

Fee-for-Service Medicare for People with Alzheimer's Disease

The following information answers questions Medicare beneficiaries with Alzheimer's disease and their families may have about their Medicare coverage. This document supplements other brochures and fact sheets that provide a complete explanation of original fee-for-service Medicare coverage. If you are enrolled in a Medicare managed care plan, such as a Health Maintenance Organization, you may be covered for services that are not covered by original fee-for-service Medicare.

Medicare does not cover most long-term care, the biggest expense for people with Alzheimer's disease. It does cover most other regular health care expenses. Although Medicare is a health insurance program, beneficiaries with Alzheimer's disease have experienced problems in payment of certain claims. The following are answers to some of the questions frequently asked by Medicare beneficiaries with Alzheimer's disease and their caregivers.

1. Will Medicare pay for my husband's doctor to evaluate and diagnose him with Alzheimer's disease?

Yes. Medicare will pay for your husband to be evaluated for and diagnosed with Alzheimer's disease by his doctor. Medicare will also pay for other doctor's services, including treatment and management of the disease, consultation by other doctors and care plan oversight. Consultation services are paid when the treating doctor requests a second doctor to review the patient's history and test results or even to examine the patient. Care plan oversight is paid for when there is doctor supervision of the patient who is receiving home health care or hospice care, which often requires regular doctor review of the care plans.

2. How much does Medicare pay for my doctor's visit? How much do I have to pay?

Doctors' bills are paid under the Medicare Part B program. Each year you have a deductible (\$135 in 2009) before Medicare will pay for your Part B claims. Once you have met that deductible, Medicare will pay 80 percent of your doctor's bill, in most circumstances.

Sometimes Medicare improperly pays only 50 percent of a doctor's visit for diagnosis or treatment of Alzheimer's disease. The beneficiary is billed for the 50 percent balance of the bill. This problem often occurs because the wrong billing code was used on the claim form submitted for payment.

As discussed in the answer to question 5 below, Medicare only pays 50 percent for mental health visits. However, Medicare rules are clear that the diagnosis and treatment of Alzheimer's disease is not considered treatment of a mental illness and therefore the doctor should be reimbursed at the 80 percent rate. When Medicare pays the incorrect amount of a claim, you should contact your doctor and be sure that the doctor is using the correct billing codes.

3. What diagnostic and laboratory tests will Medicare pay for my wife to be tested for Alzheimer's disease?

After the doctor has completed a thorough physical and history of your wife, her doctor may order a variety of tests to assist in diagnosing Alzheimer's disease. Some of the tests Medicare pays for are blood studies, urinalysis, electrocardiograms, chest x-rays, Computerized Tomography (CT Scans), electroencephalography (EEG), and Magnetic Resonance Imaging (MRI).

Presently, Medicare will only pay for Positron Emission Tomography Scans (PET) for certain conditions related to heart disease, lung disease, and certain types of cancer and refractory seizures. In limited circumstances, Medicare will pay for the use of PET scans for diagnosis of Alzheimer's disease.

4. Will Medicare pay for my father to see a psychiatrist, clinical psychologist or social worker?

Yes, Medicare will pay for your father's visits to a psychiatrist, clinical psychologist or social worker under certain circumstances. However, Medicare sometimes denies payment for psychotherapy services for a person with a primary diagnosis of Alzheimer's disease on the theory that a person with dementia may be too impaired to benefit from psychotherapy. If your father has a condition that requires psychotherapy and/or behavior management, such as depression, agitation, aggression and personality changes, it is important that the mental health provider also list that condition as a reason for which he is receiving the therapy.

Medicare does pay for diagnostic evaluation by a psychiatrist and for outpatient medication management by a psychiatrist. This benefit can be of significant importance if your father is taking medication to control agitation or aggressive behavior.

Medicare will also reimburse for family counseling services provided to your father's family if the primary purpose is the treatment of your father's condition and not the treatment of a family member's problems. Family counseling services may be appropriate when there is a need for his doctor to observe your father's interaction with the family members or when it is necessary for his doctor to assess the capability of and assist the family members in aiding the management of your father.

5. How much does Medicare pay for my father to see a psychiatrist, psychologist or social worker?

Medicare pays psychiatrists, clinical psychologists or social workers in an outpatient setting based on a fee schedule. However, the actual payment of the claims depends on whether the purpose of the visit was for diagnosis or therapy.

If the primary reason for the visit was for diagnosis or medical management of Alzheimer's disease, Medicare will pay 80 percent of the Medicare approved amount. If the primary service was psychotherapy, then Medicare payment is limited to 50 percent of the Medicare approved amount. This limitation is called the outpatient mental health treatment limitation.

The outpatient mental health treatment limitation does not apply to the diagnosis of Alzheimer's disease. Medical treatments provided to a person with Alzheimer's disease are considered medical management of the disease and not subject to the limitation.

6. My mother broke her hip and was receiving physical therapy. The therapy has stopped because Medicare will not pay if she is not improving. Is this correct?

Although Medicare does pay for physical therapy, there are certain limitations on how long she will receive the therapy services. In order for Medicare to pay for physical therapy, there must be a written treatment plan which provides for the physical therapy and the therapy must be "reasonable and necessary" for the treatment of your mother's broken hip.

To be reasonable and necessary, your mother must receive services that require the skills of a therapist (rather than a non-skilled aide) to safely and effectively meet her needs. Also, the services must be provided with the expectation that your mother will improve significantly over a reasonable or predictable period of time, or are necessary to establish a safe and effective maintenance program to prevent or minimize deterioration caused by her broken hip or by her Alzheimer's disease.

Sometimes Medicare will deny claims for therapy services for beneficiaries with Alzheimer's disease because the beneficiary does not improve quickly enough or because Medicare does not believe the beneficiary is able to learn or benefit from the therapy. If this happens, it is important to talk to your mother's treating doctor and physical therapist.

There is clear evidence that people with Alzheimer's disease can benefit from rehabilitation therapy. You should appeal the Medicare decision if the treating doctor or therapist believes your mother can still benefit from the physical therapy.

7. Will Medicare pay for my father to receive home health care?

Medicare pays for home health care if your father meets certain conditions. He has to be confined to his home and require physical or speech therapy, or intermittent skilled nursing care, which will be provided from a home health agency under his doctor's plan of treatment.

If your father meets these conditions, Medicare will pay for him to receive any of the following home health benefits as specified in his treatment plan: part-time or intermittent nursing care; physical, occupational or speech therapy; medical social services; part-time or intermittent home health aide services; medical supplies and durable medical equipment. The duration and number of visits will depend on his treatment care plan written by his doctor.

Your father must need a skilled service to be eligible for home health care benefits. Many people with Alzheimer's disease have significant chronic care needs, but they do not require the services of a skilled professional.

If he does receive home health benefits under Medicare, there are no deductibles or coinsurance payments for which he would be required to pay for these services, except for the durable medical equipment.

8. Will Medicare pay for my mother's personal aide who comes to my mother's home and helps her bathe, groom, dress and use the toilet?

Generally, Medicare will not pay for your mother's personal aide. However, if your mother needs skilled services that make her eligible for Medicare home health services, she may also receive home health aide services for personal care, dressing changes, taking medications and other activities as ordered by your mother's physician.

9. Can my dad continue to receive home health benefits if he goes to adult day care?

The answer depends on the reason he attends adult day care and your father's overall condition. If your father participates in therapeutic, psychosocial or medical treatments in an adult day care program that is licensed/certified by the state, then his attendance should not affect his receiving home health benefits.

Remember, in order to receive home health benefits, your father must be considered confined to his home or "home-bound." If the adult day care meets the specified requirements, and it takes a "considerable and taxing effort" for him to attend the day care, then he is still considered "homebound" for purposes of eligibility for home health benefits.

10. Will Medicare pay for my father to attend adult day care?

No, Medicare does not pay for adult day care.

11. I take care of my father in my home. Does Medicare pay for respite care?

Generally, Medicare does not pay for respite care. However, if your father is receiving hospice care through Medicare, respite care is provided as a hospice benefit. See the answer to question 17 below for information regarding the Medicare hospice benefit.

12. Will Medicare pay for my mother's nursing home stay?

Medicare will only pay for nursing home care in specific circumstances.

Medicare will pay for up to 100 days per spell of illness for skilled care in a nursing home. To qualify, your mother must have been an inpatient in a hospital for at least three days, admitted to the nursing home

within 30 days of the hospital discharge and require daily skilled care for the same condition for which your mother was hospitalized.

It is rare for a person to receive the full 100 days of Medicare coverage because most people do not receive daily skilled care in a nursing home. Most residents in the nursing home receive skilled care a couple of days a week, which is not sufficient to meet the Medicare requirements.

If your mother only requires personal care, such as assistance with feeding, dressing, toileting and bathing, then Medicare will not cover her stay at the nursing home.

13. Will Medicare cover experimental treatment or clinical trials?

Under limited circumstances, Medicare will pay for an experimental treatment if the Medicare program has determined that, with certain controls, the treatment is safe and effective. The Medicare program regularly makes Medicare coverage determinations regarding payment for treatments that have been sufficiently tested and for which the Medicare program is reasonably assured that the treatment is safe and effective.

Similarly, under certain circumstances, Medicare will pay for routine costs of qualifying clinical trials as well as items and services used to diagnose and treat complications when the beneficiary participates in a clinical trial. The researchers conducting the trial should have information about Medicare coverage of the particular trial.

14. Does Medicare pay for any of my mother's outpatient prescription drugs?

Yes, Medicare will pay for most outpatient prescription drugs, including treatment for Alzheimer's disease. Prescription drug coverage is available to all Medicare beneficiaries through private insurance plans. Each plan is different regarding the drugs it covers and the out-of-pocket costs (i.e. premiums, deductible and copayments.) Please see the specific facts sheets regarding the Medicare drug benefit on www.alz.org

In addition, if your mother is receiving hospice care through Medicare, prescription drugs are provided as a hospice benefit. See the answer to question 17 below for information regarding the Medicare hospice benefit.

15. Will Medicare pay for my mother's vitamins or nutritional supplements?

No, Medicare does not pay for over-the-counter nutritional supplements such as vitamins or *Ginkgo biloba*.

16. My mother is incontinent. Will Medicare pay for the supplies needed to address this problem?

No, Medicare does not pay for incontinence supplies.

17. My wife's doctor told me that my wife's condition is terminal and that she will probably die in the next six months. The doctor recommends hospice care for my wife. Does Medicare pay for hospice care?

Yes, Medicare covers hospice care for a terminally ill beneficiary who is expected to die within six months. If your wife (or her representative) elects to receive hospice benefits, she will waive her right to most of her Medicare Part A and B benefits for treatment of the terminal illness. She can receive hospice benefits for two periods of 90 days, and an unlimited number of periods of 60 days each. There is no deductible. There is a small coinsurance for a drug or biological and respite care.

Under the hospice benefit, Medicare will pay for your wife's doctor's services; nursing services; physical, occupation and speech therapy; medical social services; physician services; home health aide and homemaker services; counseling services for your wife and your family; respite care; prescription drugs; and medical appliances and supplies. Please see the specific facts sheet regarding the Medicare hospice benefit on www.alz.org

18. If I have a Medicare supplemental (Medigap) policy or retiree health insurance policy, will it cover what Medicare did not?

It depends on your policy. Medigap policies are designed to fill the gaps of fee-for-service Medicare coverage. There are 12 standard policies, identified by letters A through L. Some of the policies will cover services not covered by Medicare, such as medical care while traveling outside the United States.

Other policies will just pay the deductibles and coinsurance payments associated with Medicare. Retiree health insurance policies are usually comprehensive health insurance policies. Although Medicare is typically the primary insurer, many retiree health policies will pay for health services not covered by Medicare, such as routine physicals and examinations.

19. What can I do if I think Medicare improperly denied payment for a claim, or paid the wrong amount for a claim?

If you think that Medicare made a mistake in payment of a claim, you may want to appeal the decision. With the exception of some expedited Part A appeals of discharge from a hospital, all appeals must be in writing.

There are standard appeal procedures for Part A claims and Part B claims. The initial decision, or formal notice, that you receive from a Medicare contractor, is often called an “initial determination” and is in the Medicare Summary Notice (MSN). The first level of appeal is called a redetermination and must be requested within 120 days of the MSN. The Medicare contractor makes the reconsideration determination and should be made within 60 days. If you are dissatisfied with the redetermination decision, you have 180 days to request a review called a reconsideration, by an independent entity called a Qualified Independent Contractor (QIC). The QIC has 60 days to issue its decision. If you disagree with the reconsideration decision and the amount in controversy is at least \$120 (\$200 for hospital claims), you can request a hearing before an Administrative Law Judge.

If you are still dissatisfied after your hearing decisions under Part A or Part B, depending on the amount in controversy, you can request a review by the Medicare Appeals Council, and ultimately appeal to the federal district court in your area.

There is also an expedited appeals process for some Part A denials when an individual receives a Notice of Discharge or Service Termination. The process to file an expedited appeal should be on the written notice.

20. How much of my mother's out-of-pocket expenses are deductible from her federal taxes?

Personal care, long-term care and prescription drug expenses are deductible from federal income taxes in the same manner as other medical expenses. For more information on deductions, see the Alzheimer's Association's publication “Are Alzheimer Care Expenses Tax Deductible?”

For additional information

- Centers for Medicare and Medicaid Services: www.cms.hhs.gov
- Medicare Web site: www.medicare.gov
- State Health Insurance Assistance Programs (SHIPS): www.shiptalk.org
- Eldercare Locator to find your local Area Agency on Aging: www.eldercare.gov

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