

# The Medicare Counselor

## MARCH/APRIL 2012

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### In this issue...

In these three pages you will find a frequently asked question from our Professional Helpline, information about observation stays in the hospital, and a Crossword puzzle full of Medicare trivia!

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### Medicare Resources

- **Medicare Interactive:**  
<http://www.medicareinteractive.org/>
- **Medicare Rights Center:**  
<http://www.medicarerights.org/>
- **Medicare:**  
<http://www.medicare.gov>
- **Health Care Reform and Medicare:**  
<http://www.medicarerights.org/issues-actions/health-reform-and-medicare.php>

### Hot Topic from the Helpline

**My client has Medicare and Medicaid. She just called after she went to her cardiologist and was charged a copayment for the visit. I thought she shouldn't be charged because she has Medicaid. Is that right?**

**-Professional Helpline Caller**

This is a great question. The answer depends on two things: whether the client is enrolled in the Medicare Savings Program QMB, and whether the provider accepts Medicaid. If the client has QMB, then she cannot be billed the cost-sharing for any service covered by Medicare. If the provider accepts Medicaid, the client cannot be charged whether or not she has QMB.

A person with QMB cannot be balance billed by any Medicare provider. This means that providers cannot charge people with QMB for Medicare copayments, coinsurances, or deductibles. A person with QMB can be charged only a nominal copayment set by the state Medicaid agency for any Medicare-covered service, including Part B drugs, specialist visits, and Durable Medical Equipment (DME). This protection applies regardless of whether another payer, such as the state Medicaid agency, pays the provider for the Medicare cost-sharing. This rule protects people with QMB who are enrolled in Original Medicare, as well as people in Medicare Advantage plans.

We have seen a great deal of confusion about this rule from doctors, pharmacists, and even Medicaid representatives. Because of this confusion, people with QMB are frequently billed despite this balance billing protection. Remind clients to let their providers know that they cannot balance bill people with QMB because of a Medicare rule that is binding on any doctor who has not formally opted out of the Medicare program.

Providers who are able to bill Medicaid may receive at least some compensation from their

state Medicaid office for Medicare cost-sharing for people with QMB. When a person with QMB goes to a provider who does not accept Medicaid, however, it is likely that these providers will receive full compensation for the services they provide. This means that the provider will be compensated 80 percent by Medicare but will not receive the remaining 20 percent of their payment from Medicaid, so they are not paid in full. Some providers choose not to accept patients with QMB because they believe that they are not being paid fairly for their services. This problem is avoidable if people with QMB go to providers who accept Medicaid.

People with QMB or Medicaid should go to providers who are participating in Medicare. By seeing participating providers, they will not be billed up-front. If they are billed, they can explain to their providers why they should not be responsible for the balance of the Medicare payment. QMB members should not make payments to providers up front, because it is easier to avoid making a payment than it is to request a reimbursement from a doctor's office.

Most people with Medicaid also have QMB, because the eligibility requirements for Medicaid are generally more restrictive than QMB requirements. However, enrollment in Medicaid does not automatically result in enrollment in QMB. People with a Medicaid spend-down, for example, may choose not to enroll in QMB because enrolling in the program would increase their Medicaid spend-down.

If a person with Medicare and Medicaid goes to a provider that accepts Medicaid, then that provider should accept the Medicaid payment as payment in full. Even if Medicaid does not make any payment above what Medicare has paid, the provider is not allowed to charge the client the balance. The maximum that a client could be charged in this circumstance is a nominal Medicaid copayment.

Those who are enrolled in Medicare and Medicaid but not QMB can be billed for Medicare coinsurances, copayments, and deductibles if they go to providers who do not accept Medicaid. There is no rule prohibiting Medicare providers from balance billing people with Medicaid. People in this situation should be sure that all of their providers accept both programs, or they may find themselves receiving unexpected bills.

## **Understanding Observation Stays**

Hospital services are not just covered by Medicare Part A. Some services, like outpatient hospital services, are covered under Medicare Part B. Out-

patient hospital services include x-rays, minor surgeries and observation stays. An observation stay happens when a physician orders that a patient stay in the hospital so their condition can be monitored, but they are not admitted to the hospital. The patient being held for observation is an outpatient, not an inpatient, even if they stay in the hospital overnight. Observation stays are usually reserved for hospital patients who come into the emergency room and have symptoms that require the hospital physicians to monitor them. This monitoring should lead to a decision about whether or not to admit the patient to the hospital with an inpatient status or release the patient after observation.

Usually, the decision to admit or release a beneficiary in the hospital for observation can be made in less than 48 hours. However, there are exceptional cases where outpatient observation lasts longer than 48 hours. This is why it is very important to encourage all beneficiaries and their caregivers to ask their doctors if they are an inpatient or an outpatient. Oftentimes, patients assume that because they have been placed in a hospital bed or a hospital room, they are automatically an inpatient. This is not the case; a doctor must sign a form that actively admits someone as an inpatient.

When a beneficiary enters the hospital under observation, their care is charged to Medicare Part B. This means they are subject to Part B coinsurances and deductibles for the time that they were an outpatient in the hospital. If a patient has Original Medicare, they will have a 20 percent coinsurance after they meet the \$140 deductible in 2012. If a patient has a Medicare Advantage plan, they will have to pay that plan's copayment for outpatient services.

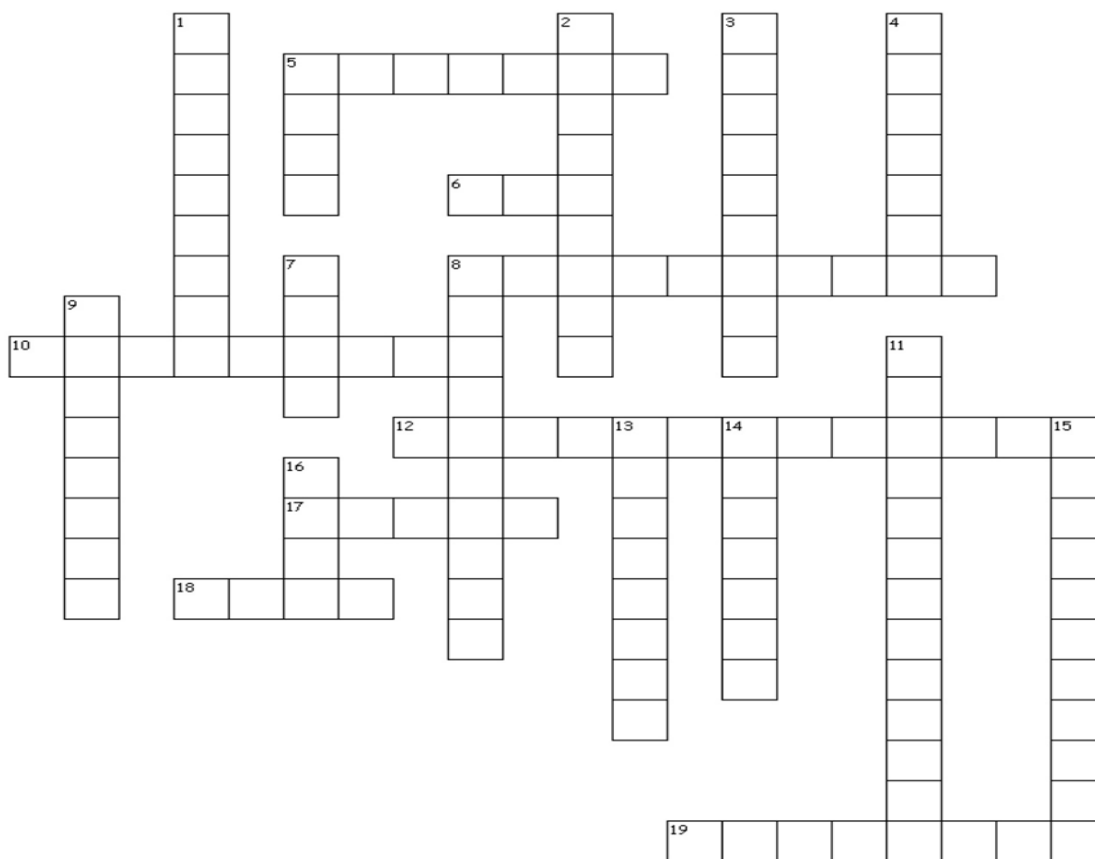
How someone is admitted to the hospital, affects his or her transfer to skilled nursing facilities (SNFs). Someone with Medicare must have a three-day qualifying inpatient stay in a hospital to qualify for Medicare coverage of SNF care. The day the person becomes an inpatient counts toward the qualifying days and the day they are discharged from the hospital does not. However, if someone enters the hospital under observation, their status is that of an outpatient instead of an inpatient, which will affect whether they qualify for SNF coverage. Clients must ask the doctor about their inpatient status to be sure they are an inpatient for the qualifying number of days.

In some cases, a hospital can retroactively assign someone to an inpatient status so they can qualify for SNF care. This means that once someone leaves the hospital, their patient status can be changed from outpatient to inpatient. However, someone's hospital status cannot be changed from

inpatient to outpatient after they leave the hospital. If a doctor is changing a patient's status from inpatient to outpatient, that beneficiary must be notified of the change before they are discharged. It is important to remind clients that while doctors may retroactively

change hospital statuses from outpatient to inpatient, this does not often happen. Beneficiaries should ask their doctors about their inpatient status while they are in the hospital.

## Medicare Counselor Crossword



### Across

- 5. Signer of Medicare law
- 6. Vaccine covered under Part B
- 8. Tool to help people pick drug coverage
- 10. Complaint filed against plan
- 12. The amount of time during which Medicare pays for hospital and skilled nursing facility (SNF) services
- 17. Percentage discount on brand-name drugs during the doughnut hole in 2012
- 18. Signer of Medicare Improvements for Patients and Providers Act (MIIPA)
- 19. Supplemental Insurance

### Down

- 1. Medicare private health plans
- 2. List of covered drugs
- 3. Care not covered by Medicare independent of skilled care
- 4. Medical equipment covered by Medicare
- 5. Part B effective month if you sign up during the General Enrollment Period
- 7. People who have Medicare and Medicaid are \_\_\_\_ eligible
- 8. Type of service available for free under Medicare thanks to health reform
- 9. Physician, Nurse Practitioner, Physicians Assistant
- 11. Providers who always take assignment
- 13. Percentage discount on generic drugs during the doughnut hole in 2012
- 14. Health care plan for active-duty military service members, retirees, and their families
- 15. In 2012 it can't be more than \$320
- 16. Medicare Advantage plan that allows you to also get a PDP