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Chapter 2

Medicare

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SYNOPSIS

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This chapter will clarify important information you need to know about Medicare. It also will answer your questions about eligibility requirements and enrollment processes. This chapter outlines the services that Medicare Part A, Part B, and Part C cover, and provides a brief discussion of the prescription drug program covered under Part D, which became effective in 2006. Medicare payment policies, payment methods, and appeal processes are explained, and the advantages and disadvantages of each are discussed.

2-1. Medicare

Medicare is a three-part federal health insurance program managed by the Social Security Administration. It helps pay hospital and medical costs for people who are 65 years or older, and for some people with disabilities who are under 65. Medicare is not a "means tested" program. This means that your eligibility for Medicare benefits does not depend upon the amount of your income or your resources. However, the monthly premium structure for Medicare Part B benefits changed in 2007, and the premiums are now determined by your income (means determination).

Medicare Hospital Insurance is called Medicare Part A. It usually covers a medically necessary stay in the hospital. It also may cover skilled nursing care and rehabilitation in a nursing facility or health care in your home after you leave the hospital. It is very important to notice that Medicare Part A does not cover doctors' and ambulance services. Medicare Part B covers these services (see below).

Medicare Medical Insurance is called Medicare Part B. In order to get Part B coverage, you must choose it and pay a monthly premium. Medicare Part B reimburses at the rate of 80 percent of the reasonable charge for medically necessary covered services.

The premium structure for Part B changed in 2007, and income is now considered. The monthly premium ranges from $96.40 to $308.30. The monthly premium is $96.40 for the beneficiary whose income is less than or equal to $85,000, or $170,000 if filing a joint tax return. The monthly premium is significantly higher based on a lower income if a married beneficiary has an income greater than $85,000 and files a separate tax return, rather than a joint return.

Medicare Part B covers doctors' services, ambulance and outpatient services, preventive services, and medical supplies. It also covers home health services prescribed by your physician even if you have not been hospitalized. It must be *medically necessary* based on such criteria as a change in your functional status — for example, due to a fall or injury.

Medicare Part C is also called Medicare Advantage. It requires eligible participants to elect this coverage and assign their Medicare Part A and Part B benefits to a managed care organization or health maintenance organization (HMO). Technically, Medicare Advantage plans must cover the same medically necessary services and benefits that are covered under original Medicare Parts A and B. However, the criteria for determination of "medical necessity" and eligibility for services, such as for rehabilitation and therapy services, may differ. These plans also may provide additional benefits that are excluded under Medicare Parts A and B, such as a wellness program and vision and dental care. You can either elect to have original Medicare Parts A and B, or to enroll in a Part C plan (HMO).

Medicare Part D, which covers the prescription drug program, began in January 2006, and is intended to cover prescription drugs as a result of the Medicare Prescription Drug Improvement and Modernization Act of 2003. The annual open enrollment period for Medicare Part D is from November 15 to December 31. This is also the period in which you can change your plan enrollment.

Medicare Eligibility

You are eligible for Medicare if:

- ▶ You are age 65 or older and qualify for Social Security or Railroad Retirement benefits, even if you are not actually receiving them;
- ▶ You are a former federal employee who retired on or after 1983;
- ▶ You are disabled and have met the Social Security or Railroad Retirement disability requirements for 24 months or two years;
- ▶ You have end-stage kidney (renal) disease and have been treated with dialysis for three months (generally, you become eligible for Medicare benefits on the first day of the third month of dialysis treatment); or
- ▶ You have Lou Gehrig's disease (ALS). You become eligible for Medicare benefits as soon as you are determined to be eligible for Social Security Disability Income (SSDI) benefits, without the requirement of the 24-month waiting period.

If you are age 65 or older but not eligible under the above requirements, you may still choose to enroll in the Medicare program. You must live in the United States and have been a citizen or legal alien for at least five years. If you choose to enroll, you must pay monthly premiums that are generally higher than those charged to eligible beneficiaries. The 2009 Medicare Part A monthly premiums for voluntary enrollees are up to $443 depending on the number of quarters the person paid into Social Security.

How to Enroll

People who elect and receive Social Security retirement benefits before they are 65 will be automatically enrolled in Medicare at age 65. People who have been receiving Social Security Disability benefits for 24 months also will be automatically enrolled in Medicare. These people will receive a Medicare card in the mail from the Social Security Administration three months before their 65th birthday (or on the 24th month of disability), along with a notice informing them of their Medicare Part A enrollment and that they automatically will be enrolled in Medicare Part B unless they refuse this coverage. If you are in one of these categories and do not receive your notice and card, contact the Social Security Administration.

If you have not chosen early retirement, you should apply for Medicare three or fewer months before your 65th birthday, even if you plan to continue working. As the age of eligibility for full Social Security benefits is increasing, many people may need to enroll in Medicare at age 65 without also registering for Social Security benefits. If you do not apply by this time, you can still enroll in Part A any time after that. But, you may miss your opportunity to timely enroll in Medicare Part B, as you can only sign up for Part B between January 1 and March 31 of each year, with coverage beginning on July 1.

Also, there is a 10 percent penalty added to the premium for each full 12-month period an individual is late in enrolling for Medicare Part B, unless you qualify for the "Special Enrollment Period" (you have group health plan insurance coverage based upon the current employment of you or a family member). So, it is very important that you enroll as soon as you are eligible, unless you are still covered by your own or your spouse's employee health plan. Then, you can enroll for Part B either any time or during the eight-month period beginning when the employment or group health plan coverage ends, whichever first occurs.

Your monthly Medicare Part B premium will be deducted from your Social Security check. If you are not yet receiving Social Security, you will be billed for these premiums.

2-2. Medicare Benefits Covered

Benefits Covered Under Part A

Hospital Services

Hospital services (considered reasonable and medically necessary by Medicare) are covered for a hospitalization in an acute care hospital, an inpatient rehabilitation facility (IRF), or a long-term acute care hospital (LTAC). These services can include:

- Semi-private room and board, including special care units;
- General nursing services;
- Inpatient prescription drugs;
- Supplies;
- Use of equipment normally furnished by the hospital;
- Operating and recovery room costs;
- Blood transfusions after the first three pints;
- Diagnostic, therapeutic, or rehabilitative services and items the hospital normally furnishes; and
- Inpatient mental health care in a psychiatric hospital (lifetime maximum benefit of 190 days).

Skilled Nursing Facility (SNF) Services

These include:

- Skilled nursing care;
- Semi-private room and board;
- Physical, occupational, and speech therapy;
- Medical social services;
- Inpatient prescription drugs; and
- Use of durable medical equipment such as wheelchairs, walkers, and special beds.

A skilled nursing facility also may furnish intermediate and custodial care, which is not a covered benefit. Medicare only pays if you receive skilled nursing or therapy services or both and pays only under specific circumstances.

Hospice Services

Hospice care is concerned with maintaining a person's quality of life as she or he approaches death and is appropriate for people with a terminal illness who have a life expectancy of six months or less if the disease process runs its normal course. Beneficiaries or their designees must sign a written hospice election form with the hospice organization of choice, choosing hospice care over regular Medicare Part A covered benefits for the terminal illness. This election can be cancelled at any time.

The Medicare Part A hospice benefit *does not* include payment for room and board at a skilled nursing facility or hospice facility. However, if the beneficiary also has Medicaid benefits, Medicaid generally will cover this cost of room and board. Hospice benefits include:

- Physician services;
- Skilled nursing care;

- Physical, occupational, and speech therapy for purposes of symptom control or to enable the beneficiary to maintain functional skills;
- Durable medical equipment (DME) such as hospital bed and wheelchair rental;
- Pain-relieving medication and all other medications (*Note:* Medicare Part D changes some of these reimbursements);
- Medical social services;
- Home health aide and homemaker services;
- Medical supplies and appliances;
- Spiritual, grief, and loss counseling; and
- Short-term inpatient care not for treatment of the terminal disease.

Benefits Covered by Part A and Part B

Home Health Care Services

Medicare benefits covered by Part A and Part B pay for home health care ordered by your physician and provided by a certified Medicare home health care agency. This benefit is limited to "reasonable" and "medically necessary" intermittent care. The beneficiary may choose any Medicare-certified home health care agency, and there is no cost to the beneficiary for these home health care services. Covered home health care services include:

- Skilled nursing care;
- Physical, occupational, and speech therapy;
- Limited services of a home health aide to assist the beneficiary with his or her activities of daily living (ADLs);
- Medical social services;
- Medical supplies; and
- Equipment provided by the agency.

Medicare Benefits Covered by Part B

Part B covers the following medically necessary services and items:

- Physicians' services;
- Ambulance services;
- Home health services prescribed by a doctor if you have not been hospitalized, or met the required three-day hospitalization to trigger Medicare Part A benefits;
- Outpatient physical, occupational, and speech therapy;
- Rental or purchase of durable medical equipment (DME) such as walkers, wheelchairs, and all-in-one commode chairs;
- Prosthetic devices and medically necessary shoes such as for diabetics;

- Services in an emergency room, outpatient clinic, or ambulatory surgery center;
- Some hospital outpatient services and supplies (such as diagnostic x-ray tests and radium and radioactive isotope therapy);
- Some preventive services and tests at specified intervals, including vaccinations (flu, pneumonia, and hepatitis B shots), mammograms, Pap smears, and screening tests for abdominal aortic aneurysm, bone density, cardiovascular health, colorectal cancer, diabetes, glaucoma, and prostate cancer);
- Smoking cessation counseling, as ordered by your physician for up to two cessation attempts within a 12-month period, with each cessation attempt having up to four face-to-face visits. Requires you to be diagnosed with a smoking-related illness or using medication that may be affected by tobacco;
- Diabetes education and some supplies;
- Surgical dressings, splints, and casts;
- Limited chiropractic care;
- A percentage of the cost of oxygen and equipment; and
- Kidney dialysis services and supplies.

Services and Supplies NOT Covered by Medicare Parts A or B

Although Medicare has broad coverage, it does not pay for many services and supplies. These non-covered services include:

- Acupuncture;
- Custodial care in a skilled nursing facility or at home;
- Services not "reasonable" or "medically necessary" as defined by Medicare;
- Room and board costs for a person on hospice who resides at a skilled nursing facility or hospice facility (see the "Hospice Services" section, above);
- Services the patient has no legal duty to pay for;
- Services paid by a governmental agency;
- Personal comfort items;
- Routine check-ups other than the "Welcome to Medicare" one-time physical examination done within the first six months of enrolling in Part B;
- Homemaker services;
- Hearing aids/examinations;
- Eye glasses/routine eye examinations;
- Most chiropractic services;
- Cosmetic surgery;
- Dental care;

- ▶ Optional private hospital rooms;
- ▶ Orthopedic shoes; and
- ▶ Health care while traveling outside the United States.

Medicare Benefits Covered by Part C (Medicare Advantage)

If you are entitled to benefits under Medicare Part A and also are enrolled under Part B, you may choose to receive Medicare Part C from a Medicare Advantage plan. Medicare Part C plans must provide the services currently available under original Medicare Parts A and B. These plans may offer supplemental benefits, for which a separate premium may be charged. Part C provides beneficiaries with alternatives to original fee-for-service Medicare.

Medicare Advantage plans may include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service plans. Currently in Colorado, Health Maintenance Organizations (HMOs) are the only type of Medicare Advantage plan available to Medicare beneficiaries (see Chapter 3, "Health Insurance Beyond Medicare," for information on Medicare HMOs).

Some Medicare beneficiaries choose to enroll in Medicare HMOs because the monthly premiums usually are lower and additional services are provided at lower costs to them. Before enrolling in a Medicare HMO or Medicare Advantage plan, investigate whether it will meet your particular health care and rehabilitation needs.

Medicare Payment Policies

As with private insurance policies, Medicare Parts A and B have deductibles that you must pay before Medicare pays anything. Part B has a monthly premium, which is deducted from your Social Security check. Medicare Parts A and B also have co-insurance payments that go into effect after certain Medicare payments are made. You then must share some of the costs with Medicare.

Part A

The Medicare Part A hospitalization benefit has a year 2009 deductible of $1,068 for each "benefit period" or "spell of illness." Medicare measures your use of Part A hospital insurance with "benefit periods," which also are called "spells of illness." A benefit period is a period of consecutive days during which medical benefits for covered services, with certain maximum limitations, are available to you, the beneficiary. Your first benefit period begins the first day you enter a hospital after your insurance goes into effect.

A new benefit period of 90 days of hospitalization coverage begins each time you are hospitalized, if it has been at least 60 consecutive days since your last discharge from a hospital or skilled nursing facility. Each benefit period is called a "spell of illness," and the number of benefit periods or spells of illness is unlimited.

Hospital Care

The Medicare Part A benefit allows you to receive up to 90 days of hospital care for each spell of illness. The following is what you must pay:

- For the first 60 consecutive days, Medicare requires you to pay only the deductible for the spell of illness, which in 2009 is $1,068. Medicare pays the remaining covered expenses.
- For the next 30 days (days 61 to 90), Medicare requires that you pay a co-payment or co-insurance charge for each day you are in the hospital. For 2009, this daily co-insurance rate is $267. Medicare pays the remaining covered expenses.
- Each beneficiary has a lifetime reserve of 60 days for days 91 to 150. This benefit is not renewable. Any number of the lifetime reserve days can be used for any spell of illness, up to the maximum the beneficiary has. So, after day 90, you may use some or all of your 60 lifetime reserve days. The 2009 co-insurance daily charge for each lifetime reserve day is $534. Medicare pays the remaining covered expenses for each day, up to a 60-day maximum.

Skilled Nursing Care

Medicare Part A hospitalization insurance benefits provide up to 100 days of inpatient extended care benefit coverage for skilled nursing and skilled therapy services. However, there is no absolute right to payment for all 100 days unless they are "reasonable" and "medically necessary."

Medicare Part A pays 100 percent of all costs for the first 20 days of covered skilled nursing care and skilled therapy services in a Medicare-certified facility after you are discharged from a hospital, following the required stay of at least three consecutive days, not including the day of discharge. Days 21 through 100 require a daily co-insurance rate of $133.50, and Medicare pays the remaining covered expenses. After 100 days, you are responsible for payment of the full amount and Medicare pays nothing. However, you may be eligible for Medicaid payment for long-term care (see Chapter 4, "Medicaid"). The level of care requirements for skilled nursing facility coverage are very restrictive. Rarely do individuals receive the full 100 days of coverage.

Home Health Visits

Home care services must start within 14 days of your discharge from the inpatient or skilled nursing facility. Medicare Parts A and B pay for the *full* approved cost of home health visits by a Medicare-certified home health agency following a treatment plan of care prepared by a nurse or a physical, occupational, or speech therapist and approved by your physician. Strict requirements limit the coverage of home health services. The person receiving services must be "confined to her or his home" or "home bound" in order to receive home health services. This means it would take considerable and taxing effort to leave home. The person may be able to leave home for doctor appointments, an occasional walk or drive, or other limited trips outside the home. Another requirement is that the services are needed only on an intermittent basis, rather than continually.

Home health care agencies *must* give the beneficiary a minimum of two days' notice of their intent to either cut back or terminate services. This notice must also explain the procedure for seeking review of the termination or cut back in services. If Medicare refuses to cover you for these types of services, you have a right to appeal this decision. You may want to ask an attorney or someone else knowledgeable about Medicare to help you through the appeal process.

Hospice Care

The usual deductibles and co-payments do not apply to hospice care. Unless your prescriptions are covered from some other source or Medicare Part D, you pay 5 percent of the cost for prescription drugs, up to $5 per prescription. You also pay 5 percent of the cost of respite care, up to a maximum equal to the yearly inpatient hospital deductible.

Part B

Medicare Part B payment rules for covered medical services:

- Services must be reasonable and medically necessary, as defined by Medicare; and
- Medicare pays 80 percent of the approved charge after you pay your yearly deductible of $135 for 2009 (which is unchanged from 2008). You pay the remaining 20 percent, plus any difference between the doctor's charge and the approved charge.

The approved charge is the amount that Medicare considers to be the value of the services you received. It is not always the same as the amount that the provider bills you for the services.

Medicare Payment Methods

Under Medicare Part A, you do not have to send in any bills you receive from a participating hospital, skilled nursing facility, or home health agency. The health care provider will file the claim for you, and Medicare will pay its share directly to the provider. You will then receive a Medicare Summary Notice (MSN) explaining what Medicare paid. If you disagree with this payment, you have the right to appeal (see section 2-3, "Appeal Rights").

Payment is made two ways under Medicare Part B Medical Insurance:

1) **Assigned Claims**. Participating physicians and health care providers who accept assignment will bill Medicare directly. You are responsible only for 20 percent of the approved Medicare charge and not for any additional amount above the approved charge. If the doctor is a participating physician who has agreed to take Medicare assignment, then he or she has agreed not to charge above the Medicare approved rate, and also to accept the Medicare approved rate as payment in full. The simplest way to find out if the doctor is a participating physician who has agreed to take Medicare assignment is to ask in advance.

2) **Non-Assigned Claims**. With this method, the physician or health care provider sends in a completed claim form, but the payment from Medicare is paid directly to you. You are then responsible for paying the provider the full amount of the bill for the services provided to you. Under this method, a physician or health care provider may bill you for the full charges, even if it is more than the Medicare-approved charge.

With non-assigned claims, you are responsible for payment of the difference between the Medicare approved charge and the actual charge. For example, if the bill was $100 and the Medicare approved charge was $90, you would be responsible for the difference of $10 ($100 minus $90), plus 20 percent of the approved charge (20 percent times $90 equals $18), for a total payment of $28. The doctor cannot charge more than 115 percent of the approved charge.

Under either payment system, as Medicare Part B pays a maximum of 80 percent of the approved charge, you must pay at least 20 percent of the approved charge, plus any unpaid part of your $135 (for 2009) annual Medicare Part B deductible. You pay your share directly to the physician or health care provider.

The New Prescription Drug Plan: Part D (Under Title 16 of the Social Security Act)

On January 1, 2006, the new Medicare prescription drug plan began. Medicare has contracted with private companies to offer this drug coverage. Colorado currently has 53 presciption drug plans, with varying premiums, deductibles, and benfits. (*See* www.medicare.gov/mpdpf.) These companies offer a variety of options, with different covered prescriptions and different costs. Medicare prescription drug plans are voluntary. If you want to participate, you must choose a plan offering the coverage that best meets your needs and then enroll. In most cases, there is no automatic enrollment to get a Medicare prescription drug plan.

Medicare prescription drug plans vary, but in general, this is how they work. When you join, you will pay a monthly premium (cost varies from $18.40 to $112.70 for Colorado plans) in addition to any premiums for Medicare Part A and Part B. Medicare prescription drug plans can offer coverage like this or more generous coverage for higher premiums. Joining is your choice. However, just as described above for enrollment in Part B, if you do not join when you are first eligible, you may have to pay a higher premium if you choose to join later. You will have to pay this higher premium for as long as you have a Medicare prescription drug plan.

Enrollment

To enroll, you must be eligible for Medicare Part A or Part B. You can first enroll three months before you become eligible for Medicare and until three months after you become eligible for Medicare. This is called the "initial enrollment period." Enrolling is your choice.

You can find the most up-to-date Medicare information and answers to your questions anytime on Medicare's official website, www.medicare.gov. You also can call (800) MEDICARE ((800) 633-4227). This toll-free help line is available 24 hours a day, seven days a week to answer your questions. *Note:* after your initial enrollment period, you can change your plan during the open enrollment period, which is from November 15 to December 31 each year. Your new Medicare prescription drug plan will begin January 1 of the following year.

Plan Costs to You

In 2009, the standard drug benefit plan includes your payment of an annual maximum deductible of $295 (the Colorado plans range from $0 to $295) prior to payment of any prescription drug costs.

- If your yearly drug costs are $0 to $295 (or your deductible), you pay 100 percent of these costs;
- If your yearly drug costs are $295.01 to $2,700, you pay 25 percent of your yearly costs and your plan pays the other 75 percent (*e.g.*, you would pay $601.25 for $2,405 in prescriptions);
- If your yearly drug costs are $2,701 to $4,350, you pay 100 percent of your drug costs for the amount between $2,701 and $4,350. This is called the "donut hole," "coverage in the gap," or "coverage gap"; then
- In 2009, when your total expense on formulary drugs reaches $4,350, you pay 5 percent of your drug costs for the rest of the calendar year, and your plan pays the rest.

Additional Low-Income Assistance

If your monthly income is below $1,354 ($16,245 annual income) for a single person or $1,821 ($21,855 annual income) if you are married and living with your spouse, you may qualify for extra financial assistance through the Low-Income Prescription Drug Subsidy Program. Slightly higher income levels may apply if you provide half-support to other family members living with you, or if you work or reside in Alaska or Hawaii.

If your resources (including your savings and stocks, but not counting your home or car) are less than $12,510 (for a single person) or less than $25,010 (for a married couple), you may qualify for extra help paying for your Medicare prescription drug costs. You can apply for this Low-Income Subsidy through the Social Security Administration or your State Medical Assistance Office. If the Social Security Administration can determine your eligibility by its internal records, an application will be sent to you. For others, you must apply.

The amount of subsidy you get depends on your income and resources. You still must join a Medicare prescription drug plan for Medicare to pay for any of your drug costs.

If you qualify for the Low-Income Subsidy, you will have continuous drug coverage and will pay only a small amount for your prescriptions. The Social Security Administration (SSA) at (800) 772-1213 or www.ssa.gov can provide more information on the low-income subsidy (LIS) for prescription drug costs and information on how to apply for it.

2-3. Appeal Rights

Medicare beneficiaries are required to receive written notice of termination of services, non-coverage, and cutbacks in coverage pursuant to Medicare Parts A and B. Original Medicare Parts A and B Fee-For-Service Plans have five levels of appeals of the denial of payment of services. (*See* www.cms.hhs.gov/OrgMedFFSAppeals/01_overview.asp?.) The notice should state the appeal procedure you need to follow. Most appeals must be written, and must be filed within the number of days stated on the notice. It is recommended that all appeals and related correspondence be sent via certified mail, with a return receipt requested, so you have proof that you sent your appeal and it was done on time. Usually the appeal forms are included with the notices. Otherwise, the appeal forms can be obtained from the Medicare website at www.medicare.gov. *Note:* if you have a Medicare Advantage Plan (Medicare Part C), you need to read your plan materials carefully to learn how to file an appeal and whether you have the right to an "expedited review" or fast appeal.

Parts A and B

Original Medicare Parts A and B plans send you a Medicare Summary Notice (MSN) every three months. This MSN lists all the services you have had and states whether Medicare paid for these services. It also states your appeal rights. If Medicare denies payment of your claim, you may ask for an informal review or redetermination of the decision by:

1) Circling the items you disagree with on the MSN;
2) Writing an explanation on the MSN, which is signed and dated;
3) Including your telephone number;
4) Attaching any supporting documentation to the redetermination request;
5) Sending the MSN or a copy by certified mail, return receipt requested, to the Fiscal Intermediary (FI), Carrier, or Medicare Administrative Contractor (MAC) listed in the appeals section of the MSN; and
6) Keeping a copy of all documents you send.

You must ask for that review within 120 days of the date of the decision in the MSN. If you still disagree with Medicare's decision of redetermination, you have 180 days from the date you receive this second denial of payment to submit a written request for review and reconsideration to the Qualified Independent Contractor. If you disagree with the independent review, and the amount in dispute is $120 or more, you may ask for a formal hearing from the Office of Medicare Hearings and Appeals from an Administrative Law Judge (ALJ). You must do so within 60 days of Medicare's review decision. If you still disagree with the decision of the Office of Medicare Hearings and Appeals, you then can appeal within 60 days to the Medicare Appeals Council, which ultimately may decline a review.

Your fifth and final avenue of appeal is to the federal district court for judicial review if the amount in dispute is $1,180 or more. If both you and Medicare maximize the time limits allowed for sending an appeal and giving a redetermination, your final appeal to the federal district court can take almost 23 months. Considering the present shortage of Colorado federal district court judges, it probably will take in excess of a year for your appeal to be determined, unless your appeal can be expedited.

To appeal a denial of Medicare approval for a hospital admission or continued hospital stay, call the Colorado Foundation for Medical Care at (303) 695-3300, or (800) 727-7086 outside Denver.

If you feel your Medicare-covered services from a hospital, skilled nursing facility, home health care agency, comprehensive outpatient rehabilitation center, or hospice are ending too soon, you might have the right to a "fast" or "expedited" appeal with an independent reviewer to determine if your services should continue. You have by noon on the next calendar day after receiving the Notice of Discharge or Service Termination to appeal this decision for the Quality Improvement Organization Redetermination, which has 72 hours (3 days) to make its decision. Your second level of appeal is to the Qualified Independent Contractor and must be done within 72 hours of the first denial. It also has 72 hours to give its decision.

If you still have concerns with this decision, your third level of appeal is to file an appeal within 60 days to the Office of Medicare Hearings and Appeals. You then follow the procedure and time lines as stated for a regular appeal. The Colorado Senior Health Insurance Assistance Program (SHIP), (888) 696-7213, (303) 894-7944, or (800) 930-3745 (toll-free), can assist you with filing an appeal.

Supplemental Health Insurance (Medigap)

Since Medicare does not pay all your medical or long-term care expenses, private insurance companies sell insurance to supplement Medicare, which is known as "Medigap" coverage. Supplemental Health Insurance is especially important to have for covering your daily co-insurance charges and deductibles. It is highly recommended coverage. (See Chapter 3, "Health Insurance Beyond Medicare," for information on Medigap or supplemental coverage.)

Medicare Information Resources

If you need help or more information, an excellent Medicare resource is the non-profit organization, the Center for Medicare Advocacy, Inc. Its website is www.medicareadvocacy.org. It has a large library of excellent articles on a variety of Medicare topics.

You also can look at www.medicare.gov. This is Medicare's official consumer website, where you can find the most up-to-date Medicare information and answers to your questions anytime. You also can call (800) MEDICARE ((800) 633-4227), and (877) 486-2048 for TTY users. This toll-free help-line is available 24 hours a day, 7 days a week, and has customer service representatives to answer your questions in either English or Spanish. These customer service representatives, however, may not be willing or able to answer any questions from currently non-eligible Medicare beneficiaries, such as family members of a beneficiary or educators.

The Social Security Administration sends free booklets providing detailed information on Medicare when you enroll. Also, the Social Security Administration provides periodic updates to information concerning Medicare Part A and Part B, as these programs are subject to change and review by Congress and the Centers for Medicare and Medicaid Services, formerly Health Care Financing Administration (HCFA).

The "Medicare & You 2009" handbook should have been mailed to each Medicare beneficiary between late October and late November 2008. You can also view it at www.medicare.gov, or call (800) MEDICARE ((800) 633-4227) to request a copy. TTY users should call (877) 486-2048.

2-4. Glossary

Approved Charge. The amount Medicare approves as the value of services received. It is not always what the provider charges.

Assignment. A method of payment under Medicare Part B, in which the physician or supplier agrees not to charge the patient more than the Medicare-approved charge. The doctor sends the completed Medicare claim form to Medicare. Medicare then pays the doctor 80 percent of the approved charge after deductibles have been met.

Co-Insurance Payments. Payments you make to share costs with Medicare.

Deductible. Amount of the medical bill you must pay before Medicare begins coverage.

Hospice. Care provided for the terminally ill that emphasizes comfort rather than aggressive treatment.

Lifetime Reserve Days. Sixty extra days you may use for hospitalization. You share daily costs with Medicare. These days can be used only after you have stayed more than 90 days in a hospital and can be used only once. This benefit is *not* renewable.

Medicare Hospital Insurance (also called Medicare Part A). Insurance that covers a necessary hospital stay, skilled nursing care in a nursing facility, and other home health services.

Medicare Medical Insurance (also called Medicare Part B). Insurance that covers doctors' and outpatient services, medical supplies, ambulance, and other services.

Medigap. See Chapter 3, "Health Insurance Beyond Medicare," for a detailed explanation of Medigap coverage.

Non-Assigned Claims. A method of payment under Medicare Part B. The doctor sends Medicare a completed claim form, but you are responsible for paying the doctor the full billed amount. Medicare will send you 80 percent of the approved charge if all of your yearly deductible is paid.

Spells of Illness. Benefit periods beginning with the first day you enter the hospital after your Medicare goes into effect. These benefit periods end when you have been out of a hospital or skilled nursing facility for 60 days.

2-5. Resources

See the “Resources” section in Chapter 5, “Government Programs and Financial Assistance,” for Area Agency on Aging offices, legal aid, and legal aid services offices. For more information about Medicare and Medicaid, call your nearest senior center.

Medicare Information:

U.S. Department of Health and Human Services
Provides counseling and information on Medicare benefits, eligibility guidelines, etc.
200 Independence Ave., SW
Washington, D.C. 20201
(202) 619-0257
(877) 696-6775
www.hhs.gov

The Center for Medicare Advocacy, Inc.
National non-profit organization.
P.O. Box 350
Willimantic, CT 06226
(202) 293-5760
(860) 456-7790
www.medicareadvocacy.org

Medicare Claims
(800) 633-4227

Medicare Helpline
(800) 633-4227
(877) 486-2048 (TTY)
www.medicare.gov

Social Security Administration
(800) 722-1213
www.ssa.gov

Health Insurance Counseling for Information:

AARP — Colorado Chapter
Provides counseling and information on health insurance to AARP members.
303 E. 17th Ave., Ste. 510
Denver, CO 80203
(866) 554-5376
www.aarp.org/states/co/

Colorado Division of Insurance

Provides information on Medicare benefits, Medigap, etc.
(303) 894-7499
(800) 930-3745
www.dora.state.co.us/insurance

Colorado Foundation for Medical Care

23 Inverness Wy. E., Ste. 100
Englewood, CO 80112-5708
(303) 695-3300
www.cfmc.org

Colorado Senior Health Insurance Assistance Program (SHIP)

Provides Medicare denial of services appeal filing assistance, answers questions about Medigap policies, long-term care insurance, Medicare rights and protection, and Medicare health plan choices.
(303) 894-7499
(800) 930-3745
www.dora.state.co.us/insurance/senior/senior.htm

Senior Answers and Services

Provides counseling regarding health insurance issues, Medicare, etc.
3006 E. Colfax Ave.
Denver, CO 80206
(303) 333-3482
www.senioranswers.org

Teletips — Better Business Bureau

1020 Cherokee St.
Denver, CO 80204-4039
(303) 758-2100
www.denverbbb.org