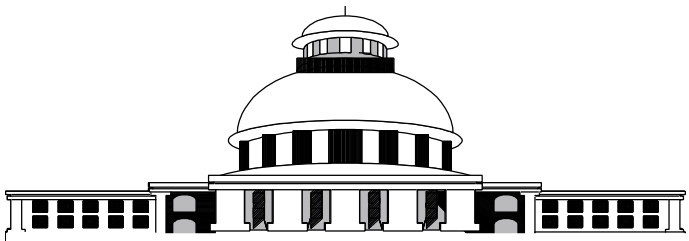
MEDICARE

Health Care Financing Administration



DEPARTMENT OF HEALTH & HUMAN SERVICES

MEDICARE PROGRAM FOR PEOPLE

- **65 OR OLDER**
- **ANY AGE:**
  - *** Permanent Kidney Failure (End Stage Renal Disease)**
  - *** Disabled**

Medicare is a federally funded health insurance program for people over 65 and for certain individuals who qualify due to disability or end stage renal disease (ESRD). While Medicare entitlement is automatic at age 65 for working people who have contributed at least 40 quarters to the FICA system; disabled and persons with ESRD must file an application with the Social Security Office and meet medical qualifications.

This form of health insurance coverage resulted from laws passed by Congress in 1965 during President Lyndon Johnson's administration and was originally proposed as a part of his Great Society progam.

The first Medicare beneficiaries were ex-president Harry Truman and his wife.

The first day that the Medicare program was in effect was July 1, 1966.

Today there are over 39 million Americans enrolled in Medicare.

The Social Security Office has the responsibility of handling enrollment into Medicare. Approximately three months before an individual (who has met the working requirements) turns 65, an information package is mailed to the person's home. This package includes all information regarding Medicare Part A and Part B benefits.

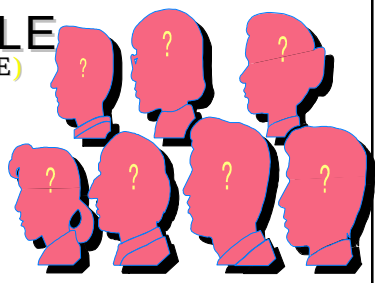
Enrollment becomes automatic on the first day of the month in which the person turns 65. An individual who chooses NOT to enroll in Medicare must return the information to Social Security Office indicating that they do not wish to be covered. Persons with disabilities or ESRD must go to SSA office to fill out an application for Medicare

The Social Security Office also has the responsibility of providing information about the program. Additional information is available throughout the efforts of Medicare Carriers and Intermediaries who prepare print materials for beneficiaries and who provide outreach activities within their territories.

Beneficiaries who need a replacement card, or if they have added or dropped Part A or Part B enrollment, may go to the Social Security office or call their phone number at 1-800-772-1213.

WHO IS ELIGIBLE

PART A (PREMIUM FREE)

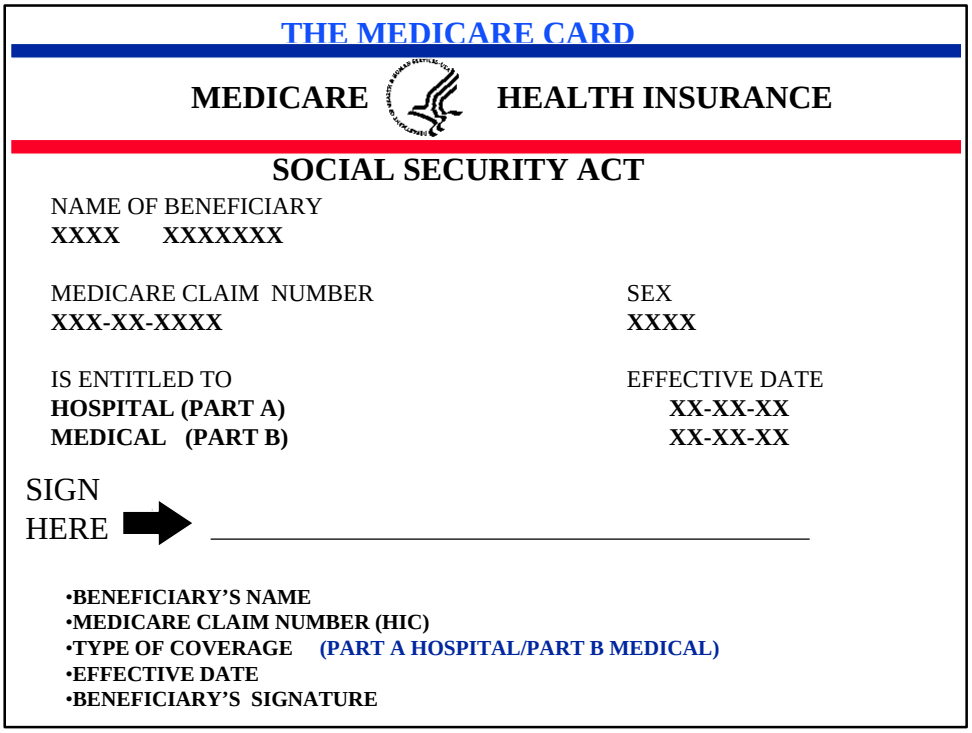


- **65 Or Older**
  Meeting work requirements.
  Individuals who do not have credits may buy Medicare A
- **Under Age 65:**
  Receiving disability benefits under Social Security or Railroad Retirement for more than 24 months
- **End Stage Renal patients with permanent kidney failure requiring maintenance dialysis or kidney transplant**
- **Certain government employees and certain members of their families disabled for more than 29 months**

PART B (NOT PREMIUM FREE)

The groups of individuals entitled to Medicare receive Part A premium free. This means that they are able to have comprehensive inpatient hospital, skilled nursing facility, home health and hospice coverage without any monthly payment. The beneficiary has only the financial responsibility of deductibles and co-insurance payments when services are provided. Beneficiaries choosing coverage through a Medicare health maintenance organization (HMO) may not even have to pay these charges.

Part B coverage is not free. Individuals choosing coverage for physicians and other professionals as well as outpatient services must pay a monthly premium. In 1999 this premium is $45.50 per month. The cost may be deducted from their social security check or may be paid directly though the local social security office. If a beneficiary fails to pay their Part B premium for 3 months in a row, the social security office will cancel the Part B coverage. Coverage can be resumed if back payment is made, or restarted in the future, if the beneficiary is able to meet the monthly premium requirement.



THE MEDICARE CARD

MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
XXXX XXXXXXX

MEDICARE CLAIM NUMBER
XXX-XX-XXXX

SEX
XXXX

IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)

EFFECTIVE DATE
XX-XX-XX
XX-XX-XX

SIGN HERE _____

- **BENEFICIARY'S NAME**
- **MEDICARE CLAIM NUMBER (HIC)**
- **TYPE OF COVERAGE (PART A HOSPITAL/PART B MEDICAL)**
- **EFFECTIVE DATE**
- **BENEFICIARY'S SIGNATURE**

The Medicare card is the beneficiary's insurance card. It states his/her full name and health insurance claim (HIC) Number. This number is the only method by which a claims processing office can identify and verify the beneficiary's entitlement to Medicare. It must be present on all Medicare claims. Providers are advised to make a photostatic copy of the card in order to be able to prepare accurate claims for processing. If the Medicare number is inaccurately reported, the Intermediary or Carrier may not be able to locate the beneficiary's records. If this occurs, no payment may be made for rendered services.

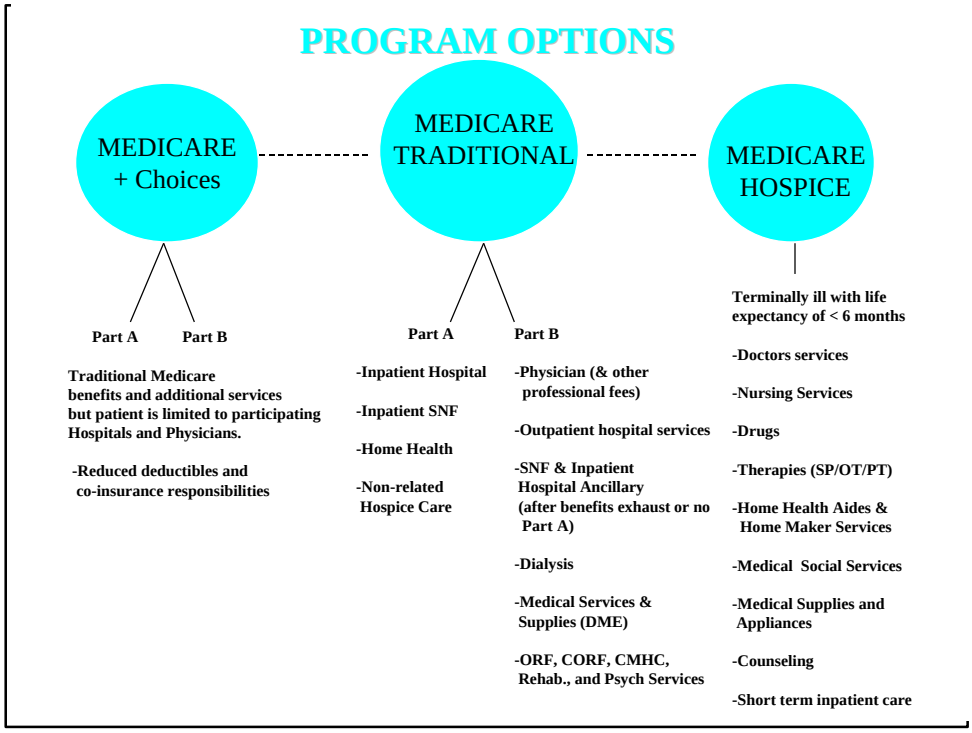
Providers are cautioned to crosscheck the beneficiary's entitlement records via their electronic connection to their processing office. This is to validate that Part A and Part B are still in effect. The Medicare card is NOT reissued if Part A or Part B is canceled for some reason. It is possible for a beneficiary to change their enrollment in Medicare to an HMO or to hospice and the original card would not show the change. It is also possible for Part B to be revoked and the original card would not show the change.

Health Insurance Claim (HIC) Number Suffixes

SUFFIX		BENEFICIARY	MEANING OF SYMBOL	SEX
A		Wage Earner	Age 65 or over	Male or Female
B		Wife	Age 65 or over	Female Only
B	1	Husband	Age 65 or over	Male Only
B	2	Wife	Under age 65, with a child in her care	Female Only
B	3	Wife	Age 65 or over; second claimant	Female Only
B	4	Husband	Age 65 or over; second claimant	Male Only
B	5	Wife	Under age 65; second claimant	Female Only
B	6	Divorced Wife	First claimant	Female Only
B	7	Wife	Under age 65; third claimant	Female Only
B	8	Wife	Age 65 or over; third claimant	Female Only
B	9	Divorced Wife	Second claimant	Female Only
C		Child (including disabled or student child)		Male and Female
C	1	Youngest Child		Male and Female
C	2	Next Youngest Child, etc.		Male and Female
D		Widow	Age 65 or over; first claimant	Female Only
D	1	Widower	First claimant	Male Only
D	2	Widower	Age 65 or over; second claimant	Female Only
D	3	Widower	Second claimant	Male Only
D	4	Widow	Remarried after age 60	Female Only
D	5	Widower	Remarried after age 62	Male Only
D	6	Surviving Divorced Wife	First claimant	Female Only
D	7	Surviving Divorced Wife	Second claimant	Female Only
D	8	Widow	Age 65 or over; third claimant	Female Only
E		Mother (Widow)	First claimant	Female Only
E	1	Surviving Divorced Mother	First claimant	Female Only
E	2	Mother (Widow)	Second claimant	Female Only
E	3	Surviving Divorced Mother	Second claimant	Female Only
F	1	Father		Male Only
F	2	Mother		Female Only
F	3	Stepfather		Male Only
F	4	Stepmother		Female Only
F	5	Adopting Father		Male Only
F	6	Adopting Mother		Female Only
HA		Disability Insurance		Male or Female
HB		Wife		Female Only
HB	1	Husband		Male Only
HB	2	Wife	Child in her care	Female Only
HB	6	Divorced Wife		Female Only
HC		Child (including disabled or student child)		Male and Female
J	1	Primary	Special age 72 benefits; entitled to Part A; has less than three quarters of coverage	Male or Female
J	2	Primary	Special age 72 benefits; entitled to Part A; has at least three quarters of coverage	Male or Female
J	3	Primary	Special age 72 benefits; not entitled to Part A; has less than three quarters of coverage	Male or Female
J	4	Primary	Special age 72 benefits; not entitled to Part A; has at least three quarters of coverage	Male or Female

SUFFIX		BENEFICIARY	MEANING OF SYMBOL	SEX
K	1	Wife	Wife of J1	Female Only
K	2	Wife	Wife of J2	Female Only
K	3	Wife	Wife of J3	Female Only
K	4	Wife	Wife of J4	Female Only
M			Entitled to Part B only	Male or Female
M	1		Elected to file for Part B only	Male or Female
W		Disabled Widow		Female only
W	1	Disabled Widower		Male only
W	2	Disabled Widow	Second claimant	Female only
W	3	Disabled Widower	Second claimant	Male only
W	6	Disabled Surviving Divorced Mother		Female only
W	7	Disabled Surviving Divorces Wife	Second Claimant	Female only
T			Not entitled to any monthly benefit (SS or RR); CRD under age 65	Male or Female

Valid Prefixes (RRB); A, MA, WA, WD, CA, WCA, WCD, PA, PD, H, MH, WH, WCH, PH, JA



The diagram illustrated above contains the three major choices of program options that a Medicare beneficiary may select.

If you are in one program, you are NOT eligible for the benefits provided by another (except in rare cases). A beneficiary may change their selection of programs during the course of entitlement.

Currently, the largest group of beneficiaries is covered by **Traditional** Medicare. This is also known as the "fee for service" option. The beneficiary may go to **any** Medicare certified provider for services. Beneficiaries have coinsurance and deductible responsibilities on most services.

The Medicare + Choices is a "managed care" form of coverage. There are two forms of Medicare HMOs. The first is the **RISK** group. Beneficiaries must stay in their NETWORK of providers except in emergency situations. **COST** HMOs also have a network, but allow the beneficiary to outside of network if they choose. If this occurs, the patient must pay applicable deductibles and coinsurance amounts.

In addition to the HMO programs, beneficiaries may also choose Point of Service (POS), Provider Sponsored Organization (PSO), or Preferred Provider Organization (PPO). Also available in certain areas are private fee-for-service plans, Medicare Medical Savings Accounts, and Religious Fraternal Benefit Society plans.

The hospice benefit is provided to those individuals whom the physician has determined has a terminal condition and is within the last 6 months of their life. People choosing the hospice benefit receive special care in their homes. By choosing hospice, the beneficiary revokes all other Medicare options.

PART A
HOSPITAL INSURANCE

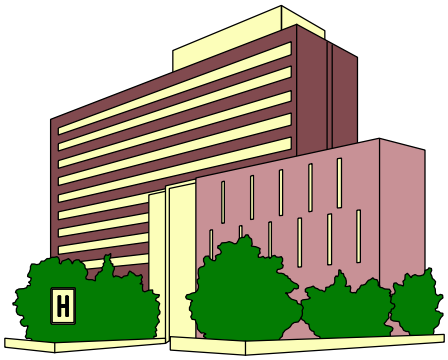
Can Help Pay for Many Health Care Needs

***Inpatient Hospital Care**

*Skilled Care in Nursing Facility

*Skilled Services Provided
Through a Home Care Program

*Hospice Care



Medicare Part A is referred to in Title XVIII of the Social Security Act as "Hospital Insurance".

It contains four major benefits:

- Hospital Inpatient
- Skilled Nursing Facility (SNF) Inpatient
- Home Health
- Hospice

It is interesting to note that even though this is known as the "hospital benefit," only one of the provisions is actually rendered in the hospital.

Beneficiaries must be educated regarding the Part A coverage. Many do not understand that Part A "Hospital Insurance" only covers an overnight inpatient admission. Part A does not cover outpatient hospital services (this is covered by Part B), nor does it cover any of the professional fees of physicians, radiologists, anesthesiologists, etc., who may see a patient during an inpatient stay.

To be fully covered, the beneficiary needs to be enrolled both in Part A (Hospital Insurance) and Part B (Medical Insurance).

PART B
MEDICAL INSURANCE

Can Help Pay for the Following Medically Necessary Services

***Doctor**
***Hospital Ancillary Services**
***Skilled Nursing Facility Ancillary Services**
***Outpatient**
***Dialysis**
***Other Medical Services and Supplies**

Medicare Part B is referred to in Title XVIII of the Social Security Act as "medical insurance" or "supplementary Medicare."

A beneficiary enrolled in Medicare Part B may use his/her insurance to cover a large range of services provided on an outpatient basis. These services range from care in a private physician's office to care at a hospital emergency room, clinic and/or freestanding outpatient facility such as an ESRD clinician outpatient rehabilitation facility and a community mental health clinic.

In addition, if the Part A benefit exhausts (there is a limit on the number of days that may be covered in any one benefit period), the beneficiary who is still in the hospital or SNF may be entitled to have certain ancillary services paid under the Part B program.

HOW DOES MEDICARE WORK

Payments are handled by private insurance organizations under contract with the federal government.

PART A
INTERMEDIARIES
Hospitals
Skilled Nursing Facilities
Home Health Agencies
Hospices
CORFs/ORFs/CMHCs
Dialysis Facilities

PART B
CARRIERS
Physicans
Freestanding Labs and X-Rays
Vendors/Suppliers

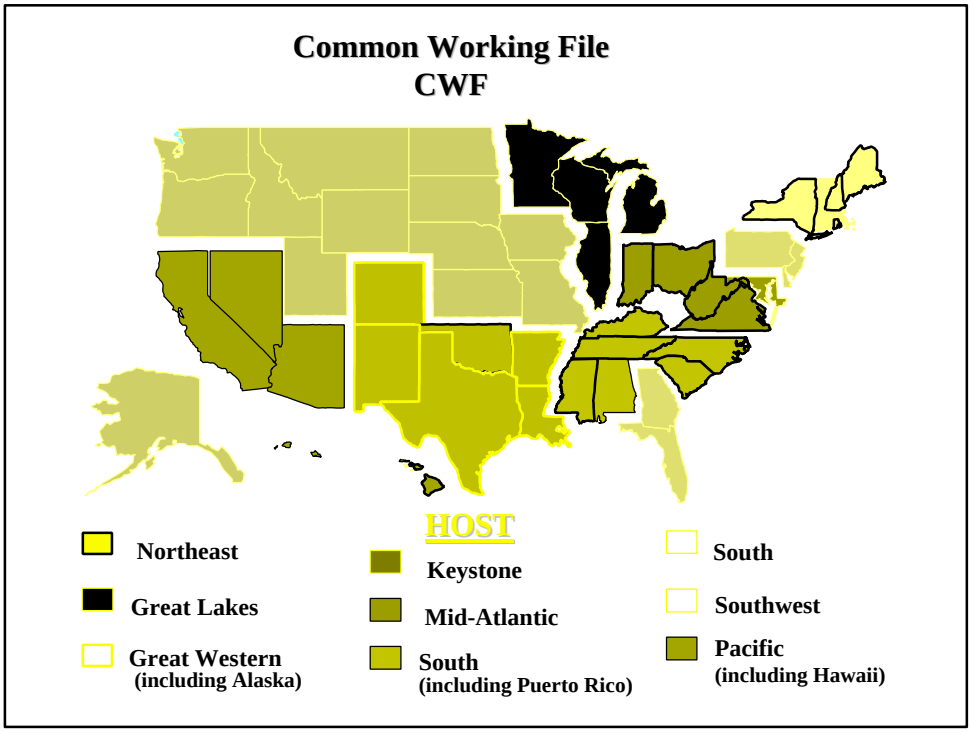
Medicare Beneficiaries must use hospitals and doctors that participate in the Medicare Program to have payment made on his or her behalf

The Health Care Financing Administration (HCFA) certifies certain insurance companies to be processing agents for Medicare claims. These contractors are known as fiscal intermediaries (Part A) and carriers (Part B).

It should be noted that intermediaries, who process institutional claims for inpatients (Part A) and outpatients (Part B), actually pay benefits out of both the Part A and Part B trust funds.

Carriers process claims strictly for Part B services and all dollars paid out come from the Part B trust fund.

In each case, beneficiaries must select providers who are participating with Medicare. If their choice of physician or hospital is one who is not participating, Medicare will not make payment for the services unless it involves an emergency situation.



Common Working File (CWF) was developed in 1989 as a means to maintain all of the records for each Medicare beneficiary.

These files keep an account of entitlement, inpatient stays, outpatient services, enrollment in hospice or Medicare HMO programs, Medicare secondary insurance coverage, spell of illness data, deductibles paid, dates of mammography services, home health services, and benefit periods.

A beneficiary's records reside in any one of nine different Host regions. The region is determined by the primary residence of the beneficiary at the time that he/she is eligible for Medicare. However, a beneficiary may receive services anywhere in the United States or its territories, and these records may be accessed via claims processing or the information inquiry function of a Medicare contractor.

Regardless of where services are rendered, a record of those services will post to CWF. This protects the Medicare Trust Fund from being depleted by the payment of claims for which the beneficiary is not eligible.

COST SHARING
2000 COSTS

Part A Deductible	**= $776.00**
Part A Coinsurance	**= $194.00**
Part A LTR Coinsurance	**= $388.00**
Part A SNF Coinsurance	**= $ 97.00**

Part B Deductible	**= $100.00**
Part B Coinsurance	**= 20% approved charge at the Carrier**
	= Varied amount based on service and payment methodology at the fiscal intermediary

Buy In

Part A Premium	**= $301.00 per Month**
Part B Premium	**= $ 45.50 per Month**

Financial assistance for a low income beneficiary is available through the Medicaid Program to pay patient's cost share under Medicare

The beneficiary financial responsibility is outlined on this page for those who are enrolled in the Traditional Medicare ("fee for service") option.

Part A services deductible and co-insurance day charges are based on a **benefit period** rather than a calendar year. An existing benefit period is "broken" and a new benefit period is begun when a beneficiary is facility free (inpatient) for a period of 60 consecutive days (or remains at a "custodial level of care" while living in a SNF for 60 consecutive days). This means that a Medicare beneficiary could possibly pay an inpatient deductible multiple times in a year.

The Part B deductible is based on a calendar year. The first $100.00 of any medically necessary services each year are patient responsibility. Co-insurance is calculated differently if the service is processed by a carrier or a intermediary. Carriers apply 20% of the Medicare approved payment as the beneficiary's co-insurance charge. At the Intermediary, co-insurance is applied in a variety of methods based on the service provided and the reimbursement policy for that service. **Certain services do not get charged against deductible or co-insurance.**

People not entitled to Medicare may purchase this federal insurance. Low income beneficiaries may get state assistance in paying deductibles and co-insurance.

MEDICARE PART A HOSPITAL INSURANCE REFERENCE CHART
Deductible and Coinsurance Amounts
1966 TO 2000

	Inpatient Hospital			Skilled Nursing Facility	Home Health Agency	
For Benefit Periods Beginning In	**First 60 Days**	**61st through 90th Day**	**60 Lifetime Reserve Days (Non Renewable)**	**21st through 100th day**	**Unlimited Visits**	**Blood**
	Deductible	Coinsurance Per Day Always Equal to 1/4 of Inpatient Hospital Deductible	Coinsurance Per Day Always Equal to 1/2 of Inpatient Hospital Deductible	Coinsurance Per Day Always Equal to 1/6 of Inpatient Hospital Deductible	No Deductible or Coinsurance	Deductible First 3 Pints (Or Equivalent Units of Packed Red Blood Cells) in a Benefit Period
1966	$ 40	$ 10	Not Covered	Not Covered		
1967	40	10	Not Covered	$ 5.00		
1968	40	10	$ 20	5.00		
1969	44	11	22	5.50		
1970	52	13	26	6.50		
1971	60	15	30	7.50		
1972	68	17	34	8.50		
1973	72	18	36	9.00		
1974	84	21	42	10.50		
1975	92	23	46	11.50		
1976	104	26	52	13.00		
1977	124	31	62	15.50		
1978	144	36	72	18.00		
1979	160	40	80	20.00		
1980	180	45	90	22.50		
1981	204	51	102	25.50		
1982	260	65	130	32.50		
1983	304	76	152	38.00		
1984	356	89	178	44.50		
1985	400	100	200	50.00		
1986	492	123	246	61.50		
1987	520	130	260	65.00		
1988	540	135	270	67.50		
1989	560	N/A	N/A	25.50*		
1990	592	148	296	74.00		
1991	628	157	314	78.50		
1992	652	163	326	81.50		
1993	676	169	338	84.50		
1994	696	174	348	87.00		
1995	716	179	358	89.50		
1996	736	184	368	92.00		
1997	760	190	380	95.00		
1998	764	191	382	95.50		
1999	768	192	384	96.00		
2000	776	194	388	97.00		

*For first 8 days.

HOSPITAL INSURANCE PREMIUMS												
Effective	7/73	7/74	7/75	7/76	7/77	7/78	7/79	7/80	7/81	7/82	7/83	1/84
Basic Rate	$33	$36	$40	$45	$54	$63	$69	$78	$89	$113	$113	$155
Effective	1/85	1/86	1/87	1/88	1/89	1/90	1/91	1/92	1/93	1/94	1/95	1/96
Basic Rate	$174	$214	$226	$234	$156	$175	$177	$192	$221	$245	$261	$289

Basic premium increased by 10% for each 12 months on non-enrollment.

1 For services furnished on or after January 1, 1982, the coinsurance amounts are based on the inpatient deductible for the year in which the services were furnished.

For services furnished prior to January 1, 1982, the coinsurance amounts are based on the inpatient hospital deductible applicable for the year in which the individual's benefit period began.

2 For care in psychiatric hospital – 190 day lifetime limit.

3 Prior to July 1, 1981, benefits were limited to 100 visits per benefit period under Part A and 100 visits per calendar year under Part B.

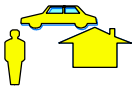
4 Not applicable prior to 7/93.

*For first 8 days

MEDICARE AND OTHER INSURANCE
MEDICARE SECONDARY PAYER

Coordination of benefits where another insurer could have primary payment responsibility

- **Working Aged (EGHP)**
- **End Stage Renal Disease 'ESRD' (EGHP)**
- **Disabled**
- **Veterans Administration (VA)**
- **Black Lung (BL)**
- **Workers' Compensation (WA)**
- **Automobile, No Fault**
- **Liability**



IRS/SSA/HCFA DATA MATCH

Employers provide benefit information for Medicare eligible employees and their spouses covered under Employer Group Health Plans (EGHP)

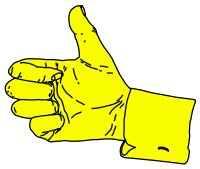
When Medicare was first established in 1966 as a federal insurance program for the elderly and disabled, little attention was given to any other insurance coverage that the beneficiary might have. Beginning in 1981 laws were amended to modify the program and make forms of insurance pay first before Medicare.

Today there are 8 categories in which another insurance plan might pay first for Medicare beneficiary's services. Any and all providers who treat Medicare patients must make a concerted effort to determine if Medicare is the primary insurer or if another policy is required by law to make payment.

Medicare inpatient benefits are not reduced by the number of days or services paid by another insurer. Medicare coverage may begin at the point in which the other insurer's benefits exhaust or if they deny payment as long as the beneficiary has remained at a skilled level of care during the time covered by the other insurer.

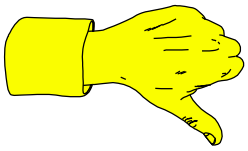
In 1992 the IRS, SSA and HCFA combined forces to compile a list of Medicare beneficiaries still covered by an employer group health plan. These are known as the Data Match Files.

WHAT DOES MEDICARE PAY



Medicare will pay for care that Is "Reasonable and Necessary" for the treatment of an illness or an Injury

Medicare does NOT pay for services that are **"Routine/Custodial"** Or **"Inpatient care that could be provided by persons without professional skills/training"**



The Medicare program never pre-authorizes payment of services. All services determined to be a "covered" service by statute and regulation are still subject to the "reasonable and necessary" clause.

The intermediary and carrier offices monitor whether the services are "reasonable and necessary" during their medical review process. This review allows the Medicare Trust Fund to be protected against payment of services which are not reasonable and necessary for the treatment of a illness or injury.

In addition to contractor review teams, inpatient hospital claims are monitored by the Peer Review Organization (PRO).

Medicare was designed to provide insurance coverage for acute or skilled care. Its programs do not provide financial reimbursement for custodial care or care that could be provided by persons without professional skills or training.

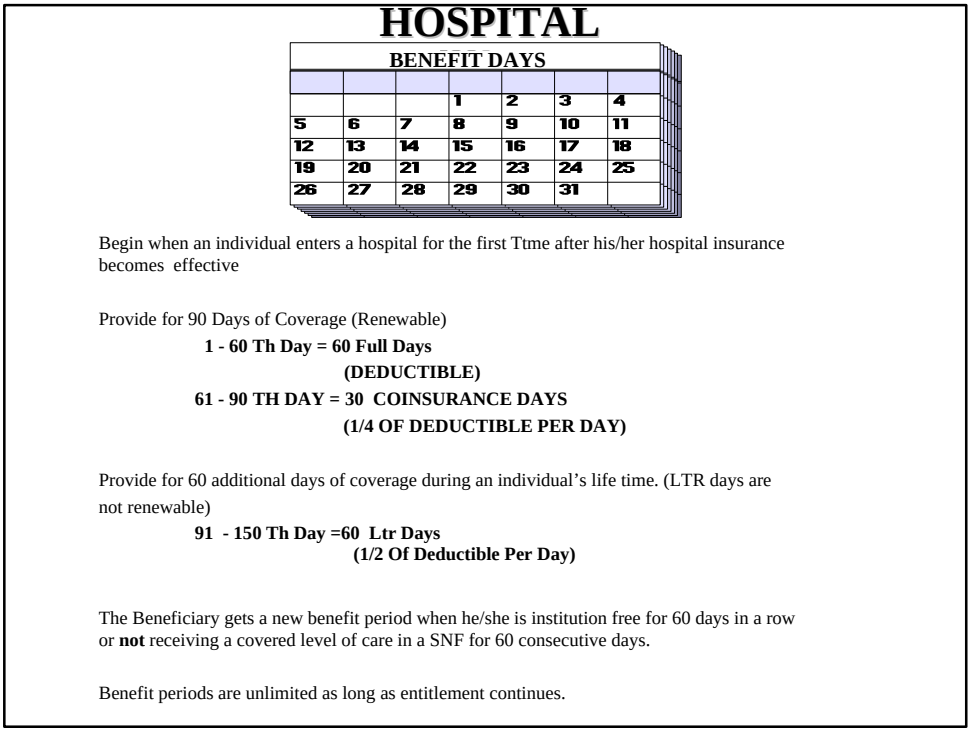
FOREIGN HEALTH CARE

- **Puerto Rico, Virgin Islands, Guam, American Samoa, and Northern Mariana Islands are considered part of the United States.**
- **A Medicare beneficiary traveling outside the United States should inquire about special short term health insurance for foreign travel.**

Payment for medical services received by a beneficiary is contingent upon those services being rendered or provided by a medical professional or institution which has been certified by Medicare. For this reason, it is general policy that the program is in effect only within the United States and its territories.

Certain limited coverage is available in Canada and Mexico if the beneficiary is traveling between two United States sites. Coverage of foreign claims is also limited to emergency situations in which the beneficiary is unable to return to the United States to receive treatment.

There are special claims processing offices which must handle foreign claims.



Part A coverage in a hospital has a limited number of days which can be paid by Medicare in each benefit period. The first 60 days are paid in full (with the exception of the inpatient deductible) for all medically necessary services. This is followed by 30 days in which Medicare will pay for all medically necessary services with the exception of a patient co-insurance responsibility. These 90 days are renewable if the beneficiary begins a new benefit period.

In addition, every beneficiary has 60 lifetime reserve days (LTR) which can be used for an extended hospital stay. These days have a patient co-insurance responsibility. Once used, the LTR days are not renewable. It is the patient's choice whether or not to use these days or pay privately (or utilize another insurance policy) when the full and co-insurance days are exhausted.

The number of benefit periods that a Medicare beneficiary may have are unlimited as long as they meet the criteria for starting each new period. That criteria is 60 consecutive days facility free (inpatient) or 60 consecutive days at a non-skilled level of care in a SNF.

COVERED HOSPITAL INPATIENT SERVICES NOT LIMITED TO.....

- **Semiprivate room**
- **All meals, including special diets**
- **Regular nursing services**
- **Intensive care /coronary care units**

DRUGS

MEDICATIONS

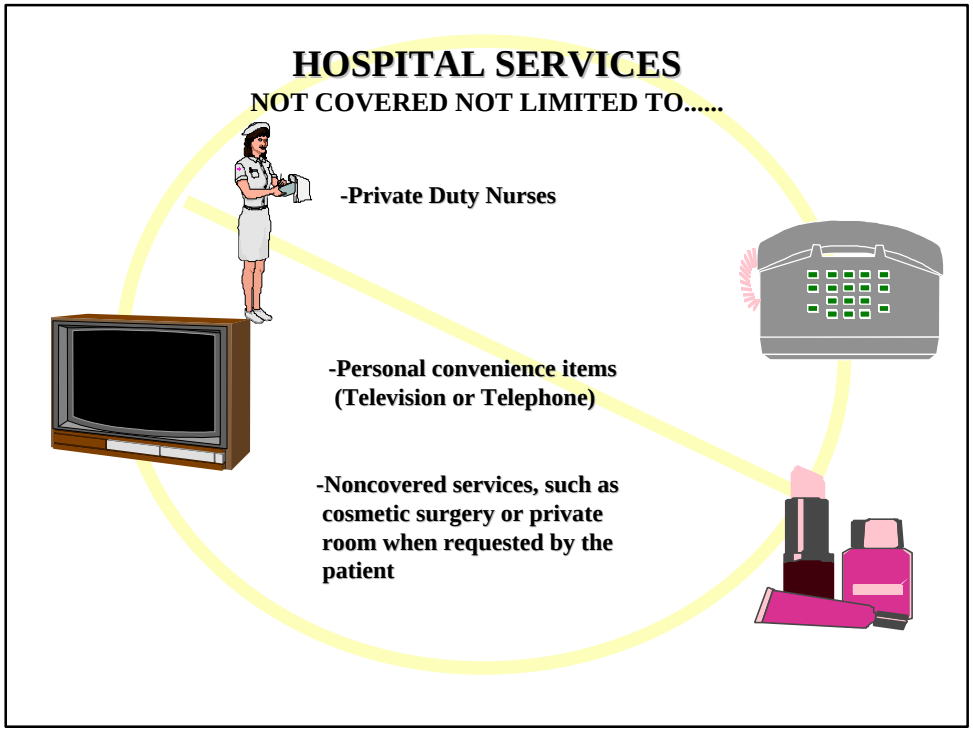
- **Operating / recovery room costs**
- **Lab Tests, X-Ray , radiology services**
- **Other hospital services**
- **Blood transfusions**
- **Rehabilitation services**
- **Speech, physical, occupational therapy**

In general, the Medicare inpatient benefit pays for room and board and all ancillary services needed to treat the beneficiary's illness or injury.

All covered ancillary services should be reported to the fiscal intermediary on a HCFA 1450 claim form. Under the PPS (prospective payment system) reimbursement for the claim will be based on the DRG (diagnostic related group). The number of ancillaries and charges for these services does not factor into base payment of the claim, but may qualify for a cost outlier.

For facilities not under the PPS system, a "per diem" payment is made. In this case the reporting of ancillaries does effect final reimbursement at the time of cost report settlement.

Services not covered by the Medicare program should not be coded on the claim, unless reported as non-covered charges.



Services determined to be non-covered need not be reported on a Medicare claim.

If the beneficiary needs a statement for another insurer that shows Medicare will not cover a certain service or item, the claim may be coded to show non-covered charges.

SPECIAL RULES FOR INPATIENT PSYCHIATRIC SERVICES (PSYCH)

Payment is limited to a total of 190 psychiatric (Psych) days during an individual's lifetime for inpatient services furnished in a psychiatric hospital.

The 190 psych days work in conjunction with the 150 hospital benefit days.

The 150 days immediately before the first day of entitlement must be counted against the 150 hospital benefit days, but not against the psychiatric lifetime days.

The pre-entitlement psych days do NOT count against the lifetime limitations.

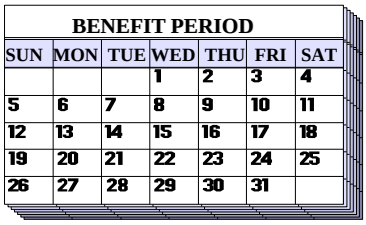
A special inpatient benefit is included in the Medicare program for beneficiaries who receive services in a psychiatric hospital. These psychiatric benefit days are not applied when care is provided in the psychiatric floor of an acute care hospital.

The days must be applied in tandem with a medical (hospital) benefit day. It is the medical benefit day which determines the deductible and co-insurance responsibility of the patient. The lifetime psychiatric benefit day does not in itself contain a patient financial liability.

In order to utilize an inpatient psychiatric benefit day in a psychiatric hospital the care must be for an acute psychiatric episode. As in the medical benefit, Medicare does not pay for care which is custodial in nature.

The psychiatric benefit does not renew. Once used, the days cannot be re-established by the normal process of breaking a benefit period.

SNF



BENEFIT PERIOD						
SUN	MON	TUE	WED	THU	FRI	SAT
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Part A provides up to 100 Days of medically necessary SNF care per benefit period.

1- 20th day = 20 days covered in full
21-100th day = 80 coinsurance days (1/8 OF DEDUCTIBLE PER DAY)

Requirements:

- **Preceded by a covered hospital stay of at least three days not counting day of discharge**
- **Requires care for a condition which was treated in the hospital**
- **Admitted to the SNF within 30 days of hospital discharge (Exceptions: readmission and medical predictability)**
- **Certified by a physician, nurse practitioner, or clinical nurse specialist that the resident requires care in a SNF**

The SNF inpatient Part A benefit is limited to maximum of one hundred days of care in a SNF (in any one benefit period) if the resident meets both technical and medical qualifications under the Medicare. The Part A SNF inpatient days are not a once in a lifetime benefit, but can be renewed if the beneficiary is facility free for 60 consecutive days or is at a custodial level of care for 60 consecutive days while living in the SNF.

The original legislation for SNF was to provide a progression from the hospital acute care to the SNF daily skilled care to the intermittent skilled care provided under the home health benefit. The Medicare program does not provide reimbursement for long term care in a nursing home.

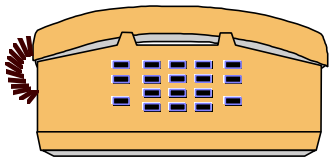
When the beneficiary exhausts their inpatient SNF Part A days, he/she is eligible for coverage of certain ancillary services under the Part B benefit.

COVERED SNF INPATIENT SERVICES
NOT LIMITED TO.....

- **Semiprivate room**
- **All meals, including special diets**
- **Nursing services**
- **Drugs and medications**
- **Medical equipment/supplies**
- **Rehabilitation services: speech, physical, occupational therapy**

NON-COVERED SNF INPATIENT SERVICES
NOT LIMITED TO.....

- **Personal convenience items**
- **Private duty nurses**
- **Private room when requested by the patient**



When a beneficiary qualifies for Part A coverage in a SNF, payment includes room and board and ancillary services. Among those services are nursing care, meals and special diets, labs, X-rays, drugs and biologicals, therapy services, and special equipment usage.

However, not all services are covered. As in the case of a hospital stay, personal convenience items, experimental drugs, custodial care, private rooms, maintenance therapy and private duty nursing are not covered. If a resident requires or choose to have any of these services, they must privately pay for them.

SWING BED FACILITIES

Rural Hospitals with f**ewer than 100 Beds and who have a lack of nursing home beds in their area may apply for "swing bed" designation.**

* 3rd position of the provider number is changed to a "U" for acute care hospitals with a swing bed designation
* 3rd position of the provider number is changed to a "W" for long-term hospitals with a swing bed designation

Hospital submits a transfer bill, and "SWINGS" the beneficiary into a hospital bed with a SNF designation.

"CAP" on number of swing bed days if the facility has over 49 beds

Admissions after the CAP is met will be denied payment

Hospital must transfer the beneficiary to regular SNF within 5 days of notification of availability of bed in a SNF.

The assignment of swing bed status to hospitals occurs when rural areas are lacking SNFs to care for patients who require extended skilled care following a hospital stay. If there is a lack of SNF beds in their immediate area, rural hospitals can apply to be certified as a "swing bed" hospital.

In the event that the hospital patient no longer requires acute care, and there is no available bed in a SNF in which to transfer the patient, the certified "swing bed" hospital can reassign that patient to the SNF benefit. The hospital discharges (transfers) the beneficiary as if he/she were actually leaving the hospital. Subsequent billing is then submitted to the Intermediary using the swing bed provider number.

The benefit days used in a "swing bed" are taken from the SNF benefit. All coverage determinations are made based on the required skilled care criteria applied to SNFs.

The swing bed benefit is a Part A only benefit. If the beneficiary exhausts 100 days of SNF care in a swing bed, the beneficiary then would be covered by the hospital Part B benefit.

HOSPITAL/SNF INPATIENT SERVICES COVERED UNDER PART B

Payment may be made under Part B for the following medical and other health services when furnished by a participating hospital to an inpatient of a hospital or SNF when payment for these services cannot be made under Part A:

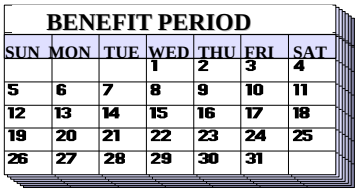
- ✓ **Diagnostic X-Ray, laboratory, and other tests**
- ✓ **X-Ray, radium/radioactive isotope therapy, including materials/services of technicians**
- ✓ **Primary/secondary surgical dressings, splints, casts, and other devices used for reduction of fractures/dislocations**
- ✓ **Prosthetic devices**
- ✓ **Orthotics devices**
- ✓ **Inpatient dialysis services (Not billable if rendered in a SNF)**
- ✓ **Speech, physical, occupational Therapy**
- ✓ **Certain pharmacy items, limited to following:**
  - **Pneumococcal Pneumonia/Flu Vaccine**
  - **Hepatitis B Vaccine**
  - **Immunosuppressive drugs furnished to organ transplant patients after a Medicare transplant procedure**
  - **Oral cancer drugs**

The Part B ancillary services are limited in scope. The allowable ancillaries are the same for both hospital and SNF stays that exceed the beneficiary's Part A benefit.

If the beneficiary is no longer covered by Part A, that beneficiary or his/her next insurer would make payment for room and board and all services not on the list of allowable Part B services.

Any services not covered by the Part B benefit should not appear on the Medicare claim unless the beneficiary needs a denial for another insurer.

HOSPICE



Two 90 Day Periods
Unlimited 60 Day Periods
Periods may be used consecutively or at intervals.

The physician must certify that the patient is terminally ill.

The beneficiary revokes traditional Medicare coverage.

All services must be provided by a certified hospice agency.

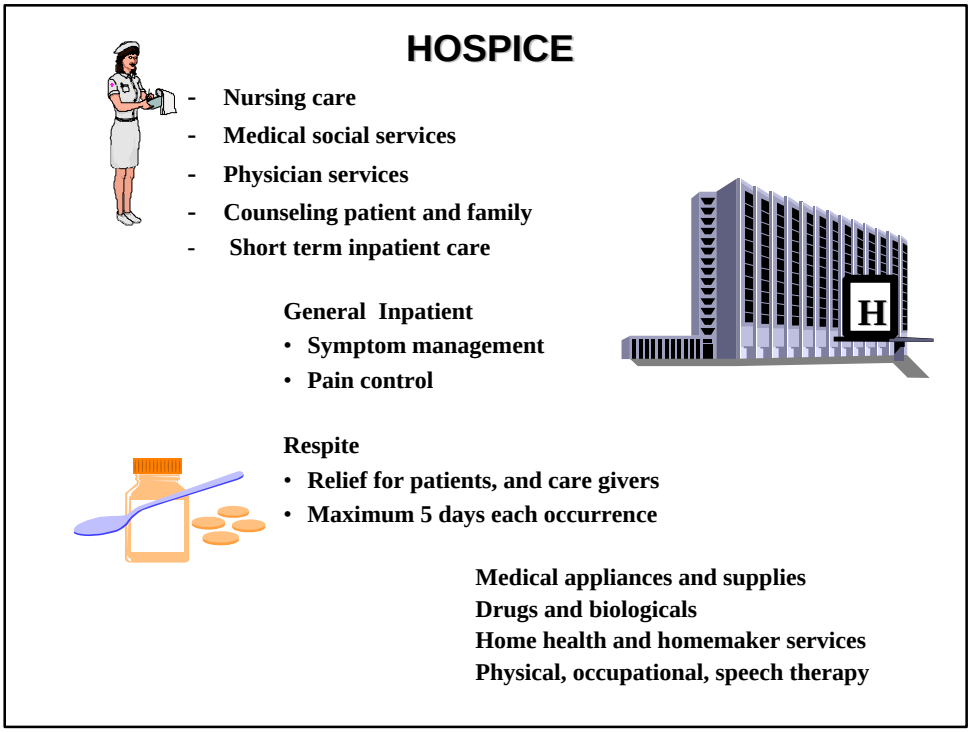
If treated for a condition unrelated to terminal illness, traditional Medicare coverage and reimbursement rules continue to apply.

The Hospice benefit was designed to allow a beneficiary to remain in his/her home during their final days of a terminal illness and still be covered by Medicare for intensive services.

Once a beneficiary elects the Medicare hospice benefit, he/she revokes traditional Medicare including the SNF and hospital coverage because all of their care (for the terminal illness) is provided by the hospice agency.

A beneficiary may “dis-enroll” from the hospice benefit at any time. If the beneficiary does that in the middle of any of the Hospice benefit periods, those Hospice benefit days remaining in that period are lost. If the beneficiary then chooses to “re-enroll”, he begins with the next usable hospice benefit period.

Traditional Medicare benefits are payable if the hospice beneficiary needs medical treatment for a condition unrelated to their terminal illness. This care may be rendered in a hospital or a SNF.



The services provided to a Medicare hospice beneficiary include care by medical professionals, therapists and counselors. Unlike other Medicare programs, the benefit can provide 24-hour a day care in the home and homemaker services.

Each hospice beneficiary must have a primary care giver at home. Because this responsibility can be so overwhelming, a respite benefit is a part of the hospice program. This allows the beneficiary to go into a SNF for up to 5 days in a row. No specific medical need is required. This coverage is intended to give the caregiver a break from their duties.

Inpatient hospital care for symptom management and pain control is covered by the benefit. In some circumstances, the patient's condition requires treatment in a hospital setting. These stays are a covered service.

HOME HEALTH

Medicare Can Pay for Services in the Home by a Participating Home Health Agency (HHA)

All four of the following conditions must be met:

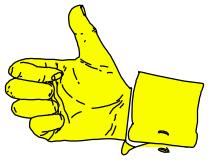
- ✓ **The care includes intermittent skilled nursing care, physical, occupational or speech therapy**
- ✓ **Confined to home (homebound)**
- ✓ **Doctor prescribes a home treatment plan**
- ✓ **Medicare certified Home Health Agency**

The home health benefit may be a natural progression of care from a hospital to SNF to home. In addition it is possible for a beneficiary to go directly into this program without the hospitalization. In all cases, a physician must establish a plan of care for the beneficiary's home care, and the patient must be confined to the home. If the patient were not confined to home, they would be able to seek treatment under the outpatient hospital benefit and the home health program would not be necessary.

The Balanced Budget Act of 1997 modified the home health program in the area of trust fund payment. Beginning in 1999 any beneficiary starting home health care following a hospital/SNF stay will have the first 100 visits paid for under Medicare Part A. Subsequent visits would be paid from the Part B trust fund. If the patient does not have a prior hospital stay, all visits come from the Part B trust fund.

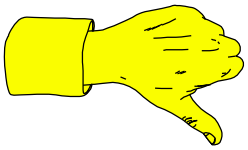
HOME HEALTH

COVERED SERVICES NOT LIMITED TO:



- **Skilled nursing care**
- **Speech, physical and occupational therapy**
- **Part-time or intermittent services of home health aides**
- **Medical social worker**

NONCOVERED SERVICES NOT LIMITED TO:



- **Full-time nursing care**
- **Drugs and medications**
- **Homemaker services or meals delivered to home**

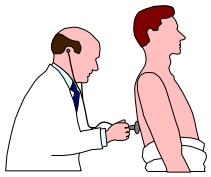
As in all Medicare programs, in order to cover home health services, those services must be reasonable and necessary to treat an illness or injury.

Home health providers must be certified by Medicare in order for payment to be made.

Because the beneficiary must be homebound in order to qualify, the home health provider is often the only outside contact that the beneficiary sees. The inclusion of care by home health aides and medical social workers is essential in monitoring the patient's condition.

Unlike the hospice program, the home health benefit does NOT include 24-hour a day care or homemaker services.

OUTPATIENT PART B SERVICES
COVERED SERVICES



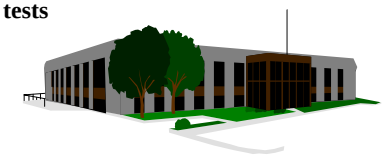
DOCTOR'S SERVICES
HOSPITAL/SNF OUTPATIENT SERVICES
HOME HEALTH CARE
OTHER SERVICES AND SUPPLIES

Covered Doctor Services:

- **Hospital/office visits and consultations**
- **Surgery**
- **Anesthesia**
- **Diagnostic tests**
- **Second opinions**

Covered Outpatient Hospital Services:

- **X-Rays, other radiology services and lab tests**
- **Emergency room or outpatient clinic**
- **Drugs and medications**
- **Supplies, such as casts and splints**



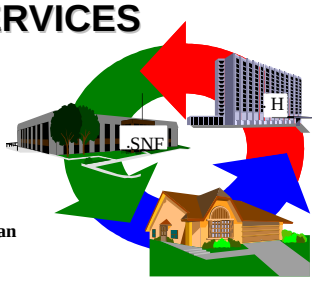
When seeking medical care outside of a hospital or SNF stay, the beneficiary has a wide range of covered services under traditional Medicare and the Medicare HMO benefit.

This care can be provided in the office of a professional or in a hospital emergency room or clinic. In addition, services may be treated in free standing sites such as dialysis centers and rehabilitation facilities.

The beneficiary must be enrolled in Medicare Part B in order to be covered for services provided on an outpatient basis. The claims may be sent either to the carrier or the intermediary depending on where the service was rendered.

In general, there is no limit to the number of outpatient services a beneficiary may receive. Exceptions to this rule include therapy, screening mammograms, PSA tests, and pap smears. These services may be covered, but only at certain intervals of time or (as in the case of therapy) until a certain payment level is reached.

PART B OUTPATIENT SERVICES



AMBULANCE

Transportation by any other means would endanger the patient's health

- **From home to hospital or SNF**
- **Hospital or SNF to home**

PROSTHESES

Replaces the function of permanent inoperative/malfunctioning body organ or all/part of internal body organ

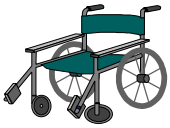
Covered Prostheses and Medical Devices

- **Pacemakers**
- **Artificial limbs**
- **Colostomy/iIleostomy supplies**

DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment Is equipment that the doctor prescribes for use in the home

- **Wheelchairs,**
- **Beds**



SPEECH, PHYSICAL, OCCUPATIONAL THERAPY

Doctor prescribes/periodically reviews plan of treatment

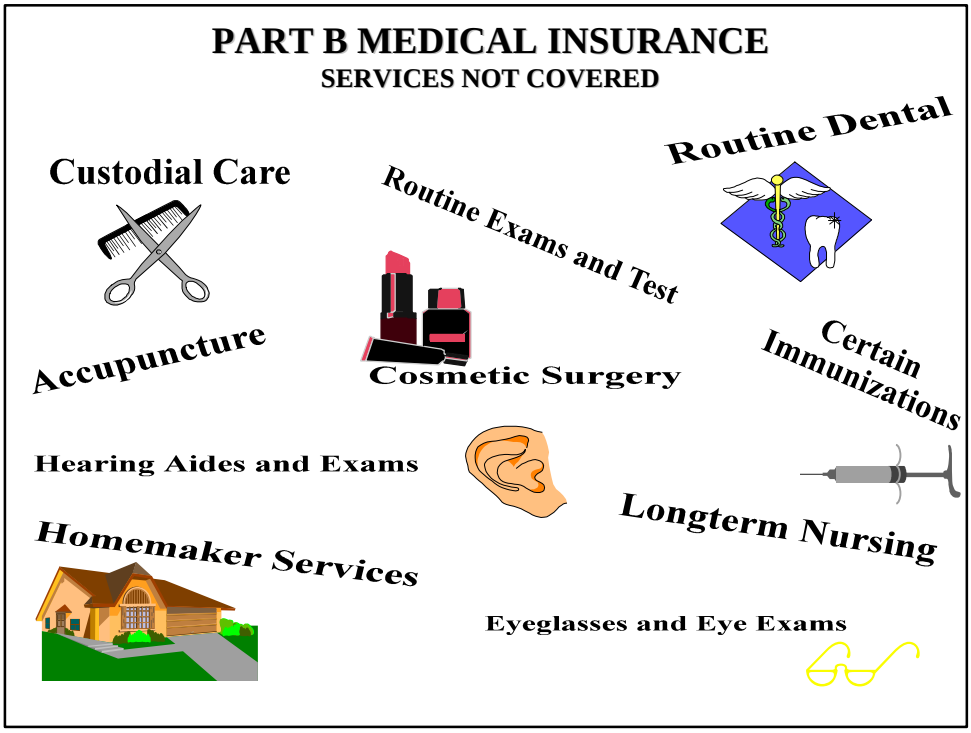
- **Unlimited visits/hospital outpatient, but subject to a "cap" in other settings**

Medicare provides many services that are not associated with an inpatient hospital or SNF stay or not a part of a home health or hospice program.

These outpatient services range from transportation by ambulance to durable medical equipment for use in the home. All items and services must be ordered by a physician and be medically necessary in order for Medicare to make payment.

Certain items listed above are billed to the carrier (ambulance) or a specialty carrier (durable medical equipment) known as a DMERC.

Therapy may be covered in a variety of settings from the outpatient hospital clinic to an outpatient rehabilitation facility (ORF), comprehensive outpatient rehabilitation facility (CORF), or SNF, as well as in the home under home health or hospice. Outpatient therapy must be restorative in nature. In most circumstances, Medicare does not pay for maintenance therapy.



The Medicare program is not all encompassing. It does not include coverage for every type of service that can be provided by a medical professional. The original intent of the program was to provide acute and skilled care. It has only been in recent years that preventative services have been added to the program.

In general, services which are routine in nature are not covered. Services which provide assistance with the activities of daily living are not covered, nor is long term care in a nursing home. Experimental drugs, procedures and treatments are not covered.

Unfortunately, the Medicare program does not, as a rule, provide reimbursement for items which most beneficiaries often require – eyeglasses, hearing aids, dentures or specialty shoes.

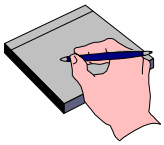
PEER REVIEW ORGANIZATIONS (PRO)

Groups of nnrses and physicians in each state under contract with the federal government to:

- **Determine whether care is reasonable and necessary**
- **Decide if care is furnished in the appropriate setting**
- **Monitor quality of care**

PRO responsibility falls under HCFA criteria, some of their review issues include:

- **Review hospital notices of noncoverage**
- **DRG validation**
- **Handle written beneficiary complaints and appeals**
- **Authority to deny payments**



Each Medicare contractor has a medical review department. This department has the responsibility to request and review medical records to determine the appropriateness of the service. Medical review professionals also check for certifications, documentation and determine if the billed service was "reasonable and necessary" for the treatment of the beneficiary's illness or injury.

Medicare intermediaries do not have the authority to review inpatient hospital claims. This responsibility belongs to the Peer Review Organization (PRO). If the PRO makes a determination that all or part of an inpatient hospital stay should not have been paid, they will instruct the intermediary to do an adjustment to alter the original payment.

As intermediary, Empire Medicare Services works very closely with the PRO in order to coordinate the activity between the decision making process of appropriate care and the payment process for that stay.

Notes