

MEDICARE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

PURPOSE

Medicare is a federal health insurance plan administered by the Centers for Medicare Services (CMS) for persons age 65 and older, and for eligible individuals with disabilities. The Social Security Administration (SSA) helps CMS by enrolling people in Medicare and by collecting Medicare premiums. Eligibility is NOT based on need or income/asset limits.

Medicare - Part A covers hospital and related health care.

Medicare - Part B is a voluntary medical insurance program that provides assistive technology (AT) purchased as Durable Medical Equipment (DME) and must be "necessary and reasonable."

Medicare - Part D is a voluntary insurance for prescription drugs.

CONTACT

For information about applying for Medicare, eligibility, or replacing a lost Medicare card contact the Social Security Administration:
(800) 772-1213
www.medicare.gov

For general Medicare information call the Medicare Hotline: (800) 633-4227

ELIGIBILITY

- Persons 65 years of age or older
- Persons who are blind and permanently disabled and must have been receiving Social Security Disability Insurance (SSDI) payments for twenty-four (24) months
- Persons with End Stage Renal Disease or Amyotrophic Lateral Sclerosis (ALS)

AT SERVICES PROVIDED/COVERED

- Assessments & Evaluations
- Fabrication of Devices
- Training for Consumer & Family
- Maintenance & Repairs

AT DEVICES PROVIDED/COVERED

- | | |
|----------------------------|-------------------------------|
| Aids for Daily Living † | Medical Supplies |
| Aids for Vision Impaired | Prosthetics & Orthotics |
| Augmentative Communication | Seating/Positioning Equipment |
| Hospital Beds | Wheelchairs & Mobility Aids |

† Lenses for cataract surgery

APPLICATION PROCESS

- Applications for a Medicare health insurance card are taken at all local offices of the Social Security Administration.
- For eligibility information and to locate the Social Security Office nearest you, call the Social Security information hotline at (800) 772-1213.

APPEALS PROCESS

1. If Medicare makes a decision you disagree with, you can file an appeal. If you disagree with the decision made at any level of the process, you can generally go to the next level. After each level, you will be given instructions on how to proceed to the next level of appeal.
2. Level 1 is a redetermination by the company that handles claims for Medicare. A redetermination is a second look at a claim. If you disagree with the decision made on your claim, you must request a redetermination within 120 days from the date you got your Medicare Summary Notice (MSN). Follow the directions on the MSN to do this. You will get a response called a "Medicare Redetermination Notice" about 60 days after the company gets your appeal request.
3. If you disagree with the redetermination decision in level 1, you have 180 days after you get your decision to ask for a reconsideration. This is the second level of appeal.

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CONTACT

Questions regarding general information about Medicare, Medicaid, managed care plans and the various types of health insurance available to supplement Medicare, assistance with sorting out medical bills, and filing insurance, contact the Senior Health Insurance Counseling Program (SHICP) of the Oklahoma Insurance Department.

(405) 521-6628
(800) 763-2828

For general information about Medicare, concerns about being asked to leave the hospital too soon, and complaints about the Medicare paid settings, contact the Peer Review Organization, Oklahoma Foundation for Medical Quality.

(405) 840-2891
(800) 522-3414

See Appendix B for Oklahoma Department of Human Services County Offices.

FINANCIAL CRITERIA

- None

4. Level 2 is a reconsideration by the Qualified Independent Contractor (QIC).
5. To check the status of your reconsideration you can call 1-800-Medicare (800 633-4227).
6. For assistance contact the Office of the Medicare Ombudsman's (OMO) by calling the above number. They can receive and provide help regarding complaints, grievances, and requests for information from people with Medicare.

PIECES OF THE PUZZLE

- Medicare - Most people will pay the Part B premium of \$115.40 in 2011.
- In October 2009, new rules went into effect for certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to vendors in order to be paid by Medicare. The new requirements for suppliers include being accredited and having a surety bond, which will help to prevent Medicare fraud and assure that you continue to get high-quality products and services. If your supplier doesn't meet these requirements, you will have to look for another Medicare-approved supplier in order for Medicare to pay for your equipment and supplies.
- Durable Medical Equipment (DME) is equipment which meets all of the following requirements:
 - can withstand repeated use;
 - is primarily and customarily used to serve a medical purpose;
 - is generally not useful to a person in the absence of an illness or injury; and
 - is appropriate for use in the home.
- A physician will prescribe special equipment for use by a beneficiary in his/her home. The equipment may provide therapeutic benefits or enable the beneficiary to perform certain tasks that s/he is unable to undertake due to certain medical conditions and/or illnesses.
- For DME the amount you pay varies. If a supplier of DME doesn't accept Medicare authorized reimbursement, there is no limit to what can be charged. You may also have to pay the entire bill (your share and Medicare's share) at the time you get the DME. Ask if the supplier is a participating supplier in the Medicare Program before you get your DME. If the supplier is a participating supplier, they must accept Medicare authorized reimbursement. If the supplier is enrolled in Medicare but isn't "participating," they have the option to accept Medicare authorized reimbursement. Make sure your supplier is enrolled in Medicare and has a Medicare supplier number. Suppliers have to meet strict standards to qualify for a Medicare supplier number. If the supplier isn't enrolled in Medicare, then Medicare won't pay your claim.
- The rate schedules place a cap on how much Medicare will pay for a particular DME item. If the supplier's price is higher than the amount allowed under Medicare, the consumer will have to pay the difference. Because of low reimbursement, it may be necessary and advantageous to combine Medicare with private sources, or the consumer may need to pay the remainder. This process can be useful in obtaining higher quality products.

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- Medicare covers power-operated vehicles (scooters), walkers, and wheelchairs as DME that your doctor prescribes for use in your home. Before Medicare helps pay for a power wheelchair you must have a face-to-face examination and a written prescription from a doctor or other treating provider.
- The Medicare website, www.medicare.gov/ is very informational. The website also has a directory to look up DME suppliers and Physicians online at: www.medicare.gov/
- In an effort to provide greater efficiency in the Medicare program as it applies to DMEPOS, the Centers for Medicare and Medicaid Services (CMS) awarded contracts to four health care contractors. These four contractors are referred to as Durable Medical Equipment Regional Carriers (DMERCs). Each Durable Medical Equipment Medicare Administrative Contractor (DME MAC) covers a specific geographic region of the country and only processes Medicare claims for DMEPOS items. Please contact 1-800-MEDICARE (800-633-4227) for the DME MAC that covers your area. You must provide them with your Medicare card number.
- Individuals with low income may qualify for additional financial assistance to help pay for Part B premiums, deductibles and co-payments. To apply for the Qualifying Medicare Benefits Program or Specified Low-Income Medicare Beneficiary Programs, see Appendix B for Oklahoma Department of Human Services County Offices.