What inpatient hospital services are paid for under Part A (Hospital Insurance)?

Subject to a deductible and coinsurance, Medicare Part A (Hospital Insurance) pays for inpatient hospital service for up to ninety days in each “benefit period” (also called a “spell of illness”). Medicare will also pay (except for a coinsurance amount) for sixty additional hospital days over each person’s lifetime (called the “lifetime reserve” days).

Medicare pays for hospital care if the patient meets the following four conditions: (1) a physician prescribes inpatient hospital care for treatment of an illness or injury, (2) the patient requires the kind of care that can be provided only as an inpatient in a hospital, (3) the hospital is participating in Medicare (except in certain emergency situations), and (4) the utilization review committee of the hospital, a Quality Improvement Organization (QIO), or the applicable Medicare Administrative Contractor (MAC) does not disapprove of the stay.

The patient must pay a deductible of $1,260 in 2015 for the first sixty days in each benefit period. If the stay is longer than sixty days during a benefit period, coinsurance of $315 a day must be paid for each additional day up to a maximum of thirty days.

Thus, a ninety-day stay in 2015 would cost the patient $10,710. After ninety days, the patient pays the full bill unless the lifetime reserve of sixty days is drawn upon. The patient must pay coinsurance of $630 a day for each of the sixty additional lifetime reserve days.

The coinsurance amounts are based on those in effect when services are furnished, rather than on those in effect at the beginning of the beneficiary’s benefit period.

A “benefit period” is a way of measuring the patient’s use of services under Part A (Hospital Insurance). A new ninety-day benefit period starts with each new spell of illness, beginning with the day a patient begins receiving inpatient hospital care. A benefit period ends when the patient has been out of a hospital or other facility primarily providing skilled nursing or rehabilitative services for sixty days in a row (including the day of discharge). After one benefit period has ended, another one will start whenever the patient again receives inpatient hospital care.

There is no limit to the number of ninety-day benefit periods a person can have in a lifetime (except in the case of hospitalization in a psychiatric hospital for mental illness), but the lifetime reserve of sixty days is not renewable. Also, special limited benefit periods apply to hospice care.

Specifically, what inpatient hospital services are paid for under Part A (Hospital Insurance)?

***Example 1*:** Mr. Smith enters the hospital on February 5. He is discharged on February 15. He has used 10 days of his first benefit period. Mr. Smith is not hospitalized again until August 20. Since more than 60 days have elapsed between his hospital stays, he begins a new benefit period in August. Part A (Hospital Insurance) will again pay for up to 60 days of inpatient hospital coverage, subject to Mr. Smith’s payment of the deductible, and another 30 days subject to Mr. Smith’s payment of coinsurance.

***Example 2***: Mr. Jones enters the hospital on September 14. He is discharged on September 24. He also has used 10 days of his first benefit period. He is then readmitted to the hospital on October 20. Because fewer than 60 days have elapsed between hospital stays, Mr. Jones remains in the same benefit period and will not be required to pay another hospital deductible when he re-enters the hospital on October 20. This means that the first day of his second admission is counted as the eleventh day of hospital care in that benefit period. Mr. Jones will not begin a new benefit period until he has been out of the hospital (and has not received any skilled care in a skilled nursing facility) for 60 consecutive days.

“Lifetime reserve” days include an extra sixty hospital days a patient can use if the patient has a long illness and needs to stay in the hospital for more than ninety days. A patient has only sixty reserve days in a lifetime. For example, if a patient uses eight reserve days in that individual’s first hospital stay covered under Medicare Part A, he or she will have only fifty-two reserve days left to use during subsequent hospital stays, whether or not such stays fall within new benefit periods. A patient can decide when and whether to use lifetime reserve days.

If a patient does not want to use lifetime reserve days, the patient must tell the hospital in writing, either at the time of admission or at any time up to ninety days after discharge. If a patient uses reserve days and then decides that he or she did not want to use them, the patient must request approval from the hospital to have the lifetime reserve days restored. A patient must pay the full hospital costs for any day after the first ninety days in a benefit period if the patient is not using lifetime reserve days to offset the costs after the ninety days. During 2015, Part A (Hospital Insurance) pays for all covered services except $630 a day for each reserve day the patient uses.

What inpatient hospital services are paid for under Part A (Hospital Insurance)?

Medicare beneficiaries have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of their illness or injury. Under federal law, a beneficiary’s discharge date must be determined solely by medical needs, not by the diagnosis-related group (DRG) or Medicare payments. Beneficiaries have the right to be fully informed about decisions affecting their Medicare coverage and payment for their hospital stay and for any post-hospital services. They also have the right to request a review by a quality improvement organization (QIO) of any written notice of noncoverage they receive from the hospital stating that Medicare will no longer pay for their hospital care. QIOs are usually groups of physicians who are paid by the federal government to review medical necessity, appropriateness and quality of hospital treatment furnished to Medicare patients.

The following inpatient services are covered by Part A (Hospital Insurance):

* *Bed and board in a semiprivate room* (two to four beds) or a ward (five or more beds). Part A (Hospital Insurance) will pay the cost of a private room only if it is required for medical reasons (e.g., the patient needs isolation for medical reasons or needs immediate hospitalization and no other accommodations are available). If the patient requests a private room, Part A will pay the cost of semiprivate accommodations; the patient must pay the extra charge for the private room. The patient or family must be told the amount of this extra charge when a private room is requested. Normally, Medicare patients are assigned to semiprivate rooms. Ward assignments are made only under extraordinary circumstances.
* *All meals*, including special diets.
* *Nursing services* provided by or under the supervision of licensed nursing personnel (other than the services of a private duty nurse or attendant).
* Services of the hospital’s *medical social workers*.
* Use of regular hospital *equipment*, *supplies, and appliances*, such as oxygen tents, wheel chairs, crutches, casts, surgical dressings, splints, and hospital “admission packs” (toilet articles) when routinely furnished by the hospital to all patients. Certain equipment, supplies and appliances used by the patient in the hospital continue to be covered after the patient has been discharged. Examples include a cardiac pacemaker and an artificial limb.

What inpatient hospital services are paid for under Part A (Hospital Insurance)?

* *Drugs and biologicals* ordinarily furnished by the hospital. A limited supply of drugs needed for use outside the hospital is also covered, but only if medically necessary in order to facilitate the patient’s departure from the hospital and the supply is necessary until the patient can obtain a continuing supply. Drugs and biologicals that the hospital obtains for the patient from a private source (community pharmacy) are covered when the hospital is responsible for making payment to the supplier.
* *Diagnostic or therapeutic items and services* ordinarily furnished by the hospital or by others (including clinical psychologists, as defined by the Centers for Medicare & Medicaid Services), under arrangements made with the hospital.
* *Operating and recovery room costs*, including hospital costs for anesthesia services.
* Services of *interns and residents in training* under an approved teaching program.
* *Blood transfusions*, after the first three pints. Part A (Hospital Insurance) helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If the patient receives blood as an inpatient of a hospital or skilled nursing facility, Part A will pay for these blood costs, except for any non-replacement fees charged for the first three pints of whole blood or units of packed red cells per calendar year. The non-replacement fee is the amount that some hospitals and skilled nursing facilities charge for blood that is not replaced. The patient is responsible for the non-replacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. If the patient is charged non-replacement fees, the patient has the option of either paying the fees or having the blood replaced. If the patient chooses to have the blood replaced, the patient can either replace the blood personally or arrange to have another person or an organization replace it. A hospital or skilled nursing facility cannot charge a patient for any of the first three pints of blood that the patient replaces or arranges to replace. If the patient has already paid for or replaced blood under Part B (Medical Insurance) of Medicare during the calendar year, the patient does not have to meet those costs again under Part A.
* *X-rays* and other radiology services, including radiation therapy, billed by the hospital.

What inpatient hospital services are paid for under Part A (Hospital Insurance)?

* *Lab tests*.
* *Respiratory or inhalation therapy*.
* *Independent clinical laboratory services* under arrangement with the hospital.
* *Alcohol detoxification and rehabilitation services* when furnished as inpatient hospital services. Alcohol detoxification and rehabilitation services may also be covered under Part B (Medical Insurance) when furnished as physician services.
* *Dental services* when the patient requires hospitalization because of the severity of the dental procedure or because of the patient’s underlying medical condition and clinical status.
* Cost of *special care units*, such as an intensive care unit, coronary care unit, etc.
* *Rehabilitation services*, such as physical therapy, occupational therapy, and speech pathology services.
* *Appliances* (such as pacemakers, colostomy fittings, and artificial limbs) that are permanently installed while the patient is in the hospital.
* *Lung and heart-lung transplants*.

Part A (Hospital Insurance) does not pay for:

* Services of physicians and surgeons, including the services of pathologists, radiologists, anesthesiologists, and physiatrists. (Part A [Hospital Insurance] also does not pay for the services of a resident physician or intern other than those provided by an intern or resident in training under an approved teaching program.)
* Services of a private duty nurse or attendant, unless the patient’s condition requires such services and the nurse or attendant is a bona fide employee of the hospital.
* Personal convenience (comfort) items supplied at the patient’s request, such as television rental, radio rental, or telephone.
* The first three pints of whole blood (or packed red blood cells) received in a calendar year.

What inpatient hospital services are paid for under Part A (Hospital Insurance)?

* Supplies, appliances and equipment for use outside the hospital, unless continued use is required (e.g., a pacemaker).