Informational Update Vol 12 #4

1. **<u>What Medical Services are not Covered by Original Medicare</u>** - Original Medicare covers costs associated with doctors and hospital services that are considered medically necessary. However, it generally does not cover services that are cosmetic or alternative health treatments. Routine dental, vision and hearing services are also not covered by Original Medicare unless they are related to a medical condition. For example, routine eye exams to determine a prescription for eyeglasses is not covered. However, Original Medicare would cover an eye exam for glaucoma. If you are in a hospital, Part A will cover emergency dental procedures and some dental services, but not dentures.

The following are additional services Original Medicare does not cover:

- **Nursing home care** – Includes help with daily personal care such as bathing, dressing, and using the bathroom.
- **Non-medical services –** Includes **c**anceled appointments for which you are charged, private hospital rooms, and any other no-medical services.
- **Routine foot care –** Routine medical care for feet, such as callus removal, is not covered. However, Original Medicare will cover foot exams or treatment if it is related to a diabetes condition, or care for such foot issues as hammertoe, bunion deformities and heel spurs.
- **Care in foreign countries** – With few exceptions, generally not covered. However, some secondary plans, like Emblem Health, may cover the service.
- **Hearing aids** – Original Medicare will cover ear-related medical conditions but not hearing aids or routine hearing tests.

2. **<u>Skilled Nursing Facility</u>** – If you are on Medicare and in need of a physical therapy after an operation, you normally will be sent to a skilled nursing facility if it's needed to meet your health goal. This goal is determined by your doctor who has decided you need daily skilled care given by skilled nursing or therapy staff.

What is a Skilled Nursing Facility?

Often, individuals confuse nursing homes with a skilled nursing facility (SNF) because of the similarities. In fact, many times the terms are used interchangeably. To be clear, a SNF provides more “skilled” medical expertise and services than a nursing home. Basically, a SNF provides rehabilitation services to help injured, sick or disabled individuals get back on their feet.

Generally, hospitals make the arrangements to transfer a patient to a SNF after an acute hospital stay, such as surgery. The transfer occurs when the patient is released from the hospital. In the SNF, the patient will receive whatever rehab he or she needs like physical or speech therapy until he or she is ready to go home.

What is the coverage for staying at an SNF?

§ Days 1-20: $0 (covered by Medicare)

§ Days 21-100: $0. (covered by Blue Cross Blue Shield)

§ Days 101 and beyond: You pay all costs.

3. **Medicare Summary Notice** – If you are on Medicare, you will receive a Medicare Summary Notice each time you used a Medicare doctor or were in the hospital. This document lists your claims and costs for a given period. It is NOT a bill, although it will inform you how much you may be billed, the providers involved, and whether Medicare approved your claims. The document also mentions how to report a fraud and how to file an appeal for a denied claim.

Because it is the right thing to do, you should report any claims that appear fraudulent. But what you may not realize, a fraudulent claim can have a negative impact on your coverage. For example, you review a Medicare Summary Notice and see a claim from a physical therapist for $600. However, you report this claim as fraudulent since you never received the therapy on the date mentioned. If you had not reported it,

then your $2,110 of Medicare coverage for physical therapy would have been reduced by $600. Motto? Review the Medicare Summary Notices carefully.

4. **Question of the Month**

Q. My wife and I each received a check from the city for $1,735.20. What was that for?

A. **The $1,735.20 is the reimbursement of your 2019 Medicare Part B premium. The reimbursement was based on your monthly payments of $144.60. In the past it was calculated on your monthly payments of $109, requiring you to file for the difference of what you received and were actually paid. In 2019, that is not the case; you were reimbursed for what you actually paid. You no longer will have to file for a difference since there is none**

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