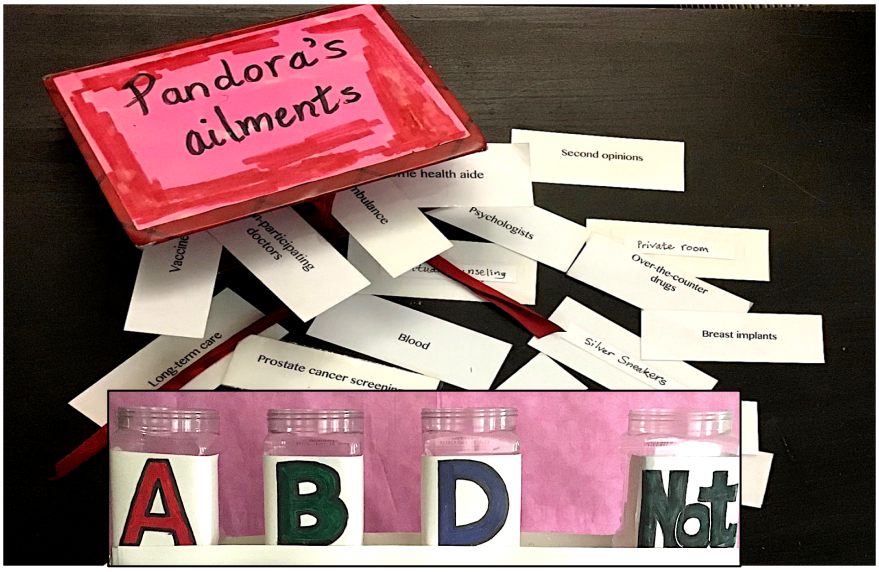
Pandora's Leftovers (the remaining ailments) (rev. Dec 2024)



These are the answers to the other cards in The Game that I didn't get to in the presentation. Reading through these is important, as they illustrate how ambiguous some of the billing can be and how necessary it is to keep asking questions. Try guessing them for yourself before looking at the answers!

Acupuncture: MOSTLY NOT COVERED, PART B Some of the Medicare Advantage plans have been offering acupuncture as an "extra" of several years, but it's only been included as a Part B benefit since Jan 2021, and only for lower back pain. Medicare covers up to 12 sessions in a 90-day period (20 sessions across 12 months) for back pain lasting 12 weeks, having no known cause, and not associated with surgery or pregnancy (!). The doctor, dentist or chiropractor must have a master's or doctorate in acupuncture and be state licensed. It's possible that the resistance to Asian medicine will decrease in the future and the benefit will be added to Original Medicare. There is a growing effort to resort to non-opioid plan management.

Alcohol misuse screening and counseling: PART B You can get 4 brief counseling sessions at no cost if the doctor thinks you need these.

Anesthesiologists: PART A or B (if opt-out MD, NOT) Doctors, as we know, are providers, so we think of them as Part B, but Medicare says if you're inpatient, they'd be covered under Part A, and as an outpatient or in an ambulatory surgery situation, B. I've heard of people getting bills for anesthesiologists, but don't know the specific conditions that caused that billing in each case. And if you're in an HMO, where you're out of pocket for a physician not in your plan, you really don't want any surprises. Sometimes it's even difficult to find out before an operation who your anesthesiologist would be, as the hospital doesn't schedule operations too far in advance.

I'm still a little vague as to how the billing went down for a surgery I had. My Advantage plan (HMO) had to approve the whole operation, and once they did, everything that related to the surgery was taken care of, I never saw a bill. When I called the plan beforehand to check on the doctor's co-

surgeons and other medical staff, they specifically told me that as long as the operation had been approved, everything would be covered. I am not even sure I was "admitted." The doctor *told* me beforehand that I *would* be admitted, and that he'd be keeping me overnight to check my calcium before sending me home. But I don't know if he used the word "admitted" in the official way, i.e., formally admitted. Maybe he just meant "kept," as this was definitely an outpatient surgery. There's such a thing called "Ambulatory surgical centers," where you're expected to be released within 24 hours. If that was where I was, I didn't know it at the time. I thought I was at a regular big hospital in NYC.

Blood: PART A or B From what I read, the handling of your transfusion is billed under Part A or B, depending on whether you're an inpatient or not. If the facility gets the actual pints free, there's no cost to you, and if they have to buy them, you either have to pay for the first 3 pints unless you have supplemental coverage, or you could have the blood donated by yourself or someone else beforehand to keep the cost of the blood to zero. Administering the transfusion is different: there's a Part B copay for that. There is a blood deductible for the blood itself, which is in addition to other Part A or B deductibles.

Breast implants: NOT, or PART A or B Cosmetic implants not covered. For reconstruction surgery, surgically implanted breasts are covered by Part A for inpatient surgery and Part B for ambulatory surgery; also included is a post-surgical bra. Medicare.gov also says that some external breast prostheses are covered by Part B after a mastectomy. As for removal of an implant, health insurance companies are legally required when medically necessary to remove implants inserted during a mastectomy; if the implant was done in cosmetic surgery, paying for the removal is up to the plan. Any external prosthesis would be Part B. The Women's Health and Cancer Rights Act of 1998 mandated insurance companies cover breast reconstruction and prosthetics (see this CMS link: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet). Policy guidance on this topic at this CMS link: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52478, and more guidance on what can be reimbursed here: https://www.medicaresupplement.com/coverage/does-medicare-cover-mastectomy-bras/.

Chemotherapy: PARTS A, B, and D Any chemo given to you as an inpatient is Part A, in a doctor's office or clinic: B. As new oral cancer drugs become available, Part B may cover them, but if not, Part D might very well. Anti-nausea drugs would be also be Part D.

Diabetes supplies: PARTS B and D Medicare Part B covers certain supplies (e.g., glucose monitors, blood sugar test strips, lancet devices and lancets), as well as equipment associated with a pump, a piece of durable medical equipment. But Part D plans and Advantage Plans with a drug component will pay for injectable insulin and supplies (like syringes, swabs). Part D plans may cover insulin and related supplies for injecting it.

The cost of insulin is brutal for some people, and the Inflation Reduction Act gave some relief beginning in 2023: plans can't charge more than $35 a month for each Part D-covered insulin prescription, nor is there a deductible.

Eyeglasses: PART B One pair of glasses or one set to contact lenses after each cataract surgery that implants a lens.

Hearing aids or the exams to fit them: NOT, or Part B A hearing exam is covered once every 12 months without an order from a doctor in certain circumstances. The FDA Reauthorization Act of 2017 directed the FDA to create a category for over-the-counter hearing aids for people with mild to moderate hearing loss, and a rule was finalized in August 2022 that allows these people to get them online or from a store without a prescription, exam, or fitting.

Incontinence pads: generally NOT, unless PART A, B or C Medicare doesn't cover throw-away or absorbent items, so for normal senior incontinence, the pads are not covered. Part A will cover these when you're an inpatient, and the agency who is managing your home health care will sometimes leave you with various kinds of supplies. I can't say which part of Medicare paid for the pads that just appeared when one of my parents needed them after surgery. We never saw a bill for these. I am seeing that some Medicare Advantage (Part C) plans do cover pads to some extent, and it seems that if surgery permanently changes the stoma for your urinary tract, Medicare will cover pads. In both of these cases you might have to get them through a supplier. Look for "diaper banks" in your community if you need help purchasing these.

Long-term care: NOT Rehab is covered, but not long-term care. You need separate insurance for that.

Orthotics: mostly NOT Information varies on this, but only prescribed by your doctor for medical necessity. Medicare.gov says orthotic inserts are covered by Part B for custom-molded shoes. Other websites indicate Medicare will cover them for reasons other than diabetes or specific therapeutic shoes. The doctor treating your diabetes must certify your need for therapeutic shoes or inserts, and the podiatrist or other certified doctor must prescribe them, and you must get them from these practitioners.

OTC drugs: mostly NOT Over-the-counter-drugs are generally not covered by Medicare Part D plans, even with a prescription, but some Advantage and Part D plans have been allowing the purchase of an OTC drugs with a prescription. Look out for "Medicare Advantage Over the Counter Drug Cards," which are prepaid card for some drugs and products. Most policies include cold, cough, and flu meds; antibiotic ointments; band-aids and first-aid materials; denture-related products; digestive meds; and orthopedic support. Check with each plan you're considering.

Private room: NOT, or PART A or B Medicare says it covers "semi-private" rooms, but will cover a private room if you require isolation or no other room is available. But it has been explained to me that hospitals and facilities in this area are going in the direction of giving people small private rooms, each with its own bathroom, instead of double-occupancy. These are billed at Medicare's "normal" or "standard" rate, i.e., for semi-private rooms.

Prostate cancer screening: PART B Digital rectal exams and PSA (Prostate Specific Antigen) tests are covered once every 12 months for men over 50. The exam has the normal 20% copay plus any copayment for the hospital outpatient setting, the PSA test is free.

Preventive screenings like this PSA, or mammograms and colonoscopies, are offered free in set time intervals, like a mammogram every year. You count it from the last time Medicare paid for this service, so if the last time you had a colonoscopy you weren't yet on Medicare, Medicare would cover you the first time you asked for one, then regularly thereafter. And something else interesting: if you're allowed one of these services every 12 months, you could get it again after a span of 11 full months. So if you got a mammo on June 10 of one year, the 11th full month after that would be May, and Medicare would be for another one any time after June 1 the following year.

If something that needs treatment is found in a screening, we were told by Medicare that the coding is changed to diagnostic, and therefore no longer free. I find that strange, and I'm not sure it's correct. Change a code? In any case, any subsequent diagnostic treatments would be paid for, under B.

Psychologists: Part B (if not in Medicare, NOT) Also psychiatrists, physician assistants, nurse practitioners, social workers, lab tests ordered by the doctor, outpatient care. With the Inflation Reduction Act, marriage and family therapists are allowed to join Medicare as well. But many of these people are opt-out providers because they wish to practice using their own fee schedules and the paperwork is overwhelming. You cannot submit their bills to Medicare. This mental health services guide was revised in August 2023: https://www.medicare.gov/publications/10184-medicare-and-your-mental-health-benefits.pdf.

Silver Sneakers: NOT This physical fitness program at gyms is offered as an "extra" by Advantage Plans, as well as some Medigaps. But Medicare doesn't cover it.

Spiritual counseling: PART A This is offered to people in Hospice, which is a Part A benefit.