

Medicare Benefit Policy Manual

Chapter 7 - Home Health Services

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(Rev. 10738, 05-07-21)

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10 - Home Health Prospective Payment System (HH PPS)

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

The unit of payment under the HH PPS is a national 30-day period rate with applicable adjustments. The periods, rate, and adjustments to the rates are detailed in the following sections.

10.1 - National 30-Day Period Payment Rate

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A. Services Included

The law requires the 30-day period to include all covered home health services, including medical supplies, paid on a reasonable cost basis. That means the 30-day period payment rate includes costs for the six home health disciplines and the costs for routine and nonroutine medical supplies. The six home health disciplines included in the 30-day period payment rate are:

1. Skilled nursing services;
2. Home health aide services;
3. Physical therapy;
4. Speech-language pathology services;
5. Occupational therapy services; and
6. Medical social services.

The 30-day period payment rate also includes amounts for nonroutine medical supplies and therapies that could have been unbundled to Part B prior to HH PPS. (See §10.11.C for those services.)

B. Excluded Services

The law specifically excludes durable medical equipment (DME) from the 30-day period payment rate and consolidated billing requirements. DME continues to be paid the fee schedule amounts or through the DME competitive bidding program outside of the HH PPS rate.

Certain injectable osteoporosis drugs which are covered where a woman is post-menopausal and has a bone fracture are also excluded from the 30-day period payment rate, but must be billed by the home health agency (HHA) while a patient is under a home health plan of care since the law requires consolidated billing of these osteoporosis drugs. These osteoporosis drugs continue to be paid on a reasonable cost basis.

Negative pressure wound therapy (NPWT) using a disposable device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy (in lieu of a conventional NPWT DME system), is also excluded from the 30-day period payment rate, but must be billed by the home health agency (HHA) while a patient is under a home health plan of care since the law requires consolidated billing of NPWT using a disposable device.

Furnishing NPWT using a disposable device means the application of a new applicable disposable device, as that term is defined in §1834 of the Social Security Act (the Act), which includes the professional services (specified by the assigned CPT code) that are provided.

10.2 - Adjustments to the 30-Day Period Payment Rate

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Case-Mix Adjustment

A case-mix methodology adjusts the 30-day payment rate based on characteristics of the patient and his/her corresponding resource needs (e.g., diagnoses, functional impairment level, and other factors). The 30-day period payment rate is adjusted by a case-mix methodology based on information from home health claims, other Medicare claims, and data elements from the Outcome and Assessment Information Set (OASIS). The claims information and OASIS data elements are used to group 30-day periods of care into their case-mix groups.

The following case-mix variables are obtained from home health or other Medicare claims:

- **Admission Source**-Institutional (i.e., acute hospital, inpatient rehabilitation facility, skilled nursing facility, long-term care hospital, inpatient psychiatric facility) or Community;
- **Timing**-Early (the first 30-day period of care) or Late (all subsequent 30-day periods of care, unless there is a gap of more than 60-days between the end of one period of care and the start of another),
- **Clinical Group**-As determined by the principal diagnosis reported on home health claims; 30-day periods are assigned to one of 12 clinical groups describing the primary reason for the home health encounter:

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Musculoskeletal Rehabilitation	Therapy (physical, occupational or speech) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (physical, occupational or speech) for a neurological condition or stroke
Wounds – Post-Op Wound Aftercare and Skin/Non-Surgical Wound Care	Assessment, treatment & evaluation of a surgical wound(s); assessment, treatment & evaluation of non-surgical wounds, ulcers, burns, and other lesions

Clinical Groups	The Primary Reason for the Home Health Encounter is to Provide:
Behavioral Health Care	Assessment, treatment & evaluation of psychiatric and substance abuse conditions
Complex Nursing Interventions	Assessment, treatment & evaluation of complex medical & surgical conditions including IV, TPN, enteral nutrition, ventilator, and ostomies
Medication Management, Teaching and Assessment (MMTA)	
MMTA –Surgical Aftercare	Assessment, evaluation, teaching, and medication management for surgical aftercare
MMTA – Cardiac/Circulatory	Assessment, evaluation, teaching, and medication management for cardiac or other circulatory related conditions
MMTA – Endocrine	Assessment, evaluation, teaching, and medication management for endocrine related conditions
MMTA – GI/GU	Assessment, evaluation, teaching, and medication management for gastrointestinal or genitourinary related conditions
MMTA – Infectious Disease/Neoplasms/Blood-forming Diseases	Assessment, evaluation, teaching, and medication management for conditions related to infectious diseases, neoplasms, and blood-forming diseases
MMTA –Respiratory	Assessment, evaluation, teaching, and medication management for respiratory related conditions
MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the previously listed groups

- **Comorbidity Adjustment**-As determined by certain secondary diagnoses reported on home health claims; a 30-day period of care can receive no comorbidity adjustment, a low comorbidity adjustment, or a high comorbidity adjustment.

The following case mix variable is determined from responses to certain items on the OASIS assessment:

- **Functional Impairment Level**-As determined by responses to certain OASIS items. A 30-day period of care can be assigned a low, medium, or high functional impairment level.

Each 30-day period is assigned into one of 432 case-mix groups based on the variables described above. Each group's case-mix weight reflects the predicted mean cost of the group relative to the overall average across all groups.

B. Labor Adjustments

The labor portion of the 30-day period payment rate is adjusted to reflect the wage index based on the site of service of the beneficiary. The beneficiary's location is the determining factor for the labor adjustment. The HH PPS rates are adjusted by the pre-floor and pre-reclassified hospital wage index. The hospital wage index is adjusted to account for the geographic reclassification of hospitals in accordance with

§§1886(d)(8)(B) and 1886(d)(10) of the Social Security Act (the Act.) According to the law, geographic reclassification only applies to hospitals. Additionally, the hospital wage index has specific floors that are required by law. Because these reclassifications and floors do not apply to HHAs, the home health rates are adjusted by the pre-floor and pre-reclassified hospital wage index.

NOTE: The pre-floor and pre-reclassified hospital wage index varies slightly from the numbers published in the Medicare inpatient hospital PPS regulation that reflects the floor and reclassification adjustments. The wage indices published in the home health final rule and subsequent annual updates reflect the most recent available pre-floor and pre-reclassified hospital wage index available at the time of publication.

10.3 - Continuous 60-Day Recertifications

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

While HH PPS payment is now made for each 30-day period, the home health PPS permits continuous 60-day recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous 60-day recertifications for beneficiaries who continue to be eligible for the home health benefit. Each 60-day certification can include two 30-day payment periods.

Recertification is required at least every 60 days when there is a need for continuous home health care after an initial 60-day certification. The recertification visit can be done during the prior certification period. With some minor exceptions, the Medicare Conditions of Participation at 42 CFR 484.55(d)(1), require that the recertification assessment be done during the last 5 days of the previous certification period (for example, during the initial 60-day certification period, the recertification visit is required to be done on days 56-60).

10.4 - Split Percentage Payment Approach to the 30-Day *Period* Unit of Payment

(Rev. 10738, Issued: 05-07-21, Effective: 01-01-21, Implementation: 08-09-21)

The HH PPS has set forth a split percentage payment approach to the 30-day unit of payment in calendar year (CY) 2020 only. For each 30-day period in CY 2020, there will be a 20/80 split percentage payment. That is, there will be a split percentage payment of 20 percent at the beginning of each 30-day period and a final percentage payment of 80 percent at the end of each 30-day period, unless there is an applicable adjustment, such as a low-utilization payment adjustment (LUPA).

For CY 2020, HHAs initially certified for participation in Medicare on or after January 1, 2019, do not receive split-percentage payments but will submit “no-pay” RAPs at the beginning of every 30-day period and will receive a final payment with a claim submission at the end of each 30-day period, unless there is an applicable adjustment.

For CY 2021, all HHAs will submit a ‘‘no pay’’ RAP at the beginning of each 30-day period to allow the beneficiary to be claimed in the CWF and also to trigger the

consolidated billing edits. This means that existing HHAs (those certified for participation in Medicare on or before December 31, 2018) will have their initial split-percentage payment reduced from 20 percent in CY 2020 to zero percent in CY 2021 for all 30-day periods of care and will submit a “no-pay” RAP for all 30-day periods of care in CY 2021. Newly enrolled HHAs (those certified for participation in Medicare on or after January 1, 2019) will continue to submit “no-pay” RAPs at the beginning of a 30-day period of care in order to establish the home health period of care, as well as every 30 days thereafter in CY 2021.

Where the plan of care dictates that multiple 30-day periods of care will be required to effectively treat the beneficiary, the HHA may submit both the RAP for the first 30-day period of care and the RAP for the second 30-day period of care (for a 60-day certification or a 60-day recertification) at the same time to help further reduce provider administrative burden.

Additionally, for CY 2021, there will be a non-timely submission reduction in payment amount tied to late submission of any “no-pay” RAPs when the HHA does not submit the RAP within 5 calendar days from the start of care date for the first 30-day period of care in a 60-day certification period and within 5 calendar days of day 31 for the second 30-day period of care in the 60-day certification period.

See Pub. 100-04, Medicare Claims Processing Manual, Chapter 10, “Home Health Agency Billing” for requirements regarding split-percentage payments and RAP submissions.

10.5 - Requirements for Submission of “No-Pay” RAPs

(Rev. 10738, Issued: 05-07-21, Effective: 01-01-21, Implementation: 08-09-21)

For CY 2021, submission of “no-pay” RAPs can be made when the following criteria have been met:

- (1) The appropriate physician’s or allowed practitioner’s written or verbal order that sets out the services required for the initial visit has been received and documented as required at §§ 484.60(b) and 409.43(d);*
- (2) The initial visit within the 60-day certification period must have been made and the individual admitted to home health care.*

10.6 - Low Utilization Payment Adjustment (LUPA)

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

The LUPA threshold varies for a 30-day period of care depending on the payment group to which it is assigned. For each payment group, the 10th percentile value of visits is used to create a payment group-specific LUPA threshold with a minimum threshold of at least 2 visits for each group. A 30-day period with visits less than the LUPA threshold for the payment group is paid the national per visit amount by discipline adjusted by the

appropriate wage index based on the site of service of the beneficiary. Such periods that do not meet the LUPA threshold for the payment group are paid the wage-adjusted per visit amount for each of the visits rendered instead of the full 30-day period payment amount. The national per visit amounts by discipline (skilled nursing, home health aide, physical therapy, speech-language pathology, occupational therapy, and medical social services) are updated and published annually by the applicable market basket for each visit type. To offset the full cost of longer, initial visits in some LUPA periods, the LUPA payment is increased by an add-on amount for LUPAs that occur as the only 30-day period or the initial 30-day period during a sequence of adjacent periods.

10.7 - Partial Payment Adjustment

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A. Partial Payment Adjustment Criteria

An HHA receives a national, standardized 30-day payment of a predetermined rate for home health services unless CMS determines an intervening event warrants a new 30-day period for purposes of payment.

The partial payment adjustment is a proportion of the period payment and is based on the span of days including the start-of-care date (for example, the date of the first billable service) through and including the last billable service date under the original plan of care before the intervening event, defined as a—

- Beneficiary elected transfer, or
- Discharge and return to home health that would warrant, for purposes of payment, a new OASIS assessment, certification of eligibility, and a new plan of care.

When a new 30-day period begins due to an intervening event, the original 30-day period will be proportionally adjusted to reflect the length of time the beneficiary remained under the agency's care prior to the intervening event. The proportional payment is the partial payment adjustment.

B. Methodology Used to Calculate Partial Payment Adjustment

The partial payment adjustment for the original 30-day period is calculated to reflect the length of time the beneficiary remained under the care of the original HHA based on the first billable visit date through and including the last billable visit date. The partial payment adjustment will be calculated by using the span of days (first billable service date through and including the last billable service date) under the original plan of care as a proportion of the 30-day period. The proportion will then be multiplied by the original case-mix and wage index to produce the 30-day payment.

C. Common Ownership Exception to Partial Payment Adjustment

The partial payment adjustment does not apply in situations of transfers among HHAs of common ownership. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the ownership

interest until the end of the 30-day period. The common ownership exception to the transfer partial payment adjustment does not apply if the beneficiary moved out of their Metropolitan Statistical Area (MSA) or non-MSA during the 30-day period before the transfer to the receiving HHA.

D. Beneficiary Elected Transfer Verification

In order for a receiving HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.50(d). The receiving HHA must also document in the record that it accessed the Medicare contractor's inquiry system to determine whether or not the patient was under an established home health plan of care and it must contact the initial HHA on the effective date of transfer. In the rare circumstance of a dispute between HHAs, the Medicare contractor is responsible for working with both HHAs to resolve the dispute. If the receiving HHA can provide documentation of its notice of patient rights on Medicare payment liability provided to the patient upon transfer and its contact of the initial HHA of the transfer date, then the initial HHA will be ineligible for payment for the period of overlap in addition to the appropriate partial payment adjustment. If the receiving HHA cannot provide the appropriate documentation, the receiving HHA's RAP and/or final claim will be cancelled, and full period payment will be provided to the initial HHA. For the receiving HHA to properly document that it contacted the initial HHA on the effective date of transfer it must maintain similar information as the initial HHA, including the same basic beneficiary information, personnel contacted, dates and times. The initial HHA must also properly document that it was contacted and it accepted the transfer. Where it disputes a transfer, the initial HHA must call its Medicare contractor to resolve the dispute. The Medicare contractor is responsible for working with both HHAs to resolve the dispute.

10.8 - Outlier Payments

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

When cases experience an unusually high level of services in a 30-day period, Medicare systems will provide additional or "outlier" payments to the case-mix and wage-adjusted 30-day period payment. Outlier payments can result from medically necessary high utilization in any or all-home health service disciplines. CMS makes outlier payments when the cost of care exceeds a threshold dollar amount. The outlier threshold for each case-mix group is the 30-day period payment amount for that group or the partial payment adjustment amount for the 30-day period, plus a fixed dollar loss amount, which is the same for all case-mix groups. The outlier payment is a proportion of the amount of imputed costs beyond the threshold. CMS calculates the imputed cost for each 30-day period by first taking the national per-visit payment amounts for each discipline and calculating per-unit payment amounts (1 unit = 15 minutes). The per-unit amounts are then multiplied by the number of units in the discipline and computing the total imputed cost for all disciplines (summed across the six disciplines of care).

If the imputed cost for the 30-day period is greater than the sum of the case-mix and wage-adjusted 30-day period payment plus the fixed dollar loss amount (the outlier threshold), a set percentage (the loss sharing ratio) of the difference between the imputed amount and outlier threshold will be paid to the HHA as a wage-adjusted outlier payment in addition to the 30-day period payment.

The amount of the outlier payment is determined as follows:

1. Calculate the case-mix and wage-adjusted 30-day period payment (including non-routine supplies (NRS));
2. Add the wage-adjusted fixed dollar loss amount. The sum of steps 1 and 2 is the outlier threshold for the 30-day period;
3. Calculate the wage-adjusted imputed cost of the 30-day period by first multiplying the total number of units for each home health discipline by the national per unit amounts, and wage-adjusting those amounts. Sum the per discipline wage-adjusted imputed amounts to yield the total wage-adjusted imputed cost for the 30-day period;
4. Subtract the total imputed cost for the 30-day period (total from Step 3) from the sum of the case-mix and wage-adjusted 30-day period payment and the wage-adjusted fixed dollar loss amount (sum of Steps 1 and 2 - outlier threshold);
5. Multiply the difference by the loss sharing ratio; and
6. That total amount is the outlier payment for the 30-day period.

Effective January 1, 2010, an outlier cap precludes any HHA from receiving more than 10 percent of their total home health payment in outliers.

10.9 - Discharge Issues

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Hospice Election Mid-Period

If a patient elects hospice before the end of the 30-day period and there was no PEP or LUPA adjustment, the HHA will receive a full 30-day period payment. The 30-day period with visits less than the LUPA threshold for the payment group would be paid at the low utilization payment adjusted amount.

B. Patient's Death

The documented event of a patient's death would result in a full 30-day period payment, unless the death occurred in a low utilization payment adjusted 30-day period. Consistent with all episodes in which a patient receives four or fewer visits, if the patient's death

occurred during a low utilization adjusted 30-day payment period, the period would be paid at the low utilization payment adjusted amount. In the event of a patient's death during an adjusted 30-day period, the total adjusted period would constitute the full 30-day period payment.

C. Patient is No Longer Eligible for Home Health (e.g., no longer homebound, no skilled need)

If the patient is discharged because he or she is no longer eligible for the Medicare home health benefit and has received visits meeting the LUPA threshold for the payment group, then the HHA would receive the full 30-day period payment. However, if the patient becomes subsequently eligible for the Medicare home health benefit during the same 30-day period and transferred to another HHA or returned to the same HHA, then this would result in a partial payment adjustment.

D. Discharge Due to Patient Refusal of Services or is a Documented Safety Threat, Abuse Threat or is Noncompliant

If the patient is discharged because he or she refuses services or becomes a documented safety, abuse, or noncompliance discharge and has received visits meeting the LUPA threshold for the payment group, then the HHA would receive full period payment unless the patient becomes subsequently eligible for the Medicare home health benefit during the same 30-day period and transferred to another HHA or returned to the same HHA, then this would result in a PEP adjustment.

E. Patient Enrolls in Managed Care Mid-Period

If a patient's enrollment in a Medicare Advantage (MA) plan becomes effective mid period, the 30-day period payment will be proportionally adjusted with a partial payment adjustment since the patient is receiving coverage under MA. Beginning with the effective date of enrollment, the MA plan will receive a capitation payment for covered services.

F. Submission of Final Claims Prior to the End of the 30-day Period

The claim may be submitted upon discharge before the end of the 30-day period. However, subsequent adjustments to any payments based on the claim may be made due to an intervening event resulting in a partial payment adjustment or other adjustment.

G. Patient Discharge and Financial Responsibility for Part B Bundled Medical Supplies and Services

As discussed in detail under §10.11, below, the law governing the Medicare HH PPS requires the HHA to provide all bundled home health services (except DME) either directly or under arrangement while a patient is under an open home health plan of care during an open episode. Once the patient is discharged, the HHA is no longer

responsible for providing home health services including the bundled Part B medical supplies and therapy services.

H. Discharge Issues Associated With Inpatient Admission Overlapping Into Subsequent 60-Day Recertifications

1. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent 60-day recertification and there is no recertification assessment of the patient, then the new certification begins with the new start of care date after inpatient discharge.
2. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent 60-day recertification and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay on day 61, if the home health resource group (HHRG) remains the same then the 30-day period of care following the inpatient stay would be considered continuous and thus be considered a recertification. However, if the HHRG is different, this would result in a new start of care OASIS and thus be considered a new certification and begins with the new start of care date after inpatient discharge.
3. If a patient is admitted to an inpatient facility and the inpatient stay overlaps into what would have been the subsequent 60-day recertification and there was a recertification assessment of the patient during days 56-60 and the patient returns home from the inpatient stay after day 61 (after the first day of the next 60-day recertification of care), then a new certification begins with the new start of care date after inpatient discharge.

10.10 - Consolidated Billing

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

For individuals under a home health plan of care, payment for all services and supplies, with the exception of certain injectable osteoporosis drugs, DME, and furnishing NPWT using a disposable device is included in the HH PPS base payment rates. HHAs must provide the covered home health services (except DME) either directly or under arrangement, and must bill for such covered home health services.

Payment must be made to the HHA.

A. Home Health Services Subject to Consolidated Billing Requirements

The home health services included in the consolidated billing governing the HH PPS are:

- Part-time or intermittent skilled nursing services;
- Part-time or intermittent home health aide services;
- Physical therapy;

- Speech-language pathology services;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Covered osteoporosis drug as defined in §1861(kk) of the Act, but excluding other drugs and biologicals;
- Furnishing NPWT using a disposable device as that term is defined in §1834 of the Act, which includes the professional services (specified by the assigned CPT code) that are provided;
- Medical services provided by an intern or resident-in-training of the program of the hospital in the case of an HHA that is affiliated or under common control with a hospital with an approved teaching program; and
- Home health services defined in §1861(m) of the Act provided under arrangement at hospitals, SNFs, or rehabilitation centers when they involve equipment too cumbersome to bring to the home or are furnished while the patient is at the facility to receive such services.

B. Medical Supplies

The law requires that all medical supplies (routine and nonroutine) be provided by the HHA while the patient is under a home health plan of care. The agency that establishes the 30-day period is the only entity that can bill and receive payment for medical supplies during a 30-day period for a patient under a home health plan of care. Both routine and nonroutine medical supplies are included in the base rates for every Medicare home health patient regardless of whether or not the patient requires medical supplies during the 30-day period.

Due to the consolidated billing requirements, CMS provided additional amounts in the base rates for those nonroutine medical supplies that have a duplicate Part B code that could have been unbundled to Part B prior to HH PPS. See §50.4 for detailed discussion of medical supplies.

Medical supplies used by the patient, provider, or other practitioners under arrangement on behalf of the agency (other than physicians) are subject to consolidated billing and bundled into the HHA 30-day period payment rate. Once a patient is discharged from home health and not under a home health plan of care, the HHA is not responsible for medical supplies.

DME, including supplies covered as DME, are paid separately from the HH PPS and are excluded from the consolidated billing requirements governing the HH PPS. The determining factor is the medical classification of the supply, not the diagnosis of the patient.

Certain injectable osteoporosis drugs are included in consolidated billing under the home health benefit. However, payment is not bundled into the HH PPS payment rates. HHAs must bill for the osteoporosis drug in accordance with billing instructions. Payment is in addition to the HH PPS payment.

Furnishing NPWT using a disposable device is included in consolidated billing under the home health benefit. However, payment is not bundled into the HH PPS payment rates. HHAs must bill for NPWT using a disposable device in accordance with billing instructions. Payment is in addition to the HH PPS payment.

C. Relationship Between Consolidated Billing Requirements and Part B Supplies and Part B Therapies Included in the Baseline Rates That Could Have Been Unbundled Prior to HH PPS That No Longer Can Be Unbundled

The HHA is responsible for the services provided under arrangement on their behalf by other entities. Covered home health services at §1861(m) of the Act (except DME) are included in the baseline HH PPS rates and subject to the consolidated billing requirements while the patient is under a plan of care of the HHA. The time the services are bundled is while the patient is under a home health plan of care.

Physician services or nurse practitioner services paid under the physician fee schedule are not recognized as home health services included in the PPS rates. Supplies incident to a physician service or related to a physician service billed to the Medicare contractor are not subject to the consolidated billing requirements. The physician would not be acting as a supplier billing the DME Medicare contractor in this situation.

Therapies (physical therapy, occupational therapy, and speech-language pathology services) are covered home health services that are included in the baseline rates and subject to the consolidated billing requirements. In addition to therapies that had been paid on a cost basis under home health, CMS has included in the rates additional amounts for Part B therapies that could have been unbundled prior to PPS. These therapies are subject to the consolidated billing requirements. There are revenue center codes that reflect the ranges of outpatient physical therapy, occupational therapy, and speech-language pathology services and Healthcare Common Procedure Coding System (HCPCS) codes that reflect physician supplier codes that are physical therapy, occupational therapy, and speech-language pathology services by code definition and are subject to the consolidated billing requirements. Therefore, the above-mentioned therapies must be provided directly or under arrangement on behalf of the HHA while a patient is under a home health plan of care and cannot be separately billed to Part B during an open 30-day period of care.

D. Freedom of Choice Issues

A beneficiary exercises his or her freedom of choice for the services under the home health benefit listed in §1861(m) of the Act, including medical supplies, but excluding DME covered as a home health service by choosing the HHA. Once a home health patient chooses a particular HHA, he or she has clearly exercised freedom of choice with respect to all items and services included within the scope of the Medicare home health benefit (except DME). The HHA's consolidated billing role supersedes all other billing situations the beneficiary may wish to establish for home health services covered under the scope of the Medicare home health benefit during the certified episode.

E. Knowledge of Services Arranged for on Behalf of the HHA

The consolidated billing requirements governing HH PPS requires that the HHA provide all covered home health services (except DME) either directly or under arrangement while a patient is under a home health plan of care. Providing services either directly or under arrangement requires knowledge of the services provided during the 30-day period. In addition, in accordance with current Medicare conditions of participation and Medicare coverage guidelines governing home health, the patient's plan of care must reflect the physician or allowed practitioner ordered services that the HHA provides either directly or under arrangement. An HHA would not be responsible for payment in the situation in which they have no prior knowledge (unaware of physician or allowed practitioner orders) of the services provided by an entity during a 30-day period to a patient who is under their home health plan of care. An HHA is responsible for payment in the situation in which services are provided to a patient by another entity, under arrangement with the HHA, during a 30-day period in which the patient is under the HHA's home health plan of care. However, it is in the best interest of future business relationships to discuss the situation with any entity that seeks payment from the HHA during a 30-day period in an effort to resolve any misunderstanding and avoid such situations in the future.

10.11 - Change of Ownership Relationship to Periods Under HH PPS (Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A. Change of Ownership With Assignment

When there is a change of ownership and the new owner accepts assignment of the existing provider agreement, the new owner is subject to all the terms and conditions under which the existing agreement was issued. The provider number remains the same if the new HHA owner accepts assignment of the existing provider agreement. As long as the new owner complies with the regulations governing home health PPS, billing, and payment for 30-day periods with applicable adjustments for existing patients under an established plan of care will continue on schedule through the change in ownership with assignment. The 30-day period would be uninterrupted spanning the date of sale. The former owner is required to file a terminating cost report. Instructions regarding when a cost report is filed are in the Provider Reimbursement Manual, Part 1, §1500.

B. Change of Ownership Without Assignment

When there is a change of ownership, and the new owner does not take the assignment of the existing provider agreement, the provider agreement and provider number of the former owner is terminated. The former owner will receive partial payment adjusted payments in accordance with the methodology set forth in the Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing," §40.2, and 42 CFR 484.235, based on the last billable visit date for existing patients under a home health plan of care ending on or before the date of sale. The former owner is required to file a terminating cost report. The new owner cannot bill Medicare for payment until the effective date of the Medicare approval. The new HHA will not be able to participate in the Medicare program without going through the same process as any new provider, which includes an initial survey. Once the new owner is Medicare-approved, the HHA may start a new 30-day period for purposes of payment, OASIS assessment, and certification of the home health plan of care for all new patients in accordance with the regulations governing home health PPS, effective with the date of the new provider certification.

C. Change of Ownership - Mergers

The merger of a provider corporation into another corporation constitutes a change of ownership. For information on specific procedures, refer to Pub. 100-07, State Operations Manual, chapter 2, section 2202.17.

10.12 - Change of Ownership Relationship to Episodes Under PPS

(Rev. 139, Issued: 02-16-11, Effective: 01-01-11, Implementation: 03-10-11)

A. Change of Ownership With Assignment

When there is a change of ownership and the new owner accepts assignment of the existing provider agreement, the new owner is subject to all the terms and conditions under which the existing agreement was issued. The provider number remains the same if the new HHA owner accepts assignment of the existing provider agreement. As long as the new owner complies with the regulations governing home health PPS, billing, and payment for episodes with applicable adjustments for existing patients under an established plan of care will continue on schedule through the change in ownership with assignment. The episode would be uninterrupted spanning the date of sale. The former owner is required to file a terminating cost report. Instructions regarding when a cost report is filed are in the Provider Reimbursement Manual, Part 1, §1500.

B. Change of Ownership Without Assignment

When there is a change of ownership, and the new owner does not take the assignment of the existing provider agreement, the provider agreement and provider number of the former owner is terminated. The former owner will receive partial episode payment adjusted payments in accordance with the methodology set forth in the Medicare Claims Processing Manual, Chapter 10, "Home Health Agency Billing," §40.2, and 42 CFR 484.235, based on the last billable visit date for existing patients under a home health plan of care ending on or before the date of sale. The former owner is required to file a

terminating cost report. The new owner cannot bill Medicare for payment until the effective date of the Medicare approval. The new HHA will not be able to participate in the Medicare program without going through the same process as any new provider, which includes an initial survey. Once the new owner is Medicare-approved, the HHA may start a new episode for purposes of payment, OASIS assessment, and certification of the home health plan of care for all new patients in accordance with the regulations governing home health PPS, effective with the date of the new provider certification.

C. Change of Ownership - Mergers

The merger of a provider corporation into another corporation constitutes a change of ownership. For information on specific procedures, refer to Pub. 100-07, State Operations Manual, chapter 2, section 2202.17.

20 - Conditions To Be Met for Coverage of Home Health Services

(Rev. 1, 10-01-03)

A3-3116, HHA-203

Medicare covers HHA services when the following criteria are met:

1. The person to whom the services are provided is an eligible Medicare beneficiary;
2. The HHA that is providing the services to the beneficiary has in effect a valid agreement to participate in the Medicare program;
3. The beneficiary qualifies for coverage of home health services as described in §30;
4. The services for which payment is claimed are covered as described in §§40 and 50;
5. Medicare is the appropriate payer; and
6. The services for which payment is claimed are not otherwise excluded from payment.

20.1 - Reasonable and Necessary Services

(Rev. 1, 10-01-03)

A3-3116.1. HHA-203.1

20.1.1 - Background

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

In enacting the Medicare program, Congress recognized that the physician or allowed practitioner would play an important role in determining utilization of services. The law requires that payment can be made only if a physician or allowed practitioner certifies the need for services and establishes a plan of care. The Secretary is responsible for ensuring

that Medicare covers the claimed services, including determining whether they are "reasonable and necessary."

20.1.2 - Determination of Coverage

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

The Medicare contractor's decision on whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR 484.55 or a medical record of the individual patient. Medicare does not deny coverage solely on the basis of the reviewer's general inferences about patients with similar diagnoses or on data related to utilization generally, but bases it upon objective clinical evidence regarding the patient's individual need for care. Coverage of skilled nursing care or therapy to perform a maintenance program does not turn on the presence or absence of a patient's potential for improvement from the nursing care or therapy, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, to prevent or slow further deterioration of the patient's condition.

20.2 - Impact of Other Available Caregivers and Other Available Coverage on Medicare Coverage of Home Health Services

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Where the Medicare criteria for coverage of home health services are met, patients are entitled by law to coverage of reasonable and necessary home health services. Therefore, a patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether there is someone available to furnish the services. However, where a family member or other person is or will be providing services that adequately meet the patient's needs, it would not be reasonable and necessary for HHA personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the HHA unless the patient or family indicates otherwise and objects to the provision of the services by the HHA, or unless the HHA has first hand knowledge to the contrary.

Similarly, a patient is entitled to reasonable and necessary Medicare home health services even if the patient would qualify for institutional care (e.g., hospital care or skilled nursing facility care) and Medicare payment should be made for reasonable and necessary home health services where the patient is also receiving supplemental services that do not meet Medicare's definition of skilled nursing care or home health aide services.

EXAMPLE 1:

A patient who lives with an adult daughter and otherwise qualifies for Medicare coverage of home health services, requires the assistance of a home health aide for bathing and assistance with an exercise program to improve endurance. The daughter is unwilling to bathe her elderly father and assist him with the exercise program. Home health aide services would be reasonable and necessary.

EXAMPLE 2:

A patient who is being discharged from a hospital with a diagnosis of osteomyelitis and requires continuation of the I.V. antibiotic therapy that was begun in the hospital was found to meet the criteria for Medicare coverage of skilled nursing facility services. If the patient also meets the qualifying criteria for coverage of home health services, payment may be made for the reasonable and necessary home health services the patient needs, notwithstanding the availability of coverage in a skilled nursing facility.

EXAMPLE 3:

A patient who needs skilled nursing care on an intermittent basis also hires a licensed practical (vocational) nurse to provide nighttime assistance while family members sleep. The care provided by the nurse, as respite to the family members, does not require the skills of a licensed nurse (as defined in §40.1) and therefore has no impact on the beneficiary's eligibility for Medicare payment of home health services even though another third party insurer may pay for that nursing care.

20.3 - Use of Utilization Screens and "Rules of Thumb"

(Rev. 1, 10-01-03)

A3-3116.3, HHA-203.3

Medicare recognizes that determinations of whether home health services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Therefore, denial of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms is not appropriate.

30 - Conditions Patient Must Meet to Qualify for Coverage of Home Health Services

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

To qualify for the Medicare home health benefit, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, a Medicare beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician or allowed practitioner;
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or
- Have a continuing need for occupational therapy.

For purposes of benefit eligibility, under §§1814(a)(2)(C) and 1835(a)(2)(A) of the Act, "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

A patient must meet each of the criteria specified in this section. Patients who meet each of these criteria are eligible to have payment made on their behalf for services discussed in §§40 and 50.

30.1 - Confined to the Home

(Rev. 1, 10-01-03)

A3-3117.1, HHA-204.1

30.1.1 - Patient Confined to the Home

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

For a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician or allowed practitioner certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criterion One:

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

OR

- Have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the criterion one conditions, then the patient must ALSO meet two additional requirements defined in criterion two below.

2. Criterion Two:

- There must exist a normal inability to leave home;

AND

- Leaving home must require a considerable and taxing effort.

To clarify, in determining whether the patient meets criterion two of the homebound definition, the clinician needs to take into account the illness or injury for which the patient met criterion one and consider the illness or injury in the context of the patient's overall condition. The clinician is not required to include standardized phrases reflecting the patient's condition (e.g., repeating the words "taxing effort to leave the home") in the patient's chart, nor are such phrases sufficient, by themselves, to demonstrate that criterion two has been met. For example, longitudinal clinical information about the patient's health status is typically needed to sufficiently demonstrate a normal inability to leave the home and that leaving home requires a considerable and taxing effort. Such clinical information about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment. Absences attributable to the need to receive health care treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists are listed below.

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk.

- A patient who is blind or senile and requires the assistance of another person in leaving their place of residence.
- A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence.
- A patient in the late stages of ALS or neurodegenerative disabilities. In determining whether the patient has the general inability to leave the home and leaves the home only infrequently or for periods of short duration, it is necessary (as is the case in determining whether skilled nursing services are intermittent) to look at the patient's condition over a period of time rather than for short periods within the home health stay. For example, a patient may leave the home (meeting both criteria listed above) more frequently during a short period when the patient has multiple appointments with health care professionals and medical tests in 1 week. So long as the patient's overall condition and experience is such that he or she meets these qualifications, he or she should be considered confined to the home.
- A patient who has just returned from a hospital stay involving surgery, who may be suffering from resultant weakness and pain because of the surgery and; therefore, their actions may be restricted by their physician or allowed practitioner to certain specified and limited activities (such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.).
- A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity.
- A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

The aged person who does not often travel from home because of frailty and insecurity brought on by advanced age would not be considered confined to the home for purposes of receiving home health services unless they meet one of the above conditions.

Although a patient must be confined to the home to be eligible for covered home health services, some services cannot be provided at the patient's residence because equipment is required that cannot be made available there. If the services required by an individual involve the use of such equipment, the HHA may make arrangements with a hospital, SNF, or a rehabilitation center to provide these services on an outpatient basis. (See §50.6.) However, even in these situations, for the services to be covered as home health services the patient must be considered confined to home and meet both criteria listed above.

If a question is raised as to whether a patient is confined to the home, the HHA will be requested to furnish the Medicare contractor with the information necessary to establish that the patient is homebound as defined above.

30.1.2 - Patient's Place of Residence

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

A patient's residence is wherever he or she makes his or her home. This may be his or her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution. However, an institution may not be considered a patient's residence if the institution meets the requirements of §§1861(e)(1) or 1819(a)(1) of the Act..

Included in this group are hospitals and skilled nursing facilities, as well as most nursing facilities under Medicaid. (See the Medicare State Operations Manual, §2166.)

Thus, if a patient is in an institution or distinct part of an institution identified above, the patient is not entitled to have payment made for home health services under either Part A or Part B since such an institution may not be considered their residence. When a patient remains in a participating SNF following their discharge from active care, the facility may not be considered their residence for purposes of home health coverage.

A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during a period of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home, or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. The requirements of homebound must be met at each location (i.e., the patient must meet both criteria listed in section 30.1.1 above).

A. Assisted Living Facilities, Group Homes, and Personal Care Homes

An individual may be "confined to the home" for purposes of Medicare coverage of home health services if he or she resides in an institution that is not primarily engaged in providing to inpatients:

- Diagnostic and therapeutic services for medical diagnosis;
- Treatment;
- Care of injured, disabled or sick persons;
- Rehabilitation services or other skilled services needed to maintain a patient's current condition or to prevent or slow further deterioration; or

- Skilled nursing care or related services for patients who require medical or nursing care.

If it is determined that the assisted living facility (also called personal care homes, group homes, etc.) in which the individuals reside are not primarily engaged in providing the above services, then Medicare will cover reasonable and necessary home health care furnished to these individuals.

If it is determined that the services furnished by the home health agency are duplicative of services furnished by an assisted living facility when provision of such care is required of the facility under State licensure requirements, claims for such services should be denied under §1862(a)(1)(A) of the Act. Section 1862(a)(1)(A) excludes services that are not necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member from Medicare coverage. Services to people who already have access to appropriate care from a willing caregiver would not be considered reasonable and necessary to the treatment of the individual's illness or injury.

Medicare coverage would not be an optional substitute for the services that a facility is required to provide by law to its patients or where the services are included in the base contract of the facility. An individual's choice to reside in such a facility is also a choice to accept the services it holds itself out as offering to its patients.

B. Day Care Centers and Patient's Place of Residence

The current statutory definition of homebound or confined does not imply that Medicare coverage has been expanded to include adult day care services.

The law does not permit an HHA to furnish a Medicare covered billable visit to a patient under a home health plan of care outside his or her home, except in those limited circumstances where the patient needs to use medical equipment that is too cumbersome to bring to the home. Section 1861(m) of the Act stipulates that home health services provided to a patient be provided to the patient on a visiting basis in a place of residence used as the individual's home. A licensed/certified day care center does not meet the definition of a place of residence.

C. State Licensure/Certification of Day Care Facilities

Per Section 1861(m) of the Act, an adult day care center must be either licensed or certified by the State or accredited by a private accrediting body. State licensure or certification as an adult day care facility must be based on State interpretations of its process. For example, several States do not license adult day care facilities as a whole, but do certify some entities as Medicaid certified centers for purposes of providing adult day care under the Medicaid home and community based waiver program. It is the responsibility of the State to determine the necessary criteria for "State certification" in such a situation. A State could determine that Medicaid certification is an acceptable standard and consider its Medicaid certified adult day care facilities to be "State certified." On the other hand, a State could determine Medicaid certification to be

insufficient and require other conditions to be met before the adult day care facility is considered "State certified".

D. Determination of the Therapeutic, Medical or Psychosocial Treatment of the Patient at the Day Care Facility

It is not the obligation of the HHA to determine whether the adult day care facility is providing psychosocial treatment, but only to assure that the adult day care center is licensed/certified by the State or accrediting body. The intent of the law, in extending the homebound exception status to attendance at such adult day care facilities, recognizes that they ordinarily furnish psychosocial services.

30.2 - Services Are Provided Under a Plan of Care Established and Approved by a Physician or Allowed Practitioner

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

30.2.1 – Definition of an Allowed Practitioner

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Allowed practitioners in addition to physicians, can certify and recertify beneficiaries for eligibility, order home health services, and establish and review the care plan. Allowed practitioners are defined at § 484.2 as a physician assistant, nurse practitioner, or clinical nurse specialist as defined at this part. NPs, CNSs, and PAs are required to practice in accordance with state law in the state in which the individual performs such services. Individual states have varying requirements for conditions of practice, which determine whether a practitioner may work independently without a written collaborative agreement or supervision from a physician, or whether general or direct supervision and collaboration is required.

30.2. 2 - Content of the Plan of Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The HHA must be acting upon a physician or allowed practitioner plan of care that meets the requirements of this section for HHA services to be covered. For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment. In addition, the plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits as well as those items listed in 42 CFR 484.60(a) that establish the need for such services. All care provided must be in accordance with the plan of care.

If the plan of care includes a course of treatment for therapy services:

- The course of therapy treatment must be established by the physician or allowed practitioner after any needed consultation with the qualified therapist;

- The plan must include measurable therapy treatment goals which pertain directly to the patient's illness or injury, and the patient's resultant impairments;
- The plan must include the expected duration of therapy services; and
- The plan must describe a course of treatment which is consistent with the qualified therapist's assessment of the patient's function.

30.2.3 - Specificity of Orders

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services.

EXAMPLE 1:

SN x 7/wk x 1 wk; 3/wk x 4 wk; 2/wk x 3 wk, (skilled nursing visits 7 times per week for 1 week; 3 times per week for 4 weeks; and 2 times per week for 3 weeks) for skilled observation and evaluation of the surgical site, for teaching sterile dressing changes and to perform sterile dressing changes. The sterile change consists of (detail of procedure).

Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided to home health patients under a home health plan of care. When a range of visits is ordered, the upper limit of the range is considered the specific frequency.

EXAMPLE 2:

SN x 2-4/wk x 4 wk; 1-2/wk x 4 wk for skilled observation and evaluation of the surgical site.

Orders for services to be furnished "as needed" or "PRN" must be accompanied by a description of the patient's medical signs and symptoms that would occasion a visit and a specific limit on the number of those visits to be made under the order before an additional physician or allowed practitioner order would have to be obtained.

30.2.4 - Who Signs the Plan of Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

The physician or allowed practitioner who signs the plan of care must be qualified to sign the certification as described in 42 CFR 424.22.

30.2.5 - Timeliness of Signature

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A. Initial Percentage Payment

If a physician or allowed practitioner signed plan of care is not available at the beginning of the 30-day period, the HHA may submit a RAP for the initial percentage payment based on physician or allowed practitioner verbal orders OR a referral prescribing detailed orders for the services to be rendered that is signed and dated by the physician or allowed practitioner. If the RAP submission is based on verbal orders, the verbal order must be recorded in the plan of care, include a description of the patient's condition and the services to be provided by the home health agency, include an attestation (relating to the physician's or allowed practitioner's orders and the date received per 42 CFR 409.43), and the plan of care is copied and immediately submitted to the physician or allowed practitioner. A billable visit must be rendered prior to the submission of a RAP.

B. Final Percentage Payment

The plan of care must be signed and dated by a physician or allowed practitioner as described who meets the certification and recertification requirements of 42 CFR 424.22 and before the claim for each 30-day period for services is submitted for the final percentage payment. Any changes in the plan of care must be signed and dated by a physician or allowed practitioner.

30.2.6 - Use of Oral (Verbal) Orders

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

When services are furnished based on a physician or allowed practitioner's oral order, the orders may be accepted and put in writing by personnel authorized to do so by applicable State and Federal laws and regulations as well as by the HHA's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services. The orders may be signed by the supervising registered nurse or qualified therapist after the services have been rendered, as long as HHA personnel who receive the oral orders notify that nurse or therapist before the service is rendered. Thus, the rendering of a service that is based on an oral order would not be delayed pending signature of the supervising nurse or therapist. Oral orders must be countersigned and dated by the physician or allowed practitioner before the HHA bills for the care in the same way as the plan of care.

Services which are provided from the beginning of the 60-day certification period based on a request for anticipated payment and before the physician or allowed practitioner signs the plan of care are considered to be provided under a plan of care established and approved by the physician or allowed practitioner where there is an oral order for the care

prior to rendering the services which is documented in the medical record and where the services are included in a signed plan of care.

Services that are provided in the subsequent 60-day certification period are considered provided under the plan of care of the subsequent 60-day episode where there is an oral order before the services provided in the subsequent period are furnished and the order is reflected in the medical record. However, services that are provided after the expiration of the plan of care, but before the acquisition of an oral order or a signed plan of care are not considered provided under a plan of care.

EXAMPLE 1:

The HHA acquires an oral order for I.V. medication administration for a patient to be performed on August 1. The HHA provides the I.V. medication administration August 1 and evaluates the patient's need for continued care. The physician or allowed practitioner signs the plan of care for the I.V. medication administration on August 15. The visit is covered since it is considered provided under a plan of care established and approved by the physician or allowed practitioner, and the HHA had acquired an oral order prior to the delivery of services.

EXAMPLE 2:

The patient is under a plan of care in which the physician or allowed practitioner orders I.V. medication administration every 2 weeks. The last day covered by the initial plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician or allowed practitioner signs the plan of care for the new period on August 1. The I.V. medication administration on August 5 was provided under a plan of care established and approved by the physician or allowed practitioner.

EXAMPLE 3:

The patient is under a plan of care in which the physician or allowed practitioner orders I.V. medication administration every 2 weeks. The last day covered by the plan of care is July 31. The patient's next I.V. medication administration is scheduled for August 5 and the physician or allowed practitioner does not sign the plan of care until August 6. The HHA acquires an oral order for the I.V. medication administration before the August 5 visit, and therefore the visit is considered to be provided under a plan of care established and approved by the physician or allowed practitioner.

Any increase in the frequency of services or addition of new services during a 60-day certification must be authorized by a physician or allowed practitioner by way of a written or oral order prior to the provision of the increased or additional services.

30.2.7 - Frequency of Review of the Plan of Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The plan of care must be reviewed and signed by the physician or allowed practitioner who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician or allowed practitioner and the date of review.

30.2.8 - Facsimile Signatures

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The plan of care or oral order may be transmitted by facsimile machine. The HHA is not required to have the original signature on file. However, the HHA is responsible for obtaining original signatures if an issue surfaces that would require verification of an original signature.

30.2.9 - Alternative Signatures

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

HHAs that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The HHA must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.

30.2.10 - Termination of the Plan of Care - Qualifying Services

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The plan of care is considered to be terminated if the patient does not receive at least one covered skilled nursing, physical therapy, speech-language pathology service, or occupational therapy visit in a 60-day certification period since these are qualifying services for the home health benefit. An exception is if the physician or allowed practitioner documents that the interval without such care is appropriate to the treatment of the patient's illness or injury.

30.2.11 - Sequence of Qualifying Services and Other Medicare Covered Home Health Services

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Once patient eligibility has been confirmed and the plan of care contains physician or allowed practitioner orders for the qualifying service as well as other Medicare covered home health services, the qualifying service does not have to be rendered prior to the other Medicare covered home health services ordered in the plan of care. The sequence

of visits performed by the disciplines must be dictated by the individual patient's plan of care. For example, for an eligible patient in an initial 60-day certification period that has both physical therapy and occupational therapy orders in the plan of care, the sequence of the delivery of the type of therapy is irrelevant as long as the need for the qualifying service is established prior to the delivery of other Medicare covered services and the qualifying discipline provides a billable visit prior to transfer or discharge in accordance with 42 CFR 409.43(f).

NOTE: Dependent services provided after the final qualifying skilled service are not covered under the home health benefit, except when the dependent service was not followed by a qualifying skilled service due to unexpected inpatient admission, death of the patient, or some other unanticipated event.

30.3 - Under the Care of a Physician or Allowed Practitioner

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The patient must be under the care of a physician or allowed practitioner who is qualified to sign the certification and plan of care in accordance with 42 CFR 424.22.

A patient is expected to be under the care of the physician or allowed practitioner who signs the plan of care. It is expected that in most instances, the physician or allowed practitioner who certifies the patient's eligibility for Medicare home health services, in accordance with §30.5 below, will be the same physician or allowed practitioner who establishes and signs the plan of care.

30.4 - Needs Skilled Nursing Care on an Intermittent Basis (Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample), Physical Therapy, Speech-Language Pathology Services, or Has Continued Need for Occupational Therapy

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The patient must need one of the following types of services:

1. Skilled nursing care that is
 - Reasonable and necessary as defined in §40.1;
 - Needed on an "intermittent" basis as defined in §40.1.3; and
 - Not solely needed for venipuncture for the purposes of obtaining blood sample as defined in §40.1.2.13; or
2. Physical therapy as defined in §40.2.2; or
3. Speech-language pathology services as defined in §40.2.3; or

4. Have a continuing need for occupational therapy as defined in §§40.2.4.

The patient has a continued need for occupational therapy when:

1. The services which the patient requires meet the definition of "occupational therapy" services of §40.2.4, and
2. The patient's eligibility for home health services has been established by virtue of a prior need for skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample), speech-language pathology services, or physical therapy in the current or prior certification period.

EXAMPLE: A patient who is recovering from a cerebrovascular accident (CVA) has an initial plan of care that called for physical therapy, speech-language pathology services, occupational therapy, and home health aide services. In the next certification period, the physician or allowed practitioner orders only occupational therapy and home health aide services because the patient no longer needs the skills of a physical therapist or a speech-language pathologist, but needs the services provided by the occupational therapist. The patient's need for occupational therapy qualifies him for home health services, including home health aide services (presuming that all other qualifying criteria are met), because in the prior certification period the beneficiary's eligibility for home health services was established by virtue of prior needs for physical therapy and speech-language pathology, and occupational therapy was initiated while the patient still required physical therapy and/or speech language-pathology.

30.5 - Physician or Allowed Practitioner Certification and Recertification of Patient Eligibility for Medicare Home Health Services (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The HHA must be acting upon a plan of care as described in §30.2, and a physician or allowed practitioner certification or recertification that meets the requirements of the following sections in order for HHA services to be covered.

30.5.1 - Physician or Allowed Practitioner Certification (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A certification (versus recertification) is considered to be anytime that a Start of Care OASIS is completed to initiate care. In such instances, a physician or allowed practitioner must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1.1;

2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician or allowed practitioner must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification;
3. A plan of care has been established and is periodically reviewed by a physician or allowed practitioner;
4. The services are or were furnished while the patient is or was under the care of a physician or allowed practitioner;
5. For episodes/periods with starts of care beginning January 1, 2011 and later, in accordance with §30.5.1.1 below, a face-to-face encounter occurred no more than 90 days prior to or within 30 days after the start of the home health care, was related to the primary reason the patient requires home health services, and was performed by a physician or non-physician practitioner. The certifying physician or allowed practitioner must also document the date of the encounter.

Example Certification Statement:

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan. The patient had a face-to-face encounter with a physician or an allowed non-physician practitioner on 11/01/2020 and the encounter was related to the primary reason for home health care.

Physician or allowed practitioner's Signature and Date Signed: **John Doe, MD**
11/05/2020

Physician or Allowed Practitioner's Name and Address

John Doe, MD
2121 Washington Pkwy
Suite 220
Washington, DC 20000

NOTE: This represents one example of a valid certification statement. Certification statements can be included in varying forms or formats as long as the content requirements (#1-5 above) for the certification are met.

If the patient is starting home health directly after discharge from an acute/post-acute care setting where the physician or allowed practitioner, with privileges, that cared for the patient in that setting is certifying the patient's eligibility for the home health benefit, but

will not be following the patient after discharge, then the certifying physician or allowed practitioner must identify the community physician or allowed practitioner who will be following the patient after discharge. One of the criteria that must be met for a patient to be considered eligible for the home health benefit is that the patient must be under the care of a physician or allowed practitioner (number 4 listed above). Otherwise, the certification is not valid.

The certification must be complete prior to when an HHA bills Medicare for reimbursement; however, physicians and allowed practitioners should complete the certification when the plan of care is established, or as soon as possible thereafter. This is longstanding CMS policy as referenced in Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4, section 30.1. It is not acceptable for HHAs to wait until the end of a 60-day certification period to obtain a completed certification/recertification.

30.5.1.1 – Face-to-Face Encounter

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

1. Allowed Provider Types

As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician or allowed practitioner himself or herself, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP).

NPPs who are allowed to perform the encounter are:

- A nurse practitioner or a clinical nurse specialist working in accordance with State law and in collaboration with the certifying physician or in collaboration with an acute or post-acute care physician, with privileges, who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health;
- A certified nurse midwife, as authorized by State law, under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health;
- A physician assistant under the supervision of the certifying physician or under the supervision of an acute or post-acute care physician with privileges who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health.

NPPs performing the encounter are subject to the same financial restrictions with the HHA as the certifying physician, as described in 42 CFR 424.22(d).

2. Timeframe Requirements

- The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.
- In situations when a physician or allowed practitioner orders home health care for the patient based on a new condition that was not evident during a visit within the 90 days prior to start of care, the physician or an allowed NPP must see the patient again within 30 days after admission. Specifically, if a patient saw the physician or NPP within the 90 days prior to start of care, another encounter would be needed if the patient's condition had changed to the extent that standards of practice would indicate that the physician or a non-physician practitioner should examine the patient in order to establish an effective treatment plan.

3. Exceptional Circumstances

When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the HHA to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.

4. Telehealth

The face-to-face encounter can be performed via a telehealth service, in an approved originating site. An originating site is considered to be the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

The originating sites authorized by law are:

- The office of a physician or practitioner;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics (RHC);
- Federally Qualified Health Centers (FQHC);
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

30.5.1.2 – Supporting Documentation Requirements

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

As of January 1, 2015, documentation in the certifying physician or allowed practitioner's medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined.

Documentation from the certifying physician or allowed practitioner's medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS). In turn, an HHA must be able to provide, upon request, the supporting documentation that substantiates the eligibility for the Medicare home health benefit to review entities and/or CMS. If the documentation used as the basis for the certification of eligibility is not sufficient to demonstrate that the patient is or was eligible to receive services under the Medicare home health benefit, payment will not be rendered for home health services provided.

The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain information that justifies the referral for Medicare home health services. This includes documentation that substantiates the patient's:

- Need for the skilled services; and
- Homebound status;

The certifying physician or allowed practitioner and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:

- Occurred within the required timeframe,
- Was related to the primary reason the patient requires home health services; and
- Was performed by an allowed provider type.

This information can be found most often in clinical and progress notes and discharge summaries. While the face-to-face encounter must be related to the primary reason for home health services, the patient's skilled need and homebound status can be substantiated through an examination of all submitted medical record documentation from the certifying physician or allowed practitioner, acute/post-acute care facility, and/or HHA (see below). The synthesis of progress notes, diagnostic findings, medications, nursing notes, etc., help to create a longitudinal clinical picture of the patient's health status.

- Information from the HHA, such as the plan of care required per 42 CFR §409.43 and the initial and/or comprehensive assessment of the patient required per 42

CFR §484.55, can be incorporated into the certifying physician or allowed practitioner's medical record for the patient and used to support the patient's homebound status and need for skilled care. However, this information must be corroborated by other medical record entries in the certifying physician or allowed practitioner's and/or the acute/post-acute care facility's medical record for the patient. This means that the appropriately incorporated HHA information, along with the certifying physician or allowed practitioner's and/or the acute/post-acute care facility's medical record, creates a clinically consistent picture that the patient is eligible for Medicare home health services.

- The certifying physician or allowed practitioner demonstrates the incorporation of the HHA information into his/her medical record for the patient by signing and dating the material. Once incorporated, the documentation from the HHA, in conjunction with the certifying physician or allowed practitioner and/or acute/post-acute care facility documentation, must substantiate the patient's eligibility for home health services.

30.5.2 - Physician or Allowed Practitioner Recertification **(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)**

At the end of the 60-day certification, a decision must be made whether or not to recertify the patient for a subsequent 60-days. An eligible beneficiary who qualifies for a subsequent 60-day certification would start the subsequent 60-day certification on day 61. Under HH PPS, the plan of care must be reviewed and signed by the physician or allowed practitioner every 60 days unless one of the following occurs:

- A beneficiary transfers to another HHA; or
- A discharge and return to home health during the 60-day certification.

For recertification of home health services, the physician or allowed practitioner must certify (attest) that:

1. The home health services are or were needed because the patient is or was confined to the home as defined in §30.1;
2. The patient needs or needed skilled nursing services on an intermittent basis (other than solely venipuncture for the purposes of obtaining a blood sample), or physical therapy, or speech-language pathology services; or continues to need occupational therapy after the need for skilled nursing care, physical therapy, or speech-language pathology services ceased. Where a patient's sole skilled service need is for skilled oversight of unskilled services (management and evaluation of the care plan as defined in §40.1.2.2), the physician or allowed practitioner must include a brief narrative describing the clinical justification of this need as part of the recertification, or as a signed addendum to the recertification;

3. A plan of care has been established and is periodically reviewed by a physician or allowed practitioner; and
4. The services are or were furnished while the patient is or was under the care of a physician or allowed practitioner.

Medicare does not limit the number of continuous 60-day recertifications for beneficiaries who continue to be eligible for the home health benefit. The certification may cover a period less than but not greater than 60 days. Because the updated home health plan of care must include the frequency and duration of visits to be made, the physician or allowed practitioner does not have to estimate how much longer skilled services will be needed for the recertification.

30.5.3 - Who May Sign the Certification or Recertification

(Rev. 10738, Issued: 05-07-21, Effective: 01-01-21, Implementation: 08-09-21)

The physician or allowed practitioner who signs the certification or recertification must be permitted to do so by 42 CFR 424.22. A physician or other allowed non-physician practitioner, *other than the certifying physician or certifying allowed practitioner who established the home health plan of care, may sign the plan of care or the recertification statement in the absence of the certifying physician or certifying allowed practitioner. This is only permitted when such physician or allowed non-physician practitioner has been authorized to care for the certifying physician's or allowed practitioner's patients in his/her absence. The HHA is responsible for ensuring that the physician or allowed non-physician practitioner who signs the plan of care and recertification statement was authorized by the physician or allowed practitioner who established the plan of care and completed the certification for his/her patient in his/her absence.* The physician or allowed practitioner that performed the required face-to-face encounter must sign the certification of eligibility, unless the patient is directly admitted to home health care from an acute or post-acute care facility and the encounter was performed by a physician or allowed practitioner in such setting.

30.5.4 – Physician or Allowed Practitioner Billing for Certification and Recertification

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Certification and recertification claims are Part B claims paid for under the Physician Fee Schedule. These claims are billed using HCPCS codes G0180 (certification) or G0179 (re-certification). The descriptions of these two codes indicate that they are used to bill for certification or recertification of patient eligibility “for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with the HHA and review of reports of patient status required by physicians or allowed practitioners to affirm the initial implementation of the plan of care that meets patient's needs, per certification period”. As noted above, these codes are for certification or recertification for Medicare-covered home health services. If there are no Medicare-covered home health services, these codes should not be billed or paid. As such, claims

for certification/recertification of eligibility for home health services (G0180 and G0179, respectively) will not be covered if the HHA claim itself was non-covered because the certification/recertification of eligibility was not complete or because there was insufficient documentation to support that the patient was eligible for the Medicare home health benefit.

40 - Covered Services Under a Qualifying Home Health Plan of Care (Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Section 1861(m) of the Act governs the Medicare home health services that may be provided to eligible beneficiaries by or under arrangements made by a participating home health agency (HHA). Section 1861(m) describes home health services as

- Part-time or intermittent skilled nursing care (other than solely venipuncture for the purposes of obtaining a blood sample);
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Medical supplies (including catheters, catheter supplies, ostomy bags, supplies related to ostomy care, and a covered osteoporosis drug (as defined in §1861(kk of the Act), but excluding other drugs and biologicals);
- Durable medical equipment while under the plan of care established by physician or allowed practitioner;
- Medical services provided by an intern or resident-in-training under an approved teaching program of the hospital in the case of an HHA which is affiliated or under common control with a hospital; and
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.

The term "part-time or intermittent" for purposes of coverage under §1861(m) of the Act means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). See §50.7.

For any home health services to be covered by Medicare, the patient must meet the qualifying criteria as specified in §30, including having a need for skilled nursing care on

an intermittent basis, physical therapy, speech-language pathology services, or a continuing need for occupational therapy as defined in this section.

40.1 - Skilled Nursing Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1, HHA-205.1

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury as discussed in §40.1.1, below, and must be intermittent as discussed in §40.1.3. Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.

40.1.1 - General Principles Governing Reasonable and Necessary Skilled Nursing Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

If all other eligibility and coverage requirements under the home health benefit are met, skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or, when provided by regulation, a licensed practical (vocational) nurse ("skilled care") are necessary. Skilled nursing services are covered where such skilled nursing services are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the services needed do not require skilled nursing care because they could safely and effectively be performed by the patient or unskilled caregivers, such services will not be covered under the home health benefit.

Skilled nursing care is necessary only when (a) the particular patient's special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel as provided by regulation, including 42 C.F.R. 409.32.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the

service cannot be regarded as a skilled nursing service although a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled nursing service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service, regardless of the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers.

The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient's illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician or allowed practitioner has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification period.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each 30-day period, which includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit, (including the response or changes in behavior to previously administered skilled services) and the skilled services applied on the current visit, and
- the patient/caregiver's response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results,
- a detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home

Clinical notes should be written so that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example, terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

EXAMPLE 1:

The presence of a plaster cast on an extremity generally does not indicate a need for skilled nursing care. However, the patient with a preexisting peripheral vascular or circulatory condition might need skilled nursing care to observe for complications, monitor medication administration for pain control, and teach proper skin care to preserve skin integrity and prevent breakdown. The documentation must support the severity of the circulatory condition that requires skilled care. The clinical notes for each home health visit should document the patient's skin and circulatory examination as well as the patient and/or caregiver application of the educational principles taught since the last visit. The plan for the next visit should describe the skilled services continuing to be required.

EXAMPLE 2:

The condition of a patient, who has irritable bowel syndrome or is recovering from rectal surgery, may be such that he or she can be given an enema safely and effectively only by

a nurse. If the enema were necessary to treat the illness or injury, then the visit would be covered as a skilled nursing visit. The documentation must support the skilled need for the enema, and the plan for future visits based on this information.

EXAMPLE 3:

Giving a bath does not ordinarily require the skills of a nurse and, therefore, would not be covered as a skilled nursing service unless the patient's condition is such that the bath could be given safely and effectively only by a nurse (as discussed in §30.1 above).

EXAMPLE 4:

A patient with a well-established colostomy absent complications may require assistance changing the colostomy bag because they cannot do it themselves and there is no one else to change the bag. Notwithstanding the need for the routine colostomy care, changing the colostomy bag does not become a skilled nursing service when the nurse provides it.

EXAMPLE 5:

A patient was discharged from the hospital with an open draining wound that requires irrigation, packing, and dressing twice each day. The HHA has taught the family to perform the dressing changes. The HHA continues to see the patient for the wound care that is needed during the time that the family is not available and willing to provide the dressing changes. The wound care continues to be skilled nursing care, notwithstanding that the family provides it part of the time, and may be covered as long as the patient requires it.

EXAMPLE 6:

A physician has ordered skilled nursing visits for a patient with a hairline fracture of the hip. The home health record must document the reason skilled services are required and why the nursing visits are reasonable and necessary for treatment of the patient's hip injury.

EXAMPLE 7:

A physician has ordered skilled nursing visits for teaching of self-administration and self-management of the medication regimen for a patient, newly diagnosed, with diabetes mellitus in the home health plan of care. Each visit's documentation must describe the patient's progress in this activity.

EXAMPLE 8:

Following a cerebrovascular accident (CVA), a patient has an in-dwelling Foley catheter because of urinary incontinence, and is expected to require the catheter for a long and indefinite period. The medical condition of the patient must be described and documented to support the need for nursing skilled services in the home health plan of

care. Periodic visits to change the catheter as needed, treat the symptoms of catheter malfunction, and teach proper catheter care would be covered as long as they are reasonable and necessary, although the patient is stable, even if there is an expectation that the care will be needed for a long and indefinite period. However, at every home health visit, the patient's current medical condition must be described and there must be documentation to support the need for continued skilled nursing services.

EXAMPLE 9:

A patient with advanced multiple sclerosis undergoing an exacerbation of the illness needs skilled teaching of medications, measures to overcome urinary retention, and the establishment of a program designed to minimize the adverse impact of the exacerbation. The clinical notes for each home health visit must describe why skilled nursing services were required. The skilled nursing care received by the patient would be covered despite the chronic nature of the illness.

EXAMPLE 10:

A patient with malignant melanoma is terminally ill, and requires skilled observation, assessment, teaching, and treatment. The patient has not elected coverage under Medicare's hospice benefit. The documentation should describe the goal of the skilled nursing intervention, and at each visit the services provided should support that goal. The skilled nursing care that the patient requires would be covered, notwithstanding that the condition is terminal, because the documentation and description must support that the needed services required the skills of a nurse.

40.1.2 - Application of the Principles to Skilled Nursing Services

(Rev. 1, 10-01-03)

A3-3118.1.B, HHA-205.1.B

The following discussion of skilled nursing services applies the foregoing principles to specific skilled nursing services about which questions are most frequently raised.

40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's clinical condition and/or treatment regimen has stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered

for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Information from the patient's home health record must document the rationale that demonstrates that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period. Such signs and symptoms as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment. Where these signs and symptoms are such that there is a reasonable potential that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered. However, observation and assessment by a nurse is not reasonable and necessary for the treatment of the illness or injury where fluctuating signs and symptoms are part of a longstanding pattern of the patient's condition which has not previously required a change in the prescribed treatment.

EXAMPLE 1:

A patient with atherosclerotic heart disease with congestive heart failure requires observation by skilled nursing personnel for signs of decompensation or adverse effects resulting from newly prescribed medication. Skilled observation is needed to determine whether the new drug regimen should be modified or whether other therapeutic measures should be considered until the patient's clinical condition and/or treatment regimen has stabilized. The clinical notes for each home health visit should reflect the deliberations and their outcome.

EXAMPLE 2:

A patient has undergone peripheral vascular disease treatment including a revascularization procedure (bypass). The incision area is showing signs of potential infection, (e.g., heat, redness, swelling, drainage) and the patient has elevated body temperature. For each home health visit, the clinical notes must demonstrate that the skilled observation and monitoring is required.

EXAMPLE 3:

A patient was hospitalized following a heart attack. Following treatment he was discharged home. Because it is not known whether increasing exertion will exacerbate the heart disease, skilled observation is reasonable and necessary as mobilization is initiated in the patient's home. The patient's necessity for skilled observation must be documented at each home health visit until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 4:

A frail 85-year old man was hospitalized for pneumonia. The infection was resolved, but the patient, who had previously maintained adequate nutrition, will not eat or eats poorly. The patient is discharged to the HHA for monitoring of fluid and nutrient intake and assessment of the need for tube feeding. Observation and monitoring by skilled nurses of the patient's oral intake, output and hydration status is required to determine what further treatment or other intervention is needed. The patient's necessity for skilled observation and treatment must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 5:

A patient with glaucoma and a cardiac condition has a cataract extraction. Because of the interaction between the eye drops for the glaucoma and cataracts and the beta-blocker for the cardiac condition, the patient is at risk for serious cardiac arrhythmia. Skilled observation and monitoring of the drug actions is reasonable and necessary until the patient's condition is stabilized. The patient's necessity for skilled observation must be documented at each home health visit, until the clinical condition and/or patient's treatment regimen has stabilized.

EXAMPLE 6:

A patient with hypertension suffered dizziness and weakness. The physician found that the blood pressure was too low and discontinued the hypertension medication. Skilled observation and monitoring of the patient's blood pressure and medication regimen is required until the blood pressure remains stable and in a safe range. The patient's necessity for skilled observation must be documented at each home health visit, until the patient's clinical condition and/or treatment regimen has stabilized.

EXAMPLE 7:

A patient has chronic non-healing skin ulcers, Diabetes Mellitus Type I, and spinal muscular atrophy. In the past, the patient's wounds have deteriorated, requiring the patient to be hospitalized. Previously, a skilled nurse has trained the patient's wife to perform wound care. The treating physician orders a continuation of skilled care for a subsequent 60-day certification period, at a frequency of one visit every 2 weeks to perform observation and assessment of the patient's skin ulcers to make certain that they are not worsening. This order is reasonable and necessary because, although the unskilled family caregiver has learned to care for the wounds, the skilled nurse can use observation and assessment to determine if the condition is worsening.

40.1.2.2 - Management and Evaluation of a Patient Care Plan
(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. For

skilled nursing care to be reasonable and necessary for management and evaluation of the patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery and medical safety in view of the patient's overall condition.

EXAMPLE 1:

An aged patient with a history of diabetes mellitus and angina pectoris is recovering from an open reduction of the neck of the femur. He requires, among other services, careful skin care, appropriate oral medications, a diabetic diet, a therapeutic exercise program to preserve muscle tone and body condition, and observation to notice signs of deterioration in his condition or complications resulting from his restricted, but increasing mobility. Although a properly instructed person could perform any of the required services, that person would not have the capability to understand the relationship among the services and their effect on each other. Since the combination of the patient's condition, age, and immobility create a high potential for serious complications, such an understanding is essential to ensure the patient's recovery and safety. The management of this plan of care requires skilled nursing personnel until nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury until the patient recovers. Where nursing visits are not needed to observe and assess the effects of the non-skilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary, and the management and evaluation of the care plan would not be considered a skilled service.

EXAMPLE 2:

An aged patient with a history of mild dementia is recovering from pneumonia which has been treated at home. The patient has had an increase in disorientation, has residual chest congestion, decreased appetite, and has remained in bed, immobile, throughout the period with pneumonia. While the residual chest congestion and recovery from pneumonia alone would not represent a high risk factor, the patient's immobility and increase in confusion could create a high probability of a relapse. In this situation, skilled oversight of the unskilled services would be reasonable and necessary pending the elimination of the chest congestion and resolution of the persistent disorientation to ensure the patient's medical safety. For this determination to be made, the home health documentation must describe the complexity of the unskilled services that are a necessary part of the medical treatment and which require the involvement of a registered nurse in order to ensure that essential unskilled care is achieving its purpose. Where visits by a licensed nurse are not needed to observe and assess the effects of the unskilled services being provided to treat the illness or injury, skilled nursing care would not be considered reasonable and necessary to treat the illness or injury.

EXAMPLE 3:

A physician orders one skilled nursing visit every 2 weeks and three home health aide visits each week for bathing and washing hair for a patient whose recovery from a CVA

has left him with residual weakness on the left side. The cardiovascular condition is stable and the patient has reached the maximum restoration potential. There are no underlying conditions that would necessitate the skilled supervision of a licensed nurse in assisting with bathing or hair washing. The skilled nursing visits are not necessary to manage and supervise the home health aide services and would not be covered.

40.1.2.3 - Teaching and Training Activities

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.3, HHA-205.1.B.3

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

Where it becomes apparent after a reasonable period of time that the patient, family, or caregiver will not or is not able to be trained, then further teaching and training would cease to be reasonable and necessary. **The reason why the training was unsuccessful should be documented in the record.** Notwithstanding that the teaching or training was unsuccessful, the services for teaching and training would be considered to be reasonable and necessary prior to the point that it became apparent that the teaching or training was unsuccessful, as long as such services were appropriate to the patient's illness, functional loss, or injury.

In determining the reasonable and necessary number of teaching and training visits, consideration must be given to whether the teaching and training provided constitutes reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents initial instruction. Where the teaching represents initial instruction, the complexity of the activity to be taught and the unique abilities of the patient are to be considered. Where the teaching constitutes reinforcement, an analysis of the patient's retained knowledge and anticipated learning progress is necessary to determine the appropriate number of visits. Skills taught in a controlled institutional setting often need to be reinforced when the patient returns home. Where the patient needs reinforcement of the institutional teaching, additional teaching visits in the home are covered.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

EXAMPLE 1:

A physician has ordered skilled nursing care for teaching a diabetic who has recently become insulin dependent. The physician has ordered teaching of self-injection and management of insulin, signs, and symptoms of insulin shock, and actions to take in emergencies. The education is reasonable and necessary to the treatment of the illness or injury, and the teaching services and the patient/caregiver responses must be documented.

EXAMPLE 2:

A physician has ordered skilled nursing care to teach a patient to follow a new medication regimen in which there is a significant probability of adverse drug reactions due to the nature of the drug and the patient's condition, to recognize signs and symptoms of adverse reactions to new medications, and to follow the necessary dietary restrictions. After it becomes apparent that the patient remains unable to take the medications properly, cannot demonstrate awareness of potential adverse reactions, and is not following the necessary dietary restrictions, skilled nursing care for further teaching would not be reasonable and necessary, since the patient has demonstrated an inability to be taught. The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses. The health record should also describe the reason for the failure of the educational attempts.

EXAMPLE 3:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years and there is no change in the patient's physical or mental status that would require re-teaching. The skilled nursing visits would not be considered reasonable and necessary since the patient has a longstanding history of being able to perform the service.

EXAMPLE 4:

A physician has ordered skilled nursing visits to teach self-administration of insulin to a patient who has been self-injecting insulin for 10 years because the patient has recently lost the use of the dominant hand and must be retrained to use the other hand. Skilled nursing visits to re-teach self-administration of the insulin would be reasonable and necessary. The patient's response to teaching must be documented at each home health visit, until the patient has learned how to self-administer.

EXAMPLE 5:

A patient recovering from pneumonia is being sent home requiring I.V. infusion of antibiotics four times per day. The patient's spouse has been shown how to administer the drug during the hospitalization and has been told the signs and symptoms of infection. The physician has ordered home health services for a nurse to teach the administration of the drug and the signs and symptoms requiring immediate medical attention.

EXAMPLE 6:

A spouse who has been taught to perform a dressing change for a post-surgical patient may need to be re-taught wound care if the spouse demonstrates improper performance of wound care. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.

NOTE: There is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.

Teaching and training activities that require the skills of a licensed nurse include, but **are not limited to**, the following:

1. Teaching the self-administration of injectable medications, or a complex range of medications;
2. Teaching a newly diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and to administer insulin injections, to prepare and follow a diabetic diet, to observe foot-care precautions, and to observe for and understand signs of hyperglycemia and hypoglycemia;
3. Teaching self-administration of medical gases;
4. Teaching wound care where the complexity of the wound, the overall condition of the patient or the ability of the caregiver makes teaching necessary;
5. Teaching care for a recent ostomy or where reinforcement of ostomy care is needed;
6. Teaching self-catheterization;
7. Teaching self-administration of gastrostomy or enteral feedings;
8. Teaching care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines;
9. Teaching bowel or bladder training when bowel or bladder dysfunction exists;
10. Teaching how to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function;
11. Teaching transfer techniques, e.g., from bed to chair, that are needed for safe transfer;
12. Teaching proper body alignment and positioning, and timing techniques of a bed-bound patient;

13. Teaching ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss;
14. Teaching prosthesis care and gait training;
15. Teaching the use and care of braces, splints and orthotics and associated skin care;
16. Teaching the preparation and maintenance of a therapeutic diet; and
17. Teaching proper administration of oral medication, including signs of side-effects and avoidance of interaction with other medications and food.
18. Teaching the proper care and application of any special dressings or skin treatments, (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration due to radiation treatments)

40.1.2.4 - Administration of Medications

(Rev. 1, 10-01-03)

A3-3118.1.B.4, HHA-205.1.B.4

Although drugs and biologicals are specifically excluded from coverage by the statute (§1861(m)(5)) of the Act, the services of a nurse that are required to administer the medications safely and effectively may be covered if they are reasonable and necessary to the treatment of the illness or injury.

A. Injections

Intravenous, intramuscular, or subcutaneous injections and infusions, and hypodermoclysis or intravenous feedings require the skills of a licensed nurse to be performed (or taught) safely and effectively. Where these services are reasonable and necessary to treat the illness or injury, they may be covered. For these services to be reasonable and necessary, the medication being administered must be accepted as safe and effective treatment of the patient's illness or injury, and there must be a medical reason that the medication cannot be taken orally. Moreover, the frequency and duration of the administration of the medication must be within accepted standards of medical practice, or there must be a valid explanation regarding the extenuating circumstances to justify the need for the additional injections.

1. Vitamin B-12 injections are considered specific therapy only for the following conditions:
 - Specified anemias: pernicious anemia, megaloblastic anemias, macrocytic anemias, fish tapeworm anemia;

- Specified gastrointestinal disorders: gastrectomy, malabsorption syndromes such as sprue and idiopathic steatorrhea, surgical and mechanical disorders such as resection of the small intestine, strictures, anastomosis and blind loop syndrome, and
- Certain neuropathies: posterolateral sclerosis, other neuropathies associated with pernicious anemia, during the acute phase or acute exacerbation of a neuropathy due to malnutrition and alcoholism.

For a patient with pernicious anemia caused by a B-12 deficiency, intramuscular or subcutaneous injection of vitamin B-12 at a dose of from 100 to 1000 micrograms no more frequently than once monthly is the accepted reasonable and necessary dosage schedule for maintenance treatment. More frequent injections would be appropriate in the initial or acute phase of the disease until it has been determined through laboratory tests that the patient can be sustained on a maintenance dose.

2. Insulin Injections

Insulin is customarily self-injected by patients or is injected by their families. However, where a patient is either physically or mentally unable to self-inject insulin and there is no other person who is able and willing to inject the patient, the injections would be considered a reasonable and necessary skilled nursing service.

EXAMPLE: A patient who requires an injection of insulin once per day for treatment of diabetes mellitus, also has multiple sclerosis with loss of muscle control in the arms and hands, occasional tremors, and vision loss that causes inability to fill syringes or self-inject insulin. If there weren't an able and willing caregiver to inject her insulin, skilled nursing care would be reasonable and necessary for the injection of the insulin.

The prefilling of syringes with insulin (or other medication that is self-injected) does not require the skills of a licensed nurse and, therefore, is not considered to be a skilled nursing service. If the patient needs someone only to prefill syringes (and therefore needs no skilled nursing care on an intermittent basis, physical therapy, or speech-language pathology services), the patient, therefore, does not qualify for any Medicare coverage of home health care. Prefilling of syringes for self-administration of insulin or other medications is considered to be assistance with medications that are ordinarily self-administered and is an appropriate home health aide service. (See §50.2.) However, where State law requires that a licensed nurse prefill syringes, a skilled nursing visit to prefill syringes is paid as a skilled nursing visit (if the patient otherwise needs skilled nursing care, physical therapy, or speech-language pathology services), but is not considered to be a skilled nursing service.

B. Oral Medications

The administration of oral medications by a nurse is not reasonable and necessary skilled nursing care except in the specific situation in which the complexity of the patient's

condition, the nature of the drugs prescribed, and the number of drugs prescribed require the skills of a licensed nurse to detect and evaluate side effects or reactions. The medical record must document the specific circumstances that cause administration of an oral medication to require skilled observation and assessment.

C. Eye Drops and Topical Ointments

The administration of eye drops and topical ointments does not require the skills of a nurse. Therefore, even if the administration of eye drops or ointments is necessary to the treatment of an illness or injury and the patient cannot self-administer the drops, and there is no one available to administer them, the visits cannot be covered as a skilled nursing service. This section does not eliminate coverage for skilled nursing visits for observation and assessment of the patient's condition. (See §40.2.1.)

EXAMPLE 1:

A physician has ordered skilled nursing visits to administer eye drops and ointments for a patient with glaucoma. The administration of eye drops and ointments does not require the skills of a nurse. Therefore, the skilled nursing visits cannot be covered as skilled nursing care, notwithstanding the importance of the administration of the drops as ordered.

EXAMPLE 2:

A physician has ordered skilled nursing visits for a patient with a reddened area under the breast. The physician instructs the patient to wash, rinse, and dry the area daily and apply vitamin A and D ointment. Skilled nursing care is not needed to provide this treatment and related services safely and effectively.

40.1.2.5 - Tube Feedings

(Rev. 1, 10-01-03)

A3-3118.1.B.5, HHA-205.1.B.5

Nasogastric tube, and percutaneous tube feedings (including gastrostomy and jejunostomy tubes), and replacement, adjustment, stabilization, and suctioning of the tubes are skilled nursing services, and if the feedings are required to treat the patient's illness or injury, the feedings and replacement or adjustment of the tubes would be covered as skilled nursing services.

40.1.2.6 - Nasopharyngeal and Tracheostomy Aspiration

(Rev. 1, 10-01-03)

A3-4118.1.B.6, HHA-205.1.B.6

Nasopharyngeal and tracheostomy aspiration are skilled nursing services and, if required to treat the patient's illness or injury, would be covered as skilled nursing services.

40.1.2.7 - Catheters

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)
A3-3118.1.B.7, HHA-205.1.B.7

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary. Absent complications, Foley catheters generally require skilled care once approximately every 30 days and silicone catheters generally require skilled care once every 60-90 days and this frequency of service would be considered reasonable and necessary. However, where there are complications that require more frequent skilled care related to the catheter, such care would, with adequate documentation, be covered.

EXAMPLE: A patient who has a Foley catheter due to loss of bladder control because of multiple sclerosis has a history of frequent plugging of the catheter and urinary tract infections. The physician has ordered skilled nursing visits once per month to change the catheter, and has left a "PRN" order for up to three additional visits per month for skilled observation and evaluation and/or catheter changes if the patient or caregiver reports signs and symptoms of a urinary tract infection or a plugged catheter. During the certification period, the patient's family contacts the HHA because the patient has an elevated temperature, abdominal pain, and scant urine output. The nurse visits the patient and determines that the catheter is plugged and there are symptoms of a urinary tract infection. The nurse changes the catheter and contacts the physician to report findings and discuss treatment. The skilled nursing visit to change the catheter and to evaluate the patient would be reasonable and necessary to the treatment of the illness or injury. The need for the skilled services must be documented.

40.1.2.8 - Wound Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Care of wounds, (including, but not limited to, ulcers, burns, pressure sores, open surgical sites, fistulas, tube sites, and tumor erosion sites) when the skills of a licensed nurse are needed to provide safely and effectively the services necessary to treat the illness or injury, is considered to be a skilled nursing service. For skilled nursing care to be reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency, and quantity), and condition and appearance of the skin surrounding the wound must be documented in the clinical findings so that an assessment of the need for skilled nursing care can be made. This includes whether wound care is performed via dressing changes, NPWT using conventional DME systems or NPWT using a disposable device. Coverage or denial of skilled nursing visits for wound care may not be based solely on the stage classification of the wound, but rather must be based on all of the documented clinical findings. Moreover, the plan of care must contain the specific instructions for the treatment of the wound. Where the physician or allowed practitioner has ordered appropriate active treatment (e.g., sterile or complex dressings, NPWT, administration of prescription medications, etc.) of wounds with the following characteristics, the skills of a licensed nurse are usually reasonable and necessary:

- Open wounds which are draining purulent or colored exudate or have a foul odor present or for which the patient is receiving antibiotic therapy;
- Wounds with a drain or T-tube that require shortening or movement of such drains;
- Wounds which require irrigation or instillation of a sterile cleansing or medicated solution into several layers of tissue and skin and/or packing with sterile gauze;
- Recently debrided ulcers;
- Pressure sores (decubitus ulcers) with the following characteristics:
 - There is partial tissue loss with signs of infection such as foul odor or purulent drainage; or
 - There is full thickness tissue loss that involves exposure of fat or invasion of other tissue such as muscle or bone.

NOTE: Wounds or ulcers that show redness, edema, and induration, at times with epidermal blistering or desquamation do not ordinarily require skilled nursing care.

- Wounds with exposed internal vessels or a mass that may have a proclivity for hemorrhage when a dressing is changed (e.g., post radical neck surgery, cancer of the vulva);
- Open wounds or widespread skin complications following radiation therapy, or which result from immune deficiencies or vascular insufficiencies;
- Post-operative wounds where there are complications such as infection or allergic reaction or where there is an underlying disease that has a reasonable potential to adversely affect healing (e.g., diabetes);
- Third degree burns, and second degree burns where the size of the burn or presence of complications causes skilled nursing care to be needed;
- Skin conditions that require application of nitrogen mustard or other chemotherapeutic medication that present a significant risk to the patient;
- Other open or complex wounds that require treatment that can only be provided safely and effectively by a licensed nurse.

EXAMPLE 1:

A patient has a second-degree burn with full thickness skin damage on the back. The wound is cleansed, followed by an application of Sulfamylon. While the wound requires skilled monitoring for signs and symptoms of infection or complications, the dressing change requires skilled nursing services. The home health record at each visit must document the need for the skilled nursing services.

EXAMPLE 2:

A patient experiences a decubitus ulcer where the full thickness tissue loss extends through the dermis to involve subcutaneous tissue. The wound involves necrotic tissue with a physician's order to apply a covering of a debriding ointment following vigorous irrigation. The wound is then packed loosely with wet to dry dressings or continuous moist dressing and covered with dry sterile gauze. Skilled nursing care is necessary for proper treatment. The home health record at each visit must document the need for the skilled nursing services.

NOTE: This section relates to the direct, hands on skilled nursing care provided to patients with wounds, including any necessary dressing changes on those wounds. While a wound might not require this skilled nursing care, the wound may still require skilled monitoring for signs and symptoms of infection or complication (see §40.1.2.1) or for skilled teaching of wound care to the patient or the patient's family (see §40.1.2.3). For an example of when wound care is provided separately from the furnishing of NPWT using a disposable device, see §50.4.4.

40.1.2.9 - Ostomy Care

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.9, HHA-205.1.B.9

Ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented is a skilled nursing service. Teaching ostomy care remains skilled nursing care regardless of the presence of complications. The teaching services and the patient/caregiver responses must be documented.

40.1.2.10 - Heat Treatments

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Heat treatments that have been specifically ordered by a physician or allowed practitioner as part of active treatment of an illness or injury and require observation by a licensed nurse to adequately evaluate the patient's progress would be considered a skilled nursing service.

40.1.2.11 - Medical Gases

(Rev. 1, 10-01-03)

A3-3118.1.B.11, HHA-205.1.B.11

Initial phases of a regimen involving the administration of medical gases that are necessary to the treatment of the patient's illness or injury, would require skilled nursing care for skilled observation and evaluation of the patient's reaction to the gases, and to teach the patient and family when and how to properly manage the administration of the gases.

40.1.2.12 - Rehabilitation Nursing

(Rev. 1, 10-01-03)

A3-3118.1.B.12, HHA-205.1.B.12

Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs) would constitute skilled nursing services.

40.1.2.13 - Venipuncture

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Effective February 5, 1998, venipuncture for the purposes of obtaining a blood sample can no longer be the sole reason for Medicare home health eligibility. However, if a beneficiary qualifies for home health eligibility based on a skilled need other than solely venipuncture (e.g., eligibility based on the skilled nursing service of wound care and meets all other Medicare home health eligibility criteria), medically reasonable and necessary venipuncture coverage may continue under a home health plan of care.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act specifically exclude venipuncture, as a basis for qualifying for Medicare home health services if this is the sole skilled service the beneficiary requires. However, the Medicare home health benefit will continue to pay for a blood draw if the beneficiary has a need for another qualified skilled service and meets all home health eligibility criteria. This specific requirement applies to home health services furnished on or after February 5, 1998.

For venipuncture to be reasonable and necessary:

1. The physician or allowed practitioner order for the venipuncture for a laboratory test should be associated with a specific symptom or diagnosis, or the documentation should clarify the need for the test when it is not diagnosis/illness specific. In addition, the treatment must be recognized (in the Physician's Desk Reference, or other authoritative source) as being reasonable and necessary to the treatment of the illness or injury for venipuncture and monitoring the treatment must also be reasonable and necessary.
2. The frequency of testing should be consistent with accepted standards of medical practice for continued monitoring of a diagnosis, medical problem, or treatment regimen. Even where the laboratory results are consistently stable, periodic venipuncture may be reasonable and necessary because of the nature of the treatment.

3. The home health record must document the rationale for the blood draw as well as the results.

Examples of reasonable and necessary venipuncture for stabilized patients include, but are not limited to those described below.

- a. Captopril may cause side effects such as leukopenia and agranulocytosis and it is standard medical practice to monitor the white blood cell count and differential count on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.
- b. In monitoring phenytoin (e.g., Dilantin) administration, the difference between a therapeutic and a toxic level of phenytoin in the blood is very slight and it is therefore appropriate to monitor the level on a routine basis (every 3 months) when the results are stable and the patient is asymptomatic.
- c. Venipuncture for fasting blood sugar (FBS)
 - An unstable insulin dependent or noninsulin dependent diabetic would require FBS more frequently than once per month if ordered by the physician or allowed practitioner.
 - Where there is a new diagnosis or where there has been a recent exacerbation, but the patient is not unstable, monitoring once per month would be reasonable and necessary.
 - A stable insulin or noninsulin dependent diabetic would require monitoring every 2-3 months.
- d. Venipuncture for prothrombin
 - Where the documentation shows that the dosage is being adjusted, monitoring would be reasonable and necessary as ordered by the physician or allowed practitioner.
 - Where the results are stable within the therapeutic ranges, monthly monitoring would be reasonable and necessary.
 - Where the results remain within nontherapeutic ranges, there must be specific documentation of the factors that indicate why continued monitoring is reasonable and necessary.

EXAMPLE: A patient with coronary artery disease was hospitalized with atrial fibrillation and subsequently discharged to the HHA with orders for anticoagulation therapy as well as other skilled nursing care. If indicated, monthly venipuncture to report prothrombin (protome) levels to the physician or allowed practitioner would be

reasonable and necessary even though the patient's prothrombin time tests indicate essential stability. The home health record must document the rationale for the blood draw as well as the results.

40.1.2.14 - Student Nurse Visits

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.1.B.14, HHA-205.1.B.14

Visits made by a student nurse may be covered as skilled nursing care when the HHA participates in training programs that utilize student nurses enrolled in a school of nursing to perform skilled nursing services in a home setting. To be covered, the services must be reasonable and necessary skilled nursing care and must be performed under the general supervision of a registered or licensed nurse. The supervising nurse need not accompany the student nurse on each visit. All documentation requirements must be fulfilled by student nurses.

40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service. Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician or allowed practitioner.

Because the law precludes agencies that primarily provide care and treatment of mental diseases from participating as HHAs, psychiatric nursing must be furnished by an agency that does not primarily provide care and treatment of mental diseases. If a substantial number of an HHA's patients attend partial hospitalization programs or receive outpatient mental health services, the Medicare contractor will verify whether the patients meet the eligibility requirements specified in §30 and whether the HHA is primarily engaged in care and treatment of mental disease.

Services of a psychiatric nurse would not be considered reasonable and necessary to assess or monitor use of psychoactive drugs that are being used for non-psychiatric diagnoses or to monitor the condition of a patient with a known psychiatric illness who is on treatment but is considered stable. A person on treatment would be considered stable if their symptoms were absent or minimal or if symptoms were present but were relatively stable and did not create a significant disruption in the patient's normal living situation.

EXAMPLE 1:

A patient is homebound for medical conditions, but has a psychiatric condition for which he has been receiving medication. The patient's psychiatric condition has not required a change in medication or hospitalization for over 2 years. During a visit by the nurse, the

patient's spouse indicates that the patient is awake and pacing most of the night and has begun ruminating about perceived failures in life. The nurse observes that the patient does not exhibit an appropriate level of hygiene and is dressed inappropriately for the season. The nurse comments to the patient about her observations and tries to solicit information about the patient's general medical condition and mental status. The nurse advises the physician about the patient's general medical condition and the new symptoms and changes in the patient's behavior. The physician orders the nurse to check blood levels of medication used to treat the patient's medical and psychiatric conditions. The physician then orders the psychiatric nursing service to evaluate the patient's mental health and communicate with the physician about whether additional intervention to deal with the patient's symptoms and behaviors is warranted. The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.

EXAMPLE 2:

A patient is homebound after discharge following hip replacement surgery and is receiving skilled therapy services for range of motion exercise and gait training. In the past, the patient had been diagnosed with clinical depression and was successfully stabilized on medication. There has been no change in her symptoms. The fact that the patient is taking an antidepressant does not indicate a need for psychiatric nursing services.

EXAMPLE 3:

A patient was discharged after 2 weeks in a psychiatric hospital with a new diagnosis of major depression. The patient remains withdrawn; in bed most of the day, and refusing to leave home. The patient has a depressed affect and continues to have thoughts of suicide, but is not considered to be suicidal. Psychiatric skilled nursing services are necessary for supportive interventions until antidepressant blood levels are reached and the suicidal thoughts are diminished further, to monitor suicide ideation, ensure medication compliance and patient safety, perform suicidal assessment, and teach crisis management and symptom management to family members. The home health record at each visit should document the need for the psychiatric skilled nursing services and treatment. The home health record must also reflect the patient/caregiver response to any interventions provided.

40.1.3 - Intermittent Skilled Nursing Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The law, at §1861(m) of the Act defines intermittent, for the purposes of §§1814(a)(2) and 1835(a)(2)(A), as skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable.)

To meet the requirement for "intermittent" skilled nursing care, a patient must have a medically predictable recurring need for skilled nursing services. In most instances, this definition will be met if a patient requires a skilled nursing service at least once every 60 days. The exception to the intermittent requirement is daily skilled nursing services for diabetics unable to administer their insulin (when there is no able and willing caregiver).

Since the need for "intermittent" skilled nursing care makes the patient eligible for other covered home health services, the Medicare contractor should evaluate each claim involving skilled nursing services furnished less frequently than once every 60 days. In such cases, payment should be made only if documentation justifies a recurring need for reasonable, necessary, and medically predictable skilled nursing services. The following are examples of the need for infrequent, yet intermittent, skilled nursing services:

1. The patient with an indwelling **silicone** catheter who generally needs a catheter change only at 90-day intervals;
2. The patient who experiences a fecal impaction (i.e., loss of bowel tone, restrictive mobility, and a breakdown in good health habits) and must receive care to manually relieve the impaction. Although these impactions are likely to recur, it is not possible to pinpoint a specific timeframe; or
3. The blind diabetic who self-injects insulin may have a medically predictable recurring need for a skilled nursing visit at least every 90 days. These visits, for example, would be to observe and determine the need for changes in the level and type of care which have been prescribed thus supplementing the physician or allowed practitioner's contacts with the patient.

There is a possibility that a physician or allowed practitioner may order a skilled visit less frequently than once every 60 days for an eligible beneficiary if there exists an extraordinary circumstance of anticipated patient need that is documented in the patient's plan of care in accordance with 42 CFR 409.43(b). A skilled visit frequency of less than once every 60 days would only be covered if it is specifically ordered by a physician or allowed practitioner in the patient's plan of care and is considered to be a reasonable, necessary, and medically predictable skilled need for the patient in the individual circumstance.

Where the need for "intermittent" skilled nursing visits is medically predictable but a situation arises after the first visit making additional visits unnecessary, e.g., the patient is institutionalized or dies, the one visit would be paid at the wage-adjusted LUPA amount for that discipline type. However, a one-time order; e.g., to give gamma globulin following exposure to hepatitis, would not be considered a need for "intermittent" skilled nursing care since a recurrence of the problem that would require this service is not medically predictable.

Although most patients require services no more frequently than several times a week, Medicare will pay for part-time (as defined in §50.7) medically reasonable and necessary skilled nursing care 7 days a week for a short period of time (2 to 3 weeks). There may

also be a few cases involving unusual circumstances where the patient's prognosis indicates the medical need for daily skilled services will extend beyond 3 weeks. As soon as the patient's physician makes this judgment, which usually should be made before the end of the 3-week period, the HHA must forward medical documentation justifying the need for such additional services and include an estimate of how much longer daily skilled services will be required.

A person expected to need more or less full-time skilled nursing care over an extended period of time, i.e., a patient who requires institutionalization, would usually not qualify for home health benefits.

40.2 - Skilled Therapy Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.2, HHA-205.2

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury as discussed below. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed.

The development, implementation, management, and evaluation of a patient care plan based on the physician or allowed practitioner's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel.

A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service. However, the importance of a particular service to a patient or the frequency with which it must be performed does not, by itself, make an unskilled service into a skilled service.

Assuming all other eligibility and coverage criteria have been met, the skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury:

- a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and
- b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

To ensure therapy services are effective, at defined points during a course of treatment, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must perform the ordered therapy service. During this visit, the therapist must assess the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record. Specifically:

i. **Initial Therapy Assessment**

- For each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method which objectively measures activities of daily living such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. The measurement results must be documented in the clinical record.
- Where more than one discipline of therapy is being provided, a qualified therapist from each of the disciplines must functionally assess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.

ii. **Reassessment at least every 30 days (performed in conjunction with an ordered therapy service)**

- At least once every 30 days, for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must provide the ordered therapy service, functionally reassess the patient, and compare the resultant measurement to prior assessment measurements. The therapist must document in the clinical record the measurement results along with the therapist's determination of the effectiveness of therapy, or lack thereof.
 - For multi-discipline therapy cases, a qualified therapist from each of the disciplines must functionally reassess the patient. The therapist must document the measurement results which correspond to the therapist's discipline and care plan goals in the clinical record.
 - The 30-day clock begins with the first therapy service (of that discipline) and the clock resets with each therapist's visit/assessment/measurement/documentation (of that discipline).
- c. Services involving activities for the general welfare of any patient, e.g., general exercises to promote overall fitness or flexibility and activities to provide diversion or general motivation do not constitute skilled therapy. Unskilled individuals without the supervision of a therapist can perform those services.
- d. Assuming all other eligibility and coverage requirements have been met, in order for therapy services to be covered, one of the following three conditions must be met:
1. The skills of a qualified therapist, or by a qualified therapist assistant under the supervision of a qualified therapist, are needed to restore patient function:
 - To meet this coverage condition, therapy services must be provided with the expectation, based on the assessment made by the physician or allowed practitioner of the patient's restorative potential that the condition of the patient will improve materially in a reasonable and generally predictable period of time. Improvement is evidenced by objective successive measurements.
 - Therapy is not considered reasonable and necessary under this condition if the patient's expected restorative potential would be insignificant in relation to the extent and duration of therapy services required to reach such potential.
 - Therapy is not required to effect improvement or restoration of function where a patient suffers a transient or easily reversible loss of function (such as temporary weakness following surgery) which could reasonably be expected to improve spontaneously as the patient gradually resumes

normal activities. Therapy in such cases is not considered reasonable and necessary to treat the patient's illness or injury, under this condition.

However, if the criteria for maintenance therapy described in (3) below is met, therapy could be covered under that condition.

2. The patient's clinical condition requires the specialized skills, knowledge, and judgment of a qualified therapist to establish or design a maintenance program, related to the patient's illness or injury, in order to ensure the safety of the patient and the effectiveness of the program, to the extent provided by regulation,
 - For patients receiving rehabilitative/restorative therapy services, if the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, the expectation is that the development of that maintenance program would occur during the last visit(s) for rehabilitative/restorative treatment. The goals of a maintenance program would be to maintain the patient's current functional status or to prevent or slow further deterioration.
 - Necessary periodic reevaluations by a qualified therapist of the beneficiary and maintenance program are covered if the specialized skills, knowledge, and judgment of a qualified therapist are required.
 - Where a maintenance program is not established until after the rehabilitative/restorative therapy program has been completed, or where there was no rehabilitative/restorative therapy program, and the specialized skills, knowledge, and judgment of a qualified therapist are required to develop a maintenance program, such services would be considered reasonable and necessary for the treatment of the patient's condition in order to ensure the effectiveness of the treatment goals and ensure medical safety. When the development of a maintenance program could not be accomplished during the last visits(s) of rehabilitative/restorative treatment, the therapist must document why the maintenance program could not be developed during those last rehabilitative/restorative treatment visit(s).
 - When designing or establishing a maintenance program, the qualified therapist must teach the patient or the patient's family or caregiver's necessary techniques, exercises or precautions as necessary to treat the illness or injury. The instruction of the beneficiary or appropriate caregiver by a qualified therapist regarding a maintenance program is covered if the specialized skills, knowledge, and judgment of a qualified therapist are required. However, visits made by skilled therapists to a patient's home solely to train other HHA staff (e.g., home health aides) are not billable as visits since the HHA is responsible for ensuring that its staff is properly trained to perform any service it furnishes. The cost of a

skilled therapist's visit for the purpose of training HHA staff is an administrative cost to the agency.

3. The skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist are needed to perform maintenance therapy:
 - Coverage of therapy services to perform a maintenance program is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist or by a qualified therapist assistant under the supervision of a qualified therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered.
 - Further, under the standard set forth in the previous paragraph, skilled care is necessary for the performance of a safe and effective maintenance program only when (a) the particular patient's special medical complications require the skills of a qualified therapist or by a qualified therapist assistant under the supervision of a qualified therapist to perform a therapy service that would otherwise be considered non-skilled; or (b) the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedure.
- e. The amount, frequency, and duration of the services must be reasonable.

As is outlined in home health regulations, as part of the home health agency (HHA) Conditions of Participation (CoPs), the clinical record of the patient must contain progress and clinical notes. Additionally, in Pub. 100-04, Medicare Claims Processing Manual, Chapter 10; "Home Health Agency Billing", instructions specify that for each claim, HHAs are required to report all services provided to the beneficiary during each 30-day period, this includes reporting each visit in line-item detail. As such, it is expected that the home health records for every visit will reflect the need for the skilled medical care provided. These clinical notes are also expected to provide important communication among all members of the home care team

regarding the development, course and outcomes of the skilled observations, assessments, treatment and training performed. Taken as a whole then, the clinical notes are expected to tell the story of the patient's achievement towards his/her goals as outlined in the Plan of Care. In this way, the notes will serve to demonstrate why a skilled service is needed.

Therefore the home health clinical notes must document as appropriate:

- the history and physical exam pertinent to the day's visit , (including the response or changes in behavior to previously administered skilled services) and
- the skilled services applied on the current visit, and
- the patient/caregiver's immediate response to the skilled services provided, and
- the plan for the next visit based on the rationale of prior results.

Clinical notes should be written such that they adequately describe the reaction of a patient to his/her skilled care. Clinical notes should also provide a clear picture of the treatment, as well as "next steps" to be taken. Vague or subjective descriptions of the patient's care should not be used. For example terminology such as the following would not adequately describe the need for skilled care:

- Patient tolerated treatment well
- Caregiver instructed in medication management
- Continue with POC

Objective measurements of physical outcomes of treatment should be provided and/or a clear description of the changed behaviors due to education programs should be recorded in order that all concerned can follow the results of the applied services.

When the skilled service is being provided to either maintain the patient's condition or prevent or slow further deterioration, the clinical notes must also describe:

- A detailed rationale that explains the need for the skilled service in light of the patient's overall medical condition and experiences,
- the complexity of the service to be performed, and
- any other pertinent characteristics of the beneficiary or home.

40.2.2 - Application of the Principles to Physical Therapy Services (Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled physical therapy services applies the principles in §40.2.1 to specific physical therapy services about which questions are most frequently raised.

A. Assessment

Assuming all other eligibility and coverage requirements have been met, the skills of a physical therapist to assess and periodically reassess a patient's rehabilitation needs and potential or to develop and/or implement a physical therapy program are covered when they are reasonable and necessary because of the patient's condition. Skilled rehabilitation services concurrent with the management of a patient's care plan include objective tests and measurements such as, but not limited to, range of motion, strength, balance, coordination, endurance, or functional ability.

As described in section 40.2.1(b), at defined points during a course of therapy, the qualified physical therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of the therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

B. Therapeutic Exercises

Therapeutic exercises, which require the skills of a qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment constitute skilled physical therapy, when the criteria in §40.2.1(d) above are met.

C. Gait Training

Gait evaluation and training furnished to a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality require the skills of a qualified physical therapist and constitute skilled physical therapy and are considered reasonable and necessary if they can be expected to materially improve or maintain the patient's ability to walk or prevent or slow further deterioration of the patient's ability to walk. Gait evaluation and training which is furnished to a patient whose ability to walk has been impaired by a condition other than a neurological, muscular, or skeletal abnormality would nevertheless be covered where physical therapy is reasonable and necessary to restore or maintain function or to prevent or slow further deterioration. Refer to §40.2.1(d)(1) for the reasonable and necessary coverage criteria associated with restoring patient function.

EXAMPLE 1:

A physician has ordered gait evaluation and training for a patient whose gait has been materially impaired by scar tissue resulting from burns. Physical therapy services to evaluate the beneficiary's gait, establish a gait training program, and provide the skilled

services necessary to implement the program would be covered. The patient's response to therapy must be documented. At appropriate intervals (see above), the qualified therapist must assess the patient with objective measurements of function.

EXAMPLE 2:

A patient who has had a total hip replacement is ambulatory but demonstrates weakness and is unable to climb stairs safely. Physical therapy would be reasonable and necessary to teach the patient to climb and descend stairs safely. Once the patient has reached the goal of climbing and descending stairs safely, additional therapy services are no longer required, and thus would not be covered.

EXAMPLE 3:

A patient who has received gait training has reached their maximum restoration potential, and the physical therapist is teaching the patient and family how to safely perform the activities that are a part of the maintenance program. The visits by the physical therapist to demonstrate and teach the activities (which by themselves do not require the skills of a therapist) would be covered since they are needed to establish the program (refer to §40.2.1(d)(2)). The patient's and caregiver's understanding and implementation of the maintenance program must be documented. After the establishment of the maintenance program, any further visits would need to document why the skilled services of a physical therapist are still required.

D. Range of Motion

Only a qualified physical therapist may perform range of motion tests and, therefore, such tests are skilled physical therapy.

Range of motion exercises constitute skilled physical therapy only if they are part of an active treatment for a specific disease state, illness, or injury that has resulted in a loss or restriction of mobility (as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored). Unskilled individuals may provide range of motion exercises unrelated to the restoration of a specific loss of function often safely and effectively. Passive exercises to maintain range of motion in paralyzed extremities that can be carried out by unskilled persons do not constitute skilled physical therapy.

However, if the criteria in §40.2.1(d)(3) are met, where there is clear documentation that, because of special medical complications (e.g., susceptible to pathological bone fractures), the skills of a therapist are needed to provide services which ordinarily do not need the skills of a therapist, and then the services would be covered.

E. Maintenance Therapy

Where services that are required to maintain the patient's current function or to prevent or slow further deterioration are of such complexity and sophistication that the skills of a qualified therapist are required to perform the procedure safely and effectively, the

services would be covered physical therapy services. Further, where the particular patient's special medical complications require the skills of a qualified therapist to perform a therapy service safely and effectively that would otherwise be considered unskilled, such services would be covered physical therapy services. Refer to §40.2.1(d)(3).

EXAMPLE 4:

Where there is an unhealed, unstable fracture that requires regular exercise to maintain function until the fracture heals, the skills of a physical therapist would be needed to ensure that the fractured extremity is maintained in proper position and alignment during maintenance range of motion exercises.

EXAMPLE 5:

A Parkinson's patient or a patient with rheumatoid arthritis who has not been under a restorative physical therapy program may require the services of a physical therapist to determine what type of exercises are required to maintain the patient's present level of function or to prevent or slow further deterioration. The initial evaluation of the patient's needs, the designing of a maintenance program appropriate to the patient's capacity and tolerance and to the treatment objectives of the physician, the instruction of the patient, family or caregivers to carry out the program safely and effectively, and such reevaluations as may be required by the patient's condition, would constitute skilled physical therapy. Each component of this process must be documented in the home health record.

While a patient is under a restorative physical therapy program, the physical therapist should regularly reevaluate the patient's condition and adjust any exercise program the patient is expected to carry out alone or with the aid of supportive personnel to maintain the function being restored. Consequently, by the time it is determined that no further restoration is possible (i.e., by the end of the last restorative session) the physical therapist will already have designed the maintenance program required and instructed the patient or caregivers in carrying out the program.

F. Ultrasound, Shortwave, and Microwave Diathermy Treatments

These treatments must always be performed by or under the supervision of a qualified physical therapist and are skilled therapy.

G. Hot Packs, Infra-Red Treatments, Paraffin Baths and Whirlpool Baths

Heat treatments and baths of this type ordinarily do not require the skills of a qualified physical therapist. However, the skills, knowledge, and judgment of a qualified physical therapist might be required in the giving of such treatments or baths in a particular case, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications. There must be clear

documentation in the home health record, of the special medical complications that describe the need for the skilled services provided by the therapist.

H. Wound Care Provided Within Scope of State Practice Acts

If wound care falls within the auspice of a physical therapist's State Practice Act, then the physical therapist may provide the specific type of wound care services defined in the State Practice Act. However, such visits in this specific situation would be a covered therapy service when there is documentation in the home health record that the skills of a therapist are required to perform the service. The patient's response to therapy must be documented.

40.2.3 - Application of the General Principles to Speech-Language Pathology Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

The following discussion of skilled speech-language pathology services applies the principles to specific speech-language pathology services about which questions are most frequently raised. Coverage of speech-language pathology services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled speech-language pathology services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified speech-language pathologist are necessary.

As described in §40.2.1(b), at defined points during a course of therapy, the qualified speech-language pathologist must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

1. The skills of a speech-language pathologist are required for the assessment of a patient's rehabilitation needs (including the causal factors and the severity of the speech and language disorders), and rehabilitation potential. Reevaluation would be considered reasonable and necessary only if the patient exhibited:
 - A change in functional speech or motivation;
 - Clearing of confusion; or
 - The remission of some other medical condition that previously contraindicated speech-language pathology services.

Where a patient is undergoing restorative speech-language pathology services, routine reevaluations are considered to be a part of the therapy and cannot be billed as a separate visit.

2. The services of a speech-language pathologist would be covered if they are needed as a result of an illness or injury and are directed towards specific speech/voice production.
3. Speech-language pathology would be covered where a skilled service can only be provided by a speech-language pathologist and where it is reasonably expected that the skilled service will improve, maintain, or prevent or slow further deterioration in the patient's ability to carry out communication or feeding activities.
4. The services of a speech-language pathologist to establish a hierarchy of speech-voice-language communication tasks and cueing that directs a patient toward speech-language communication goals in the plan of care would be covered speech-language pathology.
5. The services of a speech-language pathologist to train the patient, family, or other caregivers to augment the speech-language communication, treatment, to establish an effective maintenance program, or carry out a safe and effective maintenance program when the particular patient's special medical complications require the skills of a qualified therapist (not an assistant) to perform a therapy service that would otherwise be considered unskilled or the needed therapy procedures are of such complexity that the skills of a qualified therapist are required to perform the procedures, would be covered speech-language pathology services.
6. The services of a speech-language pathologist to assist patients with aphasia in rehabilitation of speech and language skills are covered when needed by a patient.
7. The services of a speech-language pathologist to assist patients with voice disorders to develop proper control of the vocal and respiratory systems for correct voice production are covered when needed by a patient.

40.2.4 - Application of the General Principles to Occupational Therapy

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.2.D, HHA-205.2.D

The following discussion of skilled occupational therapy services applies the principles to specific occupational therapy services about which questions are most frequently raised. Coverage of occupational therapy services is not determined solely on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's need for skilled care. Assuming all other eligibility and coverage requirements have been met, skilled occupational therapy services are covered when the individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified occupational therapist are necessary.

40.2.4.1 - Assessment

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

Assuming all other eligibility and coverage requirements are met, the skills of an occupational therapist to assess and reassess a patient's rehabilitation needs and potential or to develop and/or implement an occupational therapy program are covered when they are reasonable and necessary because of the patient's condition.

As described in §40.2.1(b), at defined points during a course of therapy, the qualified occupational therapist (instead of an assistant) must perform the ordered therapy service visit, assess the patient's function using a method which allows for objective measurement of function and comparison of successive measurements, and document the results of the assessments, corresponding measurements, and effectiveness of therapy in the patient's clinical record. Refer to §40.2.1(b) for specific timing and documentation requirements associated with these requirements.

40.2.4.2 - Planning, Implementing, and Supervision of Therapeutic Programs

(Rev. 1, 10-01-03)

A3-3118.2.D.2, HHA-205.2.D.2

The planning, implementing, and supervision of therapeutic programs including, but not limited to those listed below are skilled occupational therapy services, and if reasonable and necessary to the treatment of the patient's illness or injury would be covered.

A. Selecting and Teaching Task Oriented Therapeutic Activities Designed to Restore Physical Function.

EXAMPLE: Use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns.

B. Planning, Implementing, and Supervising Therapeutic Tasks and Activities Designed to Restore Sensory-Integrative Function.

EXAMPLE: Providing motor and tactile activities to increase sensory output and improve response for a stroke patient with functional loss resulting in a distorted body image.

C. Planning, Implementing, and Supervising of Individualized Therapeutic Activity Programs as Part of an Overall "Active Treatment" Program for a Patient With a Diagnosed Psychiatric Illness.

EXAMPLE: Use of sewing activities that require following a pattern to reduce confusion and restore reality orientation in a schizophrenic patient.

D. Teaching Compensatory Techniques to Improve the Level of Independence in the Activities of Daily Living.

EXAMPLE: Teaching a patient who has lost use of an arm how to pare potatoes and chop vegetables with one hand.

EXAMPLE: Teaching a stroke patient new techniques to enable them to perform feeding, dressing, and other activities of daily living as independently as possible.

E. The Designing, Fabricating, and Fitting of Orthotic and Self-Help Devices.

EXAMPLE: Construction of a device which would enable a patient to hold a utensil and feed themselves independently.

EXAMPLE: Construction of a hand splint for a patient with rheumatoid arthritis to maintain the hand in a functional position.

F. Vocational and Prevocational Assessment and Training

Vocational and prevocational assessment and training that is directed toward the restoration of function in the activities of daily living lost due to illness or injury would be covered. Where vocational or prevocational assessment and training is related solely to specific employment opportunities, work skills, or work settings, such services would not be covered because they would not be directed toward the treatment of an illness or injury.

40.2.4.3 - Illustration of Covered Services

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A3-3118.2.D.3, HHA-205.2.D.3

EXAMPLE 1:

A physician orders occupational therapy for a patient who is recovering from a fractured hip and who needs to be taught compensatory and safety techniques with regard to lower extremity dressing, hygiene, toileting, and bathing. The occupational therapist will establish goals for the patient's rehabilitation (to be approved by the physician), and will undertake teaching techniques necessary for the patient to reach the goals. Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. Such visits would be considered covered when the skills of a therapist are required to perform the services. The patient's needs in response to therapy must be documented.

EXAMPLE 2:

A physician has ordered occupational therapy for a patient who is recovering from a CVA. The patient has decreased range of motion, strength, and sensation in both the upper and lower extremities on the right side. In addition, the patient has perceptual and

cognitive deficits resulting from the CVA. The patient's condition has resulted in decreased function in activities of daily living (specifically bathing, dressing, grooming, hygiene, and toileting). The loss of function requires assistive devices to enable the patient to compensate for the loss of function and maximize safety and independence. The patient also needs equipment such as himi-slings to prevent shoulder subluxation and a hand splint to prevent joint contracture and deformity in the right hand. The services of an occupational therapist would be necessary to:

- Assess the patient's needs;
- Develop goals (to be approved by the physician);
- Manufacture or adapt the needed equipment to the patient's use;
- Teach compensatory techniques;
- Strengthen the patient as necessary to permit use of compensatory techniques; and
- Provide activities that are directed towards meeting the goals governing increased perceptual and cognitive function.

Occupational therapy services would be covered at a duration and intensity appropriate to the severity of the impairment and the patient's response to treatment. Such visits would be considered covered therapy services when the skills of a therapist are required to perform the services. The patient's needs, course of therapy and response to therapy must be documented.

50 - Coverage of Other Home Health Services

(Rev. 1, 10-01-03)

A3-3119, HHA-206

50.1 - Skilled Nursing, Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy

(Rev. 1, 10-01-03)

A3-3119.1, HHA-206.1

Where the patient meets the qualifying criteria in §30, Medicare covers skilled nursing services that meet the requirements of §§40.1 and 50.7, physical therapy that meets the requirements of §40.2, speech-language pathology services that meet the requirements of §40.2, and occupational therapy that meets the requirements of §40.2.

Home health coverage is not available for services furnished to a qualified patient who is no longer in need of one of the qualifying skilled services specified in §30. Therefore, dependent services furnished after the final qualifying skilled service are not covered under the home health benefit, except when the dependent service was followed by a qualifying skilled service as a result of the unexpected inpatient admission or death of the patient or due to some other unanticipated event.

50.2 - Home Health Aide Services

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

For home health aide services to be covered:

- The patient must meet the qualifying criteria as specified in §30;
- The services provided by the home health aide must be part-time or intermittent as discussed in §50.7;
- The services must meet the definition of home health aide services of this section; and
- The services must be reasonable and necessary to the treatment of the patient's illness or injury.

NOTE: A home health aide must be certified consistent the competency evaluation requirements.

The reason for the visits by the home health aide must be to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury.

The physician or allowed practitioner's order should indicate the frequency of the home health aide services required by the patient. These services may include but are not limited to:

A. Personal Care

Personal care means:

1. Bathing, dressing, grooming, caring for hair, nail, and oral hygiene which are needed to facilitate treatment or to prevent deterioration of the patient's health, changing the bed linens of an incontinent patient, shaving, deodorant application, skin care with lotions and/or powder, foot care, and ear care; and
2. Feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the patient's condition, routine catheter care and routine colostomy care), assistance with ambulation, changing position in bed, assistance with transfers.

EXAMPLE 1:

A physician has ordered home health aide visits to assist the patient in personal care because the patient is recovering from a stroke and continues to have significant right side weakness that causes the patient to be unable to bathe, dress or perform hair and oral care. The plan of care established by the HHA nurse sets forth the specific tasks with which the patient needs assistance. Home health aide visits at an appropriate frequency would be reasonable and necessary to assist in these tasks.

EXAMPLE 2:

A physician ordered four home health aide visits per week for personal care for a multiple sclerosis patient who is unable to perform these functions because of increasing debilitation. The home health aide gave the patient a bath twice per week and washed hair on the other two visits each week. Only two visits are reasonable and necessary since the services could have been provided in the course of two visits.

EXAMPLE 3:

A physician ordered seven home health aide visits per week for personal care for a bed-bound, incontinent patient. All visits are reasonable and necessary because the patient has extensive personal care needs.

EXAMPLE 4:

A patient with a well-established colostomy forgets to change the bag regularly and has difficulty changing the bag. Home health aide services at an appropriate frequency to change the bag would be considered reasonable and necessary to the treatment of the illness or injury.

B. Simple Dressing Changes That Do Not Require the Skills of a Licensed Nurse
EXAMPLE 5:

A patient who is confined to the bed has developed a small reddened area on the buttocks. The physician has ordered home health aide visits for more frequent repositioning, bathing and the application of a topical ointment and a gauze 4x4. Home health aide visits at an appropriate frequency would be reasonable and necessary.

C. Assistance With Medications Which Are Ordinarily Self-Administered and Do Not Require the Skills of a Licensed Nurse to Be Provided Safely and Effectively

NOTE: Prefilling of insulin syringes is ordinarily performed by the diabetic as part of the self-administration of the insulin and, unlike the injection of the insulin, does not require the skill of a licensed nurse to be performed properly. Therefore, if HHA staff performs the prefilling of insulin syringes, it is considered to be a home health aide service. However, where State law precludes the provision of this service by other than a licensed nurse or physician, Medicare will make payment for this service, when covered, as though it were a skilled nursing service. Where the patient needs only prefilling of

insulin syringes and does not need skilled nursing care on an intermittent basis, physical therapy, speech-language pathology services, or have a continuing need for occupational therapy, then Medicare cannot cover any home health services to the patient (even if State law requires that the insulin syringes be filled by a licensed nurse).

Home health aide services are those services ordered in the plan of care that the aide is permitted to perform under State law. Medicare coverage of the administration of insulin by a home health aide will depend on whether or not the agency is in compliance with all Federal and State laws and regulations related to this task. However, when the task of insulin administration has been delegated to the home health aide, the task must be considered and billed as a Medicare home health aide service. By a State allowing the delegation of insulin administration to home health aides, the State has extended the role of aides, not equated aide services with the services of a registered nurse.

D. Assistance With Activities which Are Directly Supportive of Skilled Therapy Services but Do Not Require the Skills of a Therapist to Be Safely and Effectively Performed Such as Routine Maintenance Exercises and Repetitive Practice of Functional Communication Skills to Support Speech-Language Pathology Services

E. Provision of Services Incidental to Personal Care Services not Care of Prosthetic and Orthotic Devices

When a home health aide visits a patient to provide a health related service as discussed above, the home health aide may also perform some incidental services which do not meet the definition of a home health aide service (e.g., light cleaning, preparation of a meal, taking out the trash, shopping, etc.) However, the purpose of a home health aide visit may not be to provide these incidental services since they are not health related services, but rather are necessary household tasks that must be performed by anyone to maintain a home.

EXAMPLE 1:

A home health aide visits a recovering stroke patient whose right side weakness and poor endurance cause her to be able to leave the bed and chair only with extreme difficulty. The physician has ordered physical therapy and speech-language pathology services for the patient and home health aide services three or four times per week for personal care, assistance with ambulation as mobility increases, and assistance with repetitive speech exercises as her impaired speech improves. The home health aide also provides incidental household services such as preparation of meals, light cleaning and taking out the trash. The patient lives with an elderly frail sister who is disabled and who cannot perform either the personal care or the incidental tasks. The home health aide visits at a frequency appropriate to the performance of the health related services would be covered, notwithstanding the incidental provision of noncovered services (i.e., the household services) in the course of the visits.

EXAMPLE 2:

A physician orders home health aide visits three times per week. The only services provided are light housecleaning, meal preparation and trash removal. The home health aide visits cannot be covered, notwithstanding their importance to the patient, because the services provided do not meet Medicare's definition of "home health aide services."

50.3 - Medical Social Services

(Rev. 1, 10-01-03)

A3-3119.3, HHA-206.3

Medical social services that are provided by a qualified medical social worker or a social work assistant under the supervision of a qualified medical social worker may be covered as home health services where the beneficiary meets the qualifying criteria specified in §30, and:

1. The services of these professionals are necessary to resolve social or emotional problems that are or are expected to be an impediment to the effective treatment of the patient's medical condition or rate of recovery; and
2. The plan of care indicates how the services which are required necessitate the skills of a qualified social worker or a social work assistant under the supervision of a qualified medical social worker to be performed safely and effectively.

Where both of these requirements for coverage are met, services of these professionals which may be covered include, but are not limited to:

1. Assessment of the social and emotional factors related to the patient's illness, need for care, response to treatment and adjustment to care;
2. Assessment of the relationship of the patient's medical and nursing requirements to the patient's home situation, financial resources and availability of community resources;
3. Appropriate action to obtain available community resources to assist in resolving the patient's problem (**NOTE:** Medicare does not cover the services of a medical social worker to complete or assist in the completion of an application for Medicaid because Federal regulations require the State to provide assistance in completing the application to anyone who chooses to apply for Medicaid.);
4. Counseling services that are required by the patient; and
5. Medical social services furnished to the patient's family member or caregiver on a short-term basis when the HHA can demonstrate that a brief intervention (that is, two or three visits) by a medical social worker is necessary to remove a clear and direct impediment to the effective treatment of the patient's medical condition or to the patient's rate of recovery. To be considered "clear and direct," the behavior or actions of the family member or caregiver must plainly obstruct, contravene, or prevent the patient's medical treatment or rate of recovery. Medical social

services to address general problems that do not clearly and directly impede treatment or recovery as well as long-term social services furnished to family members, such as ongoing alcohol counseling, are not covered.

NOTE: Participating in the development of the plan of care, preparing clinical and progress notes, participating in discharge planning and in-service programs, and acting as a consultant to other agency personnel are appropriate administrative costs to the HHA.

EXAMPLE 1:

The physician has ordered a medical social worker assessment of a diabetic patient who has recently become insulin dependent and is not yet stabilized. The nurse, who is providing skilled observation and evaluation to try to restabilize the patient notices during her visits that the supplies left in the home for the patient's use appear to be frequently missing, and the patient is not compliant with the regimen although she refuses to discuss the matter. The assessment by a medical social worker would be reasonable and necessary to determine if there are underlying social or emotional problems impeding the patient's treatment.

EXAMPLE 2:

A physician ordered an assessment by a medical social worker for a multiple sclerosis patient who was unable to move anything but her head and who had an indwelling catheter. The patient had experienced recurring urinary tract infections and multiple infected ulcers. The physician ordered medical social services after the HHA indicated to him that the home was not well cared for, the patient appeared to be neglected much of the time, and the relationship between the patient and family was very poor. The physician and HHA were concerned that social problems created by family caregivers were impeding the treatment of the recurring infections and ulcers. The assessment and follow-up for counseling both the patient and the family by a medical social worker were reasonable and necessary.

EXAMPLE 3:

A physician is aware that a patient with atherosclerosis and hypertension is not taking medications as ordered and adhering to dietary restrictions because he is unable to afford the medication and is unable to cook. The physician orders several visits by a medical social worker to assist in resolving these problems. The visits by the medical social worker to review the patient's financial status, discuss options, and make appropriate contacts with social services agencies or other community resources to arrange for medications and meals would be a reasonable and necessary medical social service.

EXAMPLE 4:

A physician has ordered counseling by a medical social worker for a patient with cirrhosis of the liver who has recently been discharged from a 28-day inpatient alcohol treatment program to her home which she shares with an alcoholic and neglectful adult

child. The physician has ordered counseling several times per week to assist the patient in remaining free of alcohol and in dealing with the adult child. The services of the medical social worker would be covered until the patient's social situation ceased to impact on her recovery and/or treatment.

EXAMPLE 5:

A physician has ordered medical social services for a patient who is worried about his financial arrangements and payment for medical care. The services ordered are to arrange Medicaid if possible and resolve unpaid medical bills. There is no evidence that the patient's concerns are adversely impacting recovery or treatment of his illness or injury. Medical social services cannot be covered.

EXAMPLE 6:

A physician has ordered medical social services for a patient of extremely limited income who has incurred large unpaid hospital and other medical bills following a significant illness. The patient's recovery is adversely affected because the patient is not maintaining a proper therapeutic diet, and cannot leave the home to acquire the medication necessary to treat their illness. The medical social worker reviews the patient's financial status, arranges meal service to resolve the dietary problem, arranges for home delivered medications, gathers the information necessary for application to Medicaid to acquire coverage for the medications the patient needs, files the application on behalf of the patient, and follows up repeatedly with the Medicaid State agency.

The medical social services that are necessary to review the financial status of the patient, arrange for meal service and delivery of medications to the home, and arrange for the Medicaid State agency to assist the patient with the application for Medicaid are covered. The services related to the assistance in filing the application for Medicaid and the follow-up on the application are not covered since they must be provided by the State agency free of charge, and hence the patient has no obligation to pay for such assistance.

EXAMPLE 7:

A physician has ordered medical social services for an insulin dependent diabetic whose blood sugar is elevated because she has run out of syringes and missed her insulin dose for two days. Upon making the assessment visit, the medical social worker learns that the patient's daughter, who is also an insulin dependent diabetic, has come to live with the patient because she is out of work. The daughter is now financially dependent on the patient for all of her financial needs and has been using the patient's insulin syringes. The social worker assesses the patient's financial resources and determines that they are adequate to support the patient and meet her own medical needs, but are not sufficient to support the daughter. She also counsels the daughter and helps her access community resources. These visits would be covered, but only to the extent that the services are necessary to prevent interference with the patient's treatment plan.

EXAMPLE 8:

A wife is caring for her husband who is an Alzheimer's patient. The nurse learns that the wife has not been giving the patient his medication correctly and seems distracted and forgetful about various aspects of the patient's care. In a conversation with the nurse, the wife relates that she is feeling depressed and overwhelmed by the patient's illness. The nurse contacts the patient's physician who orders a social work evaluation. In her assessment visit, the social worker learns that the patient's wife is so distraught over her situation that she cannot provide adequate care to the patient. While there, the social worker counsels the wife and assists her with referrals to a support group and her private physician for evaluation of her depression. The services would be covered.

EXAMPLE 9:

The parent of a dependent disabled child has been discharged from the hospital following a hip replacement. Although arrangements for care of the disabled child during the hospitalization were made, the child has returned to the home. During a visit to the patient, the nurse observes that the patient is transferring the child from bed to a wheelchair. In an effort to avoid impeding the patient's recovery, the nurse contacts the patient's physician to order a visit by a social worker to mobilize family members or otherwise arrange for temporary care of the disabled child. The services would be covered.

50.4 - Medical Supplies (Except for Drugs and Biologicals Other Than Covered Osteoporosis Drugs), the Use of Durable Medical Equipment and Furnishing Negative Pressure Wound Therapy Using a Disposable Device

(Rev. 233, Issued: 02-24-17, Effective: 01-01-17, Implementation: 03-27-17)

50.4.1 - Medical Supplies

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01-11-21)

Medical supplies are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling HHA personnel to conduct home visits or to carry out effectively the care the physician has ordered for the treatment or diagnosis of the patient's illness or injury. All supplies which would have been covered under the cost-based reimbursement system are bundled under home health PPS. Payment for the cost of supplies has been incorporated into the per visit and 30-day period payment rates. Supplies fit into two categories. They are classified as:

- **Routine** - because they are used in small quantities for patients during the usual course of most home visits; or
- **Nonroutine** - because they are needed to treat a patient's specific illness or injury in accordance with the physician or allowed practitioner's plan of care and meet further conditions discussed in more detail below.

All HHAs are expected to separately identify in their records the cost of medical and surgical supplies that are not routinely furnished in conjunction with patient care visits and the use of which are directly identifiable to an individual patient.

50.4.1.1 - The Law, Routine and Nonroutine Medical Supplies, and the Patient's Plan of Care

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A. The Law

The Medicare law governing the home health PPS is specific to the type of items and services bundled to the HHA and the time the services are bundled. Medical supplies are bundled while the patient is under a home health plan of care. If a patient is admitted for a condition which is related to a chronic condition that requires a medical supply (e.g., ostomy patient) the HHA is required to provide the medical supply while the patient is under a home health plan of care during a 30-day period of care. The physician or allowed practitioner's orders in the plan of care must reflect all nonroutine medical supplies provided and used while the patient is under a home health plan of care. The consolidated billing requirement is not superseded by the exclusion of certain medical supplies from the plan of care and then distinguishing between medical supplies that are related and unrelated to the plan of care. Failure to include medical supplies on the plan of care does not relieve HHAs from the obligation to comply with the consolidated billing requirements. The comprehensive nature of the current patient assessment and plan of care requirements looks at the totality of patient needs. However, there could be a circumstance where a physician or allowed practitioner could be uncomfortable with writing orders for a preexisting condition unrelated to the reason for home health care. In those circumstances, PRN orders for such supplies may be used in the plan of care by a physician or allowed practitioner.

Thus, all medical supplies are bundled while the patient is under a home health plan of care. This includes, but is not limited to, the above listed medical supplies as well as the Part B items provided in the final PPS rule. The latter item lists are subsequently updated in accordance with the current process governing the deletion, replacement and revision of Medicare Part B codes. Parenteral and enteral nutrition, prosthetics, orthotics, DME and DME supplies are not considered medical supplies and therefore not subject to bundling while the patient is under a home health plan of care. However, §1834(h)(4)(c) of the Act specifically excludes from the term "orthotics and prosthetics" medical supplies including catheters, catheter supplies, ostomy bags and supplies related to ostomy care furnished by an HHA under §1861(m) of the Act. Therefore, these items are bundled while a patient is under a home health plan of care.

B. Relationship Between Patient Choice and Veterans Benefits

For veterans, both Medicare and Veteran's Administration (VA) benefits are primary. Therefore, the beneficiary who is a veteran has some choices in cases where the benefits overlap. The beneficiary, however, must select one or the other program as primary when obtaining active care. If the VA is selected as primary for home health care, then Medicare becomes a secondary payer. An HHA must provide the medical supplies a

Medicare beneficiary needs no matter the payer; it is not obligated to provide medical supplies that are not needed. If a patient has medical supplies provided by the VA because of the patient's preference, then the HHA must not duplicate the supplies under Medicare. The beneficiary's choice is controlling. The HHA may not require the beneficiary to obtain or use medical supplies covered by the primary payer from any other source, including the VA.

C. Medical Supplies Purchased by the Patient Prior to the Start of Care

A patient may have acquired medical supplies prior to his/her Medicare home health start of care date. If a patient prefers to use his or her own medical supplies after having been offered appropriate supplies by the HHA and it is determined by the HHA that the patient's medical supplies are clinically appropriate, then the patient's choice is controlling. The HHA is not required to duplicate the medical supplies if the patient elects to use his or her own medical supplies. However, if the patient prefers to have the HHA provide medical supplies while the patient is under a Medicare home health plan of care, then the HHA must provide the medical supplies. The HHA may not require that the patient obtain or use medical supplies from any other source. Given the possibility of subsequent misunderstandings arising between the HHA and the patient on this issue, the HHA should document the beneficiary's decision to decline HHA furnished medical supplies and use their own resources.

50.4.1.2 - Routine Supplies (Nonreportable)

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Routine supplies are supplies that are customarily used in small quantities during the course of most home care visits. They are usually included in the staff's supplies and not designated for a specific patient. These supplies are included in the cost per visit of home health care services. Routine supplies would not include those supplies that are specifically ordered by the physician or allowed practitioner or are essential to HHA personnel in order to effectuate the plan of care.

Examples of supplies which are usually considered routine include, but are not limited to:

A. Dressings and Skin Care

- Swabs, alcohol preps, and skin prep pads;
- Tape removal pads;
- Cotton balls;
- Adhesive and paper tape;
- Nonsterile applicators; and
- 4 x 4's.

B. Infection Control Protection

- Nonsterile gloves;
- Aprons;
- Masks; and
- Gowns.

C. Blood Drawing Supplies

- Specimen containers.

D. Incontinence Supplies

- Incontinence briefs and Chux Covered in the normal course of a visit. For example, if a home health aide in the course of a bathing visit to a patient determines the patient requires an incontinence brief change, the incontinence brief in this example would be covered as a routine medical supply.

E. Other

- Thermometers; and
- Tongue depressors.

There are occasions when the supplies listed in the above examples would be considered nonroutine and thus would be considered a billable supply, i.e., if they are required in quantity, for recurring need, and are included in the plan of care. Examples include, but are not limited to, tape, and 4x4s for major dressings.

50.4.1.3 - Nonroutine Supplies (Reportable)
(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Nonroutine supplies are identified by the following conditions:

1. The HHA follows a consistent charging practice for Medicare and other patients receiving the item;
2. The item is directly identifiable to an individual patient;
3. The cost of the item can be identified and accumulated in a separate cost center; and
4. The item is furnished at the direction of the patient's physician or allowed practitioner and is specifically identified in the plan of care.

All nonroutine supplies must be specifically ordered by the physician or allowed practitioner or the physician or allowed practitioner's order for services must require the use of the specific supplies to be effectively furnished.

The charge for nonroutine supplies is excluded from the per visit costs.

Examples of supplies that can be considered nonroutine include, but are not limited to:

1. Dressings/Wound Care

- Sterile dressings;
- Sterile gauze and toppers;
- Kling and Kerlix rolls;
- Telfa pads;
- Eye pads;
- Sterile solutions, ointments;
- Sterile applicators; and
- Sterile gloves.

2. I.V. Supplies

3. Ostomy Supplies

4. Catheters and Catheter Supplies

- Foley catheters; and
- Drainage bags, irrigation trays.

5. Enemas and Douches

6. Syringes and Needles

7. Home Testing

- Blood glucose monitoring strips; and
- Urine monitoring strips.

Consider other items that are often used by persons who are not ill or injured to be medical supplies only where:

- The item is recognized as having the capacity to serve a therapeutic or diagnostic purpose in a specific situation; and
- The item is required as a part of the actual physician or allowed practitioner prescribed treatment of a patient's existing illness or injury.

For example, items that generally serve a routine hygienic purpose, e.g., soaps and shampoos and items that generally serve as skin conditioners, e.g., baby lotion, baby oil, skin softeners, powders, lotions, are not considered medical supplies unless the particular item is recognized as serving a specific therapeutic purpose in the physician or allowed practitioner's prescribed treatment of the patient's existing skin (scalp) disease or injury.

Limited amounts of medical supplies may be left in the home between visits where repeated applications are required and rendered by the patient or other caregivers. These items must be part of the plan of care in which the home health staff is actively involved. For example, the patient is independent in insulin injections but the nurse visits once a day to change wound dressings. The wound dressings/irrigation solution may be left in the home between visits. Supplies such as needles, syringes, and catheters that require administration by a nurse should not be left in the home between visits.

50.4.2 - Durable Medical Equipment

(Rev. 1, 10-01-03)

A3-3119.4.B, HHA-206.4.B

Durable medical equipment which meets the requirements of the Medicare Benefit Policy Manuals, Chapter 6, "Hospital Services Covered Under Part B," §80, and Chapter 15, "Covered Medical and Other Health Services" §110, is covered under the home health benefit with the beneficiary responsible for payment of a 20 percent coinsurance.

50.4.3 – Covered Osteoporosis Drugs

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Sections 1861(m) and 1861(kk) of the Act provide for coverage of FDA approved injectable drugs for the treatment of osteoporosis. These drugs are expected to be provided by an HHA to female beneficiaries who are currently receiving services under an open home health plan of care, who meet existing coverage criteria for the home health benefit and who meet the criteria listed below. These drugs are covered on a cost basis when provided by an HHA under the circumstances listed below.

The home health visit (i.e., the skilled nurse's visit) to administer the drug is covered under all fee-for-service Medicare (Part A or Part B) home health coverage rules (see section 30 above). Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

- The individual is eligible for Medicare Part B coverage of home health services (the nursing visit to perform the injection may be the individual's qualifying service);
- The individual sustained a bone fracture that a physician, or allowed practitioner, or certified nurse midwife certifies was related to post-menopausal osteoporosis; and
- The individual's physician, or allowed practitioner, or certified nurse midwife certifies that she is unable to learn the skills needed to self-administer the drug or is otherwise physically or mentally incapable of administering the drug, and that her family or caregivers are unable or unwilling to administer the drug.

This drug is considered part of the home health benefit under Part B. Therefore, Part B deductible and coinsurance apply regardless of whether home health visits for the administration of the drug are covered under Part A or Part B.

For instructions on billing for covered osteoporosis drugs, see Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 90.1.

50.4.4 - Negative Pressure Wound Therapy Using a Disposable Device

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

Sections 1834 and 1861(m)(5) of the Act require a separate payment to an HHA for an applicable disposable device when furnished on or after January 1, 2017, to an individual who receives home health services for which payment is made under the Medicare home health benefit. Section 1834 of the Act defines an applicable device as a disposable NPWT device that is an integrated system comprised of a non-manual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy used in lieu of a conventional NPWT DME system. As required by §1834 of the Act, the separate payment amount for a disposable NPWT device is to be set equal to the amount of the payment that would be made under the Medicare Hospital Outpatient Prospective

Payment System (OPPS) using the Level I HCPCS code, otherwise referred to as Current Procedural Terminology (CPT) codes, for which the description for a professional service includes the furnishing of such a device.

Payment for HH visits related to wound care, but not requiring the furnishing of an entirely new disposable NPWT device, will be covered by the HH PPS 30-day period payment and must be billed using the HH claim. Where a home health visit is exclusively for the purpose of furnishing NPWT using a disposable device, the HHA will submit only a type of claim that will be paid for separately outside the HH PPS (TOB 34x). Where, however, the home health visit includes the provision of other home health services in addition to, and separate from, furnishing NPWT using a disposable device, the HHA will submit both a home health claim and a TOB 34x—the home health claim for other home health services and the TOB 34x for furnishing NPWT using a disposable device.

EXAMPLE:

A patient requires NPWT for the treatment of a wound. On Monday, a nurse assesses a patient's wound, applies a new disposable NPWT device, and provides wound care education to the patient and family. The nurse returns on Thursday for wound assessment and replaces the fluid management system (or dressing) for the existing disposable NPWT, but does not replace the entire device. The nurse returns the following Monday, assesses the patient's condition and the wound, and replaces the device that had been applied on the previous Monday with a new disposable NPWT device. In this scenario, the billing procedures are as follows:

For both Monday visits, all the services provided by the nurse were associated with furnishing NPWT using a disposable device. The nurse did not provide any services that were not associated with furnishing NPWT using a disposable device. Therefore, all the nursing services for both Monday visits should be reported on TOB 34x with CPT code 97607 or 97608. None of the services should be reported on the HH claim.

For the Thursday visit, the nurse checked the wound, but did not apply a new disposable NPWT device, so even though the nurse provided care related to the wound, those services would not be considered furnishing NPWT using a disposable device. Therefore, the services should be reported on bill type 32x and no services should be reported on bill type 34x.

For instructions on billing for NPWT using a disposable device, see Pub. 100-04, Medicare Claims Processing Manual, chapter 10, Section 90.3 – Billing Instructions for Disposable Negative Pressure Wound Therapy Services.

50.5 - Services of Interns and Residents

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Home health services include the medical services of interns and residents-in-training under an approved hospital teaching program if the services are ordered by the physician

or allowed practitioner who is responsible for the plan of care and the HHA is affiliated with or is under common control of a hospital furnishing the medical services. Approved means:

- Approved by the Accreditation Council for Graduate Medical Education;
- In the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association;
- In the case of an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association; or
- In the case of an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Education of the American Podiatric Association.

50.6 - Outpatient Services

(Rev. 1, 10-01-03)

A3-3119.6, HHA-206.6

Outpatient services include any of the items or services described above which are provided under arrangements on an outpatient basis at a hospital, skilled nursing facility, rehabilitation center, or outpatient department affiliated with a medical school, and (1) which require equipment which cannot readily be made available at the patient's place of residence, or (2) which are furnished while the patient is at the facility to receive the services described in (1). The hospital, skilled nursing facility, or outpatient department affiliated with a medical school must all be qualified providers of services. However, there are special provisions for the use of the facilities of rehabilitation centers. The cost of transporting an individual to a facility cannot be reimbursed as home health services.

50.7 - Part-Time or Intermittent Home Health Aide and Skilled Nursing Services

(Rev. 1, 10-01-03)

A3-3119.7, HHA-206.7, A3-3119.7A, HHA-206.7A, A3-3119.7.B, HHA-206.7.B

Where a patient is eligible for coverage of home health services, Medicare covers either part-time or intermittent home health aide services or skilled nursing services subject to the limits below. The law at §1861(m) of the Act clarified: "the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week).

50.7.1 - Impact on Care Provided in Excess of "Intermittent" or "Part-Time" Care

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Home health aide and/or skilled nursing care, in excess of the amounts of care that meet the definition of part-time or intermittent, may be provided to a home care patient or purchased by other payers without bearing on whether the home health aide and skilled nursing care meets the Medicare definitions of part-time or intermittent.

EXAMPLE: A patient needs skilled nursing care monthly for a catheter change and the home health agency also renders needed daily home health aide services 24 hours per day that will be needed for a long and indefinite period of time. The HHA bills Medicare for the skilled nursing and home health aide services, which were provided before the 35th hour of service each week, and bills the beneficiary (or another payer) for the remainder of the care. If the Medicare contractor determines that the 35 hours of care are reasonable and necessary, Medicare would cover the 35 hours of skilled nursing and home health aide visits.

50.7.2 - Application of this Policy Revision

(Rev. 1, 10-01-03)

A3-3119.7.D, HHA-206.7.D

Additional care covered by other payers discussed in §50.7.1 does not affect Medicare coverage when the conditions listed below apply. A patient must meet the criteria for Medicare coverage of home health services, before this policy revision becomes applicable to skilled nursing services and/or home health aide services. The definition of "intermittent" with respect to the need for skilled nursing care where the patient qualifies for coverage based on the need for "skilled nursing care on an intermittent basis" remains unchanged. Specifically:

1. This policy revision always applies to home health aide services when the patient qualifies for coverage;
2. This policy revision applies to skilled nursing care only when the patient needs physical therapy or speech-language pathology services or continued occupational therapy, and also needs skilled nursing care; and
3. If the patient needs skilled nursing care but does not need physical therapy or speech-language pathology services or occupational therapy, the patient must still meet the longstanding and unchanged definition of "intermittent" skilled nursing care in order to qualify for coverage of any home health services.

60 - Special Conditions for Coverage of Home Health Services Under Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B)

(Rev. 1, 10-01-03)

A3-3122, HHA-212

60.1 - Post-Institutional Home Health Services Furnished During A Home Health Benefit Period - Beneficiaries Enrolled in Part A and Part B

(Rev. 1, 10-01-03)

A3-3122.1, HHA-212.1, A3-3122.1, HHA-212.2, PMs A-97-12, A-97-16, A-98-49

Section 1812(a)(3) of the Act provides post-institutional home health services for individuals enrolled in Part A and Part B and home health services for individuals who are eligible for Part A only. For beneficiaries who are enrolled in Part A and Part B, Part A finances post-institutional home health services furnished during a home health spell of illness for up to 100 visits during a spell of illness.

Part A finances up to 100 visits furnished during a home health spell of illness if the following criteria are met:

- Beneficiaries are enrolled in Part A **and** Part B and qualify to receive the Medicare home health benefit;
- Beneficiaries must have at least a three consecutive day stay in a hospital or rural primary care hospital; and
- Home health services must be initiated and the first covered home health visit must be rendered within 14 days of discharge from a 3 consecutive day stay in a hospital or rural primary care hospital or within 14 days of discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services. If the first home health visit is not initiated within 14 days of discharge, then home health services are financed under Part B.

After an individual exhausts 100 visits of Part A post-institutional home health services, Part B finances the balance of the home health spell of illness. A home health spell of illness is a period of consecutive days beginning with the first day not included in a previous home health spell of illness on which the individual is furnished post-institutional home health services which occurs in a month the individual is entitled to Part A. The home health spell of illness ends with the close of the first period of 60 consecutive days in which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a skilled nursing facility (in which the individual was furnished post-hospital extended care services) nor provided home health services.

EXAMPLE 1:

An individual is enrolled in Part A and Part B, qualifies for the Medicare home health benefit, has a three consecutive day stay in a hospital, and is discharged on May 1. On May 5, the individual receives the first skilled nursing visit under the plan of care. Therefore, post-institutional home health services have been initiated within 14 days of discharge. The individual is later hospitalized on June 2. Prior to the June 2 hospitalization, the individual received 12 home health visits. The individual stays in the hospital for four consecutive days, is discharged and receives home health services. That

individual continues the May 5 home health spell of illness and would have 88 visits left under that home health spell of illness under Part A. That individual could not start another home health spell of illness (100 visits under Part A) until a 60-day consecutive period in which the individual was not an inpatient of a hospital, rural primary care hospital, an inpatient of a skilled nursing facility (in which the individual was furnished post-hospital extended care services), or provided home health services had passed.

EXAMPLE 2:

An individual is enrolled in Part A and Part B, qualifies for the Medicare home health benefit, has a three consecutive day stay in a hospital, and home health is initiated within 14 days of discharge. The individual exhausts the 100 visits under Part A post-institutional home health services, continues to need home health services, and receives home health services under Part B. The individual is then hospitalized for 4 consecutive days. The individual is again discharged and receives home health services. The individual cannot begin a new home health spell of illness because 60 days did not pass in which the individual was not an inpatient of a hospital or rural primary care hospital or an inpatient of a skilled nursing facility in which the individual was furnished post-hospital extended care services. The individual would be discharged and Part B would continue to finance the home health services.

60.2 - Beneficiaries Who Are Enrolled in Part A and Part B, but Do Not Meet Threshold for Post-Institutional Home Health Services (Rev. 1, 10-01-03)

A3-3122.1, HHA-212.3

If beneficiaries are enrolled in Part A and Part B and are eligible for the Medicare home health benefit, but do not meet the three consecutive day stay requirement or the 14 day initiation of care requirement, then all of their home health services would be financed under Part B. For example, this situation would include, but is not limited to, beneficiaries enrolled in Part A and Part B who are coming from the community to a home health agency in need of home health services or who stay less than three consecutive days in a hospital and are discharged. Any home health services received after discharge would be financed under Part B.

60.3 - Beneficiaries Who Are Part A Only or Part B Only (Rev. 1, 10-01-03)

A3-3122.1, HHA-212.4

If a beneficiary is enrolled **only** in Part A and qualifies for the Medicare home health benefit, then all of the home health services are financed under Part A. The 100-visit limit does **not** apply to beneficiaries who are only enrolled in Part A. If a beneficiary is enrolled **only** in Part B and qualifies for the Medicare home health benefit, then all of the home health services are financed under Part B. There is no 100-visit limit under Part B. The new definition of post-institutional home health services provided during a home health spell of illness **only** applies to those beneficiaries who are enrolled in **both** Part A and Part B and qualify for the Medicare home health benefit.

60.4 - Coinsurance, Copayments, and Deductibles

(Rev. 233, Issued: 02-24-17, Effective: 01-01-17, Implementation: 03-27-17)

There is no coinsurance, copayment, or deductible for home health services and supplies other than the following:

- coinsurance required for durable medical equipment (DME) and furnishing NPWT using a disposable device covered as a home health service; and
- deductible and coinsurance for the osteoporosis drug, which is part of the home health benefit only paid under Part B.

The coinsurance liability of the beneficiary for DME and the osteoporosis drug furnished as a home health service is 20 percent of the fee schedule amount for the services.

Coinurance for furnishing NPWT using a disposable device as a home health service is 20 percent of the payment amount.

70 - Duration of Home Health Services

(Rev. 1, 10-01-03)

A3-3123, HHA-215, A3-3123.1, HHA-215.1

70.1 - Number of Home Health Visits Under Supplementary Medical Insurance (Part B)

(Rev. 1, 10-01-03)

A3-3123.2, HHA-215.2

To the extent that all coverage requirements are met, payment may be made on behalf of eligible beneficiaries under Part B for an unlimited number of covered home health visits. The determination of Part A or Part B Trust Fund financing and coverage is made in accordance with the financing shift required by the BBA described above in §60.

70.2 - Counting Visits Under the Hospital and Medical Plans

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A. Visit Defined

A visit is an episode of personal contact with the patient by staff of the HHA, or others under arrangements with the HHA, for the purpose of providing a covered home health service. Though visits are provided under the HH benefit as part of 30-day periods, and periods are unlimited, each visit must be uniquely billed as a separate line item on a Medicare HH claim, and data on visit charges is still used in formulating payment rates.

B. Counting Visits

Generally, one visit may be covered each time an HHA employee, or someone providing home health services under arrangements with the HHA, enters the patient's home and provides a covered service to a patient who meets the criteria in §30.

If the HHA furnishes services in an outpatient facility under arrangements with the facility, one visit may be covered for each type of service provided.

If two individuals are needed to provide a service, two visits may be covered. If two individuals are present, but only one is needed to provide the care, only one visit may be covered.

A visit is initiated with the delivery of covered home health services and ends at the conclusion of delivery of covered home health services. In those circumstances in which all reasonable and necessary home health services cannot be provided in the course of a single visit, HHA staff or others providing services under arrangements with the HHA may remain at the patient's home between visits (e.g., to provide noncovered services). However, if all covered services could be provided in the course of one visit, only one visit may be covered.

EXAMPLES:

1. If an occupational therapist and an occupational therapy assistant visit the patient together to provide therapy and the therapist is there to supervise the assistant, **one** visit is counted.
2. If a nurse visits the patient in the morning to dress a wound and later must return to replace a catheter, **two** visits are counted.
3. If the therapist visits the patient for treatment in the morning and the patient is later visited by the assistant for additional treatment, **two** visits are counted.
4. If an individual is taken to a hospital to receive outpatient therapy that could not be furnished in their own home (e.g., hydrotherapy) and, while at the hospital receives speech-language pathology services and other services, **two or more** visits would be charged.
5. Many home health agencies provide home health aide services on an hourly basis (ranging from 1 to 8 hours a day). However, in order to allocate visits properly against a patient's maximum allowable visits, home health aide services are to be counted in terms of visits. Thus, regardless of the number of continuous hours a home health aide spends in a patient's home on any given day, one "visit" is counted for each such day. If, in a rare situation, a home health aide visits a patient for an hour or two in the morning, and again for an hour or two in the afternoon, two visits are counted.

C. Evaluation Visits

The HHAs are required by regulations to have written policies concerning the acceptance of patients by the agency. These include consideration of the physical facilities available in the patient's place of residence, the homebound status, and the attitudes of family members for the purpose of evaluating the feasibility of meeting the patient's medical needs in the home health setting. When personnel of the agency make such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not chargeable as a visit since at this point the patient has not been accepted for care. If, however, during the course of this initial evaluation visit, the patient is determined suitable for home health care by the agency, and is also furnished the first skilled service as ordered under the physician or allowed practitioner's plan of care, the visit would become the first billable visit in the 30-day period.

The Medicare contractor will cover an observation and evaluation (or reevaluation) visit made by a nurse (see §40.1.2.1 for a further discussion of skilled nursing observation and evaluation visits) or other appropriate personnel, ordered by the physician or allowed practitioner for the purpose of evaluating the patient's condition and continuing need for skilled services, as a skilled visit.

A supervisory visit made by a nurse or other appropriate personnel (as required by the conditions of participation) to evaluate the specific personal care needs of the patient or to review the manner in which the personal care needs of the patient are being met by the aide is an administrative function, not a skilled visit.

80 - Specific Exclusions From Coverage as Home Health Services

(Rev. 1, 10-01-03)
A3-3125, HHA-230.A

In addition to the general exclusions from coverage under health insurance listed in the Medicare Benefit Policy Manual, Chapter 16, "General Exclusions from Coverage," the following are also excluded from coverage as home health services:

80.1 - Drugs and Biologicals

(Rev. 1, 10-01-03)
A3-3125.A, HHA-230.A

Drugs and biologicals are excluded from payment under the Medicare home health benefit.

A drug is any chemical compound that may be used on or administered to humans or animals as an aid in the diagnosis, treatment, prevention of disease or other condition, for the relief of pain or suffering, or to control or improve any physiological pathologic condition.

A biological is any medicinal preparation made from living organisms and their products including, but not limited to, serums, vaccines, antigens, and antitoxins. The one drug exception is the osteoporosis drug, which is part of the home health benefit, and home health agencies may provide services such as vaccines outside the home health benefit.

80.2 - Transportation

(Rev. 1, 10-01-03)

A3-3125.B, HHA-230.B

The transportation of a patient, whether to receive covered care or for other purposes, is excluded from home health coverage. Costs of transportation of equipment, materials, supplies, or staff may be allowable as administrative costs, but no separate payment is made.

80.3 - Services That Would Not Be Covered as Inpatient Services

(Rev. 1, 10-01-03)

A3-3125C, HHA-230.C

Services that would not be covered if furnished as inpatient hospital services are excluded from home health coverage.

80.4 - Housekeeping Services

(Rev. 1, 10-01-03)

A3-3125D, HHA-230D

Services for which the sole purpose is to enable the patient to continue residing in their home (e.g., cooking, shopping, Meals on Wheels, cleaning, laundry) are excluded from home health coverage.

80.5 - Services Covered Under the End Stage Renal Disease (ESRD)

Program

(Rev. 208, Issued: 04-22-15, Effective: 01-01-15, Implementation: 05-11-15)

Renal dialysis services that are covered and paid for under the ESRD PPS, which include any item or service furnished to an ESRD beneficiary that is directly related to that individual's dialysis, are excluded from coverage under the Medicare home health benefit. However, to the extent that other requirements for coverage are met, an item or service that is not directly related to a patient's dialysis would be covered (e.g., a skilled nursing visit to furnish wound care for an abandoned shunt site). Within these restrictions, beneficiaries may simultaneously receive items and services under the ESRD PPS through their ESRD facility at home at the same time as receiving items and services under the home health benefit that are not related to ESRD.

80.6 - Prosthetic Devices

(Rev. 1, 10-01-03)

A3-3125F, HHA-230F

Prosthetic items are excluded from home health coverage. However, catheters, catheter supplies, ostomy bags, and supplies related to ostomy care are not considered prosthetic

devices if furnished under a home health plan of care and are not subject to this exclusion from coverage but are bundled while a patient is under a HH plan of care.

80.7 - Medical Social Services Furnished to Family Members

(Rev. 1, 10-01-03)

A3-3125G, HHA-230G

Except as provided in §50.3, medical social services furnished solely to members of the patient's family and that are not incidental to covered medical social services being furnished to the patient are not covered.

80.8 - Respiratory Care Services

(Rev. 265, Issued: 01-10-20, Effective: 01-01-20, Implementation: 02-11-20)

If a respiratory therapist is used to furnish overall training or consultative advice to HHA staff and incidentally furnishes respiratory therapy services to patients in their homes, the costs of the respiratory therapist's services are allowable only as administrative costs to the HHA. Visits by a respiratory therapist to a patient's home are not separately billable during a HH period of care when a HH plan of care is in effect. However, respiratory therapy services furnished as part of a plan of care other than a home health plan of care by a licensed nurse or physical therapist and that constitute skilled care may be covered and separately billed as skilled visits when the beneficiary is not in a home health period of care. Note that Medicare billing does not recognize respiratory therapy as a separate discipline, but rather sees the services in accordance with the revenue code used on the claims (i.e. 042x).

80.9 - Dietary and Nutrition Personnel

(Rev. 1, 10-01-03)

A3-3125.I, HHA-230.I

If dieticians or nutritionists are used to furnish overall training or consultative advice to HHA staff and incidentally furnish dietetic or nutritional services to patients in their homes, the costs of these professional services are allowable only as administrative costs. Visits by a dietician or nutritionist to a patient's home are not separately billable.

80.10 - Telecommunications Technology

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Telecommunications technology (other than audio-only telephone calls) can include: remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY) technology; and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician. Telecommunications technology can be ordered as part of a home health plan of care but such services cannot be reported as a visit without the provision of another skilled service. If telecommunications technologies

are used by the home health agency, the costs of any equipment, set-up, and service related to the technology are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the technology, without the provision of a skilled service, are not separately billable. However, HHAs may include the costs of telecommunications technology as an allowable administrative cost (that is, operating expense), if the technology is used by the HHA to augment the care planning process.

90 - Medical and Other Health Services Furnished by Home Health Agencies

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Payment may be made by Medicare contractors to a home health agency which furnishes either directly or under arrangements with others the following "medical and other health services" to beneficiaries with Part B coverage in accordance with Part B billing and payment rules other than when a home health plan of care is in effect.

1. Surgical dressings (for a patient who is not under a home health plan of care), and splints, casts, and other devices used for reduction of fractures and dislocations;
2. Prosthetic (Except for items excluded from the term "orthotics and prosthetics" in accordance with §1834(h)(4)(C) of the Act for patients who are under a home health plan of care);
3. Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes and adjustments to these items when ordered by a physician or allowed practitioner. (See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15);
4. Outpatient physical therapy, outpatient occupational therapy, and outpatient speech-language pathology services (for a patient not under a home health plan of care). (See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15); and
5. Rental and purchase of durable medical equipment. (See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15.) If a beneficiary meets all of the criteria for coverage of home health services and the HHA is providing home health care under the Hospital Insurance Program (Part A), any DME provided and billed to the Medicare contractor by the HHA to that patient must also be provided under Part A. Where the patient meets the criteria for coverage of home health services and the HHA is providing the home health care under the Supplementary Medical Insurance Program (Part B) because the patient is not eligible for Part A, the DME provided by the HHA may, at the beneficiary's option, be furnished under the Part B home health benefit or as a medical and other health service. Irrespective of how the DME is furnished, the beneficiary is responsible for a 20 percent coinsurance.
6. Ambulance service. (See Pub 100-02, Medicare Benefit Policy Manual, Chapter 10, Ambulance Services)

7. Hepatitis B Vaccine. Hepatitis B vaccine and its administration are covered under Part B for patients who are at high or intermediate risk of contracting hepatitis B. High risk groups currently identified include: end-stage renal disease (ESRD) patients, hemophiliacs who receive factor VIII or IX concentrates, clients of institutions for the mentally retarded, persons who live in the same household as a hepatitis B virus carrier, homosexual men, illicit injectable drug users. Intermediate risk groups currently identified include staff in institutions for the mentally retarded, workers in health care professions who have frequent contact with blood or blood-derived body fluids during routine work. Persons in the above listed groups would not be considered at high or intermediate risk of contracting hepatitis B, however, if there is laboratory evidence positive for antibodies to hepatitis B. ESRD patients are routinely tested for hepatitis B antibodies as part of their continuing monitoring and therapy. The vaccine may be administered, upon the order of a doctor of medicine or osteopathy, by home health agencies.
8. Hemophilia clotting factors. Blood clotting factors for hemophilia patients competent to use such factors to control bleeding without medical or other supervision and items related to the administration of such factors are covered under Part B.
9. Pneumococcal and influenza vaccines. See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §50.4.2 "Immunizations."
10. Splints, casts. See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."
11. Antigens. See Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services."

100 - Physician or Allowed Practitioner Certification for Medical and Other Health Services Furnished by Home Health Agency (HHA)
(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

A physician or allowed practitioner must certify that the medical and other health services covered by medical insurance, which were provided by (or under arrangements made by) the HHA, were medically required. This certification needs to be made only once where the patient may require over a period of time the furnishing of the same item or service related to one diagnosis. There is no requirement that the certification be entered on any specific form or handled in any specific way as long as the approach adopted by the HHA permits the Medicare contractor to determine that the certification requirement is, in fact, met. A written physician or allowed practitioner's order designating the services required would also be an acceptable certification.

110 - Use of Telehealth in Delivery of Home Health Services
(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Section 1895(e) governs the home health prospective payment system (PPS) and provides that telehealth services are outside the scope of the Medicare home health benefit and home health PPS.

This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As stated in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but there is no separate reimbursement for those technologies under the Medicare home health benefit. However, Medicare does recognize services furnished via telecommunications technology (see section 80.10) as an allowed administrative cost on Medicare cost reports if telecommunications technology is used by the HHA to augment the care planning process, and the technology is indicated on the plan of care.

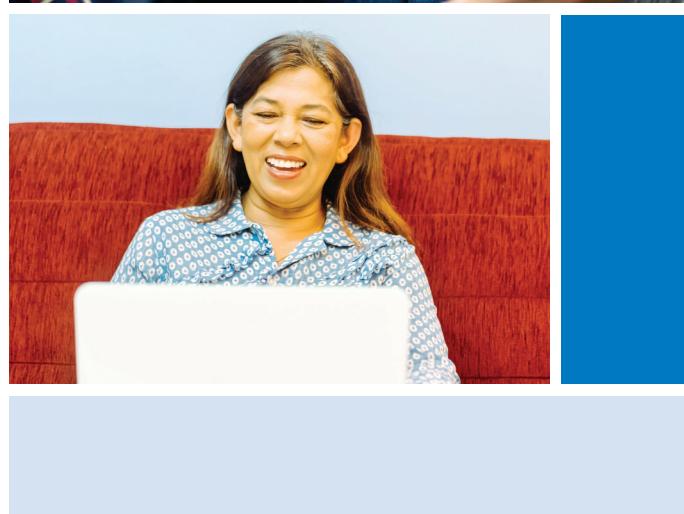
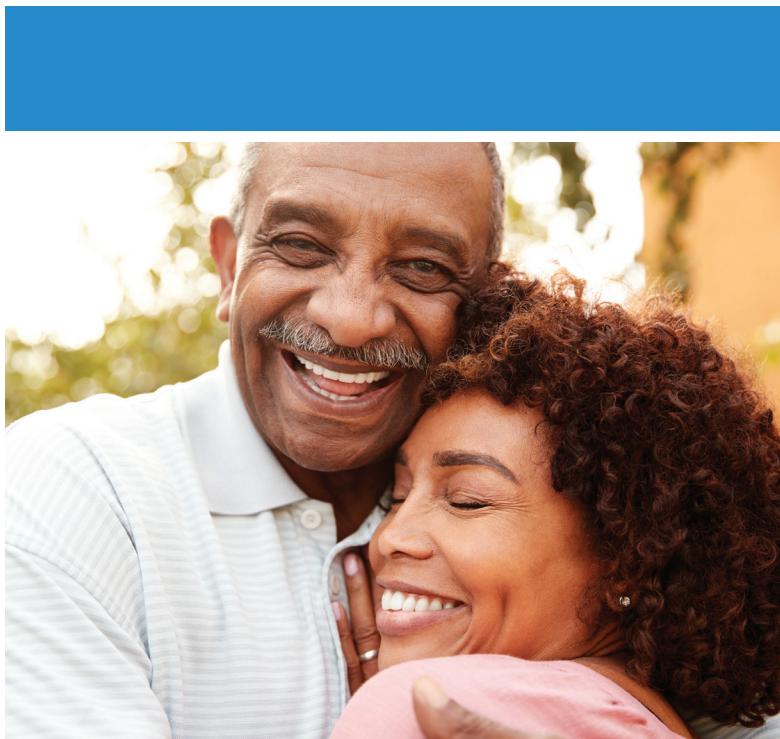
This provision does not waive the current statutory requirement for a physician or allowed practitioner certification of a home health plan of care under current §§1814(a)(2)(C) or 1835(a)(2)(A) of the Act.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R10738BP</u>	05/07/2021	Home Health Manual Update to Implement Calendar Year 2021 Request for Anticipated Payment Policies and Corrections to Certification and Recertification for Home Health Beneficiaries	08/09/2021	12218
<u>R10438BP</u>	11/06/2020	Home Health Manual Update to Incorporate Allowed Practitioners into Home Health Policy	01/11/2121	12023
<u>R265BP</u>	01/10/2020	Manual Updates Related to Calendar Year (CY) 2020 Home Health Payment Policy Changes, Maintenance Therapy, and Remote Patient Monitoring	02/11/2020	11577
<u>R258BP</u>	03/22/2019	Manual Updates Related to Home Health Certification and Recertification Policy Changes	04/22/2019	11104
<u>R233BP</u>	02/24/2017	Clarification of Payment Policy Changes for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device and the Outlier Payment Methodology for Home Health Services	03/27/2017	9898
<u>R208BP</u>	04/22/2015	Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services	05/11/2015	9119
<u>R207BP</u>	04/10/2015	Manual Updates to Clarify Requirements for Physician Certification and Recertification of Patient Eligibility for Home Health Services – Rescinded and replaced by Transmittal 208	05/11/2015	9119
<u>R179BP</u>	01/14/2014	Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius	01/07/2014	8458

<u>R176BP</u>	12/13/2013	Manual Updates to Clarify Skilled Nursing Facility (SNF), Inpatient Rehabilitation Facility (IRF), Home Health (HH), and Outpatient (OPT) Coverage Pursuant to Jimmo vs. Sebelius – Rescinded and replaced by Transmittal 179	01/07/2014	8458
<u>R172BP</u>	10/18/2013	Home Health - Clarification to Benefit Policy Manual Language on Confined to the Home Definition	11/19/2013	8444
<u>R144BP</u>	05/06/2011	Home Health Therapy Services	05/05/2011	7374
<u>R142BP</u>	04/15/2011	Home Health Therapy Services – Rescinded and replaced by Transmittal 144	05/05/2011	7374
<u>R139BP</u>	02/16/2011	Clarifications for Home Health Face-to Face Encounter Provisions	03/10/2011	7329
<u>R37BP</u>	08/12/2005	Conforming Changes for Change Request 3648 to Pub. 100-02	09/12/2005	3912
<u>R26BP</u>	11/05/2004	Inclusion of Forteo as a Covered Osteoporosis Drug and Clarification of Manual Instructions Regarding Osteoporosis Drugs	04/04/2004	3524
<u>R1BP</u>	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

[Back to top of Chapter](#)



Medicare & You

2022

The official U.S. government
Medicare handbook



What's new & important?



COVID-19-related tests, items, & services

Medicare covers several tests, items, and services related to coronavirus disease 2019 (COVID-19), like vaccines, diagnostic tests, antibody tests, and monoclonal antibody treatments. See page 37.

Cognitive assessment & care plan services

Medicare covers a cognitive assessment to help detect the earliest signs of cognitive impairment. Your doctor may perform this assessment during a routine visit. If you show signs of cognitive impairment, Medicare also covers a separate visit with your regular doctor or specialist to do a full review of your cognitive function, establish or confirm a diagnosis like dementia, including Alzheimer's disease, and develop a care plan. See page 34.

Blood-based biomarker test

Medicare covers this screening test for colorectal cancer, in certain cases, once every 3 years. See page 36.

Medicare.gov updates

We're making updates to [Medicare.gov](#) throughout the year to improve your online experience. We're focused on making it easier to find and use the information you need.

Help in accessible formats and additional languages

You can get the "Medicare & You" handbook in an accessible format at no cost to you. See page 107. To get free help in a language other than English, see pages 125-126.

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Can't find what you're looking for?

Check the "Index of topics" starting on page 10.

Symbol key

Look for these symbols throughout this book to help you understand your Medicare coverage options:



Compare: Shows comparisons between Original Medicare and Medicare Advantage Plans.



Cost & coverage: Gives information about costs and coverage for services.



Preventive service: Gives information about preventive services.

Important!

Important: Highlights information that's important to review.

New!

New: Highlights information that's new in this year's "Medicare & You."

What are the parts of Medicare?



Part A (Hospital Insurance)

Helps cover:

- Inpatient care in hospitals
- **Skilled nursing facility care**
- Hospice care
- Home health care

See pages 25-29.



Part B (Medical Insurance)

Helps cover:

- Services from doctors and other health care providers
- Outpatient care
- Home health care
- Durable medical equipment (like wheelchairs, walkers, hospital beds, and other equipment)
- Many **preventive services** (like screenings, shots or vaccines, and yearly “Wellness” visits)

See pages 29-54.



Part D (Drug coverage)

Helps cover the cost of prescription drugs (including many recommended shots or vaccines).

Plans that offer Medicare drug coverage (Part D) are run by private insurance companies that follow rules set by Medicare.

See pages 79-90.

MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A)

Coverage starts/Cobertura empieza
03-01-2016

MEDICAL (PART B)
03-01-2016

Replace your Medicare card

If you need to replace your Medicare card because it's damaged or lost, log into (or create) your secure Medicare account at [Medicare.gov](https://www.medicare.gov) to print or order an official copy of your Medicare card. You can also call 1-800-MEDICARE (1-800-633-4227) and ask for a replacement card to be sent in the mail. TTY users can call 1-877-486-2048.

Your Medicare options

When you first enroll in Medicare and during certain times of the year, you can choose how you get your Medicare coverage. There are 2 main ways to get Medicare:

Original Medicare

- Original Medicare includes Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- You can use any doctor or hospital that takes Medicare, anywhere in the U.S.
- To help pay your out-of-pocket costs in Original Medicare (like your 20% **coinsurance**), you can also shop for and buy supplemental coverage.

Part A



Part B



You can add:

Part D



You can also add:

Supplemental coverage



This includes Medicare Supplement Insurance (**Medigap**). See Section 5 (starting on page 75) to learn more about Medigap. Or, you can use coverage from a former employer or union, or **Medicaid**.

See Section 3 (starting on page 57) to learn more about Original Medicare.

Medicare Advantage

(also known as Part C)

- Medicare Advantage is a Medicare-approved plan from a private company that offers an alternative to Original Medicare for your health and drug coverage. These “bundled” plans include Part A, Part B, and usually Part D.
- In most cases, you’ll need to use doctors who are in the plan’s network.
- Plans may have lower out-of-pocket costs than Original Medicare.
- Plans may offer some extra benefits that Original Medicare doesn’t cover—like vision, hearing, and dental services.

Part A



Part B



Most plans include:

Part D



Some extra benefits

Some plans also include:

Lower out-of-pocket costs

See Section 4 (starting on page 61) to learn more about Medicare Advantage.

AT A GLANCE

Original Medicare vs. Medicare Advantage



Doctor & hospital choice

Original Medicare	Medicare Advantage (Part C)
You can go to any doctor or hospital that takes Medicare, anywhere in the U.S.	In many cases, you'll need to only use doctors and other providers who are in the plan's network (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
In most cases, you don't need a referral to see a specialist.	You may need to get a referral to see a specialist.



Cost

Original Medicare	Medicare Advantage (Part C)
For Part B-covered services, you usually pay 20% of the Medicare-approved amount after you meet your deductible . This is called your coinsurance .	Out-of-pocket costs vary —plans may have different out-of-pocket costs for certain services.
You pay a premium (monthly payment) for Part B . If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D).	You pay the monthly Part B premium and may also have to pay the plan's premium . Plans may have a \$0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's no yearly limit on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap).	Plans have a yearly limit on what you pay out of pocket for services Medicare Part A and Part B covers. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B covers for the rest of the year.
You can get Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid .	You can't buy and don't need Medigap.



Coverage

Original Medicare	Medicare Advantage (Part C)
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams. See page 55.	Plans must cover all of the medically necessary services that Original Medicare covers. Most plans offer some extra benefits that Original Medicare doesn't cover —like some routine exams and vision, hearing, and dental services.
You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).	Medicare drug coverage (Part D) is included in most plans. In most types of Medicare Advantage Plans , you can't join a separate Medicare drug plan.
In most cases, you don't have to get a service or supply approved ahead of time for Original Medicare to cover it.	In some cases, you have to get a service or supply approved ahead of time for the plan to cover it.



Foreign travel

Original Medicare	Medicare Advantage (Part C)
Original Medicare generally doesn't cover care outside the U.S. You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.	Plans generally don't cover care outside the U.S. Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.

This book explains these topics in more detail:

- **Original Medicare:** See Section 3 (starting on page 57).
- **Medicare Advantage:** See Section 4 (starting on page 61).
- **Medicare Supplement Insurance (Medigap):** See Section 5 (starting on page 75).
- **Medicare drug coverage (Part D):** See Section 6 (starting on page 79).

Get started with Medicare

If you're new to Medicare or already have experience with Medicare, it's important for you to:

- **Understand your Medicare coverage options.** There are 2 main ways to get your Medicare coverage—Original Medicare (Part A and Part B) and Medicare Advantage. See pages 5–7 to learn more.
- **Find out how and when you can enroll.** If you don't have Medicare Part A or Part B, see Section 1 (starting on page 15). If you don't have Medicare drug coverage (Part D), see Section 6 (starting on page 79). There may be penalties if you don't enroll when you're first eligible. If you have other health insurance, see pages 19–22 to find out how your other insurance works with Medicare.
- **Mark your calendar with these important dates!** This may be the only chance you have each year to change your coverage.

	October 1, 2021	Start comparing your current coverage with other options. You may be able to save money or get extra benefits. Visit Medicare.gov/plan-compare .
	October 15 to December 7, 2021	Change your Medicare health or drug coverage for 2022, if you decide to. You can join, switch or leave a Medicare Advantage Plan or a Medicare drug plan during this Open Enrollment Period each year.
	January 1, 2022	New coverage begins if you made a change. If you kept your existing coverage and your plan's costs or benefits changed, those changes also start on this date.
	January 1 to March 31, 2022	If you're in a Medicare Advantage Plan, you can change to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. Any changes you make will be effective the first of the month after the plan gets your request. See page 63.

Each year, it's important to review your Medicare health and drug coverage and make changes if it no longer meets your needs, or see if you could lower your out-of-pocket costs. You don't need to enroll in Medicare each year, but you should still review your options.

- ★ See pages 5–9 for an overview of your Medicare options.

Get the most out of Medicare

Get help choosing the coverage option that's right for you

- Get free, personalized counseling from your State Health Insurance Assistance Program (SHIP)—See pages 117–120 for the phone number. A trusted agent or broker may also be able to help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Find and compare health and drug plans at [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare).

Get the most value out of your health care

We want to make sure you have the information you need to make the best decisions about your health care. Look for  throughout this book to learn about costs and coverage for services.

Get free help with your Medicare questions

For general Medicare questions, visit [Medicare.gov](https://www.Medicare.gov) or call 1-800-MEDICARE. See pages 109–116 to learn about other resources.

Get preventive services

Medicare covers many **preventive services** at no cost to you. Ask your doctor or other health care provider which preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits) you need. See pages 30–54 and look for  to learn more about which preventive services Medicare covers.

Get help paying for health care

There are multiple programs available to help with costs. Many people with Medicare qualify. For information on these programs, see pages 91–96.

Get mental health & substance use disorder services

Medicare covers certain screenings, services, and programs that aid in the treatment and recovery of mental health and substance use disorders:

- **Alcohol misuse screening:**
See page 31.
- **Behavioral health integration services**
(to manage conditions like depression or anxiety): See page 32.
- **Counseling to prevent tobacco use & tobacco-caused disease:** See page 36.
- **Depression screening:** See page 38.
- **Mental health care:** See page 46.
- **Opioid use disorder treatment services:** See page 47.
- **Reviews with your provider, if you have a prescription for opioids:** See page 53.
- **Telehealth:** See page 50.
- **Medication (coverage rules):** See page 86.
- **Prescription safety checks:** See page 86.
- **Drug management programs:** See page 86.
- **Important tips if you're prescribed opioids:** See page 87.

Get the handbook online

Help save tax dollars by switching to the electronic version of this handbook. Log into (or create) your secure Medicare account online at [Medicare.gov](https://www.Medicare.gov) to switch to the electronic handbook. We'll email you a link to a PDF version instead of sending a paper copy in the mail each fall.

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SECTION 1

Signing up for Medicare

Will I get Part A and Part B automatically?

If you're already getting benefits from Social Security or the Railroad Retirement Board (RRB), you'll automatically get Part A and Part B starting the first day of the month you turn 65. (If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month.)

If you're under 65 and have a disability, you'll automatically get Part A and Part B after you get disability benefits from Social Security or certain disability benefits from the RRB for 24 months.

If you live in Puerto Rico, you don't automatically get Part B. You must sign up for it. See page 16.

If you have ALS (amyotrophic lateral sclerosis, also called Lou Gehrig's disease), you'll get Part A and Part B automatically the month your Social Security disability benefits begin.

If you're automatically enrolled, you'll get your red, white, and blue Medicare card in the mail 3 months before your 65th birthday or 25th month of disability benefits, and you don't need to pay a premium for Part A (sometimes called "premium-free Part A"). Most people choose to keep Part B. If you don't want Part B, let us know before the coverage start date on your Medicare card. If you do nothing, you'll keep Part B and will have to pay Part B premiums through your Social Security benefits. **If you choose not to keep Part B but decide you want it later, you may have to wait to enroll and pay a penalty for as long as you have Part B.**

See page 23.

If you need to get a replacement Medicare card because it's damaged or lost, log into (or create) your secure Medicare account at [Medicare.gov](https://www.medicare.gov) to print or order an official copy of your Medicare card. You can also use this account to manage your personal and other coverage information (like your drug list and claims status). See page 110 for more information about [Medicare.gov](https://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227) to get a replacement card. TTY users can call 1-877-486-2048. If you need to replace your card because you think that someone else is using your Medicare Number, call 1-800-MEDICARE.



Note: See pages 121-124 for definitions of blue words.

Will I have to enroll in Part A and/or Part B?

If you're close to 65, but NOT getting Social Security or Railroad Retirement Board (RRB) benefits, you'll need to enroll in Medicare. Visit socialsecurity.gov/benefits/medicare to apply for Part A and Part B. You can also contact Social Security 3 months before you turn 65 to set up an appointment. If you worked for a railroad, contact the RRB.

In most cases, if you don't sign up for Part B when you're first eligible, you may have a delay in getting Medicare Part B coverage in the future (in some cases over a year), and **you may have to pay a late enrollment penalty for as long as you have Part B**. See page 23.

If you have End-Stage Renal Disease (ESRD) and you want Medicare, you'll need to enroll. Contact Social Security to find out when and how to enroll in Part A and Part B. For more information, visit Medicare.gov/publications to view the booklet, "Medicare Coverage of Kidney Dialysis & Kidney Transplant Services."

Important! If you live in Puerto Rico and get benefits from Social Security or the RRB, you'll automatically get Part A the first day of the month you turn 65 or after you get disability benefits for 24 months. However, if you want Part B, you'll need to sign up for it by completing an "Application for Enrollment in Part B Form" (CMS-40B). Visit Medicare.gov/forms-help-resources/medicare-forms to get Form CMS-40B in English or Spanish. If you don't sign up for Part B when you're first eligible, **you may have to pay a late enrollment penalty for as long as you have Part B**. See page 23.

Where can I get more information?

Call Social Security at 1-800-772-1213 for more information about your Medicare eligibility and to enroll in Part A and/or Part B. TTY users can call 1-800-325-0778. If you worked for a railroad or get RRB benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

You can also get free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number.

Once you're enrolled in Medicare, it's time to look at your coverage options. People get coverage in different ways. To get the most out of your coverage, review all of your Medicare coverage options and find what best meets your needs. See pages 6-8 for more information.

If I didn't get enrolled in Part A and Part B automatically, when can I enroll?

If you didn't get automatically enrolled in **premium-free Part A** (for example, because you're still working and not yet getting Social Security or Railroad Retirement Board (RRB) benefits), you can sign up for premium-free Part A (if you're eligible) any time during or after your Initial Enrollment Period begins. See page 22 for more information.

If you're eligible for premium-free Part A, you can enroll in Part A any time after you're first eligible for Medicare. Your Part A coverage will go back (retroactively) 6 months from when you enroll, but no earlier than the first month you're eligible for Medicare. You can only sign up for Part B during the periods listed below.

Important! Remember, in most cases, if you don't enroll in Part A (if you have to buy it) and Part B when you're first eligible, your enrollment may be delayed and you may have to pay a late enrollment penalty. See pages 22–23.

What are the Part A and Part B enrollment periods?

You can only enroll in Part B (and/or Part A if you have to buy it) during these enrollment periods.

Initial Enrollment Period

You can first sign up for Part A and/or Part B during the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

If you enroll in Part A and/or Part B during the first 3 months of your Initial Enrollment Period, in most cases, your coverage begins the first day of your birthday month. However, if your birthday is on the first day of the month, your coverage will start the first day of the prior month.

If you enroll in and are paying for Part A and/or Part B the month you turn 65 or during the last 3 months of your Initial Enrollment Period, the start date for your Part B coverage will be delayed.

Special Enrollment Period

After your Initial Enrollment Period is over, you may have a chance to enroll in Medicare during a Special Enrollment Period. If you didn't sign up for Part B (or Part A if you have to buy it) when you were first eligible because you have group health plan coverage based on current employment (your own, a spouse's, or a family member's—if you have a disability), you can enroll in Part A and/or Part B:

- Anytime you're still covered by the group health plan
- During the 8-month period that begins the month after the employment ends or the coverage ends, whichever happens first

Usually, you don't pay a late enrollment penalty if you sign up during a Special Enrollment Period. This period doesn't apply if you're eligible for Medicare based on End-Stage Renal Disease (ESRD), or you're still in your Initial Enrollment Period.

Note: If you have a disability, and the group health plan coverage is based on a family member's current employment (other than a spouse), the employer offering the group health plan must have 100 or more employees for you to get a Special Enrollment Period.

Important! **COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, retiree health plans, VA coverage, and individual health insurance coverage (like coverage through the Health Insurance Marketplace®) aren't considered coverage based on current employment.** There may be reasons why you should take Part B instead of, or in addition to, COBRA coverage. You aren't eligible for a Special Enrollment Period to sign up for Medicare when that COBRA coverage ends. To avoid paying a higher **premium**, make sure you enroll in Medicare when you're first eligible. Your current coverage may not pay for health services you get if you don't have both Part A and Part B. See page 88 for more information about COBRA coverage.

General Enrollment Period

If you have to pay for Part A but don't sign up for it and/or don't sign up for Part B (for which you must pay premiums) during your Initial Enrollment Period, and you don't qualify for a Special Enrollment Period, you can sign up during the General Enrollment Period between January 1–March 31 each year. **Your coverage won't start until July 1 of that year, and you may have to pay a higher Part A and/or Part B premium for late enrollment.** See pages 22–23.

If you aren't sure if you qualify for a Special Enrollment Period, or to learn more about enrollment periods, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

I have other coverage. Should I get Part B?

This information can help you decide if you should get Part B based on the type of health coverage you may have.

Employer or union coverage

If you or your spouse (or family member if you have a disability) **are still working** and you have health coverage through that employer or union, contact the employer or union benefits administrator to find out how your coverage works with Medicare (see page 21). This includes federal or state employment and active-duty military service. It might be to your advantage to delay Part B enrollment while you still have health coverage based on your or your spouse's current employment.

Coverage based on current employment doesn't include:

- COBRA
- Retiree coverage
- VA coverage
- Individual health insurance coverage (like through the Health Insurance Marketplace®)

TRICARE

If you have TRICARE (health care program for active-duty and retired service members and their families), **you generally must enroll in Part A and Part B when you're first eligible to keep your TRICARE coverage.** However, if you're an active-duty service member or an active-duty family member, you don't have to enroll in Part B to keep your TRICARE coverage. For more information, contact TRICARE. See page 90.

If you have CHAMPVA coverage, you must enroll in Part A and Part B to keep it. Call 1-800-733-8387 for more information about CHAMPVA.

Medicaid

If you have **Medicaid** and don't have Part B, Medicaid may help you enroll. Medicare will pay first, and Medicaid will pay second. Medicaid may be able to help pay your Medicare out-of-pocket costs (like **premiums, deductibles, coinsurance, and copayments**).

Call your State Medical Assistance (Medicaid) office for more information and to see if you qualify. Visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone), or call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your state's Medicaid office. TTY users can call 1-877-486-2048.

Health Insurance Marketplace®

Even if you have Marketplace coverage, you should generally enroll in Medicare when you're first eligible to avoid the risk of a delay in Medicare coverage and the possibility of a Medicare late enrollment penalty.

Here are some important points to consider if you have Marketplace coverage:

- You need to end your Marketplace coverage in a timely manner to avoid an overlap in coverage.
- Once you're considered eligible for or enrolled in Part A, you won't qualify for help from the Marketplace to pay your Marketplace plan **premiums** or other medical costs. If you continue to get help paying for your Marketplace plan premiums after you have Medicare, you may have to pay back some or all of the help you got when you file your federal income taxes.

Visit HealthCare.gov to connect to the Marketplace in your state and learn more. To find out how to end your Marketplace plan or Marketplace savings when your Medicare coverage begins, visit HealthCare.gov/medicare/changing-from-marketplace-to-medicare. You can also call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

Health Savings Account (HSA)

You aren't eligible to make contributions to an HSA after you have Medicare. To avoid a tax penalty, you should make your last HSA contribution the month before your Part A coverage begins. Premium-free Part A coverage begins 6 months before the month you apply for Medicare, Social Security, or Railroad Retirement Board (RRB) benefits, but no earlier than the month you turn 65.

- If you apply for Medicare during your Initial Enrollment Period or during the 2 months after your Initial Enrollment Period ends, you should make your last HSA contribution the month before you turn 65.
- If you wait to enroll in Medicare less than 6 months after you turn 65, you can avoid a tax penalty by stopping HSA contributions the month before you turn 65.
- If you wait to enroll in Medicare 6 or more months after you turn 65, you can avoid a tax penalty by stopping HSA contributions 6 months before the month you apply for Medicare.

Note: A Medicare Medical Savings Account (MSA) plan is similar to an HSA plan. See page 67.

For information on the Part B late enrollment penalty, see page 23.

How does my other insurance work with Medicare?

When you have other insurance (like group health plan, retiree health, or **Medicaid** coverage) and Medicare, there are rules for whether Medicare or your other coverage pays first.

If you have retiree health coverage (like insurance from your or your spouse's former employment)...	Medicare pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has 20 or more employees ...	Your group health plan pays first.
If you're 65 or older, have group health plan coverage based on your or your spouse's current employment, and the employer has fewer than 20 employees ...	Medicare pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has 100 or more employees ...	Your group health plan pays first.
If you're under 65 and have a disability, have group health plan coverage based on your or a family member's current employment, and the employer has fewer than 100 employees ...	Medicare pays first.
If you have group health plan coverage based on your or a family member's employment or former employment, and you're eligible for Medicare because of End-Stage Renal Disease (ESRD)...	Your group health plan pays first for the first 30 months after you become eligible to enroll in Medicare. Medicare pays first after this 30-month period.
If you have Medicaid...	Medicare pays first.

Important!

If you're still working and have employer coverage through work, contact your employer to find out how your employer's coverage works with Medicare.

Here are some important facts to remember about how other insurance works with Medicare-covered services:

- The insurance that pays first (primary payer) pays up to the limits of its coverage.
- The insurance that pays second (secondary payer) only pays if there are costs the primary payer didn't cover.
- The secondary payer (which may be Medicare) might not pay all of the uncovered costs.
- If your group health plan or retiree health coverage is the secondary payer, you might need to enroll in Part B before your insurance will pay.

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, “Medicare and Other Health Benefits: Your Guide to Who Pays First.” You can also call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

Important! If you have other insurance or changes to your insurance, you need to let Medicare know by calling Medicare’s Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627.

If you have Part A, you may get a “Health Coverage” form (IRS Form 1095-B) from Medicare. This form verifies that you had health coverage in the past year. Keep the form for your records. Not everyone will get this form. If you don’t get Form 1095-B, don’t worry, you don’t need to have it to file your taxes.

How much does Part A coverage cost?

You usually don’t pay a monthly **premium** for Part A coverage if you or your spouse paid Medicare taxes while working for a certain amount of time. This is sometimes called premium-free Part A. If you aren’t eligible for premium-free Part A, you may be able to buy Part A. For more information on how to pay your Part A premium, see page 24.

If you buy Part A, you’ll pay a premium of either \$274 or up to \$499 each month in 2022 depending on how long you or your spouse worked and paid Medicare taxes. If you think you need help paying your Part A premium, see pages 94–96.

In most cases, if you choose to **buy** Part A, you must also have Part B and pay monthly premiums for both. If you choose NOT to buy Part A, you can still buy Part B if you’re eligible.

What’s the Part A late enrollment penalty?

If you aren’t eligible for premium-free Part A, and you don’t buy it when you’re first eligible, your monthly premium may go up 10%. You’ll have to pay the higher premium for twice the number of years you could have had Part A but didn’t enroll.

Example: If you were eligible for Part A for 2 years but didn’t enroll, you’ll have to pay a 10% higher premium for 4 years.

How much does Part B coverage cost?

The standard Part B **premium** amount in 2022 is \$170.10. Most people pay the standard Part B premium amount.

If your modified adjusted gross income is above a certain amount, you may pay an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge added to your premium.

To determine if you'll pay the IRMAA, Medicare uses the modified adjusted gross income reported on your IRS tax return from 2 years ago.

Note: You may also pay an extra amount for your Medicare drug coverage (Part D) premium if your modified adjusted gross income is above a certain amount. See page 82.

If you have to pay an extra amount and you disagree (for example, your income is lower due to a life event), visit [socialsecurity.gov](https://www.socialsecurity.gov) or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

What's the Part B late enrollment penalty?

Important!

If you don't sign up for Part B when you're first eligible, you may have to pay a late enrollment penalty for as long as you have Part B. Your monthly Part B premium may go up 10% for each full 12 months in the period that you could've had Part B, but didn't enroll. If you're allowed to sign up for Part B during a Special Enrollment Period, you usually don't pay a late enrollment penalty. See pages 17-18.

Example: Mr. Smith's Initial Enrollment Period ended December 2019. He waited to enroll in Part B until March 2022 during the General Enrollment Period. His coverage begins July 1, 2022. His Part B premium penalty is 20%, and he'll have to pay this penalty for as long as he has Part B. (Even though Mr. Smith wasn't covered a total of 27 months, this included only 2 full 12-month periods.)



Cost & coverage: To learn how to get help with Medicare costs, see Section 7 (starting on page 91).

How can I pay my Part B premium?

If you get Social Security or Railroad Retirement Board (RRB) benefits, your Part B premium will be deducted from your benefit payment.

If you're a federal retiree with an annuity from the Office of Personnel Management and not entitled to Social Security or RRB benefits, you may request to have your Part B premiums deducted from your annuity. Call 1-800-MEDICARE (1-800-633-4227) to make your request. TTY users can call 1-877-486-2048.

If you don't get these benefit payments, you'll get a bill. If you choose to buy Part A, you'll always get a monthly bill for your **premium**. There are 4 ways to pay your premium bill:

- 1. Pay online by credit card, debit card, savings or checking account.** To do this, log into (or create) your secure Medicare account at [Medicare.gov](https://www.medicare.gov). Paying online is a more secure and faster way to make your payment without sending your personal information in the mail. You'll get a confirmation number when you make your payment.
- 2. Pay directly from your savings or checking account through your bank's online bill payment services.** Ask your bank if it allows customers to pay bills online—not all banks offer this service and some may charge a fee. Your bank will need this information:
 - **Your Medicare Number:** It's important that you use the exact number on your red, white, and blue Medicare card, but without the dashes.
 - **Payee name:** CMS Medicare Insurance
 - **Payee address:**
Medicare Premium Collection Center
PO Box 790355
St. Louis, MO 63179-0355
- 3. Sign up for Medicare Easy Pay.** This is a free service that automatically deducts your premium payments from your savings or checking account each month. Visit [Medicare.gov](https://www.medicare.gov) and search for "Easy Pay," or call 1-800-MEDICARE (1-800-633-4227) to find out how to sign up. TTY users can call 1-877-486-2048.
- 4. Mail your payment to Medicare.** You can pay by check, money order, credit card, or debit card. Write your Medicare Number on your payment, and fill out your payment coupon. Mail your payment and coupon to:
Medicare Premium Collection Center
PO Box 790355
St. Louis, MO 63179-0355

Note to RRB Annuitants: If you get a bill from the RRB, mail your premium payments to:

RRB Medicare Premium Payments
PO Box 979024
St. Louis, MO 63197-9000

If you have questions about your premiums, call 1-800-MEDICARE. If you need to change your address on your bill, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

If your bills are from the RRB, call 1-877-772-5772. TTY users can call 1-312-751-4701.

For more information about paying your Medicare premiums, visit [Medicare.gov](https://www.medicare.gov).

Important! Need help paying for your Part B premium? See pages 94–95.

SECTION 2

Find out if Medicare covers your test, item, or service

What services does Medicare cover?

Medicare Part A and Part B cover certain medical services and supplies in hospitals, doctors' offices, and other health care facilities. Medicare Part D covers prescription drugs.

Your red, white, and blue Medicare card shows whether you have Part A (listed as HOSPITAL), Part B (listed as MEDICAL), or both, and the date your coverage begins. If you have Original Medicare, you'll use it to get your Medicare-covered services. If you join a **Medicare Advantage Plan** or other **Medicare health plan**, in most cases, you'll use your plan's card to get your Medicare-covered services.

You can get all of the Medicare-covered services in this section if you have both Part A and Part B.

Note: If you're not lawfully present in the U.S., Medicare won't pay for your Part A and Part B claims, and you can't join a Medicare Advantage Plan or a Medicare drug plan.

What does Part A cover?

Part A (Hospital Insurance) helps cover:

- Inpatient care in a hospital
- Inpatient care in a **skilled nursing facility (not custodial or long-term care)**
- Hospice care
- Home health care
- Inpatient care in a religious non-medical health care institution

See pages 26–29 for a list of common services Part A covers and general descriptions.

For more information on Part A-covered services, visit [Medicare.gov/coverage](https://www.medicare.gov/coverage).



Cost & coverage: Find out what's covered using your mobile device

To get Medicare coverage information, download Medicare's free "What's covered" mobile app on your smart phone or tablet. Available in the App Store and Google Play.

★ **Note:** See pages 121–124 for definitions of **blue** words.

What do I pay for services Part A covers?

Copayments, coinsurance, or deductibles may apply for each service listed on the following pages.

If you're in a **Medicare Advantage Plan** or have other insurance (like **Medigap**, **Medicaid**, or employer or union coverage), your copayments, coinsurance, or deductibles may be different. Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) or contact the plans you're interested in to find out about costs. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Part A-covered services

Blood

If the hospital gets blood from a blood bank at no charge, you won't have to pay for it or replace it. If the hospital has to buy blood for you, you must either pay the hospital costs for the first 3 units of blood you get in a calendar year, or you or someone else can donate the blood.

Home health services

Part A and/or Part B covers home health benefits. See page 43.

Hospice care

To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of 6 months or less. When you agree to hospice care, you're agreeing to comfort care (palliative care) instead of care to cure your terminal illness. You also must sign a statement choosing hospice care instead of other Medicare-covered treatments for your terminal illness and related conditions. Coverage includes:

- All items and services needed for pain relief and symptom management
- Medical, nursing, and social services
- Drugs for pain management
- Durable medical equipment for pain relief and symptom management
- Aide and homemaker services
- Other covered services you need to manage your pain and other symptoms, as well as spiritual and grief counseling for you and your family.

Medicare-certified hospice care is usually given in your home or other facility where you live, like a nursing home. Original Medicare will still pay for covered benefits for any health problems that aren't part of your terminal illness and related conditions, but hospice should cover most of your care.

Medicare won't pay room and board for your care in a facility unless the hospice medical team decides you need short-term inpatient care to manage pain and other symptoms. This care must be in a Medicare-approved facility, like a hospice facility, hospital, or **skilled nursing facility** that contracts with the hospice.

Medicare also covers inpatient respite care, which is care you get in a Medicare-approved facility so that your usual caregiver (family member or friend) can rest. You can stay up to 5 days each time you get respite care.

After 6 months, you can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies (at a face-to-face meeting) that you're still terminally ill.

You pay:

- Nothing for hospice care.
- A **copayment** of up to \$5 per prescription for outpatient drugs for pain and symptom management.
- Five percent of the **Medicare-approved amount** for inpatient respite care.

Original Medicare will be billed for your hospice care, even if you're in a **Medicare Advantage Plan**. When you get hospice care, your Medicare Advantage Plan can still cover services that aren't a part of your terminal illness or any conditions related to your terminal illness. Contact your plan for more information.

Inpatient hospital care

Medicare covers semi-private rooms, meals, general nursing, drugs (including methadone to treat an opioid use disorder), and other hospital services and supplies as part of your inpatient treatment. This includes care you get in acute care hospitals, **critical access hospitals**, **inpatient rehabilitation facilities**, **long-term care hospitals**, psychiatric care in inpatient psychiatric facilities, and inpatient care for a qualifying clinical research study. This doesn't include private-duty nursing, a television or phone in your room (if there's a separate charge for these items), personal care items (razors or slipper socks), or a private room, unless **medically necessary**.

If you also have Part B, it generally covers 80% of the Medicare-approved amount for doctors' services you get while you're in a hospital.

You pay:

- A **deductible** and no **coinsurance** for days 1–60 of each **benefit period**.
- A coinsurance amount per day for days 61–90 of each benefit period.
- A coinsurance amount per “**lifetime reserve day**” after day 90 of each benefit period (up to 60 days over your lifetime).
- All costs for each day after you use all the lifetime reserve days.

You can only get inpatient psychiatric care in a freestanding psychiatric hospital 190 days in a lifetime.

Note: Hospitals are now required to make public the standard charges for all of their items and services (including charges negotiated by Medicare Advantage Plans) to help you make more informed decisions about your care.

Am I an inpatient or outpatient?

Whether you're an inpatient or an outpatient affects how much you pay for hospital services and if you qualify for Part A skilled nursing facility coverage.

- You're an inpatient when the hospital formally admits you with a doctor's order.
- You're an outpatient if you're getting emergency or observation services (which may include an overnight stay in the hospital or services in an outpatient clinic), lab tests, or X-rays, without a formal inpatient admission (even if you spend the night in the hospital).

Each day you have to stay, you or your caregiver should always ask the hospital and/or your doctor, or a hospital social worker or patient advocate, if you're an inpatient or outpatient.

Sometimes doctors will keep you as an outpatient for observation services while they decide whether to admit you as an inpatient or release (discharge) you. If you're under observation more than 24 hours, you must get a "Medicare Outpatient Observation Notice" (also called "MOON"). This notice tells you why you're an outpatient (in a hospital or **critical access hospital**) getting observation services, and how it affects what you pay in the hospital and for care after you leave.

Religious non-medical health care institution (inpatient care)

If you qualify for inpatient hospital or **skilled nursing facility care** in these facilities, Medicare will only cover inpatient, non-religious, non-medical items and services like room and board, and items or services that don't need a doctor's order or prescription (like unmedicated wound dressings or use of a simple walker). Medicare doesn't cover the religious portion of this type of care.

Skilled nursing facility care

Medicare covers semi-private rooms, meals, skilled nursing and therapy services, and other **medically necessary** services and supplies in a skilled nursing facility. Medicare only covers these services after a 3-day minimum (not including the day you leave the hospital), medically necessary, inpatient hospital stay for a related illness or injury. If you're in a **Medicare Advantage Plan**, you may not need a 3-day hospital stay. Check with your plan. (**Note:** You may not need a 3-day minimum inpatient hospital stay if your doctor participates in an **Accountable Care Organization** or an entity participating in another type of Medicare initiative approved for a Skilled Nursing Facility 3-Day Rule Waiver. See page 114.)

You may get skilled nursing or therapy care if it's necessary to improve or maintain your current condition. You can appeal if you disagree with your discharge, like if the discharge is based solely on a lack of improvement, even though you still require skilled nursing or therapy care to keep your condition from getting worse. See page 100 for more information about your rights to appeal.

To qualify for skilled nursing facility care, your doctor must certify that you need daily skilled care (like intravenous fluids/medications or physical therapy) which, as a practical matter, you can only get as a skilled nursing facility inpatient. Medicare doesn't cover long-term care. See page 55.

You pay:

- Nothing for the first 20 days of each **benefit period**. (**Note:** If you're in a **Medicare Advantage Plan**, you may be charged **copayments** during the first 20 days.)
- A **coinsurance** amount per day for days 21–100 of each benefit period.
- All costs for each day after day 100 in a benefit period.

What does Part B cover?

Medicare Part B (Medical Insurance) helps cover **medically necessary** doctor's services, outpatient care, home health services, durable medical equipment, mental health services, and other medical services. Part B also covers many **preventive services**. See pages 30–54 for a list of common Part B-covered services and general descriptions. Medicare may cover some services and tests more often than the timeframes listed if needed to diagnose or treat a condition. To find out if Medicare covers a service not on this list, visit [Medicare.gov/coverage](https://www.medicare.gov/coverage) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. For more information on Part B-covered services, visit [Medicare.gov/coverage](https://www.medicare.gov/coverage).

What do I pay for services Part B covers?

The list of covered services (in alphabetical order on the following pages) gives general information about what you pay if you have Original Medicare and see doctors or other health care providers who accept **assignment** (see page 59). You'll pay more if you see doctors or providers who don't accept assignment. **If you're in a Medicare Advantage Plan or have other insurance (like Medigap, Medicaid, or employer or union coverage), your copayments, coinsurance, or deductibles may be different.** Contact your plan for more information.

Under Original Medicare, if the Part B deductible (\$233 in 2022) applies, you must pay all costs (up to the **Medicare-approved amount**) until you meet the yearly Part B deductible. After you meet your deductible, Medicare begins to pay its share and you typically pay 20% of the Medicare-approved amount of the service (if the doctor or other health care provider accepts assignment). **There's no yearly limit on what you pay out-of-pocket.** There may be limits on expenses you pay through supplemental coverage you may have, like Medigap, Medicaid, or employer or union coverage.

You pay nothing for most covered preventive services if you get the services from a doctor or other qualified health care provider who accepts assignment. However, for some preventive services, you may have to pay a deductible, coinsurance, or both. These costs may also apply if you get a preventive service in the same visit as a non-preventive service.

Part B-covered services



Preventive service

Abdominal aortic aneurysm screenings

Medicare covers an abdominal aortic aneurysm screening ultrasound once if you're at risk (only with a **referral** from your doctor or other qualified health care provider). You pay nothing for the screening if your doctor or other qualified health care practitioner accepts **assignment**.

Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65–75 and have smoked at least 100 cigarettes in your lifetime, you're considered at risk.

Acupuncture

Medicare covers up to 12 acupuncture visits in 90 days for chronic low back pain defined as:

- Lasting 12 weeks or longer
- Having no known cause (not related to cancer that has spread, or inflammatory or infectious disease)
- Pain not associated with surgery or pregnancy

Medicare covers an additional 8 sessions if you show improvement. If your doctor decides your chronic low back pain isn't improving or is getting worse, then Medicare won't cover your additional treatments. No more than 20 acupuncture treatments can be given in a 12-month period.

Note: Medicare doesn't cover acupuncture (including dry needling) for any condition other than chronic low back pain.

Advance care planning

Medicare covers voluntary advance care planning as part of your yearly "Wellness" visit (see page 54). This is planning for care you would get if you become unable to speak for yourself. You can talk about an advance directive with your health care provider, and they can help you fill out the forms, if you prefer. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you aren't able to make decisions about your care.

Consider carefully who you want to speak for you and what directions you want to give. You shouldn't feel forced to go against your values and preferences, and you have the right to carry out your plans without discrimination based on your age or disability. You can update your advance directive at any time. You pay nothing if it's provided as part of the yearly "Wellness" visit and your doctor or other qualified health care provider accepts assignment.

Note: Medicare may also cover this service as part of your medical treatment. When advance care planning isn't part of your yearly "Wellness" visit, the Part B **deductible** and **coinsurance** apply.

Need help with your advance directive? Visit the Eldercare Locator at eldercare.acl.gov to find help in your community.



Preventive service

Alcohol misuse screenings & counseling

Medicare covers an alcohol misuse screening if you're an adult (including if you're a pregnant woman) who uses alcohol, but you don't meet the medical criteria for alcohol dependency. If your **primary care doctor** or other primary care practitioner determines you're misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling). You must get counseling in a primary care setting, like a doctor's office. You pay nothing if your qualified primary care doctor or other primary care practitioner accepts **assignment**.

Ambulance services

Medicare covers ground ambulance transportation when you need to be transported to a hospital, **critical access hospital**, or **skilled nursing facility** for **medically necessary** services, and transportation in any other vehicle could endanger your health. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide.

In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary. For example, someone with End-Stage Renal Disease (ESRD) may need a medically necessary ambulance transport to a facility that furnishes renal dialysis.

Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need.

You pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies.

Ambulatory surgical centers

Medicare covers the facility service fees related to approved surgical procedures provided in an ambulatory surgical center (facility where surgical procedures are performed, and the patient is expected to be released within 24 hours). Except for certain **preventive services** (for which you pay nothing if your doctor or other health care provider accepts assignment), you pay 20% of the Medicare-approved amount to both the ambulatory surgical center and the doctor who treats you. The Part B deductible applies. You pay all of the facility service fees for procedures Medicare doesn't cover in ambulatory surgical centers.



Cost & coverage: Visit [Medicare.gov/procedure-price-lookup](https://www.medicare.gov/procedure-price-lookup) to get cost estimates for ambulatory surgical center outpatient procedures.



Bariatric surgery

Medicare covers some bariatric surgical procedures, like gastric bypass surgery and laparoscopic banding surgery, when you meet certain conditions related to morbid obesity.

Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another mental health condition), Medicare may pay your provider to help manage that condition if they offer the Psychiatric Collaborative Care Model. This model is a set of integrated behavioral health services, including care management support that may include:

- Care plan for behavioral health conditions
- Ongoing assessment of your condition
- Medication support
- Counseling
- Other treatment your provider recommends

Your health care provider will ask you to sign an agreement for you to get this set of services on a monthly basis. You pay a monthly fee. The Part B **deductible** and **coinsurance** apply.

Blood

If the provider gets blood from a blood bank at no charge, you won't have to pay for it or replace it. However, you'll pay a **copayment** for the blood processing and handling services for each unit of blood you get. The Part B deductible applies. If the provider has to buy blood for you, you must either pay the provider costs for the first 3 units of blood you get in a calendar year, or you or someone else can donate the blood.



Preventive service

Bone mass measurements

This test helps to see if you're at risk for broken bones. Medicare covers it once every 24 months (more often if **medically necessary**) for people who have certain medical conditions or meet certain criteria. You pay nothing for this test if your doctor or other qualified health care provider accepts **assignment**.

Cardiac rehabilitation

Medicare covers comprehensive programs that include exercise, education, and counseling if you've had at least one of these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant
- Stable chronic heart failure

Medicare also covers intensive cardiac rehabilitation programs that are usually more rigorous or more intense than regular cardiac rehabilitation programs. Medicare covers services in a doctor's office or hospital outpatient setting. You pay 20% of the **Medicare-approved amount** if you get the services in a doctor's office, and a copayment in a hospital outpatient setting. The Part B deductible applies.



Preventive service

Cardiovascular behavioral therapy

Medicare covers a cardiovascular behavioral therapy visit one time each year with your **primary care doctor** or other qualified primary care practitioner in a primary care setting (like a doctor's office) to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips on eating well. You pay nothing if your primary care practitioner accepts **assignment**.



Preventive service

Cardiovascular disease screenings

These screenings include blood tests for cholesterol, lipid, and triglyceride levels that help detect conditions that may lead to a heart attack or stroke. Medicare covers these screening blood tests once every 5 years. You pay nothing for the tests if the doctor or other qualified health care provider accepts assignment.



Preventive service

Cervical & vaginal cancer screenings

Medicare covers Pap tests and pelvic exams to check for cervical and vaginal cancers. As part of the pelvic exam, Medicare also covers a clinical breast exam to check for breast cancer. Medicare covers these screening tests once every 24 months. Medicare covers these screening tests once every 12 months if you're at high risk for cervical or vaginal cancer, or if you're of child-bearing age and had an abnormal Pap test in the past 36 months.

Medicare also covers Human Papillomavirus (HPV) tests (as part of a Pap test) once every 5 years if you're 30–65 without HPV symptoms.

You pay nothing for the lab Pap test, the lab HPV with Pap test, the Pap test specimen collection, and pelvic and breast exams if your doctor or other qualified health care provider accepts assignment.

Chemotherapy

Medicare covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting if you have cancer. You pay a **copayment** for chemotherapy in a hospital outpatient setting.

You pay 20% of the **Medicare-approved amount** for chemotherapy in a doctor's office or freestanding clinic. The Part B **deductible** applies.

For chemotherapy in an inpatient hospital setting covered under Part A, see Inpatient hospital care on pages 27–28.

Chiropractic services

Medicare covers manipulation of the spine by a chiropractor or other qualified provider if **medically necessary** to correct a subluxation (when one or more of the bones of your spine move out of position). You pay 20% of the Medicare-approved amount. The Part B **deductible** applies.

Note: Medicare doesn't cover other services or tests a chiropractor orders, including X-rays, massage therapy, and acupuncture (except for low back pain). If you think your chiropractor is billing for services that Medicare doesn't cover, call 1-800-MEDICARE (1-800-633-4227) to report the suspected Medicare fraud. TTY users can call 1-877-486-2048.

Chronic care management services

If you have 2 or more serious chronic conditions (like arthritis and diabetes) that you expect to last at least a year, Medicare may pay for a health care provider's help to manage those conditions. This includes a comprehensive care plan that lists your health problems and goals, other providers, medications, community services you have and need, and other health information. It also explains the care you need and how it will be coordinated.

If you agree to get this service, your provider will prepare the care plan, help you with medication management, provide 24/7 access for urgent care management needs, give you support when you go from one health care setting to another, review your medicines and how you take them, and help you with other chronic care needs. You pay a monthly fee, and the Part B deductible and **coinsurance** apply.

Clinical research studies

Clinical research studies test how well different types of medical care work and if they're safe, like how well a cancer drug works. Medicare covers some costs, like office visits and tests in certain qualifying clinical research studies. You may pay 20% of the Medicare-approved amount, depending on the treatment you get. The Part B deductible may apply. Visit [Medicare.gov/coverage/clinical-research-studies](https://www.medicare.gov/coverage/clinical-research-studies) for more information.

Note: If you're in a **Medicare Advantage Plan**, Original Medicare may cover some costs along with your Medicare Advantage Plan.



Cognitive assessment & care plan services

When you see your provider for a visit (including your yearly "Wellness" visit), they may perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, or making decisions about your everyday life. Conditions like depression, anxiety, and delirium can also cause confusion, so it's important to understand why you may be having symptoms.

Medicare covers a separate visit with your regular doctor or a specialist to do a full review of your cognitive function, establish or confirm a diagnosis like dementia, including Alzheimer's disease, and develop a care plan. You can bring someone with you, like a spouse, friend, or caregiver, to help provide information and answer questions.

During this visit, your doctor may:

- Perform an exam, talk with you about your medical history, and review your medications.
- Create a care plan to help address and manage your symptoms.
- Help you develop or update your advance care plan. See page 30.
- Refer you to a specialist, if needed.
- Help you understand more about community resources, like rehabilitation services, adult day health programs, and support groups.

The Part B **deductible** and **coinsurance** apply.



Preventive service

Colorectal cancer screenings

Medicare covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. Medicare may cover one or more of these screening tests:

- **Barium enema:** Medicare covers this test once every 48 months if you're 50 or older (or every 24 months if you're high risk) when your doctor uses it instead of a flexible sigmoidoscopy or colonoscopy. You pay 20% of the Medicare-approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a **copayment**. The Part B deductible doesn't apply.

Visit Medicare.gov/coverage/barium-enemas for more information.

- **Colonoscopies:** Medicare covers this test once every 120 months (or every 24 months if you're high risk) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age requirement. You pay nothing for the test if your doctor or other qualified health care provider accepts **assignment**.

Note: If your doctor finds and removes a polyp or other tissue during the colonoscopy, you may pay 20% of the **Medicare-approved amount** for your doctors' services and a copayment in a hospital outpatient setting. The Part B deductible doesn't apply.

- **Fecal occult blood tests:** Medicare covers this test once every 12 months if you're 50 or older. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.
- **Flexible sigmoidoscopies:** Medicare covers this test once every 48 months if you're 50 or older, or 120 months after a previous screening colonoscopy if you aren't at high risk. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

- **Multi-target stool DNA tests:** Medicare covers this at-home lab test generally once every 3 years if you meet all of these conditions:
 - You're between 50–85.
 - You show no symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.
 - You're at average risk for developing colorectal cancer, meaning:
 - You have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
 - You have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.

You pay nothing for the test if your doctor or other qualified health care provider accepts **assignment**.

- New!**
- **Blood-based biomarker test:** Medicare covers this lab test in certain cases (if available), once every 3 years. To be eligible you must meet all of these conditions:
 - You're between 50–85.
 - You show no symptoms of colorectal disease.
 - You're at average risk for developing colorectal cancer.
- You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.

Continuous Positive Airway Pressure (CPAP) devices, accessories, & therapy

Medicare may cover a 3-month trial of CPAP therapy if you've been diagnosed with obstructive sleep apnea. Medicare may cover it longer if you meet with your doctor in person and your doctor documents in your medical record that you meet certain conditions and the therapy is helping you.

You pay 20% of the **Medicare-approved amount** for the machine rental and purchase of related supplies (like masks and tubing). The Part B **deductible** applies. Medicare pays the supplier to rent the machine for 13 months if you've been using it without interruption. After you've rented the machine for 13 months, you own it.

Note: Medicare may cover rental or a replacement CPAP machine and/or CPAP accessories if you had a CPAP machine before you got Medicare, and you meet certain requirements.



Preventive service

Counseling to prevent tobacco use & tobacco-caused disease

Medicare covers up to 8 face-to-face visits in a 12-month period if you use tobacco. You pay nothing for the counseling sessions if your doctor or other qualified health care provider accepts assignment.

 New!

Medicare & COVID-19

Your health and safety are our highest priority in the face of the coronavirus disease 2019 (COVID-19) public health emergency. Many people with Medicare are at higher risk for serious COVID-19 illness, so it's important to take the necessary steps to keep yourself and others safe.

Medicare covers several tests, items, and services related to COVID-19. Talk with your doctor or health care provider to see which of these are right for you:

- **Vaccines:**

- FDA-approved and FDA-authorized vaccines help reduce the risk of illness from COVID-19 by working with the body's natural defenses to safely develop protection (immunity) to the virus.
- You pay nothing for the vaccine, booster shot, or additional dose (if you're immunocompromised).
- Be sure to bring your red, white, and blue Medicare card with you when you get the vaccine so your health care provider or pharmacy can bill Medicare. You'll need your Medicare card even if you're enrolled in a Medicare Advantage Plan or other Medicare health plan.

- **Diagnostic tests:**

- These FDA-authorized tests check to see if you have COVID-19.
- You pay nothing for this test during the COVID-19 public health emergency when you get it from a laboratory, pharmacy, doctor, or hospital, and when Medicare covers this test in your local area.

- **Antibody tests:**

- These FDA-authorized tests help see if you've developed an immune response and may not be at immediate risk of COVID-19 reinfection.
- You pay nothing for the test during the COVID-19 public health emergency.

- **Monoclonal antibody treatments:**

- These FDA-authorized treatments can help fight the disease and keep you out of the hospital, if you test positive for COVID-19 and have mild to moderate symptoms.
- You pay nothing for this treatment during the COVID-19 public health emergency when you get the treatment from a Medicare provider or supplier. You must meet certain conditions to qualify.

Note: Coverage could change when the public health emergency ends.

Get more information

- For more information on these Medicare-covered services and to learn how Medicare is handling the COVID-19 emergency, visit [Medicare.gov/medicare-coronavirus](https://www.medicare.gov/medicare-coronavirus).
- For more information on COVID-19, visit [CDC.gov/coronavirus](https://www.cdc.gov/coronavirus).

Defibrillators

Medicare may cover an implantable automatic defibrillator if you've been diagnosed with heart failure. If the surgery takes place in an outpatient setting, you pay 20% of the Medicare-approved amount for your doctors' services. You also pay a **copayment**. In most cases, the copayment can't be more than the Part A hospital stay **deductible**. The Part B deductible applies. Part A covers surgeries to implant defibrillators in an inpatient hospital setting. See Inpatient hospital care on pages 27-28.



Preventive service

Depression screening

Medicare covers one depression screening per year. The screening must be done in a primary care setting (like a doctor's office) that can provide follow-up treatment and/or **referrals**. You pay nothing for this screening if your doctor accepts **assignment**.



Preventive service

Diabetes screenings

Medicare covers up to 2 glucose laboratory test screenings (with and without a carbohydrate challenge) each year if your doctor determines you're at risk for developing diabetes. You pay nothing for the test if your doctor or other qualified health care provider accepts assignment.



Preventive service

Diabetes self-management training

Medicare covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking prescription drugs, and reducing risks. You must have been diagnosed with diabetes and have a written order from your doctor or other qualified non-doctor practitioner. Some patients may also be eligible for medical nutrition therapy training. You pay 20% of the **Medicare-approved amount**. The Part B deductible applies.

Diabetes equipment, supplies, & therapeutic shoes

Medicare covers meters that measure blood sugar (glucose) and related supplies, including test strips, lancets, lancet holders, and control solutions. Medicare also covers tubing, insertion sets, and insulin for patients using insulin pumps, and sensors for patients using continuous glucose monitors. In addition, Medicare covers one pair of extra-depth or custom shoes and inserts per year for people with specific diabetes-related foot problems.

You pay 20% of the Medicare-approved amount if your supplier accepts assignment. The Part B deductible applies.

Note: Medicare drug coverage (Part D) may cover insulin, certain medical supplies used to inject insulin (like syringes), disposable pumps, and some oral diabetes drugs. Check with your plan for more information.

Doctor & other health care provider services

Medicare covers **medically necessary** doctor services (including outpatient services and some inpatient hospital doctor services) and covered **preventive services**. Medicare also covers services you get from other health care providers, like physician assistants, nurse practitioners, clinical social workers, physical therapists, occupational therapists, speech-language pathologists, and clinical psychologists. Except for certain preventive services (for which you may pay nothing if your doctor or other provider accepts assignment), you pay 20% of the Medicare-approved amount for most services. The Part B **deductible** applies.

Drugs

Part B covers a limited number of outpatient prescription drugs like injections you get in a doctor's office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump), immunosuppressant drugs (see page 51), and, under very limited circumstances, certain drugs you get in a hospital outpatient setting. For some drugs used with an external infusion pump, Medicare may also cover services (like nursing visits) under the home infusion therapy benefit (see page 44). Part B also covers some injectable or implantable drugs to treat opioid use disorder when a provider administers it in a doctor's office or a hospital as an outpatient. You pay 20% of the **Medicare-approved amount** for these covered drugs. The Part B deductible applies. You won't have to pay any **copayments** for these services if you get them from a Medicare-enrolled opioid treatment program (see page 47).

If the covered drugs you get in a hospital outpatient setting are part of your outpatient services, you pay a copayment for the services. However, Part B doesn't cover other types of drugs in a hospital outpatient setting (sometimes called "self-administered drugs" or drugs you'd normally take on your own). What you pay depends on whether you have Medicare drug coverage or other drug coverage, whether your drug plan covers the drug, and whether the hospital's pharmacy is in your drug plan's network. Contact your drug plan to find out what you pay for drugs you get in a hospital outpatient setting that Part B doesn't cover.

Other than the examples above, you pay 100% for most drugs, unless you have Medicare drug coverage (Part D) or other drug coverage. See pages 79–90 for more information about Medicare drug coverage.

Durable medical equipment (DME)

Medicare covers medically necessary items like oxygen and oxygen equipment, wheelchairs, walkers, and hospital beds when a Medicare-enrolled doctor or other health care provider orders for use in the home. Most items must be rented, but some can also be purchased or become your property after a certain number of rental payments have been made. You pay 20% of the Medicare-approved amount. The Part B **deductible** applies.

Make sure your doctors and DME suppliers are enrolled in Medicare. It's important to ask your suppliers if they participate in Medicare before you get DME. To get your DME benefits, the doctor or supplier who provides the DME to you must be enrolled in Medicare. If suppliers are participating suppliers, they must accept **assignment** (which means, they can charge you only the **coinsurance** and Part B deductible for the Medicare-approved amount). If DME suppliers aren't participating and don't accept assignment, there's no limit on the amount they can charge you.

Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS)

Competitive Bidding Program: If you live in or visit a competitive bidding area and need an off-the-shelf (OTS) back or knee brace that's included in the DMEPOS Competitive Bidding Program, you generally must use specific suppliers called "contract suppliers," if you want Medicare to help pay for the item. Contract suppliers are required to provide the item to you and accept assignment as a term of their contract with Medicare.

Visit [Medicare.gov/medical-equipment-suppliers/](https://www.medicare.gov/medical-equipment-suppliers/) to see if you live in or are visiting a competitive bidding area, or to find suppliers who accept assignment. Medicare's improved supplier directory includes new features and functionality to help you:

- Customize your search with information about what you need and compare up to 3 suppliers at a time.
- Easily find medical equipment and supplies using plain language descriptions.
- Find suppliers in your area that carry the products you need using an interactive map.

You can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also call 1-800-MEDICARE if you're having problems with your DME supplier, or you need to file a complaint.

EKG or ECG (electrocardiogram) screenings

Medicare covers a one-time EKG/ECG screening if your doctor or other health care provider refers you as part of your one-time "Welcome to Medicare" visit (see page 53). You pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies. Medicare also covers EKGs as diagnostic tests (see page 51). You also pay a **copayment** if you have the test at a hospital or a hospital-owned clinic.

Emergency department services

Medicare covers these services when you have an injury, a sudden illness, or an illness that quickly gets much worse. You pay a **copayment** for each emergency department visit and 20% of the **Medicare-approved amount** for doctors' services. The Part B **deductible** applies. If your doctor admits you to the same hospital as an inpatient, your costs may be different.

E-visits

Medicare covers E-visits to allow you to talk with your doctor using an online patient portal without going to the doctor's office. Practitioners who can provide these services include doctors, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech-language pathologists, licensed clinical social workers (in specific circumstances), and clinical psychologists (in specific circumstances).

You must talk to your doctor or other provider to start these types of services. You pay 20% of the Medicare-approved amount for your doctors' services. The Part B deductible applies.

Eye glasses

If you have cataract surgery that implants an intraocular lens, Medicare covers one pair of eyeglasses with standard frames (or one set of contact lenses). You pay 20% of the Medicare-approved amount. The Part B deductible applies.

Note: Medicare will only pay for contact lenses or eyeglasses from a supplier enrolled in Medicare, no matter if you or your provider submits the claim.

Federally Qualified Health Center services

Federally Qualified Health Center services provide many outpatient primary care and preventive health services. There's no deductible, and you usually pay 20% of the charges or the Medicare-approved amount. You pay nothing for most **preventive services**. All Federally Qualified Health Centers offer discounts if your income is limited. Visit findahealthcenter.hrsa.gov to find a health center near you.



Preventive service

Flu shots

Medicare covers one flu shot (or vaccine) per flu season. You pay nothing for the flu shot if the doctor or other qualified health care provider accepts **assignment** for giving the shot.

Foot care

Medicare covers yearly foot exams or treatment if you have diabetes-related lower leg nerve damage that can increase the risk of limb loss or need medically necessary treatment for foot injuries or diseases, like hammer toe, bunion deformities, and heel spurs. You pay 20% of the Medicare-approved amount for medically necessary treatment your doctor approves. The Part B deductible applies. You also pay a copayment for medically necessary treatment in a hospital outpatient setting.



Preventive service

Glaucoma tests

Medicare covers these tests once every 12 months if you're at high risk for the eye disease glaucoma. You're at high risk if you have diabetes, a family history of glaucoma, are African American and 50 or older, or are Hispanic and 65 or older. An eye doctor who's legally allowed in your state must do or supervise the screening. You pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies. You also pay a **copayment** in a hospital outpatient setting.

Hearing & balance exams

Medicare covers these diagnostic exams if your doctor or other health care provider orders them to see if you need medical treatment. You pay 20% of the Medicare-approved amount. The Part B deductible applies. You also pay a copayment in a hospital outpatient setting.

Note: Original Medicare doesn't cover hearing aids or exams for fitting hearing aids.



Preventive service

Hepatitis B shots

Medicare covers these shots (or vaccines) if you're at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, if you live with someone who has Hepatitis B, or if you're a health care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you're at medium or high risk for Hepatitis B. You pay nothing for the shot if the doctor or other qualified health care provider accepts **assignment**.



Preventive service

Hepatitis B Virus infection screenings

Medicare covers this screening if you meet one of these conditions:

- You're at high risk for Hepatitis B Virus infection.
- You're pregnant.

Medicare will only cover this screening if your **primary care doctor** orders it.

Medicare covers Hepatitis B Virus infection screenings:

- Yearly only if you're at continued high risk and don't get a Hepatitis B shot.
- If you're pregnant:
 - At the first prenatal visit for each pregnancy
 - At the time of delivery for those with new or continued risk factors
 - At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative Hepatitis B Virus screening results

You pay nothing for the screening test if the doctor or other qualified health care provider accepts assignment.



Preventive service

Hepatitis C screening tests

Medicare covers one Hepatitis C screening test if you meet one of these conditions:

- You're at high risk because you use or have used illicit injection drugs.
- You had a blood transfusion before 1992.
- You were born between 1945–1965.

Medicare also covers yearly repeat screenings if you're at high risk.

Medicare will only cover a Hepatitis C screening test if your health care provider orders one. You pay nothing for the screening test if your **primary care doctor** or other qualified health care provider accepts **assignment**.



Preventive service

HIV (Human Immunodeficiency Virus) screenings

Medicare covers HIV screenings once every 12 months if you're:

- Between 15–65.
- Younger than 15 or older than 65, and at increased risk.

Medicare also covers this test up to 3 times during a pregnancy.

You pay nothing for the HIV screening if your doctor or other qualified health care provider accepts assignment.

Home health services

Medicare covers home health services under Part A and/or Part B. Medicare covers **medically necessary** part-time or intermittent skilled nursing care, physical therapy, speech-language pathology services, or continued occupational therapy services. Home health services may also include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. A doctor, or other health care provider, must see you face-to-face before certifying that you need home health services. A doctor or other provider must order your care, and a Medicare-certified home health agency must provide it.

Medicare covers home health services as long as you need part-time or intermittent skilled services and as long as you're “homebound,” which means:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury.
- Leaving your home isn't recommended because of your condition.
- You're normally unable to leave your home because it's a major effort.

You pay nothing for covered home health services. However, for Medicare-covered durable medical equipment, you pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies.

Home infusion therapy services

Medicare covers equipment and supplies (like pumps, IV pole, tubing, and catheters) for home infusion therapy to administer certain IV infusion drugs at home. Certain equipment and supplies (like the infusion pump) and the infusion drug are covered under the Durable Medical Equipment benefit (see page 40). Medicare also covers services (like nurse visits), training for caregivers, and monitoring. You pay 20% of the **Medicare-approved amount** for these services.

Kidney dialysis services & supplies

Generally, Medicare covers 3 dialysis treatments per week if you have End-Stage Renal Disease (ESRD). This includes most renal dialysis drugs and biological products, and all laboratory tests, home dialysis training, support services, equipment, and supplies. The dialysis facility is responsible for coordinating your dialysis services (at home or in a facility). You pay 20% of the Medicare-approved amount. The Part B **deductible** applies.

Kidney disease education

Medicare covers up to 6 sessions of kidney disease education services if you have Stage IV chronic kidney disease that will usually require dialysis or a kidney transplant, and your doctor or other health care provider refers you for the service. You pay 20% of the Medicare-approved amount per session if you get the service from a doctor or other qualified health care provider. The Part B deductible applies.

Laboratory services

Medicare covers laboratory services including certain blood tests, urinalysis, certain tests on tissue specimens, and some screening tests. You generally pay nothing for these services.



Preventive service

Lung cancer screenings

Medicare covers lung cancer screenings with Low Dose Computed Tomography once per year if you meet all of these conditions:

- You're 55-77.
- You don't have signs or symptoms of lung cancer (you're asymptomatic).
- You're either a current smoker or you quit smoking within the last 15 years.
- You have a tobacco smoking history of at least 30 "pack years" (an average of one pack a day for 30 years).
- You get a written order from your doctor.

You pay nothing for this service if your doctor accepts **assignment**.

Note: Before your first lung cancer screening, you'll need to schedule an appointment with your doctor to discuss the benefits and risks of lung cancer screening. You and your doctor can decide whether a lung cancer screening is right for you.



Preventive service

Mammograms

Medicare covers a mammogram screening to check for breast cancer once every 12 months if you're a woman 40 or older. Medicare covers one baseline mammogram if you're a woman between 35-39. You pay nothing for the test if the doctor or other qualified health care provider accepts assignment.

Note: Part B also covers diagnostic mammograms more frequently than once a year when medically necessary. You pay 20% of the **Medicare-approved amount** for diagnostic mammograms. The Part B **deductible** applies.



Preventive service

Medicare Diabetes Prevention Program

Medicare covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with weekly core sessions offered in a group setting over a 6-month period. In these sessions, you'll get:

- Training to make realistic, lasting behavior changes around diet and exercise.
- Tips on how to get more exercise.
- Strategies for controlling your weight.
- A specially trained coach to help keep you motivated.
- Support from people with similar goals and challenges.

Once you complete the core sessions, you'll get:

- 6 monthly follow-up sessions to help you maintain healthy habits.
- 12 additional months of ongoing maintenance sessions if you meet certain weight loss and attendance goals.

To be eligible, all of these conditions must apply to you:

- You have Part B.
- You have a hemoglobin A1c test result between 5.7 and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test) within 12 months prior to attending the first core session.
- You have a body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian).
- You've never been diagnosed with type 1 or type 2 diabetes, or End-Stage Renal Disease (ESRD).
- You've never participated in the Medicare Diabetes Prevention Program.

You pay nothing for these services if you're eligible. Visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone) to see if there's a Medicare Diabetes Prevention Program supplier in your area.

Mental health care (outpatient)

Medicare covers mental health care services to help with conditions like depression and anxiety. These visits are often called counseling or therapy. Coverage includes services generally provided in an outpatient setting (like a doctor's or other health care provider's office, or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, clinical nurse specialist, clinical social worker, nurse practitioner, or physician assistant. Covered mental health care includes partial hospitalization services, which are intensive outpatient mental health services provided during the day. Partial hospitalization services are provided by a hospital to its outpatients or by a community mental health center. Visit [Medicare.gov/coverage/mental-health-care-partial-hospitalization](https://www.Medicare.gov/coverage/mental-health-care-partial-hospitalization) for more information.

Generally, you pay 20% of the **Medicare-approved amount** and the Part B **deductible** applies for mental health care services.

Note: Part A covers inpatient mental health care services you get in a hospital.



Preventive service

Nutrition therapy services

Medicare may cover medical nutrition therapy services and certain related services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor refers you for services. Only a Registered Dietitian or nutrition professional who meets certain requirements can provide medical nutrition services. If you have diabetes you may also be eligible for diabetes self-management training. You pay nothing for these **preventive services** because the deductible and **coinsurance** don't apply.



Preventive service

Obesity behavioral therapy

If you have a body mass index (BMI) of 30 or more, Medicare covers obesity screenings and behavioral counseling to help you lose weight by focusing on diet and exercise. Medicare covers this counseling if your **primary care doctor** or other qualified provider gives the counseling in a primary care setting (like a doctor's office), where they can coordinate your personalized prevention plan with your other care. You pay nothing for this service if the doctor or other qualified health care provider accepts **assignment**.

Occupational therapy

Medicare covers medically necessary therapy to help you perform activities of daily living (like dressing or bathing). This therapy helps to improve or maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

Opioid use disorder treatment services

Medicare covers opioid use disorder treatment services in opioid treatment programs. The services include medication (like methadone, buprenorphine, naltrexone, and naloxone), counseling, drug testing, individual and group therapy, intake activities, and periodic assessments. Medicare covers counseling, therapy services, and assessments both in-person and by virtual delivery (using audio and video communication technology, like your phone or a computer).

Medicare pays doctors and other providers for office-based opioid use disorder treatment, including management, care coordination, psychotherapy, and counseling activities.

Under Original Medicare, you won't have to pay any **copayments** for these services if you get them from an opioid treatment program provider who's enrolled in Medicare. However, the Part B **deductible** still applies. Talk to your doctor or other health care provider to find out where to go for these services. You can also visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone) and select "Opioid Treatment Program Services" to find a program near you.

Medicare Advantage Plans must also cover opioid treatment program services. If you're in a Medicare Advantage Plan, your current opioid treatment program must be Medicare-enrolled to make sure your treatment stays uninterrupted. If not, you may have to switch to a Medicare-enrolled opioid treatment program. Since Medicare Advantage Plans can apply copayments to opioid treatment program services, you should check with your plan to see if you have to pay a copayment.

Outpatient hospital services

Medicare covers many diagnostic and treatment services you get as an outpatient from a Medicare-participating hospital. Generally, you pay 20% of the **Medicare-approved amount** for your doctors' or other health care providers' services. You may pay more for services you get in a hospital outpatient setting than you'll pay for the same care in a doctor's office. In addition to the amount you pay the doctor, you'll also usually pay the hospital a copayment for each service you get in a hospital outpatient setting (except for certain **preventive services** that don't have a copayment). In most cases, the copayment can't be more than the Part A hospital stay deductible for each service. The Part B deductible applies, except for certain preventive services. If you get hospital outpatient services in a **critical access hospital**, your copayment may be higher and may exceed the Part A hospital stay deductible.



Cost & coverage: Visit [Medicare.gov/procedure-price-lookup](https://www.medicare.gov/procedure-price-lookup) to get cost estimates for hospital outpatient procedures done in hospital outpatient departments.

Outpatient medical & surgical services & supplies

Medicare covers approved procedures, like X-rays, casts, stitches, or outpatient surgeries. You pay 20% of the Medicare-approved amount for doctor or other health care provider services. You generally pay a **copayment** for each service you get in a hospital outpatient setting. In most cases, the copayment can't be more than the Part A hospital stay deductible for each service you get. The Part B deductible applies, and you pay all costs for items or services that Medicare doesn't cover.

Physical therapy

Medicare covers evaluation and treatment for injuries and diseases that change your ability to function, or to improve or maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount. The Part B deductible applies.



Preventive service

Pneumococcal shots

Medicare covers pneumococcal shots (or vaccines) to help prevent pneumococcal infections (like certain types of pneumonia). The 2 shots protect against different strains of the bacteria. Medicare covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. You pay nothing for these shots if the doctor or other qualified health care provider accepts **assignment** for giving the shots.



Preventive service

Prostate cancer screenings

Medicare covers digital rectal exams and prostate specific antigen (PSA) tests once every 12 months for men over 50 (starting the day after your 50th birthday). For the digital rectal exam, you pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies. You also pay a copayment in a hospital outpatient setting. You pay nothing for the PSA test.

Prosthetic/orthotic items

Medicare covers these prosthetics/orthotics when a Medicare-enrolled doctor or other health care provider orders them: arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); and prosthetic devices needed to replace an internal body organ or function of the organ (including ostomy supplies, parenteral and enteral nutrition therapy, and some types of breast prostheses after a mastectomy).

For Medicare to cover your prosthetic or orthotic, you must go to a supplier that's enrolled in Medicare. You pay 20% of the Medicare-approved amount. The Part B deductible applies.

Important!

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

(DMEPOS) Competitive Bidding Program: To get an off-the-shelf back or knee brace in most areas of the country, you generally must use specific suppliers called "contract suppliers." Otherwise, Medicare won't pay and you'll likely pay full price. See page 40 for more information.

Pulmonary rehabilitation programs

Medicare covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a **referral** from the doctor treating this chronic respiratory disease. You pay 20% of the Medicare-approved amount if you get the service in a doctor's office. You also pay a copayment per session if you get the service in a hospital outpatient setting. The Part B deductible applies.



Starting January 1, 2022, Medicare will also cover pulmonary rehabilitation if you've had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least 4 weeks.

Rural health clinic services

Rural health clinics provide many outpatient primary care and preventive health services in rural and underserved areas. Generally, you pay 20% of the charges. The Part B deductible applies. You pay nothing for most **preventive services**.

Second surgical opinions

Medicare covers a second surgical opinion in some cases for medically necessary surgery that isn't an emergency. In some cases, Medicare covers third surgical opinions. You pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies.



Preventive service

Sexually transmitted infection (STI) screenings & counseling

Medicare covers STI screenings for chlamydia, gonorrhea, syphilis, and/or Hepatitis B. Medicare covers these screenings if you're pregnant or at increased risk for an STI when your primary care provider orders the tests. Medicare covers these tests once every 12 months or at certain times during pregnancy.

Medicare also covers up to 2 individual, 20-30 minute, face-to-face, high-intensity behavioral counseling sessions each year if you're a sexually active adult at increased risk for STIs. Medicare will only cover these counseling sessions with a **primary care doctor** in a primary care setting (like a doctor's office). Medicare won't cover counseling as a **preventive service** in an inpatient setting, like a **skilled nursing facility**.

You pay nothing for these services if your primary care doctor or other qualified health care provider accepts **assignment**.

Shots (or vaccines)

Part B covers:

- Flu shots. See page 41.
- Hepatitis B shots. See page 42.
- Pneumococcal shots. See page 48.
- Coronavirus disease 2019 (COVID-19) vaccine. See page 37.

Medicare drug coverage (Part D) generally covers all other recommended adult immunizations (like shingles, Tetanus, diphtheria, and pertussis vaccines) to prevent illness. Talk to your provider about which ones are right for you.

Speech-language pathology services

Medicare covers **medically necessary** evaluation and treatment to regain and strengthen speech and language skills. This includes cognitive and swallowing skills, or to improve or maintain current function or slow decline, when your doctor or other health care provider certifies you need it. You pay 20% of the Medicare-approved amount. The Part B **deductible** applies.

Surgical dressing services

Medicare covers medically necessary treatment of a surgical or surgically treated wound. You pay nothing for the supplies and 20% of the Medicare-approved amount for your doctor or other health care provider services. You pay a set **copayment** for these services when you get them in a hospital outpatient setting. The Part B deductible applies.

Telehealth

Medicare covers certain telehealth services provided by a doctor or other health care provider who's located elsewhere using audio and video communication technology, like your phone or a computer. Telehealth can provide many services that generally occur in-person, including office visits, psychotherapy, consultations, and certain other medical or health services, but only when you're at an office or other medical facility located in a rural area.

You can get certain Medicare telehealth services without being in a rural health care setting, including:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis.
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit.
- Services to treat a substance use disorder or a co-occurring mental health disorder (sometimes called a “dual disorder”) in your home.

You pay 20% of the Medicare-approved amount for your doctor or other health care provider's services. The Part B deductible applies. For most of these services, you'll pay the same amount you would if you got the services in person.



Compare: Medicare Advantage Plans and providers who are part of certain Medicare **Accountable Care Organizations (ACOs)** may offer more telehealth benefits than Original Medicare. For example, these telehealth benefits may be available no matter where you're located, and you may be able to use them at home instead of going to a health care facility. Check with your plan to see what benefits they offer. If your provider participates in an ACO, check with them to see what telehealth benefits may be available. See pages 113–114.

Tests

Medicare covers X-rays, MRIs, CT scans, EKG/ECGs, and some other diagnostic tests. You pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies.

If you get the test at a hospital as an outpatient, you also pay the hospital a **copayment** that may be more than 20% of the Medicare-approved amount. In most cases, this amount can't be more than the Part A hospital stay deductible. See Laboratory services on page 44 for other Part B-covered tests.

Transitional care management services

Medicare may cover this service if you're returning to your community after a stay at certain facilities, like a hospital or skilled nursing facility. The health care provider who's managing your transition back into the community will work to coordinate and manage your care for the first 30 days after you return home. They'll work with you, your family, caregivers, and other providers. You'll also get an in-person office visit within 2 weeks of your return home. The health care provider may also review information on the care you received in the facility, provide information to help you transition back to living at home, work with other care providers, help you with **referrals** or arrangements for follow-up care or community resources, help you with scheduling, and help you manage your medications. The Part B deductible and **coinsurance** apply.

Transplants & immunosuppressive drugs

Medicare covers doctor services for heart, lung, kidney, pancreas, intestine, and liver transplants under certain conditions, but only in Medicare-certified facilities. Medicare also covers bone marrow and cornea transplants under certain conditions.

Note: Medicare may cover transplant surgery as a hospital inpatient service under Part A. See pages 27–28.

Medicare covers immunosuppressive drugs if Medicare paid for the transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. You pay 20% of the Medicare-approved amount for the drugs. The Part B deductible applies.

If you're thinking about joining a **Medicare Advantage Plan** and are on a transplant waiting list or think you need a transplant, check with the plan before you join to make sure your doctors, other health care providers, and hospitals are in the plan's network. Also, check the plan's coverage rules for prior authorization.

Note: Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them.

Medicare pays the full cost of care for your kidney donor. You and your donor won't have to pay a deductible, **coinsurance**, or any other costs for their hospital stay.

Travel

Medicare generally doesn't cover health care while you're traveling outside the U.S. (the "U.S." includes the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). There are some exceptions, including cases where Medicare may pay for services you get while on board a ship within the territorial waters adjoining the land areas of the U.S. Medicare may pay for inpatient hospital, doctor, or ambulance services you get in a foreign country in these rare cases:

- You're in the U.S. when an emergency occurs, and the foreign hospital is closer than the nearest U.S. hospital that can treat your medical condition.
- You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another U.S. state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat the emergency.
- You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether an emergency exists.

Medicare may cover **medically necessary** ambulance transportation to a foreign hospital only with admission for medically necessary covered inpatient hospital services. You pay 20% of the **Medicare-approved amount**. The Part B **deductible** applies.

Urgently needed care

Medicare covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. You pay 20% of the Medicare-approved amount for your doctor or other health care provider services, and a **copayment** in a hospital outpatient setting. The Part B deductible applies.

Virtual check-ins

Medicare covers virtual check-ins (also called “brief communication technology-based services”) with your doctor or certain other practitioners, like nurse practitioners or physician assistants, using audio and video communication technology, like your phone or a computer. Your doctor can also conduct remote assessments using photo or video images you send for review to see whether you need to go to the doctor’s office.

Your doctor or other provider can respond to you by phone, virtual delivery, secure text message, email, or patient portal.

You can use these services if you have met these conditions:

- You have talked to your doctor or other provider about starting these types of visits.
- The virtual check-in must not be related to a medical visit within the past 7 days and must not lead to the medical visit within the next 24 hours (or the soonest appointment available).
- You must verbally consent to the virtual check-in, and your consent must be documented in your medical record. Your doctor may get one consent for a year’s worth of these services.

You pay 20% of the Medicare-approved amount for your doctor or other health care provider services. The Part B **deductible** applies.



Preventive service

“Welcome to Medicare” preventive visit

During the first 12 months that you have Part B, you can get a “Welcome to Medicare” preventive visit. The visit includes a review of your medical and social history related to your health. It also includes education and counseling about **preventive services**, including certain screenings, shots or vaccines (like flu, pneumococcal, and other recommended shots or vaccines), and **referrals** for other care, if needed.

When you make your appointment, let your doctor’s office know that you’d like to schedule your “Welcome to Medicare” preventive visit. You pay nothing for the “Welcome to Medicare” preventive visit if the doctor or other qualified health care provider accepts **assignment**.

New!

If you have a current prescription for opioids, your provider will review your potential risk factors for opioid use disorder, evaluate your severity of pain and current treatment plan, provide information on non-opioid treatment options, and may refer you to a specialist, if appropriate. Your provider will also review your potential risk factors for substance use disorder and refer you for treatment, if needed.

Important!

If your doctor or other health care provider performs additional tests or services during the same visit that Medicare doesn’t cover under this preventive benefit, you may have to pay **coinsurance**, and the Part B deductible may apply. If Medicare doesn’t cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.



Preventive service

Yearly “Wellness” visit

If you've had Part B for longer than 12 months, you can get a yearly “Wellness” visit to develop or update your personalized plan to prevent disease or disability based on your current health and risk factors. **The yearly “Wellness” visit isn't a physical exam.** Medicare covers this visit once every 12 months.

Your provider will ask you to fill out a questionnaire, called a “Health Risk Assessment,” as part of this visit. Answering these questions can help you and your provider develop a personalized prevention plan to help you stay healthy and get the most out of your visit.

New! Your provider will also perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. Signs of cognitive impairment include trouble remembering, learning new things, concentrating, managing finances, and making decisions about your everyday life. If your provider thinks you may have cognitive impairment, Medicare covers a separate visit to do a more thorough review of your cognitive function and check for conditions like dementia, depression, anxiety, or delirium. See page 34.

New! If you have a current prescription for opioids, your provider will perform services during your visit. See the “New!” flag on page 53 to learn more.

Note: Your first yearly “Wellness” visit can't take place within 12 months of your Part B enrollment or your “Welcome to Medicare” preventive visit. However, you don't need to have had a “Welcome to Medicare” preventive visit to qualify for a yearly “Wellness” visit.

You pay nothing for the yearly “Wellness” visit if the doctor or other qualified health care provider accepts **assignment**.

Important! If your doctor or other health care provider performs additional tests or services during the same visit that Medicare doesn't cover under this preventive benefit, you may have to pay a **coinsurance**, and the Part B **deductible** may apply. If Medicare doesn't cover the additional tests or services (like a routine physical exam), you may have to pay the full amount.

What's NOT covered by Part A and Part B?

Medicare doesn't cover everything. If you need certain services Part A or Part B doesn't cover, you'll have to pay for them yourself unless:

- You have other coverage (including **Medicaid**) to cover the costs.
- You're in a **Medicare Advantage Plan** or Medicare Cost Plan that covers these services. Medicare Advantage Plans and Medicare Cost Plans may cover some extra benefits, like fitness programs and vision, hearing, and dental services.

Some of the items and services that Original Medicare doesn't cover include:

- ✖ Most dental care
- ✖ Eye exams (for prescription glasses)
- ✖ Dentures
- ✖ Cosmetic surgery
- ✖ Massage therapy
- ✖ Routine physical exams
- ✖ Hearing aids and exams for fitting them
- ✖ Long-term care
- ✖ Concierge care (also called concierge medicine, retainer-based medicine, boutique medicine, platinum practice, or direct care)
- ✖ Covered items or services you get from an opt out doctor (see page 60) or other provider (except in the case of an emergency or urgent need)

Paying for long-term care

Long-term care (sometimes called “long-term services and supports”) includes non-medical care for people who have a chronic illness or disability. This includes non-skilled personal care assistance, like help with everyday activities, including dressing, bathing and using the bathroom. Non-medical care also includes home-delivered meals, adult day health care, and other services. **Medicare and most health insurance, including Medicare Supplement Insurance (Medigap), don't pay for this type of care.** You may be eligible for this care through Medicaid, or you can choose to buy private long-term care insurance.

You can get long-term care at home, in the community, in an assisted living facility, or in a nursing home. It's important to start planning for long-term care now to maintain your independence and to make sure you get the care you may need, in the setting you want, now and in the future.

Long-term care resources

Use these resources to get more information about long-term care:

- Visit longtermcare.acl.gov to learn more about planning for long-term care.
- Call your State Insurance Department to get information about long-term care insurance. Visit Medicare.gov/talk-to-someone or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- Call your Medicaid office (State Medical Assistance Office), and ask for information about long-term care coverage. Visit Medicare.gov/talk-to-someone to get the phone number for your state's Medicaid office. First, choose your state from the drop-down under "What state do you live in?" and then click "Go." You'll be taken to a page with contact information that's specific for your state. Then, in the left hand column of that page, choose "Other insurance programs," and look for the text "Medicaid program" under the hyperlink, in the list of options. You can also call 1-800-MEDICARE to get the phone number for your state's Medicaid office.
- Get a copy of "A Shopper's Guide to Long-Term Care Insurance" from the National Association of Insurance Commissioners at content.naic.org/sites/default/files/publication-ltc-ip-shoppers-guide-long-term.pdf.
- Call your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number.
- Visit the Eldercare Locator, a public service of the Administration for Community Living, at eldercare.acl.gov to find help in your community.

SECTION 3

Original Medicare

How does Original Medicare work?

Original Medicare is one of your Medicare health coverage choices. You'll have Original Medicare unless you choose a **Medicare Advantage Plan** or other type of **Medicare health plan**.

You generally have to pay a portion of the cost for each service Original Medicare covers. There's no limit to what you'll pay out of pocket in a year unless you have other coverage (like **Medigap**, **Medicaid**, or employee or union coverage) or enroll in a Medicare Advantage Plan. See page 59 for the general rules about how it works.

Original Medicare

Can I get my health care from any doctor, other health care provider, or hospital?	In most cases, yes. You can go to any Medicare-enrolled doctor, other health care provider, hospital, or other facility that accepts Medicare patients anywhere in the U.S. Visit Medicare.gov/care-compare to find and compare providers, hospitals, and facilities in your area.
Does it cover prescription drugs?	No, with a few exceptions (see pages 26–27, 47, and 51), Original Medicare doesn't cover most drugs. You can add Medicare drug coverage (Part D) by joining a separate Medicare drug plan. See pages 79–90.
Do I need to choose a primary care doctor?	No.
Do I have to get a referral to see a specialist?	In most cases, no.
Should I get a supplemental policy?	You may already have Medicaid, military retiree, or employer or union coverage that may pay costs that Original Medicare doesn't. If not, you may want to buy a Medicare Supplement Insurance (Medigap) policy if you're eligible. See pages 75–78.

What else do I need to know about Original Medicare?	<ul style="list-style-type: none">• You generally pay a set amount for your health care (deductible) before Medicare pays its share. Once Medicare pays its share, you pay a coinsurance or copayment for covered services and supplies. There's no yearly limit for what you pay out of pocket unless you have other insurance (like Medigap, Medicaid, or employee, retiree, or union coverage).• You usually pay a monthly premium for Part B.• You generally don't need to file Medicare claims. Providers and suppliers must file your claims for the covered services and supplies you get.
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What do I pay?

Your out of pocket costs in Original Medicare depend on:

- Whether you have Part A and/or Part B. Most people have both.
- Whether your doctor, other health care provider, or supplier accepts “**assignment**.” See page 59.
- The type of health care you need and how often you need it.
- If you choose to get services or supplies Medicare doesn’t cover. If so, you pay all costs unless you have other insurance that covers them.
- Whether you have other health insurance that works with Medicare.
- Whether you have Medicaid or get help from your state to pay your Medicare costs.
- Whether you have Medicare Supplement Insurance (Medigap).
- Whether you and your doctor or other health care provider sign a private contract. See page 60.

How do I know what Medicare paid?

If you have Original Medicare, you'll get a "Medicare Summary Notice" (MSN) that lists all the services billed to Medicare. You can sign up to get this Notice electronically every month (see below) or a Medicare contractor will mail it to you every 3 months. It's not a bill. The MSN shows what Medicare paid and what you may owe the provider. Review your MSNs to be sure you got all the services, supplies, or equipment listed. If you disagree with Medicare's decision not to pay for (cover) a service, the MSN will tell you how to appeal. See page 99 for information on how to file an appeal.

If you need to change your address on your MSN, call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

Your MSN will tell you if you're enrolled in the Qualified Medicare Beneficiary (QMB) program. If you're in the QMB program, Medicare providers aren't allowed to bill you for Medicare Part A and/or Part B **deductibles**, **coinsurance**, or **copayments**. In some cases, you may be billed a small copayment through **Medicaid**, if one applies. For more information about QMB and steps to take if a provider bills you for these costs, see page 94.

Important!

Get your Medicare Summary Notices electronically

Sign up to get your "Medicare Summary Notices" (also called "eMSNs") electronically. Visit [Medicare.gov](#) to log into (or create) your secure Medicare account. If you sign up for eMSNs, we'll send you an email each month when they're available in your online Medicare account. The eMSNs have the same information as paper MSNs. You won't get printed copies in the mail if you choose eMSNs.

You have options in how you get your Medicare claims information. A growing number of computer and mobile apps are connected to Medicare through Blue Button 2.0. If you agree to share your information with one of these apps, it can show you the details of the claims that Medicare has paid on your behalf. See page 111 for more information.

What's assignment?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the **Medicare-approved amount** as full payment for covered services.

If your doctor, provider, or supplier accepts assignment:

- Your out-of-pocket costs may be less.
- They agree to charge you only the Medicare deductible and coinsurance amount and usually wait for Medicare to pay its share before asking you to pay your share.
- They have to submit your claim directly to Medicare and can't charge you for submitting the claim.

Some providers haven't agreed and aren't required by law to accept **assignment** for all Medicare-covered services, but they can still choose to accept assignment for individual services. The providers who haven't agreed to accept assignment for all services are called "non-participating." You might have to pay more for their services if they don't accept assignment for the care they provide to you. Here's what happens if your doctor, provider, or supplier doesn't accept assignment:

- **You might have to pay the entire charge at the time of service.** Your doctor, provider, or supplier is supposed to submit a claim to Medicare for any Medicare-covered services they provide to you. If they don't submit the Medicare claim once you ask them to, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- **They can charge you more than the Medicare-approved amount. In many cases, the charge can't be more than an amount called "the limiting charge."**

If you have Original Medicare, you can see any provider you want that takes Medicare, anywhere in the U.S.



Compare: If you have a Medicare Advantage Plan, in most cases, you'll need to use doctors and other providers who are in the plan's network.

To find out if someone accepts assignment or participates in Medicare, visit [Medicare.gov/care-compare](https://www.medicare.gov/care-compare) or [Medicare.gov/medical-equipment-suppliers](https://www.medicare.gov/medical-equipment-suppliers). TTY users can call 1-877-486-2048. You can also contact your State Health Insurance Assistance Program (SHIP) to get free help with these topics. See pages 117-120 for the phone number.

What if I want to use a provider who opts out of Medicare?

Certain doctors and other health care providers who don't want to work with the Medicare program may "opt out" of Medicare. Medicare doesn't pay for any covered items or services you get from an opt out doctor or other provider, except in the case of an emergency or urgent need. If you still want to see an opt out provider, you and your provider can set up payment terms that you both agree to through a private contract.

A doctor or other provider who chooses to opt out must do so for 2 years, which automatically renews every 2 years unless the provider requests not to renew their opt out status. If you want to find a provider who's opted out of Medicare, visit [Medicare.gov/forms-help-resources/find-providers-who-opted-out-of-medicare](https://www.medicare.gov/forms-help-resources/find-providers-who-opted-out-of-medicare). You can search for a provider by their first and last name, **National Provider Identifier (NPI)**, specialty, or ZIP code.

SECTION 4

Medicare Advantage Plans & other options

What are Medicare Advantage Plans?

A **Medicare Advantage Plan** is another way to get your Medicare Part A and Part B coverage. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by Medicare-approved private companies that must follow rules set by Medicare. Most Medicare Advantage Plans include drug coverage (Part D). In most cases, you’ll need to use health care providers who participate in the plan’s network. These plans set a limit on what you’ll have to pay out-of-pocket each year for covered services. Some plans offer non-emergency coverage out of network, but typically at a higher cost. Remember, you must use the card from your Medicare Advantage Plan to get your Medicare-covered services. Keep your red, white, and blue Medicare card in a safe place because you’ll need it if you ever switch back to Original Medicare.

If you join a Medicare Advantage Plan, you’ll still have Medicare but you’ll get most of your Part A and Part B coverage from your Medicare Advantage Plan, not Original Medicare.

What are the different types of Medicare Advantage Plans?

- **Health Maintenance Organization (HMO) plan:** See page 66.
- **HMO Point-of-Service (HMOPOS) plan:** This HMO plan may allow you to get some services out of network for a higher **copayment** or **coinsurance**. See page 66.
- **Medical Savings Account (MSA) plans:** See page 67.
- **Preferred Provider Organization (PPO) plan:** See page 68.
- **Private Fee-for-Service (PFFS) plan:** See page 69.
- **Special Needs Plan (SNP):** See page 70.

What do Medicare Advantage Plans cover?

Medicare Advantage Plans provide all of your Part A and Part B benefits, excluding clinical trials, hospice services, and, for a temporary time, some new benefits that come from legislation or national coverage determinations. Plans must cover all emergency and urgent care, and almost all **medically necessary** services Original Medicare covers. If you’re in a Medicare Advantage Plan, Original Medicare will still help cover the cost for hospice care, some new Medicare benefits, and some costs for clinical research studies.

Plans can offer some extra benefits

Most **Medicare Advantage Plans** offer coverage for things Original Medicare doesn't cover, like fitness programs (like gym memberships or discounts) and some vision, hearing, and dental services. Plans can also choose to cover even more benefits. For example, some plans may offer coverage for services like transportation to doctor visits, over-the-counter drugs, and services that promote your health and wellness. Plans can also tailor their benefit packages to offer additional benefits to certain chronically-ill enrollees. These packages will provide benefits customized to treat specific conditions. Check with the plan before you enroll to see what benefits it offers, if you might qualify, and if there are any limitations.

Medicare Advantage Plans must follow Medicare's rules

Medicare pays a fixed amount for your coverage each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a **referral** to see a specialist or if you have to go to doctors, facilities, or suppliers that belong to the plan's network for non-emergency or non-urgent care). These rules can change each year. The plan must notify you about any changes before the start of the next enrollment year.

Remember, you have the option each year to keep your current plan, choose a different plan, or switch to Original Medicare. See page 71.

Providers can join or leave a plan's provider network any time during the year. Your plan can also change the providers in the network any time during the year. If this happens, you usually won't be able to change plans but you can choose a new provider. You generally can't change plans during the year.

Even though the network of providers may change during the year, the plan must still give you access to qualified doctors and specialists. Your plan will make a good faith effort to give you at least 30 days' notice that your provider is leaving your plan so you have time to choose a new provider. Your plan will also help you choose a new provider to continue managing your health care needs.



Compare: In most cases, you don't need a referral to see a specialist if you have Original Medicare (see page 57). You can also see any provider you want that takes Medicare, anywhere in the U.S.

Important! → Read the information you get from your plan

If you're in a **Medicare Advantage Plan**, review the "Annual Notice of Change" and "Evidence of Coverage" from your plan each year:

- **Annual Notice of Change:** Includes any changes in coverage, costs, and more that will be effective starting in January. Your plan will send you a printed copy by September 30.
- **Evidence of Coverage:** Gives you details about what the plan covers, how much you pay, and more. Your plan will send you a notice (or printed copy) by October 15, which will include information on how to access the Evidence of Coverage electronically or request a printed copy.

If you don't get these important documents, contact your plan.

What should I know about Medicare Advantage Plans?

Who can join?

To join a Medicare Advantage Plan you must:

- Have Part A and Part B.
- Live in the plan's **service area**.
- Be a U.S. citizen or lawfully present in the U.S.

Joining and leaving

- You can join a Medicare Advantage Plan even if you have a pre-existing condition.
- **You can join or leave a Medicare Advantage Plan only at certain times during the year.** See pages 71–72.
- Each year, Medicare Advantage Plans can choose to leave Medicare or make changes in coverage, costs, service area, and more. If the plan decides to stop participating in Medicare, you'll have to join another Medicare Advantage Plan or return to Original Medicare. See page 98.
- Medicare Advantage Plans must follow certain rules when giving you information about how to join their plan. See pages 105–106 for more information about these rules and how to protect your personal information.

What if I have End-Stage Renal Disease (ESRD)?

If you have ESRD, you can choose either Original Medicare or a Medicare Advantage Plan when deciding how to get Medicare coverage. You can enroll in a Medicare Advantage Plan during Open Enrollment (October 15–December 7, 2021). Your plan coverage will start January 1, 2022.

Medicare drug coverage (Part D)

Most Medicare Advantage Plans include Medicare drug coverage (Part D). In certain types of plans that don't include Medicare drug coverage (like Medical Savings Account Plans and some Private-Fee-for-Service Plans), you can join a separate Medicare drug plan. However, if you join a Health Maintenance Organization or Preferred Provider Organization Plan which doesn't cover drugs, you can't join a separate Medicare drug plan.

What if I have other coverage?

Talk to your employer, union, or other benefits administrator about their rules before you join a **Medicare Advantage Plan**. In some cases, joining a Medicare Advantage Plan might cause you to lose your employer or union coverage for yourself, your spouse, and dependents and you may not be able to get it back. In other cases, if you join a Medicare Advantage Plan, you may still be able to use your employer or union coverage along with the Medicare Advantage Plan you join. Your employer or union may also offer a Medicare Advantage retiree health plan that they sponsor. You can only be in one Medicare Advantage Plan at a time.

What if I have Medicare Supplement Insurance (Medigap)?

You can't enroll in (and can't use) **Medigap** while you're in a Medicare Advantage Plan. You can't use Medigap to pay for any costs (**copayments**, **deductibles**, and **premiums**) you have under a Medicare Advantage Plan.

Important! If you already have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap. **Keep in mind that if you drop Medigap to join a Medicare Advantage Plan, you may not be able to get it back. See page 78.**

What do I pay?

Your out-of-pocket costs in a Medicare Advantage Plan depend on:

- Whether the plan charges a monthly premium. Many Medicare Advantage Plans have a \$0 premium. If you enroll in a plan that does charge a premium, you pay this in addition to the Part B premium (and the Part A premium if you don't have premium-free Part A).
- Whether the plan pays any of your monthly Part B premiums. Some Medicare Advantage Plans will help pay all or part of your Part B premium. This is sometimes called a "Medicare Part B premium reduction."
- Whether the plan has a yearly deductible or any additional deductibles for certain services.
- How much you pay for each visit or service (copayments or **coinsurance**). Medicare Advantage Plans can't charge more than Original Medicare for certain services, like chemotherapy, dialysis, and **skilled nursing facility care**.
- The type of health care services you need and how often you get them.
- Whether you get services from a network provider or a provider that doesn't contract with the plan. If you go to a doctor, other health care provider, facility, or supplier that doesn't belong to the plan's network for non-emergency or non-urgent care services, your plan may not cover your services, or your costs could be higher. In most cases, this applies to Medicare Advantage Plans, Health Maintenance Organizations, and Preferred Provider Organizations. It also applies to Private Fee-for-Service Plans that have a contracted network of providers.
- Whether you go to a doctor or supplier who accepts **assignment** (if you're in a Preferred Provider Organization or Private Fee-for-Service plan, or Medical Savings Account plan and you go out of network). See page 59 for more information about assignment.

- Whether the plan offers extra benefits (in addition to Original Medicare benefits) and if you need to pay extra to get them.
- The plan's yearly limit on your out of pocket costs for all Part A and Part B medical services. Once you reach this limit, you'll pay nothing for Part A and Part B covered services.
- Whether you have **Medicaid** or get help from your state through a Medicare Savings Program. See pages 94–95.

To learn more about your costs in specific **Medicare Advantage Plans**, contact the plan or visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

How do I find out if my plan covers a service, drug, or supply?

You or your provider can get a decision, either orally or in writing, from your plan in advance to see if it covers a service, drug, or supply. You can also find out how much you'll have to pay. **This is called an “organization determination.”** Sometimes you have to do this as prior authorization for your plan to cover the service, drug, or supply.

You, your representative, or your doctor can request an organization determination. The requested organization determination can be either oral or written. Based on your health needs, you, your representative, or your doctor can ask for a fast decision on your organization determination request. If your plan denies coverage, the plan must tell you in writing, and you have the right to appeal. See pages 98–100.

If a plan provider refers you for a service or to a provider outside the network, but doesn't get an organization determination in advance, **this is called “plan directed care.”** In most cases you won't have to pay more than the plan's usual cost sharing. Check with your plan for more information about this protection.

Types of Medicare Advantage Plans

HMO

Health Maintenance Organization (HMO) plan

Can I get my health care from any doctor, other health care provider, or hospital?

No. You generally must get your care and services from doctors, other health care providers, or hospitals in the plan's network (except for emergency care, out-of-area urgent care, or temporary out-of-area dialysis, which is covered whether it's provided in the plan's network or outside the plan's network).

However, some HMO plans, known as HMO Point-of-Service (HMOPOS) plans, offer an out of network benefit.

Do these plans cover prescription drugs?

In most cases, yes. If you're planning to enroll in an HMO and you want Medicare drug coverage (Part D), you must join an HMO plan that offers drug coverage. If you join an HMO plan without drug coverage, you can't join a separate Medicare drug plan.

Do I need to choose a primary care doctor?

In most cases, yes.

Do I have to get a referral to see a specialist?

In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- If your doctor or other health care provider leaves the HMO plan's network, your plan will notify you. You may choose another doctor in the plan's network.
- If you get non-emergency health care outside the plan's network without authorization, you may have to pay the full cost.
- It's important that you follow the plan's rules, like getting prior approval for a certain service when needed.
- Check with the plan for more information.

Note: HMO POS plans (a type of HMO plan) may allow you get some services out of network for a higher **copayment** or **coinsurance**.

MSA**Medical Savings Account (MSA) plan**

Can I get my health care from any doctor, other health care provider, or hospital?

Yes. MSA plans usually don't have a network of doctors, other health care providers, or hospitals.

Do these plans cover prescription drugs?

No. If you join a Medicare MSA plan and want Medicare drug coverage (Part D), you'll have to join a separate Medicare drug plan.

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

No.

What else do I need to know about this type of plan?

The plan deposits money into a special savings account for you to use to pay health care expenses. The amount of the deposit varies by plan. You can use this money to pay your Medicare-covered costs before you meet the **deductible**. Money left in your account at the end of the year stays there. If you keep your plan the following year, your plan will add any new deposits to the amount left over.

- MSA plans don't charge a **premium**, but you must continue to pay your Part B premium.
- The plan will only begin to cover your costs once you meet a high yearly deductible, which varies by plan.
- Some plans may cover some extra benefits, like dental, vision, and hearing services. You may pay a premium for this extra coverage.
- For more information about using your MSA plan, visit Medicare.gov or check with your plan.

PPO

Preferred Provider Organization (PPO) plan

Can I get my health care from any doctor, other health care provider, or hospital?

Yes. PPO plans have network doctors, specialists, hospitals, and other health care providers you can use. You can also use out-of-network providers for covered services, usually for a higher cost, if the provider agrees to treat you and hasn't opted out of Medicare (for Medicare Part A and Part B items and services). You're always covered for emergency and urgent care.

Do these plans cover prescription drugs?

In most cases, yes. If you're planning to enroll in a PPO and you want Medicare drug coverage (Part D), you must join a PPO plan that offers drug coverage. If you join a PPO Medicare Advantage Plan without drug coverage, you can't join a separate Medicare drug plan.

Do I need to choose a [primary care doctor](#)?

No.

Do I have to get a [referral](#) to see a specialist?

In most cases, no. But if you use plan specialists (in-network), your costs for covered services will usually be lower than if you use non-plan specialists (out of network).

What else do I need to know about this type of plan?

- Because certain providers are “preferred,” you can save money by using them.
- Check with the plan for more information.

PFFS**Private Fee-for-Service (PFFS) plan****Can I get my health care from any doctor, other health care provider, or hospital?**

You can go to any Medicare-approved doctor, other health care provider, or hospital that accepts the plan's payment terms, agrees to treat you, and hasn't opted out of Medicare (for Medicare Part A and Part B items and services). If you join a PFFS plan that has a network, you can also see any of the network providers who have agreed to always treat plan members. If you choose an out-of-network doctor, hospital, or other provider who accepts the plan's terms, you may pay more.

Do these plans cover prescription drugs?

Sometimes. If your PFFS plan doesn't offer drug coverage, you can join a separate Medicare drug plan to get Medicare drug coverage (Part D).

Do I need to choose a primary care doctor?

No.

Do I have to get a referral to see a specialist?

No.

What else do I need to know about this type of plan?

- The plan decides how much you pay for services. The plan will tell you about your cost sharing in the "Annual Notice of Change" and "Evidence of Coverage" documents that it sends each year.
- Some PFFS plans contract with a network of providers who agree to always treat you, even if you've never seen them before.
- Out of network doctors, hospitals, and other providers may decide not to treat you, even if you've seen them before.
- In a medical emergency, doctors, hospitals, and other providers must treat you.
- For each service you get, make sure to show your plan member card before you get treated.
- Check with the plan for more information.

SNP**Special Needs Plan (SNP)**

An SNP provides benefits and services to people with specific diseases, certain health care needs, or limited incomes. SNPs tailor their benefits, provider choices, and list of drugs (formularies) to best meet the specific needs of the groups they serve.

Can I get my health care from any doctor, other health care provider, or hospital?

Some SNPs cover services out of network and some don't. Check with the plan to see if they cover services out of network, and if so, how it affects your costs.

Do these plans cover prescription drugs?

Yes. All SNPs must provide Medicare drug coverage (Part D).

Do I need to choose a primary care doctor?

Generally, yes.

Do I have to get a referral to see a specialist?

In most cases, yes. Certain services, like yearly screening mammograms, don't require a referral.

What else do I need to know about this type of plan?

- These groups are eligible to enroll in an SNP:
 - People who live in certain institutions (like nursing homes) or who live in the community but require nursing care at home (also called an “Institutional SNP” or I-SNP).
 - People who are eligible for both Medicare and Medicaid (also called a “Dual Eligible SNP” or D-SNP). D-SNPs contract with your state Medicaid program to help coordinate your Medicare and Medicaid benefits.
 - People who have specific severe or disabling chronic conditions (like diabetes, End-Stage Renal Disease (ESRD), HIV/AIDS, chronic heart failure, or dementia) (also called a “Chronic condition SNP” or C-SNP). Plans may further limit membership to a single chronic condition or a group of related chronic conditions.
- An SNP provides benefits targeted to its members' special needs, including care coordination services.
- Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to find and compare **Medicare Advantage Plans**. Select “Special Needs Plans” to see if an SNP is available in your area.
- Check with the plan for more information.

You can join, switch, drop, or make changes to your Medicare Advantage Plan

Initial Enrollment Period See page 17	When you first become eligible for Medicare	If you enrolled in a Medicare Advantage Plan during your Initial Enrollment Period, you can change to another Medicare Advantage Plan (with or without drug coverage) or go back to Original Medicare (with or without a separate Medicare drug plan) within the first 3 months you have Medicare.
General Enrollment Period See page 18	January 1 to March 31	If you have Part A coverage and you get Part B for the first time during this period, you can also join a Medicare Advantage Plan. Your coverage will start July 1. Remember, you must have Part A and Part B to join a Medicare Advantage Plan.
Open Enrollment Period	October 15 to December 7	You can join, switch, or drop a Medicare Advantage Plan during the Open Enrollment Period each year. Your coverage will begin on January 1 (as long as the plan gets your request by December 7). If you join a Medicare Advantage Plan during this period but change your mind, you can switch back to Original Medicare or change to a different Medicare Advantage Plan (depending on which coverage works better for you) during the Medicare Advantage Open Enrollment Period (January 1 - March 31).

Medicare Advantage Open Enrollment Period	January 1 to March 31	<p>If you're in a Medicare Advantage Plan (with or without drug coverage), during this period you can:</p> <ul style="list-style-type: none"> • Switch to another Medicare Advantage Plan (with or without drug coverage). • Drop your Medicare Advantage Plan and return to Original Medicare. You'll also be able to join a separate Medicare drug plan. <p>During this period, you can't:</p> <ul style="list-style-type: none"> • Switch from Original Medicare to a Medicare Advantage Plan. • Join a separate Medicare drug plan if you're in Original Medicare. • Switch from one Medicare drug plan to another if you're in Original Medicare. <p>You can only make one change during this period, and any changes you make will be effective the first of the month after the plan gets your request. If you're returning to Original Medicare and joining a separate Medicare drug plan, you don't need to contact your Medicare Advantage Plan to disenroll. The disenrollment will happen automatically when you join the drug plan.</p>
Special Enrollment Period	Qualifying Life Event	In most cases, if you're enrolled in a Medicare Advantage Plan, you must stay enrolled for the calendar year starting the date your coverage begins. However, in certain situations, like if you move or you lose other insurance coverage, you may be able to join, switch, or drop a Medicare Advantage Plan during a Special Enrollment Period. Visit Medicare.gov or check with your plan for more information.
5-star Special Enrollment Period	December 8 to November 30 Note: You can use this Special Enrollment Period only once during this period	<p>Medicare uses star ratings from 1-5 to help you compare plans based on quality and performance.</p> <p>If a Medicare Advantage Plan, Medicare drug plan, or Medicare Cost Plan with a 5-star rating is available in your area, you can use the 5-star Special Enrollment Period to switch from your current Medicare plan to a Medicare plan with a "5-star" quality rating.</p> <p>Visit Medicare.gov for more information.</p>

Important!

If you drop your Medicare Supplement Insurance (**Medigap**) policy to join a **Medicare Advantage Plan**, you may not get the same policy back. Rules vary by state and your situation. Also, if you don't drop your Medicare Advantage Plan and return to Original Medicare within 12 months of joining, you may be limited in your ability to get a Medigap policy when you return to Original Medicare. See page 78.

Always review the materials your plan sends you (like the "Annual Notice of Change" and "Evidence of Coverage"), and make sure your plan will still meet your needs for the following year. You can also visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to compare other available options with your current plan.

Does Medicare offer other types of plans or programs to get health coverage?

Yes, some other plans and programs may be offered in your area. Some provide both Hospital (Part A) and Medical (Part B) coverage, while others provide only Part B coverage. Some also provide drug coverage. They have some of the same rules as Medicare Advantage Plans. However, each has special rules and exceptions, so you should contact any plans you're interested in to get more details.

Cost Plans

Cost Plans are a type of **Medicare health plan** available in certain, limited areas of the country.

- In general, you can join even if you only have Part B.
- If you have Part A and Part B and go to a non-network provider, Original Medicare covers the services. You'll pay the Part A and Part B **coinsurance** and **deductibles**.
- You can join any time the Cost Plan is accepting new members.
- You can leave any time and return to Original Medicare.
- You can join a separate Medicare drug plan or you can get drug coverage from the Cost Plan (if offered). Even if the Cost Plan offers drug coverage, you can choose to get drug coverage from a separate Medicare drug plan.

Note: You can add or drop drug coverage only at certain times. See pages 80–81.

To see if there are Cost Plans in your area, visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare). You can contact the plan you're interested in for more information. Your State Health Insurance Assistance Program (SHIP) can also help you. See pages 117–120 for the phone number.

Program of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who otherwise need a nursing home-level of care to remain in the community, like a home, apartment, or other appropriate setting. To qualify for PACE, you must meet these conditions:

- You're 55 or older.
- You live in the **service area** of a PACE organization.
- You're certified by your state as needing a nursing home-level of care.
- At the time you join, you're able to live safely in the community with the help of PACE services.

PACE covers all Medicare- and Medicaid-covered care and services, and other services that the PACE team of health care professionals decides are necessary to improve and maintain your health. This includes drugs, as well as any other **medically necessary** care, like doctor or health care provider visits, transportation, home care, hospital visits, and even nursing home stays when necessary.

If you have **Medicaid**, you won't have to pay a monthly **premium** for the long-term care portion of the PACE benefit. If you have Medicare but not Medicaid, you'll be charged a monthly premium to cover the long-term care portion of the PACE benefit and a premium for Medicare drug coverage (Part D). However, in PACE, there's never a **deductible** or **copayment** for any drug, service, or care approved by the PACE team of health care professionals.

Visit [Medicare.gov/pace](https://www.medicare.gov/pace) to see if there's a PACE organization that serves your community.

Medicare Innovation Projects

Medicare develops innovative models, **demonstrations**, and pilot projects to test and measure the effect of potential changes in Medicare. These projects help to find new ways to improve health care quality and reduce costs. Usually, they operate only for a limited time and for a specific group of people and/or are offered only in specific areas. Examples of current models, demonstrations, and pilot projects include innovations in primary care, care related to specific procedures (like hip and knee replacements), cancer care, and care for people with End-Stage Renal Disease (ESRD). Ask your doctor if they participate in these models, and what it means for your care. To learn more about the current Medicare models, demonstrations, and pilot projects, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

SECTION 5

Medicare Supplement Insurance (Medigap)

How does Medigap work?

Original Medicare pays for much, but not all, of the cost for covered health care services and supplies. Medicare Supplement Insurance (**Medigap**) policies sold by private companies, can help pay some of the remaining health care costs for covered services and supplies, like **copayments**, **coinsurance**, and **deductibles**.

Some Medigap policies also offer coverage for services that Original Medicare doesn't cover, like medical care when you travel outside the U.S. Generally, Medigap doesn't cover long-term care (like care in a nursing home), vision or dental services, hearing aids, eyeglasses, or private-duty nursing.

Medigap plans are standardized

Medigap must follow federal and state laws designed to protect you, and they must be clearly identified as "Medicare Supplement Insurance." Insurance companies can sell you only a "standardized" plan, identified in most states as plans A – D, F, G, and K – N. All plans offer the same basic benefits, but some offer additional benefits so you can choose which one meets your needs. In Massachusetts, Minnesota, and Wisconsin, Medigap plans are standardized in a different way. If you live in one of these states and want more information, visit [Medicare.gov](#) or [Medicare.gov/publications](#) to view the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Important!

Plans C and F are no longer available to people new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020, but not yet enrolled, you may be able to buy Plan C or Plan F. People new to Medicare on or after January 1, 2020, have the right to buy Plans D and G instead of Plans C and F.

If you're eligible to buy one of these plans, other policies might offer better value.



Note: See pages 121–124 for definitions of blue words.

How do I compare Medigap plans?

The chart below shows basic information about the different benefits that Medicare Supplement Insurance (**Medigap**) plans cover for 2022. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you're responsible for the rest. Out-of-pocket costs (like **deductibles**) might change for 2023.

Benefits	Medigap plans									
	A	B	C	D	F*	G*	K	L	M	N
Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Medicare Part B coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%***
Blood (first 3 pints)	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Part A hospice care coinsurance or copayment	100%	100%	100%	100%	100%	100%	50%	75%	100%	100%
Skilled nursing facility care coinsurance			100%	100%	100%	100%	50%	75%	100%	100%
Part A deductible		100%	100%	100%	100%	100%	50%	75%	50%	100%
Part B deductible			100%		100%					
Part B excess charges					100%	100%				
Foreign travel emergency (up to plan limits)			80%	80%	80%	80%			80%	80%
								Out-of-pocket limit in 2022**		
								\$6,620	\$3,310	

*Plans F and G also offer a high-deductible plan in some states. With this option, you must pay for Medicare-covered costs (coinsurance, copayments, and deductibles) up to the deductible amount of \$2,490 in 2022 before your policy pays anything. (You can't buy Plans C and F if you were new to Medicare on or after January 1, 2020. See previous page for more information.)

**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$233 in 2022), the Medigap plan pays 100% of covered services for the rest of the calendar year.

***Plan N pays 100% of the Part B coinsurance. You must pay a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

What else should I know about Medigap?

- Before you can buy Medicare Supplement Insurance (**Medigap**), you must have Part A and Part B.
- You pay the private insurance company a monthly **premium** for Medigap in addition to the monthly Part B premium you pay to Medicare. Also, if you buy Medigap and a separate Medicare drug plan from the same company, you may need to make 2 separate premium payments. Contact the company to find out how to pay your premiums.
- A Medigap policy only covers one person. Spouses must buy separate coverage.
- You can't have drug coverage in both Medigap and your Medicare drug plan. See page 89.
- It's important to compare Medigap policies since the costs can vary between policies for exactly the same coverage, and may go up as you get older. Some states limit Medigap premium costs.
- In some states, you may be able to buy another type of Medigap policy called Medicare SELECT. Medicare SELECT is a type of Medigap policy sold in some states that requires you to use hospitals and, in some cases, doctors within its network to be eligible for full insurance benefits (except in an emergency). If you buy Medicare SELECT, you have rights to change your mind within 12 months and switch to standard Medigap.

Note: Medigap plans sold to people who are new to Medicare on or after January 1, 2020 aren't allowed to cover the Part B **deductible**. Because of this, Plans C and F are no longer available to people new to Medicare on or after January 1, 2020.

When to buy

- The best time to buy a Medigap policy is during your Medigap Open Enrollment Period. This 6-month period begins the first month you have Medicare Part B (Medical Insurance), **and** you're 65 or older. (Some states have additional Open Enrollment Periods.) **After this enrollment period, you may not be able to buy Medigap. If you're able to buy Medigap, it may cost more.**
- If you delay enrolling in Part B because you have group health coverage based on your (or your spouse's) current employment, your Medigap Open Enrollment Period won't start until you sign up for Part B.
- Federal law generally doesn't require insurance companies to sell Medigap to people under 65. If you're under 65, you might not be able to buy the policy you want, or any policy, until you turn 65. However, some states require Medigap insurance companies to sell Medigap policies to people under 65. If you're able to buy one, it may cost more.

Check with your State Health Insurance Assistance Program (SHIP) (see pages 117-120 for the phone number of your local SHIP), or your State Insurance Department to learn more about your rights to buy a Medigap policy. A trusted agent or broker may also be able to help.

Can I have Medigap and a Medicare Advantage Plan?

- If you have a **Medicare Advantage Plan**, it's illegal for anyone to sell you a **Medigap** policy unless you're switching back to Original Medicare. If you aren't planning to leave your Medicare Advantage Plan, and someone tries to sell you a Medigap policy, report it to your State Insurance Department.
- If you have Medigap and join a Medicare Advantage Plan, you may want to drop Medigap. You can't use Medigap to pay your Medicare Advantage Plan **copayments, deductibles**, and **premiums** because Medicare Advantage Plans provide other protections that Medigap doesn't.

Important!

If you want to cancel your Medigap policy, contact your insurance company. In most cases, if you drop your Medigap policy to join a Medicare Advantage Plan, you may not be able to get the same policy back.

- If you join a Medicare Advantage Plan for the first time, and you aren't happy with the plan, you'll have special rights under federal law to buy a Medigap policy and a separate Medicare drug plan if you return to Original Medicare within 12 months of joining the Medicare Advantage Plan.
 - If you had Medigap before you joined, you may be able to get the same policy back if the company still sells it. If it isn't available, you can buy another policy.
 - If you joined a Medicare Advantage Plan when you were first eligible for Medicare (and you aren't happy with the plan), you can choose from any Medigap policy when you switch to Original Medicare within the first year of joining.
 - Some states provide additional special rights to buy a Medigap policy.

Note: If you don't drop your Medicare Advantage Plan and return to Original Medicare within 12 months of joining, generally, you must keep your Medicare Advantage Plan for the rest of the year. You can disenroll or change plans during the Open Enrollment Period or if you qualify for a Special Enrollment Period. Depending on the type of Special Enrollment Period, you may or may not have the right to buy a Medigap policy.

Where can I get more information?

- Call your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number.
- Call your State Insurance Department. Visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone) or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.
- Visit [Medicare.gov/medigap-supplemental-insurance-plans](https://www.medicare.gov/medigap-supplemental-insurance-plans) to find policies in your area.
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

SECTION 6

Medicare drug coverage (Part D)

How does Medicare drug coverage work?

Medicare drug coverage (Part D) helps pay for prescription drugs you need. Even if you don't take prescription drugs now, you should consider getting Medicare drug coverage. Medicare drug coverage is optional and is offered to everyone with Medicare. If you decide not to get it when you're first eligible, and you don't have other **creditable prescription drug coverage** (like drug coverage from an employer or union) or get **Extra Help**, you'll likely pay a late enrollment penalty if you join a plan later. Generally, you'll pay this penalty for as long as you have Medicare drug coverage (see pages 83–84). To get Medicare drug coverage, you must join a Medicare-approved plan that offers drug coverage. Each plan can vary in cost and specific drugs covered. Visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to find and compare plans in your area.

There are 2 ways to get Medicare drug coverage (Part D):

1. **Medicare drug plans.** These plans add Medicare drug coverage (Part D) to Original Medicare, some Medicare Cost Plans, some Private Fee-for-Service plans, and Medical Savings Account plans. You must have Part A and/or Part B to join a separate Medicare drug plan.
2. **Medicare Advantage Plans or other Medicare health plans with drug coverage.** You get your Part A, Part B, and Medicare drug coverage (Part D) through these plans. Remember, you must have Part A and Part B to join a Medicare Advantage Plan, and not all of these plans offer drug coverage.

In either case, you must live in the **service area** of the plan you want to join and be lawfully present in the U.S. **Both types of plans are called “Medicare drug coverage” in this handbook.**

Important! If you have employer or union coverage

Call your benefits administrator before you make any changes, or sign up for any other coverage. If you sign up for other coverage, you could lose your employer or union health and drug coverage for you and your dependents. If this happens, you may not be able to get your employer or union coverage back. If you want to know how Medicare drug coverage (Part D) works with other drug coverage you may have, see page 88.

When can I join, switch, or drop a plan?

You can join, switch, or drop a Medicare drug plan or a **Medicare Advantage Plan** with drug coverage during these times:

- **Initial Enrollment Period.** When you first become eligible for Medicare, you can join a plan. See page 17.
- **Open Enrollment Period.** From October 15 – December 7 each year, you can join, switch, or drop a plan. Your coverage will begin on January 1 (as long as the plan gets your request by December 7).
- **Medicare Advantage Open Enrollment Period.** From January 1 – March 31 each year, if you're enrolled in a Medicare Advantage Plan, you can switch to a different Medicare Advantage Plan or switch to Original Medicare (and join a separate Medicare drug plan) once during this time. See page 71.

If you have to pay a **premium** for Part A and enroll in Part B for the first time during the General Enrollment Period, you can also join a plan from April 1 – June 30. Your coverage will begin on July 1.

Special Enrollment Periods

Generally, you must stay enrolled in your plan for the entire year. But when certain events happen in your life, like if you move or lose other insurance coverage, you may qualify for a Special Enrollment Period. You may be able to make changes to your plan mid-year if you qualify. Check with your plan for more information.

How do I switch plans?

You can switch to a new Medicare drug plan or Medicare Advantage Plan with drug coverage simply by joining another plan during one of the times listed above. Your old drug coverage will end when your new drug coverage begins. You should get a letter from your new plan telling you when your coverage begins, so **you don't need to cancel your old plan**. You can switch plans by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

How do I drop my plan?

If you want to drop your separate Medicare drug plan or **Medicare Advantage Plan** with drug coverage and don't want to join a new plan, you can only do so during certain times (see page 80). You can disenroll by calling 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also send a letter to the plan to tell them you want to disenroll. If you drop your plan and want to join another Medicare drug plan or **Medicare health plan** with drug coverage later, you have to wait for an enrollment period. You may have to pay a late enrollment penalty if you don't have **creditable prescription drug coverage**. See pages 83-84.

Read the information you get from your plan

Review the "Evidence of Coverage" and "Annual Notice of Change" your plan sends you each year. The Evidence of Coverage gives you details about what the plan covers, how much you pay, and more. The Annual Notice of Change includes any changes in coverage, costs, provider networks, **service area**, and more that will be effective in January. If you don't get these important documents in early fall, contact your plan.

How much do I pay?

Your drug costs will vary based on the plan you choose. Remember, plan coverage and costs can change each year. You may have to pay a **premium**, **deductible**, **copayments**, or **coinsurance** throughout the year. Learn more about these costs on the next page.

Your actual drug coverage costs will vary depending on:

- Your prescriptions and whether they're on your plan's list of covered drugs (**formulary**). See page 85.
- What "tier" the drug is in. See page 85.
- Which drug benefit phase you're in (like whether you've met your deductible, or if you're in the catastrophic coverage phase). See page 83.
- Which pharmacy you use (whether it offers preferred or standard cost sharing, is out of network, or is mail order). Your out-of-pocket drug costs may be less at a preferred pharmacy because it has agreed with your plan to charge less.
- Whether you get **Extra Help** paying your Medicare drug costs. See page 91.



Cost & coverage: You may be able to lower the cost of your drugs. Some ways include choosing generics over brand name or paying the non-insurance cost of a drug. Ask your pharmacist—they can tell you if there's a less expensive option available. Check with your doctor to make sure the generic option is best for you.

Monthly premium

Most drug plans charge a monthly fee that varies by plan. You pay this in addition to the Part B **premium**. If you're in a **Medicare Advantage Plan** or a Medicare Cost Plan with drug coverage, the monthly premium may include an amount for drug coverage.

Note: Contact your plan (not Social Security or the Railroad Retirement Board (RRB)) if you want your drug premium deducted from your monthly Social Security or RRB payment. If you want to stop premium deductions and get billed directly, contact your plan.

Important! **If you have a higher income, you might pay more for your Medicare drug coverage.** If your income is above a certain limit (in 2022: \$91,000 if you file individually or \$182,000 if you're married and file jointly), you'll pay an extra amount in addition to your plan premium (sometimes called "Part D-IRMAA"). You'll also have to pay this extra amount if you're in a Medicare Advantage Plan that includes drug coverage. This doesn't affect everyone, so most people won't have to pay an extra amount. If you have Part B and you have a higher income, you may also have to pay an extra amount for your Part B premium, even if you don't have Medicare drug coverage (Part D). See page 23.

Usually, the extra amount will be deducted from your Social Security or RRB payment. If Medicare or the RRB bills you for the extra amount instead of deducting it from your Social Security or RRB payment, then you must pay the extra amount to Medicare or the RRB, not your plan. If you don't pay the extra amount, you could lose your Medicare drug coverage (Part D). You may not be able to enroll in another plan right away, and you may have to pay a late enrollment penalty for as long as you have drug coverage.

You'll pay Part D-IRMAA payments separately, even if your employer or another third party (like a retirement system) pays your plan premiums.

If you have to pay an extra amount and you disagree (for example, you have one or more life changing events that lower your income), visit socialsecurity.gov or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Yearly deductible

This is the amount you must pay before your plan begins to pay its share of your covered drugs. Some plans don't have a **deductible**.

Copayments or coinsurance

These are the amounts you pay for your covered drugs after the deductible (if the plan has one). You pay your share and your plan pays its share for covered drugs. If you pay **coinsurance**, these amounts may vary throughout the year due to changes in the drug's total cost. The amount you pay will also depend on the tier level assigned to your drug. See page 85.

Once you and your plan spend \$4,430 combined on drugs (including deductible), you'll generally pay no more than 25% of the cost for prescription drugs until your out-of-pocket spending is \$7,050, under the standard drug benefit.

Catastrophic coverage

Once your out-of-pocket spending reaches \$7,050, you'll automatically get "catastrophic coverage." In most cases, you'll pay no more than 5% of the cost for covered drugs for the rest of the year.

Note: If you get **Extra Help**, you won't have some of these costs. See pages 91–92.

Important!

Visit Medicare.gov/plan-compare to get specific Medicare drug plan and **Medicare Advantage Plan** costs, and call the plans you're interested in to get more details. For help comparing plan costs, contact your State Health Insurance Assistance Program (SHIP). See pages 117–120 for the phone number.

What's the Medicare drug coverage (Part D) late enrollment penalty?

The late enrollment penalty is an amount that's permanently added to your Medicare drug coverage (Part D) **premium**. You may owe a late enrollment penalty if at any time after your Initial Enrollment Period is over, there's a period of 63 or more days in a row when you don't have Medicare drug coverage or other **creditable prescription drug coverage**. You'll generally have to pay the penalty for as long as you have Medicare drug coverage.

Note: If you get Extra Help, you don't pay a late enrollment penalty.

3 ways to avoid paying a penalty:

1. Enroll in Medicare drug coverage (Part D) when you're first eligible.

Even if you don't take drugs now, you should consider joining a separate Medicare drug plan or a Medicare Advantage Plan with drug coverage to avoid a penalty. You may be able to find a plan that meets your needs with little to no monthly premiums. See pages 5–9 to learn more about your choices.

2. Enroll in Medicare drug coverage (Part D) if you lose other creditable coverage.

Creditable prescription drug coverage could include drug coverage from a current or former employer or union, TRICARE, Indian Health Service, the Department of Veterans Affairs, or individual health insurance coverage. Your plan must tell you each year if your non-Medicare drug coverage is creditable coverage. If you go 63 days or more in a row without Medicare drug coverage or other creditable prescription drug coverage, you may have to pay a penalty if you sign up for Medicare drug coverage later.

3. Keep records showing when you had other creditable drug coverage, and tell your plan when they ask about it.

If you don't tell your **Medicare plan** about your previous creditable prescription drug coverage, you may have to pay a penalty for as long as you have Medicare drug coverage.

How much more will I pay for a late enrollment penalty?

The cost of the late enrollment penalty depends on how long you didn't have **creditable prescription drug coverage**. Currently, the late enrollment penalty is calculated by multiplying 1% of the "national base beneficiary premium" (\$33.37 in 2022) by the number of full, uncovered months that you were eligible but didn't enroll in Medicare drug coverage (Part D) and went without other creditable prescription drug coverage. The final amount is rounded to the nearest \$.10 and added to your monthly **premium**. Since the "national base beneficiary premium" may increase each year, the penalty amount may also increase each year. After you enroll in Medicare drug coverage, the plan will tell you if you owe a penalty and what your premium will be.

Example:

Mrs. Martinez is currently eligible for Medicare, and her Initial Enrollment Period ended on May 31, 2018. She doesn't have prescription drug coverage from any other source. She didn't join by May 31, 2018, and instead joined during the Open Enrollment Period that ended December 7, 2020. Her drug coverage was effective January 1, 2021.

2021

Since Mrs. Martinez was without creditable prescription drug coverage from June 2018–December 2020, her penalty in 2021 was 31% (1% for each of the 31 months) of \$33.06 (the national base beneficiary premium for 2021) or \$10.25. Since the monthly penalty is always rounded to the nearest \$0.10, she paid \$10.30 each month in addition to her plan's monthly premium.

Here's the math:

.31 (31% penalty) × \$33.06 (2021 base beneficiary premium) = \$10.25

\$10.25 rounded to the nearest \$0.10 = \$10.30

\$10.30 = Mrs. Martinez's monthly late enrollment penalty for 2021

2022

In 2022, Medicare recalculated Mrs. Martinez's penalty using the 2022 base beneficiary premium (\$33.37). So, Mrs. Martinez's new monthly penalty in 2022 is 31% of \$33.37, or \$10.34 each month. Since the monthly penalty is always rounded to the nearest \$0.10, she pays \$10.30 each month in addition to her plan's monthly premium.

Here's the math:

.31 (31% penalty) × \$33.37 (2022 base beneficiary premium) = \$10.34

\$10.34 rounded to the nearest \$0.10 = \$10.30

\$10.30 = Mrs. Martinez's monthly late enrollment penalty for 2022

What if I don't agree with the late enrollment penalty?

Your Medicare drug plan or **Medicare Advantage Plan** with drug coverage will send you a letter stating you have to pay a late enrollment penalty. If you disagree with your penalty, you can request a review (generally within 60 days from the date on the letter). Fill out the "reconsideration request form" you get with your letter by the date listed in the letter. You can provide proof that supports your case, like information about previous creditable prescription drug coverage. If you need help, call your plan.

Which drugs are covered?

All plans must cover a wide range of prescription drugs that people with Medicare take, including most drugs in certain “protected classes,” like drugs to treat cancer or HIV/AIDS. Information about a plan’s list of covered drugs (called a “**formulary**”) isn’t included in this handbook because each plan has its own formulary. A Medicare drug plan can make some changes to its drug list during the year if it follows guidelines set by Medicare. Your plan may change its drug list during the year because drug therapies change, new drugs are released, or new medical information becomes available. Your plan may raise the **copayment** or **coinsurance** you pay for a particular brand name drug or generic drug when the manufacturer raises the price, or when a plan starts to offer a generic form of a brand name drug, but you continue to take the brand name drug.

Many Medicare drug plans and **Medicare health plans** with drug coverage place drugs into different levels called “tiers” on their formularies. Drugs in each tier have a different cost. For example, a drug in a lower tier will generally cost you less than a drug in a higher tier. Check with the plan to see if a drug is covered for your health condition. A plan may cover a drug for one condition but not another.

What happens if my drug is in a higher tier?

In some cases, if your drug is in a higher tier and your prescriber (your doctor or other health care provider who’s legally allowed to write prescriptions) thinks you need that drug instead of a similar drug in a lower tier, you or your prescriber can ask your plan for an exception to get a lower coinsurance or copayment for the drug in the higher tier. See page 100 for more information on exceptions.

Plans can change their formularies at any time. Your plan may notify you of any formulary changes that affect drugs you’re taking.

Note: Medicare drug coverage (Part D) includes drugs for medication-assisted treatment for opioid use disorders. It also covers drugs like methadone and buprenorphine when prescribed for pain. However, Medicare Part A covers methadone when used to treat an opioid use disorder as an inpatient in a hospital, and Part B now covers methadone when you receive it through an opioid treatment program. See page 47 for more information about opioid treatment programs.

Contact the plan for its current formulary, or visit the plan’s website. You can also visit Medicare.gov/plan-compare or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Important!

- Each month you fill a prescription, your plan mails you an “Explanation of Benefits” notice. Review your notice and check it for mistakes. Contact your plan if you have questions or find mistakes. If you suspect fraud, call the Medicare Drug Integrity Contractor at 1-877-7SAFERX (1-877-772-3379). See page 106.

Plans may have coverage rules for certain drugs

- **Prior authorization:** You and/or your prescriber must contact your plan before you can fill certain prescriptions. Your prescriber may need to show that the drug is **medically necessary** for the plan to cover it. Plans may also use prior authorization when they cover a drug for only certain medical conditions it is approved for, but not others. When this occurs, plans will likely have alternative drugs on their list of covered drugs (**formulary**) for the other medical conditions the drug is approved to treat.
- **Quantity limits:** Limits on how much medicine you can get at a time.
- **Step therapy:** You may need to try one or more similar, lower-cost drugs before the plan will cover the prescribed drug.
- **Prescription safety checks at the pharmacy (including opioid pain medicine):** Before the pharmacy fills your prescriptions, your Medicare drug plan and pharmacy perform additional safety checks, like checking for drug interactions and incorrect dosages. These safety checks also include checking for possible unsafe amounts of opioids, limiting the days supply of a first prescription for opioids, and use of opioids at the same time as benzodiazepines (commonly used for anxiety and sleep). Opioid pain medicine (like oxycodone and hydrocodone) can help with certain types of pain, but have risks and side effects (like addiction, overdose, and death). These can increase when you take opioids with certain other drugs, like benzodiazepines, anti-seizure medications, gabapentin, muscle relaxers, certain antidepressants, and drugs for sleeping problems. Check with your doctor or pharmacist if you have questions about risks or side effects.
- **Drug Management Programs:** Medicare drug plans and health plans with drug coverage have a program in place to help you use these opioids and benzodiazepines safely. If your opioid use could be unsafe, for example due to getting opioid prescriptions from multiple doctors or pharmacies, or if you had a recent overdose from opioids, your plan will contact the doctors who prescribed them for you to make sure they're medically necessary and you're using them appropriately.

If your plan decides your use of prescription opioids and benzodiazepines may not be safe, the plan will send you a letter in advance. This letter will tell you if the plan will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from one doctor or pharmacy you select. You and your doctor have the right to appeal these limitations if you disagree with the plan's decision (see page 99). The letter will also tell you how to contact the plan if you have questions or would like to appeal.

Prescription safety checks at the pharmacy and Drug Management Programs generally don't apply if you have cancer or sickle cell disease, are getting palliative or end-of-life care, are in hospice, or live in a long-term care facility.

If you or your prescriber believe that your plan should waive one of these coverage rules, you can ask for an exception. See page 100.

Important tips if you're prescribed opioids:

- Opioid medications can be an important part of pain management, but they also can have serious health risks if misused.
- Talk with your doctor about having naloxone at home. Medicare covers naloxone, a drug that your doctor may prescribe as a safety measure in case you need to rapidly reverse the effects of an opioid overdose.
- Talk with your doctor about your dosage and the length of time you'll be taking them. You and your doctor may decide later you don't need to take all of your prescription.
- Talk with your doctor about other options that Medicare covers to treat your pain, like non-opioid medications and devices, physical therapy, acupuncture for lower back pain, individual and group therapy, behavioral health integration services, and more.
- Never take more opioids than prescribed. Also, talk with your doctor about any other pain medicines you're taking.
- Safely store and dispose of unused prescription opioids through your community drug take-back program or your pharmacy mail-back program.

For more information on safe and effective pain management and opioid use, visit [Medicare.gov/coverage/pain-management](https://www.medicare.gov/coverage/pain-management) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Do you get automatic prescription refills in the mail?

Some people with Medicare get their drugs through an “automatic refill” service that automatically delivers prescription drugs before they run out. To make sure you still need a prescription before they send you a refill, drug plans may offer a voluntary auto-ship program. Contact your plan for more information.

Medication Therapy Management program

Plans with Medicare drug coverage (Part D) must offer free Medication Therapy Management services if you meet certain requirements or are in a program to help members use their opioids safely. If you qualify, you can get these services to help you understand how to manage and use drugs safely. Medication Therapy Management services usually include a discussion with a pharmacist or health care provider to review your medications. These services may vary in some plans.

The pharmacist or health care provider may talk with you about:

- How well your medications are working and any problems you're having
- Whether your medications have side effects
- If there might be interactions between the drugs you're taking
- Whether you can get lower costs
- How to safely dispose of unused medications

Contact your plan for specific details and to see if you're eligible for a Medication Therapy Management program. Or, visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to find and compare health and drug plans.

Part D Senior Savings Model

You may be able to get Medicare drug coverage that gives supplemental benefits specifically for insulin. The Part D Senior Savings Model is available to all people with Medicare. Plans that participate in this model will offer coverage choices that include multiple types of insulin at a maximum **copayment** of \$35 for a month's supply. (The \$35 maximum copayment doesn't apply during the catastrophic phase of Medicare drug plan coverage.) If you're getting full **Extra Help**, your copayment for insulin is less than \$35 outside of the model.

How do other insurance and programs work with Medicare drug coverage (Part D)?

Medicaid

If you have Medicare and full **Medicaid** coverage, Medicare covers your prescription drugs.

Medicaid may still cover some drugs that Medicare doesn't cover.

Note: You automatically qualify for Extra Help if you have Medicare and Medicaid. See page 92.

Employer or union health coverage

This is health coverage from your, your spouse's, or other family member's current or former employer or union. If you have drug coverage based on your current or previous employment, your employer or union will notify you each year to let you know if your drug coverage is creditable. **Keep the information you get.** Call your benefits administrator for more information before making any changes to your coverage.

Note: If you get Medicare drug coverage, you, your spouse, or your dependents may lose your employer or union health coverage.

COBRA

This is a federal law that may allow you to temporarily keep employer or union health coverage after the employment ends or after you lose coverage as a dependent of the covered employee. There may be reasons why you should take Part B instead of, or in addition to, COBRA coverage (see page 18). However, if you take COBRA and it includes **creditable prescription drug coverage**, you'll have a Special Enrollment Period to get Medicare drug coverage (Part D) without paying a penalty when the COBRA coverage ends.

Talk with your State Health Insurance Assistance Program (SHIP) to see if COBRA is a good choice for you. See pages 117-120 for the phone number. If you have questions about Medicare and COBRA, call the Benefits Coordination & Recovery Center at 1-855-798-2627. TTY users can call 1-855-797-2627.

Medicare Supplement Insurance (Medigap) with drug coverage

Medigap policies can no longer be sold with drug coverage, but if you currently have Medigap with drug coverage, you can keep it. You may choose to join a separate Medicare drug plan because most Medigap drug coverage isn't creditable, and you may pay more if you join a drug plan later. See page 82.

You can't have drug coverage in both Medigap and your Medicare drug plan. If you join a separate Medicare drug plan, tell your Medigap insurance company so they can remove the drug coverage and adjust your **premiums**. Call your Medigap insurance company for more information.

Note: Keep any **creditable prescription drug coverage** information you get from your plan. You may need it if you decide to join a separate Medicare drug plan later. Don't send creditable coverage letters or certificates to Medicare.

How does other government insurance work with Medicare drug coverage (Part D)?

The types of insurance listed below are all considered creditable prescription drug coverage. In most cases, it's to your advantage to keep this coverage if you have it.

Federal Employee Health Benefits Program (FEHB)

This is health coverage for current and retired federal employees and covered family members. These plans usually include creditable prescription drug coverage, so you don't need to get Medicare drug coverage (Part D). However, if you decide to get Medicare drug coverage, you can keep your FEHB plan, and in most cases, the **Medicare plan** will pay first. For more information, visit opm.gov/healthcare-insurance/healthcare, or call the Office of Personnel Management at 1-888-767-6738. TTY users can call 1-800-877-8339. If you're an active federal employee, contact your Benefits Officer. Visit apps.opm.gov/abo for a list of Benefits Officers. You can also call your plan if you have questions.

Veterans' benefits

This is health coverage for veterans and people who have served in the U.S. military. You may be able to get drug coverage through the U.S. Department of Veterans Affairs (VA) program. You may join a separate Medicare drug plan, but if you do, you can't use both types of coverage for the same drug at the same time. For more information, visit va.gov or call the VA at 1-800-827-1000. TTY users can call 711.

CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)

This is a comprehensive health care program in which the Department of Veterans Affairs shares the cost of covered health care services and supplies with eligible beneficiaries. You may join a separate Medicare drug plan, but if you do, you won't be able to use the Meds by Mail program which can give your maintenance drugs to you at no charge (no premiums, deductibles, and copayments). For more information, visit va.gov/communitycare/programs/dependents/champva/ or call CHAMPVA at 1-800-733-8387.

TRICARE (military health benefits)

This is a health care plan for active-duty service members, military retirees, and their families. **Most people with TRICARE entitled to Part A must have Part B to keep TRICARE drug benefits.** If you have TRICARE, you don't need to join a separate Medicare drug plan. However, if you do, your Medicare drug plan pays first, and TRICARE pays second.

If you join a **Medicare Advantage Plan** with drug coverage, your Medicare Advantage Plan and TRICARE may coordinate their benefits if your Medicare Advantage Plan network pharmacy is also a TRICARE network pharmacy. Otherwise, you can file your own claim to get paid back for your out-of-pocket costs. For more information, visit tricare.mil, or call the TRICARE Pharmacy Program at 1-877-363-1303. TTY users can call 1-877-540-6261.

Indian Health Service (IHS)

The IHS is the primary health care provider to the American Indian/Alaska Native Medicare population. The Indian health care system, consisting of tribal, urban, and federally operated IHS health programs, delivers a spectrum of clinical and preventive health services through a network of hospitals, clinics, and other entities. Many Indian health facilities participate in the Medicare drug program (Part D). If you get drugs through an Indian health facility, you'll continue to get drugs at no cost to you, and your coverage won't be interrupted. Joining a Medicare drug plan or Medicare Advantage Plan with drug coverage may help your Indian health facility because the plan pays the Indian health facility for the cost of your drugs. Talk to your local Indian health benefits coordinator who can help you choose a plan that meets your needs and tell you how Medicare works with the Indian health care system.

Note: If you're getting care through an IHS or tribal health facility or program without being charged, you can continue to do so for some or all of your care. Getting Medicare doesn't affect your ability to get services through the IHS and tribal health facilities.

SECTION 7

Get help paying your health & drug costs

Get Extra Help paying your Medicare drug costs

If you have limited income and resources, you may qualify for help to pay for some health care and drug coverage costs.

Extra Help is a program to help people with limited income and resources pay Medicare drug costs. You may qualify for Extra Help if your yearly income and resources are below these limits in 2021:

	Yearly income	Other resources
Single person	less than \$19,320	less than \$14,790
Married person living with a spouse and no other dependents	less than \$26,130	less than \$29,520

These amounts may change in 2022. You may qualify even if you have a higher income (like if you still work, live in Alaska or Hawaii, or have dependents living with you). Resources include money in a checking or savings account, stocks, bonds, mutual funds, and Individual Retirement Accounts (IRAs). Resources **don't** include your home, car, household items, burial plot, up to \$1,500 for burial expenses (per person), or life insurance policies.

If you qualify for Extra Help and join a separate Medicare drug plan or **Medicare Advantage Plan** with Medicare drug coverage (Part D):

- You'll get help paying your drug coverage costs.
- You won't pay a late enrollment penalty.

Note: Extra Help isn't available in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa. See page 96 for information about programs available in those areas.



Cost & coverage: Most people with Medicare can only make changes to their drug coverage at certain times of the year. If you have **Medicaid** or receive **Extra Help**, you may be able to make changes to your coverage one time during each of these periods:

- January – March
- April – June
- July – September

If you make a change, it will begin the first day of the following month. You'll have to wait for the next period to make another change. You can't use this Special Enrollment Period October – December. However, all people with Medicare can make changes to their coverage October 15 – December 7. The changes will begin on January 1.

You automatically qualify for Extra Help if you have Medicare and meet any of these conditions:

- You have full Medicaid coverage.
- You get help from your state Medicaid program paying your Part B **premiums** (in a Medicare Savings Program). See pages 94–96.
- You get Supplemental Security Income (SSI) benefits.

Medicare will mail you a purple letter to let you know you automatically qualify for Extra Help. Keep this for your records. You don't need to apply for Extra Help if you get this letter.

- If you don't already have Medicare drug coverage (Part D), you must get it to use this Extra Help.
- If you don't have drug coverage, Medicare may enroll you in a separate Medicare drug plan so that you'll be able to use the Extra Help. If Medicare enrolls you in a plan, you'll get a yellow or green letter letting you know when your coverage begins, and you'll have a Special Enrollment Period to change plans if you want to enroll in a different plan than the one Medicare enrolled you in.
- Different plans cover different drugs. Check to see if the plan you're enrolled in covers the drugs you use and if you can go to the pharmacies you want. Visit Medicare.gov/plan-compare or call 1-800-MEDICARE (1-800-633-4227) to compare your plan with other plans in your area. TTY users can call 1-877-486-2048.
- If you have Medicaid and live in certain institutions (like a nursing home) or get home- and community-based services, you pay nothing for your covered drugs.

If you don't want to join a separate Medicare drug plan (for example, because you want only your employer or union coverage), call the plan listed in your letter, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Tell them you don't want to be in a Medicare drug plan (you want to "opt out"). If you continue to qualify for **Extra Help** or if your employer or union coverage is **creditable prescription drug coverage**, you won't have to pay a penalty if you join later.

- Important!** If you have employer or union coverage and you get Medicare drug coverage (Part D), you may lose your employer or union coverage (for you and your dependents) even if you qualify for Extra Help. Call your employer's benefits administrator before you get Medicare drug coverage.

Drug costs in 2022 for people who qualify are generally no more than \$3.95 for each generic drug and \$9.85 for each brand-name drug. Look on the Extra Help letters you get, or contact your plan to find out your exact costs.

If you didn't automatically qualify for Extra Help, you can apply any time:

- Visit socialsecurity.gov/i1020 to apply online.
- Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Note: When you apply for Extra Help, you can also begin the application process for a Medicare Savings Program. These state programs provide help with other Medicare costs. Social Security will send information to your state unless you tell them not to on the Extra Help application.

To get answers to your questions about Extra Help and help choosing drug coverage, call your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number. You can also call 1-800-MEDICARE.

What if I need help paying for my Medicare health care costs?

Medicare Savings Programs

If you have limited income and resources, you may be able to get help from your state to pay your Medicare costs if you meet certain conditions.

There are 4 kinds of Medicare Savings Programs:

- 1. Qualified Medicare Beneficiary (QMB) Program:** If you're eligible, the QMB Program helps pay for Part A and/or Part B **premiums**. In addition, Medicare providers aren't allowed to bill you for services and items Medicare covers, including **deductibles**, **coinsurance**, and **copayments**. If you get a bill for these charges, tell your provider or the debt collector that you're in the QMB Program and can't be charged for Medicare deductibles, coinsurance, and copayments. If you've already made payments on a bill for services and items Medicare covers, you have the right to a refund. If you're enrolled in a **Medicare Advantage Plan**, you should also contact the plan to ask them to stop the charges. In some cases, you may be billed a small copayment through **Medicaid**, if one applies.

Note: To make sure your provider knows you're in the QMB Program, show both your Medicare and Medicaid or QMB card each time you get care. If you have Original Medicare, you can also give your provider a copy of your "Medicare Summary Notice" (MSN). Your MSN will show you're in the QMB Program and shouldn't be billed. Log into (or create) your secure Medicare account at **Medicare.gov** at any time to sign up to get your MSNs electronically.

If your provider won't stop billing you, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. We can also confirm that you're in the QMB Program.

- 2. Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums only.
- 3. Qualifying Individual (QI) Program:** Helps pay Part B premiums only. Applications are granted on a first come, first-served basis.
- 4. Qualified Disabled and Working Individuals (QDWI) Program:** Helps pay Part A premiums only. You may qualify for this program if you have a disability, you're working, and you lost your Social Security disability benefits and premium-free Part A because you returned to work.

If you qualify for a QMB, SLMB, or QI Program, you automatically qualify to get **Extra Help** paying for Medicare drug coverage (Part D). See pages 91-93.

Important!

The names of these programs and how they work may vary by state. Medicare Savings Programs aren't available in Puerto Rico or the U.S. Virgin Islands.

How do I qualify?

In most cases, to qualify for a Medicare Savings Program, you must have income and resources below a certain limit.

States have different limits and ways of counting your income and resources, so you should check with your state Medicaid office to see if you qualify.

For more information

- Call or visit your Medicaid office (State Medical Assistance Office), and ask for information about Medicare Savings Programs. Visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone) to get the phone number for your state's Medicaid office. First, choose your state from the drop-down under "What state do you live in?" and then click "Go." You'll be taken to a page with contact information that's specific for your state. Then, in the left hand column of that page, choose "Other insurance programs." Find "Medicaid program" in the list of options under "Topics: Other insurance programs." You can also call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your state's Medicaid office. TTY users can call 1-877-486-2048.
- Contact your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number.

Medicaid

Medicaid is a joint federal and state program that helps pay health care costs if you have limited income and (in some cases) resources and meet other requirements. Some people qualify for both Medicare and Medicaid.

What does Medicaid cover?

- If you have Medicare and full Medicaid coverage, most of your health care costs are covered. You can get your Medicare coverage through Original Medicare or a [Medicare Advantage Plan](#).
- If you have Medicare and full Medicaid coverage, Medicare covers your prescription drugs. You automatically qualify for [Extra Help](#) paying your Medicare drug costs (see page 91). Medicaid may still cover some drugs that Medicare doesn't cover.
- People with full Medicaid coverage may get coverage for services that Medicare doesn't cover or only partially covers, like nursing home care, personal care, transportation to medical services, home- and community-based services, and dental, vision, and hearing services.

How do I qualify?

- Medicaid programs vary from state to state. They may also have different names, like "Medical Assistance" or "Medi-Cal."
- Each state has different income and resource requirements.
- Call your Medicaid office for more information and to see if you qualify. Visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone) or call 1-800-MEDICARE.

Medicare-Medicaid Plans

Medicare is working with some states and health plans to offer [demonstration](#) plans for certain people who have both Medicare and Medicaid and make it easier for them to get the services they need. They're called Medicare-Medicaid Plans. These plans include drug coverage and are only in certain states. If you're interested in joining a Medicare-Medicaid Plan, visit [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare) to see if one is available in your area.

State Pharmacy Assistance Program

Many states have State Pharmacy Assistance Programs that help certain people pay for prescription drugs based on financial need, age, or medical condition. To find out if there's a State Pharmacy Assistance Program in your state and how it works, call your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number. You can also visit [Medicare.gov/pharmaceutical-assistance-program/#state-programs](https://www.medicare.gov/pharmaceutical-assistance-program/#state-programs).

Pharmaceutical Assistance Programs (also called Patient Assistance Programs)

Many major drug manufacturers offer assistance programs for people with Medicare drug coverage (Part D) who meet certain requirements. Visit [Medicare.gov/pharmaceutical-assistance-program](https://www.medicare.gov/pharmaceutical-assistance-program) to learn more about Pharmaceutical Assistance Programs.

Program of All-inclusive Care for the Elderly (PACE)

PACE is a Medicare and Medicaid program offered in many states that allows people who need a nursing home-level of care to remain in the community. See page 74.

Supplemental Security Income (SSI) benefits

SSI is a cash benefit Social Security pays to people with limited income and resources who are blind, 65 or older, or have a disability. These benefits aren't the same as Social Security retirement benefits. You may be able to get both SSI and Social Security benefits at the same time if your Social Security benefit is less than the SSI benefit amount, due to a limited work history, a history of low-wage work, or both. If you're eligible for SSI, you automatically qualify for [Extra Help](#), and are usually eligible for Medicaid.

You can visit [benefits.gov/ssa](https://www.benefits.gov/ssa), and use the "Benefit Eligibility Screening Tool" to find out if you're eligible for SSI or other benefits. Call Social Security at 1-800-772-1213 or contact your local Social Security office for more information. TTY users can call 1-800-325-0778.

Note: People who live in Puerto Rico, the U.S. Virgin Islands, Guam, or American Samoa can't get SSI.

Programs for people who live in the U.S. territories

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your Medicaid office (State Medical Assistance Office) to learn more. Visit [Medicare.gov/talk-to-someone](https://www.medicare.gov/talk-to-someone) or call 1-800-MEDICARE (1-800-633-4227) to get the phone number. TTY users can call 1-877-486-2048.

SECTION 8

Know your rights & protect yourself from fraud

What are my Medicare rights?

All people with Medicare have certain rights and protections. You have the right to:

- Be treated with courtesy, dignity, and respect at all times.
- Be protected from discrimination.
- Have personal and health information kept private.
- Get information in a way you understand from Medicare, health care providers, and, under certain circumstances, contractors.
- Learn about your treatment choices in clear language you can understand, and participate in treatment decisions.
- Get Medicare information and health care services in a language you understand.
- Get your Medicare information in an accessible format, like braille or large print. See “CMS Accessible Communications” on page 107. **Note:** If you need plan information in a language other than English or in an accessible format, contact your plan.
- Get answers to your Medicare questions.
- Have access to doctors, specialists, and hospitals for medically necessary services.
- Get Medicare-covered services in an emergency.

Get a decision about health care payment, coverage of items and services, or drug coverage. When you or your provider files a claim, you’ll get a notice letting you know what will and won’t be covered. This notice comes from one of these:

- Medicare
- Your **Medicare Advantage Plan** (Part C) or other Medicare health plan
- Your Medicare drug plan for Medicare drug coverage (Part D)

If you disagree with the decision of your claim, you have the right to file an appeal.

- Request a review (appeal) of certain decisions about health care payment, coverage of items and services, or drug coverage.
- Be able to file complaints (sometimes called “grievances”), including complaints about the quality of your care. You can file a complaint if you have concerns about the quality of care and other services you get from a Medicare provider. Visit [Medicare.gov](#) or call 1-800-MEDICARE (1-800-633-4227) to learn more about filing a complaint. TTY users can call 1-877-486-2048.

What are my rights if my plan stops participating in Medicare?

Medicare health and drug plans can decide not to participate in Medicare for the coming year. In these cases, your coverage under the plan will end after December 31. Your plan will send you a letter explaining your options. If this happens:

- You can choose another plan between October 15–December 7. Your coverage will begin January 1.
- **You'll also have a special right to join another Medicare plan until the last day in February.**
- You may have the right to buy certain [Medigap](#) policies within 63 days after your plan coverage ends.

What's an appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision by Medicare or your Medicare plan. For example, you can appeal if Medicare or your plan denies:

- A request for a health care service, supply, item, or drug you think Medicare should cover.
- A request for payment of a health care service, supply, item, or drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or drug.

You can also appeal:

- If Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or drug you think you still need.
- An at-risk determination made under a drug management program that limits access to coverage for frequently abused drugs, like opioids and benzodiazepines. See page 86.

If you decide to file an appeal, you can ask your doctor, supplier, or other health care provider for any information that may help your case. This will make your appeal stronger. Keep a copy of everything related to your appeal, including what you send to Medicare or your plan.

How do I file an appeal?

How you file an appeal depends on the type of Medicare coverage you have.

If you have Original Medicare

- Get the “Medicare Summary Notice” (MSN) that shows the item or service you’re appealing. See page 59 for more information about MSNs.
- Circle the item(s) on the MSN you disagree with. Write an explanation of why you disagree with the decision. You can write on the MSN or on a separate piece of paper and attach it to the MSN.
- Include your name, phone number, and Medicare Number on the MSN. Keep a copy for your records.
- Send the MSN, or a copy, to the company that handles bills for Medicare (Medicare Administrative Contractor) listed on the MSN. You can include any other additional information you have about your appeal, like information from your health care provider. Or, you can use CMS Form 20027. To view or print this form, visit [CMS.gov/cmsforms/downloads/cms20027.pdf](https://www.cms.gov/cmsforms/downloads/cms20027.pdf), or call 1-800-MEDICARE (1-800-633-4227) to have a copy mailed to you. TTY users can call 1-877-486-2048.
- You must file your appeal by the date in the MSN. If you missed the deadline for appealing, you may still file an appeal and get a decision if you can show good cause for missing the deadline.
- You’ll generally get a decision from the Medicare Administrative Contractor within 60 days after they get your request. If Medicare will cover the item(s) or service(s), it will be listed on your next MSN.
- You may have the right to a fast appeal if you think your Medicare services from a hospital or other facility are ending too soon. See page 100.

If you have a Medicare Advantage or other Medicare health plan

The timeframe for filing an appeal may be different than Original Medicare. To learn more, look at the materials your plan sends you, call your plan, or visit [Medicare.gov/claims-appeals/how-do-i-file-an-appeal](https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal).

In some cases, you can file a fast appeal. See materials from your plan and page 100.

If you have a separate Medicare drug plan

You have the right to do all of these (even before you buy a certain drug):

- Get a written explanation for drug coverage decisions (called a “coverage determination”) from your Medicare drug plan. A coverage determination is the first decision your Medicare drug plan (not the pharmacy) makes about your benefits. This can be a decision about if your drug is covered, if you met the plan’s requirements to cover the drug, or how much you pay for the drug. You’ll also get a coverage determination decision if you ask your plan to make an exception to its rules to cover your drug.
- Ask for an exception if you or your prescriber (your doctor or other health care provider who’s legally allowed to write prescriptions) believes you need a drug that isn’t on your plan’s list of covered drugs (**formulary**).
- Ask for an exception if you or your prescriber believes that your plan should waive a coverage rule (like prior authorization).

- Ask for an exception if you think you should pay less for a higher tier drug because you or your prescriber believe you can't take any of the lower tier drugs for the same condition.

How do I ask for a coverage determination or exception?

You or your prescriber must contact your plan to ask for a coverage determination or an exception. If your network pharmacy can't fill a prescription, the pharmacist will give you a notice that explains how to contact your Medicare drug plan so you can make your request. If the pharmacist doesn't give you this notice, ask for a copy.

If you're asking for drug benefits you haven't gotten yet, you or your prescriber may make a standard request or an expedited (fast) request by phone or in writing. If you're asking to get paid back for prescription drugs you already bought, your plan can require you or your prescriber to make the standard request in writing.

You or your prescriber can call or write your plan for an expedited (fast) request. Your request will be expedited if you haven't gotten the prescription and your plan determines, or your prescriber tells your plan, that your life or health may be at risk by waiting.

Important! If you're requesting an exception, your prescriber must provide a statement explaining the medical reason why your plan should approve the exception.

What are my rights if I think my services are ending too soon?

If you're getting Medicare services from a hospital, **skilled nursing facility**, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon (or that you're being discharged too soon), you can ask for a fast appeal (also known as an "immediate appeal" or an "expedited appeal"). Your provider will give you a notice called a Notice of Medicare Non Coverage before your services end telling you how to ask for a fast appeal. You should read this notice carefully. If you don't get this notice, ask your provider for it. With a fast appeal, an independent reviewer will decide if your covered services should continue. You can contact your Beneficiary and Family Centered Care-Quality Improvement Organization for help with filing an appeal. See page 115.

A fast appeal only covers the decision to end services. You may need to start a separate appeals process for any items or services you may have received after the decision to end services. Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, "Medicare Appeals."

How can I get help filing an appeal?

You can appoint a representative to help you. Your representative can be a family member, friend, advocate, attorney, financial advisor, doctor, or someone else who will act on your behalf. For more information, visit [Medicare.gov/claims-appeals/how-do-i-file-an-appeal](https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal). You can also get help filing an appeal from your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number.

What's an "Advance Beneficiary Notice of Noncoverage" (ABN)?

If you have Original Medicare, your doctor, other health care provider, or supplier may give you a notice called an "Advance Beneficiary Notice of Noncoverage" (ABN) if they think Medicare doesn't cover the care they'll provide. This notice says Medicare probably (or certainly) won't pay for some services in certain situations.

What happens if I get an ABN?

- You'll be asked to choose whether to get the items or services listed on the notice.
- If you choose to get the items or services listed on the notice, you're agreeing to pay if Medicare doesn't.
- You'll be asked to sign the notice to say that you've read and understood it.
- Doctors, other health care providers, and suppliers don't have to (but still may) give you a notice for services that Medicare never covers. See page 55.
- An ABN isn't an official denial of coverage by Medicare. If Medicare denies payment, you can still file an appeal once you receive the "Medicare Summary Notice" (MSN) showing the item or service in question. However, you'll have to pay for the items or services if Medicare decides that the items or services aren't covered (and no other insurer is responsible for payment).

Can I get an ABN for other reasons?

- You may get a "Skilled Nursing Facility ABN" when the facility believes Medicare will no longer cover your stay or other items and services.
- You may get an ABN if you're getting an off-the-shelf back or knee brace that's included in the DMEPOS Competitive Bidding Program and the supplier isn't a contract supplier.

What if I didn't get an ABN?

If your provider was required to give you this notice but didn't, in most cases, your provider must give you a refund for what you paid for the item or service.

Where can I get more information about appeals and the ABN?

- Visit [Medicare.gov/claims-appeals/how-do-i-file-an-appeal](https://www.medicare.gov/claims-appeals/how-do-i-file-an-appeal).
- Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view the booklet, "Medicare Appeals."
- If you're in a [Medicare plan](#), call your plan to see if it covers a service or item.

Note: If you have a [Medicare Advantage Plan](#), you have the right to ask the plan in advance if it covers a certain service, drug, or supply. Contact your plan to request and submit a pre-service organization determination. The plan's response will include instructions to file a timely appeal, if you want one. You also may get plan directed care. This is when a plan provider refers you for a service or to a provider outside the network without getting an organization determination in advance. See page 65.

Your right to access your personal health information

By law, you or your legal representative generally has the right to view and/or get copies of your personal health information from health care providers who treat you, or by health plans that pay for your care, including Medicare. In most cases, you also have the right to have a provider or plan send copies of your information to a third party that you choose, like other providers who treat you, a family member, a researcher, or a mobile app you use to manage your personal health information.

This includes:

- Claims and billing records
- Information related to your enrollment in health plans, including Medicare
- Medical and case management records (except psychotherapy notes)
- Any other records that have information that doctors or health plans use to make decisions about you

You may have to fill out a health information “request” form, and pay a cost-based fee for copies. Your providers or plans should tell you about the fee when you make the request. If they don’t, you should ask. The fee can only be for the labor to make the copies, copying supplies, and postage (if needed). In most cases, you shouldn’t be charged for viewing, searching, downloading, or sending your information through an electronic portal.

Generally, you can get your information on paper or electronically. If your providers or plans store your information electronically, they generally must give you electronic copies, if that’s your preference.

You have the right to get your information in a timely manner, but it may take up to 30 days to fill the request.

For more information, visit

[hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers](https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers).

If you need help getting and using your health records, the Office of the National Coordinator (ONC) in the U.S. Department of Health and Human Services (HHS) created “The Guide to Getting & Using Your Health Records.” This guide can help you through the process of getting your health records and show you how to make sure your records are accurate and complete, so you can get the most out of your health care. Visit [healthit.gov/how-to-get-your-health-record](https://www.healthit.gov/how-to-get-your-health-record) to view the guide.

How does Medicare use my personal information?

Medicare protects the privacy of your health information. The next 2 pages describe how Medicare may use and give out your information, and explain how you can get this information.

Notice of Privacy Practices for Original Medicare

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The law requires Medicare to protect the privacy of your personal medical information. It also requires us to give you this notice so you know how we may use and share (“disclose”) the personal medical information we have about you.

We must provide your information to:

- You, to someone you name (“designee”), or someone who has the legal right to act for you (your personal representative)
- The Secretary of the Department of Health and Human Services, if necessary
- Anyone else that the law requires to have it

We have the right to use and provide your information to pay for your health care and to operate Medicare. For example:

- Medicare Administrative Contractors use your information to pay or deny your claims, collect your **premiums**, share your benefit payment with your other insurer(s), or prepare your “Medicare Summary Notice.”
- We may use your information to provide you with customer services, resolve complaints you have, contact you about research studies, and make sure you get quality care.

We may use or share your information under these limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare is making proper payments and to help federal/state **Medicaid** programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like investigating fraud and abuse)
- For judicial and administrative proceedings (like responding to a court order)
- For law enforcement purposes (like providing limited information to find a missing person)
- For research studies that meet all privacy law requirements (like research to prevent a disease or disability)
- To avoid a serious and imminent threat to health or safety
- To contact you about new or changed Medicare benefits
- To create a collection of information that no one can trace to you
- To health care providers and their business associates for care coordination and quality improvement purposes, like participation in Accountable Care Organizations (ACOs)

We don't sell or use and share your information to tell you about health products or services ("marketing"). We must have your written permission (an "authorization") to use or share your information for any purpose that isn't described in this notice.

You may take back ("revoke") your written permission at any time, unless we've already shared information because you gave us permission.

You have the right to:

- See and get a copy of the information we have about you.
- Have us change your information if you think it's wrong or incomplete, and we agree. If we disagree, you may have a statement of your disagreement added to your information.
- Get a list of people who get your information from us. The listing won't cover information that we gave to you, your personal representative, or law enforcement, or information that we used to pay for your care or for our operations.
- Ask us to communicate with you in a different manner or at a different place (for example, by sending materials to a PO Box instead of your home address).
- Ask us to limit how we use your information and how we give it out to pay claims and run Medicare. We may not be able to agree to your request.
- Get a letter that tells you about the likely risk to the privacy of your information ("breach notification").
- Get a separate paper copy of this notice.
- Speak to a Customer Service Representative about our privacy notice. Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you believe your privacy rights have been violated, you may file a privacy complaint with:

- The Centers for Medicare & Medicaid Services (CMS). Visit Medicare.gov or call 1-800-MEDICARE.
- The U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR). Visit hhs.gov/hipaa/filing-a-complaint.

Filing a complaint won't affect your coverage under Medicare.

The law requires us to follow the terms in this notice. We have the right to change the way we use or share your information. If we make a change, we'll mail you a notice within 60 days of the change.

The Notice of Privacy Practices for Original Medicare became effective September 23, 2013.

How can I protect myself from identity theft?

Identity theft happens when someone uses your personal information without your consent to commit fraud or other crimes. Personal information includes things like your name and your Social Security, Medicare, credit card, or bank account numbers, and your online Medicare account user name and password. Guard your cards and protect your Medicare and Social Security numbers.

Keep this information safe.

Only give personal information, like your Medicare Number, to doctors, insurance companies (and their licensed agents or brokers), or plans acting on your behalf, or trusted people in the community who work with Medicare like your State Health Insurance Assistance Program (SHIP). Don't share your Medicare Number or other personal information with any unsolicited person who contacts you by phone, email, or in person. Medicare, or your Medicare plan representative, will only call you in limited situations:

- A **Medicare plan** can call you if you're already a member of the plan. The agent who helped you join can also call you.
- A customer service representative from 1-800-MEDICARE (1-800-633-4227) can call you if you've left a message, or a representative said that someone would call you back. TTY users can call 1-877-486-2048.
- If you filed a fraud report, you may get a call from someone representing Medicare to follow up on your investigation.

If you suspect identity theft, or feel like you gave your personal information to someone you shouldn't have, call your local police department and the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338. TTY users can call 1-866-653-4261. Visit ftc.gov/idtheft to learn more about identity theft.

How can I protect myself from fraud and medical identity theft?

Medical identity theft is when someone steals or uses your personal information (like your name, Social Security Number, or Medicare Number) to submit fraudulent claims to Medicare and other health insurance companies without your permission. When you get health care services, record the dates on a calendar and save the receipts and statements you get from providers to check for mistakes. If you think you see an error or a provider bills you for services you didn't get, take these steps to find out what was billed:

- Check your "Medicare Summary Notice" (MSN) if you have Original Medicare to see if the service was billed to Medicare. If you're in a **Medicare health plan**, check the statements you get from your plan.
- If you know the health care provider or supplier, call and ask for an itemized statement. They should give this to you within 30 days.
- Log into (or create) your secure Medicare account at Medicare.gov to view your Medicare claims if you have Original Medicare. Your claims are generally available online within 24 hours after processing. You can also use Medicare's Blue Button to download your claims information. See page 111. You can also call 1-800-MEDICARE.

If you've contacted the provider and you suspect that Medicare is being charged for a service or supply that you didn't get, or you don't know the provider on the claim, call 1-800-MEDICARE.

You can also call 1-800-MEDICARE (1-800-633-4227) if you believe your Medicare number has been used fraudulently. TTY users can call 1-877-486-2048.

For more information about Medicare fraud, visit [Medicare.gov](#) or contact your local Senior Medicare Patrol Program. Learn more about the Senior Medicare Patrol Program and find help in your state by going to [smpresource.org](#) or call 1-877-808-2468.

Plans must follow rules

Medicare plans and agents must follow certain rules when marketing their plans and getting your enrollment information. They can't ask you for credit card or banking information over the phone or via email, unless you're already a member of that plan. Plans don't need your personal information to provide a quote. Medicare plans can't enroll you into a plan over the phone unless you call them and ask to enroll, or you've given them permission to contact you.

Important! ➤ Call 1-800-MEDICARE to report any plans or agents that:

- Ask for your personal information over the phone or email
- Call to enroll you in a plan
- Use false information to mislead you

You can also call the Medicare Drug Integrity Contractor (MEDIC) at 1-877-7SAFERX (1-877-772-3379). The MEDIC fights fraud, waste, and abuse in Medicare Advantage and Medicare drug plans.

Fighting fraud can pay

You may get a reward if you help us fight fraud and meet certain conditions. For more information, visit [Medicare.gov](#) or call 1-800-MEDICARE.

Investigating fraud takes time

Every tip counts. Medicare takes all reports of suspected fraud seriously. When you report fraud, you may not hear of an outcome right away. It takes time to investigate your report and build a case, but rest assured that your information is helping us protect Medicare.

What's the Medicare Beneficiary Ombudsman?

An “ombudsman” is a person who reviews questions, concerns, and challenges with how a program is administered, and helps to resolve them when possible.

There are several resources to get answers to your Medicare questions and get help with your Medicare coverage, like [Medicare.gov](#), 1-800-MEDICARE, and State Health Insurance Assistance Programs (SHIPs). The Medicare Beneficiary Ombudsman works closely with those resources and Medicare to help make sure information and help are available for you and works to improve your experience with Medicare.

Visit [Medicare.gov](#) for information on how the Medicare Beneficiary Ombudsman can help you.

Accessible Communications

Medicare provides free auxiliary aids and services, including information in accessible formats like braille, large print, data or audio files, relay services and TTY communications. If you request information in an accessible format, you won’t be disadvantaged by any additional time necessary to provide it. This means you’ll get extra time to take any action if there’s a delay in fulfilling your request.

To request Medicare or Marketplace information in an accessible format you can:

1. Call us:

For Medicare: 1-800-MEDICARE (1-800-633-4227)
TTY: 1-877-486-2048

2. Send us a fax: 1-844-530-3676

3. Send us a letter:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

Your request should include your name, phone number, type of information you need (if known), and the mailing address where we should send the materials. We may contact you for additional information.

Note: If you’re enrolled in a Medicare Advantage Plan or Medicare drug plan, contact your plan to request its information in an accessible format. For Medicaid, contact your State Medicaid office.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CMS directly or through a contractor or any other entity with which CMS arranges to carry out its programs and activities.

You can contact CMS in any of the ways included in this notice if you have any concerns about getting information in a format that you can use.

You may also file a complaint if you think you've been subjected to discrimination in a CMS program or activity, including experiencing issues with getting information in an accessible format from any Medicare Advantage Plan, Medicare drug plan, State or local Medicaid office, or Marketplace Qualified Health Plans. There are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online:

hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

2. By phone:

Call 1-800-368-1019. TTY users can call 1-800-537-7697.

3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

SECTION 9

Get more information

Get personalized help

1-800-MEDICARE (1-800-633-4227)

TTY users can call **1-877-486-2048**

Mail us at PO Box 1270, Lawrence, KS 66044

Get information 24 hours a day, including weekends

- Speak clearly and follow the voice prompts to pick the category that best meets your needs.
- Have your Medicare card in front of you, and be ready to give your Medicare Number.
- When prompted for your Medicare Number, speak the numbers and letters clearly one at a time.
- If you need help in a language other than English or Spanish, or need to request a Medicare publication in an accessible format (like large print or braille), let the customer service representative know.

Important!

If you need someone to be able to call 1-800-MEDICARE on your behalf

You can fill out and mail a “Medicare Authorization to Disclose Personal Health Information” form, so Medicare can give your personal health information to someone other than you. Medicare must process the form before the authorization becomes effective.

Visit [Medicare.gov/medicareonlineforms](https://www.medicare.gov/medicareonlineforms) to find the form or call 1-800-MEDICARE.

If your household got more than one copy of “Medicare & You”

If you want to get only one copy of this handbook in the future, call 1-800-MEDICARE. If you want to stop getting paper copies in the mail, you can request this by logging into (or creating) your account on [Medicare.gov](https://www.medicare.gov).

If you need a new copy of your Medicare card

If you need to replace your card because it’s damaged or lost, visit [Medicare.gov](https://www.medicare.gov) to log into (or create) your secure Medicare account to print or order an official copy of your Medicare card. You can also call 1-800-MEDICARE and ask for a replacement card to be sent in the mail.

If you need to replace your card because you think that someone else is using your Medicare Number, call 1-800-MEDICARE.

If you moved

If you recently moved or plan to move, update your address to continue getting important information from Medicare. Call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you get Railroad Retirement Board (RRB) benefits, call the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

 **Note:** See pages 121-124 for definitions of blue words.

State Health Insurance Assistance Programs (SHIPs)

SHIPs are state programs that get money from the federal government to give local health insurance counseling to people with Medicare at no cost to you. SHIPs aren't connected to any insurance company or health plan. SHIP staff and trained volunteers work hard to help you with these and other Medicare questions:

- Your Medicare rights.
- Billing problems.
- Complaints about your medical care or treatment.
- Plan comparison and enrollment.
- How Medicare works with other insurance.
- Finding help paying for health care costs.

See pages 117-120 for the phone number. Contact a SHIP in your state to get free personalized help with your Medicare questions, or learn how to become a volunteer SHIP counselor.

Find general Medicare information online

Visit Medicare.gov

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.
- Find Medicare-participating doctors or other health care providers and suppliers.
- See what Medicare covers, including **preventive services** (like screenings, shots or vaccines, and yearly "Wellness" visits).
- Get Medicare appeals information and forms.
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospices, **inpatient rehabilitation facilities**, and **long-term care hospitals**.
- Look up helpful websites and phone numbers.

Get personal Medicare information online

Visit Medicare.gov to create an account online

Visit **Medicare.gov** to log into (or create) your secure Medicare account. You can also:

- Add your prescriptions and pharmacies to help you better compare Medicare health and drug plans in your area.
- Sign up to get your yearly "Medicare & You" handbook and claims statements, called "Medicare Summary Notices," electronically.
- View your Original Medicare claims as soon as they're processed.
- Print a copy of your official Medicare card.
- See a list of preventive services you're eligible to get in Original Medicare.
- Learn about your Medicare **premiums**, and pay them online if you get a bill from Medicare.



Medicare's Blue Button®

Medicare's Blue Button makes it easy for you to download your personal health information to a file on your computer or other device. Having access to your information can help you make more informed decisions about your health care. Blue Button is safe, secure, reliable, and easy to use. By getting your information through Blue Button, you can:

- Download and save a file of your personal health information, including your Part A, Part B, and Part D claims.
- Print or email the information to share with others after you've saved the file.
- Import your saved file into other computer-based personal health management tools.

Remember: Treat your personal and health information the same way you treat other confidential information. Before you share, find out how others will use your information, keep it secure, and protect your privacy.

Visit [Medicare.gov](#) and log into (or create) your secure Medicare account to use Blue Button today.

Blue Button 2.0®

Medicare has a data service that makes it easy for you to share your Part A, Part B, and Part D claim information with a growing list of authorized apps, services, and research programs. You authorize each app individually and you can return to your secure Medicare account online at [Medicare.gov](#) any time to change the way an app uses your information.

Once you use your Medicare account to authorize sharing of your information with an app, you can use that app to view your past and current Medicare claims.

For [Medicare Advantage Plans](#), only Part D information is available through this service. If you have a Medicare Advantage Plan, check with your plan to see if they offer a similar service to Blue Button 2.0.

Medicare keeps a list of authorized apps. To learn more, visit [Medicare.gov/manage-your-health/medicares-blue-button-blue-button-20/blue-button-apps](https://www.medicare.gov/manage-your-health/medicares-blue-button-blue-button-20/blue-button-apps).

Compare the quality of health care providers

Visit [Medicare.gov/care-compare](https://www.Medicare.gov/care-compare) to find and compare the quality of care health care providers like nursing homes, hospitals, and doctors give their patients. You can find information about providers and facilities based on your individual needs, and get helpful resources to make more informed decisions about where you get your health care. Talk to your doctor or other health care provider when choosing a provider. You can also ask what they think about the quality of care of other providers.

Compare the quality of Medicare health & drug plans

When you visit [Medicare.gov/plan-compare](https://www.Medicare.gov/plan-compare) to find and compare health and drug plans, you'll see a star rating system for Medicare health and drug plans. The overall star rating gives an overall rating of the plan's quality and performance for the types of services each plan offers.

For plans that cover health services, this is a summary rating of health plan quality for many medical/health care services that fall into 5 categories and includes:

- 1. Staying healthy—screenings, tests, and vaccines:** Whether members got various screenings, tests, vaccines, and other check-ups to help them stay healthy.
- 2. Managing chronic (long-term) conditions:** How often members with certain conditions got recommended tests and treatments to help manage their condition.
- 3. Member experience with health plan:** Member surveys about the plan.
- 4. Member complaints and changes in the health plan's performance:** How often members had problems with the plan. Includes how much the plan's performance improved (if at all) over time.
- 5. Health plan customer service:** How well the plan handles member calls and questions.

For plans that cover prescription drugs, this is a summary rating of drug plan quality for drug-related services that fall into 4 categories and includes:

- 1. Drug plan customer service:** How well the plan handles member calls and questions.
- 2. Member complaints and changes in the drug plan's performance:** How often members had problems with the plan. Includes how much the plan's performance improved (if at all) over time.
- 3. Member experience with drug plan:** Member surveys about the plan.
- 4. Drug safety and accuracy of drug pricing:** How accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that's safer and clinically recommended for their condition.

For plans that cover **both** health services and prescription drugs, the overall star rating for quality and performance covers all of the topics above.

You can compare the quality of health care providers and **Medicare plan** services nationwide by visiting [Medicare.gov](#) or by calling your State Health Insurance Assistance Program (SHIP). See pages 117-120 for the phone number.

Medicare is working to better coordinate your care

Medicare continues to look for ways to better coordinate your care and to make sure that you get the best health care possible.

Here are examples of how your health care providers can better coordinate your care:

Electronic Health Records

Electronic health records are a history of your medical conditions, health care, and treatment that your doctor, other health care provider, medical office staff, or hospital keeps on a computer.

- They can help lower the chances of medical errors, eliminate duplicate tests, and may improve your overall quality of care.
- Your doctor's electronic health records may be able to link to a hospital, lab, pharmacy, other doctors, or immunization information systems (registries), so the people who care for you can have a more complete picture of your health.

Electronic prescribing

This is an electronic way for your prescribers (your doctor or other health care provider who's legally allowed to write prescriptions) to send your prescriptions directly to your pharmacy. Electronic prescribing can save you money and time, and help keep you safe.

Accountable Care Organizations (ACOs)

An ACO is a group of doctors, hospitals, and/or other health care providers that work together to improve the quality and experience of care you get. These organizations may help health care providers better coordinate your care and are intended to give you better quality care. Coordinated care saves time and costs by avoiding repeated tests and unneeded appointments. It may make it easier to spot potential problems before they become more serious—like drug interactions that can happen if one doctor isn't aware of what another has prescribed. Medicare evaluates how well each organization meets these goals every year. ACOs that do a good job can earn a financial bonus. If they earn a bonus, these organizations may use the payment to invest more in your care or share a portion directly with your health care providers. Sometimes, ACOs may owe money to Medicare if their care increases costs.

An ACO can't limit your choice of health care providers. Your Original Medicare benefits aren't changing. You still have the right to visit any doctor, hospital, or other provider that accepts Medicare at any time, just like you do now. It **isn't** a **Medicare Advantage Plan**, which is an alternative to Original Medicare, offered by private companies approved by Medicare. It also **isn't** an HMO plan, or an insurance plan of any kind.

Note: If your primary care provider has notified you that they're participating in an ACO and you need **skilled nursing facility care**, talk to your provider about the Skilled Nursing Facility 3-Day Rule Waiver. This waiver may allow Medicare to cover certain skilled nursing facility services without requiring you to have a 3-day inpatient hospital stay before getting skilled nursing facility coverage. The 3-Day Rule Waiver doesn't apply if you could be treated as an outpatient, or require long-term care.

Sharing your health care information with ACOs

To help your providers coordinate your health care better, Medicare gives certain information about your care to ACOs that are working with your health care providers. Giving your data to your ACO and doctor helps make sure all the providers involved in your care have access to your health information when and where they need it. If you don't want Medicare to share your health care information in this manner, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you decide you don't want Medicare to give your health care information to your ACO or doctor, Medicare will continue to use your information for some purposes, like evaluating the financial and quality of care performance of the health care providers participating in ACOs. If you have questions or concerns, you can talk about them during your office visit with your health care provider.

Note: Patients whose primary care provider participates in an ACO may have access to additional tools or services. Log into (or create) your secure Medicare account at [Medicare.gov](https://www.medicare.gov) to select a primary care provider who can help you manage your health care in an ACO.

For more information about ACOs, visit [Medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations](https://www.medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations) or call 1-800-MEDICARE.

Other ways to get Medicare information

Medicare emails

Visit [Medicare.gov](https://www.medicare.gov) to create your secure Medicare account. Include your email address to get important reminders and information about Medicare.

Publications

Visit [Medicare.gov/publications](https://www.medicare.gov/publications) to view, print, or download copies of publications on different Medicare topics. You can also call 1-800-MEDICARE. See page 107 for information about getting publications in accessible formats at no cost.

Social media

Stay up to date and connect with other people with Medicare by following us on Facebook (facebook.com/Medicare) and Twitter (twitter.com/MedicareGov).

Videos

Visit [YouTube.com/cmshhsgov](https://www.youtube.com/cmshhsgov) to see videos covering different health care topics.

Other helpful contacts

Social Security

Visit socialsecurity.gov to apply for and enroll in Original Medicare, and see if you qualify for **Extra Help** with Medicare drug costs. Also, when you open a personal “my Social Security” account, you can review your Social Security Statement, verify your earnings, change your direct deposit information, request a replacement Medicare card, and more. Visit socialsecurity.gov/myaccount to open your personal account. You can also call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778.

Benefits Coordination & Recovery Center

Contact the Benefits Coordination & Recovery Center at 1-855-798-2627 to report changes in your insurance information or to let Medicare know if you have other insurance. TTY users can call 1-855-797-2627.

Beneficiary and Family Centered Care-Quality Improvement Organization

Contact your Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if you think Medicare coverage for your service is ending too soon (like if your hospital says that you must be discharged and you disagree). You may have the right to a fast appeal if you think your Medicare-covered services are ending too soon. You can also contact them to ask questions or report complaints about the quality of care you got for a Medicare-covered service (and you aren’t satisfied with the way your provider has responded to your concern). Visit Medicare.gov/talk-to-someone or call 1-800-MEDICARE (1-800-633-4227) to get the phone number of your BFCC-QIO. TTY users can call 1-877-486-2048.

Department of Defense

Get information about TRICARE for Life (TFL) and the TRICARE Pharmacy Program.

TFL:

1-866-773-0404, TTY: 1-866-773-0405

tricare.mil/tfl

tricare4u.com

TRICARE Pharmacy Program:

1-877-363-1303, TTY: 1-877-540-6261

tricare.mil/pharmacy

militaryrx.express-scripts.com/

Department of Veterans Affairs (VA)

Contact the VA if you’re a veteran or have served in the U.S. military and you have questions about veteran benefits.

1-800-827-1000, TTY: 711

va.gov

vets.gov

eBenefits.va.gov

Office of Personnel Management

Get information about the Federal Employee Health Benefits Program for current and retired federal employees.

Retirees:

1-888-767-6738, TTY: 711

opm.gov/healthcare-insurance/Guide-Me/Retirees-Survivors/

Active federal employees:

Contact your Benefits Officer. Visit apps.opm.gov/abo for a list of Benefits Officers.

Railroad Retirement Board (RRB)

If you get benefits from the RRB, call them to change your address or name, check eligibility, enroll in Medicare, replace your Medicare card, or report a death.

1-877-772-5772, TTY: 1-312-751-4701

rrb.gov

State Health Insurance Assistance Programs (SHIPs)

For free, personalized help with questions about appeals, buying other insurance, choosing a health plan, buying a Medigap policy, and Medicare rights and protections.

Alabama

State Health Insurance Assistance Program (SHIP)
1-800-243-5463

Alaska

Medicare Information Office
1-800-478-6065
TTY: 1-800-770-8973

Arizona

Arizona State Health Insurance Assistance Program (SHIP)
1-800-432-4040

Arkansas

Senior Health Insurance Information Program (SHIIP)
1-800-224-6330

California

California Health Insurance Counseling & Advocacy Program (HICAP)
1-800-434-0222

Colorado

State Health Insurance Assistance Program (SHIP)
1-888-696-7213

Connecticut

Connecticut's Program for Health Insurance Assistance, Outreach, Information and Referral, Counseling, Eligibility Screening (CHOICES)
1-800-994-9422

Delaware

Delaware Medicare Assistance Bureau
1-800-336-9500

Florida

Serving Health Insurance Needs of Elders (SHINE)
1-800-963-5337
TTY: 1-800-955-8770

Georgia

GeorgiaCares SHIP
1-866-552-4464 (option 4)

Guam

Guam Medicare Assistance Program (GUAM MAP)
1-671-735-7415

Hawaii

Hawaii SHIP
1-888-875-9229
TTY: 1-866-810-4379

Idaho

Senior Health Insurance Benefits
Advisors (SHIBA)
1-800-247-4422

Illinois

Senior Health Insurance Program
(SHIP)
1-800-252-8966
TTY: 1-888-206-1327

Indiana

State Health Insurance Assistance
Program (SHIP)
1-800-452-4800
TTY: 1-866-846-0139

Iowa

Senior Health Insurance
Information Program (SHIIP)
1-800-351-4664
TTY: 1-800-735-2942

Kansas

Senior Health Insurance
Counseling for Kansas (SHICK)
1-800-860-5260

Kentucky

State Health Insurance Assistance
Program (SHIP)
1-877-293-7447

Louisiana

Senior Health Insurance
Information Program (SHIIP)
1-800-259-5300

Maine

Maine State Health Insurance
Assistance Program (SHIP)
1-800-262-2232

Maryland

State Health Insurance Assistance
Program (SHIP)
1-800-243-3425

Massachusetts

Serving Health Insurance Needs
of Everyone (SHINE)
1-800-243-4636
TTY: 1-877-610-0241

Michigan

MMAP, Inc.
1-800-803-7174

Minnesota

Minnesota State Health
Insurance Assistance Program/
Senior LinkAge Line
1-800-333-2433

Mississippi

MS State Health Insurance
Assistance Program (SHIP)
844-822-4622

Missouri

CLAIM
1-800-390-3330

Montana

Montana State Health Insurance
Assistance Program (SHIP)
1-800-551-3191

Nebraska

Nebraska SHIP
1-800-234-7119

Nevada

Nevada Medicare Assistance
Program (MAP)
1-800-307-4444

New Hampshire

NH SHIP - ServiceLink
Resource Center
1-866-634-9412

New Jersey

State Health Insurance Assistance
Program (SHIP)
1-800-792-8820

New Mexico

New Mexico ADRC-SHIP
1-800-432-2080

New York

Health Insurance Information
Counseling and Assistance
Program (HIICAP)
1-800-701-0501

North Carolina

Seniors' Health Insurance
Information Program (SHIIP)
1-855-408-1212

North Dakota

State Health Insurance
Counseling (SHIC)
1-888-575-6611
TTY: 1-800-366-6888

Ohio

Ohio Senior Health Insurance
Information Program (OSHIIP)
1-800-686-1578
TTY: 1-614-644-3745

Oklahoma

Oklahoma Medicare Assistance
Program (MAP)
1-800-763-2828

Oregon

Senior Health Insurance Benefits
Assistance (SHIBA)
1-800-722-4134

Pennsylvania

Pennsylvania Medicare Education
and Decision Insight (PA MEDI)
1-800-783-7067

Puerto Rico

State Health Insurance Assistance
Program (SHIP)
1-877-725-4300
TTY: 1-878-919-7291

Rhode Island

Senior Health Insurance Program
(SHIP)
1-888-884-8721
TTY: 401-462-0740

South Carolina

Insurance Counseling Assistance
and Referrals for Elders (I-CARE)
1-800-868-9095

South Dakota

Senior Health Information &
Insurance Education (SHIINE)
1-800-536-8197

Tennessee

TN SHIP
1-877-801-0044
TTY: 1-800-848-0299

Texas

Health Information Counseling
and Advocacy Program (HICAP)
1-800-252-9240

Utah

Senior Health Insurance
Information Program (SHIP)
1-800-541-7735

Vermont

Vermont State Health Insurance
Assistance Program (SHIP)
1-800-642-5119

Virgin Islands

Virgin Islands State Health
Insurance Assistance Program
(VISHIP)
1-340-772-7368 St. Croix area;
1-340-714-4354 St. Thomas area

Virginia

Virginia Insurance Counseling
and Assistance Program (VICAP)
1-800-552-3402

Washington

Statewide Health Insurance
Benefits Advisors (SHIBA)
1-800-562-6900
TTY: 1-360-586-0241

Washington D.C.

DC SHIP
202-727-8370

West Virginia

West Virginia State Health
Insurance Assistance Program
(WV SHIP)
1-877-987-4463

Wisconsin

WI State Health Insurance
Assistance Program (SHIP)
1-800-242-1060
TTY: 711

Wyoming

Wyoming State Health Insurance
Information Program (WSHIIP)
1-800-856-4398

SECTION 10

Definitions

Accountable Care Organizations (ACO)

Groups of doctors, hospitals, and other health care professionals working together to give you high-quality, coordinated service and health care.

Assignment

An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Benefit period

The way that Original Medicare measures your use of hospital and skilled nursing facility services. A benefit period begins the day you're admitted as an inpatient in a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a skilled nursing facility) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.

Coinurance

An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment

An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

Creditable prescription drug coverage

Prescription drug coverage (for example, from an employer or union) that's expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Critical access hospital

A small facility located in a rural area more than 35 miles (or 15 miles if mountainous terrain or in areas with only secondary roads) from another hospital or critical access hospital. This facility provides 24/7 emergency care, has 25 or fewer inpatient beds, and maintains an average length of stay of 96 hours or less for acute care patients.

Deductible

The amount you must pay for health care or prescriptions before Original Medicare, your Medicare Advantage Plan, your Medicare drug plan, or your other insurance begins to pay.

Demonstrations

Special projects, sometimes called “pilot programs” or “research studies,” that test improvements in Medicare coverage, payment, and quality of care. They usually operate only for a limited time, for a specific group of people, and in specific areas.

Extra Help

A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, like premiums, deductibles, and coinsurance.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Inpatient rehabilitation facility

A hospital, or part of a hospital, that provides an intensive rehabilitation program to inpatients.

Lifetime reserve days

In Original Medicare, these are additional days that Medicare will pay for when you’re in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-term care hospital

Acute care hospitals that provide treatment for patients who stay, on average, more than 25 days. Most patients are transferred from an intensive or critical care unit. Services provided include comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and (in some cases) resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically necessary

Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits, with a few exclusions, for example, certain aspects of clinical trials which are covered by Original Medicare even though you're still in the plan. Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

If you're enrolled in a Medicare Advantage Plan:

- Most Medicare services are covered through the plan
- Most Medicare services aren't paid for by Original Medicare
- Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount

In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan

Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Program of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare plan

Any way other than Original Medicare that you can get your Medicare health or drug coverage. This term includes all Medicare health plans and Medicare drug plans.

Medigap

Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

National Provider Identifier (NPI)

A unique identification number for covered health care providers.

Premium

The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services

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).

Primary care doctor

The doctor you see first for most health problems. They make sure you get the care you need to keep you healthy. They also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare Advantage Plans, you must see your primary care doctor before you see any other health care provider.

Referral

A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Service area

A geographic area where the plan accepts members. The plan may limit membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled nursing facility (SNF) care

Skilled nursing care and therapy services provided on a daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a physical therapist or a registered nurse.

Help in other languages

If you, or someone you're helping, has questions about Medicare, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-MEDICARE (1-800-633-4227).

العربية (Arabic) إن كان لديك أو لدى شخص تساعدك أسئلة بخصوص Medicare فإن من حقك الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة. للتحدث مع مترجم اتصل بالرقم 1-800-MEDICARE (1-800-633-4227).

հայերեն (Armenian) Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Medicare-ի մասին, ապա Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով։ Թարգմանչի հետ խոսելու համար զանգահարեք 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով։

中文 (Chinese-Traditional) 如果您，或是您正在協助的個人，有關於聯邦醫療保險的問題，您有權免費以您的母語，獲得幫助和訊息。與翻譯員交談，請致電 1-800-MEDICARE (1-800-633-4227)。

فارسی (Farsi) اگر شما، یا شخصی که به او کمک میرسانید سوالی در مورد اعلامیه مختصر مدیکردارید، حق این را دارید که کمک و اطلاعات به زبان خود به طور رایگان دریافت نمایید. برای مکالمه با مترجم با این شماره زیر تماس بگیرید (1-800-633-4227) 1-800-MEDICARE.

Français (French) Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions au sujet de l'assurance-maladie Medicare, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le 1-800-MEDICARE (1-800-633-4227).

Deutsch (German) Falls Sie oder jemand, dem Sie helfen, Fragen zu Medicare haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-MEDICARE (1-800-633-4227) an.

Kreyòl (Haitian Creole) Si oumenm oswa yon moun w ap ede, gen kesyon konsènan Medicare, se dwa w pou jwenn èd ak enfòmasyon nan lang ou pale a, san pou pa peye pou sa. Pou w pale avèk yon entèprèt, rele nan 1-800-MEDICARE (1-800-633-4227).

Italiano (Italian) Se voi, o una persona che state aiutando, vogliate chiarimenti a riguardo del Medicare, avete il diritto di ottenere assistenza e informazioni nella vostra lingua a titolo gratuito. Per parlare con un interprete, chiamate il numero 1-800-MEDICARE (1-800-633-4227).

日本語 (Japanese) Medicare（メディケア）に関するご質問がある場合は、ご希望の言語で情報を取り得し、サポートを受ける権利があります（無料）。通訳をご希望の方は、1-800-MEDICARE (1-800-633-4227) までお電話ください。

한국어(Korean) 만약 귀하나 귀하가 돋는 어느 분이 메디케어에 관해서 질문을 가지고 있다면 비용 부담이 없이 필요한 도움과 정보를 귀하의 언어로 얻을 수 있는 권리가 귀하에게 있습니다. 통역사와 말씀을 나누시려면 1-800-MEDICARE(1-800-633-4227)로 전화하십시오.

Polski (Polish) Jeżeli Państwo lub ktoś komu Państwo pomagają macie pytania dotyczące Medicare, mają Państwo prawo do uzyskania bezpłatnej pomocy i informacji w swoim języku. Aby rozmawiać z tłumaczem, prosimy dzwonić pod numer telefonu 1-800-MEDICARE (1-800-633-4227).

Português (Portuguese) Se você (ou alguém que você esteja ajudando) tiver dúvidas sobre a Medicare, você tem o direito de obter ajuda e informações em seu idioma, gratuitamente. Para falar com um intérprete, ligue para 1-800-MEDICARE (1-800-633-4227).

Русский (Russian) Если у вас или лица, которому вы помогаете, возникли вопросы по поводу программы Медикэр (Medicare), вы имеете право на бесплатную помощь и информацию на вашем языке. Чтобы воспользоваться услугами переводчика, позвоните по телефону 1-800-MEDICARE (1-800-633-4227).

Español (Spanish) Si usted, o alguien que está ayudando, tiene preguntas sobre Medicare, usted tiene el derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-MEDICARE (1-800-633-4227).

Tagalog (Tagalog) Kung ikaw, o ang isang tinutulungan mo, ay may mga katanungan tungkol sa Medicare, ikaw ay may karapatan na makakuha ng tulong at impormasyon sa iyong lenguwahe ng walang gastos. Upang makipag-usap sa isang tagasalin ng wika, tumawag sa 1-800-MEDICARE (1-800-633-4227).

Tiếng Việt (Vietnamese) Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Medicare, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện qua thông dịch viên, gọi số 1-800-MEDICARE (1-800-633-4227).

Keep this handbook for future reference.

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“Medicare & You” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

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Moving? Visit socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users can call 1-800-325-0778. If you get RRB benefits, contact the RRB at 1-877-772-5772. TTY users can call 1-312-751-4701.

¿Necesita usted una copia de este manual en Español?
Llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.

General comments about this handbook are welcome. Email us at medicareandyou@cms.hhs.gov.

