SHIP Navigational Guide

Book 1

LOCAL HELP FOR PEOPLE WITH MEDICARE

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Counselor Guidelines

STATE HEALTH INSURANCE ASSISTANCE PROGRAM (SHIP)
CODE OF CONDUCT FOR VOLUNTEERS

As a SHIP Volunteer Counselor:

- I will not use the title of SHIP volunteer to promote personal opinions or causes.
- I will keep personal opinions and actions separate from those made as a representative of this organization.
- I will remain impartial in discussions and writing to people with Medicare, general public, and the media.
- I must not misrepresent SHIP for the financial gain of myself, friends, or family members.
- I may not accept payment or in-kind contributions for my services.
- I am committed to upholding the Conflict of Interest policy and agree to discuss any potential appearance of a conflict with an Area Manager and will be truthful in all matters to do with my volunteer relationship with SHIP.
- I will treat others with dignity, care, and respect. I will be sensitive to and educate myself about individual and group differences. I will respect all clients' rights to self-determination and agree to support people in making their own personal choices.
- I agree to maintain respectful and professional relationships and appropriate boundaries with others during the course of my volunteer work.
- I will uphold the standards of the State Health Insurance Assistance Program and keep updated with new information and training.

- I understand that lack of training and education may limit my ability to serve clients and recognize the need to ask for assistance or refer when appropriate.
- I agree to complete the necessary training before and during the course of volunteering. I will do this by keeping updated on new information that is sent to me, attending scheduled counselor meetings and fall and Spring trainings, and by taking advantage of opportunities such as seminars and workshops offered both within and outside of SHIP.
- I agree to participate in supervision that is acceptable, reasonable, regular, and visible according to the guidelines of SHIP.
- I shall hold all privileged information concerning clients STRICTLY CONFIDENTIAL.
- I agree to report to duty free from all influences of drugs or alcohol.
- I will avoid conduct that would jeopardize program effectiveness.

I understand that failure to adhere to any and all parts of this code may result in suspension from my volunteer duties and/or termination of my volunteer relationship with SHIP.

Social Security Number Protection and Compliance Q&A

Question: **Why should we be concerned about Social Security Protection?**

Answer: Identity theft is the fastest growing crime in America. It occurs every 79 seconds. If it hasn't already affected you or someone you know, it likely soon will. It is estimated that almost 11 millions people have been affected by this crime at this point.
(http://idtheft.about.com/od/dataandstat1/a/ID_Theft_Stats.htm)

Question: **Why should we as SHIP volunteers be concerned about the protection of other people's Social Security numbers or Medicare numbers?**

Answer: The Indiana legislature and the Office of the Attorney General have recently responded to this growing problem with new laws and regulations. These laws directly affect the State Health Insurance/SHIP and you, as even a negligent disclosure can be a criminal infraction.

Question: **What is the general law regarding the disclosure of Social Security Numbers?**

Answer: SHIP may not disclose an individual's Social Security number or Medicare number. However, disclosing the last four digits of a Social Security number is NOT considered a disclosure.

Question: **How does SHIP comply with this general law?**

Answer: SHIP will be in compliance by removing or completely and permanently obscuring a Social Security number or Medicare number on Client Contact forms or other printed materials after use. SHIP counselors will need to permanently black out Medicare numbers before submitting Client Contact forms. It is okay to have the SSN or Medicare number available on an open case. However, if you don't need it, don't get it, and don't keep it.

Question: **Are there any circumstances when SHIP may disclose an individual's Social Security Number or Medicare Number?**

Answer: Yes. SHIP may disclose an individual's Social Security Number or Medicare number in the following circumstances:

- To a state, local, or federal agency (unless prohibited by state law, federal law, or court order).
- If the disclosure of the SSN or Medicare number is expressly required by state law, federal law, or court order.
- If the individual <u>expressly</u> consents to the disclosure in writing. This needs to be signed and dated in a legible form.

Question: **What happens if a SHIP counselor wrongfully discloses a Social Security Number or Medicare number?**

Answer: This depends on the circumstances surrounding the disclosure and how the counselor responds to the situation.

Criminal Disclosures- SHIP Counselors who knowingly, intentionally, or recklessly disclose an SSN or Medicare number in violation of the above laws are committing a Class D felony.

The AG's office may investigate any allegation that an SSN or Medicare number has been disclosed in violation of the above laws. If there is evidence of a criminal act, the AG must report the findings to the prosecutor's office and the state police department.

Negligent Disclosures- When a SHIP counselor negligently discloses an SSN or Medicare number, the SG's office has the discretion to determine that a release was negligent and not criminal if one or more of the following has been met:

1. The release of the SSN or Medicare number is immediately stopped.
2. Affected individuals are notified in a timely manner.
3. The release was unintended, de minims, and nonsystematic.
4. If the release involves a SHIP sponsoring agency, the sponsoring agency's contract contained a clause that requires the agency to comply with the above laws.
5. The agency has reasonable policies and procedures in place to prevent unauthorized disclosures.
6. The agency has taken steps to prevent further disclosures under similar circumstances.
7. Other relevant circumstances.

Question: **What steps must SHIP counselors take if an SSN or Medicare Number is wrongfully disclosed?**

Answer: Within two (2) days of the disclosure the SHIP counselor must notify the SHIP Program Director of the following:

1. The nature of the release.
2. The steps taken by the Counselor to:
    A. Stop the current release.

    B. Notify the individuals affected.

    C. Prevent future releases.

LIABILITY ISSUES

The Governor's Office has advised that "so long as a counselor is acting in good faith in performing the counselor's functions within the scope of the counselor's service to SHIP, the State would indemnify the counselor for any judgment taken against the counselor" (after a review of Indiana Code 34-3-16.5-5{b}). This means the State would pay any loss incurred from a lawsuit, **AS LONG AS** the counselor acted in good faith, while performing services **WITHIN** the guidelines of SHIP. The Attorney General's office would defend the counselor under these same stated conditions.

Should a lawsuit be brought against a counselor and (upon review by the State) it is determined the counselor acted with malicious intent or acted outside the guidelines of SHIP, the counselor would then be responsible for obtaining and paying for their own defense, plus any loss incurred from the lawsuit.

Generally, a volunteer will not be held personally liable by a client for any of his actions, if such actions are performed within the scope of his duties and in good faith, without any malicious intent.

For these reasons, it is extremely important that you always use the written disclosure statement and the Client Agreement form. You must also follow your training instructions and not advise clients to enter into or to terminate specific transactions. **Your role is to educate the client** in an unbiased manner on elements of health insurance which they may wish to consider; **or to refer** the client to seek the assistance of an attorney of their choice or a public agency with relevant resources and jurisdiction.

If you act in other ways, you run the risk of incurring liability for yourself.

COUNSELING GUIDELINES

Introduction

As a SHIP counselor, you are providing a unique service to the residents of our state. You are providing guidance and information to your clients in order to help

them make well-informed decisions about their health insurance. You will need to draw upon your SHIP training, past experiences, and communication skills to be an effective counselor.

There are three types of communication: **verbal, non-verbal (body language), and written correspondence (including e-mail).** Always remember to be cordial, yet professional.

Verbal Communication

- Speak clearly, loudly, and slowly. Many of your clients may have hearing impairments, or English may not be their first language. Hearing impaired clients may be better served in a face-to-face meeting.
- Be careful to not use slang or jargon. Your client may not understand these terms, acronyms, and phrases that you find familiar.
- If you know that the client has difficulty hearing or with comprehending, it may be best to ask that a relative or representative be present.
- Ask yes-or-no **and** open-ended questions. Asking only yes or no questions will not give the client an opportunity to give you the whole picture.

Listening Skills

Practice good listening skills to improve your communication:

- **Be open** to differences in values, attitudes, cultures, and beliefs.
    - **Paraphrasing** is a good way to show your client that you have really listened to him/her and understand their situation. When there is a natural pause in the conversation, restate briefly what you heard your client say by rephrasing in your own words. Then ask if this is correct.
    - **Clarification-** Ask questions and clarify anything your client said that you don't quite understand. Make sure that you understand your client's situation before you react to what has been said. Don't provide information that is not pertinent or helpful.
    - **Feedback-** Provide feedback by sharing, with the client, your understanding of what they have told you.

Non-verbal (Body Language)

- Let your facial expressions show your understanding and interest. Gently nodding lets the client know that they are getting the information across to you.
- Sit or stand in an attentive posture. Let the client know that you are interested in the conversation.
- Avoid habits such as using excessive hand gestures, clicking of pens, drumming on the table, and other body language that can be very distracting. These habits may prevent you from effectively communicating with your client. Out of politeness, clients will not usually tell you about these personal habits.

Written Communication

- **Keep it professional and non-biased** when you are responding to a client's request or when you are providing information to media sources. Be sure to take advantage of the many brochures and booklets that we have available to share with your clients.
- Always end your letter or e-mail with an invitation to contact you again.

Not everyone gets along with everyone; however, you should feel comfortable and at ease in discussions with clients. If a client makes you feel uncomfortable (for example, uses inappropriate language or is over-bearing), don't let this get in the way of getting them help. Discuss the problem with your Local Coordinator or Area Manager.

Telephone Conversations

A simple, direct, and effective way to answer the telephone is: "**State Health Insurance Assistance Program, how may I help you?"** At once you have told the client that they may or may not have called the correct number and that you are willing to help them.

Be Prepared, the caller/client will:

- **Start out fast and get faster!** After multiple tries, they may have finally reached a real person and they don't want to miss the chance to tell all.

- Mistake you for their insurance company representative and start logging their complaint or start asking one question right after the other.
- Have no clue why they called **you** except that they need help and someone gave them SHIP's number.
- Be an insurance agent or provider simply seeking information.
- Be responding to information that they got through the media, from a friend, Medicare, Medicaid, their doctor's office, Social Security, their insurance company, or through the mail.

As a counselor you need an abundance of patience. Let the caller have their say. Wait for an opening, **(taking notes as they speak),** and then simply ask:

- "Are you familiar with SHIP and our services?" (It is probably their first contact with a SHIP counselor). If they are not aware of SHIP, reply with:

"We are a federally funded agency in Indiana under the Indiana State Department of Insurance. All of our counseling and information is free to you. So that I can determine how we may best help you, may I ask you some questions?"

Then begin with questions like:

- "Are you currently covered by an insurance plan?"
- "Are you retired? From where did you retire?"
- "What is your age, please?" If they are under age 65, ask if they are receiving Social Security Benefits.
- "Do you have Medicare Part A & Part B?"
- "Are you on a limited income?"
- "Are you a veteran?"

By this time you have now established a mutual trust and a cross-flow of information. The conversation will progress from there. To better help your client, you may need to make an appointment with them for further discussions. The following guidelines will help:

COUNSELING PROCESS

Session Location

Counseling sessions may be held at the local SHIP site, over the phone, at a client's home, or other suitable locations.

- **SHIP Site** Contact the client and make an appointment. Complete your Client Contact form, explain your role as a SHIP counselor, and tell them what information they are to bring to your meeting. Close the call and remind them of the appointment time/date and what to bring.
- **Telephone** State that you are calling (or returning their call) to discuss their health insurance situation. If further discussions are needed, set another appointment. Begin the call with using a Contact Form. If you are taking 800 calls, see Navigational Guide 4 section R-forms.
- **Client's home (for homebound clients).**Take your SHIP I.D. card with you to show the client. Take another counselor with you to act as a witness to the information you have shared. Ask to sit at a table where both of you can be comfortable and can write or display information. Start the session with the Client Contact form.

Session Guidelines

- **Introduce Yourself.** Put the client at ease with brief general conversation. Explain your role as a SHIP counselor and the time limit you want for the session.
- **Client Contact form.** Complete this form as you work with the client.
- **Client Agreement Form.** This form should be signed by the client and kept in a secure place either by you or your local coordinator. Do not send this form to the SHIP state office.
- **Client questions or concerns.** Ask the client if they have questions or concerns that you can review and use as a basis for developing a strategy to help them. Provide information, analyze policies, organize claims records, and/or make referrals.
- **Decide on the next step.** Schedule another appointment and if necessary, refer the client to an appropriate source. You may want to advise the client to review all materials discussed and tell the client how you will help them.

- **Close the session.** After closing the session, complete the Client Contact form and forward it to your Local Coordinator on the schedule that has been arranged.

SHIP 800 Telephone Counselor Guidelines

We really can't predict what our peak times will be, but volunteers are needed daily.

You can't count on one particular day or week of the month being the busiest. Below is an example of a seven month period.

MONTH	BUSIEST DAY OF THE MONTH	BUSIEST WEEK OF THE MONTH
January	Tuesday	Week 4
February	Thursday	Week 1
March	Monday	Week 3
April	Tuesday	Week 4
May	Wednesday	Week 2
June	Tuesday	Week 1
July	Wednesday	Week 4

If you choose to volunteer to help with the 800 line, sometimes you will be swamped and sometimes you will receive only a few calls. In either situation, your assistance is always greatly appreciated by the staff.

Notify your Area Manager and the operators at 1-800-452-4800 that you are volunteering and what hours each week you are willing to take calls. Try to choose a time that is slow at your site and no appointments have been scheduled.

At the time that you are scheduled to take calls, call 1-800-452-4800, Ext. 4 then option 1 at the next prompt and let the operator know that you are ready to receive calls. If not, an operator will attempt to call you at the times you are scheduled. If you need to change your schedule just let us know. If you are leaving early, call the SHIP operator and let them know so that she doesn't continue to transfer calls.

Most 800 counselors take calls to keep fresh and to be exposed to a variety of counseling questions. Taking 800 calls keeps counselors sharp and on top of the most important issues for people with Medicare.

If the operator asks you to take "call backs", you do not have to accept them. These are calls that need to be returned because the caller left a message. If you are too busy, just say so or tell the operator how many call backs you can take. **If you end up with call backs that you are not able to reach or get to by the end of your scheduled time, call the 800 operator and let them know that you were not able to complete the call.** Counselors often take these calls to arrange meetings with the caller at their local site. Some sites will take all call backs that are offered, even in different areas just so they keep busy.

Remember that there is no reason for your site to incur the cost of any long distance calls. All you need to do is call the 800 number and the operator will transfer your call.

Sometimes you may only receive a few calls during your time, so be prepared to take on other responsibilities at your local site. The Medicare Prescription Drug plans have made many consumers aware of their local sites. So be available for local calls coming into your agency. Also, check with your Local Coordinator to see if there is office work that needs to be done. Arrange presentations or deliver brochures to other agencies if this is a slow call period. All of us can use the time to review our Navigational Guides or catch up on the latest Medicare rules and regulations.

Be sure to fill out a Client Contact form for each call, even if the call lasted a few minutes. You want credit for all of the work that you do.

If you have trouble answering a question, be assured that we are here to help. The SHIP staff is available in the main office to assist you during normal business hours.

Remember that you are serving an important role for hundreds of Hoosiers statewide who call in for help at 1-800-452-4800.

KEEPING UP-TO-DATE

Change – Change – Change! The insurance business and government programs are constantly changing. To add to the complexity, many companies are either going out of business or reforming, leaving thousands of individuals and families with no health insurance coverage. To keep you informed, we will send you updated information in monthly SHIP updates.

Please verify any information that you see or hear through media sources with your Area Manager.

When you receive new information, immediately insert or write it in your manual. New information could be a new list, chart, a new telephone number, new figures, or a new page to be inserted into your manual.

Cross out or throw away old outdated information. Updating materials is extremely important in providing the correct information.

Keep learning. Read the Medicare and You handbook and the Guide to Health Insurance for People with Medicare as well as the various brochures that SHIP has available. Try completing the Long Term Care Insurance Self-Assessment Guide **for yourself**. It's good practice and you may be surprised at what you find out about your own insurance needs.

THANK YOU!! Your willingness to help others is truly appreciated.

SHIP has invested time in training you to be a SHIP Volunteer counselor and your local SHIP site has agreed to have you as one of their volunteers. It is now your turn to use your experience, training, and most of all, your **good judgment** to help those in need.

Remember to look for opportunities to provide SHIP counseling and be of service to your community.

COUNSELING OBLIGATIONS

Never make decisions for your client. Do NOT tell them to buy, not to buy, which company to use, or where to go for medical services. Give them information, review with them viable options, and then let them make the decisions. When asked for an opinion, be careful with your answer. You can simply state," **Only you and/or your caregivers can decide what is best for you."**

Before giving the client an answer or presenting options with them, be sure that **you** understand their situation and that you have all of the facts.

WHEN IN DOUBT, CHECK IT OUT! It is always safe to say up front, "I don't know." Of course you could add that you will get the correct answer for them. You can't be expected to know everything and information changes very quickly.

You have many sources to help you including your **Navigational Guides,** other SHIP counselors, and other counselors at your counseling site, the SHIP state staff, toll-free telephone numbers, and the internet. Many questions can best be answered by the agencies which are going to provide services to your client. **Use their information hotlines.**

Never tell clients that their claims will definitely be resolved. **Nothing is ever definite!** Even after a client has been qualified and is receiving services, there may be changes to their status and benefits.

Before you finish the contact with your client, discuss whether a follow-up is needed. Summarize what you have both accomplished and what steps are next for the client. Be sure to **follow through.**

ALL CLIENT INFORMATION IS CONFIDENTIAL. Everything a client tells you is to be used and shared only with their permission. When you need to contact an agency on the client's behalf, ask the client for permission to discuss their personal information.

If you need to write down a client's Social Security number or Medicare Claim number, **ALWAYS use a black marker to mark out the numbers.** We must be very careful to not let our client's personal information fall into the hands of others.

When giving a public presentation, speaking with the media, with caregivers, or with a client, **speak objectively; never give an opinion.**

When discussing a client's health insurance policy, have the policy in your hands, and use the policy checklist.

REPORTING REQUIREMENTS

SHIP receives a grant from The Centers for Medicare & Medicaid Services (CMS). To justify this funding, we must report to these sources our activities, progress, and accomplishments. The form that you will use to help with our reporting is called the "State Health Insurance Assistance Program (SHIP) Client Contact Form." We commonly call this form the:

CLIENT CONTACT FORM

The Client Contact Form should be used whenever possible with **every type of contact** that you have with a client including:

At SHIP sites	At work	Talking with relatives
Over the telephone	Visiting homebound clients	Visiting clients in facilities
Counseling at presentations	Counseling on the internet	Counseling caregivers

It is important that you complete the Client Contact form accurately and completely even if it was just a quick telephone call. The form is divided into sections including your information, contact information, client information, client's demographics, topics discussed during counseling sessions, and informational materials needed and/or given. **Please print whenever possible-cursive handwriting can be difficult to read.** A separate PUBLIC AND MEDIA EVENTS form (PAM) is used for presentations, health fairs, etc.

Please use the latest edition of the Client Contact Form. If you are not sure that you have a current form, ask your Local Coordinator, your Area Manager, or call the SHIP toll-free number and request that you be sent a supply of forms.

The contact forms **CAN BE ENTERED ONLINE** or are to be given or sent to your Area Manager who reviews them and forwards them to our SHIP state office for data entry. Talk with your Area Manager to determine the schedule for submitting your completed forms.

SHIP VISION

To be the premier health benefit education, counseling, and assistance network in the nation.

SHIP MISSION

To ensure that healthcare consumers have a competent, committed, and compassionate, consumer-focused network of staff and volunteers who provide accurate and objective information through innovative community programs at the state and local levels. We promote fairness and quality and empower consumers by facilitating solutions to individual and systemic health benefits problems.

SHIP STRUCTURE

State staff consists of the State Program Director, Training Director, Clerical Staff, and Counselor Assistance Consultant. State staff is responsible for development, implementation, administration, supervision, and evaluation of the program. Their duties include, but are not limited to:

State Program Director: Supervises all functions of the SHIP program to ensure effective implementation.

Training Director: Creates a standardized curriculum for volunteer and staff training, conducts new counselor trainings, semi-annual update trainings and specialized training sessions as needed, and publishes monthly updates.

Clerical Staff: Operates 800 helpline, gathers statewide data, submit reports to CMS, and mails materials and supplies.

Counselor Assistance Consultant: Assists volunteer counselors with understanding and resolving insurance problems facing their clients.

AREA MANAGERS- Are responsible for the local administration of SHIP. Their duties include, but are not limited to:

- **Volunteer Coordination –** Recruit and retain volunteers, provide orientations, facilitate teambuilding, provide volunteer recognition, and conduct conflict resolution.
- **Counselor Support-** Set up initial and update training, provide technical support and mentoring, review client assessment forms, assist with counselor updates, report changes in counselor status, and utilize volunteers' abilities.
- **Sponsoring Agency Support-** Discuss and address organization's needs and/or concerns, assess organization's compliance with its agreement with the state, recommend plans for program development, act as a resource, coordinate site's educational and promotional materials.
- **Public Education-** Educate the community about SHIP's services, conduct presentations, cover local health fairs and senior expos, and educate the public about senior health insurance rights and options.

SPONSORING ORGANIZATIONS- Agree to sponsor the SHIP program within their agencies. They have agreed to:

- Provide suitable space for training and counseling services and adopt the title of "State Health Insurance Assistance Program."
- Assist with appointing a properly qualified individual, who may be a volunteer, as a Local Coordinator of counseling activities.
- Ensure that the Local Coordinator has submitted Client Assessment Forms filled out by the volunteers on a monthly basis.
- Provide telephone, copying, supplies, postage, and a place to keep records in confidence.
- Monitor the Local Coordinator's activities and have him/her report to the Area Manager on a regular basis to ensure program integrity.
- Assist in local publicity of SHIP services.

LOCAL COORDINATORS- Are responsible for the administrative aspects of their local SHIP site. Their duties include, but are not limited to:

- Assist the Area Manager with volunteer counselor recruitment, advertising, interviewing, scheduling, etc.
- Receive consumer contact during normal working hours and refer the calls to a counselor.
- Investigate opportunities and assist with the distribution of counseling and informational materials on the local level.

VOLUNTEER COUNSELORS- Provide objective, confidential counseling to people with Medicare. Their duties include, but are not limited to:

- Answering questions related to Medicare, Medicare Supplemental Insurance, Medicare Prescription Drug Plans, Medicare Managed Care Plans, Long Term Care Insurance, help with prescription costs, and low-income assistance.
- Make client contacts through face-to-face appointments, local telephone calls, 800 telephone calls, presentations, and other local activities.
- Complete a Client Contact form on each contact.
- Attend semi-annual training events and keep current on update information provided by the State Office.

Section SSMB: Social Security and Medicare Basics

Social Security Overview

Social Security was established when President Franklin D. Roosevelt signed the Social Security Act into law August 14, 1935. The Act created a program to pay retired workers 65 and older a continuing income after retirement. Other provisions included unemployment insurance, old age assistance, aid to dependent children, and grants to states to provide various medical assistance. Over time Social Security has evolved to include benefits to aged spouses, dependents, and the disabled.

The **Social Security Administration (SSA)** handles the eligibility and enrollment functions of Medicare. The local office of the Social Security Administration must be notified of any change in address or other information. The SSA is divided into 10 regional offices. Indiana's regional office is located in Chicago. Contact information for field offices located in Indiana can be found in the SHIP Telephone Directory.

For specific Social Security questions or applicants, contact the local Social Security office, or call **toll-free 1-800-772-1213**. SSA's toll-free number is in operation from 7:00 a.m. to 7:00 p.m. Monday through Friday. There is a touch tone automated system available on the 800 number after hours and on weekends. More information can be found at www.ssa.gov. Most Social Security issues can be handled by phone and/or mail.

Social Security Retirement Benefits

Most people need **40 credits** (10 work years) to qualify for **full** Social Security retirement benefits. Work credits are earned based on a set income requirement per calendar quarter. This income is subject to change annually. In 2012, you will have to earn $1,120 per calendar quarter to earn one work credit. You can earn up to four credits each year.

When you were born will determine when you can expect to retire and receive **full** Social Security benefits. Those born **after** 1937 must be older than 65 to be eligible for **full** retirement benefits.

Full Retirement

How old do you have to be to retire? It depends upon the year of your birth.

Year of Birth	Full Retirement Age
1937 or earlier	65 Years
1938	65 years & 2 months
1939	65 years & 4 months
1940	65 years & 6 months
1941	65 years & 8 months
1942	65 years & 10 months
1943-1954	66 years
1955	66 years & 2 months
1956	66 years & 4 months
1957	66 years & 6 months
1958	66 years & 8 months
1959	66 years & 10 months
1960	67 years

The above chart refers to eligibility for **full** Social Security retirement income benefits. Currently, **Medicare still begins at age 65 (**unless you are disabled).

Your retirement benefits are based on the earned average over your lifetime. SSA will use the adjusted earnings for the 35 years you earned the most to calculate your retirement benefit.

Once you reach you full retirement age you may sign up to receive your full Social Security retirement benefits. You are not required to retire once you reach your full retirement age. You may choose to delay your retirement. By continuing to work, you may increase your Social Security benefits. Each year you work will add an additional year of earning to your work record. Higher lifetime earnings may lead to higher retirement benefits. In addition, by delaying retirement, your retirement will be increased by a certain percentage. These increases, called **delayed retirement credits,** will be added automatically until you retire or reach the age of 70.

Early Retirement

At age 62, you are able to begin collecting Social Security retirement benefits. With **early retirement,** benefits are reduced by 1%-20% of the full benefits that you are able to get at full retirement age. Benefits for early retirees are reduced in order to stretch the benefits out over a longer period of time. Your benefit will not change once you reach full retirement age. You will continue to receive the reduced benefit for the remainder of your lifetime.

Spousal Benefits

If your spouse has never worked, they would be entitled to retirement benefits based on your work record. At full retirement age, your spouse will be eligible for up to one half of your full retirement amount. Your spouse may choose early retirement as early as age 62. If this is the case, their benefit will be permanently reduced based on their age.

Divorced Persons

If you are divorced, you can get benefits on a former husband's or wife's Social Security record:

- If the marriage lasted **at least ten years**.
- **Both you and your divorced spouse must be 62 or older.**
- If the spouse has been divorced at least two years he or she can get benefits even if the worker is not retired. However, the worker must have enough credits to qualify for benefits and be age 62 or older.

- The amount of benefits a divorced spouse receives has no effect on the benefits of a current spouse.

Widow or Widower's Benefits

In order to receive Social Security benefits you would have had to have been married to the deceased at least nine months prior to death. There are a few exceptions if you meet certain criteria. You can choose to receive widow/widower at your full retirement age or choose a reduced amount at age 60. If you are a **disabled widow/widower,** you may receive benefits at age 50.

Generally you cannot get widow/widower's benefits if you remarry prior to the age of 60, but marriage after 60 (or 50 if disabled widow/widower) will have no effect on your eligibility.

Supplemental Security Income (SSI)

You may receive SSI benefits if you are either age 65 or older, blind or disabled, and have limited income and assets. Effective January 1, 2013, the SSI payment to a single individual is $698 and $1,048 for an eligible married couple.

SSI funds come out of the government's general revenues, not from Social Security Income takes. Support received for children and from other sources **will count** toward income and could affect the amount of SSI payment. (*See Navigation Guide for Low Income Assistance and Prescription Assistance.)*

Social Security Disability Benefits

To qualify, you **must have worked five of the last ten years** before becoming disabled (criteria changes if under age 31). In Indiana, eligibility decisions are made by the Disability Determination Section of Vocational Rehabilitation.

Disability

The Social Security Administration defines a disability as:

> *The inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months.*

For a blind worker aged 55 or older, disability is defined as:

> *The inability, due to blindness, to engage in any substantial gainful activity requiring skills comparable with those in any gainful activity in which they were previously engaged with some regularity and over a substantial period of time. Blindness is defined as central visual acuity of 20/200 or less in the better eye with the use of a correcting lens or tunnel vision of 20 degrees or less.*

Medicare as Secondary Payer for Persons Under 65 and Disabled Beneficiaries- Medicare will be the secondary payer for a disabled **employee** under age 65 who is **actively working** and covered under both Medicare and an employer group health plan. Medicare will also be the secondary payer when a **disabled spouse** with Medicare under age 65 is covered under an **actively working spouse's** employer health plan. These rules apply when an employer has 100 or more employees. If fewer then 100 employees, Medicare stays primary.

Checklist for Medicare Beneficiaries Under 65 and Disabled – If a beneficiary is under 65 and disabled, the following options for insurance and assistance **may** be available:

- Medicare
- Medicaid
- Medicare Supplement –there is no open enrollment period for under 65 and disabled. Normal rules will apply at 65.
- Medicare Managed Care Plan
- COBRA
- ICHIA
- Veteran's Administration
- Pharmaceutical Manufacturer's Drug Assistance Program

Under 65 and Disabled

Generally, for individuals under age 65, disability Medicare automatically begins (Part A is free) after a person has been entitled to disability benefits for 24

consecutive months, (the qualifying period), and begins the first day of the 25th month of entitlement to disability benefits. **To qualify for disability benefits an individual must have worked five (5) of the last ten (10) years before becoming disabled.** The process is**:**

1. Social Security determines the disability start date.

2. From the start date, there is a **full five (5) month waiting period** beginning with the **first full month of disability.**
   For example:
   If the disability date (called the **onset date**) is 6-1, the waiting period starts on 6-1, ends 10-31, and disability starts 11-1.

   If the disability date (**onset**) is 6-15, the waiting period starts 7-1, ends 11-30, and disability starts 12-1 (the person must have **five (5) full months** waiting time).

Note- Individuals under age 31 have different guidelines.

AMYOTROPHIC LATERAL SCLEROSIS (ALS) Lou Gehrig's disease

Individuals medically determined to have ALS **will not** have to serve the 24 month qualifying period.

END STAGE RENAL DISEASE (ESRD) Permanent Kidney Failure

Different rules apply – see ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services*** for more information.

DISABILITY RE-ENTITLEMENT

In Disability Re-entitlement cases, months from the previous entitlement disability may be counted in determining when the 24-month qualifying period is met. Examples of other specific cases include:

- Disabled Adult Child (DAC)
- Disabled workers or disabled widow/widower who had a previous entitlement to disability that ended within a certain time period before the current disability started.

Medicare Basics

Medicare is the federal health insurance program for people *65 and older* and for those *under 65 and disabled.* Medicare is administered by the **Centers for Medicare & Medicaid Services (CMS),** formerly known as the Health Care Financing Administration (HCFA). For Medicare claims questions contact Medicare at 1-800-633-4227. Medicare and Medicaid programs were signed into law by President Lyndon Johnson, July 30, 1965 in a ceremony held in Independence, Missouri. President Harry S. Truman was the first beneficiary to enroll in Medicare. The Part B premium was $3 a month.

Medicare Part A – Hospital Insurance
Helps pay for inpatient hospital care, limited coverage in a skilled nursing facility, and full coverage for eligible home health care and hospice care.

Medicare Part B – Medical Insurance
Helps pay for physician's services, outpatient hospital services, durable medical equipment, some home health care, and other services.

The Medicare Card
The Medicare Card shows the following information:

- **Beneficiary's name-** In order to avoid delays in having your Medicare claims paid, always provide your doctor or service provider your name as it appears on your Medicare card.
- **Medicare Claim Number-** (usually the Social Security number with one or two letters). The letters indicate how you qualify for Medicare- on your work record, your spouse's work record, under 65 and disabled, etc. Note: A **Railroad Retiree's Medicare Card** has a prefix instead of a suffix.
  See chart on following page for more information on the beneficiary identification codes.

Beneficiary Identification Codes used in Medicare Claim Numbers

Beneficiary Identification Codes	
A	**Primary Claimant**
B	**Aged wife, age 62 or older**

B1	**Aged husband, age 62 or older**
B6	**Divorced wife, age 62 or older**
BR	**Divorced husband, age 62 or older**
D	**Aged widow, age 60 or older**
D1	**Aged widower, aged 60 or older**
D9	**Remarried widow**
DP	**Remarried widower**
T	**End-stage Renal Disease Beneficiary**
TA	**Medicare qualified government employee**
W	**Disabled widow, age 50 or older**
W1	**Disabled widower, age 50 or older**

Medicare Card (cont'd)

- **Medicare coverage-** Part A, Part B, or both.
- **Date Medicare coverage became effective-** Effective dates of coverage may not be the same for Parts A & B.

Medicare Eligibility

You are eligible for Medicare Part A & B benefits if you meet residency requirements and are either age 65 + or are under age 65 with a disability.

Part A is usually free if you or your spouse earned enough work credits. **Part B does have a monthly premium** which is normally deducted from Social Security checks. For details, contact your local Social Security office.

Government employees

Government employees may have different eligibility criteria to receive Social Security benefits. If you have any questions you should contact your local SSA.

Social Security Disability

A person may be eligible for **premium-free** Medicare Part A if they have been a disabled beneficiary under Social Security Disability or Railroad Retirement Disability for **24 months** or more. You may work and still be disabled. In this case, Medicare could continue for up to 48 months after you begin working and are still considered disabled by Social Security. After 48 months, you can buy Medicare Parts A & B (not B only). Medicare coverage will end if your recover from the disability unless you are 65+.

Lou Gehrig's Disease: Amyotrophic Lateral Sclerosis (ALS) Disease

As of July 1, 2001, There is no longer a 24 month waiting period for Medicare entitlement for individuals whose disability is ALS. Entitlement began either July 1, 2001, or the first month of entitlement to disability benefits, whichever was later. For specific information about ALS, call **1-800-782-4747,** the Amyotrophic Lateral Sclerosis Association Patient Services Hotline.

Kidney Failure (End Stage Renal Disease- ESRD

You will get Medicare Part A free if you are receiving regular kidney dialysis or have received a kidney transplant due to permanent kidney failure. Medicare ends 12 months after dialysis treatment stops or 36 months after a kidney transplant. (For more information wee ***Medicare Coverage of Kidney Dialysis and Kidney Transplant Services.)***

What would happen when Social Security denies eligibility for Medicare?

The Social Security Administration will write you a letter informing you that you are **not** eligible to receive Medicare benefits.

- You should appeal at the local Social Security office and find out what information you will need to proceed with the appeal process.
- You will need to provide evidence proving that you meet the Medicare Eligibility requirements.

Buying Medicare

At age 65 (and meeting all of the requirements), you can enroll in Parts A & B

unless you notify Medicare that you want to delay enrollment. If you are 65+ and have not earned 40 work credits, you are not eligible to receive Part A **premium-free.** However, you may **buy** Medicare Part A and Part B. You must be a United States citizen or an alien lawfully admitted for permanent residence and have lived in the U.S. for **five consecutive years** before applying for Medicare.

- **Buying Part A.** You **must also buy Part B** (persons 65+ may not buy Medicare Part A only) If you decide to cancel Part B, Part A will be lost. You may have just Part B.
- **Buying Part B.** If you **delay enrollment** in Part B, the monthly **premium may increase by 10% for each 12 month period** that you could have had Part B. With a few exceptions, (an example is if you continue working and are covered by a company plan) this extra amount will continue for as long as you have Part B.

For more information about buying Medicare, call the Social Security Administration at **1-800-772-1213**.

Medicare Enrollment

Four Types of Enrollment

1. automatic
2. initial
3. general
4. special

Automatic Enrollment

If you are already receiving Social Security benefits and meet one of the following criteria, you are **automatically** enrolled in Medicare Parts A & B (Part B can be refused by contacting a Social Security Office).

- **Age 65** and already receiving Social Security **Retirement** benefits. A Medicare card will be sent approximately three months prior to your 65th birthday.

- **Under age 65** and receiving Social Security **Disability** benefits. A Medicare card will be sent approximately 24 months from the determined disability date, which may include an additional five month waiting period.
- **A Widow or Widower** receiving Social Security **Widow or Widower's** benefits prior to age 65. A Medicare card will be sent approximately three months prior to your 65th birthday.

If you are automatically enrolled Medicare, you will receive a Medicare card approximately three months prior to the date Medicare is scheduled to begin. You will be enrolled in both Parts A & B. You can refuse Part B by contacting your local Social Security office.

Initial Enrollment

An **Individual must initiate** this process **and has a seven month enrollment period** to sign up for Medicare**.** This enrollment period begins three months **before** the 65th birthday month and ends three months **after** the 65th birthday month.

If the birthday is on the first of the month, the previous month is considered to be the birthday month.

The date of a person's initial enrollment determines the effective date of Medicare Coverage.

If the Beneficiary enrolls	Then Medicare coverage begins
During the three months prior to the 65th birthday	The 1st day of the month of the 65th birthday
The month of the 65th birthday	The 1st day of the month following the month of the birthday
The month after month of the birthday	Up to two months after the month of enrollment
During the two to three months after the month of the 65th birthday	Up to three months after the month of enrollment

General Enrollment

If you fail to enroll in Medicare Part B during the time of the initial enrollment period, you must wait for a general enrollment period to sign up. Reinstating a cancelled Part B must be done during a General Enrollment Period.

A Medicare General Enrollment Period is held every year from: January 1- March 31

When you enroll during the General Enrollment Period, Medicare **coverage begins July 1** of that year. You **may be charged a premium penalty for late enrollment** unless you qualify for a special enrollment period. (See #4, Special Enrollment Period)

It is a good idea to get Part A at age 65. It is usually free.

You may decline Part B without penalty if you are **actively working** and covered under an employer group health or covered under the **current** employment of a spouse or another family member. This also applies if you must buy Part A.

If you **enroll late for Medicare Part B** (again, you must enroll during a General Enrollment Period – unless you qualify for a Special Enrollment Period), **a 10% surcharge may be charged** on the Part B premium for **each year** after you were eligible to sign up during the Initial Enrollment Period. The Part B 10% penalty surcharge will be the same every year, so the dollar amount increases when Medicare Part B premiums increase. This penalty will continue as long as you have Part B.

If you are **under 65, disabled, and do not take Medicare**, you will not lose the Social Security Disability benefit.

Special Enrollment

The Special Enrollment Period for Medicare lasts eight months. This includes the month in which you retire.

You may enroll in Part B anytime while still working or just prior to retiring. (This also applies to Part A if you must buy Part A.) A Medicare Special Enrollment

Period begins the month the group health insurance ends. If you take Medicare Part A and have group health insurance, Medicare will be the secondary payer until the group health insurance ends unless you are disabled.

Disabled Special Enrollment Period

If you are disabled, you also have a Medicare Special Enrollment Period due to discontinuation of health insurance through your own or a spouse's employer or due to retirement. You would also have a Special Enrollment Period if your group health insurance plan is no longer classified as a large group health insurance plan of 100+ employees.

Options if you are not eligible for Medicare

If you retire before age 65 and do not qualify for Medicare, you may have difficulty finding individual medical insurance coverage.

Options may include:

- Medicaid
- A parent who is a legal dependent of an employed person may be eligible through an employee health plan.
- Hospital or specific indemnity insurance plans.
- Veteran's benefits for services related to a disability or condition
- Group travel Insurance
- Memberships in organizations that sponsor group health insurance plans
- Enrollment in a college or school that provides group health insurance.
- Conversion of prior group coverage to individual coverage
- Retiree Insurance plans
- Healthy Indiana Plan
- Special clinics
- Enrollment in a state high risk pool, such as the Indiana Comprehensive Health Insurance Association (ICHIA) (See: *Navigation Guide Section on Supplemental and Other Insurance.)*

For more information on Medicare eligibility and enrollment, see *The Medicare and You Handbook.* Consumers may obtain this by calling either:

State Health Insurance Assistance Program at 1-800-452-4800
Social Security Administration at 1-800-772-1213.

Section A: Medicare Part A

2013 Medicare Part A Covered Services and Copayments

Hospitalization	Benefit	Medicare Pays	You Pay
Semi-private room & board, general nursing & other hospital services and supplies. Medicare payments are based on benefit periods.	First 60 days	All but $1,184 deductible per benefit period	$1,184 deductible per benefit period
	Days 61-90	All but $296 per day	$296 per day
	Days 91-150	All but $592 per day	$5928 per day
	Days 151 +	Nothing	All costs
Skilled Nursing Facility	Benefit	Medicare Pays	You Pay
Semi-private room & board, general nursing, skilled nursing, rehabilitative services, other services & supplies. Medicare payments are based on benefit periods.	First 20 days	100% Medicare Approved Amount	Nothing
	Next 80 days	All but $148 per day	Up to $148 per day
	Beyond 100 days	Nothing	All costs.

Home Health Care	Benefit	Medicare Pays	You Pay
Part-time or intermittent skilled care, home health aide services, durable medical equipment & supplies and other services.	Unlimited as long as you meet Medicare conditions.	100% Medicare Approved Amount for most services 80% Medicare Approved Amount for Durable Medical Equipment	Nothing 20% Medicare Approved Amount for Durable Medical Equipment
Hospice Care	**Benefit**	**Medicare Pays**	**You Pay**
Pain relief, symptom management, support services for the terminally ill.	Unlimited as long as doctor certifies the need.	All but limited co-pay for outpatient drugs and inpatient respite care	Up to $5 per prescription of outpatient drugs to manage pain & symptoms; 5% for inpatient respite care
Blood	**Benefit**	**Medicare Pays**	**You Pay**
	Unlimited if medically necessary.	All but first 3 pints of blood per calendar year	For the first 3 pints of blood, if not replaced

2013 Medicare Part A Coverage and Premiums

2013 Part A Premiums

If you worked 40 or more quarters – Free

If you worked 30-39 quarters - $248 per month

If you worked up to 30 quarters - $441 per month

Deductibles & Co-Payments

- **Hospitalization**
    - Deductible - $1,184 per benefit period
    - Co-Payment for days 61-90 - $296 per day
    - Co-Payment for lifetime reserve days - $592 per day
    - Co-Payment for days 91-150 - $592 per day
    - All costs for days beyond 150

- **Skilled Nursing Facility**
    - Medicare pays 100% for days 1-20
    - Co-Payment for days 21-100 - $148 per day
    - All costs for days beyond 100

- **Blood**
    - In most cases, the hospital gets blood from a blood bank at no charge, and you will not have to pay for nor replace the blood. If the hospital has to buy blood, you must either pay the hospital costs for the first 3 units of blood in the calendar year, or have the blood donated.

Medicare Part A

- Medicare Part A is often referred to as hospital insurance. When all requirements are met Part A helps pay for:
    - **Inpatient hospital care** – including critical access hospitals;
    - Limited coverage in a **skilled nursing facility** – but not custodial or long term care;
    - Full coverage for eligible **home health care**; and
    - Full coverage for eligible **hospice care**.

Part A is usually free, if you or your spouse has worked enough quarters to earn 40 work credits. About 99% of Medicare beneficiaries do not have to pay a premium for Part A.

Buying Part A

If you are 65 or older and have not earned 40 work credits, you are not eligible to receive Part A premium free; however, you may buy Medicare Part A. In order to do so, you must be:

- A United States citizen, or
- An alien lawfully admitted for permanent residence and have lived in the U.S. for 5 consecutive years before applying for Medicare.

When buying Part A, you must also buy Part B (individuals 65 or older may not buy Medicare Part A only). If you decide to cancel Part B, your Part A will be lost.

If you do not buy Part A when you are first eligible, you may have to pay a late-enrollment penalty equal to 10% of the Part A premium. You will have to pay the penalty for twice the number of years you could have had Part A, but did not sign up. For example, if you delay enrollment for 2 years, you must pay the 10% penalty for 4 years.

If you are not sure if you have Part A, check your Medicare card. If you have Part A, you will find "HOSPITAL (PART A)" along with the effective date printed on your card.

Inpatient Hospital Benefit

Medicare Part A helps pay for inpatient hospital care when all of the following conditions are met:

- A physician prescribes inpatient treatment of an illness or injury.
- The kind of care required can be provided only in a hospital.
- The hospital participates in Medicare.
- The hospital's Utilization Review Committee, the Quality Improvement Organization (in Indiana, Health Care Excel) or the Medicare Intermediary does not disapprove of the stay.

Hospital Benefit Period

Medicare coverage of hospital care is measures in benefit periods, not based on the calendar year. A hospital benefit period begins the first day that you receive Medicare covered inpatient hospital services, and continues until you have been out of the hospital or skilled nursing facility for 60 consecutive days.

The benefit period could continue if you are transferred from the hospital to another facility that provides skilled nursing or rehabilitation services. The benefit period ends when you have been out of the facility or have not received skilled care in a facility for 60 consecutive days.

A new hospital benefit period begins when inpatient hospital services are again required after 60 consecutive days have passed since you left the hospital or skilled care facility. You can experience more than one hospitalization during a benefit period, even for a different condition, without a new deductible.

You can have more than one benefit period during a year, if the hospitalizations are more than 60 days apart from discharge (from hospital or skilled care facility) to admittance. You may have an unlimited number of benefit periods during your lifetime – benefit periods are renewable. You must pay the Part A deductible each time a new benefit period begins.

Hospital Deductible for Medicare Part A

The Part A deductible is the full amount you will pay for Medicare covered services during the first 60 days of inpatient hospital care. Only one deductible per benefit period may be charged by the hospital.

Services Covered by Medicare Part A During a Hospital Stay

- Semi-private room and board, including meals for special diets.
    - A private room will be paid for only if it is medically necessary, or if the hospital only has private rooms.
    - Normally, telephones and televisions are not covered if listed separately from the room charge.
- Special care units, such as intensive care or coronary care units.
- Regular nursing services, but not private duty nursing.
- Drugs furnished by the hospital during the inpatient stay.

- Lab tests included in the hospital bill
    - May include diagnostic tests provided up to 72 hours prior to admission, if the tests are related to the reason for admission.
- Radiology services included in the hospital bill, such as x-rays or radiation therapy.
- Medical supplies such as casts, splints and surgical dressings.
- Operating and recovery room costs.
- Use of medical appliances such as wheelchairs.
- Rehabilitation services such as physical therapy, occupational therapy, and speech pathology services.
- Blood transfusions during a hospital stay, after the first three pints per calendar year.
    - Unless the hospital can get the blood from the blood bank free of charge, you must either pay for the first 3 pints of blood, have a donor replace them, or build a reserve prior to the need.

Doctor services received in the hospital are covered by Medicare Part B.

Medicare Part A Payment for Days 61-150 in a Hospital

During the 61st-150th days of hospitalization, Medicare pays all covered hospital costs except for a daily charge, called a co-payment. The hospital will bill the co-payment to you, or to your other insurance. Your daily co-payment for days 91-150 is higher than it is for days 61-90.

Lifetime Reserve Days

If hospitalization extends beyond 150 days, you will be charged for the hospital stay. You may pay the charges, or elect to use your Lifetime Reserve Days to have Medicare assist with the payment.

With Medicare you have 60 extra inpatient hospital days, called Lifetime Reserve Days. These can be used only once in a lifetime, and only after you have used 90 inpatient hospital days. The hospital stay must still be Medicare approved, and the Lifetime Reserve Days include a daily co-payment. This co-payment is the same as the co-payment for days 91-150.

- Lifetime Reserve Days are not renewable. The use of these days can be spread out over several benefit periods, but they can only be used once.
- You decide when to use the reserve days and how many to use within a given benefit period.
- Unless the hospital is notified in writing either upon admission, or up to 90 days after discharge, the hospital will assume that you want to use reserve days. You can have this decision reversed by contacting the hospital.

Care in a Psychiatric Hospital

Psychiatric care in a general hospital is treated the same as any other Medicare inpatient hospital care. Psychiatric care in a freestanding psychiatric hospital is subject to a lifetime limit.

Medicare Part A pays for no more than 190 days of inpatient care in a freestanding, Medicare participating, hospital in a lifetime. Lifetime Reserve Days can be used for care received in a freestanding psychiatric hospital after Medicare has paid for 90 days of care in a benefit period.

Care in a Christian Science Sanitarium

Medicare pays for inpatient care received in a participating Christian Science sanitarium if it is operated or listed and certified by the First Church of Christ Scientist, in Boston, Massachusetts. Part B will not pay for the practitioner.

How Medicare Pays Hospitals

Medicare reimbursement to hospitals is determined through the Prospective Payment System (PPS). Hospitals are paid by the diagnosis, not by the length of the hospital stay. Payments are based on the average costs for treating a particular illness or injury. The various illness categories are called Diagnosis Related Groups (DRGs).

In special cases where costs for necessary care are unusually high or the length of stay is unusually long, Medicare may make extra payments to the hospital. Discharge form a hospital occurs when the Diagnosis Related Group payment is exhausted or when your condition stabilizes and other means of treatment are available.

You are only responsible for the Part A deductible, the daily co-payment (days 61-150) and the cost of any non-covered services. You have the right to appeal

a hospital's and/or Medicare's decision to deny coverage for inpatient hospital stays.

Important Message from Medicare is given to Medicare beneficiaries upon admission to the hospital. This document lists your rights as a hospital patient. Your rights include the right to receive the necessary Medicare covered hospital services, the right to know about decisions concerning your hospital stay, as well as information about discharge and appeal rights. This document can be found online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/downloads//CMSR193.pdf .

IMPORTANT MESSAGE FROM MEDICARE

YOUR RIGHTS AS A HOSPITAL PATIENT

- You have the right to receive necessary hospital services covered by Medicare, or covered by your Medicare Health Plan ("your Plan") if you are a Plan enrollee.
- You have the right to know about any decisions that the hospital, your doctor, your Plan, or anyone else makes about your hospital stay and who will pay for it.
- Your doctor, your Plan, or the hospital should arrange for services you will need after you leave the hospital. Medicare or your Plan may cover some care in your home (home health care) and other kinds of care, if ordered by your doctor or by your Plan. You have a right to know about these services, who will pay for them, and where you can get them. If you have any questions, talk to your doctor or Plan, or talk to other hospital personnel.

YOUR HOSPITAL DISCHARGE & MEDICARE APPEAL RIGHTS

Date of Discharge: When your doctor or Plan determines that you can be discharged from the hospital, you will be advised of your planned date of discharge. You may appeal if you think that you are being asked to leave the hospital too soon. If you stay in the hospital after your planned date of discharge, it is likely that your charges for additional days in the hospital will not be covered by Medicare or your Plan.

Your Right to an Immediate Appeal without Financial Risk: When you are advised of your planned date of discharge, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your Quality Improvement Organization (also known as a QIO). The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You may call Medicare toll-free, 24 hours a day, at 1-800-MEDICARE (1-800-633-4227), or TTY/TTD: 1-877-486-2048, for more information on asking your QIO for a second opinion. If you appeal to the QIO by noon of the day after you receive a non-coverage notice, you are not responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with you. The QIO will decide within one day after it receives the necessary information.

Other Appeal Rights: If you miss the deadline for filing an immediate appeal, you may still request a review by the QIO (or by your Plan, if you are a Plan enrollee) before you leave the hospital. However, you will have to pay for the costs of your additional days in the hospital if the QIO (or your Plan) denies your appeal. You may file for this review at the address or telephone number of the QIO (or of your Plan).

OMB Approval No. 0938-0692. Form No. CMS-R-193 (January 2003)

Foreign Travel and Medicare

In most situations, Medicare will not pay for health care or supplies you receive outside of the United States. The term “outside of the United States” means anywhere other than the 50 states of the US; Washington D.C.; and the territories of Puerto Rico, The US Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

However, there are three situations when Medicare may help pay for certain types of health services received in a foreign hospital:

1. You are in the US when they have a medical emergency, and the foreign hospital is closer than the nearest US hospital that can treat your illness or injury.
2. You are traveling through Canada, without unreasonable delay, by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest US hospital that can treat the illness or injury. Medicare determines what qualifies as "without unreasonable delay" on a case-by-case basis.
3. You live in the US and the foreign hospital is closer to your home than the nearest US hospital that can treat your medical condition, regardless of whether it is an emergency.

In these situations, Medicare will help pay for only the Medicare-covered services received in the foreign hospital. Medicare will cover the following services:

- Part A covers inpatient hospital care – care you receive when you have been formally admitted, with a doctor's order, to the foreign hospital as an inpatient.
- Part B covers emergency ambulance and doctors services you receive immediately before and during the covered inpatient stay.
- Part B covers non-emergency doctor and ambulance services that you receive immediately before and during the covered inpatient stay.
- NOTE: If Medicare doesn't cover the Part A inpatient hospital stay, Medicare generally will not pay for the services covered under Part B.

If your situation matches one of the exceptions listed above, and Medicare covers the items or services, you will still pay the coinsurance/copayments and deductibles you would normally pay if the services or supplies were received inside the United States. If the situation does not match the exceptions listed above, you would be responsible for the full cost to the health care provider.

Unlike US hospitals, foreign hospitals are not required to file Medicare claims. If the foreign hospital does not submit a claim to Medicare for you, then you must submit an itemized bill to Medicare for the doctor, inpatient and ambulance services. For information on how to complete and where to send a foreign claim, you can visit http://www.medicare.gov/MedicareOnlineForms/ , and select the form "Patient's Request for Medical Payment" (CMS 1490S).

End-Stage Renal Disease and Medicare Hospital Coverage

If you are entitled to Medicare based on End-Stage Renal Disease (ESRD), you are entitles to all Medicare Part A and Part B services covered under Original Medicare. There are also Medicare covered services for transplant patients. Although Medicare covers medically necessary hospitalizations for ESRD patients, those who are undergoing a kidney transplant have special coverage.

Medicare Part A covers inpatient hospital services for a kidney transplant and/or preparation for a transplant. The hospital must be a Medicare approved transplant center. Medicare covers both living and cadaver donors. The full cost of care for the kidney donor in the hospital is covered, including any care necessary due to complications.

Skilled Nursing Care Benefit

Medicare Part A may help pay for Skilled Nursing Facility (SNF) Care. Your condition must require skilled nursing or skilled rehabilitation services. This skilled must be performed by or under the supervision of licensed nursing personnel and/or under the supervision of a professional therapist.

This does not include custodial or long-term care. Medicare does not cover custodial care if it is the only kind of care you need. Custodial care is care that helps you with usual daily activities, like getting in and out if bed, eating, bathing, dressing and using the bathroom. It may also include care that most people do themselves, like using eye drops, oxygen and taking care of a colostomy or bladder catheters. Custodial care is often given in a nursing facility. Generally, skilled care is available only for a short time after a hospitalization. Custodial care may be needed for a much longer period of time.

Medicare Requirements for Skilled Nursing Facility Care

To qualify for Skilled Nursing Facility coverage under Medicare Part A the following requirements must be met:

- You must be admitted to a Medicare participating skilled nursing facility, to a Medicare designated bed.
- Your condition requires skilled nursing or skilled rehabilitation services on a daily basis in a skilled nursing facility, and a medical professional has certified that you need to receive this care.
- You must have spent at least three (3) days in the hospital, not counting the day of discharge.

    - Note: time spent in observation status or in the emergency room, prior to (or in lieu of) being admitted to the hospital as inpatient, does not count toward the 3 day hospital stay requirement.
- Admission to the skilled nursing facility must occur within 30 days after leaving the hospital.
- Care in the skilled nursing facility is for a condition that was treated in the hospital or for a condition that arose while receiving care in the skilled nursing facility.
- The Medicare Intermediary does not disapprove of the stay.

Skilled Nursing Facility Benefit Period

Medicare Part A helps pay for a maximum of 100 days in a skilled nursing facility in each benefit period. A benefit period begins the first day that you are transferred from a hospital to the skilled nursing facility. If you are discharged from the skilled nursing facility before using the 100 days and are readmitted within 60 days, the same benefit period will continue. You will pick up where you left off – for example, if you left the skilled nursing facility after using 45 days and return to the facility within 25 days, your first day of readmission will be day 46 in your benefit period. A new benefit period will start only after you have been out of the skilled nursing facility or hospital for over 60 consecutive days.

A new three day prior hospital stay would only be required when you have not received skilled care in a hospital or skilled nursing facility for 31 days or more - even though you are in the same benefit period. If the new three-day hospital stay occurs within the same benefit period, you will not have to pay the Part A deductible again. A new 3 day hospital stay would also be required if Medicare has paid for 100 days in a benefit period.

Services Covered by Medicare Part A Skilled Nursing Facility Care

- Semi-private room and board, including special diets and dietary counseling. Private room if medically necessary.
- Regular nursing services, not private duty nurses.
- Doctor ordered physical, occupational and speech therapy, if it is needed to meet your health goal.
- Medications furnished by the skilled nursing facility during the stay.

- Use of medical equipment and supplies furnished by the skilled nursing facility including wheelchairs, splints, casts, etc.
- Medical social services.

Home Health Benefit

If you need skilled health care at home for treatment of an illness or injury, Medicare pays 100% for all covered Home Health Care services – except for durable medical equipment. Medicare pays 80% of the Medicare approved amount for durable medical equipment received from providers that accept Medicare assignment. Accepting Medicare assignment means the provider will accept the Medicare approved amount as the full payment for the equipment, regardless of the amount billed. If the provider does not accept assignment, you will be responsible for whatever the durable medical equipment provider charges over and above the Medicare approved amount, in addition to the 20% coinsurance.

Coverage for home health care services is usually covered under Medicare Part A; however, there are some situations that Medicare Part B will pay for home health care services. These situations are as follows:

- Medicare Part A will usually pay for home health care services for up to 100 visits after a 3 day hospital stay. After you exhaust 100 visits covered by Part A, Part B covers the balance of the home health care services.
    - There is no 100 day limit for Part A if you are enrolled in Part A only.
- If you have not had a prior 3 days hospital stay Medicare Part B will pay for your home health care services.
- If you are enrolled in Part B only and qualify for home health care services, Part B will pay for the services.
    - There is no 100 day limit for Part B coverage.
- The Medicare Part B deductible does not apply in these cases.

Home health care agencies should do a free evaluation to see if you qualify for Medicare home health care coverage. Your doctor should refer you to a Medicare participating home health care agency, or can contact your local Area Agency on Aging, call Medicare 1-800-633-4227 or visit http://www.medicare.gov and use the Home Health Compare tool.

Medicare Requirements for Home Health Care Coverage

In order to receive Medicare home health care coverage, you must meet the following requirements:

- Your doctor determines the need and sets up a plan for home health care. Per the Affordable Care Act, prior to certifying your eligibility for the Medicare home health benefit, your doctor must document that either the doctor or a non-physician practitioner has had a face-to-face encounter with you.
- The agency providing home health care services must be Medicare participating and provide skilled nursing care.
- You must be homebound, but not necessarily bed ridden.
    - Homebound means that you are normally unable to leave home or that leaving home is a major effort.
    - Leaving your home is not recommended because of your condition.
    - Your condition keeps you from leaving home without help – such as using a wheelchair or walker, needing special transportation, or getting help from another person.
    - When you leave home, it must be infrequent, for a short time, to get medical care (may receive medical care from adult day care) or attend a religious service. You can ask the home health care agency where you can go.
- You must need skilled care (on a part-time or intermittent basis) or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy.
    - Medicare defines part-time or intermittent as skilled nursing care that's needed or given on fewer than 7 days each week, or less than 8 hours each day over a period of 21 days (or less) with some exceptions in special circumstances.
    - Hour and day limits may be extended in exceptional circumstances when your doctor can predict when your need for care will end.
- No prior hospitalization is required to receive covered home health care services.

Services Covered during Home Health Care Visits

If you are eligible for Medicare-covered home health care, Medicare covers the following services if they are reasonable and necessary for the treatment of your illness or injury:

- **Skilled nursing care** – Skilled nursing services are covered when they are given on a part-time or intermittent basis. Skilled nursing services are given by either a registered nurse (RN) or a licensed practical nurse (LPN). If you get services from a LPN, your care will be supervised by a RN. Home health nurses provide direct care and teach you and your caregivers about your care. Examples of skilled nursing care include:
    - Giving IV drugs, shots or tube feedings
    - Changing dressings, wound care
    - Teaching about prescription drugs or diabetic care.
    - Any service that could be done safely by non-medical person, or by you, without the supervision of a nurse is not skilled nursing care.
    - Home health side services may be covered when given on a part-time basis if needed as support services for skilled nursing care. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care, or other physical therapy, occupational therapy, or speech-language pathology services form the home health agency.

- **Physical therapy, occupational therapy, and speech-language pathology services** – Medicare uses the following criteria to assess whether these therapy services are reasonable and necessary in the home setting:
    - The therapy services must be a specific, safe and effective treatment for your condition.
    - The therapy services must be complex or your condition must require services that can safely and effectively be performed only by qualified therapist.
    - One of the three following conditions must exist:

    - It is expected that your condition will improve in a reasonable and generally-predictable period of time.
    - Your condition requires a skilled therapist to safely and effectively establish a maintenance program.
    - Your condition requires a skilled therapist to safely and effectively preform maintenance therapy.

- **Medical social services** – these services are covered when given under the direction of a doctor to help you with social and emotional concerns related to your illness. This might include counseling to help finding resources in your community.
- **Medical supplies** – supplies, like wound dressings are covered when they are ordered as part of your care.
- **Durable medical equipment** – Medicare will help cover durable medical equipment when it is ordered by your doctor. If your home health agency does not supply durable medical equipment directly, the home health agency staff will usually arrange for a home equipment supplier to bring the items you need to your home.

Before your home health care begins, the home health agency should tell you how much of your bill Medicare will pay. The agency should also tell you if any items or services they give you are not covered by Medicare and how much you will have to pay for them. This should be explained by both talking with you and in writing.

The home health agency is responsible for meeting all of your medical, nursing, rehabilitative, social, and discharge planning needs, as reflected in your home health plan of care. This includes skilled therapy services for a condition that may not be the primary reason for getting home health services. Home health agencies are required to perform a comprehensive assessment of each of your care needs when you are admitted to the home health care agency and communicate those needs to the doctor responsible for the plan of care. After that, home health agencies are required to routinely assess your needs.

Services Not Covered During Home Health Care Visits

Below are some examples of what Medicare does not pay for:

- 24-hour-a-day care at home.

- Meals delivered to your home.
- Homemaker services like shopping, cleaning and laundry when this is the only care you need, and when these services are not related to your plan of care.
- Personal care given by home health aides like bathing, dressing and using the bathroom when this is the only care you need.
- Services provided by your relative or a member of your household.

Your Rights as a Person with Medicare

In general, as a person with Medicare getting home health care from a Medicare-certified home health agency, you are guaranteed certain rights, including the following:

- To get a written notice of your rights before your care starts
- To have your home and property treated with respect
- To be told, in advance, what care you will be getting and when your plan of care is going to change
- To participate in your care planning and treatment
- To get written information about your privacy rights and your appeal rights
- To have your personal information kept private
- To get written and verbal information about how much Medicare is expected to pay and how much you will have to pay for any services that you will be getting
- To make complaints about your care and have the home health agency follow up on them
- To know the phone number of the Home-Health Complaint Hotline and the Quality Improvement Organization where you can call with complaints or questions about your care
    - In Indiana, Home-Health Complaint Hotline 1-800-227-6334; Quality Improvement Organization - Health Care Excel 1-800-288-1499, website http://www.hce.org

Hospice Care Benefit

Hospice care is care that focuses on patient comfort and quality of life rather than curing the illness. The goal of hospice care is to provide pain relief and symptom management to terminally ill patients; as well as supportive services to the patients and their families. The Medicare Hospice Benefit was added in 1982.

Medicare Requirements for Hospice Care

In order to receive Medicare hospice benefits you must meet all of the following conditions:

- You are eligible for Medicare Part A.
- Your doctor and the hospice medical director certify that you are terminally ill and have less than 6 months or less to live if your illness runs its normal course.
- You sign a statement choosing hospice care instead of other Medicare-covered benefits to treat your terminal illness.
    - Medicare will still pay for covered benefits for any health problems that aren't related to your terminal illness.
- You get care from a Medicare approved hospice program.

How Hospice Works

If you qualify for hospice care, you will have a specially trained team and support staff available to help you and your family cope with your illness. You and your family are the most important part of the team; your team may also include some or all of the following: doctors, nurses, counselors, social workers, therapists, hospice aides, homemakers, and volunteers.

A hospice doctor is part of your medical team. Your regular doctor or a nurse practitioner can also be part of this team as the attending medical professional to supervise your care. However, only your regular, not a nurse practitioner, and the hospice medical director can certify that you are terminally ill and have six months or less to live. The hospice benefit allows you and your family to stay together in the comfort of your home unless you need care in an inpatient facility.

If the hospice team determines that you need inpatient care, the hospice team will make the arrangements for your stay.

Services Covered Under Hospice

Medicare covers the following hospice services when they are needed to care for your terminal illness and related conditions:

- **Doctor services**
- **Nursing care**
- **Medical equipment** – such as wheelchairs or walkers
- **Medical supplies** – such as bandages and catheters
- **Prescription drugs for symptom control or pain relief** – small copayment
- **Hospice aide and homemaker services**
- **Physical and occupational therapy**
- **Speech-language pathology services**
- **Social worker services**
- **Dietary counseling**
- **Grief and loss counseling for you and your family**
    - Grief counseling for family can be provided up to 1 year following the patient's death.
- **Short term inpatient care** – for pain and symptom management
- **Short term respite care** – small coinsurance
- You can get inpatient respite care in a Medicare –approved facility (such as hospice inpatient facility, hospital, or nursing home) if your usual caregiver needs a rest.
- You can stay up to 5 days each time you get respite care; you can get respite care more than once, but it can only be provided on an occasional basis.

It is important to remember that Medicare will still pay for covered benefits for any health problems that are not related to your terminal illness, such as care for an injury. In this case you will pay the normal Medicare deductibles, copayments, and coinsurance.

What Medicare Will Not Cover

When you choose hospice care, you have decided that you no longer want care to cure your terminal illness and/or your doctor has determined that efforts to cure your illness are not working. Medicare will not cover any of the following once you choose hospice care:

- **Treatment intended to cure your terminal illness** – talk with your doctor if you are thinking about getting treatment to cure your illness. As a hospice patient, you always have the right to stop hospice care at any time.
- **Prescription drugs to cure your illness** – rather than for symptom control and/or pain relief.
- **Care from any hospice provider that was not set up by your hospice medical team.**
    - You must get hospice care from the hospice provider you chose. All care that you get for your terminal illness must be given by or arranged by the hospice team. You cannot get the same type of hospice care from a different provider, unless you change your hospice provider. However, you can still see your regular doctor who you have chosen to be your attending medical professional who helps supervise your hospice care.
- **Room and board**
    - Medicare does not cover room and board if you get hospice care in your home or if you live in a nursing home or a hospice inpatient facility. However, if the hospice team determines that you need short-term inpatient or respite care services that they arrange, Medicare will cover your stay in the facility. You may have to pay a small copayment for the respite stay.
- **Care received from family or member of your household**.
- **Care in an emergency room, inpatient facility care, or ambulance transportation** - unless it is either arranged by your hospice team or is unrelated to your terminal illness.

Contact your hospice team, before you get any of these services or you might have to pay the entire cost.

What You Pay for Hospice Care

Medicare pays the hospice provider 100% for most covered hospice services. There is no deductible to meet. You will have to pay for the following:

- No more than $5 for each prescription drug and other similar products for pain relief and symptom management.
- 5% of the Medicare-approved amount for inpatient respite care. For example, if Medicare pays $150 per day for inpatient respite care, you will pay $7.50 per day. The amount you pay for respite care can change each year.

If you have Original Medicare, you might also have a Medigap policy. Your Medigap policy may cover your hospice costs for drugs and respite care and still helps cover health care costs for problems that are not related to your terminal illness. Contact your Medigap insurance company for more information.

Hospice and Medicare Health Plans

All Medicare covered services you get while in hospice care are covered under Original Medicare, even if you are enrolled in a Medicare Advantage Plan or other Medicare Health Plan. That includes any Medicare covered services for conditions unrelated to your terminal illness or provided by your attending doctor. If your plan covers extra services not covered by Original Medicare (like dental or vision benefits), you plan will continue to cover these extra services.

Hospice Benefit Periods

Hospice care is intended for people with 6 months or less to live if the disease runs its normal course. If you live longer than 6 months, you can still get hospice care, as long as the hospice medical director or other doctor recertifies that you are terminally ill.

Hospice care is given in benefit periods. You can get hospice care for two 90-day periods followed by an unlimited number of 60-day periods. At the start of each benefit period, the hospice medical director or other hospice doctor must recertify that you are terminally ill, so you continue to get hospice care. A benefit period starts the day you begin to get hospice care and it ends when your 90-day or 60-day period ends.

Stopping Hospice Care

If your health improves or your illness goes into remission, you no longer need hospice care. Also, you always have the right to stop hospice care at any time for any reason. If you stop your hospice care, you will get the type of Medicare coverage you had before you chose a hospice program. If you are eligible, you can go back to hospice care at any time.

Your Medicare Rights

As a Medicare beneficiary, you have certain guaranteed rights. If your hospice program or doctor believes that you are no longer eligible for hospice care because your condition has improves and you do not agree, you have the right to ask for a review of your case. Your hospice should give you a notice that explains your rights to an expedited review by an independent reviewer contracted by Medicare, called a Quality Improvement Organization. If you do not get this notice, ask for one.

You have the right to change providers only once during each benefit period. You can het hospice care for two 90-day periods followed by an unlimited number of 60-day periods.

Section B: Medicare Part B

2013 MEDICARE PART B COVERED SERVICES AND COPAYMENTS

Doctor's Services	Benefit	Medicare Pays	You Pay
Services that are medically necessary, including outpatient and some doctor services you get when you are a hospital inpatient; some preventive services.	Unlimited if medically necessary	80% of the Medicare approved amount, after the Part B deductible; 60% for most outpatient mental health services	After $147 deductible, 20% of the Medicare approved amount plus any excess charge; 40% for most outpatient mental health services plus any excess charge
Clinical Laboratory Services	**Benefit**	**Medicare Pays**	**You Pay**
Semi-private room & board, general nursing, skilled nursing, rehabilitative services, other services & supplies. Medicare payments are based on benefit periods.	Unlimited if medically necessary	100% Medicare Approved Amount, if the lab accepts Medicare assignment.	Nothing, after annual Part B deductible
		80% Medicare Approved Amount, if the lab accepts Medicare assignment.	After deductible, 20% of the Medicare approved amount plus any excess charge

Home Health Care	**Benefit**	**Medicare Pays**	**You Pay**
Part-time or intermittent skilled care, home health aide services, durable medical equipment & supplies and other services.	Unlimited as long as you meet Medicare conditions	100% Medicare Approved Amount for most services	Nothing
		80% Medicare Approved Amount for Durable Medical Equipment	20% Medicare Approved Amount for Durable Medical Equipment
Outpatient Hospital Treatment	**Benefit**	**Medicare Pays**	**You Pay**
Services for the diagnosis or treatment of illness or injury – emergency room, outpatient surgery, observation stays etc.	Unlimited if medically necessary	Medicare payment to hospital based on hospital cost.	20% of billed amount per procedure code after the deductible
Blood	**Benefit**	**Medicare Pays**	**You Pay**
	Unlimited if medically necessary.	80% of approved amount starting with 4th pint of blood per calendar year	First 3 pints of blood, if not replaced, then 20% of approved amount plus any excess charge

MEDICARE PART B PREMIUMS AND FIGURES

2013 Premiums

Yearly Income Filed Individual Tax Return for 2010	Yearly Income Filed Joint Tax Return for 2010	Monthly Premium
$85,000 or less	$170,000 or less	$104.90
$85,001-$107,000	$170,001-$214,000	$146.90
$107,001-$160,000	$214,001-$320,000	$209.80
$160,001-$214,000	$320,001-$428,000	$272.70
$214,001 or more	$428,000 or more	$335.70

2013 Deductible

$147 for the calendar year

Limiting Charge

115% of Medicare's approved amount for services received from providers that do not accept Medicare assignment (nonparticipating Medicare providers).

Blood

In most cases, the provider gets blood from a blood bank at no charge, and you will not have to pay for nor replace the blood. However, you will pay a copayment for the blood processing and handling services for every unit of blood you get and the Part B deductible applies. If the provider has to buy blood, you must either pay the hospital costs for the first three units of blood in the calendar year, or have the blood donated.

MEDICARE PART B

Medicare Part B helps pay for medical services such as doctor services, outpatient hospital care, durable medical equipment and preventive services. Part B is sometimes referred to as medical insurance. Coverage for eligible beneficiaries is optional. To decline Part B, contact Social Security for required forms.

Part B Premium

Every Medicare beneficiary who is receiving Medicare Part B pays a monthly premium. The Part B premium is normally deducted from your Social Security, Railroad Retirement or Federal Retirement benefits. If you are not receiving a Social Security, Railroad Retirement or Federal Retirement benefit, you will be billed on a quarterly basis for the Part B premium. The same would be true if your benefit or retirement payment is not enough to cover the Part B premium. You can choose to pay the billed amount by credit card, check or money order.

Your monthly premium will be based on your annual income. According Medicare, most beneficiaries will pay the 2013 standard premium of $104.90. Some Medicare beneficiaries with higher annual incomes pay a higher Part B premium. These amounts can change each year. Income reported on your tax return from 2 years ago is used to determine the monthly Part B premium. Income reported on your 2011 tax return filed in 2012 was used to determine your 2013 premium. If you filed an amended return or you income has gone down, you can request a more recent tax year be used to determine the monthly premium. For information about the Part B premiums contact:

- Social Security
    - Call 1-800-772-1213; TTY 1-800-325-0078
    - Website http://www.ssa.gov
- Railroad Retirement Board
    - Call 1-877-772-5722; TTY 1-312-751-4701
    - Website http://www.rrb.gov

- U.S. Office of Personnel Management for Federal Employees
    - Call 1-888-767-6738; TTY 1-800-878-5707
    - Website http://www.opm.gov/insure

If you cannot afford to pay your Part B Premium, the Medicare Savings Program may help you. If you meet the income and asset limits are at or below the annual limit, you may qualify to have your Part B premium paid. The 2012 limits, effective April 1, 2013 are as follows:

- Individual
    - Monthly income $1,500 or less
    - Asset limit $7,080 or less
- Married
    - Monthly income $2,250 or less
    - Asset limit $10,620 or less

Part B Late Enrollment Penalty

If you do not sign up for Part B when you are first eligible, you may have to pay a late enrollment penalty for as long as you have Medicare. Your monthly premium for Part B may go up 10% for each full 12-month period that you could have had Part B, but did not sign up for it.

- For example: Mr. Smith's initial enrollment period ended September 30, 2008. He waited to sign up for Part B until the General Enrollment Period in March 2011. His Part B premium penalty is 20%. While Mr. Smith waited a total of 30 months to sign up, this only included two full 12-month periods.

If you did not sign up for Part B when you were first eligible because you were covered under a group health plan based on your or your spouse's active employment, you can sign up for Part B without penalty if you enroll during the Special Enrollment Period. This special Enrollment Period does not apply if you are eligible for Medicare due to End-Stage Renal Disease.

COBRA and retiree health plans are not considered coverage based on current employment. You are not eligible for a Special Enrollment Period when COBRA

or retiree coverage ends. To avoid paying a late enrollment penalty, make sure you enroll in Medicare when you are first eligible.

Part B Deductible and Coinsurance

You are responsible for the Part B deductible in each calendar year. Services not covered by Medicare and charges in excess of the Medicare approved amount do not apply toward the deductible. The deductible must be met only once per calendar year. The Part B deductible for 2013 is $147.

Medicare Part B pays 80% of approved charges for covered services unless otherwise specified. You are responsible for your cost share (coinsurance) of the Medicare approved amount, which is usually 20% of the approved amount. There is no yearly limit for what you pay out-of-pocket.

How Medicare Pays Providers

Medicare approved amounts for Part B are based on the Medicare fee schedule amounts. The fee schedule applies to physicians and certain suppliers nationwide, and lists payments for each Part B service. Geographic variations in the cost of practice are taken into consideration in setting the fee schedule. The fee schedule amount is often less than the actual charges billed by physicians and suppliers.

Part B claims are submitted to the Medicare Carrier. The Medicare Carrier is the company contracted by Medicare to process the Part B claims. In Indiana the Medicare Carrier is National Government Services. When a Part B claim is submitted, National Government Services compares the actual charge shown on the claim with the fee schedule amount for that service - the Medicare approved amount is the lower of the two. Medicare will then usually pay 80% of this approved amount.

Participating in Medicare

Physicians, non-physician practitioners and other Part B health care suppliers must enroll in the Medicare program to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries. When a provider or supplier enrolls in Medicare, they choose whether or not to "participate in Medicare." In Medicare, **"participation" means that a provider agrees to accept assignment of claims for all services** that are furnish to you. By agreeing to accept assignment, providers agree to always accept Medicare approved amounts as payment in full and not to collect more than the Medicare deductible and coinsurance from you. Participating providers agree to accept

assignment of Medicare benefits for all covered services for all Medicare beneficiaries. Unlike many private insurance plans, Medicare requires providers to submit claims for Medicare beneficiaries whether they participate or not. The benefits of Medicare participation include:

- Medicare reimbursement is 5% higher than it is for providers who do not participate;
- Medicare payments are made directly to the provider/supplier;
- Claim information is forwarded to Medigap (Medicare Supplement) insurers.

A list of local participating providers/suppliers is available by contacting Medicare. To get a copy of this list call 1-800-Medicare (1-800-633-4227) or find a provider/supplier by using the *Physician Compare* on Medicare's website http://www.medicare.gov.

When going to a Medicare provider who chooses to accept assignment, you will only be responsible for paying the following:

- Part B deductible
- 20% coinsurance

The following services are always subject to assignment:

- Clinical diagnostic laboratory services and physician laboratory services
- Physician services to individuals dually entitled to Medicare and Medicaid
- Services of the following:
    - Anesthesiologist assistants
    - Certified nurse midwives
    - Certified registered nurse anesthetists
    - Certified nurse specialists
    - Clinical psychologists
    - Clinical social workers
    - Medical nutrition therapists
    - Nurse practitioners
    - Physician assistants

- American College of Surgeons facility services
- Services of mass immunization roster billers
- Drug and biological
- Ambulance services

Participation is valid for a yearlong period from January 1 through December 31. Renewal is automatic each year, unless the provider terminates or changes the agreement at the end of the year.

Non-participating Providers

If a Medicare provider chooses not to accept assignment they are referred to as "Non-participating Providers." However the **provider may choose to accept Medicare assignment on a claim-by-claim basis**. Medicare does not send their reimbursement directly to a non-participating provider; rather Medicare will send the reimbursement to you, the Medicare beneficiary, along with your Medicare Summary Notice. The provider can then bill you for the service. When going to a non-participating provider, you will be responsible for the following charges:

- Part B deductible
- Medicare reimbursement of 80% that is included with the Medicare Summary Notice
- Beneficiary coinsurance 20%
- Limiting charges/excess charges

Non-participating providers receive a lower reimbursement for services, and may not charge you more than the Medicare approved up to the "Limiting Charge". The limiting charge is the amount over the Medicare approved amount a non-participation provider can add to your bill. Limiting charges apply to the following services regardless of who furnishes or bills for them:

- Physicians' services;
- Services and supplies commonly furnished in physicians' offices that are incident to physicians' services;
- Outpatient physical and occupational therapy services furnished by an independently practicing therapist;
- Diagnostic tests; and

- Radiation therapy services, including x-ray, radium, radioactive isotope therapy, materials and technician services.

With the exception of pharmaceuticals, equipment and supplies, the limiting charge is 115% of the Medicare approved amount. For example:

Non-Participating Provider (does not accept assignment) Medicare Approved Amount for Procedure X	$190.00
Limiting Charge for Procedure X	$218.50 ($190.00 x 1.15 = 115% of the Medicare Approved Amount)
Amount Non-Participating Provider Can Bill for Procedure X	$218.50 $152.00 – Medicare's 80% +$38.00 – 20% Coinsurance +$28.50 – Limiting Charge $218.50 – Total Bill for Procedure X

If you have paid more than the limiting charge, ask the provider for a refund or a reduction in the charges. Credits to an existing account may be given for only services already performed.

The amount you are responsible for paying can vary depending on whether or not your provider participates (accepts assignment) or is non-participating (does not accept assignment) for services provided. Following is a comparison on the payment amounts that participating and non-participating providers and suppliers receive.

	Participating Provider/Supplier (Accepts Assignment on All Claims)	**Non-Participating Provider/Supplier** (Does Not Accept Assignment)	**Non-Participating Provider/Supplier When They Choose to Accept Assignment on a Claim**
Submitted Amount	$125.00	$125.00	$125.00
Medicare Approved Amount	$100.00	$95.00	$95.00
Medicare Payment Amount (80% of Medicare approved amount)	$80.00	$76.00	$76.00
Beneficiary Coinsurance (after the deductible has been met)	$20.00	$33.25	$19.00
Total Payment Made to Provider	$100.00	$109.25 ($95.00 +limiting charge)	$95.00

All providers and suppliers must collect unmet deductibles, coinsurance and copayments from the beneficiary. If a beneficiary is unable to pay these charges, they should sign a waiver that explains the financial hardship. If a waiver is not signed, the beneficiary's medical record should reflect normal and reasonable attempts to collect the charges before they are written off. The same attempts to collect charges must be applied to both Medicare beneficiaries and non-Medicare beneficiaries.

Special rule for non-participating providers and elective surgery: If the elective surgery is to cost more than $500.00, the non-participating provider must give you a written estimate of the Medicare approved charges including any excess or limiting charges. If no written estimate was given, the non-participating provider must refund all charges in excess of the Medicare approved amount. You would not be responsible for anything over the Medicare approved amount. If you are unsure of charges or whether you have been charged the correct amount, first contact your service provider. If contacting your service provider

does not solve the situation, contact National Government Services at 1-800-622-4792.

Private Contract Physicians

A private contract is an agreement between you and a doctor who has decided not to furnish services through the Medicare program. The private contract only applies to services given by the doctor who asked you to sign it. This means that Medicare and Medigap (Medicare Supplement Insurance) will not pay for the services you get from the doctor with whom you have a private contract. You cannot be asked to sign a private contract in an emergency or for urgently needed care. You still have the right to see other Medicare doctors for services.

If you sign a private contract with your doctor:

- No Medicare payment will be made for the services you get from this doctor.
- Your Medigap policy, if you have one, will not pay anything for this service.
- You will have to pay whatever this doctor or provider charges you. The Medicare limiting charge will not apply.
- Medicare managed care plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is submitted.
- The doctor cannot bill Medicare for 2 years for any services provided to anyone with Medicare.

The following providers may opt-out of Medicare and privately contract with you for the purpose of furnishing items or services that would otherwise be covered:

- Doctors of medicine, osteopathy, podiatry, optometry, dental surgery or dental medicine;
- Certified nurse midwives, registered nurse anesthetists;
- Clinical nurse specialists, psychologists and social workers;
- Nurse practitioners;
- Physician assistants; and
- Nutrition professionals and registered dieticians.

PART B BENEFITS

In general, Medicare covered services are those services that are considered medically reasonable and necessary to the overall diagnosis and treatment of your condition and are reimbursable to the provider or supplier. Services or supplies are considered medically necessary if they:

- Are proper and needed for the diagnosis or treatment of your medical condition;
- Are furnished for the diagnosis, direct care, and treatment of your medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of you, the provider or the supplier.

For every service billed, the provider or supplier must indicate the specific sign, symptom or beneficiary complaint necessitating the service. Medicare pays for provider professional services that are furnished in:

- The United States – including the District of Columbia, Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa and territorial waters adjoining the land areas of the United States; and
- The home, office, institution or at the scene of an accident.

Medicare Part B covers medically necessary services like physician services, outpatient care, home health services, durable medical equipment and preventive services. Covered Part B services include, but are not limited to, the following:

- Physician services
- Services and supplies furnished incident to physician professional services
- Outpatient dialysis services, including home dialysis, for End-Stage Renal Disease
- Outpatient hospital services furnished incident to physician services
- Outpatient diagnostic services furnished by a hospital
- Outpatient physical therapy services
- Outpatient occupational therapy services
- Outpatient speech-language pathology services

- Diagnostic x-ray tests, laboratory tests and other diagnostic tests
- X-ray, radium and radioactive isotope therapy services
- Surgical dressings and splints, casts and other devices used for reduction of fractures and dislocations
- Rental or purchase of durable medical equipment for use in the beneficiary's home
- Ambulance services
- Certain prosthetic devices that replace all or part of an internal organ
- Leg, arm, back and neck braces ad artificial legs, arms and eyes
- Ambulatory Surgical Center services
- Certain preventive services

Medicare Coverage for Physician Services

Physician services are the professional services performed by a doctor or doctors for you including diagnosis, therapy, surgery, consultation and care plan oversight. Physicians include Doctors of Medicine (MD) or Doctors of Osteopathy (DO). A service may be considered to be a physician's service where the doctor either examines you in person or is able to directly visualize some aspect of your condition. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

Doctor's services covered include:

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures
- Radiology and pathology services – inpatient and outpatient
- Medications and biological drugs (injectable drugs) that cannot be self-administered, except for certain oral cancer drugs
- Transfusions of blood and blood components after the 3rd pint
- Services of the doctor's nurse
- Medical supplies and x-rays furnished incident to doctor's services

Limited Coverage of Doctor's Services

Limited coverage for doctor's services includes chiropractor's, podiatrist's and optometrist's services.

Chiropractor Services

Manual manipulation of the spine to correct a subluxation is a covered service under Medicare. Subluxation is when one or more of the bones in your spine move out of position and create pressure on or irritate spinal nerves. There are no caps or limits in Medicare for covered chiropractic care, as long as the care is considered to be medically reasonable and necessary. In preforming manual manipulation of the spine, some chiropractors use manual devices that are hand-held with the thrust of the force of the device being controlled manually. The use of such a hand-held device may be covered, there is no separate payment permitted for the use of this device. All other services furnished or ordered by chiropractors are not covered.

Maintenance therapy is not considered by Medicare to be medically reasonable and necessary, and is not covered by Medicare. Maintenance therapy is defined by Medicare as a treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life; or therapy that is preformed to maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy.

If a chiropractor orders, takes or interprets an x-ray or other diagnostic procedure to demonstrate a subluxation of the spine, the x-ray can be used for documentation. However, there is no coverage or payment for these services or for any other diagnostic or therapeutic service ordered or furnished by the chiropractor. A chiropractor may act as a supplier of durable medical equipment, if they have a Medicare supplier number, but will not receive payment if they ordered the durable medical equipment.

Chiropractors may choose to be participating or non-participating providers. However, chiropractors may not enter into private contracts with Medicare beneficiaries they treat.

Podiatrist

Medicare Part B will help pay for covered services provided by a licensed podiatrist to treat injuries and diseases of the foot. Certain foot care related services are not generally covered by Medicare. In general, the following

services, whether performed by a podiatrist, osteopath or doctor, and without regard to difficulty or complexity of the procedure, are not covered by Medicare:

- **Treatment of flat foot** – the term flat foot is defined as a condition in which one or more arches of the foot have flattened out. Services or devices directed toward the care or correction of flat foot, including the prescriptions of supportive devices, are not covered.
- **Routine foot care** – in general, routine foot care is excluded from Medicare coverage. Services normally considered routine care and not covered by Medicare:
    - The cutting or removal of corns and calluses;
    - The trimming, cutting, clipping or debriding of nails; and
    - Other hygienic and preventive maintenance care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients, and any other service performed in the absence of localized illness, injury or symptoms involving the foot.
- **Supportive devices for feet** – generally, Medicare will not cover orthopedic shoes and other supportive devices for the feet, unless it is an integral part of a leg brace and its expense is included as part of the cost of the brace.

There are exceptions to the above exclusion these exceptions include:

- Orthopedic shoes that are an integral part of a leg brace
- Therapeutic shoes furnished to diabetics
- Services that are a necessary and integral part of otherwise covered services, such as diagnosis and treatment of ulcers, wounds or infections
- Treatment of warts on the foot, including plantar warts
- Treatment of mycotic nails – nail fungal infection
- Routine foot care, if you are under the active care of a doctor for certain medical conditions and the doctor has documented the condition. These conditions include, but are not limited to, the following:
    - Diabetes mellitus

- Arteriosclerosis obliterans (arteriosclerosis of the extremities, occlusive peripheral arteriosclerosis)
- Buerger's disease (thromboangiitis obliterans)
- Chronic thrombophlebitis
- Peripheral neuropathies involving the feet- associated with:
    - Malnutrition and vitamin deficiency
    - Carcinoma
    - Diabetes mellitus
    - Drugs and toxins
    - Multiple sclerosis
    - Chronic renal disease
    - Traumatic injury
    - Leprosy or neurosyphilis
    - Hereditary disorders

Optometrist

Medicare will not pay for routine eye exams or eyeglasses. Medicare Part B will help pay for a licensed optometrist's services that are involved in the diagnosis and treatment of injury or disease of the eye. Covered services also include, but not limited to, the following:

- Cataract surgery
- Intraocular lenses when implanted following cataract surgery
- Eyeglass frames and lenses, or one pair of contact lenses, after cataract surgery that implants an intraocular lens
- Treatment of age-related macular degeneration called ocular photodynamic therapy with verteporfin under certain circumstances.
- Eye prostheses are covers for patients with absences or shrinkage of an eye due to birth defect, trauma or surgical removal. Medicare generally covers replacement every 5 years. Polishing and resurfacing in covered twice per year.
- Services performed in conjunction with or incidental to services in conjunction with an eye disease.

Medical Services Not Covered

There are some medical services that are not covered by Medicare. There are 3 categories of items and services that are not covered under Medicare: services and supplies that are not medically reasonable and necessary; excluded items and services; and items and services that are covered by other organizations or furnished without charge.

Services and supplies that are not medically reasonable and necessary to the overall diagnosis and treatment of your condition will not be covered. Some examples include:

- Services furnished in a hospital or skilled nursing facility that, based on your condition, could have been furnished elsewhere such as at home or in a nursing home.
- Hospital or skilled nursing facility services that exceed Medicare length of stay limits.
- Evaluation and management services that are in excess of those considered medically reasonable and necessary.
- Therapy or diagnostic procedures that are in excess of Medicare usage limits.
- Screening tests and examinations for which you have no symptoms or documented conditions, with the exception of Medicare covered preventive services.
- Services not warranted based on your diagnosis, such as biofeedback therapy, acupuncture and transcendental meditation.
- Items and services given to you for the purpose of causing or assisting in causing death – assisted suicide.

Excluded items and services include the following:

- In most situations, Medicare will not pay for health care or supplies you receive outside of the United States. The term “outside of the United States” means anywhere other than the 50 states of the US; Washington D.C.; and the territories of Puerto Rico, Virgin Islands, Guam, American Samoa, the Northern Mariana Islands and territorial waters adjoining the land areas of the United States.

- However, there are three situations when Medicare may help pay for certain types of health services received in a foreign hospital:
    1. You are in the US when they have a medical emergency, and the foreign hospital is closer than the nearest US hospital that can treat your illness or injury.
    2. You are traveling through Canada, without unreasonable delay, by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest US hospital that can treat the illness or injury. Medicare determines what qualifies as "without unreasonable delay" on a case-by-case basis.
    3. You live in the US and the foreign hospital is closer to your home than the nearest US hospital that can treat your medical condition, regardless of whether it is an emergency.
- Items and services that are required as a result of war or an act of war and that occur after the effective date of your current entitlement date are not covered.
- Personal comfort items and services such as radios, televisions, and beauty and barber services.
    - Exceptions to this exception are basic personal services that residents in skilled nursing facilities, general psychiatric hospitals and tuberculosis hospitals need but cannot perform themselves such as:
        - Shaves
        - Haircuts
        - Shampoos
        - Simple hair sets
- Routine services and appliances as follows:
    - Routine or annual physical checkups or exams
    - Physical examinations that are performed without a specific sign, symptom or beneficiary complaint, or that are required by third parties (insurance companies, business establishments, or government agencies).
    - Eye examinations for the purpose of prescribing, fitting or changing eyeglasses

- Eye refractions furnished by all practitioners for any purpose
- Eyeglasses and contact lenses
- Hearing aids or examination for hearing aids
  - Cochlear, auditory brainstem or osseointegrated implants may be covered as prosthetic devices.
- Immunizations/vaccinations – with the following exceptions:
  - Vaccinations directly related to the treatment of an injury or direct exposure to a disease or condition, e.g. anti-rabies treatment.
  - Vaccinations that are specifically covered by statute, e.g. flu, pneumococcal and Hepatitis B.

- Cosmetic surgery and expenses incurred in connection with cosmetic surgery are not covered. Cosmetic surgery includes any surgical procedure directed at improving your appearance. Exceptions to this exclusion include the prompt repair of an accidental injury or the improvement of the functioning of a malformed body member some examples include:
  - Surgery performed in connection with the treatment of severe burns.
  - Surgery to repair the face following a serious automobile accident.
  - Surgeries for therapeutic purposes that mat coincidentally also serve some cosmetic purpose.
- Items and services furnished by your immediate relatives and members of your household.
- Dental services – items and services that are furnished in connection with the care, treatment, filling, removal or replacement of teeth or the structures directly supporting the teeth are not covered.
- Routine foot care
- Most prescription drugs

Items and services that are covered by other organizations or furnished without charge are as follows:

- Services reimbursable by other automobile, no-fault or liability insurance or workers' compensation. Payments will not be made for items and services when payment has been made or can reasonably be expected to be paid

promptly other insurance or workers' compensation. Exceptions to this exclusion include:

- The Group Health Plan denies payment for services because:
  - You are not covered by the health plan;
  - Benefits under the plan are exhausted for a particular service;
  - The service is not covered under the plan;
  - A deductible applies; or
  - You are not entitled to benefits.
- The no-fault or liability insurer denies payment or does not [ay the bill because benefits haven been exhausted.
- The workers' compensation denies payment.
- Federal Black Lung Program does not pay the bill.
- In liability, no-fault or workers' compensation situations, a conditional payment for covered services may be made to prevent your financial hardship when:
  - The claim is not expected to be paid promptly;
  - A properly submitted claim was denied in whole or in part; or
  - A proper claim has not been filed with the primary insurer due to your physical or mental incapacity.

- Items and services authorized or paid for by a government entity – in general, payments will not be made for the following items or services that are furnished by a government or nongovernment provider or other individual at public expense by an authorization issued by a Federal agency – for example, Veterans Administration authorized services.
- Items and services for which you, another individual or an organization has no legal obligation to pay for or furnish.

Second Opinion before Surgery

If your doctor says you need surgery to diagnosis or treat a health problem that is not an emergency, you should consider getting a second opinion. It is up to you to decide when and if you will have surgery. You might also want a second opinion if your doctor tells you that you should have certain kinds of major non-surgical procedures.

Medicare does not pay for surgeries or procedures that are not medically necessary, such as cosmetic surgery. This means that Medicare will not pay for second opinions for surgeries or procedures that are not medically necessary.

You should not wait for a second opinion if you need emergency surgery. Some types of emergencies may require surgery right away, such as the following:

- Acute appendicitis
- Blood clot or aneurysm
- Accidental injuries

Make sure the doctor giving the second opinion accepts Medicare. You can ask your doctor for the name of another doctor to see for a second opinion. You can also ask another doctor you trust to recommend a doctor. Before you visit the second doctor, you should do the following:

- To avoid duplicate testing when seeking a second opinion, ask your doctor to send your medical records to the doctor giving the second opinion.
- Call the second doctor's office and make sure they received your records.
- Write down a list of questions to take with you to the appointment.
- Ask a friend or a loved one to go to the appointment with you.
- Tell the second doctor what surgery you are considering and the tests you have already had.
    - The second doctor may ask you to have additional tests performed as a result of the visit. Medicare will help pay for these tests just as it helps pay for other services that are medically necessary.

If the second doctor does not agree with the first, you may feel confused about what to do. In that case, you may want to talk more about your condition with your first doctor, or talk to a third doctor. Medicare will pay for a third opinion. See Medicare handout "*Getting a Second Opinion before Surgery*."

Coverage of Outpatient Hospital Services

Outpatient services in a participating hospital for diagnosis and treatment of an illness or injury. **With each procedure, you are responsible for a 20% of the hospital charge up to a maximum limit set by law.** The maximum amount you will have to pay for each procedure will be no more than the Part A hospital deductible. If you have outpatient surgery, the actual surgery can be considered

one procedure and the anesthesia another procedure. **Part B deductible does apply.** Services covered include:

- Emergency room or outpatient clinic
- Outpatient/same day surgery
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Laboratory tests billed by the hospital
- Drugs and biological which cannot be self-administered
- Blood transfusions furnished to an outpatient
- Mental health care in a partial hospitalization psychiatric program, as long as a doctor certifies that inpatient treatment would be required without it.

Outpatient Surgery at an Ambulatory Surgical Center

An ambulatory surgical center operates exclusively for the purpose of furnishing outpatient surgical services. An ambulatory surgical center can be a hospital-operated facility or be independent. **Medicare pays 80% of the approved amount for certain procedures after the Part B deductible has been met.** Covered procedures include, but are not limited to:

- Nursing, technician and related services
- Use of the facility where the surgical procedure are preformed
- Laboratory testing
- Medical and surgical supplies
- Equipment
- Surgical dressings
- Implanted prosthetic devices, including intraocular lenses, and related accessories and supplies
- Implanted durable medical equipment and related accessories and supplies
- Splints and casts and related devices
- Radiology services and other diagnostic tests or interpretive services that are integral to a surgical procedure

- Materials, including supplies and equipment for the administration and monitoring of anesthesia
- Supervision of the services of an anesthetist by the operating surgeon

Home Health Care Services

Coverage for home health care services is usually covered under Medicare Part A; however, there are some situations that Medicare Part B will pay for home health care services. These situations are as follows:

- Medicare Part A will usually pay for home health care services for up to 100 visits after a 3 day hospital stay. After you exhaust 100 visits covered by Part A, Part B covers the balance of the home health care services.
    - There is no 100 day limit for Part A if you are enrolled in Part A only.
- If you have not had a prior 3 days hospital stay Medicare Part B will pay for your home health care services.
- If you are enrolled in Part B only and qualify for home health care services, Part B will pay for the services.
    - There is no 100 day limit for Part B coverage.
- The Medicare Part B deductible does not apply in these cases.

Outpatient Therapy

Medicare Part B helps pay for medically necessary outpatient physical therapy, occupational therapy and speech-language pathology services. In order for Medicare to cover outpatient therapy the therapy services must:

- Require the skills of a qualified therapist;
- Be furnished by a physician, qualified non-physician practitioner, therapist or assistant supervised by a therapist;
- Be medically reasonable and necessary;
- Be appropriate in type, frequency, intensity and duration for your needs;
- Be furnished while you are under a plan of care certified by a physician or non-physician practitioner; and
- Follow other Medicare policies and guidelines.

Services can be provided through outpatient hospital rehabilitation facility, skilled nursing facility, home health care agency, clinic, rehabilitation facility, public health agency or comprehensive outpatient rehabilitation facility. Therapy

sessions can be delivered by an independently practicing physical or occupational therapist in their office or your home if the treatment is prescribed by your doctor.

The Balance Budget Act of 1997 set annual caps for outpatient therapy. The therapy caps are determined for a beneficiary on a calendar year basis, so all beneficiaries began a new cap for outpatient therapy services received on January 1, 2012. For physical therapy and speech language pathology services combined, the 2013 limit for a beneficiary on incurred expenses is $1,900. There is a separate cap for occupational therapy services of $1,900 for 2013.

The Deficit Reduction Act of 2005 directed that a process for exceptions to therapy caps for medically necessary services be implemented. Currently the exception process has been extended through December 31, 2013. The exception process is taken care of on the claim form for the services; you do not have to fill anything out to request the therapy cap exception.

Medicare will pay 80% of the Medicare approved amount for covered services after the Part B deductible has been met for the year.

Comprehensive Outpatient Rehabilitation Facility

Comprehensive outpatient rehabilitation facilities (CORF) are facilities that are primarily engaged in providing outpatient rehabilitation for the treatment of Medicare beneficiaries who are injured, disabled or recovering from an illness. Skilled rehabilitation services are defined as services that require the skills of physical therapists, occupational therapists or respiratory therapists who may provide skilled respiratory therapy. Medicare covered services must:

- Be reasonable and medically necessary to the overall diagnosis and treatment of your illness or injury or to improve the function of a malformed body member; therefore, you must show potential for restoration or improvement of your lost or impaired functions;
- Be needed because you require skilled rehabilitation services provided under therapy plans of care that are certified and recertified, as appropriate, by physicians; and
- Be the type of service that would be covered if provided in a hospital, but it is not necessary for you to require a hospital level of care or meet other requirements unique to hospital care.

The annual **Part B deductible and 20% coinsurance apply** to Medicare covered services received from a comprehensive outpatient rehabilitation facility.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are Medicare participating facilities that are located in both rural and urban areas. These health centers were created by the Omnibus Budget Reconciliation Act of 1990. Federally Qualified Health Centers are "safety net" providers such as community health centers, public housing centers, outpatient health programs funded by the Indian Health Service, and programs serving migrants and the homeless. The main purpose of this program is to enhance the provision of primary care in underserved urban and rural communities.

Payments are made directly to the health center for covered services. Services are covered when they are provided at the health center, your home, or elsewhere – such as the scene of an accident. A Federally Qualified Health Center generally provides the following services:

- Physician services;
- Services and supplies incident to the services of physicians;
- Nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, and clinical social worker services;
- Services and supplies incident to the services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers;
- Visiting nurse services of you a homebound in an area that Medicare has determined that there is a shortage of Home Health Agencies;
- Medicare Part B covered drugs that are furnished by, and incident to , services of a provider; and
- Outpatient diabetes self-management training and medical nutrition therapy if you have diabetes or kidney disease.

Federally Qualified Health Centers also furnish preventive primary health services when furnished by or under the direct supervision of a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker. The following preventive primary health services are covered when you receive them from a Federally Qualified Health Center:

- Medical social services;

- Nutritional assessment and referral;
- Preventive health education;
- Children's eye and ear examinations;
- Well child care, including periodic screening;3immunizations, including tetanus-diphtheria booster and influenza vaccine;
- Voluntary family planning services;
- Taking patient history;
- Blood pressure measurement;
- Weight measurement;
- Physical examination targeted to risk;
- Visual acuity screening;
- Hearing screening;
- Cholesterol screening;
- Stool testing for occult blood;
- Tuberculosis testing for high risk beneficiaries;
- Dipstick urinalysis;
- Risk assessment and initial counseling regarding risk;
- Prenatal and post-partum care;
- Prenatal services;
- Clinical breast examination;
- Referral for mammogram; and
- Thyroid function test (for women only).

Preventive primary services that are not covered include:

- Group or mass information programs, health education classes, or group education activities, including media productions and publications; and
- Eyeglasses, hearing aids, and preventive dental services.

Items or services that are covered under Medicare Part B, but are not Federally Qualified Health Center services, include:

- Certain laboratory services;
- Durable medical equipment – including crutches, hospital beds and wheelchairs used in your home;
- Ambulance services;
- The technical component of the following preventive services:
    - Screening pap smears;
    - Prostate cancer screening;
    - Colorectal cancer screening tests;
    - Screening mammograms;
    - Glaucoma screenings and
    - Bone mass measurements;
- Prosthetic devices that replace all or part of an internal body organ, including colostomy bags, supplies directly related to colostomy care, and the replacement of such devices; and
- Leg, arm and neck braces and artificial legs, arms and eyes, including replacements (if required because of a change in your physical condition).

Generally, Medicare pays the Federally Qualified Health Centers an all-inclusive per visit payment. **You will not have to pay the Part B deductible for services received, but you are responsible for paying the 20% coinsurance**, with the exception of:

- Influenza and pneumococcal vaccines, which are paid at 100%;
- Hepatitis B vaccine (HBV), which is paid at 100%;
- Personalized prevention plan services; and
- Any covered preventive service that is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

The health center can waive all or part of the Medicare coinsurance, depending on your ability to pay. To find a Federally Qualified Health Center you can go online at http://www.hrsa.gov/gethealthcare/index.html or call 1-877-464-4772.

Rural Health Clinic Services

The Rural Health Clinic Services Act of 1977 was enacted to address an inadequate supply of physicians serving Medicare beneficiaries in rural areas and to increase the use of non-physician practitioners such as nurse practitioners and physician assistances in rural areas. Services provided by Rural Health Clinics include the following:

- Physician services;
- Services and supplies incident to the services of physicians;
- Nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, and clinical social worker services;
- Services and supplies incident to the services of nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, and clinical social workers;
- Medicare Part B covered drugs that are furnished by, and incident to , services of a provider; and
- Visiting nurse services of you a homebound in an area that Medicare has determined that there is a shortage of Home Health Agencies.

To qualify as a Rural Health Clinic, a clinic must be located in a non-urbanized area (as defined by the U.S. Census Bureau) and an area currently designated by the Health Resources and Services Administration as a certified shortage area. The Rural Health Clinic must:

- Employ a nurse practitioner, or a physician assistant;
- Have a nurse practitioner, physician assistant or certified nurse midwife working at the clinic at least 50% of the time the Rural Health Clinic operates;
- Directly furnish routine diagnostic and laboratory services;
- Have arrangements with one or more hospitals to furnish medically necessary services that are not available at the health clinic;
- Have available drugs and biological necessities for treatment of emergencies and
- Furnish onsite all of the following laboratory tests:
    - Chemical examination of urine by stick or tablet method or both;
    - Hemoglobin or hematocrit;

- Blood sugar;
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory.

Generally, Medicare pays the Rural Health Clinics an all-inclusive per visit payment – laboratory tests are paid separately. **You are responsible for paying the Part B deductible as well as the 20% Part B coinsurance for services received**, with the exception of the following:

- Medicare covered preventive services with waived deductible and coinsurance;
- Personalized prevention plan services; and
- Any covered preventive service that is recommended with a grade of A or B by the U.S. Preventive Services Task Force.

Outpatient Mental Health Services

Medicare Part B helps cover mental health services that you would generally receive outside a hospital, including visits with a psychiatrist or other physician, visits with a clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, certified nurse midwife and independently practicing psychologist. The mental health services that may be covered by Medicare include:

- Psychiatric diagnostic interviews;
- Individual psychotherapy;
- Interactive psychotherapy;
- Family psychotherapy
    - with the patient present if the primary purpose is treatment of the individual's condition or
    - without the patient present if it is medically reasonable and necessary and the primary purpose is treatment of the patient's condition;
- Group psychotherapy;
- Psychoanalysis;
- Pharmacologic management;

- Electroconvulsive therapy;
- Diagnostic psychological and neuropsychological tests;
- Hypnotherapy;
- Narcosynthesis; and
- Biofeedback therapy.

The mental health services that are not covered by Medicare are:

- Environmental intervention;
- Geriatric day care programs;
- Individual psychophysiological therapy that incorporated biofeedback training;
- Marriage counseling;
- Pastoral counseling; and
- Transportation and meals.

A psychiatrist or independently practicing psychologist may choose whether to participate (accept Medicare assignment for services) or not. However, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or certified nurse midwife's services are always subject to Medicare assignment.

Prior to 2010, Medicare beneficiaries were required to pay a 50% coinsurance for outpatient mental health services. The Medicare Improvements for Patients and Providers Act of 2008, changed to coinsurance amount so that over time the coinsurance will reduce to 20% of the Medicare approved amount.

Outpatient Mental Health Beneficiary Coinsurance	
Year	**Coinsurance Amount**
Effective January 1, 2010	45%
Effective January 1, 2012	40%
Effective January 1, 2013	35%
Effective January 1, 2014	20%

Ambulance Coverage

Medicare Part B covers ambulance services to or from a hospital, critical access hospital or a skilled nursing facility only when other transportation could endanger your health. In some cases, Medicare may also cover ambulance services in the following situations:

- If you need to go from your home or a medical facility to get health care for a condition that requires you to be transported by ambulance, or
- If you have End-Stage Renal Disease, need dialysis and need ambulance transportation to or from a dialysis facility because other transportation could endanger your health.

Medicare will only cover ambulance services to the nearest appropriate medical facility that is able to give you the care you need. If you choose to be transported to a facility farther away, Medicare's payment will be based in the charge to the closest appropriate facility.

You can get emergency ambulance transportation after you have had a sudden medical emergency, when your health is in serious danger and when every second counts to prevent your health from getting worse. Medicare coverage depends on the seriousness of your medical condition and whether you could have been safely transported by other means.

Air transportation – Medicare may pay for emergency ambulance transportation in a helicopter if your health condition requires immediate and rapid ambulance transportation that ground transportation cannot provide, and one of the following applies:

- Your pickup location cannot be easily reached by ground transportation;
- Long distances or other obstacles, like heavy traffic, could stop you from getting care quickly if you traveled by ground ambulance.

If Medicare covers your ambulance trip, **you pay 20% of the Medicare approved amount, after you have met the yearly Part B deductible**. All ambulance companies must accept assignment. However, in some cases, what you pay may be different if you are transported by a critical access hospital, or an entity that is owned and operated by a critical access hospital. Critical access hospital is defined as a small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

If Medicare does not pay for an ambulance trip you think should be covered, you should carefully review your Medicare Summary Notice and any other paperwork about your ambulance bill. You may find errors in the paperwork that can be fixed. If refilling your claim does not result in payment, you may file an appeal.

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment in covered under Medicare Part B as a medical or other health service and is equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an illness or injury; and
- 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. The item must also be ordered or prescribed by a physician and the supplier must be Medicare certified.

Claims for durable medical equipment are filed based on your state of permanent residency. Currently suppliers can choose to be participating (accept Medicare assignment) or be non-participating. Non-participating suppliers can choose to accept assignment on claim-by-claim bases. With few exceptions, suppliers must now file claim with Medicare. Medicare will determine whether an item is to be purchased or rented.

Medicare Covered Durable Medical Equipment, Prosthetics, Orthotics and Supplies Include:

- Oxygen equipment;
- Wheelchairs, power operated vehicles and walking aids;
- Hospital beds and other medical equipment;
- Prosthetic devices that are used to replace or assist body parts such as: pacemakers, corrective lenses after cataract surgery, ostomy bags and related supplies, breast prostheses and surgical brassieres;
- Artificial limbs and eyes;
- Arm, leg, neck and back braces;

- Orthopedic shoes, if part of leg braces, and therapeutic shoes for diabetics;
- Supplies ordered by a physician such as surgical dressings, splints and casts;
- Outpatient radiation therapy given under medical supervision;
- Oral anticancer drugs:
    - Busulfan
    - Capecitabine
    - Cyclophosphamide
    - Etoposide
    - Melphalan
    - Methotrexate
    - Temozolomide
    - List is subject to change
- Oral anti-emetics prescribed for use within 48 hours of chemotherapy:
    - 3 oral drug combination of:
        - Aprepitant
        - A 5-HT3 Antagonist
        - Dexamethasone
    - Chlorpromazine Hydrochloride
    - Diphenhydramine Hydrochloride
    - Dolasetron Mesylate – within 24 hours
    - Dronabinol
    - Granisetron Hydrochloride – within 24 hours
    - Hydroxyzine Pamoate
    - Ondansetron hydrochloride
    - Nabilone
    - Perphenazine
    - Prochlorperazine Maleate

    - Trimethobenzamide Hydrochloride
    - List is subject to change
- Immunosuppressive drugs for Medicare covered kidney transplant recipients:
    - Azathioprine – oral and parenteral
    - Cyclophosphamide – oral
    - Cyclosporine – oral and parenteral
    - Daclizumab – parenteral
    - Lymphocyte Immune Globulin
    - Antithymocyte Globulin – parenteral
    - Mexthotrezare – oral
    - Methylprednisolone – oral
    - Methylprednisolone Sodium Succinate Injection
    - Muromonab-Cd3 – parenteral
    - Mycophenolate Acid – oral
    - Mycophenolate Mofetil – oral
    - Prednisolone – oral
    - Prednisone – oral
    - Sirolimus – oral
    - Tacrolimus – oral and parenteral
    - List is subject to change
- Diabetic supplies including:
    - Glucose monitors,
    - Blood testing strips, and
    - Lancets.
    - Before paying for testing strips, Medicare must either purchase a monitor or a doctor's order must state that you already have a monitor.

- Infusion pump and insulin – to qualify you must test your blood glucose at least 4 times a day and take at least 3 shots of insulin daily. Type I diabetics must keep a log if testing more than 3 times a day. Type II diabetics must keep a log if testing more than once a day.

Durable Medicare Equipment and the Limiting Charge

It is important that you find a supplier that accepts Medicare assignment – a participating supplier. Unlike physicians, **non-participating suppliers are not subject to the limiting charge**. This means you will pay more out of pocket by using a supplier that does not accept assignment. This information is not usually posted – you will need to ask about assignment.

If a supplier accepts assignment, you will be responsible for the Part B deductible and the 20% coinsurance. If the supplier does not accept assignment, you will be responsible for the Part B deductible, and the difference between what Medicare pays and the amount charged by the supplier.

For example: You need to purchase a cane and have satisfied your Part B deductible for the year. The supplier bills Medicare for $100; Medicare approved amount is $20.

- If you use a participating supplier, Medicare will pay $16 (80% of the approved amount) and you will pay $4 coinsurance.
- If you use a non-participating supplier, Medicare will pay $16 and you will be responsible for the remainder of the charge amount - $84.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies and Competitive Bidding Program

Starting January 1, 2011, Medicare is phasing in a new competitive bidding program in some area of the country. This program will change the amount Medicare pays suppliers for certain durable medical equipment, prosthetics, orthotics and supplies and make changes to which suppliers Medicare will pay to supply these items to you.

The program replaces the prices Medicare is currently paying with lower, more accurate prices. Under this program suppliers submit bids to furnish certain medical equipment and supplies at a lower price than what Medicare now pays for these items. Qualified, accredited suppliers with winning bids are chosen as Medicare contract suppliers.

If you have Medicare and you live in one of the covered areas and use equipment or supplies included in the program (or get the items while visiting), you will have to use Medicare contract suppliers in you want Medicare to help you pay for the item.

Round 1

Starting January 1, 2011, the new program will apply to people with original Medicare who live in or travel to the following 9 areas:

- Charlotte-Gastonia-Concord (North Carolina and South Carolina)
- **Cincinnati-Middletown (Ohio, Kentucky and Indiana)**
- Cleveland-Elyria-Mentor (Ohio)
- Dallas-Fort Worth-Arlington (Texas)
- Kansas City (Missouri and Kansas)
- Miami-Fort Lauderdale-Pompano Beach (Florida)
- Orlando-Kissimmee (Florida)
- Pittsburgh (Pennsylvania)
- Riverside-San Bernardino-Ontario (California)

These included areas are arranged by ZIP codes. If your permanent residence is in one of these ZIP codes, then the new program applies to you. Your permanent residence is the address that the Social Security Administration has on file for you. You can find a list of ZIP codes for each area of the program by visiting Medicare's website at http://www.medicare,gov or by calling 1-800-633-4227. TTY users should call 1-877-486-2048.

The following categories of items are included in the first phase of the program:

- Oxygen, oxygen equipment and supplies;
- Standard power wheelchairs, scooters and related accessories
- Complex rehabilitative power wheelchairs and related accessories (Group 2 only);
- Mail-order diabetic supplies;
- Enteral nutrients, equipment and supplies;

- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beads and related accessories;
- Walkers and related accessories;
- Support surfaces (Group 2 mattresses and overlays in Miami-Fort Lauderdale-Pompano Beach only).

A complete listing of these suppliers by product category is posted on Medicare's website http://www.medicare.gov or calling 1-800-633-4227. TTY users should call 1-877-486-2048.

Round 2

Implementation of the contracts and pricing for Round 2 of the competitive bidding program will be **July 1, 2013**. There are 91 areas included in Round 2. Two of the 91 areas include:

- Chicago-Joliet-Naperville (Illinois, Indiana and Wisconsin) and
- Indianapolis-Carmel (Indiana)

A listing of the ZIP codes included in Round 2 can be found online at http://www.dmecompetitivebid.com/Palmetto/Cbic.Nsf/files/Round_2_ZIP_Codes_combined.pdf/$File/Round_2_ZIP_Codes_combined.pdf.

The following categories of items are included in the Round 2 of the program:

- Oxygen supplies and equipment;
- Standard (power and manual) wheelchairs, scooters and related accessories;
- Enteral nutrients, equipment and supplies;
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories;
- Hospital beads and related accessories;
- Walkers and related accessories;
- Support surfaces (Group 2 mattresses and overlays);
- Negative Pressure Wound Therapy (NPWT) Pumps and related supplies and accessories.

National mail-order competition of the competitive bidding program includes diabetic testing supplies and occurs at the same time as the Round 2 competition. The **national mail-order competition includes all parts of the United States**, including all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and American Samoa.

Medicare Coverage

In most cases, in you have Original Medicare and get program items in program areas, Medicare will only help pay for these items if they are furnished by contract suppliers. However, there are a few exceptions. For example, if you rent oxygen or certain other durable medical equipment and your current supplier is not a contract supplier, you may be able to continue renting these items if you current supplier when the program take effect, if your current supplier decided to participate in the program as a "grandfathered" supplier.

A non-contract supplier that decides not to become a "grandfathered" supplier is required to pick up the item from your home after the program begins and you have been notified. Your supplier must notify you 3 times before they can pick up the item:

- The supplier must send you a letter at least 30 business days before the program begins telling you that it will no longer provide rental items to you after a certain date. This letter will tell you the date on which a Medicare contract supplier must begin to furnish you with the rented item.
- Before the supplier can pick up your equipment, it must call you 10 days prior to picking up the item.
- The supplier must call you again 2 business days prior to picking up the item.

Medicare will help pay for certain medical equipment and supplies, such as a walker, furnished by your doctor or treating health care practitioner, even if they are not a Medicare contract supplier, as long as the item is supplied in the office during a visit for medical care. If you are admitted to a hospital and need a walker, Medicare will also help pay for it if it is furnished to you by the hospital while you are admitted or on the day you are discharged, even if the hospital is not a contract supplier.

In general, if you live in these areas, or get these items while visiting the area, and **do not use a Medicare contract supplier or a "grandfathered" supplier, Medicare will not usually pay for the item** and you will likely pay full price.

DIABETIC SUPPLIES

Medicare Part B will cover certain supplies if you have diabetes. These supplies include:

- Blood sugar monitors;
- Therapeutic shoes; and
- Insulin pumps.

Blood Sugar Monitors

Medicare will cover the blood sugar testing monitor as well as the test strips, lancet devices and lancets. You are covered whether or not you are insulin dependent. A prescription from your doctor is required. You must get your supplies from a Medicare supplier. You may pay more for your supplies if you use a supplier that does not accept assignment.

If your supplier accepts assignment, you will **pay the 20% coinsurance after the annual Part B deductible has been met**. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you are responsible for the remainder of the amount charged. Claims must be submitted by the supplier. Beneficiaries are no longer able to submit claims for diabetic supplies to Medicare.

Therapeutic Shoes

If you have diabetes and meet certain conditions Medicare will cover therapeutic shoes if you need them. The types of shoes covered each year are one pair of depth-inlay shoes and three pairs of inserts, or one pair of custom-molded shoes and two additional inserts. In order for Medicare to cover these shoes you must meet all of the following conditions:

- You must have diabetes;
- Have at least one of the following conditions in one or both feet:
    - Partial or complete foot amputation;
    - Past foot ulcers;
    - Calluses that could lead to foot ulcers;
    - Nerve damage because of diabetes with signs of problems with calluses;
    - Poor circulation; or

    - Deformed foot; and
- Are being treated under a comprehensive diabetes care plan and need therapeutic shoes and/or inserts because of diabetes.

Medicare also requires that a podiatrist or other qualified doctor prescribes the shoes. Also that the shoes are fitted and provided by a doctor or other qualified provider like a podiatrist, orthopedist or prosthetic.

If your supplier accepts assignment, you will **pay the 20% coinsurance after the annual Part B deductible** has been met. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you are responsible for the remainder of the amount charged.

Insulin Pumps

If you need to use an insulin pump worn outside of the body, Medicare may cover the pump as well as the insulin to be used with the pump. You must meet certain conditions and have the doctor prescribe the pump. Work with your doctor to see if you meet the requirements for Medicare to cover the pump.

If your supplier accepts assignment, you will **pay the 20% coinsurance after the annual Part B deductible has been met**. If your supplier does not accept assignment, Medicare will send you the 80% of the Medicare approved amount and you are responsible for the remainder of the amount charged.

LABORATORY SERVICES

Diagnostic X-ray, laboratory and other diagnostic tests, including materials and the services of technicians, are covered by Medicare. A diagnostic laboratory test can be covered regardless of whether it is performed in:

- A physician's office, by an independent laboratory;
- By a hospital laboratory for its outpatients or non-patients;
- In a rural health clinic;
- Dialysis laboratory;
- Nursing facility laboratory; or
- Other institutions.

In order for diagnostic services to be covered by Medicare Part B, the diagnostic services must be related to your illness, injury, symptom or complaint and ordered by a physician or non-physician practitioner who is treating you. Laboratories must be certified by the Secretary of Health and Human Services and accept Medicare assignment.

Medicare Part B will **cover 100% of the approved amount for diagnostic services**; however, you will generally have to pay 20% coinsurance for the doctor's visit.

Laboratory services include, but are not limited to, the following:

- Clinical laboratory services:
- X-rays, including portable x-rays;
- Computerized Axial Tomography (CAT), including portable procedures;
- MRI procedures;
- Nuclear Medicine Imaging and radionuclides used in the procedures;
- Diagnostic mammography;
- Ultrasound diagnostic procedures;
- Radiation oncology; and
- Physiological labs – EKG and EEG diagnostic services.

PREVENTIVE SERVICES

Preventive Service	Frequency	What You Pay
Welcome to Medicare Preventive Visit	Once within the first 12 months of getting Medicare Part B	Nothing if your doctor accepts assignment
Annual Wellness Visit	Once every 12 months	Nothing if your doctor accepts assignment
Abdominal Aortic Aneurysm	Once in a lifetime	Nothing if your doctor

Screening		accepts assignment
Alcohol Misuse Screening & Counseling	Screening once every 12 months; 4 face-to-face counseling sessions per year	Nothing if your doctor accepts assignment
Bone Mass Measurement	Once every 24 month	Nothing if your doctor accepts assignment
Cardiovascular Disease Risk Reduction Visit	Once per year	Nothing if your doctor accepts assignment
Cardiovascular Disease Screening Blood Tests	Once every 5 years	Nothing
Colorectal Cancer Screening - Fecal Occult Blood Test Age 50 or older	Once every 12 months	Nothing if your doctor accepts assignment
Colorectal Cancer Screening - Flexible Sigmoidoscopy Age 50 or older	Normal risk - once every 4 years or 10 years after colonoscopy; High risk – once every 4 years	Nothing if your doctor accepts assignment
Colorectal Cancer Screening – Colonoscopy	Normal risk – once every 10 years; High risk - once every 24 months; or Once every 4 years after	Nothing if your doctor accepts assignment

	flexible sigmoidoscopy	
Colorectal Cancer Screening - Barium Enema Age 50 or older	Normal risk – once every 4 years; High risk - once every 24 months	Deductible is waived, you pay 20% of Medicare approved amount for the doctor's services
Depression Screening	Once every 12 months	Nothing if your doctor accepts assignment
Diabetes Screening	Twice every 12 months - if diagnosed with pre-diabetes Once every 12 months - all others	Nothing
Diabetes Self-Management Training	10 hours of training per year	20% coinsurance after Part B deductible
Glaucoma Screening	Once every 12 months if at high risk	20% coinsurance after Part B deductible
Human Immunodeficiency Virus (HIV) Screening	Once every 12 months or up to 3 times during pregnancy	Nothing
Obesity Screening and Counseling	One face-to-face visit each week for the first month; One face-to-face visit every other week for months 2-6; One face-to-face visit every month for months 7-12.	Nothing if your doctor accepts assignment
Pap Tests, Pelvic Exams	Normal risk – once every	Nothing if your doctor

and Clinical Breast Exams	24 months; High risk – once every 12 months	accepts assignment
Prostate Cancer Screening – Prostate Specific Antigen (PSA) Blood Test & Digital Rectal Exam Age 50 or older	Once every 12 months	PSA Blood Test – Nothing; Digital Rectal Exam – 20% coinsurance after Part B deductible
Screening Mammogram Age 40 or older	Once every 12 months	Nothing if your doctor accepts assignment
Smoking Cessation Services – Diagnosed with a Tobacco-Related Disease	Two cessation attempts of up to 8 sessions per year	20% coinsurance after Part B deductible
Smoking Cessation Services – Preventive, No Diagnosed Tobacco-Related Disease	Two cessation attempts of up to 8 sessions per year	Nothing if your doctor accepts assignment
Vaccine – Hepatitis B	Series of 3 shots	Nothing if your doctor accepts assignment
Vaccine – Influenza	One per flu season	Nothing if your doctor accepts assignment
Vaccine – Pneumococcal	Once in a lifetime; more if medically necessary	Nothing if your doctor accepts assignment
Vaccine – Shingles	Medicare Part B does not cover the shingles vaccine. This preventive service is	Check with your prescription drug plan for

	covered by Medicare Prescription Drug Plans	your cost share

PREVENTIVE SERVICES

Welcome to Medicare Preventive Visit

All Medicare beneficiaries with Part B are eligible for a one time preventive physical exam – also known as Initial Preventive Physical Examination. The goals of the Welcome to Medicare Preventive Visit are health promotion and disease prevention and detection. Components of this preventive service include the following:

- Review of you medical and social history
    - Past medical/surgical history – experiences with illnesses, hospital stays, operations, allergies, injures and treatments;
    - Current medications and supplements;
    - Family history;
    - History of alcohol, tobacco and illicit drug use;
    - Diet; and
    - Physical activities,
- Review of your potential risk factors for depression and other mood disorders.
- Review of your functional ability and level of safety. At minimum:
    - Hearing impairment;
    - Activities of daily living;
    - Fall risk; and
    - Home safety.
- An examination including:
    - Height, weight and blood pressure;
    - Visual acuity screen;
    - Measurement of body mass index; and

    - Other factors deemed appropriate based on your medical and social history.
- End-of-life planning is a required service, upon your consent. This can be verbal or written information provided to you regarding:
    - Your ability to prepare an advance directive in the case that an injury or illness causes you to be unable to make health care decisions, and
    - Whether or not the physician is willing to follow your wishes as expressed in the advance directive.
- Provide education, counseling and referral based on the five previous components.
- Provide education, counseling and referral for other preventive services. This includes a brief written plan, such as a checklist, to be given to you for obtaining a screening electrocardiogram (EKG) as appropriate, and the appropriate screenings and other Medicare covered preventive services.

You should bring the following things with you when you go to your Welcome to Medicare Preventive Visit:

- Medical records, including immunization records, if you are seeing a new doctor for the first time;
- Family health history, in as much detail as possible; and
- A full list of medications and supplements, including calcium and vitamins, how often and how much of each is taken.

The Welcome to Medicare visit can be furnished by a physician, physician assistant, nurse practitioner or certified clinical nurse specialist. This is not a routine physical exam or checkup, but rather an introduction to Medicare and covered benefits and focuses on health promotion and disease prevention and detection to help you stay well. Medicare does not cover routine physical examinations.

Medicare will only cover the Welcome to Medicare visit for all beneficiaries who receive the service **within the first 12 months** after the effective date of their first Medicare Part B coverage period. This is a **one-time benefit**.

There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full. The Welcome to Medicare visit does not include any clinical laboratory tests. The provider may provide and bill

separately for screening and other preventive services that are currently covered and paid for by Medicare Part B.

Annual Wellness Visit

Beginning January 1, 2011, Medicare covers an Annual Wellness Visit, providing a personalized preventing plan services at no cost to you if you go to a participating provider – accepts Medicare assignment as payment in full. This new benefit will provide an ongoing focus on prevention that can be adapted as your health needs change over time.

The first Annual Wellness Visit providing a personalized prevention plan includes the following key elements:

- Establishment of your medical and family history, including:
    - Past medical and surgical history;
    - Use or exposure to medications and supplements, including calcium and vitamins; and
    - Medical events in your parents and any siblings and children, including diseases that may be hereditary or place you at increased risk;
- Measurement of your height, weight, body mass index, blood pressure and other routine measurements as deemed appropriate, based on your medical and family history;
- Establishment of a list of your current providers and suppliers that regularly provide your medical care;
- Detection of any cognitive impairment that you may have – this includes the assessment of your cognitive function by direct observation with consideration of information obtained by your reports or concerns, concerns raised by family members, friends, caretaker or others;
- Review of your potential risk factors for depression or other mood disorders;
- Review of you functional ability and level of safety. At minimum:
    - Hearing impairment;
    - Activities of daily living;
    - Fall risk; and

    - Home safety.
- Establishment of a written screening schedule for you, such as a checklist for the next 5 to 10 years, as appropriate, based on your health status, screening history and age-appropriate preventive services covered by Medicare;
- Establishment of a list of risk factors and conditions of which primary, secondary or tertiary interventions are recommended or underway for you, including any mental health conditions or risk factors that were identified through your Welcome to Medicare Preventive Visit, and a list of treatment options and their associated risks; and
- Provision of personalized health advice to you and a referral, as appropriate, to health education or preventive counseling services or programs.

Subsequent Annual Wellness Visits include the following key elements:

- Update to your medical and family history;
- Measurement of your weight, blood pressure and other routine measurements as deemed appropriate based on your medical and family history;
- Update the list of your current providers and suppliers;
- Detection of any cognitive impairment that you may have;
- Update your written screening schedule;
- Update your list of risk factors and conditions for interventions;
- Furnish appropriate personalized health advice to you and referrals, as appropriate, to health education or preventive counseling services or programs.

The Annual Wellness Visit can be furnished by a physician, physician assistant, nurse practitioner, clinical nurse specialist, health educator, registered dietitian, nutrition professional, other licensed practitioner or a team of such medical professionals who are working under the direct supervision of a physician. **The Annual Wellness Visit is a preventive wellness visit and is not a routine physical exam or checkup.** Medicare does not provide coverage for a routine physical exam.

After you have had Part B for longer than 12 months, you can get an Annual Wellness Visit to develop or update a prevention plan. Medicare covers **one**

Annual Wellness Visit every 12 months. You do not need to get the Welcome to Medicare Preventive Visit before getting an Annual Wellness Visit. If you did receive the Welcome to Medicare Preventive Visit, you will have to wait 12 months before you are eligible to get your first Annual Wellness Visit. **You will pay nothing for this service if you use a participating provider** – accepts Medicare assignment. If your provider furnishes any other services during the Annual Wellness Visit, they may bill Medicare for the service and you may be responsible for any applicable deductible or coinsurance.

Abdominal Aortic Aneurysm Screening

An aneurysm is an abnormal bulge or "ballooning" in the wall of an artery. Most aneurysms occur in the aorta, the main artery that carries blood from the heart to the rest of the body. Three out of four aortic aneurysms are located in the abdomen. Abdominal aortic aneurysms may be asymptomatic for years, but if left untreated may eventually result in a rupture creating a life-threatening emergency.

Medicare coverage of a **one-time preventive ultrasound screening** for the early detection of abdominal aortic aneurysms for at-risk beneficiaries began January 1, 2007. For Medicare to cover this service you must meet the following criteria:

- The service results from a referral from the Welcome to Medicare Preventive Visit;
- Receive the ultrasound screening from a provider who is authorized to provide the services under Medicare;
- You have not previously received an ultrasound screening under the Medicare programs; and
- Have at least one of the following risk factors:
    - Male gender;
    - Aged 65 or older;
    - History of ever smoking – at least 100 cigarettes in your lifetime;
    - Coronary heart disease;
    - Family history of abdominal aortic aneurysms;
    - High cholesterol (hypercholesterolemia)

- High blood pressure (hypertension); or
- Cerebrovascular disease.

Medicare will pay for this screening once in a lifetime. There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Alcohol Misuse Screening and Counseling
Beginning October 14, 2011, Medicare will cover annual alcohol screening, and for those that screen positive Medicare will cover up to 4 brief face-to-face behavioral counseling interventions per year for beneficiaries:

- Who misuse alcohol, but whose levels or patterns of alcohol consumption do not meet the criteria for alcohol dependence
    - Alcohol dependence is defines as at least 3 of the following:
        - Tolerance,
        - Withdrawal symptoms,
        - Impaired control,
        - Preoccupation with acquisition and/or use,
        - Persistent desire or unsuccessful efforts to quit,
        - Sustains social, occupational or recreational disability, or
        - Use continues despite adverse consequences;
- Who are competent and alert at the time that counseling is provided; and
- Whose counseling is furnished by qualified primary care physicians or other primary care practitioners in a primary care setting.
    - A primary care setting could be physician's office, outpatient hospital; independent clinic or state or local public health clinic.

You will pay nothing for this service if you use a participating provider – accepts Medicare assignment.

Bone Mass Measurement

Osteoporosis is a disease of the skeletal system characterized by low bone mass and deterioration of the bone tissue. One out of every 2 women and 1 in 4 men aged 50 and older will have an osteoporosis-related fracture in their lifetime.

Bone mass measurement can aid in the early detection of osteoporosis before fractures happen and determine rate of bone loss. Medicare provides coverage if bone mass measurements that meet coverage listed below:

1. You are a qualified individual. A qualified individual is a Medicare beneficiary who meets the medical indications for at least one of the following:
    a. A woman who has been determined to be estrogen-deficient and at clinical risk for osteoporosis;
    b. A beneficiary with vertebral abnormalities shown by an X-ray to be indicative of osteoporosis, osteopenia (low bine mass) or vertebral fracture;
    c. A beneficiary receiving, or expecting to receive, steroid therapy equivalent to an average of 5.0 mg of prednisone or greater per day for more than 3 months;
    d. A beneficiary with known primary hyperparathyroidism (disorder of one or more of the parathyroid glands); or
    e. A beneficiary being monitored to for the response to, or efficacy of an osteoporosis drug therapy.
2. Your physician or non-physician practitioner orders the test after evaluating your need for the test.
3. The service must be a radiologic, radioisotopic or other procedure that meets the following requirements:
    a. Is performed with a bone densitometer or a bone sonometer (e.g., ultrasound) device;
    b. Is performed for the purpose of identifying bone mass, detecting bone loss or determining bone quality; and
    c. Includes a physician's interpretation of the procedure's results.
4. A qualified supplier or provider must furnish such services under appropriate level of supervision by a physician.
5. The service must be reasonable and medically necessary to diagnose, treat or monitor a qualified individual.
6. The service must be **at least 23 months after the last covered bone mass measurement test** was performed.
    a. Note: if medically necessary, Medicare may provide coverage more frequently than every 2 years.

For dates of service on or after January 1, 2011 both the coinsurance and Part B deductible are waived. There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Cardiovascular Disease Risk Reduction Visit

Effective November 8, 2011, Medicare covers intensive behavioral therapy for cardiovascular disease. Medicare covers one face-to-face cardiovascular disease risk reduction visit per year. The counseling must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. Emergency rooms, inpatient hospital settings, skilled nursing facilities, inpatient rehabilitation facilities and hospices are not considered primary care settings.

The risk reduction visit consists of the following three components:

- Encouraging aspirin use for the primary prevention of cardiovascular disease when the benefits outweigh the risk;
- Screening for high blood pressure in adults age 18 years or older; and
- Intensive behavioral counseling to promote a healthy diet for adults with hyperlipidemia, hypertension, advance age and other known risk factors for cardiovascular and diet-related chronic disease.

There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Cardiovascular Disease Screening Blood Tests

Every year thousands of Americans die of heart disease and stroke. Millions more currently live with one or more types of cardiovascular disease including:

- Coronary heart disease
- Stroke
- High blood pressure
- Congestive heart failure
- Congenital cardiovascular defects
- Hardening of the arteries

Medicare coverage of cardiovascular screening blood tests began for dates of service on or after January 1, 2005, for early detection of cardiovascular disease or abnormalities associated with an elevated risk of heart disease and stroke.

These tests can help determine your cholesterol and other blood lipid levels such as triglycerides. The cardiovascular screening blood tests covered by Medicare include the following:

- Total Cholesterol Test;
- Cholesterol Test for high Density Lipoproteins, and
- Triglycerides Test.
- Other cardiovascular screening blood tests remain non-covered.

Medicare provides coverage of cardiovascular screening blood tests for all beneficiaries who show no sign or symptoms of cardiovascular disease, **every 5 years** (at least 59 months after the last covered screening tests). **You will pay nothing** for the cardiovascular screening blood tests.

Colorectal Cancer Screening

Individuals with colorectal cancer rarely display any symptoms and the cancer can progress unnoticed and untreated until it becomes fatal. Colorectal cancer is largely preventable through screening, which can find pre-cancerous polyps which can be removed before they develop into cancer. Medicare provides coverage of the following colorectal cancer screening services:

- Fecal Occult Blood Test - checks for hidden blood in the stool,
- Flexible Sigmoidoscopy - used to check for polyps and cancer in the lower third of the colon,
- Colonoscopy - used to check for polyps and cancer in the entire colon, and
- Barium Enema - an X-ray examination of the large intestine.

All **Medicare beneficiaries aged 50 and older are covered**; however, if you are at **high risk, there is no minimum age required to receive a screening colonoscopy**.

Colorectal Cancer Screenings			
Tests & Requirements	**Normal Risk** **Covered once every**	**High Risk** **Covered once every**	**You pay**

Fecal Occult Blood Test Age 50 or older	12 months	12 months	Nothing if your doctor accepts assignment
Flexible Sigmoidoscopy Age 50 or older	4 years or 10 years after a previous screening colonoscopy for those not at high risk	4 years	Nothing if your doctor accepts assignment
Colonoscopy	10 years or 4 years after a previous flexible sigmoidoscopy	24 months – unless a screening flexible sigmoidoscopy is performed, then only every 4 years	Nothing if your doctor accepts assignment
Barium Enema Age 50 or older	4 years	24 months	There is no deductible for this test. You pay 20% of the Medicare approved amount for the doctor's services. In a hospital setting, you pay a copayment.

Annual Depression Screening

Effective October 14, 2011, Medicare covers annual screening for depression for beneficiaries in primary care settings that have staff-assisted depression care supports in place to assure accurate diagnosis, effective treatment and follow-up. Various screening tools are available for screening for depression. The decision to use a specific toll is at the discretion of the clinician in the primary care setting

Coverage is limited to screening services and does not include treatment options for depression or any diseases, complications or chronic conditions resulting from depression, nor does it address therapeutic interventions such as medication, combination therapy or other interventions for depression. Symptoms of major depression that are felt nearly every day include, but are not limited to:

- Feeling sad or empty
- Less interest in daily activities
- Weight loss or gain when not dieting
- Less ability to think or concentrate
- Tearfulness
- Feelings of worthlessness
- Thoughts of death or suicide

There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Diabetes Screening Tests

Millions of people have diabetes and do not know. Diabetes is the leading cause of blindness amount adults and the leading cause of End-Stage Renal Disease. Scientific evidence shows that early detection and treatment of diabetes with diet, physical activity and new medications can prevent or delay many of the illnesses and complications associated with diabetes. Medicare provides coverage of diabetes screening tests if you are in a risk group or have been diagnosed with pre-diabetes.

To be eligible for the diabetes screening tests, you must have any of the following risk factors:

- Hypertension – high blood pressure,
- Dyslipidemia – abnormal cholesterol and triglyceride levels;
- Obesity, or
- Previous identification of an elevated impaired fasting glucose or glucose tolerance.

Or at least two of the following characteristics:

- Overweight,
- Family history of diabetes,
- Aged 65 years and older, or
- A history of gestational diabetes or delivered a baby weighing greater than 9 pounds.

Medicare provides coverage of diabetes screening tests after a referral from a physician or qualified non-physician practitioner for a beneficiary at risk for diabetes. Medicare provides coverage with the following frequency:

- Beneficiaries diagnosed **with pre-diabetes**
    - Maximum of 2 diabetes screenings within a 12 month period, but
    - Not less than 6 months apart.
- Beneficiaries previously tested but not diagnosed as pre-diabetic or who have never been tested
    - Medicare covers 1 screening test within a 12 month period.

You will pay nothing for this benefit.

Diabetes Self-Management Training

Medicare helps pay for diabetes self-management training if you have been recently diagnosed with diabetes, or were determined to be at risk for complications from diabetes. This service is intended to educate beneficiaries in the successful self-management of diabetes. A qualified program includes the following services:

- Instruction in self-monitoring of blood glucose,
- Education about diet and exercise,
- An insulin treatment plan developed specifically for insulin-dependent beneficiaries, and
- Motivation for beneficiaries to use the skills for self-management.

Medicare will **cover up to 10 hours** of diabetes outpatient self-management training during one calendar year. Each session lasts for at least 30 minutes and is provide in a group of 2 to 20 people. You can get individual sessions if no group session is available or id your doctor says you have special needs that would prevent you from participating in group training.
You may also qualify for up to 2 hours of follow-up training if:

- Your doctor ordered it as part of your plan of care
- It takes place in a calendar year after the year you received your initial training.

You will pay the annual **Medicare Part B deductible and 20% coinsurance** for this service.

Glaucoma Screening

Glaucoma occurs when increased fluid pressure in the eye presses against the optic nerve, causing damage. Since glaucoma progresses with few or no warning signs or symptoms and vision loss from glaucoma is irreversible, annual screening of people at high risk for the disease is vitally important. Medicare coverage of glaucoma screenings began January 1, 2002.

While anyone can develop glaucoma, certain groups of people are at higher risk for the disease. Medicare covers an annual glaucoma screening if you have at least one of the following high risk factors:

- Individuals with diabetes,
- Individuals with family history of glaucoma,
- African-Americans aged 50 and older, or
- Hispanic-Americans aged 65 and older.

Medicare will help pay for glaucoma screening tests, when provided by or under the direct supervision of an optometrist or ophthalmologist, **once every 12 months**. You will pay the **annual Medicare Part B deductible and 20% of the Medicare approved amount**.

Human Immunodeficiency Virus (HIV) Screening

HIV or human immunodeficiency virus is the virus that causes AIDS. This virus attacks the immune system by destroying a type of white blood cells that is vital to fighting off infection. Beginning December 8, 2009, Medicare covers HIV screening for people with Medicare who are pregnant or people at increased risk for the infection, including anyone who asks for the test. People considered at increased risk are as follows:

- Men who have had sex with men after 1975;
- Men and women having unprotected sex with more than one partner;
- Past or present injection drug users;
- Men and women who exchange sex for money or drugs or who have sex partners who do;
- Individuals who past or present sex partners were HIV-infected, bisexual or injection drug users;
- Individuals being treated for sexually transmitted diseases;

- Individuals with a history of blood transfusion between 1978 and 1985; and
- Individuals who request an HIV test despite reporting no individual risk factors, since this group is likely to include individuals not willing to disclose high-risk behaviors.

Medicare provides coverage for HIV screening tests as follows:

- A maximum of **once per year for beneficiaries** at increased risk for HIV infection; and
- A **maximum of 3 times per term of pregnancy** for pregnant beneficiaries beginning with the date of the first test when ordered by her clinician, at the following times:
    - When the diagnosis of pregnancy is known;
    - During the third trimester; and
    - At labor, if ordered by the woman's physician.

You **will pay nothing for this screening** test. Beneficiaries with any known prior diagnosis of HIV-related illness are not eligible for this screening test.

Obesity Screening and Counseling

Clinical evidence indicates that intensive behavioral therapy for obesity is reasonable and necessary for the prevention or early detection of illness or disability. Effective November 29, 2011, Medicare covers obesity screening and intensive behavioral therapy. This service consists of the following:

- Screening for obesity in adults using measurement of body mass index, which is calculated by dividing weight by the square of height;
- Dietary (nutritional) assessment; and
- Intensive behavioral counseling and behavioral therapy to promote sustained weight loss through high intensity interventions on diet and exercise.

For beneficiaries with obesity, who are competent and alert at the time that counseling is provided and whose counseling is furnished by a qualified primary care physician or other primary care practitioner and in a primary care setting, Medicare covers a maximum of 22 sessions in a 12 month period. If you receive your first session in January 2012 and receive all 22 sessions, you may get another first session in January 2013. Medicare covers this service as follows:

- One face-to-face visit every week for the first month;

- One face-to-face visit every other week for months 2-6; and
- One face-to-face visit every month for months 7-12, if you meet the 6.6 lbs. weight loss.

At the sixth month visit, a reassessment of obesity and determination of the amount of weight loss must be performed. To be eligible for additional face-to-face visits you must have achieved a reduction in weight of at least 6.6 lbs. over the course of the first 6 months of intensive therapy. If you do not achieve a weight loss of at least 6.6 lbs. during the first 6 months, a reassessment of you readiness to change and body mass index is appropriate after an additional 6 month period.

There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Pap Tests, Pelvic Exams and Clinical Breast Exams

As part of your Medicare benefits, Medicare covers Pap test and a pelvic exam to check for cervical and vaginal cancers. The pelvic exam also includes a clinical breast exam to check for breast cancer. According to the American Cancer Society cervical cancer was once the number one cause of cancer death in women, but since the use of Pap tests to detect cancer the number of deaths has declined.

This preventive service is **available to all women** who have Medicare. Medicare will cover the Pap test and pelvic exam **once every 24 months**. However, if you are of childbearing age and have had an abnormal Pap test within the past 36 months or are at high risk for cervical or vaginal cancer, Medicare will cover a Pap test and pelvic exam **every 12 months. High risk** factors for cervical and vaginal cancer include the following:

- Early onset of sexual activity (aged 16 and younger),
- Multiple sexual partners (five or more in a lifetime),
- History of a sexual transmitted disease, fewer than 3 negative Pap test or no Pap test within the previous 7 years,
- DES (diethylstilbestrol) exposed daughters of women who took DES during pregnancy,
- Smoking, and
- Using birth control pills for an extended period of time (5 or more years).

There is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Prostate Cancer Screening

Medicare helps pay for prostate cancer screening for the early detection of prostate cancer. The two most common screenings used by physicians are Prostate Specific Antigen (PSA) blood test and the screening Digital Rectal Examination. All men are at risk for prostate cancer; however, the causes of prostate cancer are not yet clearly understood. Through research, several factors have been identified that increase the risk for prostate cancer. Risks factors include the following:

- Family history of prostate cancer,
- Men aged 50 and older, diet of red meat and high fat dairy,
- Smoking, and
- Member of high risk ethnic group – African-Americans and Caucasians are highest risk groups.

Medicare provides coverage of an annual preventive prostate cancer screening PSA blood test and Digital Rectal Exam **once every 12 months** for **all male beneficiaries aged 50 and older**. Coverage begins the day after your 50th birthday.

You will **pay nothing for the screening PSA blood test**. You will pay the annual **Medicare Part B deductible and 20%** coinsurance for the Digital Rectal Exam.

Screening Mammogram

Breast cancer is the most frequently diagnosed non-skin cancer in women ad is second only to lung cancer as the leading cause of death among women in the United States. Every woman is at risk, and this risk increases with age. Your risk increases if you:

- Are older,
- Have a personal history of breast cancer,
- Have family history of breast cancer,
- Have dense breast tissue,
- Been diagnosed with certain benign breast conditions,

- Are Caucasian,
- Started menstruation before age 12 or menopause after age 55,
- Have a personal history of chest radiation therapy,
- Was given (or mother was given) the drug diethylstilbestrol (DES) during pregnancy,
- Had first baby after age 30,
- Never had a baby,
- Consume excessive amounts of alcohol, or
- Are overweight or obese.

A screening mammogram is a radiologic procedure, an X-ray of the breast, used for the early detection of breast cancer in women who have no signs or symptoms if the disease and includes a physician's interpretation of the results. A diagnostic mammogram is an X-ray of the breast to check for breast cancer after a lump or other sign or symptom of breast cancer has been found.

Medicare provides coverage of an annual screening **mammogram once every 12 months** for women aged 40 and older. Mammograms should be scheduled so that they are after the 11th month. If your last mammogram was February 15, 2012, you can schedule your next screening February 1, 2013 or after.

Coverage for Screening Mammography Services	
Age	**Frequency**
Aged 35 and younger	None
Aged 35-39	One Baseline Screening
Aged 40 and older	Once Every 12 Months

Beginning for services on or after January 1, 2011, there is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full. However, you will pay the annual Medicare Part B deductible and 20% coinsurance for a diagnostic mammogram.

Smoking Cessation Services – Diagnosed with Tobacco-Related Disease

Medicare Part B covers cessation counseling for individuals who use tobacco and have been diagnosed with a recognized tobacco-related disease or who exhibit symptoms consistent with tobacco-related disease. Medicare will cover **two cessation attempts per year**. Each attempt may include up to 4 counseling sessions, with a total annual benefit **covering up to 8 sessions in a 12 month period**.

Services can be provided in the hospital or on an outpatient basis; however, the benefit does not cover hospitalization if tobacco cessation is the primary reason for the hospital stay. You must get counseling from a qualified Medicare provider – physician, physician assistant, nurse practitioner, clinical nurse specialist or clinical psychologist.

You will pay the annual **Medicare Part B deductible and 20% coinsurance** for these counseling sessions. Many drugs are available to help you quit smoking, like nicotine patches, and these may be covered by your Medicare prescription drug plan.

Smoking Cessation Services – Preventive with No Diagnosed Tobacco-Related Disease

As of August 25, 2010, Medicare covers tobacco cessation counseling to prevent tobacco use for outpatient and hospitalized Medicare beneficiaries. This preventive service is available to you if you:

- Use tobacco, regardless of whether you have signs or symptoms of tobacco-related disease;
- Are competent and alert at the time the counseling is provided; and
- Receive counseling by a qualified physician, or other non-physician practitioner.

Medicare will cover **two cessation attempts per year**. Each attempt may include up to 4 counseling sessions, with a total benefit covering **up to 8 sessions within a 12 month period**. Services can be provided in the hospital or on an outpatient basis; however, the benefit does not cover hospitalization if tobacco cessation is the primary reason for the hospital stay

You will pay the annual **Medicare Part B deductible and 20% coinsurance** for these counseling sessions. Many drugs are available to help you quit smoking,

like nicotine patches, and these may be covered by your Medicare prescription drug plan.

Vaccine – Hepatitis B

Hepatitis B is a serious disease that can affect people of all ages. Hepatitis B attacks the liver and can cause chronic infection, resulting in cirrhosis of the liver, liver cancer, liver failure and death. Medicare provides coverage of the hepatitis B vaccine and its administration for certain beneficiaries at intermediate to high risk.

High risk groups currently identified include:

- Individuals with End-Stage Renal Disease,
- Individuals with hemophilia who receive Factor VIII or IX concentrates,
- Clients of institutions for the developmentally disabled,
- Individuals who live in the same household as a Hepatitis B carrier,
- Homosexual men, and
- Illicit injectable drug users.

Intermediate risk groups currently identified include:

- Staff in institutions for the developmentally disabled, and
- Workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work.

The hepatitis B vaccine is administered in 3 doses. Beginning for services on or after January 1, 2011, there is **no cost for this service, if you go to a participating provider** – accepts Medicare assignment as payment in full.

Vaccine – Influenza

Influenza, also known as the flu, is a contagious disease caused by influenza viruses that generally occurs during winter months. It attacks the respiratory tract. The flu is a serious illness that can lead to pneumonia. The risks for complications, hospitalizations and deaths from influenza are higher among individuals aged 65 and older, young children and individuals with certain health conditions.

Medicare provides coverage of the seasonal influenza virus vaccine and its administration for **all Medicare beneficiaries regardless of risk** for the disease. Medicare will pay for one flu shot per flu season. Medicare determines when the

flu season per each year. Usually there is one season per year, but there can be more. Vaccination is recommended for all individuals aged 6 months or older.

If you receive your flu shot from a Medicare provider **that accepts assignment, you will pay nothing for the vaccine**. If your provider does not accept assignment you are responsible for all excess charges for the administration of the vaccine, **there is no limiting charge**. Your provider must bill Medicare for the vaccination, Medicare no longer reimburses for the shot.

Vaccine – Pneumococcal

Pneumococcal disease is an infection caused by the bacteria Streptococcus pneumonia, also known as pneumococcus. Invasive pneumococcal infection kills thousands of people in the United States each year, most of them aged 65 and older. This disease can strike at any time during the year. Medicare coverage of the pneumococcal polysaccharide vaccine and its administration began July 1, 1981. Coverage for pneumococcal conjugate vaccine and its administration began January 1, 2008.

Generally, Medicare provides coverage pneumococcal vaccination **once in a lifetime for all** Medicare beneficiaries. Medicare may provide coverage of additional vaccinations based on risk or uncertainty of vaccination status. Revaccination may be appropriate if you are at highest risk and those most likely to have rapid declines in antibody levels. This group includes individuals with the following conditions:

- Functional or anatomic asplenia – from sickle cell disease or splenectomy,
- Human Immunodeficiency Virus (HIV),
- Leukemia,
- Lymphoma,
- Hodgkin's disease,
- Multiple myeloma,
- Generalized malignancy,
- Chronic renal failure,
- Nephrotic syndrome, and
- Other conditions with immunosuppression.

If you receive your flu shot from a Medicare provider **that accepts assignment, you will pay nothing for the vaccine**. If your provider does not accept assignment you are responsible for all excess charges for the administration of the vaccine, **there is no limiting charge**.

Vaccine – Shingles

The shingles vaccine **is not covered by Medicare Part B**; however, this vaccine is covered by the Medicare Part D prescription drug plans.

People who have had chickenpox in the past are at risk for developing shingles because the virus remains inactive in certain nerve cells of the body and can become active later in life. Check with your Part D drug plan for information about the cost of the vaccine.

Section C: Claims Processing

Medicare Claims Processing

All Providers, participating and nonparticipating, are required by law to file Medicare claims for covered services and to each provider you must supply correct information including:

- Your Medicare claim number
- All health coverages, including Medicare A & B (to determine primary or secondary payer)
- Your name exactly as it appears on your Medicare card (no nicknames)
- Notify Social Security of any changes in address, phone number, and ask that changes be made in the Master File (which will also change the information in your Medicare file)
- Update providers' files with changes in address, phone number, etc.

Medicare is authorized to ask service providers for important medical or personal information about you, **but only with your permission**. This information is given to Medicare intermediaries, carriers, the medical review board, and providers in order to administer Medicare claims.

You **may refuse** to give permission to **release** the requested information, but **you must give information about** …

- work injuries
- auto injuries
- other liability related insurance claims

Keep in mind, withholding information may result in slow or no payment. You have the right to obtain information about their claims.

Medicare Part A Claims

How Are Part A Claims Processed?

Medicare participating facilities submit the claim to Medicare. If the facility accepts assignment, Medicare pays the facility directly.

When Should You Pay the Facility?

You should wait until you know that Medicare and any other insurance has paid before you pay anything. **You must inform the facility of your intention to wait.**

Usually, facilities file all private insurance claims as well as Medicare claims and receive reimbursement directly from the insurer. You may request an itemized bill from the facility, but this will not reflect Medicare's payment, only what was paid.

You will receive a Medicare Summary Notice (MSN) from Medicare. This form describes days used, and the deductible, and/or the co-payments that you owe. The MSN is usually received within 60-90 days **after** hospitalization. Wait on **both** the Medicare Summary Notice **and** the hospital bill before paying.

Can the Service Provider Bill You for More Money?

If the provider accepts assignment for Medicare Covered Services the facility **cannot** bill you for the difference between Medicare's payment and the facility's actual costs. The facility may bill you only for Medicare covered services that are counted toward the deductible, any co-payment, and any Medicare non-covered services provided.

Who Is the Intermediary?

The intermediary is the organization that processes Part A claims. Hospital and skilled nursing facility claims are processed in Indiana by **Wisconsin Physicians Service Insurance Corporation**. Home health care and hospice claims are processed by regional intermediaries. Indiana's regional intermediary is **Palmetto Government Services.** Durable medical Equipment claims are processed by **National Government Services**.

Medicare Part B Claims

When Are Part B Claims Processed by the Part A Intermediary?

This occurs when the individual receives Part B services in a Part A facility. In these instances, services are reimbursed according to Part B coverage through the Part A intermediary. This usually means that you must meet the Part B deductible and co-insurance.

Railroad Retirees and Medicare

For Part B claims, **Railroad Retirees** should deal with **United Health Care.** Regional carriers are listed in the Railroad Medicare Handbook. The phone number will also be listed on the beneficiary's Medicare Summary Notice and in the SHIP Telephone Reference.

When Services Occur Outside Indiana

Medicare claims must be submitted to the Medicare carrier or intermediary **in the state where the individual received the service.** If you have residences in more than one state, take special note of where the service was performed, because there is an **exception** to this rule. Durable Medical Equipment claims are filed by the supplier with regional carriers in the state of your permanent residence (the address where you spend six (6) months of the year). The Social Security Administration can supply the name of each state's Medicare carrier. Carriers are listed in the back of the *Medicare and You Handbook*.

Medicare Summary Notice

The **Medicare Summary Notice (MSN)** is an easy to read statement that clearly details your insurance claim information. You will normally receive your MSN from the carrier. **These notices are sent on a quarterly basis (every three months), u**nless you are due a payment check from Medicare. In that case the MSN will be sent as your claims are processed. Individual MSNs can be accessed on-line at any time.

The MSN lists the details of services you received and the amount you may be billed. It is important to compare the MSN to bills received from providers to determine which have been processed and paid and which have not.

- When it is determined that some medical bills have not been processed, request that the service provider **resubmit** the bills to Medicare.
- **Denied** payments may indicate that the service provider may have used an incorrect code. You should call the provider and ask them to double check the coding and **resubmit** the claim.
- If the deductible has not been met, it is subtracted from the Medicare approved amount. Medicare's 80% payment is then calculated.

Non-Participating Providers

When a provider does not normally participate with Medicare, you will be sent a check from Medicare to pay the provider. **The check will be attached to the bottom of the MSN.** These MSNs are sent out as the claims are processed. Be careful to not file MSN attachments without understanding their purpose. Many beneficiaries do not notice the check and file it away without cashing it.

- **Deposit** the check, then **write a personal check** to the provider. This creates a way to track payments.
- Keep a copy of the MSN until the bill is completely settled.
- Send only copies of the MSN or other papers

Submitting Claims

Assigned and non-assigned providers must submit claims within **12 months** of providing service to you. Non-assigned providers may request a three (3) month extension. Medicare will usually deny payments on late claims. In these cases you are not responsible for paying the amount Medicare would have paid if the claim was filed on time, nor for paying any co-insurance.

If you have already paid money on these claims, Medicare will instruct the provider to **refund** the money. **Non-participating** providers on unassigned claims will b e asked my Medicare to refund money paid by you, **but they are not required** to offer a refund. If a provider refused to submit a claim, or if you have a problem with delayed payments, contact:

1-800-Medicare (1-800-633-4227).

If you must submit a claim yourself, send all information to:

Medicare Part B Claims, P.O. Box 6160, Indianapolis, IN 46204-6160

Important Points of the MSN

- There are separate MSNs for Medicare Part A and Medicare Part B (See copies of MSN brochures)
- A claim is paid unless there is a message in the **Notes** section that says it was not or if the **Non-Covered Charges** column contains amounts other than zero (0)
- The Notes section contains valuable information that will explain how the claim was processed
- The MSN provides the right to appeal the payment or claim denial. A beneficiary simply circles the item on the MSN he/she disagrees with, signs the form, and returns it to National Government Services for review. It is only necessary to return the form if the beneficiary disputes a denied claim or other problem.
- Deductible and coinsurance amounts are not shown separately. The two (2) amounts are added together and shown in the deductible and coinsurance column. The Notes section identifies the amount of the deductible not met and still to be met.
- The dates of service do not appear at the top of the claim information. These dates are shown several lines down below the words “referred by”. They refer to the date the service was reviewed, not the date the patient was referred for service.
- The logo in the upper left hand corner of the MSN refers to the Centers for Medicare and Medicaid Services (CMS). CMS is the government agency responsible for the Medicare and Medicaid programs. The logo shows both Medicare and Medicaid, but that does **not** mean that beneficiary has both.

Below is a sample of an MSN for Part A and information on how to read it.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Summary Notice

1 June 16, 2006

2 CUSTOMER SERVICE INFORMATION

4 Name
Street Address
City, State ZIP Code

Your Medicare Number: 111-11-1111-A 3

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

5 **BE INFORMED:** Protect your Medicare Number as you would a credit card number.

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Hospital Services
TTY users should call: 1-877-486-2048.

This is a summary of claims processed from 5/15/06 through 8/15/06.

6 **PART A HOSPITAL INSURANCE - INPATIENT CLAIMS**

Dates of Service	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
7 Claim number 12345-84956-84556 8 Hospital Name, Street Address, City, State ZIP Code Referred by: Paul Jones, M.D. 9 04/07/06–05/09/06	10 14 days used	11 $0.00	12 $876.00	13 $876.00	14 a, b

THIS IS NOT A BILL – Keep this notice for your records.

1. **Date:** Date MSN was sent

2. **Customer Service Information:** Who to contact with questions about MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).
3. **Medicare Number:** The number on your Medicare card
4. **Name and Address:** If incorrect, contact the company listed in (2), and the Social Security Administration immediately.
5. **Be informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.
6. Part A Hospital Insurance - Inpatient Claims: Type of service. See the back of MSN for additional information. (Please Note: For outpatient services, this section is called "Part B Medical Insurance – Outpatient Facility Claims".)
7. Claim Number: Number that identifies this specific claim.
8. **Provider's Name and Address:** Facility's name and billing address. The referring doctor's name will also be shown . The address shown is the billing address, which may be different from where you receive the service(s).
9. **Dates of Service:** Dates services were provided. You may use these dates to compare with the dates shown on your hospital bill.
10. **Benefit Days Used:** Shows the number of days used in the benefit period. See the back of your MSN for an explanation of benefit periods. (**Please Note**: For outpatient services, this column is called "**Amount Charged**."
11. **Non-Covered Charges:** Shows the charges for services denied or excluded by the Medicare program for which you may be billed.
12. **Deductible and Coinsurance:** The amount applied to you deductible and coinsurance.
13. **You May Be Billed:** The total amount the provider may bill you , including deductibles, coinsurance, and non-covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.
14. **See Notes Section:** If letter appears, refer to (#15) for explanation.

15 **Notes Section:**

a You have 46 full days remaining in this benefit period.

b $876.00 was applied to your inpatient deductible.

16 **Deductible Information:**

You have met the Part A deductible for this benefit period.

17 **General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

18 **Appeals Information - Part A (Inpatient)**

If you disagree with any claims decision on Part A of this notice, you can request an appeal by **October 16, 2004.**

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1. (You may also send any additional information you may have about your appeal.)

3) Sign here_____Phone Number (___)_____

15. **Notes Section:** Explains letters in (13) for more detailed information about your claim.
16. **Deductible Information:** How much of your deductible you have met for the benefit period.
17. **General Information:** Important Medicare news and information.
18. **Appeals Information:** How and when to request an appeal.

Below is a sample of an MSN for Part A and information on how to read it.

CMS

Medicare Summary Notice (1)

June 16, 2006

(2) CUSTOMER SERVICE INFORMATION

(4) Name
Street Address
City, State ZIP Code

Your Medicare Number: 111-11-1111-A (3)

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd.
Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

(5) **BE INFORMED:** Protect your Medicare Number as you would a credit card number.

Call: 1-800-MEDICARE (1-800-633-4227)
Ask For Doctor Services
TTY users should call: 1-877-486-2048.

This is a summary of claims processed from 5/15/06 through 8/15/06.

(6) **PART B MEDICAL INSURANCE - ASSIGNED CLAIMS**

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
(7) Claim number 12345-84956-84556		(10)	(11)	(12)	(13)	(14)
(8) Doctor name, Street Address, City, State ZIP Code		$55.00	$44.35	$0.00	$44.35	a
(9) 04/07/06	1 Office/Outpatient Visit, ES (99214)					b

(15) **THIS IS NOT A BILL** – Keep this notice for your records.

1. **Date:** Date MSN was sent.
2. **Customer Service Information:** Who to contact with questions about the MSN. Provide your Medicare number (3), the date of the MSN (1), and the date of the service you have a question about (7).
3. **Medicare Number:** The number on your Medicare care.

4. **Name and Address:** If incorrect, contact the company listed in (2), and the Social Security Administration immediately.
5. **Be Informed:** Messages about ways to protect yourself and Medicare from fraud and abuse.
6. **Part B Medical Insurance – Assigned Claims:** Type of service. See the back of MSN for information about assignment. (**Please Note**: For unassigned services , this section is called "**Part B Medical Insurance – Unassigned Claims.")**
7. **Claim Number:** Number that identifies this specific claim.
8. **Provider's Name and Address:** Doctor (may show clinic, group, and /or referring doctor) or provider's name and billing address. The referring doctor's name may also be shown if the service was ordered or referred by another doctor. The address shown in the billing address may be different from where you received the services.
9. **Dates of Service:** Date service or supply was received. You may use these dates to compare with the dates shown on the bill you receive from the doctor.
10. **Amount Charged:** Amount the provider billed Medicare.
11. **Medicare Approved:** Amount Medicare approves for this service or supply.
12. **Medicare Paid Provider:** Amount Medicare paid to the provider (Please Note: For unassigned services, this column is called "Medicare Paid You."
13. **You May Be Billed:** The total amount the provider may bill you including deductibles, co-insurance, and non covered charges. Medicare supplement (Medigap) policies may pay all or part of this amount.
14. **See Notes Section:** If letter appears, refer to (16) for explanation.
15. **Services Provided:** Brief description of the service or supply received. **Notes Section:** Explains letters in (14) for more detailed information about your claim.

16 **Notes Section:**

a This information is being sent to your private insurer(s). Send any questions regarding your benefits to them.

b This approved amount has been applied toward your deductible.

17 **Deductible Information:**

You have now met $44.35 of your $100 Part B deductible for 2004.

18 **General Information:**

Please notify us if your address has changed or is incorrect as shown on this notice.

19 **Appeals Information - Part B**

If you disagree with any claims decision on this notice, you can request an appeal by **October 16, 2004.**

Follow the instructions below:

1) Circle the item(s) you disagree with and explain why you disagree.

2) Send this notice, or a copy, to the address in the "Customer Service Information" box on Page 1.

3) Sign here_____Phone Number (___)_____

16. **Deductible Information**: How much of your yearly deductible you have met.
17. **General Information**: Important Medicare news and information.
18. **Appeals Information**: How and when to request an appeal.

Assigned Claims

Providers take assignment and accept Medicare's approved amount as total payment for the service. You may be billed for:

- Deductible
- Co-Insurance
- Services which are not covered by Medicare
- Non-covered services for which the person signed a waiver listing service and cost prior to receiving the service

Non-Assigned Claims

Providers do not take assignment, and do not accept Medicare's approved amount as total payment for the service. You may be billed for

- Deductible
- Co-Insurance
- Services which are not covered by Medicare
- Non-covered services for which the person signed a waiver listing service and cost prior to receiving the service
- Charges in excess of the Medicare approved amount, (not in excess of the 115% Limiting Charge.
- If a provider will not refund charges in excess of the Limiting Charge or continues to attempt to collect the excess charges, the beneficiary should report this to the Medicare Fraud and Abuse Division at: 1-800-Medicare (1-800-633-4227).

Medicare Billing

Billing for Medicare Part A, Part B, and Managed Care Plans is all processed differently. Questions about bills and claims should be directed to Medicare, the Medicare carrier, Managed Care Plan, and/or the provider, depending on the services, claims and bills in question.

Part A Claims

When the beneficiary goes into the hospital:

1. The hospital bills Medicare for all covered charges.
3. The Medicare Intermediary sends payment directly to the hospital and sends a Medicare Summary Notice to the patient.
4. The hospital bills the patient for the Part A deductible and applicable co-payments if in over 60 days, and for any other services not covered by Medicare.

Part B Claims

When the beneficiary goes to a physician or other service provider that **accepts Medicare assignment** for Medicare Part B covered services:

1. The physician or provider bills Medicare directly.
2. The Medicare carrier pays 80% of the approved charge directly to the provider minus the Part B deductible and sends the beneficiary a Medicare Summary Notice.
3. The patient is then responsible for paying the 20% coinsurance to the provider and any amount applied towards the Part B deductible.

When the beneficiary goes to a physician or other service provider that **does not accept Medicare assignment** for Medicare Part B covered services:

1. The physician or provider bills Medicare directly.
2. Medicare sends a check for 80% of the approved charge with the MSN directly to the patient.
3. The patient should deposit the Medicare check and then must pay the provider Medicare's portion of the bill, the 20% coinsurance, any amounts to be applied toward the annual deductible, and any excess charges up to the Limiting Charge.

Medicare Supplement Policies

Federal and state law mandates that companies selling Medigap policies must participate in **Medigap Cross Over.** Many Medigap companies have a contract with the Medicare carrier and arrange to have Medicare send all claims directly to the Medigap company. This is called **All Claims Cross Over.**

Medigap Cross Over	**All Claims Cross Over**
Initiated by the beneficiary.	Initiated by the Medigap company.
Service covers all participating and nonparticipating providers.	Service is only for Medicare participating providers.
Payment is sent directly to the participating physician or supplier.	Payment may be to the beneficiary or to the provider.
Federal and state law mandates that companies selling Medigap must participate in Medigap Cross Over	Companies do not have to offer this service, nor do beneficiaries have to take and buy this service.

How Does Someone Initiate Medigap Cross Over?

A beneficiary should:

- Ask the Medicare participating physician or supplier to submit a completed claim form to Medicare; sign the completed form in two (2) places, giving both Medicare and the insurance company his/her permission to send payment directly to the provider.
- Provide necessary Medigap policy information to the provider to be included on the NGS claim form #1500 in box 9.

Medicare will:

- Process Medicare's part of the claim and forward the claim information to the Medigap company. The Medigap company is required by law to accept

the claims information from Medicare. Medigap companies pay a user fee to receive these claims.

The Medigap company will:

- Pay its portion of the claim directly to the participating physician or supplier.

Managed Care Plans

Managed Care Plans provide covered services for Parts A and B. The beneficiary may have co-payments, as specified in the Managed Care agreement. There is no bill processing as is described above. Beneficiaries should contact their plan for more information on that company's billing process.

Beneficiaries should never send original copies of bills in question.

When Medicare Is Not The Primary Payer

Medicare is the secondary payer after claims have been processed through the primary insurance company for the following:

Employer Group Insurance

Medicare is secondary for persons that are 65 years old or older who have an employer group health plan through **current employment** or the **current employment of a spouse.** This law applies when the employer has 20 employees or more.

- For Medicare covered services not included under the employer's plan, Medicare would be a primary payer.
- When the employer group plan is an HMO, and the person goes to a provider outside the HMO network, Medicare will pay as the primary payer for the first few claims. Medicare will send a letter stating that Medicare will no longer pay for out-of-network providers.
- For people who are disabled, Medicare is the secondary payer if he/she accepts a group health plan and:
    1. Is under 65 years old and has Medicare due to a disability.
    2. Is covered under a group health plan because of current employment or the current employment of a family member of any age.

3. The employer has 100 or more employees.

End Stage Renal Disease Patients

Medicare is secondary for persons with ESRD that have an active employer group health plan or are on COBRA.

Veterans Administration

See the Navigation Guide for Supplemental and Other Insurance.

Federal Black Lung Program

See the Medicare and Other Health Benefits booklet.

Liability Settlements

Medicare will be the secondary payer whenever an injury has occurred which is covered and paid by a liability or no-fault insurance. This will occur in the following cases:

- Automobile Insurance Submit automobile accident related claims to the insurance company before submitting them to Medicare.
- Liability Insurance (homeowner, malpractice, etc.) These claims may be submitted to Medicare for a conditional payment after three (3) months. After a liability settlement is reached, Medicare will recover the conditional payment from the settlement amount.
- Worker's Compensation Medicare will be billed first if the claim is contested and the person is waiting for the Worker's Compensation Board decision. The bill should include a statement that the claim is being contested.

Patients must inform the provider when the injury or illness for which they are seeking medical attention is the result of a **work related incident, an auto accident,** or an injury involving **liability** or **homeowner insurance.** This type of insurance would then be the primary payer.

Medicare beneficiaries and their providers must accurately complete the section of the Medicare claim form that deals with other health insurance.

-

Medicare has the right to be a secondary insurance payer due to **subrogation laws.** Subrogation prevents people from receiving double insurance payments and making a profit on an injury. A beneficiary that receives a monetary settlement could receive demands from Medicare to return payments that Medicare had previously made. To prevent this, Medicare beneficiaries should inform Medicare whenever there is any kind of liability insurance involved.

What Medicare Pays When Medicare Is the Secondary Payer?

Medicare does **not act like a supplement** to the primary insurance. This means **Medicare will not always pay the remaining amount after the primary insurance has paid.** If the primary insurance payment is less than Medicare's approved amount, Medicare may pay the difference. If the primary payment is equal to or more than the Medicare approved amount, Medicare will pay nothing.

Medicare does not act like a supplement to the primary insurance.

Medicare deductibles must be met before Medicare will pay. This is true whether Medicare is the primary or secondary payer. National Government Services has a special department called the Medicare Secondary Payer Unit. Questions should be addressed there by calling: 1-800-633-4227.

Who Files the Claim When Medicare is the Secondary Payer?

Facilities that provide the services will usually file with-the primary insurance and also with Medicare when Medicare is the secondary payer. Doctors or suppliers have a choice of whether or not to file the claim with the primary insurance company when Medicare is a secondary payer.

When the doctor files a claim with the primary insurance and receives payment from them, then the doctor must also file the claim with Medicare

When you file the claim with the primary insurance company and receives the payment from the company, then you can do either of these:

1. Take all paperwork to the doctor including the insurance company's payment information and request the doctor file the claim with Medicare.

2. File your own claim with Medicare, using form #1490-F. This form can be obtained from the Social Security Administration or Medicare, **(1-800-633-4227)**

When filing claims with Medicare when Medicare is secondary, you must include a copy of the primary insurance company's benefit statement, whether it is the provider or the beneficiary filing the form.

Private Insurance Claims

Medigap policies **coordinate** benefits with Medicare. Some Medicare supplement policies pay for excess charges above the Medicare approved amount, usually up to the Limiting Charge. They may also pay for specific Medicare non-covered services.

Check the policy to know what it will pay.

Most private insurance companies want a copy of the Part B Medicare MSN before it will reimburse for the claim. Some also require a bill from the provider and its own insurance claim form. Some may have cross over service with Medicare. Check with the company for information about its services and requirements regarding claims. The typical filing process is as follows:

- The provider files the claim with Medicare. The beneficiary should wait to receive the MSN.
- The beneficiary attaches a copy of the MSN to the insurance company's claim form. He/she should also attach the actual bill if the insurance company requires it.
- The beneficiary mails all items in the envelope supplied by the insurance company (if there are any) to insure prompt processing.
- A beneficiary should never send his/her only copy of the MSN or other forms.

See SHIP'S Claims Record Form in the Navigation Guide 4 Section R Forms.

Privacy and Medicare

The purpose of the Privacy Act of 1974 is to provide safeguards for you against an invasion of privacy by Federal agencies. Guidelines for releasing Medicare information have been established for you living or deceased. There are **two (2) ways** to release Medicare information that include the following:

Direct Consent (or Verbal Permission) to Release Information Direct consent from you will enable the Customer Service Representative (CSR) at National Government Services (formally AdminaStar Federal) to release your information including payment if the CSR receives verbal consent over the phone from you.

Written Consent (or Authorized Permission) to Release Information Written consent from you will enable the CSR to release information including payment if the caller can verify certain information asked by the CSR and has a consent form on file at the Medicare office. Also, if the caller is a Representative Payee for you or if the caller has Power of Attorney on file at the Medicare office they can receive information about you.

Without Verbal or Written Consent to Release Information

No consent from you will limit the amount of information a CSR can give to a third party caller. Only the following four (4) types for information can be offered:

- If and when Medicare received a claim.
- When the claim was processed (not how).
- When you will receive your MSN.
- General Medicare and coverage questions.

Medicare can send the third party a consent form. There are separate consent forms for Part A, Part B and Durable Medical Equipment. Once the form is filled out, signed, and returned to the Medicare office, Medicare can release information for the Medicare beneficiary on the form only or Medicare can send a copy of the MSN directly to you. Most of the information will be on the notice. For questions or to have a consent form mailed out, call 1-800-633-4227.

Medicare: Fraud and Abuse

Most Medicare payment errors are due to simple mistakes, and not the providers trying to take advantage of system. Unfortunately there are those who do try to abuse or defraud Medicare. National Government Services (formally AdminaStar Federal) has fraud and abuse divisions where beneficiaries can report the following:

- Providers performing unnecessary or inappropriate services.
- Providers billing Medicare for services the person did not receive
- Providers who refuse to file claims to Medicare.
- The use of someone else's Medicare claim number to receive services or supplies.

To contact National Government Services use the contact information on your MSN.

Detection Tips

You should be suspicious if the provider tells you that:

- The equipment or service is free; he only needs your Medicare number for his records. NOTE: For clinical laboratory tests, there is no co-payment and a provider may in good faith state that the test is free, since there is no cost to the person with Medicare.
- Medicare wants you to have the item or service.
- They know how to get Medicare to pay for it.
- The more tests they provide the cheaper they are.

Be suspicious of providers that:

- Charge co-payments on clinical laboratory tests, and on Medicare covered Preventive Services such as PAP smears, prostate specific antigen (PSA) tests, or flu and pneumonia shots.
- Routinely waive co-payments on any services, other than those previously mentioned, without checking your ability to pay.
- Advertise "free" consultations to people with Medicare.
- Claim they represent Medicare.

- Use pressure or scare tactics to sell you high priced medical services or diagnostic tests.
- Bill Medicare for services you did not receive.
- Use telemarketing and door-to-door selling as marketing tools.

Prevention Tips

To help prevent Medicare fraud, you should report suspected instances of fraud. Whenever you receive a payment notice from Medicare, review it for errors. The payment notice shows what Medicare was billed for, what Medicare paid and what you owe. Make sure Medicare was not billed for health care services or medical supplies and equipment you did not receive.

The following is a list of tips to prevent fraud:

- Don't ever give out your Medicare Health Insurance Claim Number (on your Medicare card) except to your physician or other Medicare provider.
- Don't allow anyone, except appropriate medical professionals, to review your medical records or recommend services.
- Don't contact your physician to request a service that you do not need.
- Do be careful in accepting Medicare services that are represented as being free.
- Do be cautious when you are offered free testing or screening in exchange for your Medicare card number.
- Do be cautious of any provider who maintains that they have been endorsed by the Federal government or by Medicare.
- Do avoid a provider of health care items or services who tells you that the item or service is not usually covered, but they know how to bill Medicare to get it paid.

The carrier or intermediary need to be notified of the possible fraud or abuse, the date it occurred, and the names and addresses of the provider and beneficiary involved.

Always report suspected Medicare Fraud and Abuse.

Medicare Fraud and Abuse

INDIANA

SMP Overview

The SMP (formerly Senior Medicare Patrol) program was established in May of 1997 and is primarily funded by the Administration on Aging. The program consists of fifty-seven innovative community-based projects located in every state, the District of Columbia, Guam, U.S. Virgin Islands and Puerto Rico. The SMP projects utilize the skills and expertise of retired professionals, such as doctors, nurses, teachers, lawyers, accountants, and others to work in their communities, educating and empowering beneficiaries to take an active role in the detection and prevention of health care fraud and abuse, with a focus on the Medicare and Medicaid programs.

The Indiana SMP Project partners with the State Health Insurance Assistance Program (SHIP) to provide new counselor/volunteer training and Update training for Certification. The Indiana SMP Project is located in the Indiana Association of Area Agencies on Aging (IAAAA) office and works with the 16 Area Agencies on Aging promoting community awareness of health care errors, fraud and abuse.

SMP's work together with SHIP Counselors to educate beneficiaries and others of ways to protect their personal information, detect fraudulent scams, and report suspicious behavior.

By helping beneficiaries read and understand the Medicare Summary Notice and encouraging them to report errors, you are taking an active part in protecting them and others against fraudulent, wasteful, and abusive health care practices.

Most Medicare payment errors are due to simple mistakes, and not the providers trying to take advantage of the system. Unfortunately there are those who do try to abuse and defraud Medicare.

National Government Services has fraud and abuse divisions where beneficiaries can report the following:

- Providers performing unnecessary or inappropriate services.
- Providers billing Medicare for services the person did not receive.
- Providers who refuse to file claims to Medicare.
- The use of someone else's Medicare claim number to receive services or supplies.

To contact national Government Services use the contact information on your MSN in the Customer Service Information box.

What is Medicare Fraud?

Under the False Claims Act, it is a ***criminal offense*** to present a false or fraudulent claim for medical services if the individual ***knew*** that the claim was false or fraudulent. The most frequent kind of fraud arises from a false statement or misrepresentation that is material to entitlement or payment under the Medicare program.

What is Medicare Abuse?

Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly or intentionally misrepresented the facts to obtain payment.

Detection Tips

You should be suspicious if the provider tells you that:

- The equipment or service is free; they only need your Medicare number for their records. NOTE: For clinical laboratory tests, there is no co-payment and a provider may in good faith state that the test is free, since there is no cost to the person with Medicare.
- Medicare wants you to have the item or service.
- They know how to get Medicare to pay for it.

- The more tests they provide the cheaper they are.

Be suspicious of providers that:

- Charge co-payments on clinical laboratory tests, and on Medicare covered Preventive Services such as PAP smears, prostate specific antigen (PSA) tests, or flu and pneumonia shots.
- Routinely waive co-payments on any services, other than those previously mentioned, without checking your ability to pay.
- Advertise "free" consultations to people with Medicare.
- Claim they represent Medicare.
- Use pressure or scare tactics to sell you high priced medical services or diagnostic tests.
- Bill Medicare for services you did not receive.
- Use telemarketing and door-to-door selling as marketing tools.

What is Medicaid Fraud?

Medicaid fraud occurs when a health care provider, such as a doctor, dentist, pharmacist, hospital, nursing home or other health care service:

- Bills Medicaid for services that the Medicaid patient does not receive;
- Bills excessively for services
- Bills for services that are not necessary.

What next?

Ask beneficiaries if they have recorded medical information in a journal. (If not, suggest they request one from SHIP/SMP.)

Before calling to question or report problems, have the following information available:

- Name and Medicare or Medicaid number
- Name of company or doctor
- Date of service

- Description of the problem
- Suggest they **call the provider or plan first,** or assist them with the call.
- Suggest they call the local Area Agency on Aging at: 1-800-986-3505, or assist them with the call.
- Suggest they **call 1800 MEDICARE (1-800-633-4227)** or assist them with the call.
- Suggest they call the Office of Inspector General Hotline
- 1-800-HHS-TIPS (1-800-447-8477) or assist them with the call.

Contacts for SMP Complaints

Medicare Part A, B and Home Health and Hospice Services

TrustSolutions, LLC
Donna Casey
6755 W. Washington St
Milwaukee, Wisconsin 53214
(414) 459-6085
(414) 459-2857 (fax)

Donna.casey@trustsolutionsllc.com

Medicare Durable Medical Equipment

TriCenturion
Vicky Quinonez
7909 Parklane Rd., Suite 190
Columbia, SC, 29223
(803) 264-8144
(803) 264-7505 (fax)

Vicky.quinonezl@tricenturion.com

Medicare Part D

SafeGuard Services
MEDIC North-Medicare Drug Integrity Contractor
Doug Quave
(717) 975-4040

(717) 975-4442 (Fax)
1-877-772-3379 Toll Free hotline

Douglas.quave@eds.com

Medicaid Fraud

Medicaid Fraud Control Unit
Allen K. Pope - Director, MFCU
Medicaid Fraud Control Unit of Indiana
Office of Attorney General
8005 Castleway Dr.
Indianapolis, IN 46250-1946
(317) 915-5303
(317) 232-6523 (Fax)

apope@atg.state.in.us

Report ID Theft To: Any one of the nationwide consumer reporting companies to place a fraud alert on your credit report

1. Equifax: 1-800-525-6285 orwww.equifax.com
2. Experian: 1-888-397-3742 orwww.experian.com
3. TransUnion: 1-800-680-7289 or www.transunion.com
4. Federal Trade Commission: 1-800-438-4338 or www.consumer.gov/idtheft

Forms

- See SMPS reporting Forms in the Navigation Guide 4 Section R Forms
- Group Session Post Survey - to be completed after a presentation
- SMP Simple Inquiry - included on SHIP client contact form
- SMP Complex Issue Form - For more complicated issues

For more information about the SMP projects contact: The National Consumer Protection Technical Resource Centerwww.smpresource.org
1-877-808-2468

Section D: Medicare Appeal Process

Traditional Medicare Part A Appeals

A Traditional Medicare Part A appeal starts with a notice from the provider to the Medicare beneficiary that the provider does not believe Medicare coverage can continue past a specified date. The notice contains a form that the beneficiary may complete and return to the provider. By completing and returning the form, you can indicate that you want to continue the services (and will find a way to pay for them), and that you believe Medicare should continue to cover the service.

There are three levels of administrative appeal that an aggrieved Medicare beneficiary may pursue, followed by the option of filing a case in federal court. There are slight differences in the structure of the appeal process for hospital, skilled nursing facility, and home health cases. The rules must be followed closely. All original documentation and copies of written appeals should stay in your possession.

Hospital Appeals

"Important Message to Medicare Beneficiaries" is given to the patient upon admission. The text of the Important Message may be found on Pages 7-8 of the Medicare Hospital Manual, Transmittal 801. This Transmittal can be viewed at http://www.cms.hhs.gov/medicare/bni/R193FormInstruction.pdf

The Medicare beneficiary/patient is informed that Medicare coverage for the hospital stay will cease.

I. Immediate Review

The patient may appeal by requesting an Immediate Review.

- To request an Immediate Review, the patient is informed by the Important Message paper to call 1-800-Medicare for referral to Quality Improvement Organization, (QIO). **In Indiana it is Health Care Excel.**
- The patient must call the QIO to ask for Immediate Review.

- The call to the QIO must be made by noon of the day after hospital notification that Medicare coverage will cease.
- The QIO obtains the pertinent hospital records, reviews them, and makes a decision on Medicare coverage by the following day.
- The QIO decision is delivered in writing. If mailed, there is a presumption that it is received no later than 5 days after it was mailed.
- If the QIO affirms the Medicare coverage termination, the patient becomes liable for the cost of the care if he or she does not leave the hospital by noon of the day following receipt of the QIO's adverse Immediate Review decision.

II. Reconsideration

The beneficiary may appeal the QIO's adverse Immediate Review decision by requesting Reconsideration.

- Reconsideration must be requested in writing and request forms are available at http://www/medicare.gov/Basics/forms/default.asp.
- Reconsideration must be requested within 120 days of receipt of the Immediate Review decision. Reconsideration requests may be filed with the Social Security Administration, or with the QIO.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- There must be at least $120 at issue in order to appeal a Medicare denial of hospital coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There is no minimum amount to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $120 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Skilled Nursing Facility (SNF) Appeal

The SNF Notice: The SNF provides a written notice, called a Sarassat Notice. The Sarassat Notice informs the Medicare beneficiary that if they disagree with the SNF's determination that Medicare coverage will cease, they must complete and return the SNF form included with the notice (usually found on the back of the notice). They should indicate that they want the SNF to submit a claim to the Medicare fiscal intermediary for services provided after the date the Sarassat notice indicates that Medicare coverage will cease.

The Demand Bill

The claim submission is called a demand bill. Unless the patient remains in the SNF receiving daily skilled services and has the SNF submit a demand bill, no Medicare appeal may be brought.

I. The Medicare Initial Determination

The Medicare fiscal intermediary reaches a decision on Medicare coverage and notifies the beneficiary by sending a Medicare Summary Notice (MSN). To view Medicare Summary Notices and to obtain more information about these notices, go to http://www.medicare.gov/Basics/SummaryNotice.asp.

II. Reconsideration

The beneficiary must request Reconsideration no later than 120 days after receipt of the adverse MSN. Reconsideration must be requested in writing and request forms are available at http://www.medicare.gov/Basics/forms/default.asp.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.

There must be at least $120 at issue in order to appeal a Medicare denial of hospital coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There is no minimum to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $120 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Home Health Care

The Home Health Agency Notice

At least one day or one visit prior to the discontinuance of Medicare coverage, the home health agency gives the patient a **Home Health Advance Beneficiary Notice, (called a HHABN).** The HHABN contains a form that must be completed and returned to the home health agency to request submission of a demand bill.

Requirements to Maintain a Home Health Appeal

In order to maintain a Medicare appeal, services must be continued after the date on which the agency has notified the beneficiary that Medicare coverage will cease. A demand bill must also be submitted to the Medicare fiscal intermediary or carrier (depending upon which part of Medicare was covering the services prior to the issuance of the HHAFC).

I. The Medicare Initial Determination

The Medicare carrier or fiscal intermediary makes a decision and transmits it to the beneficiary by issuing an MSN. Medicare decisions based on demand bills are usually adverse to the beneficiary, ratifying the provider's view that Medicare coverage should cease.

II. The Reconsideration

The beneficiary must request Reconsideration in writing no later than 120 days after receipt of the adverse MSN.

- Reconsideration must be requested in writing. These request forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- Reconsideration must be requested within 120 days of receipt of the Immediate Review decision. Reconsideration requests may be filed with the Social Security Administration or with the fiscal intermediary.

III. Administrative Law Judge Hearing, (ALJ Hearing)

If the Reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing. The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision. This request must be in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp. There must be at least $120 at issue in order to appeal a Medicare denial of home health coverage to an Administrative Law Judge.

IV. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal. DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp. There is no minimum to appeal a case to the DAB.

V. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $120 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of the receipt of the adverse DAB decision. While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.

Traditional Medicare Part B Appeals

In Medicare Part B, the provider always submits the Medicare claim to the Medicare Carrier. The Medicare Carrier issues its initial determination in a notice to the beneficiary, after which, an aggrieved beneficiary may pursue three levels of administrative review, followed by the possibility of filing a federal court case. The rules governing the time lines for submission of appeals and the amount of money that must be at issue must be closely followed.

I. The Medicare Claim

The Medicare Part B provider submits the Medicare claim to the Medicare Carrier.

II. The Initial Determination

When the Medicare Carrier makes a decision on Medicare coverage, this is called an Initial Determination. The Medicare Carrier sends the Initial Determination to the beneficiary by issuing an MSN or Explanation of Medicare Benefits (EOMB). To view Medicare Summary Notices and to obtain more information about the notices, you may go to http://www.medicare.gov/Basics/SummaryNotices.asp.

III. The Review

An adverse Initial Determination is appealed by requesting a review by the carrier. A request for review must be made in writing and forms for this purpose may be found at http://www.medicare.gov/Basics/forms/default.asp.

The review request must be filed with the carrier within 120 days after receipt of the MSN or EOMB. There is a 5 day presumption for receipt after the date on which the carrier mailed the MSN or EOMB to the beneficiary.

IV. The Carrier Hearing

If the review decision is adverse, the beneficiary may appeal by requesting a Carrier Hearing.

- The Carrier Hearing must be requested within 180 days of receipt of the adverse review decision.
- There must be $100 at issue to take an appeal to a Carrier Hearing.
- The Carrier Hearing must be requested in writing and forms for requesting a Carrier Hearing may be found at http://www.medicare.gov/Basics/forms/default.asp.

V. The Administrative Law Judge Hearing, (ALJ Hearing)

If the reconsideration decision is adverse, the beneficiary may appeal by requesting an ALJ hearing.

- The ALJ hearing must be requested within 60 days of receipt of an adverse Reconsideration decision.
- The request must be made in writing and forms are available at http://www.medicare.gov/Basics/forms/default.asp.
- There must be at least $120 at issue in order to appeal a Medicare Part B coverage denial to an Administrative Law Judge.

VI. Departmental Appeal Board Review (DAB Review)

This is the last administrative stage of a Medicare appeal.

- DAB review must be requested in writing within 60 days after receipt of an adverse ALJ decision. Forms to request a DAB review are available at http://www.medicare.gov/Basics/forms/default.asp.
- There is no minimum to appeal a case to the DAB.

VII. Judicial Review

- An adverse DAB decision may be appealed to federal court.
- There must be at least $120 at issue in order to file suit in federal court.
- The court papers must be filed within 60 days of receipt of the adverse DAB decision.
- While it is not necessary to retain a lawyer to file a federal court case, and the court clerks are generally very helpful to un-represented litigants, it is advisable to have legal representation in a court case.