

Original Medicare: An outline of benefits

This fact sheet was prepared by Leslie Fried, Director of the Alzheimer's Association Medicare Advocacy Project.

Medicare is a federal health insurance program designed to provide affordable health insurance coverage to the elderly and disabled persons in this country. Medicare primarily covers acute care treatment in a traditional medical environment. From its inception, Medicare coverage of long term care has been extremely limited.

The Original Medicare program is divided into two separate and distinct parts: hospital insurance (known as Part A) and supplemental health insurance (known as Part B).

Medicare Part A covers acute care services such as

- hospitalization
- skilled nursing home care
- home health care
- hospice care

Part B covers

- physicians' services
- outpatient hospital services
- physical, occupational and speech therapy
- diagnostic x-rays
- laboratory tests
- durable medical equipment
- blood
- home health care services
- mental health services

These two Medicare parts are significantly different in benefits, deductibles and coinsurance payments. When Medicare covers a particular service, it usually pays for a portion of what Medicare has determined to be the reasonable charge for the covered service.

The Centers for Medicare and Medicaid Services (CMS) has primary responsibility for the management of the Medicare program. CMS contracts with insurance companies to process claims for services. For Part A claims,

these insurance companies are called fiscal intermediaries. For Part B claims, the insurance companies are called carriers.

Part A benefits

Inpatient hospital coverage

- Medicare covers up to 90 days of a hospital stay for a "spell of illness" period. A spell of illness begins on the first day of a hospital stay and ends 60 days after a discharge from a hospital or nursing home.
- There is an additional 60 days of hospital coverage after the initial 90 days called "lifetime reserve" days. Lifetime reserve days can be used only once.
- 2002 deductible and coinsurance payments
 - initial deductible on the first day of hospital stay: \$812
 - coinsurance for days 61-90: \$203 per day
 - coinsurance for lifetime reserve days: \$406 per day
- Psychiatric hospital stays: Medicare covers only 190 days of inpatient psychiatric hospital services during a beneficiary's lifetime.

Nursing home coverage

- Medicare may cover up to 100 days of a skilled nursing facility (SNF) stay during a spell of illness if the beneficiary:
 - Was admitted to the SNF after a minimum of three days in the hospital, within 30 days of discharge from the hospital.
 - Requires and receives daily skilled care for the condition for which the beneficiary was hospitalized.
- 2002 coinsurance payments
 - no deductible
 - no coinsurance days 1-20
 - coinsurance days 21-100: \$101.50 per day

Home health care

- Medicare may cover up to 100 visits of home health care (HHC) under Part A, if the beneficiary also has Part B benefits* and:
 - Began to receive HHC after a minimum of three days in the hospital or SNF stay of any duration, within 14 days of discharge from the facility.
 - Is confined to home under a plan of treatment by a doctor.
 - Requires part-time or intermittent skilled nursing or skilled physical or speech therapy provided by a Medicare certified home health agency.
 - Has no deductible or coinsurance.
- Covered services include part-time or intermittent nursing services; physical, speech-language and occupational therapy; medical, social and home health aide services.

*If the beneficiary does not have Part B benefits, the 100-day visit limitation does not apply.

Hospice care

- Medicare covers hospice care for a terminally ill beneficiary who is expected to die within six months and elects to receive hospice benefits in lieu of most Medicare Part A and Part B benefits.
- May elect to receive hospice benefits for two periods of 90 days and an unlimited number of periods of 60 days each.
- No deductible or coinsurance.
- Covered services include
 - physician services
 - nursing services
 - physical, occupational and speech therapy
 - medical and social services
 - home health aide services

- counseling services for beneficiary and family
- respite care
- medical appliances and supplies

Part B benefits

- Covered services include
 - medically necessary physician services
 - outpatient hospital treatments
 - diagnostic x-rays and laboratory tests
 - physical, occupational and speech therapy
 - blood
 - durable medical equipment
 - prosthetic devices
 - mental health services
- Some preventive services are now covered including
 - mammograms
 - pap smears and pelvic exams
 - screenings for colorectal cancer
 - bone mass measurements for osteoporosis
 - diabetes monitoring
 - flu and pneumonia vaccinations
- Home health care is covered under Part B for an unlimited number of visits if the beneficiary meets the requirements discussed above under Part A, but does not have or is eligible to receive home health care under Part A, or has used up the 100 days under Part A.

Deductible and coinsurance payments

- Annual deductible: \$100 per year
- Medicare pays 80 percent of the approved charge for most claims:
 - The beneficiary is responsible for 20 percent of the Medicare-approved charge if the provider accepts assignment. If the provider does not accept assignment, the beneficiary is also responsible for the balance of the actual charge up to 15 percent above the Medicare approved charge.
 - Outpatient mental health treatment, Medicare pays 50 percent of the approved claim.

If you have Alzheimer's disease

Although Medicare will cover for the diagnosis, evaluation and treatment for Alzheimer's disease, Original Medicare **will not** cover

- prescription drugs
- over-the-counter nutritional supplements (vitamins. *Ginkgo biloba*)
- adult day care
- respite care (except as described under Part A hospice benefit)
- personal aide assistance (except as provided under the home health care benefit)
- custodial care in a nursing home
- incontinence supplies
- experimental treatment

Claim denials in Original Medicare

Sometimes Medicare will refuse to pay for certain medical treatment even though it is a covered service. Some examples:

- Home health care – Medicare might deny a claim for home health care because Medicare has determined that the beneficiary is not confined to the home.
- Physical, occupational and speech therapy – Medicare might deny a claim for therapy because Medicare does not believe that the beneficiary can benefit from the therapy.
- Mental health services – As with rehabilitation therapy, Medicare might deny a claim mental health therapy because Medicare does not believe that the beneficiary can benefit from the mental health services.
- If the above services were ordered by your doctor and provided by an appropriate provider, but Medicare refused to pay for them, file an appeal of Medicare's decision.
- For more information about how to appeal a Medicare denial of a claim, contact your local State Health Insurance Assistance Program (SHIP) or local Area Agency on Aging.

For additional information

Centers for Medicare and Medicaid Services

<http://www.cms.hhs.gov/default.asp?>

<http://www.medicare.gov/>

State Health Insurance Assistance Programs (SHIPS)

<http://www.medicare.gov/contacts/static/allStateContacts.asp>

Eldercare Locator to find your local Area Agency on Aging

<http://www.eldercare.gov/Eldercare/Public/Home.asp>

The Alzheimer's Association, the world leader in Alzheimer research, care and support, is dedicated to finding prevention methods, treatments and an eventual cure for Alzheimer's.

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