Checking Medicare coverage before a transfer

Have your insurance card, the facility name and the proposed level of care ready. Ask what coverage has been confirmed for this stay, what still needs a decision and what you may owe.

When a hospital recommends another level of care, start with the exact facility, service and payer. Long-term hospital care and intensive inpatient rehabilitation have different purposes and coverage requirements. Keep the insurance card, proposed admission date and name of the person coordinating the referral together for the coverage conversation.

A person who still needs hospital treatment for ventilation, a difficult wound, IV medicines or several conditions may be referred for long-term acute care. Clinical appropriateness, clinical acceptance, coverage and cost are separate decisions. A number of days spent in an ICU or on a ventilator is not by itself an individual guarantee of Medicare coverage.

Medicare generally serves people age 65 or older. Some younger people qualify through disability, end-stage renal disease or ALS. The timing and requirements differ by situation. Ask Medicare or the Social Security Administration about your own eligibility and enrollment date.

Understanding Parts A and B

Original Medicare includes Part A hospital insurance and Part B medical insurance. Part A may cover a qualifying inpatient hospital stay; Part B can cover physician services, including physician services during inpatient rehabilitation. Medicare Advantage provides Medicare benefits through a private plan and may have different authorization, network and cost-sharing rules.

Part A at a glance:

- Most people qualify for premium-free Part A based on their own or a spouse's Medicare-covered work history. Being eligible for Medicare does not by itself establish coverage for a particular proposed hospital stay.
- Some people who do not qualify for premium-free Part A can buy it if they meet eligibility requirements. Confirm enrollment and effective dates with Medicare before relying on coverage.

Part B at a glance:

- Part B covers eligible medical services, including physician services and outpatient care. Ask which part of the stay will be billed through Part A and which professional services may be billed through Part B.
- Part B generally has a monthly premium. Depending on your circumstances, assistance may be available. Check your enrollment and plan information for the amount that applies to you.
- Medicare's hospice benefit is generally covered by Part A for people who qualify. If hospice or other benefits are relevant, ask how those arrangements affect the proposed setting.
- Ask the provider and payer about the professional services, hospital services and follow-up services expected during this episode. Separate bills or different cost-sharing rules can apply.

What hospital services does Medicare cover?

Medicare Part A can cover care in a qualifying long-term care hospital. It can also cover medically necessary inpatient rehabilitation for eligible patients who need an intensive rehabilitation program, physician supervision and coordinated care. Discuss with the payer how the proposed service is classified. Coverage can include:

- Inpatient hospital services, medications and supplies

- Nursing care
- Rehabilitation services
- Pain management
- Semi-private room
- Meals

Under Original Medicare, an inpatient hospital benefit period generally begins with inpatient admission and ends after 60 consecutive days without inpatient hospital care or skilled care in a skilled nursing facility. An emergency department visit alone is not an inpatient admission. Ask how a direct transfer or a prior inpatient stay affects the deductible.

A new benefit period can mean a new deductible. Costs can change with the length of the stay and any lifetime reserve days used. Check the current Medicare amounts, your remaining benefit days and the terms of any supplemental or other coverage before transfer.

What doesn't Medicare cover?

Examples of items or services that may not be covered as part of an inpatient stay, or may have separate charges, include:

- Convenience items like razors
- Custodial care
- Private-duty nursing care
- A private room when it is not medically necessary.
- Care beyond the applicable hospital benefit and available reserve days, subject to the individual's other coverage.

What would I need to pay?

You may be responsible for paying a portion of inpatient care that is not covered by Medicare Part A. These can include:

- Your deductible. Check with Medicare to determine what your deductible is for a given year.
- Coinsurance. This is the part of Medicare-approved costs for transitional hospital care that you may need to pay after you've met your deductible.

Use Medicare.gov to look up long-term care hospital services, inpatient rehabilitation care and appeal rights. If your plan denies the service, request the written notice and follow its instructions and deadline. Keep the date, call reference and the name or department responsible for follow-up.

For questions about a possible stay, call Lakeview Admissions at (262) 534-8509. During a stay, ask the bedside nurse who can help with your question.

Patient information — https://www.medicare.gov/coverage/inpatient-rehabilitation-care

https://www.lakeviewsystem.com/admissions