

Original Medicare: An outline of benefits

Original Medicare is the traditional fee-for-service program offered directly through the federal government. It's sometimes called Traditional Medicare or Fee-for-Service Medicare. Medicare is designed to provide affordable health insurance coverage to elderly and disabled Americans.

When electing coverage, eligible individuals can choose between Original Medicare or one of the Medicare Advantage Plans, which are health plans offered by private companies that contract with Medicare to provide Part A and Part B benefits. While the plans must cover the same services as Original Medicare Parts A and B, the costs can vary from Original Medicare.

Medicare primarily covers acute care treatment in a traditional medical environment. From its inception, Medicare's coverage of long-term care has been extremely limited.

The Centers for Medicare & Medicaid Services (CMS) is primarily responsible for the management of the Medicare program, which is divided into two distinct parts: hospital insurance (known as Part A) and supplemental health insurance (known as Part B). These two parts are significantly different in benefits, deductibles and coinsurance payments. CMS contracts with insurance companies, called Medicare Administrative Contractors (MACs), to process claims for services under Parts A and B. Medicare drug coverage (known as Part D) is provided only by private insurance companies.

Medicare Part A covers acute care services, such as:

- Inpatient hospital care.
- Inpatient skilled nursing facility (not custodial or long-term care).
- Inpatient care in a religious nonmedical health care institution.
- Inpatient psychiatric care.
- Home health care.
- Hospice care.

Part B generally covers:

- Physician services.
- Outpatient hospital services.
- Physical, occupational and speech therapy.
- Diagnostic X-rays.

- Laboratory tests.
- Durable medical equipment.
- Blood work.
- Mental health services.

When Medicare covers a particular service, they determine a reasonable charge for the covered service. This amount is known as the “Medicare-approved amount,” of which Medicare usually pays a portion.

If you have Alzheimer's disease

Medicare now covers care planning services for people recently diagnosed with cognitive impairment, including Alzheimer's and other dementias. Care planning allows individuals and their caregivers to learn about medical and non-medical treatments, clinical trials and services available in the community, and additional information and support that can contribute to a higher quality of life.

Under this new coverage, physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse midwives can provide detailed care planning that includes:

- Evaluating cognition and function.
- Measuring neuropsychiatric symptoms.
- Medication reconciliation.
- Evaluating safety (including driving ability).
- Identifying caregivers and caregiver needs.
- Identifying and assessing care directives.
- Planning for palliative care needs.
- Referrals to community services for both the beneficiary and his or her caregiver.

Experts note that care planning for individuals living with dementia is an ongoing process and that a formal update to a care plan should occur at least once per year. Talk to your health care provider about care planning services. If your provider is not familiar with Medicare coverage of care planning, they can visit alz.org/careplanning for more information.

Although Original Medicare will cover the diagnosis, evaluation, treatment and care planning for Alzheimer's disease, it will not cover:

- Over-the-counter nutritional supplements and vitamins.
- Adult day care.
- Respite care (except as described under the Part A hospice benefit).

- Personal aide assistance (except as provided under the home health care benefit).
- Custodial care in a nursing home.
- Incontinence supplies.

Part A Benefits

Inpatient hospital and inpatient skilled nursing facility coverage

Medicare covers up to 90 days of a hospital stay for a defined period of illness called a “benefit period.” A benefit period begins on the first day you are admitted as an inpatient into a hospital or skilled nursing facility and ends when you haven’t received any inpatient hospital or skilled nursing facility care for 60 consecutive days.

- At the time of admission, ask the doctor if you are being “admitted” into the hospital or being “observed,” as this may affect Medicare coverage of your hospital stay.

There is an additional 60 days of hospital coverage after the initial 90 days called “lifetime reserve” days. There are 190 days in a lifetime reserve for inpatient care in a psychiatric hospital. Lifetime reserve days can be used only once, but can come from different benefit periods.

Deductible and coinsurance payments (2024):

- Initial deductible per benefit period: \$1,632
- Your coinsurance for days 1-60: \$0
- Your coinsurance for days 61-90: \$408 per day
- Your coinsurance for days 91 and over for each benefit period (lifetime reserve days): \$816 per day
- You are responsible for all costs after your lifetime reserve days have been used.

Skilled nursing facility coverage

Medicare may cover up to 100 days of a skilled nursing facility (SNF) stay during a benefit period if the beneficiary:

- Was admitted to the SNF after a minimum of three days’ admission as a hospital inpatient and within 30 days of discharge.
- Requires and receives daily skilled care for the condition that required hospitalization.

Deductible and coinsurance payments (2024):

- No deductible.
- Your coinsurance for days 1-20: \$0
- Your coinsurance for days 21-100: \$204 per day

Home health care

Medicare Part A and/or Part B covers eligible home health services such as intermittent skilled nursing care, physical therapy, speech-language pathology services, continued occupational services and more. It does not cover 24-hour home care, home-delivered meals, homemaker services or personal care.

All people with Part A and/or Part B who meet the following conditions are covered for eligible home health services:

1. You must be under the care of a doctor and be receiving services under a plan of care established and reviewed regularly by a doctor.
2. A doctor must certify that you need one or more of the below services:
 - Intermittent skilled nursing care (other than just drawing blood).
 - Physical therapy, speech-language pathology or continued occupational therapy services.
3. The home health agency must be Medicare-certified.
4. You must be homebound, with a doctor's certification to verify. To be homebound, you must meet both of these requirements:
 - Difficulty leaving the house without help (including using a cane, wheelchair, walker or crutches, or requiring special transportation or help from another person) because of an illness or injury.
 - Leaving the home isn't medically recommended because of your condition, and you're normally unable to leave your home because it's a major effort.

Note: You may leave home for medical treatment or short, infrequent absences or non-medical reasons, like attending religious services. You can still get home health care if you attend adult day care.

Deductible and coinsurance payments (2024):

- No deductible or coinsurance.
- 20% of the Medicare-approved amount for durable medical equipment.
- Before you start receiving your home health care, ask the home health agency how much Medicare will pay, if all the services being offered are covered by Medicare, and, if they aren't, how much you'll have to pay for them.

Hospice care

Medicare covers hospice care for a terminally ill beneficiary who is expected to die within six months and elects to receive hospice benefits in lieu of Medicare Part A and Part B benefits for treatment of the terminal condition. The beneficiary may elect to receive hospice benefits for two 90-day periods and an unlimited number of 60-day periods.

There is no deductible or minimal coinsurance for drugs and respite care.

Covered services include:

- Doctor services.
- Nursing care.
- Physical and occupational therapy.
- Speech-language pathology services.
- Medical social services.
- Hospice aide (also known as home health aide) and homemaker services.
- Prescription drugs for symptom control or pain relief.
- Grief and loss counseling services for the beneficiary and his or her family.
- Short-term respite care.
- Medical equipment and supplies.

Part B Benefits

Covered services include:

- Medically necessary physician services.
- Outpatient hospital services.
- Diagnostic X-rays and laboratory tests.
- Physical, occupational and speech therapy.
- Blood work.
- Durable medical equipment.
- Prosthetic devices.
- Mental health services.
- Some ambulance services.

Some preventive services are now covered, including:

- One-time “Welcome to Medicare” exam.
- Annual wellness visit.
- Mammogram screenings.
- Pap smears and pelvic exams.
- Colon and prostate cancer screenings.

- Abdominal aortic aneurysm screening.
- Bone mass measurements for osteoporosis.
- Diabetes screening, monitoring and self-management, and supplies.
- Cardiovascular screening.
- Flu, hepatitis B and pneumonia vaccinations.
- Glaucoma tests.
- HIV screening.
- Medical nutrition therapy services.
- Tobacco-use cessation counseling.
- Alcohol misuse screening.
- Depression screening.
- Hepatitis C screening.
- Lung cancer screening.
- Obesity screening and counseling.
- Sexually transmitted infections screenings and counseling.

Premium, deductible and coinsurance payments (2024)

- Standard monthly Part B premium: \$174.70 (or higher, depending on your income).
- Annual deductible: \$240 per year.
- After the deductible is met, you typically pay 20% of the Medicare-approved amount for most doctor services (including outpatient therapy and durable medical equipment) if the provider accepts Medicare assignment.
- You pay \$0 for Medicare-approved clinical laboratory services.
- There is no coinsurance or deductible for the annual wellness visit and certain preventive care services if you go to a health care provider who accepts Medicare assignment.

Outpatient mental health treatment

- \$0 for yearly depression screening if the doctor or provider accepts Medicare assignment.
- Copay is 20% of the Medicare-approved amount for visits to a doctor or other health care provider to diagnose or treat your condition. The Part B deductible applies. Copays or coinsurance may differ if you get your services in a hospital outpatient clinic or hospital outpatient department.

Partial hospitalization mental health services

You pay a percentage of the Medicare-approved amount for each service you get from a doctor or certain other qualified mental health professional if that professional accepts assignment. You also pay coinsurance for each day of partial hospitalization services

provided in a hospital outpatient setting or community health center. The Part B deductible applies.

Outpatient hospital services

- Generally, 20% of the Medicare-approved amount for the doctor or other health care provider's services, and the Part B deductible applies.
- You also may pay a copayment for all other services you get in an outpatient hospital setting.

Part D Benefits

Medicare prescription drug coverage

Prescription drug coverage is available to all Medicare beneficiaries through private insurance plans. Each plan is different regarding the drugs it covers and the out-of-pocket costs (e.g., premiums, deductible and co-payments.) Visit the [Medicare page](#) of alz.org/care for more information.

Claim denials in Original Medicare

Sometimes Medicare will refuse to pay for certain medical treatment even though it is a covered service. Examples include:

- Home health care: A claim may be denied because Medicare has determined that the beneficiary is not confined to the home.
- Physical, occupational and speech therapy: A claim may be denied because Medicare does not believe that the beneficiary can benefit from the therapy.
- Mental health services: As with rehabilitation therapy, a claim may be denied because Medicare does not believe that the beneficiary can benefit from the mental health services.

If the above services were ordered by your doctor and provided by an appropriate skilled clinician but Medicare refused to pay for them, you can file an appeal of Medicare's decision. The skilled clinician will need to justify and document in the care plan the need for continued services.

For more information about how to appeal a Medicare denial of a claim, contact your local State Health Insurance Assistance Program (SHIP) or local Area Agency on Aging.

Visit [alz.org/medicare](#) to learn more.

Additional resources

- **Medicare**
alz.org/medicare
- **Centers for Medicare & Medicaid Services (CMS)**
cms.hhs.gov
- **Medicare**
medicare.gov
800.633.4227
- **State Health Insurance Assistance Programs (SHIPs)**
shiphelp.org
- **Eldercare Locator (to find your local Area Agency on Aging)**
eldercare.acl.gov
800.677.1116

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