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Medicare

What is Medicare?

Medicare is a federal health insurance program for people 65 and over; people of any age who have gotten Social Security disability benefits for more than two years; people suffering from ALS (also called Lou Gehrig's disease); and some people with kidney disease.

Is Medicare different from Medicaid?

Yes, Medicaid is a program only for people with very low incomes. It has no age limitation. It is possible for a low-income older or disabled person to be eligible for both Medicare and Medicaid.

What does Medicare cover?

What Medicare covers depends on the type of Medicare a person has. Most people have "original" or "traditional" Medicare. That version of Medicare includes hospital insurance, called Part A. Part A also covers hospice care, some therapy and home health care, some durable medical equipment, and very limited skilled nursing facility care, described below.

Traditional Medicare includes optional medical coverage (for doctors and diagnostic testing, some types of medication and therapy, some kinds of durable medical equipment, blood and ambulance services, outpatient care, etc.), called Part B.

Medicare also offers a managed-care program called Medicare+ Choice or Medicare Advantage. This coverage is based on an HMO model or works with a group of "preferred providers". Finally, there is another optional Medicare program, called Part D that covers some prescription costs.

What does Medicare coverage cost?

What the coverage costs depend on the program, how old the person is when he or she signs up for coverage, and, to some extent, how much care the person needs.

What is the cost for Medicare Part A?

People 65 and older are eligible for Medicare Part A at no charge if they are eligible for Social Security Retirement benefits or Railroad Retirement benefits. They can be eligible based on either their own lifetime earnings or on the earnings of a spouse. Even though at age 65 most people are automatically eligible, they still must register with the Social Security Administration for the Part A benefit. Social Security recommends doing so in the period two months before the birth month of the applicant, the birth month, or in the period two months after reaching age 65. Most people who are not eligible for retirement benefits can purchase Part A coverage. For someone who is 65 or older but not automatically eligible, the Part A premium from about \$260 to \$460 per month. There is a temporary penalty or surcharge for late Part A enrollment.

All Part A Medicare beneficiaries not covered by Medicaid must pay a deductible of around \$1,100 for a hospital stay in a "benefit period", explained below.

Part A usually pays most of a hospital bill, including a semi-private room, medications while in the hospital, meals, regular nursing services, lab tests, x-rays, and medical equipment and supplies. Part A will also pay for intensive care. It will not pay for an optional private room, private duty nurse, or such things as a phone or TV.

If you enter a hospital, you must pay approximately \$1,100 of charges; Medicare pays the rest for covered services while you are in the hospital for the first 60 days. Hardly anyone stays this long in the hospital. If you stay that long, though, on the 61st through 90th days you will have a daily co-payment of approximately \$275 per day; Medicare then pays the remaining amounts for covered services. If you stay in the hospital longer than 90 days, you begin using your only remaining hospital coverage. These are called lifetime reserve days. You have only 60 lifetime reserve days, and you pay about \$550 per day as a co-payment. Once you have used all 60 lifetime reserve days, Medicare won't pay anything for hospital stays longer than 90 days per benefit period. A benefit period begins when you first enter the hospital. A benefit period ends when you have been out of the hospital, skilled nursing or rehabilitation services for 60 days in a row. If you leave and must go back to the hospital before the 60 days ends, you do not have to pay \$1,100 for the new hospitalization.

Many people believe that Medicare will pay for nursing home care if they need it. Although Part A does pay for some nursing home care following a hospital stay of at least three days, very few people meet the strict requirements. In addition, in order for Medicare to pay, you must be in a nursing home that is licensed to provide skilled care and is approved by Medicare. You must be getting skilled care, such as physical therapy, at least five days per week.

If you meet all of the requirements, Medicare will cover up to 100 days of skilled care. After the first 20 days, there is a co-payment of about \$137.50 per day.

Medicare does not pay for other kinds of care facilities. Medicare will not pay for the care that people with stable medical conditions need, such as help with dressing, eating, walking, bathing, toileting or taking medications.

Part A can pay for home health visits if you are confined to your home and need occasional skilled medical services. Part A also covers hospice services for people who are terminally ill and who are expected to live six months or less. A doctor must certify that someone is likely to die within that time. If the person lives beyond that time, the doctor merely needs to recertify. The person can continue with hospice services.

What does Medicare Part B cost?

Medicare Part B requires the payment of monthly premiums, and patients are responsible for a co-payment for services they receive. The monthly premium is about \$100. It generally rises a small amount annually.

Medicare Part B premiums may be permanently higher for those who wait until after they are 65 to enroll. The longer they wait, the higher the premium will be. A few people who have other insurance that Medicare accepts as being as good as Medicare and then change to Medicare do not have to pay this higher premium.

What does a Medicare Advantage plan cost?

The Medicare Advantage program combines hospital and medical coverage plans. These plans typically limit the patient to a certain geographic area or certain doctors and hospitals. The plans vary greatly in the scope of their coverage. Some plans even cover some types of prescription medicines.

Medicare Advantage plans have a monthly premium, and generally, require co-payments for services and medications. The premiums can range from around \$200 per month to more than \$600 per month.

What does Medicare Part D cost?

The cost of the premiums for the Medicare Part D prescription drug coverage can vary significantly from plan to plan. So do co-payments, even within a single plan, depending on the medication needed. The drug plan premiums may be permanently higher for those who do not apply when first eligible. People who have either Medicare Parts A or B or Medicare Advantage, are eligible for the plan.

Unlike Parts A and B Medicare, however, all Part D plans are private plans. You cannot sign up for one of them at Social Security. You must apply for them directly from an insurance company. Insurance companies are constantly sending information about their policies to seniors. How can a person make an intelligent choice?

Choosing among dozens of plans can be confusing and frustrating—and potentially expensive. Medicare has a website, www.Medicare.gov, that gives some comparisons of Part D plans and a description of private supplemental coverage. Many people do not find the website very helpful. Fortunately, New Mexico sponsors the Senior Health Insurance Program (SHIP), where highly trained staff and volunteers can help seniors evaluate their medical needs and the type of insurance coverage that is most likely to help them address their needs. You can reach that program at (800) 432-2080, (505) 222-4510, or (505) 263-4780.

Can't low-income people have their prescriptions paid for by Medicaid?

It used to be that low-income people could rely on Medicaid for their prescriptions. Now they must use a Medicare plan. Social Security offers a subsidy that pays all or some of the cost of prescriptions that Medicare won't cover completely, under a program it calls "extra help". Information about "extra help" is available from Social Security. Applications are available from

either a Social Security office or online at www.ssa.gov.

Medicare Appeals

When does Medicare deny a claim for payment?

Medicare covers only “medically necessary” treatment, services, and medical equipment. The law requires it to deny claims for services that are not medically needed. It has complex rules that can make it difficult to tell what is necessary in a specific situation.

In addition, every claim Medicare receives goes through many hands—doctors, nurses, ambulance personnel, billing staff, and others—before it gets to Medicare. Any one of the people responsible for submitting the claim can make an error. And so can Medicare staff.

With all the people and paperwork involved, the Center for Medicare and Medicaid Services (CMS, which oversees the Medicare program) estimates that it mistakenly denies more than \$1 billion in legitimate claims every year. For someone who will have to pay a medical bill out of pocket if Medicare denies a claim, it is important to prevent and watch for errors in the billing process.

How does a person know whether Medicare has paid a claim?

Every three months, Medicare sends to every Medicare beneficiary who got medical care during that period a form called an explanation of benefits (EOB). When an EOB comes in the mail, it’s important to read it carefully for errors. Did someone bill you for a service you never got? Did the hospital bill for the right number of days? Did Medicare reject any of your claims?

How can a Medicare patient appeal a denial of payment for service?

In general, how to appeal depends on the kind of Medicare coverage a patient has. For example, people who have Part A or Part B Medicare follow one set of steps to appeal; people with Medicare Advantage (also called Medicare + Choice, or Medicare HMO) have a different process to appeal. And the Medicare Part D prescription drug program has its own process.

The systems can be very confusing. Fortunately, every EOB has information about how to appeal the denial of payment for a particular service.

What steps are needed to appeal Part A and Part B denials?

The process for getting Medicare to pay a denied claim is the same for Parts A (hospital) and B (medical treatment) in traditional, or original, Medicare.

The first step is a redetermination. Someone at an insurance company looks at the bill and decides if the original decision is correct. You may want to get your doctor to give the reviewer more information about your medical problem so that the redetermination takes into account everything that was done. In some states that track appeals at this level, Medicare ends up paying, after all, more than 50 percent of the time after a redetermination.

The next step is reconsideration. A different team looks at the treatment information. If there are more medical records the appeal should consider, the reconsideration stage is the last chance for the patient to submit the records.

If the patient is unsuccessful at the reconsideration stage, the person can ask for a hearing by an administrative law judge with CMS. The amount of the claim must be at least \$120 in 2009—it goes up when the national Consumer Price Index goes up.

If the claim is still unsuccessful, you can ask the Medicare Appeals Council to look at the claim. And if that effort is unsuccessful, and if the claim is at least \$1,220 (in 2009), you can appeal the claim in federal court.

If a redetermination doesn't result in Medicare coverage of the bill, it is a good idea to find an advocate who is knowledgeable about the Medicare rules. New Mexico's Aging and Long-Term Care Department has a special office that can help—at no charge. That office is the Senior Health Insurance Project (SHIP). You may want to contact SHIP even before you ask Medicare for a redetermination.

There are time limits involved in appealing all of these steps:

Redetermination: within 120 days after receiving the notice Medicare denied the claim.

Reconsideration: within 180 days after the claim is denied at the redetermination level.

Administrative Law Judge Hearing: within 60 days after denial at reconsideration.

If any of these levels there is no decision in 60 days, the claim is "deemed" (assumed to be) denied.

Sometimes a hospital will tell a patient that he or she must leave—but the patient does not feel well enough to go. There is a special appeal process for people who are in the hospital. It allows Medicare coverage to continue while the hospital evaluates the patient's condition.

This appeal is available to people with Part A coverage and people with Medicare Advantage.

When the hospital says it is going to discharge someone who is not recovered enough to leave, the patient or a caregiver should ask for and complete a Notice of Non-coverage. The patient will have at least one more day of Medicare coverage in the hospital while the staff reviews the patient's condition. Often this is enough time for the patient to become able to leave the hospital, even if the hospital decides the patient should have gone before. Medicare will continue to cover the stay until the review is over, regardless of the decision.

What is the appeal process for a denial of coverage in a nursing facility?

Medicare Part A pays for skilled care in a nursing facility only for a short time and only after a minimum three-day hospital stay for a diagnosed condition. If you go into a skilled nursing facility where Medicare is covering the skilled care, the facility will review your condition often. At some point, it may tell you that you no longer need or are no longer entitled to skilled care. If it does that, it must give you a written notice explaining why, and tell you how to appeal the decision. In both hospitals and skilled nursing facilities, your doctor may prescribe rehabilitation therapy for

you. The hospital or facility may say it is cutting off those services because you are “not improving fast enough”. That is not a proper reason to stop therapy. You should talk to your doctor about whether the facility should keep giving you therapy. If the doctor agrees you still can benefit from therapy, and the facility will not give you the therapy, you should ask for a written notice with instructions on how to appeal.

How does a Medicare HMO deny claims?

A Medicare HMO (also called Medicare Advantage) plan is more likely to deny service than to deny

a claim after a patient has already gotten treatment.

When the organization refuses to provide service that you believe is medically necessary, the HMO has 14 days to decide if its decision was correct. If you appeal the second decision, it has 30 days to review its denial of service. This procedure is similar to a redetermination. If your condition would worsen seriously if the HMO does not provide the care you need, you can ask for it to expedite its decision.

If the HMO still refuses to provide treatment you need, you have 60 days in which to ask in writing for a reconsideration. The request will go to an independent reviewer outside the HMO. If your HMO denied coverage for care you have already received, you have 60 days from the date you receive the denial notice to make a written request for reconsideration by the HMO. If the HMO supports the original denial, it must send your request to an independent reviewer. The review entity will then send you its decision.

If you don't agree with the reconsideration decision, and the amount in dispute is \$120 or more, you can ask for a hearing. You have 60 days from the date you received the reconsideration decision notice to make a written request for a hearing with an administrative law judge from CMS. Unlike in a regular Medicare appeal, the judge does not have any time limit in which to make a decision in your managed care case. If there is at least \$1,220 (in 2009) at issue, you can appeal the hearing decision to federal court.

What is the appeal process for a denial of a prescription medicine under Medicare Part D?

The appeal process after a denial of prescription medications is very fast. The first level of appeal (redetermination) allows the insurer only three days to make a decision in an ordinary denial, one day to make a decision where a doctor has said there is emergency need for a particular medicine.

There are several possible reasons for a denial of coverage of prescriptions. There is no standard prescription coverage; all the Part D insurance comes from private companies that offer different kinds of plans. One common reason for denial of coverage is that the medicine the doctor prescribed is not part of the insurance plan's “formulary”. Its formulary is a list of drugs that it will pay for. A patient may need a different medicine. To get it, the patient must ask for an exception. The patient must have a good reason from his or her doctor.

Another common reason for denial of coverage is that the insurer wants people to get a cheaper generic version of a medicine rather than the more expensive brand their doctor has prescribed. If the patient has already tried the generic or even another brand, that doesn't work or that has side effects, the patient and the doctor must provide evidence of the problem caused by using the generic or cheaper version.

All pharmacies that offer prescriptions under the Medicare Part D program must post a notice that tells customers how and where to file their appeals if Medicare will not pay for their prescription.

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