Section 3: Medicare

Program Purpose

Established in 1965 under Title XVIII of the Social Security Act. It is federal health care assistance for older Americans and individuals who are blind or permanently disabled. Funding for the program is the responsibility of the federal government. The program is administered by the Health Care Finance Administration (HCFA), a division of the Department of Health and Human Services.

Medicare is a federal health insurance program for individuals 65 years and older, and those with certain disabilities. Medicare has two types of insurance coverage for eligible Individuals:

- Part A provides (hospital insurance)
    - Individuals eligible for Part A pay no premium, or payment on a monthly or quarterly basis, for this coverage
    - Individuals eligible may be required to pay a deductible and a co-pay of an established annual amount
- Part B provides optional medical insurance that individuals choose to enroll in.
    - Individuals pay a monthly payment or premium.
    - Individuals may pay an annual deductible amount
- Co-Insurance with other providers. Other insurers may cover deductibles, co-pays, and the difference between the assignment and the actual cost. Medicaid, for example, may pay these costs if an individual qualifies for their program. Major medical insurance companies, if an individual is enrolled in one, may pay the co-pay.

Eligibility

Those eligible for premium free Medicare Part A coverage include individuals 65 years and older who:

- Currently receive benefits under Social Security or Railroad Retirement systems
- Eligible to receive benefits under these systems but have not yet applied
- Have had Medicare-covered government employment, or are the spouse of someone who has
- Have been disabled for a specified number of months.

Services Provided

- Medicare Part A
    - Inpatient Hospital Stays
    - Outpatient Appointments
    - Skilled Nursing Facilities
    - Home Health Agencies
    - Hospices
- Medicare Part B
    - Services by doctor
    - Medical Personnel
    - Flu Shots
    - Durable Medical Equipment
    - Outpatient therapies
    - Labs

Service Consideration

- Medicare provides a fee schedule for services and providers. Healthcare providers may charge fees that exceed the amount approved by Medicare.
- Private supplemental Insurance may be purchased to cover at-home recovery, prescriptive drugs, preventative care, etc.
- Limited Coverage for dental surgery, chiropractor, podiatrist and optometrist under Medicare B

Assistive Technology Covered

Medicare Part B covers Durable Medical Equipment (DME). The equipment must be medically necessary and prescribed by a doctor. Suppliers of DME must be approved by Medicare and have a Medicare number.

To be defined as DME by Medicare:

- Equipment must primarily serve a medical purpose
- Be able to be used again by another patient
- Not be useful in the absence of illness or injury
- Must be appropriate for use in the home

Service Considerations:

Part B also requires that the equipment be "necessary and reasonable." When determining whether services are "necessary and reasonable," the Medicare Carriers Manual suggests that the following be considered:

- Would the expense of the item be disproportionate to the therapeutic effects that could be derived from use of the equipment?
- Is the item substantially more costly than a medically appropriate and realistically feasible alternative?
- Does the item serve essentially the same purpose as equipment already available to the beneficiary?

Augmentative Communication Devices (ACD)

- Reimbursement process includes:
    - **Medical Necessity:** The device is required to treat a severe speech or communication impairment due to illness, injury, or a disabling condition.
    - **Functional Limitation:** The patient is unable to communicate effectively using natural speech, and no alternative methods are sufficient.
    - **Durability & Home Use:** The device is durable, primarily serves a medical purpose, and is appropriate for use in the home environment.
    - **Evaluation Required:** A comprehensive assessment by a qualified speech-language pathologist (SLP) is necessary, documenting the patient's condition, communication needs, cognitive and physical ability, and justification for the selected device.
    - **Not Generally Useful Without Illness/Injury:** The device must not be typically useful to individuals without a medical condition.
    - **No Equivalent Device Available:** A medically appropriate, non-customized alternative must not meet the patient's needs.

Challenges Obtaining Assistive Technology

- **Strict Medical Necessity:**
    - Equipment must serve a medical purpose, withstand repeated use, and not be useful without illness or injury.
    - Devices for convenience, educational use, or primarily outside the home may be excluded.
- **Reimbursement Caps:**
    - Medicare and Kansas Medicaid pay based on fee schedules.

    - If provider charges exceed approved rates, beneficiaries may be responsible for the difference.
- **Rental vs. Ownership:**
    - Some items (e.g., oxygen, wheelchairs) are rented under Part B and may not become the property of the beneficiary immediately.
    - Ownership depends on the item type and rental period.
- **Home Use Requirement:**
    - Equipment must be appropriate for use in the home.
    - Devices intended primarily for use outside the home (e.g., vehicle lifts, transfer equipment) are generally not covered.
- **Hearing and Vision Limitations:**
    - Routine hearing aids, hearing exams, and most vision services are not covered by Medicare.
    - Some Medicare Advantage plans may offer additional coverage for these services.

Application Process

If you are receiving either Social Security or Railroad Retirement benefits, you will automatically receive a medical card when:

- You become age 65
- If you have a disability, you will automatically receive a card in the mail when you have been a beneficiary for 24 months.
- If you are not receiving any retirement benefits and do not plan to apply for them, you can apply for Medicare at your local Social Security Office.

Appeals Process

Reasons you may appeal:

- Cover a healthcare service, supply, item, or drug that should be covered
- Change the amount you pay for a healthcare service, supply, item, or drug
- Pay for a healthcare service, supply, item, or drug that you already got

Quick Summary of Medicare's Appeals Process:

- Put it in writing – All appeal requests must be written (use CMS forms or letters).
- Watch deadlines – Most appeal deadlines are 60 days, but some allow up to 120 or 180 days.
- Keep copies – Save everything you send and receive.

- Get representation – You may appoint someone using Form CMS-1696.
- Step 1: Redetermination (MAC) – Ask Medicare's contractor to review again within 120 days.
- Step 2: Reconsideration (QIC) – Request independent review within 180 days; include all evidence now.
- Step 3: OMHA Hearing (ALJ Judge) – Request within 60 days; you can have a phone, video, or paper review.
- Steps 4–5: Appeals Council → Federal Court – Ask the Council within 60 days; if still unresolved, you may file in U.S. District Court (must meet dollar threshold).

State Health Insurance Assistance Program (SHIP) - can provide free personalized health Insurance counseling and assist in filing an appeal.

Appeal forms are available from your carrier or your local Social Security Office.