favor of coverage. Keep in mind that Medicare views the treatment of pain as reasonable and necessary.

C. Medical Equipment in Nursing Homes

Recall the rule above that durable medical equipment must be “appropriate for use in the home” in order for Medicare to pay. What happens if your family member is a long-term resident in a nursing home? Due to a strict interpretation of “home,” Medicare Part B does not pay for DME, including wheelchairs, for residents in facilities that have a Medicare-certified skilled nursing unit. Your family member may have to pay for equipment, especially customized items, out-of-pocket. If she is eligible for Medicaid, that program may pay for the equipment under its own coverage rules.

D. Power Operated Wheelchairs

Medicare covers power operated wheelchairs and scooters in certain cases. Coverage is limited to those who are homebound. A recent rule change requires Medicare to base its coverage decisions on the extent to which a person needs the device to perform mobility-related activities of daily living in the home, like feeding, bathing and going to the toilet. The person need not be confined to a bed or chair to qualify for coverage.

For a list of local DME suppliers, see the Supplier Directory at www.medicare.gov. Click on “Find Suppliers of Medical Equipment in Your Area.”

E. Ambulance Services

Medicare covers medically necessary **ambulance** transportation services. This includes emergencies, along with some non-emergency services depending on the patient's condition. Medicare will cover ambulance trips 1) from a patient's home to a hospital or skilled nursing facility (SNF); 2) from a hospital or SNF to the patient's home; 3) from a SNF to a hospital; 4) from a hospital to a SNF; 5) from one hospital to another; and 6) from one SNF to another.

Coverage Rules - Medicare covers ambulance transportation when:

- An ambulance is the only safe means of transportation available to the patient, and that the patient's health would have been placed in jeopardy by other means of transportation.
- The travel is to the nearest hospital or skilled nursing facility (SNF) with "appropriate facilities." This means that generally Medicare only covers local ambulance transportation.
- The ambulance provider is Medicare-certified.

Medicare's rule about transport to the nearest appropriate facility means that Medicare will not necessarily pay for a trip to a hospital where your family member's doctor has staff privileges. Medicare's policy manual says this: "Ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities."

Hazel's 72 year old sister, Maxine, lives alone in a nearby suburb. Two months ago, she slipped and fell climbing out of the bathtub and broke her arm. In severe pain, Maxine called 9-1-1. An ambulance arrived promptly and transported her to the emergency room at a nearby hospital. Doctors set the arm in a cast, gave her a prescription for pain medication, and released her later that day. Hazel drove her home.

When Maxine met Hazel for dinner this past weekend, she reported that Medicare denied coverage for the ambulance trip. After a call to the ambulance company, she was dismayed to learn that she owes \$500 out of pocket. Maxine is still wearing a cast on her arm, and asks Hazel if she has any advice.

The issue is whether or not Maxine could have gone safely to the hospital in a car. Was an ambulance really needed? It depends entirely on Maxine's medical condition. Does she have other conditions that complicate her case and require monitoring or treatment by the ambulance crew? Does she have, for example, a heart condition, or a bleeding condition? Was she in shock? Does she have high blood pressure? Was her pain level so high that she needed immediate medical attention? Any of these underlying factors could make an ambulance trip necessary in Maxine's case.

Hazel would do well to encourage Maxine to appeal the denial and ask her physician to write a letter that explains to Medicare how her overall condition made the ambulance necessary. Note that it makes no difference to Medicare if other transportation is available. The lack of a car or taxi does not figure into its coverage decision. Medicare's rules say that where transport other than an ambulance could be used safely, whether or not it is actually available, Medicare cannot pay for ambulance service. In other words, Medicare makes a judgment call that will benefit from information that helps describe the patient's overall condition.

If an ambulance trip does not involve an emergency, the ambulance company must obtain a physician's written order within 48 hours of an unscheduled trip. The physician's order must certify and explain the patient's need for the ambulance instead of other transportation modes. With respect to billing, be aware that Medicare requires ambulance service providers to accept assignment on claims for all Medicare patients.

F. Exceptions to the Coverage Rules

“For every rule there’s an exception,” or so the saying goes. With Medicare, some rules are hard and fast. Others have exceptions. The exceptions can sometimes cause confusion. Recall from above that Medicare has exclusions from coverage. These include cosmetic surgery, services received outside the United States, and routine foot, eye, and dental care. Does this mean that your family member will never receive covered services from a podiatrist or ophthalmologist? Not necessarily. That’s because Medicare covers some of these services when they are not “routine.” Here are a few exceptions to the exclusions rules:

- **Foot care:** Medicare does not cover treatment of flat feet or the removal of corns and calluses or trimming of nails in routine cases. But when a patient has a condition affecting her circulatory or nervous system, like diabetes or neuropathy, Medicare will pay a podiatrist to provide many foot care services.
- **Eye Care:** Original Medicare does not cover routine refractions for eyeglasses. But when a patient has a disease or injury of the eye, such as a detached retina, Medicare pays for treatment. Along with this, Medicare pays for cataract surgery and related glasses and lens implants.
- **Cosmetic Surgery:** Medicare does not cover surgeries like “tummy tucks” and “face lifts.” But it does cover reconstructive surgery related to an illness or injury. An example is breast reconstruction following a mastectomy.

G. Exceptions to the Part B 80/20 Payment Rule

Generally, Medicare Part B pays 80 percent of the approved amount for a covered service or item after a person meets an annual deductible. But there are exceptions that include:

- No deductible for some prevention benefits like screening mammograms, flu shots, diabetes screening lab tests, laboratory screening blood tests for cardiovascular disease, the “Welcome to Medicare” physical (eff. 1/1/09), and some other screening services.
- No coinsurance for diabetes screening lab tests, fecal occult blood tests for colorectal cancer, laboratory screening blood tests for cardiovascular disease, and flu and pneumonia vaccines if the provider accepts assignment.

- **Outpatient hospital coinsurance charges.** Medicare may pay more or less than 80 percent of the approved amount for outpatient care, based on the type of service. While Medicare currently is phasing in an “Outpatient Prospective Payment System,” the patient’s share of the approved amount may not equal 20 percent. Look carefully at the Medicare Summary Notices (MSN) for Outpatient Services where outpatient payment details appear.
- **Mental health services, including individual and group counseling with psychologists and other licensed therapists.** Medicare pays 50 percent of the approved amount for covered services. Medicare supplement insurance policies usually cover the 50% co-insurance charge that remains.

V. WAIVER OF LIABILITY & ADVANCE BENEFICIARY NOTICES (ABN)

Who is liable for the cost of care when Medicare denies payment because a service or item isn't medically necessary? In other words, when your family member receives a medical service thinking that Medicare will pay the bill, what happens if Medicare says "no" to coverage for lab tests, ambulance services, physician services and the like?

Your family member's financial liability for a bill will often depend on whether she knew, or could be expected to know, that Medicare would not approve payment for the care. This is called Medicare's "waiver of liability rule." A care provider cannot hold a patient liable for a bill that Medicare has denied for lack of medical necessity, if the patient had no way of knowing that Medicare would probably not approve payment for the service.

It means that Medicare waives the patient's liability in most cases where the provider did not inform the patient in writing about the chance that Medicare could deny payment for lack of medical necessity. If a provider does not issue a notice to the patient, the provider may be liable for the cost of care when Medicare later decides the services were not necessary. It might work like this.

Elaine's older sister, Diane, has a rare medical condition that causes severe anemia. Because Diane is very weak, Elaine takes her to medical appointments. These included three visits to the doctor for ferrous gluconate (iron supplement) injections.

Recently, Diane asked Elaine to look into a billing problem involving the injections. The doctor's office had sent a statement requesting immediate payment of their entire cost. The statement reported, "Medicare Payment: \$0." "That's odd," said Elaine, "Medicare didn't pay. I wonder if that means you owe the doctor for this bill."

What should Elaine do? Her first step is to look at the Medicare Summary Notices (MSN) for the injections. The MSNs contain notes that explain Medicare's decisions. As Elaine investigated, she found a note that read, "It appears that you did not know that Medicare would not pay for this service so you are not liable. Do not pay your provider for this service."

Medicare denied payment because, in most cases, people take iron supplements as tablets by mouth. Medicare Part B does not pay for most medications that people can take themselves. But, because the doctor's office did not inform Diane in writing about the likely coverage problem, Medicare waives her liability. The doctor should not try to collect payment from her. If Diane has already paid, Medicare will pay her back and later seek repayment from the doctor.

Aside from liability for the bill, was there a good medical reason for the injections? Perhaps so. Diane's rare condition could justify the injections in a doctor's office instead of oral medications. Her doctor can appeal the denial by asking Medicare to make a redetermination based on new information that shows the need for injections to treat Diane's anemia.

It should come as no surprise that the waiver of liability rule puts pressure on providers to notify patients when there is any doubt about Medicare coverage. Be aware that providers are liable for the bill if Medicare finds that they knew or should have known that Medicare would not pay for the service.

What does this mean for you as a caregiver? It means that your family member may receive an [Advance Beneficiary Notice \(ABN\)](http://www.cms.hhs.gov/BNI/) [http://www.cms.hhs.gov/BNI/] from a health care provider. A properly completed ABN should describe the service or item in question and explain

why the provider believes that Medicare is likely to deny payment. If the ABN does not contain this required information it is not valid.

What is the effect of a valid ABN? It shifts the financial liability for the bill to the patient if Medicare denies payment. Medicare assumes that someone who receives an ABN should know that Medicare may not cover a service. The ABN, however, is not an official Medicare coverage decision. It only states the provider's opinion about how Medicare's coverage rules may apply. The best way to find out if Medicare will cover the service is to ask the provider to send the bill to Medicare. Medicare may decide to cover the service. If it doesn't, it is a good idea to appeal the decision and ask the doctor to provide new information about your family member's medical condition that shows medical need (see page 37, below).

VI. FILLING THE COST SHARING GAPS IN ORIGINAL MEDICARE

How will your family member pay for Original Medicare's deductibles and coinsurance charges that we described above? There are several ways in which people fill these "gaps" in Medicare.

Employer and Union Group Plans: Many retirees receive health insurance benefits that "wrap around" Medicare coverage. Some of them cover Medicare's Part A and Part B deductible and coinsurance costs completely. Others cover a percentage of these costs. Some have a lifetime cap on payments. Usually the best way to learn about a plan's coverage is to call the plan's benefit office. Note that these group plans' benefits are subject to change. They may change annually or with contract renewals.

Medicare Supplement (Medigap) Policies: Medigap insurance policies are specifically designed to fill the cost-sharing gaps in the Original Medicare program. All of them cover the 20 percent Part B coinsurance charge and the Part A inpatient hospital coinsurance charges. Most of them cover the Part A hospital deductible. Medigap policies tend to vary in price based on the number and type of gaps they fill. A national system of standard policies makes it fairly easy to compare one company's policies to another's. To assist consumers, many state insurance departments both offer free Medicare Supplement shopper guides. These publications contain helpful cost-comparisons, information on enrollment and continuation rights, and consumer tips. Also, the state-sponsored SHIP programs are excellent sources of help in evaluating and comparing the pro's and con's of these and other insurance options (see Helpful Resources, page 39).

TRICARE for Life: Many military retirees and their spouses have supplemental health insurance through TRICARE for Life. The plan operates like a Medicare Supplement in that it covers the Part A and Part B deductibles and coinsurance costs. It also covers prescription drugs. Those who are eligible normally have no need for other Medigap insurance. For information, go to the program's web-site at www.tricare.org.

Medicaid and the Medicare Savings Programs: People with limited financial means may be eligible for state-sponsored programs including Medicaid and the Medicare Savings Programs (MSP) that cover all or part of Medicare's cost sharing gaps. One MSP, called the Qualified Medicare Beneficiary (QMB) program, covers all the Medicare deductibles and coinsurance costs and pays the monthly Part B premium for individuals with limited income whose countable assets are \$4,000 or less (excluding the

home). Note that several states have expanded eligibility for the Medicare Savings Programs by excluding a person's assets entirely from eligibility decisions. Check with your local Medicaid office or SHIP program for more information and help.

VII. MEDICARE ADVANTAGE PLANS

People throughout the country have two ways to receive their Medicare benefits. They can get them through the Original Medicare program, or through Medicare Advantage plans that include Medicare Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO), Private Fee-for-Service (PFFS) plans, and more.

Be aware that Medicare Advantage plans “become Medicare” for people who join them. Members of a Medicare HMO, PPO, or PFFS plan agree to get their covered care through the plan, not through Original Medicare. The Original Medicare program does not pay for services for people who belong to a Medicare Advantage plan.

Plan members also agree to follow the plan's rules to receive covered care. Medicare HMOs often have, for example, rules that require a primary care physician to pre-approve a visit to a specialist. Medicare HMOs also require patients to use “network providers” except in emergencies and urgent care situations. This means that the plan only pays when a patient uses doctors and hospitals that have payment agreements with the plan. In contrast, people in Original Medicare can go to any physician or hospital in the country that is willing to provide care.

Medicare Advantage plans must cover at least the same services that the Original Medicare program covers. In addition, most plans provide some services that Original Medicare does not cover, including annual physical exams, routine eye care and glasses, and routine hearing tests and hearing aids. But Medicare Advantage plans **are not** supplemental insurance policies. They're not designed to fill in the deductibles and coinsurance charges in the Original Medicare program. They have co-payments of their own, and no separate insurance policy covers a Medicare Advantage plan's co-payments.

What is the benefit to your family member in joining a Medicare Advantage plan? For many people, Medicare Advantage plans offer a less costly way to receive medical care. Annual out-of-pocket spending for health care is lower on average for those in a Medicare Advantage plan than for folks who have

Original Medicare and a supplement insurance (Medigap) policy that may cost \$100 per month or more.

Monthly premiums for Medicare Advantage plans may also be comparatively low. Some have no premium in addition to the Part B premium that Medicare beneficiaries already pay. Fixed co-payments for doctor visits may also be relatively low, for example, \$15 for primary care physicians and \$40 for specialists. See the “Compare Health Plan Options” tool at www.medicare.gov, for detailed information about the plans’ coverage and costs, or call your local SHIP program for information and guidance (see Helpful Resources, page 39).

The Medicare Advantage plans, as noted above, cover some services and items that Original Medicare doesn’t cover. The extra benefit that drew many people to these plans was prescription drug coverage. Since January 1, 2006, however, all people with Medicare have access to Medicare prescription drug coverage through a stand-alone Prescription Drug Plan (PDP) or through a Medicare Advantage plan. To compare drug plan options and costs, see the “Compare Medicare Prescription Drug Plans” tool at www.medicare.gov, or contact your local SHIP program.

As a caregiver, one important thing to know about Medicare Advantage plans is that plan members must be able to cover the plan’s co-payments. Some plans have an annual out-of-pocket maximum amount, or cap (as much as \$4,000) that may limit one’s exposure to catastrophic financial risk. Your family member should expect to pay substantial co-payments for inpatient hospital stays and some outpatient hospital services. These can quickly add up for multiple visits. A basic question to ask is, “Can my family member afford to pay the co-payments using his savings or money in his annual health care budget, or will the co-payments create a barrier to the care he needs?” The next story illustrates the problem.

Otis is an 80 year old widower. He had a mild stroke that partially paralyzed his left arm and leg. He was in the hospital for six days, and his prospects for rehabilitation seemed good. Because Otis's sister, Carolyn, was willing to drive her brother to medical appointments, Otis's doctor ordered outpatient physical therapy at a local hospital three times per week for two weeks following his discharge.

Carolyn took Otis to his first two physical therapy appointments. When she arrived to take him the third time, Otis declined to go. "I don't know how I can keep paying for this therapy," he said. "I can't afford it at \$50 a visit! I'll owe \$300 by the end of next week, and that's on top of the \$1,100 I already owe the hospital for my inpatient stay." What can Carolyn do?

Carolyn knew that Otis's \$1,300 monthly income made him ineligible for assistance programs that could cover the co-payments. She also knew that her brother always had tried to avoid debt. Aside from paying the physical therapy co-payments herself, Carolyn could explain Otis's financial situation and ask a hospital manager to waive or reduce the co-payments. A second option is to ask Otis's doctor to order in-home physical therapy. Though the treatments may not be as intense as in an outpatient setting, the co-payments for in-home physical therapy visits may be cheaper.

VIII. MEDICARE APPEAL RIGHTS

If a health care provider informs your family member that Medicare will not cover or continue to cover a service, or if Medicare or a Medicare Advantage plan denies payment for medical care, keep in mind that your family member has appeal rights under Medicare law. Often more details about a patient's overall condition can make the difference between a Medicare payment and a payment denial. The appeals process is an important way to bring those details to a decision-maker's attention.

A. Fast Appeals

Medicare has “expedited determination” and “immediate review” procedures to ensure speedy decisions for some kinds of coverage problems. Starting in July 2005, Original Medicare has expedited procedures when someone disagrees with a provider's decision to end skilled nursing facility, home health agency and Comprehensive Outpatient Rehabilitation Facility (CORF) services. Separate Medicare rules detail the process for a fast review of inpatient hospital continued stay denials, for Medicare Advantage plan denials or service terminations, and for Prescription Drug Plan denials under Medicare's new prescription drug benefit.

If you have any question about the need for ongoing care for your family member after she receive a service termination or discharge notice, consider using these procedures. They require someone who is independent of the health care provider to look into the case and make an official Medicare coverage decision. Most importantly, read these notices very carefully for information about deadlines, who to call or write to ask for a review, and the start date of patient liability for ongoing services. Your family member may have to weigh the chance of success on appeal against the cost of paying out-of-pocket for continued care.

B. General Appeal Procedures

Aside from the fast appeal procedures above, Original Medicare and Medicare Advantage plans have separate appeal procedures for most other coverage decisions, including for example, payment denials for physician and ambulance services. In Original Medicare, your family member normally has 120 days after receiving a Medicare Summary Notice (MSN) to ask for a “redetermination” of Medicare's decision to deny payment. See the MSN for instructions, including the mailing address to which you would send a written request for redetermination. In Medicare Advantage plans, a person normally has 30 days to start the appeal process following an adverse plan decision.

Following a redetermination that upholds Medicare's payment denial, a person has a right to ask for reconsideration. The redetermination and reconsideration appeal levels involve "paper reviews" of the medical record. There is no opportunity to meet with a decision maker until the third step in the appeals process. For those who lose at the reconsideration level, they have a further right to a hearing before an Administrative Law Judge (ALJ) if at least \$120 (in 2008) is at stake.

Because the filing deadlines and procedures differ at the reconsideration and hearing levels, look carefully at the letters that come from Medicare. All contain specific information about when, where and how to seek relief in the next step of the appeal process.

Free help is available for those who appeal a Medicare coverage decision. The SHIP programs throughout the country assist caregivers and their family members with the appeals process (see Helpful Resources, page 39). The Health Assistance Partnership also provides helpful information: <http://www.hapnetwork.org/original-medicare/appeals.html>.

IX. CONCLUSION

Medicare is vital to your family member's access to health care. Because it is so important, the time you spend now to inform yourself about its coverage, costs and limits will be time well spent. When challenges or confusion arise, please keep in mind that you are not alone. Along with many caring people who work in the nation's health care facilities, the volunteers and staff who work with the SHIP programs in all 50 states, the District of Columbia and the territories, stand ready to offer guidance and help with questions about insurance coverage and in resolving coverage and billing problems. Call on them if and when the need arises.

APPENDIX A: HELPFUL RESOURCES

Social Security Administration 1-800-772-1213
www.ssa.gov

Centers for Medicare & Medicaid Services (CMS)

Medicare Call Centers: 1-800-MEDICARE (1-800-633-4227)
www.medicare.gov
www.cms.hhs.gov

Medicare Coordination of Benefits (when Medicare is a secondary payer)

Call Center: 1-800-999-1118

Quality Improvement Organizations (QIO, formerly Peer Review Organizations)

Medicare's Helpful Contacts: <http://www.medicare.gov/Contacts/>

State Health Insurance Assistance Programs (SHIPs)

(free, local counseling and assistance programs for people with Medicare)

HAP's SHIP Locator: <http://www.hapnetwork.org/ship-locator/>

State Insurance Departments

Medicare's Helpful Contacts: <http://www.medicare.gov/Contacts/>

Area Agencies on Aging (AAA)

(free information on aging and long-term care services)

Elder Care Locator: 1-800-677-1116

TRICARE for Life: 1-888-363-5433
www.tricare.osd.mil/tfl

Health Assistance Partnership: www.hapnetwork.org

Center for Medicare Advocacy: www.medicareadvocacy.org

Medicare Rights Center: www.medicarerights.org