Medicare coverage ; Medicare coverage in Nursing Homes; Observation Status

MEDICARE COVERAGE

Part A – Hospital Insurance

Covers inpatient hospital, with deductible of $1556 for 2022.

Also covers Nursing Homes (limited); Home Health (limited) and Hospice.

Part B - Medical Insurance

Covers Outpatient Services, Physician Visits, Ambulance, Procedures, Testing, and some Medical Equipment.

Deductible of $233 in 2022

Covers 80% after deductible

Premium of $170.10 (higher if income threshold is exceeded)

MEDICARE COVERAGE

Part C – Medicare Advantage Plans

These are private plans with low or no premiums.

You must still have Parts A & Part B

They must offer at least the same level of coverage as Parts A and B. Might offer additional benefits, including drug coverage.

The plan can decide NOT to participate in Medicare at anytime – you will then return to original Medicare or look for another plan.

Your providers /facilities must contract with that plan in order to be eligible for coverage.

MEDICARE COVERAGE

Part D – Prescription Drug Benefit

- These are private insurance plans.
- Each offers different premiums
- Each offers different drug coverage.

Supplemental Plans

- These are known as Medigap policies.
- If you have original Medicare , these plans may cover co-pays, and deductibles, depending on the plan.
- They are NOT Prescription Drug Plans.

MEDICARE COVERAGE IN NURSING HOMES

- What are the criteria for Medicare coverage in a Nursing Home?
  - For original Medicare, you must have a "qualifying" hospital stay. This means an inpatient hospital stay of 3 consecutive nights. It does include the day of admission, but NOT the day of discharge. You must be admitted to the Nursing Home within 30 days. *
  - You must require "skilled" care on a daily basis. This means you require and can tolerate Physical Therapy , Occupational Therapy, or Speech Therapy 5 days a week for at least 30 minutes a day OR you require an RN to perform duties 7 days a week. **

*Most Medicare Advantage plans now waive the 3 day requirement for admission.

FOR DAYS	WHAT MEDICARE COVERS	WHAT YOU PAY
Day 1 – Day 20	FULL COST	NOTHING
DAY 21-Day 100	All but co-insurance. ($194.50/DAY)	$194.50 /day Unless your supplemental plan covers.
BEYOND DAY 100	NOTHING	FULL COST

WHAT HAPPENS BETWEEN DAY 1-DAY 100?

- At any time, if therapy is no longer required, or you are too ill or refuse to do therapy 5 days a week for 30 minutes, your coverage will be discontinued. **
- You or your representative will receive a Notice of NON COVERAGE letter.
- You can file an immediate appeal – and another appeal.
- If denied, you are responsible for the full cost of care.
- After day 100 – your coverage will end until a new benefit period begins.
- In order to begin a new benefit period, you must have not been in a hospital or Nursing Home receiving skilled care for at least 60 days in a row.

IF THE BREAK IN CARE LASTS…	
LESS THAN 30 DAYS	You don’t need a new 3 day inpatient stay, but must still require “skilled” care” Since the break is less than 60 days, your current benefit period continues
30 DAYS BUT LESS THAN 60 DAYS	You must have a new 3 day inpatient hospital stay. Since the break is still less than 60 days, your current benefit period continues.
AT LEAST 60 DAYS	You must have a new 3 day inpatient hospital stay AND since the break is 60 days, your benefit period ends – you now have another 100 days available.

HOME HEALTH COVERAGE

- You must be considered “HOMEBOUND” – i.e. You may leave the home for medical treatment or short infrequent absences that are non medical , like religious services.
- Your must require the skilled services of a Nurse, Physical Therapist, Occupational Therapist, or Speech Therapist through a Certified Home Health Agency.
- Your skilled nursing care must be intermittent or part time i.e. not 24 hrs a day
- Personal care by a Home Health Aide is only covered if and as long as you require skilled care.
- Your physician has to order the care.

OBSERVATION STATUS

- WARNING WARNING WARNING

- This is an "OUTPATIENT" classification. Medicare A DOES NOT PAY for this.

- You may be in an Emergency room or hospital room receiving medical and nursing care, tests, treatments, drugs, food etc. – UNDER OBSERVATION.

- If you are receiving services under Observation for more than 24 hrs, the hospital must issue a 'Medicare Outpatient Observation Notice (MOON).

CONSEQUENCES OF OBSERVATION STATUS

- No Part A coverage for hospital stay. If you have Part B – it will cover 80% of tests, IVs and physician services. Medications will NOT be covered.
- If you do not have Part B – you will be responsible for entire hospital bill.
- Observation status can continue for days – if the physician cannot find a medical reason to admit you as an inpatient.
- The number of days you are under Observation status does NOT count toward a 3 day qualifying stay for Nursing Home admission!
- NOTE: Most Medicare Advantage Plans (Part C) waive the 3 day stay so Observation would not be a barrier to coverage.
- There is NO appeal process allowed for Observation Status under the Medicare rules.

WHAT CAN YOU DO??

- While you are still in the hospital, seek the doctor’s or YOUR primary doctors’ help to “admit you as an inpatient”.
- Remind the hospital (case manager or doctor) of the “2 midnight rule”. If the doctor expects you to require hospital care for at least 2 midnights, they should be able to admit you as an inpatient.
- If you are no longer in the hospital, there is no method for appeal.
- If you have gone to a Nursing Home, ask for a Medicare determination.

QUESTIONS?????

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