



ODI

Ohio Department
of Insurance

John R. Kasich, Governor

Mary Taylor, Lt. Governor/Director

July 26, 2012 OSHIIP Webinar: Medicare: Part A and Part B Review

Medicare Part A (Hospital Insurance)

- Most people receive Part A premium free
- Less than 10 years of Medicare-covered employment
 - Can pay a premium to get Part A
- For information, call SSA at 1-800-772-1213
 - TTY users call 1-800-325-0778

Medicare Part A Helps Pay For

Hospital Stays	Semi-private room, meals, general nursing, and other hospital services and supplies. Includes care in critical access hospitals and inpatient rehabilitation facilities. Inpatient mental health care in psychiatric hospital (lifetime 190-day limit).
Skilled Nursing Facility Care	Semi-private room, meals, skilled nursing and rehabilitation services, and other services and supplies.
Home Health Care Services	Can include part-time or intermittent skilled care, and physical therapy, speech-language pathology, and occupational therapy.
Hospice Care	Includes drugs and medical, and support services from a Medicare-approved hospice.
Blood	In most cases, if you need blood as an inpatient, you won't have to pay for it or replace it.

Benefit Period

- Charges based on “benefit period”
 - Inpatient hospital care and skilled nursing facility (SNF) services
 - Begins day admitted to hospital
 - Ends when out of a hospital or SNF for 60 days in a row
 - You pay deductible for each benefit period
 - No limit to number of benefit periods

Paying for Hospital Stays

- For each benefit period in 2012 you pay
 - \$1,156 total deductible for days 1 – 60
 - \$289 co-payment per day for days 61 – 90
 - \$578 co-payment per day for days 91 – 150
(60 lifetime reserve days)
 - All costs for each day beyond 150 days

Coverage Outside the USA and on Cruise Ships

- Foreign Hospitals and Cruise Ships
 - Medicare does not generally pay claims outside of the country
- Beneficiaries may have foreign travel coverage through a Medicare Supplement (Medigap) policy, group health insurance or other insurance product

Hospital Discharge Appeals

- Beneficiary can appeal if not ready to leave the hospital
- Appeal through Ohio KePRO, Ohio's Quality Improvement Organization (QIO)

Ohio KePRO

Rock Run Center, Suite 100
5700 Lombardo Center Drive
Seven Hills OH 44131
(216) 447-9604
1-800-589-7337 (toll-free)
(216) 447-7925 (fax)



Hospital Discharge Rights

- Important Message from Medicare (IM)
 - Given at or near admission
 - Signed by you & copy provided
 - Follow-up copy may be delivered before discharge

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.
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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 noncoverage 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).

Other Types of Hospitals

- Critical Access Hospitals (CAH)
 - Usually in rural areas
 - Receive 101% of reasonable cost from Medicare

- Inpatient Psychiatric Hospitals
 - Medicare pays for no more than 190 days (lifetime total) of inpatient care in a participating psychiatric hospital

Skilled Nursing Facility Coverage

- Semi-private room
- Meals
- Skilled nursing care
- Physical, occupational, & speech-language therapy
- Medical social services
- Medications, medical supplies/equipment
- Ambulance transportation (limited)
- Dietary counseling

Paying for Skilled Nursing Facility Care

For each benefit period in 2012 you pay

- \$0 for days 1 – 20
- \$144.50 per day for days 21-100
- All costs after 100 days

Medicare covers skilled nursing care only when:

1. You require daily skilled nursing care,
2. You require a 3-day hospital stay, AND
3. You enter the skilled nursing facility within 30 days of hospital discharge

Home Health Care

- Four conditions for home health coverage
 - Doctor must meet with patient in person – 90 days before care starts or 30 days after – may be conducted by a hospitalist
 - Must need specific skilled services
 - Must be homebound
 - Home health agency must be Medicare-approved

Home Health Care Coverage

- Part-time/intermittent skilled nursing care
- Physical, occupational & speech-language therapy
- Medical social services
- Some home health aide services
- Durable medical equipment, supplies

Paying for Home Health Care

- In Original Medicare you pay
 - Nothing for covered home health care services
 - 20% of Medicare-approved amount for durable medical equipment

Hospice Care

- Special care for terminally ill and family
 - Expected to live 6 months or less
- Focuses on comfort, not on curing the illness
- Doctor must certify for each “period of care”
 - Two 90-day periods, then unlimited 60-day periods
 - Prior to the 180th day of recertification, the patient must have a face-to-face encounter with the doctor or nurse practitioner
- Hospice provider must be Medicare-approved

Covered Hospice Services

- Medical equipment and supplies
- Drugs for symptom control and pain relief
- Short-term hospital inpatient care (limited)
- Respite care in a Medicare-certified facility
 - Up to 5 days each time with no limit to number of times
- Home health aide and homemaker services
- Social worker services
- Dietary counseling
- Grief counseling

Paying for Hospice Care

- In Original Medicare you pay
 - Nothing for hospice care
 - Up to \$5 for prescription drugs for pain and symptom mgmt
 - 5% for inpatient respite care
 - Amount can change each year
- You generally pay 100% for room and board in a facility

Blood (Inpatient)

- If the hospital gets blood free from a blood bank
 - You won't have to pay for it or replace it
- If the hospital has to buy blood for you, you either
 - Pay the hospital costs for the first 3 units of blood you get in a calendar year **or**
 - Have the blood donated by you or someone else

Part B Coverage

- Doctors' services
- Outpatient medical/surgical services and supplies
- Diagnostic tests
- Outpatient therapy
- Outpatient mental health services
- Some preventive health care services
- Other medical services

Enrolling in Medicare Part B

Automatic Enrollment	<ul style="list-style-type: none">▪ If you already get Social Security, Railroad Retirement, or disability benefits▪ Must opt out if you don't want to be enrolled
Initial Enrollment Period (IEP)	<ul style="list-style-type: none">▪ 7 month period. Starts 3 months before month of eligibility, and includes the month you turn 65 and 3 months after the month you turn 65
General Enrollment Period (GEP)	<ul style="list-style-type: none">▪ January 1 through March 31 each year▪ Coverage effective July 1▪ Premium penalty<ul style="list-style-type: none">– 10% for each 12-month period eligible but not enrolled– Paid for as long as the person has Part B– Limited exceptions

Part B and Employer or Union Coverage

- Find out how your insurance works with Medicare
 - Contact your employer/union benefits administrator
- You may want to delay enrolling in Part B if
 - You have employer or union coverage and
 - You or your spouse is still working

Employer or Union Coverage Ends

- When your employment ends
 - You may get a chance to elect COBRA
 - You may get a special enrollment period
 - Sign up for Part B without a penalty
- Important -- Medigap open enrollment period
 - Starts when you are both 65 and sign up for Part B
 - Once started cannot be delayed or repeated

Monthly Part B Premium

	Persons filing an individual tax return	Married couples filing a joint tax return
Your monthly Part B premium	If your annual income is	
\$99.90	\$85,000 or less	\$170,000 or less
\$139.90	\$85,001 - \$107,000	\$170,001 – \$214,000
\$199.80	\$107,001 - \$160,000	\$214,001 - \$320,000
\$259.70	\$160,001 - \$ 214,000	\$320,001 - \$ 428,000
\$319.70	More than \$214,000	More than \$428,000

Paying the Part B Premium

- Deducted monthly
 - Social Security
 - Railroad retirement
 - Federal retirement payments
- If not deducted
 - Billed every 3 months, or
 - Use Medicare Easy Pay
- Contact SSA, RRB or OPM about paying premiums

Part B Late Enrollment Penalty

- Penalty for not signing up when first eligible
 - 10% more for each full 12-month period
 - May have penalty as long as you have Part B
- Usually no penalty if you sign up during a SEP

Paying for Part B Services

- In Original Medicare you pay
 - Yearly deductible of \$140 in 2012
 - 20% coinsurance for most services
 - 40% mental health services coinsurance
 - Some copayments
- Some programs may help pay these costs

Assignment

- Medicare doctors/providers/ suppliers
 - Accept the Medicare-approved amount
 - As full payment for covered services
 - Only charge Medicare deductible/coinsurance amount
 - They submit your claim to Medicare directly
- Applies to Original Medicare Part B claims
- We say “accepts assignment”

Providers who do NOT Accept Assignment

- May charge more than Medicare-approved amount
 - Limit of 15% more for most services
 - “The limiting charge”
- May ask you to pay entire charge at time of service
- Providers sometimes must accept assignment
 - Medicare Part B-covered Rx drugs
 - Ambulance providers

Balance Billing Ban

- Non-participating providers in Ohio may NOT charge the up-to-15% excess surcharge
- Report violations to the Ohio Dept. of Health
- Ohio residents traveling outside Ohio may be subject to the excess charge if they see a non-participating provider in another state

Private Contracts

- A beneficiary is always free to obtain non-covered services
- A beneficiary can enter into a private contract with a provider
 - Payment is worked out between the beneficiary and provider
- A provider can never ask to sign a private contract in an emergency

Medicare Part B Helps Pay For

Doctor Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services.
Medical and Other Services	For approved outpatient procedures (like a cast, or stitches).
Tests (other than lab tests)	Including X-rays, MRIs, CT scans, EKGs, and some other diagnostic tests.
Clinical Laboratory Services	Includes certain blood tests, urinalysis, some screening tests, and more.
Preventive Services	Certain health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Medicare Part B Helps Pay For (continued)

Home Health Services	Covers medically-necessary part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or a continuing need for occupational therapy. A doctor must order the care from a Medicare-certified home health agency.
Mental Health Services	To get help with mental health conditions such as depression or anxiety. Includes services generally given outside a hospital or in a hospital outpatient setting, including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist, or clinical social worker; substance abuse services; and lab tests.
Outpatient Therapy	Physical therapy, speech-language pathology therapy, and occupational therapy when your doctor certifies you need it.

Non-Covered Services

- Medicare does not cover services or supplies that are not medically necessary
- Covers limited services from
 - Chiropractors
 - Optometrists
 - Dentists
 - Podiatrists

Covered Preventive Services

- One time “Welcome to Medicare” physical exam (1st 12 months after Part B starts)
- Physical Exam (yearly “Wellness Exam”)
- Abdominal aortic aneurysm screening*
- Bone mass measurement
- Cardiovascular disease screenings
- Colorectal cancer screenings
- Diabetes screenings
- EKG Screening*
- Flu shots
- Glaucoma tests
- Hepatitis B shots
- HIV Screening
- Mammograms (screening)
- Pap test/pelvic exam/clinical breast exam
- Prostate cancer screening
- Pneumococcal shots
- Smoking cessation
- Alcohol misuse screening and counseling (effective Oct. 2011)
- Depression screening (effective Oct. 2011)
- Obesity screening and counseling (effective Nov. 2011)

*When referred during Welcome to Medicare physical exam

Ambulance Services

- 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 cover ambulance services from your home or a medical facility to get care for a health condition that requires you to be transported only by ambulance.
- Medicare may also cover ambulance services to or from a dialysis facility for people with End-Stage Renal Disease (ESRD) who need dialysis, and other transportation could endanger their health.

Therapy Caps

- Patients may be limited in outpatient therapy services
 - \$1,880 in physical therapy / language therapy combined in 2012
 - \$1,880 in occupational therapy

Coordination of Benefits (COB)

- Medicare usually pays primary
- Exceptions
 - Over age 65 and group plan has more than 20 members
 - Under age 65 and the group has more than 100 members
 - ESRD – Medicare pays primary after 30 months
 - Medicare does not pay if the healthcare is under liability or no-fault coverage, or if another federal insurance is involved (Workers Comp, VA, etc.)
 - Call 1-800-999-1118 for Medicare COB

Limitation of Liability

- Provider must notify the beneficiary if Medicare might deny the claim
- Present an Advance Beneficiary Notice before the procedure
- Does not apply to non-Medicare covered services

Protection from Unexpected Bills

(continued)

- Advanced Beneficiary Notice of Noncoverage (ABN)
 - When Medicare payment is expected to be denied

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) _____ below.

(D)	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS:	Check only one box. We cannot choose a box for you.
<input type="checkbox"/>	OPTION 1. I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
<input type="checkbox"/>	OPTION 2. I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
<input type="checkbox"/>	OPTION 3. I don't want the (D) _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:	(J) Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

DMEPOS—What You Need to Know

- ▶ DMEPOS stands for
 - Durable Medical Equipment, Prosthethics, Orthotics and Supplies
- ▶ Equipment /supplies covered under Medicare Part B
- ▶ New competitive bidding program
 - Effective 1/1/11
- ▶ If you live in affected area and need certain products
 - You must use contract supplier, or
 - Medicare won't cover

DMEPOS—What You Need to Know

- Expected to save Medicare and Beneficiaries
 - \$28 billion over 10 years
 - \$17 billion in Medicare expenditures
 - \$11 billion in Beneficiary coinsurance and monthly premium payments

Who will Competitive Bidding Affect?

- Beneficiaries who have Original Medicare and
 - Permanently reside in a ZIP Code in a CBA
 - Obtain competitive bid items while visiting a CBA
- To find out if a ZIP Code is in a Competitive Bidding Area
 - Call 1-800-MEDICARE
 - Visit medicare.gov
- Medicare Advantage enrollees can use suppliers designated by their plan

Round 1 Rebid CBAs

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

Round 2

- ▶ Expands program to 91 Metropolitan Statistical Areas
- ▶ Visit cms.gov/DMEPOSCompetitiveBid/
- ▶ Midwest Areas:

- Akron, OH
- Chicago-Naperville-Joliet,
IL-IN-WI
- Columbus, OH
- Dayton, OH
- Detroit-Warren-Livonia, MI
- Flint, MI
- Grand Rapids-Wyoming, MI
- Huntington-Ashland, WV-
KY-OH

- Indianapolis-Carmel, IN
- Milwaukee-Waukesha-West
Allis, WI
- Minneapolis-St. Paul-
Bloomington, MN-WI
- Omaha-Council Bluffs, NE-IA
- Toledo, OH
- Wichita, KS
- Youngstown-Warren-
Boardman, OH-PA



Products Included in the Program

1. Oxygen, oxygen equipment, and supplies
2. Standard power wheelchairs, scooters
3. Complex rehabilitative power wheelchairs – Group 2 only
4. Mail-order diabetic supplies
5. Enteral nutrients, equipment, and supplies
6. Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs)
7. Hospital beds and related accessories
8. Walkers and related accessories
9. Support surfaces (Group 2 mattresses/overlays) Miami only

Using Contract Suppliers

- Must use contract supplier
 - Item and services included in Competitive Bidding Program living in a CBA
 - Traveling to or visiting a CBA
- Exceptions
 - Providers can supply certain items (ex: walkers)
 - Nursing facility can supply directly if a contract supplier

Identifying Contract Suppliers

- Call 1-800-MEDICARE (1-800-633-4227)
- TTY users call 1-877-486-2048
- Visit [medicare.gov/supplier](https://www.medicare.gov/supplier)
 - DMEPOS Supplier Locator Tool

Points to Remember

- The Competitive Bidding Program does NOT affect which physician or hospital you use
- May need to change DMEPOS supplier to continue your Medicare coverage
- May stay with current supplier if “grandfathered”
- If in Medicare Advantage plan, check with your plan