Adapted from DiabetesInControl.com

Understanding Medicare and Medicaid Coverage for Patients with Diabetes

Eric Sternberg, OneSource Medical Group

Medicare is our country's basic health insurance program for people 65 years of age or older, or those people with disabilities who qualify.

Medicare has four parts and you should understand the basic definitions as it applies to your benefits.

Part A – This covers hospital insurance, helps to pay for inpatient hospital care, skilled nursing facilities, rehab centers, and additional follow up services.

Part B - This helps pay for doctor visits, outpatient care, and additional other medical services such as DME supplies (Durable Medical Equipment). Part B covers theses services up to 80% of what Medicare reimburses for these services leaving the remaining 20% to the patient. The great news is most Part B recipients have secondary or supplemental coverage that cover the remaining 20%. In the case that the patient does not have additional coverage they can contact the Centers for Medicare and Medicaid at www.medicare.gov for financial help.

Part C – This coverage is available in many parts of the country. This refers to Medicare Advantage Plans, such as HMOs and PPOs, and the coverage is dependent on the financial contribution of the patient and the plans that are chosen. These plans should be explored at great length based on the financial commitment and the financial return the patient will receive in coverage.

Part D – This plan was designed by Medicare to help recipients pay for their prescriptions for pharmaceutical therapy. It's important that patients use this benefit for their pharmacy items and not their DME Benefits. Each patient should contact the Social Security Administration to find out how much money they have allocated in this benefit to best use Part D.

It is important that patients recognize the difference between Medicare and Medicaid. Medicare is a national program as described above, while Medicaid is typically run by state and state welfare programs and is designed to help persons of low income and limited resources. Since this will vary from state to state it is important that recipients understand what plans fit them best.

Now that we have an overview of government run healthcare programs it's important that we understand how choosing coverage affects those people with diabetes.

Part A – While this covers hospital and inpatient services, patients who require diabetes supplies are covered by Part A when they are an inpatient. It is important that you let your supplier know when you are in the hospital so they do not ship you product as they will not be able to bill on your behalf.

Part B - There is a yearly cost, (out of pocket deductible), that must be met prior to Medicare covering for your DME and diabetes supplies. Typically patients meet this deductible in the first few weeks of the year as they have doctor visits. Again, as stated in the first page, Medicare will cover 80% of patients' supplies leaving the remaining 20% to be covered by the patient, typically by their secondary or supplemental insurance. If the patient doesn't have this additional coverage they can request financial hardship if they qualify and visit www.medicare.gov for financial guidance.

Part C - These Advantage Plans can help patients with parts A, B, & D plans, but again, each plan has different premiums which can be costly for patients and limit DME products and medical services, so it is important that patients make good choices if they pursue this benefit path.

Part D - It is important that this benefit only be used for your pharmacy items. While DME/diabetes supplies can be covered under this plan, this can prove to be financially restrictive to patients with diabetes. Patients who use this coverage for their diabetes supplies will pay a premium. They will be expected to pay a co-pay out of their pocket and the rest of their retail payment for these supplies will be pulled from the Part D bucket causing the patient to hit their financial "Donut Hole" at a faster pace.

What does Part B cover for Diabetes Supplies?

Part B will cover a new Blood Glucose Meter every five years, a new Lancet Device every six months, 90 days worth of test strip supplies, 90 days of lancets, syringes, 90 days of Insulin Pump supplies for patients on an Insulin Pump. If a patient is on an Insulin Pump then Part B will pay for insulin. Patients not using insulin are covered for one testing per day; patients on insulin are covered for 3 times per day testing. Although your doctor can write a prescription order for more or less testing utilization, the patient must substantiate that order with a written statement every six months supporting their testing habits. This will allow for Medicare to cover and reimburse for your testing utilization. Again Part B will only cover these supplies at 80% leaving the remaining 20% for the patient to cover with their additional coverage, pay out of pocket, or qualify for federal assistance.

It is critical that a patient who has Part B coverage use a DME (Durable Medical Equipment) company that is qualified to accept assignment to bill Medicare on behalf of the patient. The patient should ask their healthcare professional team if they have a preferred company as these companies should be nationally accredited and hold a national Medicare license and should also hold a Medicaid license as well as an HME (Home Medical Equipment) license in order to service patients with diabetes appropriately. Patients who have Part B coverage should not pay any money up front for their diabetes supplies. If they are then they are not using their benefits to the best advantage. These patients should ask their healthcare team how to best use their benefits or again visit www.medicare.gov to ask questions.