McLaren Flint

Discharge Planning Written Notice of Potential Financial Liability

Notifier: McLaren-Flint Hospital, 401 S. Ballenger Hwy, Flint, MI 48532, phone (810) 342-3096

Medicare does not pay for everything, even some supplies or services that your health care provider has recommended for you related to your total joint replacement. As part of your discharge planning, Medicare requires that the hospital inform you about potential financial liability for non-covered items or services presented to you. Read this notice so you can make an informed decision about your care. Ask questions and discuss any concerns or alternatives with your health care provider so that you can make a decision about the recommendations. Some of the uncovered charges may be covered if you have supplemental insurance coverage, and this will vary from plan to plan. Specific questions regarding the cost of the item or service can be addressed with the provider of the service or equipment. You can check coverage by calling Medicare at 1-800-MEDICARE or visiting the website https://www.mymedicare.gov/ and contacting your insurance company if you have a secondary or supplemental policy.

The following is a description of services or supplies that may not be covered by Medicare either completely or in part:

Durable Medical Equipment (DME)

Medicare Part B (Medical Insurance) partially covers walkers, including rollators, as durable medical equipment (DME) that's medically necessary and prescribed by your doctor or other treating provider for use in your home. If your supplier accepts assignment, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. Medicare pays for different kinds of DME in different ways. Depending on the type of equipment, you may have the options of renting the equipment, buying the equipment, or you may be able to choose whether to rent or buy the equipment.

Certain items are not covered, even with a doctor's prescription. This includes knee walkers and bathroom equipment such as raised toilet seats, grab bars, tub bench.

Skilled Nursing Facility (SNF)

Skilled nursing facilities (nursing homes) may be covered if medically necessary to treat a disease or condition, and if patient has had a qualifying hospital admission with a 3-day inpatient stay. You pay $0 for days 1-20, $161 per day coinsurance for days 21-100, all costs for days 101 and beyond. After January 1st of 2017, CMS waives the requirement for a 3-day stay for coverage of a SNF stay for a CJR beneficiary. However, the waiver applies only if the SNF is identified on the applicable calendar quarter list of the qualified SNFs at the time of CJR beneficiary admission to the SNF as of January 1, 2017.

Long-Term Care (also called custodial care) is not covered under Medicare

Home Infusion Services

IV Antibiotics for home infusion are not covered under Medicare Part A, but a percentage of the IV antibiotic itself is generally covered under Medicare Part D, requiring copay from the patient. The percentage covered will depend on the specific Part D plan each patient has. Aside from the antibiotic itself, Medicare does NOT pay for the supplies required to infuse the medication or to care for the IV site itself. Items NOT covered will include items like the IV bag used to contain the medication, IV tubing, IV flushing solutions such as saline or heparin, the cost of mixing the medication for infusion, or the delivery of the medication to the patient's home. The infusion company will also charge the patient a daily fee for services, and those fees will differ from one company to another. For patients who also have Medicaid as a secondary payer, all items are covered, and the copay / out of pocket for the medication itself is also reduced.

Outpatient Therapy

Medicare law limits how much it pays for your medically necessary outpatient therapy services in one calendar year. These limits are called "therapy caps" or "therapy cap limits". After you pay your yearly deductible for Medicare Part B (Medical Insurance), Medicare pays its share (80%), and you pay your share (20%) of the cost for therapy services. For more information about coverage for outpatient therapy and for specific annual therapy cap limits, contact Medicare.

Other -

This notice gives our opinion and is not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227 / TTY: 1-877-486-2048) or visiting Medicare's website at https://www.mymedicare.gov/

Signing below means that you understand and have received a copy of this notice.

_____ _____

Patient Signature Date/Time

_____ _____

Witness Signature Date/Time

PT.

MR.#/P

DR.