



*Helping Older Persons With  
Legal & Long-Term Care  
Problems*

# **Medicare Part A Coverage**

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## ***1. Who Is Eligible For Medicare Part A Hospital Benefits?***

You are entitled to enroll in Medicare Part A without a monthly premium, when

- (a) you are 65 years old and eligible for Title II Social Security or Railroad Retirement benefits; or
- (b) you have been eligible for Title II Social Security or Railroad Retirement disability benefits for at least 24 months following a five-month waiting period; or
- (c) you have end-stage renal disease.

If you are age 65, but do not meet any of the above qualifications, you can still enroll in the Part A program by paying a monthly premium.

## ***2. How Much Of My Hospital Stay Will Medicare Part A Cover?***

Medicare Part A hospital insurance benefits will cover 90 inpatient days of approved hospital care for each spell of illness. You must pay a Part A deductible of \$1,100 for each spell of illness.

Your “spell of illness” begins the first day you are hospitalized. When the hospital discharges you and you receive no additional hospital or skilled nursing care for the next 60 days, then your first spell of illness ends and a second spell of illness begins if you become sick again. For your second spell of illness, your Part A hospital insurance benefits would again cover 90 inpatient days of hospital care after you paid the new deductible.

If you need more than 60 days of hospital care in the same spell of illness, you will have to pay a daily coinsurance of \$275 for the 61st day to the 90th day of each hospital stay.

If you need more than 90 hospital days during a spell of illness, you will have to decide whether to use some of your “lifetime reserve days.” Each Medicare beneficiary has 60 nonrenewable lifetime reserve days. You will also have to pay a co-payment of \$550 for each lifetime reserve day used.

If you have limited income, the Qualified Medicare Beneficiary (QMB) program will pay your Part A premiums, deductibles and coinsurance amounts beginning the first month after QMB eligibility is determined. To find out more about QMB benefits, see Pro Seniors’ pamphlet: *Medicare Savings Programs*, or contact your County Department of Job and Family Services or the Social Security Administration.

### ***3. How Much Of My Hospital Stay Will A Medicare HMO Or Other Medicare Advantage Plan (MAP) Pay?***

Except for emergency hospitalizations and treatments, the MAP will pay for your hospitalization only if you obtain the prior approval of the MAP or your primary care physician and you use only the MAP’s hospitals.

Your out-of-pocket cost will depend on your Medicare MAP’s hospital deductible and co-payment policy for that year. For example, one MAP may charge \$250 a day for each day of hospital care up to a maximum of \$4,500 per benefit period, while another MAP may charge a flat \$300 for each hospital stay without a cap on your potential out of pocket costs. It is therefore crucial that the hospital co-payment and maximum co-payment policies be closely reviewed when selecting a Medicare Advantage Plan.

### ***4. What Role Does My Doctor Play In The Coverage Of My Hospital Stay?***

Medicare will cover your hospital stay if your physician certifies that you need inpatient hospital services for a medically necessary treatment or diagnostic study.

### ***5. What Is The Prospective Payment System?***

The Prospective Payment System provides an averaged payment for each type of diagnosis, also called a “Diagnostic Related Group,” or DRG. Hospitals must absorb the difference in cost when your care costs more than the Medicare DRG averaged payment.

A Medicare beneficiary has an absolute right to remain in a hospital as long as s/he needs hospital care, even if the cost of their individual care is more than the DRG averaged payment.

## ***6. What Role Does The Quality Improvement Organization Play In Your Hospital Stay?***

The Quality Improvement Organization, or QIO, contracts with Medicare to review appeals by patients of hospital discharge notices of noncoverage to prevent patients needing hospital care from being improperly discharged. The QIO makes sure that hospitals provide you with a written notice explaining your right to hospital and post hospital care under Medicare. The QIO also ensures that a hospital that believes you no longer need hospital care, gives you a written “Notice of Medicare Noncoverage,” also known as a Discharge Notice.

## ***7. What Can I Do If I Disagree With A Proposed Hospital Discharge?***

When you are advised of your planned date of discharge, either orally or in writing, if you think you are being asked to leave the hospital too soon, you have the right to appeal to your QIO. The QIO is authorized by Medicare to provide a second opinion about your readiness to leave. You can appeal this proposed discharge by calling 1-800-589-7337. You should then confirm your telephone appeal by writing [KePRO](#), Inc. PEPP/Review Dept., Rock Run Center, Suite 100, 5700 Lombardo Center Drive, Seven Hills, Ohio 44131.

If you appeal to the QIO by noon of the day after you receive a Discharge Notice, you are not personally responsible for paying for the days you stay in the hospital during the QIO review, even if the QIO disagrees with your appeal. The QIO will decide your appeal within one day after it receives the necessary information from the hospital. If you request an appeal after the noon deadline, you will have to pay for the costs of your additional days in the hospital, beginning on the third day after you received the Discharge Notice, if the QIO denies your appeal.

If you do not request an appeal, Medicare will not pay for the cost of your stay beginning on the third day after you received the Discharge Notice. If the hospital did not give you a written Discharge Notice, ask for a “written notice of the proposed discharge.”

You can appeal a QIO reconsideration denial to an Administrative Law Judge (ALJ) within 60 days. The ALJ decision may be appealed to the Medicare Departmental Appeals Board. You can then appeal an adverse Appeals Board decision to federal court.

## ***8. What If My MAP Wants Me Discharged And Tells Me I Will Have To Pay For All Of The Additional Care Provided?***

You have an absolute right to a written Discharge Notice and to appeal a MAP's hospital discharge decision to the Quality Improvement Organization. The MAP must put its Discharge Notice, and your right to appeal, in writing. If the MAP does issue a Discharge Notice, then you must follow the steps outlined in question 7 to avoid financial responsibility for the additional stay in the hospital while your appeal is decided.

## ***9. What Are My Discharge Planning Rights?***

A hospital must advise you of your discharge rights. "Discharge" occurs when the hospital formally releases you from its care, or transfers you to another hospital. The law requires hospitals participating in Medicare to

- (a) identify each patient at an early stage of hospitalization whose health is likely to suffer upon discharge without adequate planning;
- (b) evaluate the need for and availability of post hospital care for those patients, and for other patients who request it; and
- (c) when the doctor asks, arrange for the discharge plan to begin.

## ***10. Where Can I Get Help With My Appeal?***

If you live in Hamilton, Clermont, Butler, Clinton or Warren County, contact Pro Seniors for legal advice and representation with the appeal of Medicare coverage denials and the termination of needed medical care.

If you live outside this five-county area, Pro Seniors can still provide free advice, information and referral services on Medicare denials. For more information, call Pro Seniors' Legal Hotline at (513) 345-4160 or (800) 488-6070.

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*Pro Seniors provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If a matter cannot be resolved over the phone, seniors are referred to other Pro Seniors' staff or community resources for more in-depth assistance.*

In southwestern Ohio, Pro Seniors' staff attorneys handle matters that many private attorneys do not, such as Medicare, Medicaid, SSI, financial abuse and landlord/tenant problems. Pro Seniors may also refer seniors to a private attorney on our referral panel. Many of these attorneys have agreed to handle cases at a fee seniors can afford.

Pro Seniors' long-term care ombudsmen work with residents of southwestern Ohio to protect their rights and resolve complaints about nursing facilities and home care.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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