Medicare Minute Teaching Materials – March 2017
Medicare Coverage of Hospital Visits

1. What is the difference between an inpatient and an outpatient?

When you enter a hospital for treatment you can be classified as an inpatient or an outpatient, and your status affects Medicare costs and coverage. You are an **inpatient** if your attending physician has **formally admitted** you as an inpatient. Ask your doctor or attending physician to be sure, as there are no specific characteristics of your hospital stay that automatically make you an inpatient. For example, an overnight stay in the hospital does not necessarily mean you are an inpatient. In general, doctors will admit you as an inpatient if they expect that you need to stay in the hospital for medically necessary, inpatient-level care over two or more midnights.

If you are not formally admitted as an inpatient, then you are considered a hospital **outpatient**. There are a number of hospital services that are almost always provided as outpatient care, such as an emergency room visit or planned outpatient surgery.

2. What are observation services?

Observation services, sometimes called observation status, are **outpatient services**. They include ongoing short-term treatment and assessment of whether you should be admitted as an inpatient or if you can be discharged. Although they may involve an overnight or longer stay, **observation services are outpatient services**, so it is important to ask your doctor about the services you receive and what your hospital status is. Since observation services are provided to you as an outpatient, your coverage and costs will be different from the coverage and costs if you were an inpatient.

The hospital should provide you with a notice if you receive outpatient observation services for more than 24 hours. This is called the Medicare Outpatient Observation Notice (MOON). The MOON notifies you that you are receiving outpatient observation services and explains why you are an outpatient. Your doctor or hospital staff person should also explain this notice to you in person. This notice is meant to reduce confusion that you may experience if you are in the hospital and unsure of your inpatient or outpatient status.

3. What are Part A costs for hospital care?

If you have Original Medicare, your hospital stay is covered by Part A (hospital insurance) if you are a hospital inpatient, and by Part B (medical insurance) if you are a hospital outpatient.

If you are a hospital inpatient, you first must meet the Part A hospital deductible of $1,316 at the beginning of each benefit period (see question 4). Once you meet the deductible you pay zero dollars for the first 60 days of inpatient care in each benefit period. You owe $329 for days 61 through 90 in each benefit period and $658 per lifetime reserve day (see question 5) after day 90. You have 60 lifetime reserve days that can only be used once.

If you have a Medicare Advantage Plan, contact your plan to learn what its costs are for inpatient hospital care. Many plans have a deductible and/or daily copayments for inpatient care.

4. What is a benefit period?

A benefit period begins when you are admitted to a hospital or skilled nursing facility (SNF) as an inpatient and ends when you have been out of the hospital or SNF for at least 60 days in a row (see diagram on next page). If

you are readmitted to a hospital more than 60 days after your previous inpatient hospital stay, a new benefit period begins. This means that you owe the inpatient hospital deductible again, and your coverage days renew.

If you are readmitted to a hospital before 60 days have passed, then you are in the same benefit period. You do not owe the inpatient hospital deductible again and your coverage days continue from where you left off.

Benefit Period Begins	Benefit Period	Benefit Period Ends
You are admitted to a hospital or SNF as an inpatient.	Benefit period continues as you receive covered inpatient hospital or SNF care.	Benefit period ends when you've been out of the hospital or SNF for at least 60 days in a row.

5. What are lifetime reserve days?
Medicare Part A covers up to 60 additional lifetime reserve days. These are available when you have used all 90 covered hospital days during a single benefit period. Reserve days are **not renewable** and **can be used only once during your lifetime**.

You don't have to use these days if you would prefer not to, and you don't have to use them during the same hospital stay. If you're in the hospital for more than 90 days in a single benefit period, the hospital typically starts using your lifetime reserve days unless you decide you don't want to use them. If you are in the hospital for an extended stay, the hospital should notify you in writing on day 85 of your hospital stay that you have five coinsurance days remaining in the benefit period. You have the option of using your lifetime reserve days after day 90 or not. If you decide you don't want to use your lifetime reserve days, you must notify the hospital in writing. If you choose not to use your lifetime reserve days, Medicare won't pay toward any hospital costs beyond your standard 90 Medicare-covered days in a benefit period.

6. What are Part B costs for hospital care?
If you receive physicians' services while in the hospital, or are a hospital outpatient, then you will owe a 20% coinsurance of Medicare's approved amount for that care. You typically owe a coinsurance amount for each medical service you receive in the hospital as an outpatient, after you meet your annual Part B deductible ($183 in 2017). For example, you will have separate coinsurance charges for outpatient x-rays, lab tests, and any physicians' services you receive. Physicians' services include any time you spent with a physician while you were in the hospital, even if that physician was not your primary doctor.

If you have a Medicare Advantage Plan, contact your plan to learn what its costs are for hospital care. Medicare Advantage Plans can have high copayments for outpatient hospital services, so it is important to check with the plan to learn more about what costs you will owe.

7. Can I get a Medigap to help pay for my hospital costs?
If you have Original Medicare, you can purchase a Medigap, which is a supplemental insurance policy that pays for part or all of the Original Medicare cost-sharing gaps that you owe. In most states, there are ten standardized Medigap plans sold by private insurance companies: Plans A, B, C, D, F, G, K, L, M, and N. You pay a monthly premium to have the Medigap, and then the Medigap covers some of your out-of-pocket Original Medicare costs.

All Medigaps cover the Part A hospital coinsurance for all covered days in a benefit period, and the full cost of 365 additional hospital days during your lifetime. All Medigaps also cover the Part B coinsurance for physicians' services and any outpatient services you receive while in the hospital. Additionally, some Medigaps cover the Part A hospital deductible. You can learn more about Medigaps by calling your State Health Insurance Assistance Program (SHIP). Visit www.shiptacenter.org or call 877-808-2468 for assistance.

8. What inpatient hospital services does Part A cover?

Part A covers inpatient hospital care, including:

- A semi-private room and meals. Medicare will not pay for a private room unless it is medically necessary or it is the only room available.
- Most medications administered as treatment during your inpatient hospital stay
- General nursing
- Services you receive as part of your inpatient treatment, such as laboratory tests and x-rays
- Equipment that the hospital provides for you to use during your stay, such as a walker
- Medical supplies needed for your inpatient treatment, such as surgical dressings and splints

9. What outpatient hospital services does Part B cover?

Part B covers services and procedures you receive as an outpatient, including:

- Observation services
- Emergency room care
- Outpatient clinic services
- Ambulance services in limited cases. Medicare will only cover ambulance services if other types of transportation would endanger your health, such as if you are in shock, unconscious, or bleeding heavily.
- Hospital-billed laboratory tests and x-rays
- Medical supplies, like splints or casts
- Certain medications related to your outpatient hospital care

Part B covers all physician services provided in the hospital, **regardless of your inpatient status.**

10. How are my prescription drugs covered while I'm in the hospital?

How Medicare covers prescription drugs depends on whether you are an inpatient or an outpatient. If you are an inpatient, medically necessary medications are covered under Part A. If you are an outpatient, Part B covers a limited number of medications. Part B usually does not pay for drugs that aren't part of your treatment and that you can administer yourself.

For covered Part B prescription drugs you get in a hospital outpatient setting, you owe a copayment. If you get drugs **not covered under Part B** in a hospital outpatient setting, you pay 100 percent for the drugs, unless you have Medicare Part D or other prescription drug coverage. What you pay depends on whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network.

Part B does not cover drugs you routinely take (maintenance drugs). Many hospitals don't allow you to bring these medications with you from home, so you have to get the prescriptions through the hospital's pharmacy.

These pharmacies are rarely part of a Part D plan's network, so the drugs may be covered, but at out-of-network prices. Call your drug plan to ask about the hospital pharmacy's status.

11. What can I do if I feel I am being discharged from the hospital too soon?
If your provider decides that you no longer require hospital care, or if they believe Medicare will no longer pay for continued care, you may receive a written notice from the hospital that says you will soon be discharged. If you do not feel ready to leave the hospital, you can appeal the hospital's decision. Appealing means you ask an outside organization to reconsider the hospital's decision to discharge you.

You or a representative (such as a family member) can appeal a hospital discharge by following directions on a notice called An Important Message From Medicare, which explains why you are being discharged. Your doctor can also assist you with the appeal. The Important Message will provide you with information for the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). You must file an appeal with the BFCC-QIO by your discharge date. Once you file your appeal, the BFCC-QIO will contact you by phone to discuss your case. These types of appeals are expedited, meaning decisions are made quickly. It is important to be aware of the deadlines for appealing and to keep track of all paperwork you receive. If your first appeal with the BFCC-QIO is not successful, you can continue to appeal by following directions on the unfavorable decision that the BFCC-QIO sends you. You can still appeal once you have left the hospital, but the appeal will be handled on a standard timeline, instead of an expedited one.

12. Does Medicare cover care in a rehabilitation hospital?
Medicare covers care in a rehabilitation hospital if you meet the requirements for care. A rehabilitation hospital is a special hospital that offers intensive inpatient rehabilitation therapy. You may need care in a rehabilitation hospital if you are recovering from a serious illness, surgery, or injury. Rehabilitation hospitals provide specialized care that generally cannot be provided in another setting, such as your home. A stay in a rehabilitation hospital counts towards your 90 inpatient days in a benefit period, and you owe the hospital coinsurance charge for each day after day 60 in a benefit period.

You qualify for care in a rehabilitation hospital if your physician certifies that intensive rehabilitation is medically necessary to treat your condition. For the care to be considered medically necessary, you must require all of the following services to ensure safe and effective treatment:

- 24-hour access to a physician (meaning you require frequent, direct physician involvement, at least every 2-3 days
- 24-access to a registered nurse with specialized training of experience in rehabilitation
- Intensive therapy, which generally means at least three hours of therapy per day
    - Exceptions can be made on a case by case basis
- A coordinated team of providers including, at minimum, a physician, a rehabilitation nurse, and one therapist

Your condition must be expected to improve enough from a stay in a rehabilitation hospital to allow you to function more independently. For example, therapy may help you regain the ability for do activities of daily living on your own (such as eating, bathing, or dressing) or live at home with a family member rather than in a living facility.

13. Does Medicare cover care after I leave the hospital?
Medicare covers care at a number of different facilities once you are discharged from the hospital. Medicare covers care from a SNF, home health agency, or hospice agency.

Medicare covers care at a SNF if you were formally admitted as a hospital inpatient for three days in a row before being discharged, and you enter the SNF within 30 days of leaving the hospital. You must need skilled nursing care seven days per week or skilled therapy services (such as physical or speech therapy) at least five days per week that can only be provided in a SNF. The daily care requirement can be met with a combination of nursing and therapy services.

Medicare covers home health care if you are considered homebound, meaning you need the help of equipment or another person to leave the home, you need skilled care and/or skilled therapy, your doctor signs a home health certification, and you receive care from a Medicare-certified home health agency.

The Medicare hospice benefit offers end-of-life palliative care, focusing on the whole person, including support for your physical, emotional, social, and spiritual needs. The hospice benefit pays for your doctors and nurses as well as social worker services, grief and loss counseling for you and your family, and any other Medicare-covered services needed to manage your terminal illness, as recommended by your hospice team. The goal of hospice is to help you live comfortably, not to cure an illness. Hospice is always covered by Original Medicare Part A, even if you have a Medicare Advantage Plan.

Speak to your doctor if you have questions about your post-hospital care. In many cases, appropriate hospital staff may create a discharge plan for you, which outlines the care you will receive once you leave the hospital. This discharge plan is based on your physical, social, and emotional needs and takes into consideration the availability of different services or facilities in your area.

14. What resources are available to help me understand Medicare coverage of hospital visits?

State Health Insurance Assistance Program (SHIP): Contact your local SHIP for personalized, one-on-one counseling and assistance with understanding Medicare coverage of hospital services. SHIP counselors can explain the different parts of Medicare and how they cover different services you receive while in the hospital. The national SHIP mission is to empower, educate, and assist Medicare-eligible individuals, their families, and caregivers through objective outreach, counseling, and training, and to make informed health insurance decisions that optimize access to care and benefits. See the last page of the Teaching Materials for SHIP contact information.

Senior Medicare Patrol (SMP): Contact your local Senior Medicare Patrol (SMP) for education and assistance regarding suspected Medicare fraud, errors, or abuse. The national SMP mission is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. See the last page of the Teaching Materials for SMP program contact information.

1-800-MEDICARE: Contact Medicare if you have questions about Medicare-covered services. If you have Original Medicare, you can also call to get information about Medicare-approved hospitals and facilities.

Medicare Advantage Plan: If you have a Medicare Advantage Plan, contact your plan with questions about costs and coverage.

SHIP Case Study
Rick has Original Medicare and is going to get Medicare-covered hand surgery related to his arthritis. He wants to be prepared for the costs he will have, but he doesn't know where to start.

What should Rick do?

- Rick should contact his SHIP.
    - If he doesn't know how to find his SHIP, he can go to www.shiptacenter.org or call 1-877-839-2675 for assistance.
- The SHIP counselor can help Rick estimate his costs. The first thing Rick should find out is if he will be a hospital inpatient or outpatient. Minor surgeries like Rick's are commonly considered outpatient services. If Rick's surgery is an outpatient procedure, then he can expect to owe a 20% coinsurance for the different services he receives.
- The SHIP counselor can let Rick know that he should ask his doctor about the services he will receive. Rick can also ask about which types of providers will provide his care and if he will need to pay for any prescription medications. Asking questions helps Rick be aware of the care he will receive and the different services he will have to pay for.

SMP Case Study

Charlotte has recently become suspicious of some of the hospital services she has received. Last month, Charlotte went to the hospital with chest pains that turned out to be nothing more serious than muscle strain. Over the past few weeks Charlotte has been ordered to get a number of cardiovascular tests. At first, she thought the doctors were being cautious, but now she is starting to wonder why she needs so many tests. She is also worried about her growing medical bills as a result of all of the services.

What should Charlotte do?

- Charlotte should contact her local SMP to explain her situation.
    - If Charlotte doesn't know how to find her local SMP, she can go to www.smpresource.org or call 1-877-808-2468 for assistance.
- The SMP representative will collect clarifying information in order to understand Charlotte's situation more fully. It could be the case that Charlotte's doctor was performing unnecessary services, but the SMP will need to gather more information.
- If the SMP suspects fraud or abuse based on the information collected, they will report the situation to the proper authorities.
- The SMP representative can educate Charlotte about how to protect herself from other types of fraud or abuse, such as keeping her Medicare number safe and checking her EOBs for charges she doesn't recognize.

LOCAL HELP FOR PEOPLE WITH MEDICARE

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiptacenter.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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