Center for Medicare Advocacy
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MEDICARE PART B COVERAGE

Se habla español

Produced under a grant from the
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Medicare Part B covers some medical services not covered under Part A. After the beneficiary meets the annual deductible ($147/year in 2015), Part B will pay 80% of the "reasonable charge" for covered services, the reimbursement rate determined by Medicare. The beneficiary is responsible for the remaining 20%, as "co-insurance". Unfortunately, the reasonable charge, as determined by Medicare is often less than the provider's actual charge.

If the provider agrees to "accept assignment," s/he agrees to accept Medicare's reasonable charge rate as payment in full; the patient is only responsible for the remaining 20%. If the provider does not accept assignment, the patient may also be responsible for paying the difference between the reasonable charge and the provider's actual charge. For physicians' services, 115% of the Medicare reasonable charge is the maximum amount which may be billed.

NOTE: Payment may be less than expected for outpatient hospital services due to the Medicare Outpatient Payment System. Check with the provider for details.

Part B of Medicare is optional. It is partially financed by monthly premiums paid by individuals enrolled in the program. Participants often have this premium deducted from their Social Security Check.

The monthly Part B premium in 2015 is greater for individuals with an annual income of $85,000 or more, and for couples with annual incomes of $170,000 or more.

The major benefit under Part B is payment for physicians' services. Home health care, durable medical equipment, outpatient physical therapy, x-rays and diagnostic tests are also covered. The following is a partial list of items and services which can be covered under Part B.

- Physician services and supplies, including drugs which cannot be self-administered and which are furnished incident to physicians' services
- Home health care if the patient does not have Part A or does not meet Part A prior institutional requirement or used 100 visits under Part A
- Diagnostic x-ray tests, laboratory test, and other diagnostic tests
- X-ray therapy, radium therapy, and radioactive isotope therapy
- Surgical dressings, splint and casts
- Durable medical equipment
- Prosthetic devices
- Braces, trusses, artificial limbs and eyes
- Ambulance services
- Outpatient and therapy services
- Institutional and home dialysis services, supplies and equipment
- Therapeutic shoes (for individuals with severe diabetic foot disease)
- Qualified psychologist services
- Mammography screening
- Pap smear screening
- Flu, pneumococcal and hepatitis B vaccines
- Colorectal, diabetic, bone mass, prostate cancer and some other screening tests

Medicare Part B Appeals

A "Medicare Summary Notice" (MSN) must be obtained before a beneficiary has a right to appeal. This MSN or "Initial Determination" briefly explains what Medicare will pay on a Part B claim.

The MSN is prepared by the Medicare "Contractor." The contractor is an insurance company assigned by Medicare to handle Part B claims. Many claims are denied due to insufficient information. Also, errors are often made in billing. If you do not understand an MSN, contact Medicare at 1-800-633-4227 or visit www.medicare.gov.

If you are still dissatisfied with the MSN, you may request a "Redetermination". When in doubt about whether or not you are covered by Medicare, APPEAL!

Remember: insist on fair Medicare coverage – it's your right.

CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy provides legal advice, self-help materials, and representation for older people and people with disabilities who are unfairly denied Medicare and/or access to health care.

For more information call (860) 456-7790, in Connecticut 1-800-262-4414, or visit our website:

www.medicareadvocacy.org

MEDICARE PART B
APPEALS PROCESS

The Medicare Contractor issues a Medicare statement (MSN) denying coverage for services.

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Request a Redetermination by the Contractor

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If the Contractor issues a Redetermination denying coverage, request a Reconsideration by the Qualified Independent Contractor (QIC)

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If the QIC issues a Reconsideration denying coverage and the amount in controversy is at least $150, request an Administrative Law Judge hearing.

CENTER FOR MEDICARE ADVOCACY, INC.

Advancing fair access to Medicare & health care

(860) 456-7790 **P. O. Box 350**

TOLL FREE 1-800-262-4414 **WILLIMANTIC, CT 06226**

www.medicareadvocacy.org

Need help?

Contact your State's Health Insurance Assistance Program (SHIP)

In Connecticut, this is CHOICES, (800) 994-9422.

There is also a great deal of information and Self-help packets on the Center for Medicare Advocacy's website:
www.MedicareAdvocacy.org

HELP KEEP THIS INFORMATION AVAILABLE!

Donate Securely Online At:
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Or Mail Your Check To:
Center for Medicare Advocacy, Inc.
P.O. Box 350, Willimantic, CT 06226.

Thank you!

The Center for Medicare Advocacy is a nonprofit, tax exempt organization under §501(c)(3) of the Internal Revenue Code. Contributions are tax-deductible to the extent provided by law.

2016 MEDICARE DEDUCTIBLE
CO-INSURANCE & PREMIUM AMOUNTS

PART A:

Hospital

Deductible: $1,288

Co-insurance:

Days 1-60: $0

Days 61-90: $322/Day

Days 91-150: $644/Day

Skilled Nursing Facility

Co-insurance:

Days 1-20: $0

Days 21-100: $161.00

Home Health

No co-insurance or deductible

Part A Premium (For voluntary enrollees *only*)

$226/Month
(If individual has 30-39 quarters of Social Security coverage)

$411/Month
(If individual has 29 or fewer quarters of Social Security Coverage)

PART B: Deductible: $166/Year

Standard Premium: $104.90/Month

If individual income < $85,000/Year

If individual income $85,000 - $107,000: $170.50/Mo.

$107,000 - $160,000: $243.60/Mo.

$160,000 - $214,000: $316.70/Mo.

$214,000 or more: $389.80/Mo.

CENTER FOR MEDICARE ADVOCACY, INC.

The Center for Medicare Advocacy, founded in 1986, is a national non-profit law organization that works to ensure fair access to Medicare and quality health care. The Center is based in Connecticut and Washington, DC, with offices around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of health care coverage and services.

Staffed by attorneys, legal assistants, nurses, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State health insurance program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.

- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

The Center for Medicare Advocacy is the most experienced organization for Medicare beneficiaries and their families.

Visit our website:
www.MedicareAdvocacy.org

4/2016