
Fee-for-service Medicare for people with Alzheimer's disease

Medicare pays for most regular health care expenses but does not cover most long-term care, which is the biggest expense for people with Alzheimer's disease. In addition, even though Medicare is a health insurance program, beneficiaries (patients) with Alzheimer's may experience challenges getting certain kinds of claims paid. Those enrolled in a Medicare-managed care plan, such as a Health Maintenance Organization (HMO), may be eligible for services that are not covered by original fee-for-service Medicare.

To help people living with Alzheimer's and their caregivers navigate Medicare as it relates to the treatment of the disease, we've created a few sample questions and answers. For more detailed information, visit the [Medicare page](#) of the Alzheimer's and Dementia Caregiver Center (alz.org/care).

1. Does Medicare pay for my doctor to evaluate and diagnose me with Alzheimer's disease?

Yes, Medicare pays for the evaluation and diagnosis by doctors who accept Medicare assignment. Medicare also pays for other doctors' services, including treatment and management of the disease, detailed care planning and consultation by other doctors. Care planning coverage includes several areas of assessment, such as evaluating cognition, function and safety; identifying caregivers; and planning for future care needs. Consultation services are paid when your doctor requests a second doctor to review your medical history and test results and to examine you. Sometimes, doctors are paid by Medicare for coordinating the care if you're discharged from the hospital and transitioned to a nursing home or other setting. In addition, Medicare covers care plan oversight when a doctor supervises your home health care or hospice care, which often requires a regular doctor review. Prior to seeking care, be sure to inquire if doctors and other health professionals accept Medicare assignment.

2. How much does Medicare pay for my doctor's visit? How much do I have to pay?

Doctor bills are paid under the Medicare Part B program. Each year, you must meet the deductible before Medicare pays for your Part B claims. In most circumstances, once the deductible is met, Medicare pays 80 percent of your doctor's bill, including the diagnosis and treatment of Alzheimer's disease.

3. Which diagnostic and laboratory tests does Medicare cover while testing for Alzheimer's disease?

After the doctor has completed a thorough physical and reviewed your medical history, he or she may order a variety of tests to assist in diagnosing Alzheimer's disease. Some of the tests covered by Medicare include: blood studies, urinalysis, electrocardiograms, chest X-rays, computerized tomography (CT) scans, electroencephalography (EEG) and magnetic resonance imaging (MRI).

Currently, Medicare only pays for positron emission tomography (PET) scans for certain conditions related to heart disease, lung disease and certain types of cancer and refractory seizures. Medicare rarely pays for the use of PET scans for diagnosis of Alzheimer's disease.

4. Does Medicare pay for a person with Alzheimer's to see a psychiatrist, clinical psychologist or clinical social worker?

Medicare pays for visits to a psychiatrist, clinical psychologist or clinical social worker under certain circumstances. Medicare sometimes denies payment for psychotherapy services for a person with a primary diagnosis of Alzheimer's disease on the theory that a person with dementia may be too impaired to benefit from psychotherapy. If the person has a condition that requires psychotherapy and/or behavior management, such as depression, agitation, aggression or personality changes, it is important that the mental health provider also list that condition as a reason why the person with Alzheimer's is receiving the therapy.

Medicare pays for a diagnostic evaluation and for outpatient medication management by a psychiatrist or other doctor who accepts Medicare assignment. This benefit can be of significant importance if the person is taking medication to control agitation or aggressive behavior.

Medicare also reimburses for family counseling services if the primary purpose is the treatment of the person with Alzheimer's and not the treatment of a family member's problems. Family counseling services may be appropriate when there is a need for the doctor to observe the person's interaction with family, or when it's necessary for the doctor to assess the family's capability to provide care and assist them in care management.

5. My mother broke her hip and was receiving physical therapy. The therapy has stopped because Medicare will not pay if she is not improving. Is this correct?

Although Medicare does pay for skilled therapies such as physical therapy, occupational therapy, speech therapy, and skilled nursing, there are certain limitations on how long the patient will receive paid therapy services. For example, in order for

Medicare to pay for physical therapy, the written treatment plan must include physical therapy that is “reasonable and necessary” for the treatment of your mother’s broken hip.

To be reasonable and necessary, your mother must need services that require a skilled therapist (rather than a non-skilled aide). Also, the services must be provided with the expectation that your mother will benefit, or that they’re necessary to establish a safe and effective maintenance program that will prevent or minimize deterioration caused by her broken hip or Alzheimer’s.

Medicare has denied claims for skilled therapy services because the beneficiary didn’t improve quickly enough or because Medicare didn’t believe the beneficiary was able to learn or benefit from the therapy. If this happens, it is important to talk to your mother’s treating doctor and physical therapist and consider filing an appeal of the denial. A settlement in the *Jimmo v. Sebelius* class action lawsuit challenging the improvement standard caused the Centers for Medicare & Medicaid Services (CMS) to clarify its policy that improving the patient’s condition or recovery is not a standard for approving or denying claims for skilled therapy. The skilled clinician needs to justify and document in the care plan the need for rehabilitative therapy or maintenance therapy.

There is clear evidence that people with Alzheimer’s disease can benefit from rehabilitation therapy. You should appeal the Medicare decision if the treating doctor or therapist believes your mother can still benefit from the rehabilitative or maintenance therapy.

6. Will Medicare pay for my father’s home health care?

Many people with Alzheimer’s disease have significant chronic care needs, but they do not require the services of a skilled professional. In order to receive home health care, a doctor must certify that your father is homebound and requires skilled therapies or intermittent skilled nursing care provided by a Medicare-certified home health agency under the doctor’s plan of treatment.

To be homebound means:

- He has trouble leaving the house without help (e.g., using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury; or
- Leaving the home isn’t medically recommended because of his condition, and he’s normally unable to leave his home because it’s a major effort.
- He may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services. Note: your father may still receive home health if he attends adult day care (see the answer to question 8 for more information regarding home health benefits).

If your father meets these conditions, Medicare will pay for him to receive any of the following home health benefits as specified in his treatment plan:

- Part-time or intermittent nursing care.
- Physical, occupation or speech therapy.
- Medical social services.
- Part-time or intermittent home health aide services.
- Medical supplies and durable medical equipment.

The duration and number of visits will depend on the treatment care plan written by his doctor.

If he does receive home health benefits under Medicare, he is not required to pay deductibles or co-insurance payments for these services, except for the durable medical equipment.

7. Will Medicare pay for my mother's personal aide who comes to her home and helps her bathe, groom, dress and use the toilet?

Generally, Medicare will not pay for your mother's personal aide. However, if your mother is homebound and requires the skilled services that make her eligible for Medicare home health services, she may also receive home health aide services for personal care, dressing changes, taking medications and other activities as ordered by your mother's physician.

8. Can my dad continue to receive home health benefits if he goes to adult day care?

The answer depends on the reason your father attends adult day care and his overall condition. If your father participates in therapeutic, psychosocial or medical treatments in an adult day care program that is licensed/certified by the state, then his attendance should not affect his home health benefits.

As outlined in question 6, your father must be considered confined to his home or homebound" in order to receive home health benefits. If the adult day care meets the specified requirements and it takes a "considerable and taxing effort" for him to attend the day care, then he is still considered homebound for purposes of eligibility for home health benefits.

9. Will Medicare pay for my father to attend adult day care?

No, Medicare does not pay for adult day care.

10. I take care of my father in my home. Does Medicare pay for respite care?

Generally, Medicare does not pay for respite care. However, if your father is receiving hospice care through Medicare, respite care is provided as a hospice benefit. See the answer to question 16 for information.

11. Will Medicare pay for my mother's nursing home stay?

Medicare only pays for nursing home care in specific circumstances. To qualify, your mother must have Medicare Part A and have had inpatient status in a hospital for at least three days, been admitted to the nursing home within 30 days of the hospital discharge and require daily skilled care for the same condition that led to hospitalization.

Medicare pays for up to 100 days per benefit period for skilled care in a nursing home. However, your mom may be responsible for a daily coinsurance amount of \$161 (in 2016) per day for days 21 to 100.

It's rare for a person to receive the full 100 days of Medicare coverage because most people do not receive daily skilled care in a nursing home. Most residents receive skilled care a few days per week, which is not sufficient to meet the Medicare requirements.

If your mother only requires personal care, such as assistance with feeding, dressing, toileting and bathing, Medicare will not cover her nursing home stay. This is considered custodial care.

12. Does Medicare cover experimental treatment or clinical trials?

Under limited circumstances, Medicare pays for an experimental treatment if it has determined that, with certain controls, the treatment is safe and effective. Medicare regularly makes coverage determinations regarding payment for treatments that have been sufficiently tested.

Similarly, under certain circumstances, Medicare will pay for routine costs of qualifying clinical trials as well as items and services used to diagnose and treat complications when the beneficiary participates in a clinical trial. The researchers conducting the trial should have information about Medicare coverage.

13. Does Medicare pay for outpatient prescription drugs?

Yes, Medicare pays for most outpatient prescription drugs, including treatment for Alzheimer's if the person with the disease enrolls in a Medicare plan for prescription drugs. Prescription drug coverage is available to all Medicare beneficiaries through

private insurance plans. Each plan is different in regard to the drugs it covers and the out-of-pocket costs (e.g., premiums, deductible and copayments).

In addition, if the person is receiving hospice care through Medicare, prescription drugs are provided as a hospice benefit. See the answer to question 17 for more information.

14. Does Medicare pay for vitamins or nutritional supplements?

No, Medicare does not pay for over-the-counter nutritional supplements such as vitamins or Ginkgo biloba.

15. My mother is incontinent. Will Medicare pay for the supplies needed to address this problem?

No, Medicare does not pay for incontinence supplies.

16. My wife's doctor told me that my wife's condition is terminal and that she will probably die in the next six months. The doctor recommends hospice care for my wife. Does Medicare pay for hospice care?

Yes, Medicare covers hospice care for a terminally ill beneficiary who is expected to die within six months. If your wife (or her representative) elects to receive hospice benefits, she will waive her right to most of her Medicare Part A and B benefits for treatment of the terminal illness. She can receive hospice benefits for two 90-day periods and an unlimited number of 60-day periods. There is no deductible, but there is a small coinsurance payment for a drug or biological and respite care.

Under the hospice benefit, Medicare pays for:

- Doctor services.
- Nursing care.
- Medical equipment (e.g., wheelchairs or walkers).
- Medical supplies (e.g., bandages and catheters).
- Physical and occupational therapy.
- Speech-language pathology services.
- Medical social services.
- Dietary counseling.
- Hospice aide (also known as home health aide) and homemaker services.
- Grief and loss counseling services for the person and his or her family.
- Short-term inpatient care (for pain and symptom management).
- Short-term respite care.
- Prescription drugs for symptom control or pain relief.

- Any other Medicare-covered services needed to manage pain and other symptoms related to the terminal illness and related conditions, as recommended by the person's hospice team.

17. If I have a Medicare supplemental (Medigap) policy or retiree health insurance policy, will it cover what Medicare does not?

It depends on your policy. Medigap policies are designed to fill the gaps of fee-for-service Medicare coverage. There are 10 standard policies, identified by letters A through N. Some of the policies cover services not covered by Medicare, such as medical care while traveling outside the United States. Other policies just pay the deductibles and coinsurance payments associated with Medicare.

Retiree health insurance policies are usually comprehensive health insurance policies. Although Medicare is typically the primary insurer, many retiree health policies will pay for health services not covered by Medicare, such as routine physicals and examinations, and dental and vision care.

18. What can I do if I think Medicare improperly denied payment for a claim or paid the wrong amount?

If you think that Medicare made a mistake in payment of a claim, you may want to appeal the decision. With the exception of some expedited Part A appeals of discharge from a hospital, all appeals must be in writing.

There are standard appeal procedures for Part A claims and Part B claims. The initial decision (to pay, not pay or partially pay) or formal notice (received from a Medicare contractor and often called an “initial determination”) is in the Medicare Summary Notice (MSN).

The first level of appeal is a “redetermination” and must be requested within 120 days of the MSN. The Medicare contractor should make the redetermination decision within 60 days.

If you are dissatisfied with the redetermination decision, you have 180 days to request a review, or “reconsideration,” by an independent entity called a Qualified Independent Contractor (QIC). The QIC has 60 days to issue its decision. If you disagree with its decision and the amount in controversy is at least \$150 (in 2016), you can request a hearing before an administrative law judge.

If you're still dissatisfied after decisions under Part A or Part B, depending on the amount in controversy, you can request a review by the Medicare Appeals Council and ultimately appeal to the federal district court in your area.

There is also an expedited appeals process for some Part A denials when an individual receives a Notice of Discharge or Service Termination. The process to file an expedited appeal should be on the written notice.

19. How much of my out-of-pocket expenses can be deducted from my federal taxes?

Personal care, long-term care and prescription drug expenses are deductible from federal income taxes in the same manner as other medical expenses.

Resources

Centers for Medicare & Medicaid Services (CMS)
cms.hhs.gov

Medicare
medicare.gov
800.633.4227

State Health Insurance Assistance Programs (SHIPs)
shiptalk.org

Eldercare Locator (to find your local agency on aging)
eldercare.gov
800.677.1116

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