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M E D I C A R E

An Introduction to Medicare

The nuts and bolts of Medicare are not always as familiar as they should be to its beneficiaries, their advisors, or their doctors.

Here is an overview of Medicare's eligibility requirements, coverage, and appeals process.

By Cheryldiane Feuerman and Edward Dale

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Medicare is often misunderstood. Those covered by it generally don't fully comprehend the program or their considerable rights under what is, at its core, the nation's largest insurance system. Until they need medical care, they may not realize how limited this coverage is. They may confuse Medicare with Medicaid. Many of those eligible for Medicare will experience problems with the system. They may be unable to recognize when benefits have been improperly denied. Even when they sense that Medicare coverage has been improperly withheld, they are often disinclined to question, let alone challenge, the vast and complex Medicare bureaucracy. As a result, they may well forgo

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medical care for fear that Medicare *might* deny coverage, or may pay for health care that Medicare should have covered.

Health care providers (doctors, hospitals, etc.) often have a less than perfect grasp of Medicare coverage and beneficiary rights. Medicare usually requires providers to make the first decision as to coverage, but the system includes financial costs and penalties that discourage the award of coverage. Even helpful providers may have incomplete knowledge of the potential scope of coverage. Their training in this area comes primarily from the Health Care Financing Administration (HCFA) and its insurance company agents, who take a much more narrow view of what Medicare will pay for than Medicare law and regulation allows. Doctors, who can often provide the orders and supporting documentation that can largely ensure that Medicare coverage will be awarded, may simply not realize their own power in this regard nor be aware of coverage criteria or the financial importance that Medicare has for their patients.

Attorneys and other professionals who advise and represent the elderly may also be unfamiliar with Medicare, yet Medicare benefits can play a central role in long-range planning for the elderly. This article provides an overview of the Medicare program. In future columns we will discuss each topic in greater detail.

Background

Medicare is a federal health insurance program for the elderly and disabled created by Congress in 1965 as part of the Social Security Act.¹ Medicare is health insurance, not a social welfare program, financed largely through payroll deductions and monthly premiums. The original Medicare fee-for-service program consists of two parts: Part A, the Hospital Insurance program,² and Part B, the Supplemental Medical Insurance program.³ In 1997, as part of the Balanced Budget Act, Congress created a third part to Medicare, Part C, known as Medicare+Choice.⁴ Part C offers beneficiaries alternate choices to the fee-for-service program, consisting largely of managed care models, for delivery of their Medicare benefits.

The Department of Health and Human Services (HHS) is charged with implementing the Medicare program. Within HHS, the HCFA is responsible for overseeing the program, writing Medicare policy, and contracting with private organizations (primarily insurance companies) that handle day-to-day operations of the Medicare program, including issuing initial coverage decisions.

Medicare health insurance coverage is not all-encompassing; specific coverage and time limitations apply. It is not generally available to beneficiaries who travel outside of the United States. Nor is Medicare without cost to the beneficiary, who is responsible for premium, deductible, and coinsurance (a portion of the cost of services) payments. Most Medicare beneficiaries maintain private Medicare Supplemental (Medi-gap) insurance that covers all or part of the Medicare coinsurance and deductible amounts.

Eligibility and Coverage

Most people become eligible for Medicare Part A and Part B when they reach the age of 65 and are also eligible to receive Social Security or Railroad Retirement benefits. Individuals eligible to receive Social Security or Railroad Retirement benefits who have been disabled for over 24 months are also eligible. Those falling into either of these two categories will be automatically enrolled in both Medicare Part A and Part B. Individuals who have end-stage renal disease are also eligible for Medicare Part A and Part B but must file an application for Medicare benefits through the Social Security Administration. There is no premium charged to any of these individuals for Part A, but all must pay a monthly premium for Part B. Persons age 65 and over who are not eligible for Social Security or Railroad Retirement benefits may enroll in Medicare Part A and Part B, but will have to pay a monthly premium for each part.⁵ Eligibility and enrollment are the

only areas of Medicare that are handled by local Social Security offices.

There are three threshold criteria that must be met in order for a service or supply to be covered by Medicare. First, it must be medically reasonable and necessary.⁶ Second, the patient's physician must certify the need for the service or supply.⁷ And third, the provider must be a Medicare-certified provider.⁸

Medicare Part A: The Hospital Insurance Program

In addition to inpatient hospital care, Medicare Part A covers skilled nursing facility (SNF) care, some home health care services, and hospice care.⁹

Inpatient Hospital Care

Medicare will pay for inpatient hospital care¹⁰ that is medically necessary for treatment or diagnosis.¹¹ For nonpsychiatric hospitalizations, beneficiaries are eligible for up to 90 days of benefits for each "spell of illness," with 60 additional days per lifetime (known as "lifetime reserve days") available to each beneficiary.¹² For psychiatric hospitalizations, benefits are limited to 190 days per lifetime.¹³ A "spell of illness" is not determined exclusively by diagnosis. Rather, Medicare provisions state that a spell of illness ends, and a new spell of illness begins, 60 days after the patient is no longer receiving any inpatient hospital services or skilled nursing services in SNF.¹⁴

Medicare coverage of inpatient hospital care is also available to patients who no longer need hospital care but do require skilled care in a nursing facility

and there are no beds available in a Medicare-certified SNF.¹⁵ To be eligible for continued hospital coverage by Medicare under these circumstances, applications must be filed on the patient's behalf with SNFs located within a reasonable geographic area.¹⁶ This coverage will end if the beneficiary fails to accept the first available bed in a Medicare-certified SNF or when the need for daily nursing facility level of care ceases.¹⁷

Beneficiaries admitted for inpatient hospital care are responsible for a deductible amount per spell of illness¹⁸ and a coinsurance amount for days 61 through 150.¹⁹ The deductible and coinsurance amounts are subject to change annually.

Skilled Nursing Facility Coverage

Medicare coverage of nursing facility care²⁰ is very limited. Coverage is only available for up to 100 days per spell of illness in a SNF,²¹ with full Medicare coverage for only the first 20 days.²² Though there is no deductible amount applied, the beneficiary is responsible for a hefty coinsurance amount for days 21 through 100.²³ The coinsurance amount is subject to change annually. To be eligible for this limited SNF coverage, all of the following criteria must be met: (1) the beneficiary must be hospitalized and receiving Medicare-covered services for at least three days prior to admission to the nursing facility; (2) admission to the nursing facility must occur within 30 days of discharge from that covered hospital stay; and (3) the beneficiary

must require daily skilled care²⁴ that is related to the condition for which he or she was hospitalized or for a condition that was treated during the hospitalization and that, as a practical matter, could only be provided in an SNF.²⁵ No coverage is available to a beneficiary who is receiving solely custodial care (such as assistance with eating and toileting).²⁶

Home Health Care

Under the Medicare home health care benefit, Medicare beneficiaries can remain in their home and receive a host of medically necessary services including the services of a skilled nurse, physical therapist, occupational therapist, speech therapist, social worker, and home health aide. Medical supplies and appliances are also covered under this benefit.²⁷

For a beneficiary to be eligible for Medicare home health care benefits, a physician must order home health care services to be provided by a Medicare-certified home health care agency.²⁸ The physician must establish and periodically review a plan of care for the beneficiary²⁹ that includes part-time or intermittent skilled nursing or skilled rehabilitation services³⁰ and must certify that the beneficiary is "confined to the home" or "homebound."³¹ Confined to the home does not mean confined to a bed or chair but rather that the beneficiary is unable to leave the home without assistance. While any absences from the home must generally be medically related, infrequent absences of short duration (e.g., attending church or a family holiday din-

ner) should not result in a determination that the beneficiary no longer meets the homebound criterion.³²

The home health benefit is one of the least restrictive benefits offered by Medicare. No prior hospitalization is required. There are no durational limits; coverage should continue as long as it is medically necessary. Nor is there a deductible or coinsurance amount that the beneficiary is responsible for.³³

Hospice Care

In order for a beneficiary to be eligible for the Medicare hospice benefit,³⁴ a physician must certify that the beneficiary is terminally ill³⁵ with a life expectancy of approximately six months.³⁶ Should the beneficiary live beyond the six months, the hospice benefit can continue as long as a physician can recertify that the beneficiary is terminally ill.³⁷ The beneficiary must sign a written election to receive palliative hospice care for the terminal illness instead of curative care.³⁸ (Curative care under regular Medicare would still be available for conditions unrelated to the terminal illness.) The beneficiary may revoke the benefit at any time.³⁹

The hospice benefit is usually provided in the home. A freestanding hospice will generally limit inpatient services to the final stages of the terminal illness. Whether the hospice benefit is provided in the home or in a freestanding facility, services include physician services, nursing care, physical therapy, speech therapy, occupational therapy, medical social services, medical supplies and drugs, and

home health aides. Short-term inpatient hospital care is also available.⁴⁰ The beneficiary is responsible for payment of coinsurance for each outpatient drug or biological administered⁴¹ and for any inpatient respite care utilized.⁴²

Medicare Part B: The Supplemental Medical Insurance Program⁴³

Not to be confused with private Medicare supplemental insurance (generically known as "Medigap" insurance), Part B is an optional insurance coverage under Medicare that is available to beneficiaries with payment of a monthly premium that is deducted from their Social Security check.⁴⁴ This premium amount is subject to change every year.

The fact that Part B is an optional insurance should not lead one to believe that it is "unnecessary" coverage. In fact, Part B coverage includes most of the health care benefits that a beneficiary would use the most frequently, including physician and diagnostic services (such as laboratory tests and X rays), durable medical equipment (such as walkers and wheelchairs), medical supplies (such as prosthetic devices and surgical dressings), ambulance services, oxygen, outpatient services including surgery and physical therapy, some home health care, flu and pneumonia vaccinations, and other miscellaneous health care expenses.⁴⁵ While Part B is important coverage for beneficiaries to have, the benefit covers only limited preventive care and excludes many services and items most frequently required

by seniors. For example, routine doctor's visits, annual physicals, hearing aids and examinations, eyeglasses and examinations, dental care, foot care, personal comfort items, and most immunizations are excluded.⁴⁶

In addition to the monthly Part B premium, the Medicare beneficiary who enrolls in Part B is responsible for a \$100 annual deductible amount⁴⁷ and a coinsurance amount of 20 percent of Medicare's "approved amount."⁴⁸ The beneficiary may also be responsible for an additional portion of the bill if he or she goes to a provider or supplier that does not "accept assignment."

The dollar amount that Medicare approves for payment (Medicare's "approved amount") is almost always less than the amount the provider or supplier originally charged the beneficiary. When providers or suppliers "accept assignment," they agree to accept Medicare's approved amount as payment in full for the services, equipment, or supplies provided. Thus, if the beneficiary goes to a provider or supplier that accepts assignment, Medicare will pay 80 percent of its approved amount and the beneficiary is responsible only for the remaining 20 percent; the beneficiary cannot be charged the difference between the original bill and Medicare's approved amount.⁴⁹ However, if a beneficiary goes to a physician or other health care provider that does not accept assignment, in addition to the 20 percent coinsurance, the beneficiary can be held liable for an additional portion of the original bill. Medicare law does limit this additional

amount to 15 percent of Medicare's approved amount.⁵⁰

Medicare Part C: Medicare+Choice

Medicare+Choice⁵¹ increases the ways in which beneficiaries can receive their Medicare benefits. Those eligible for Part A and enrolled in Part B, except those with end-stage renal disease, will have the option of remaining in "traditional" Medicare on a fee-for-service basis or selecting from an array of Medicare+Choice programs.

Medicare health maintenance organizations (HMOs), a managed care model of health care delivery, have been available since 1972 as an alternative means for obtaining Medicare benefits and will continue to be available under Medicare+Choice. HMOs typically restrict services to selected physicians, hospitals, and other health care providers. Several additional types of managed care organizations included within Medicare+Choice are provider-sponsored organizations (PSOs) (owned and operated by health care providers that provide most of the services to beneficiaries), preferred provider organizations (PPOs) (consisting of a network of providers from whom the beneficiary receives Medicare benefits), and religious fraternal benefit society plans (offered only to members of the church, convention, or group). Medicare+Choice also offers beneficiaries some non-managed care options, including private fee-for-service (PFFS) plans (private indemnity-type insurance plans that set their own rates for payment to providers who contract with

them) and medical savings accounts (MSAs) (the beneficiary chooses a high-deductible Medicare+Choice plan for which Medicare pays the premium and deposits some of the savings realized in an MSA to be used by the beneficiary for health care expenses until the deductible is met).⁵² All Medicare+Choice models, except MSAs, must provide at least the same Medicare benefits that the beneficiary is entitled to under traditional Medicare Parts A and B, and may offer more.⁵³ Although the Medicare+Choice program became effective in January 1999, most of the options presented here are not yet available to Medicare beneficiaries.

Medicare Appeals Process

When a Medicare beneficiary has either been denied coverage or disagrees with the sum paid by the Medicare program, he or she has the right to challenge the decision through the Medicare appeals process.

Before a beneficiary can file a Medicare appeal, there must be an initial determination issued by a Medicare contractor (the fiscal intermediary, carrier, or peer review organization), or a Medicare managed care organization, informing the beneficiary that coverage is denied.

The Medicare appeals process has multiple levels that vary somewhat at the early stages depending on whether the denial of coverage involves benefits available under Medicare Part A, Part B, or Part C. Subject to limits on the amount in controversy, the beneficiary is always permitted to proceed to the next

level of the appeals process if a Medicare denial is upheld. Under Part A and Part B, the first stages of the appeals process are handled by the same Medicare contractors that issued the initial determination. Subsequently, the beneficiary can obtain a hearing before an administrative law judge (ALJ), with further review, if necessary, through the Medicare Departmental Appeals Board (DAB). Should the beneficiary be unsuccessful in overturning the Medicare denial during this administrative appeals process, a federal court action is available.⁵⁴

Under Part C, Medicare+Choice organizations (M+COs) are authorized to issue initial determinations denying benefits. Should the beneficiary appeal that denial, the M+CO must submit the claim to a single national organization, the Center for Health Dispute Resolution (CHDR), for a determination. If the CHDR issues an adverse determination, the regular Medicare appeals process, with an ALJ hearing, DAB review, and federal district court appeal, is available for disputes involving more than \$100.⁵⁵ M+COs are also required to have an internal grievance system to address nonbenefit denials, such as dissatisfaction with a doctor. Such grievances are not subject to the regular Medicare appeals process.⁵⁶

This concludes our overview of the Medicare program. Our next column will focus on Medicare inpatient hospital benefits, problems, and advocacy.

Endnotes

1. See 42 U.S.C. §§ 1395 *et seq* (1994).
2. See 42 U.S.C. §§ 1395c, 1395d (1994).
3. See 42 U.S.C. §§ 1395j, 1395k (1994).
4. See 42 U.S.C. §§ 1395w-21 *et seq* (1994).
5. See 42 U.S.C. §§ 426, 426-1, 1395i-2, 1395o, 1395p(f), 1395p(g), 1395r (1994); 42 C.F.R. §§ 406.5, 406.6, 407.10 *et seq* (1998).
6. See 42 U.S.C. § 1395y(a)(1)(A) (1994); 42 C.F.R. § 411.15(k) (1998).
7. See 42 U.S.C. § 1395f(a) (1994); 42 C.F.R. §§ 424.10 *et seq* (1998).
8. See 42 U.S.C. § 1395cc (1994).
9. See 42 U.S.C. § 1395c (1994).
10. See 42 U.S.C. § 1395x(b) (1994); 42 C.F.R. §§ 409.10 *et seq* (1998).
11. See 42 U.S.C. §§ 1395f(a)(3), 1395y(a)(1)(A) (1994); 42 C.F.R. § 424.13(a) (1998).
12. See 42 U.S.C. § 1395(d)(a)(1) (1994); 42 C.F.R. §§ 409.61(a), 409.65 (1998).
13. See 42 U.S.C. § 1395d(b)(3) (1994); 42 C.F.R. § 409.62 (1998).
14. See 42 U.S.C. § 1395x(a) (1994); 42 C.F.R. § 409.60 (1998).
15. See 42 U.S.C. § 1395x(v)(1)(G)(i) (1994); 42

- C.F.R. §§ 412.42(c)(1), 412.80(a)(1), 424.13(b) (1998).
16. See 42 C.F.R. § 412.80(a)(1)(i) (1998).
17. See 42 U.S.C. § 1395x(v)(1)(G)(i) (1994); 42 C.F.R. § 412.42(c)(1) (1998).
18. See 42 U.S.C. § 1395e(a)(1) (1994); 42 C.F.R. § 409.82 (1998). The deductible amount for 1999 is \$768.
19. See 42 U.S.C. §§ 1395(e)(a)(1)(A) & (B) (1994); 42 C.F.R. § 409.83 (1998). For 1999, the coinsurance amount for days 60–90 is \$192 per day and for days 90–150 is \$384 per day.
20. See 42 U.S.C. § 1395x(h); 42 C.F.R. §§ 409.20 *et seq.*
21. See 42 U.S.C. § 1395i-3(a).
22. See 42 U.S.C. § 1395d(a)(2); 42 C.F.R. § 409.61(b).
23. See 42 U.S.C. §§ 1395d(a)(2), 1395e(a)(3); 42 C.F.R. § 409.85. For 1999, the coinsurance amount for days 21–100 is \$96 per day.
24. Daily skilled care is defined as skilled nursing services seven days per week, skilled rehabilitation services at least five days per week, or a combination of both totaling seven days per week. 42 C.F.R. § 409.34 (1998).
25. See 42 U.S.C. §§ 1395f(a)(2)(B), 1395x(i) (1994); 42 C.F.R. §§ 409.30 *et seq.*, 424.20 (1998).
26. See 42 U.S.C. § 1395y(a)(9) (1994).
27. See 42 U.S.C. §§ 1395d(a)(3), 1395x(m) (1994); 42 C.F.R. §§ 409.40 *et seq.* (1994).
28. See 42 C.F.R. § 409.41(a) (1998).
29. See 42 C.F.R. §§ 409.41(b), 409.43 (1998).
30. See 42 U.S.C. § 1395x(m) (1994).
31. See 42 U.S.C. § 1395f(a)(2)(C) (1994); 42 C.F.R. §§ 409.42, 424.22 (1998).
32. See 42 U.S.C. § 1395f(a) (1994).
33. See 42 C.F.R. § 409.61(d) (1998).
34. See 42 U.S.C. §§ 1395d(a)(4) & (d), 1395y(a)(1)(C), (6) & (9), 1395x(dd) (1994); 42 C.F.R. §§ 411.15(k)(2), 418.1 *et seq.* (1998).
35. See 42 U.S.C. § 1395f(a)(7)(A)(i) (1994).
36. See 42 U.S.C. § 1395x(dd)(3)(A) (1994).
37. See 42 U.S.C. § 1395f(a)(7)(A)(ii) (1994).
38. See 42 U.S.C. § 1395d(d)(1) (1994).
39. See 42 U.S.C. § 1395d(d)(2) (1994).
40. See 42 U.S.C. § 1395x(dd)(1) (1994).
41. See 42 U.S.C. § 1395e(a)(4)(A)(i) (1994).
42. See 42 U.S.C. § 1395e(a)(4)(A)(ii) (1994).
43. See 42 U.S.C. §§ 1395j, 1395k (1994); 42 C.F.R. § 410.1 *et seq.* (1998).
44. See 42 U.S.C. §§ 1395(o) & (r) (1994). The Part B premium for 1999 is \$45.50 per month.
45. See 42 U.S.C. §§ 1395k, 1395l(i), 1395m (1994); 42 C.F.R. §§ 410.1 *et seq.* (1998).
46. See 42 U.S.C. § 1395y(a) (1994).
47. See 42 U.S.C. § 1395l(b) (1994); 42 C.F.R. § 410.160 (1998).
48. See 42 U.S.C. § 1395l(a) (1994).
49. See 42 U.S.C. § 1395l(a) (1994); 42 C.F.R. § 410.152 (1998).
50. See 42 U.S.C. § 1395w-4(g) (1994); 42 C.F.R. § 414.48 (1998).
51. See 42 U.S.C. §§ 1395w-21 *et seq.* (1994); 42 C.F.R. §§ 417.1 *et seq.*, 422.1 *et seq.* (1998).
52. See 42 U.S.C. §§ 1395w-21, 1395w-25(d), 1395w-28(b)(2), 1395w-28(b)(3), 1395w-28(e)(2) & (3) (1994); 42 C.F.R. §§ 422.4, 422.350 *et seq.* (1998).
53. See 42 U.S.C. § 1395w-22 (1994); 42 C.F.R. § 422.100 *et seq.* (1998).
54. See 42 U.S.C. §§ 1320c-4, 1395ff, 1395ii, 1395pp (1994); 42 C.F.R. §§ 404.900 *et seq.*, 405.701 *et seq.*, 405.801 *et seq.*, 466.83 *et seq.*, 473.18 *et seq.* (1998).
55. See 42 U.S.C. § 1395w-22(g) (1994); 42 C.F.R. § 422.566 *et seq.*; see also 42 C.F.R. § 417.100 *et seq.* (1998).
56. See 42 U.S.C. § 1395w-22(f) (1994); 42 C.F.R. § 422.564 (1998).