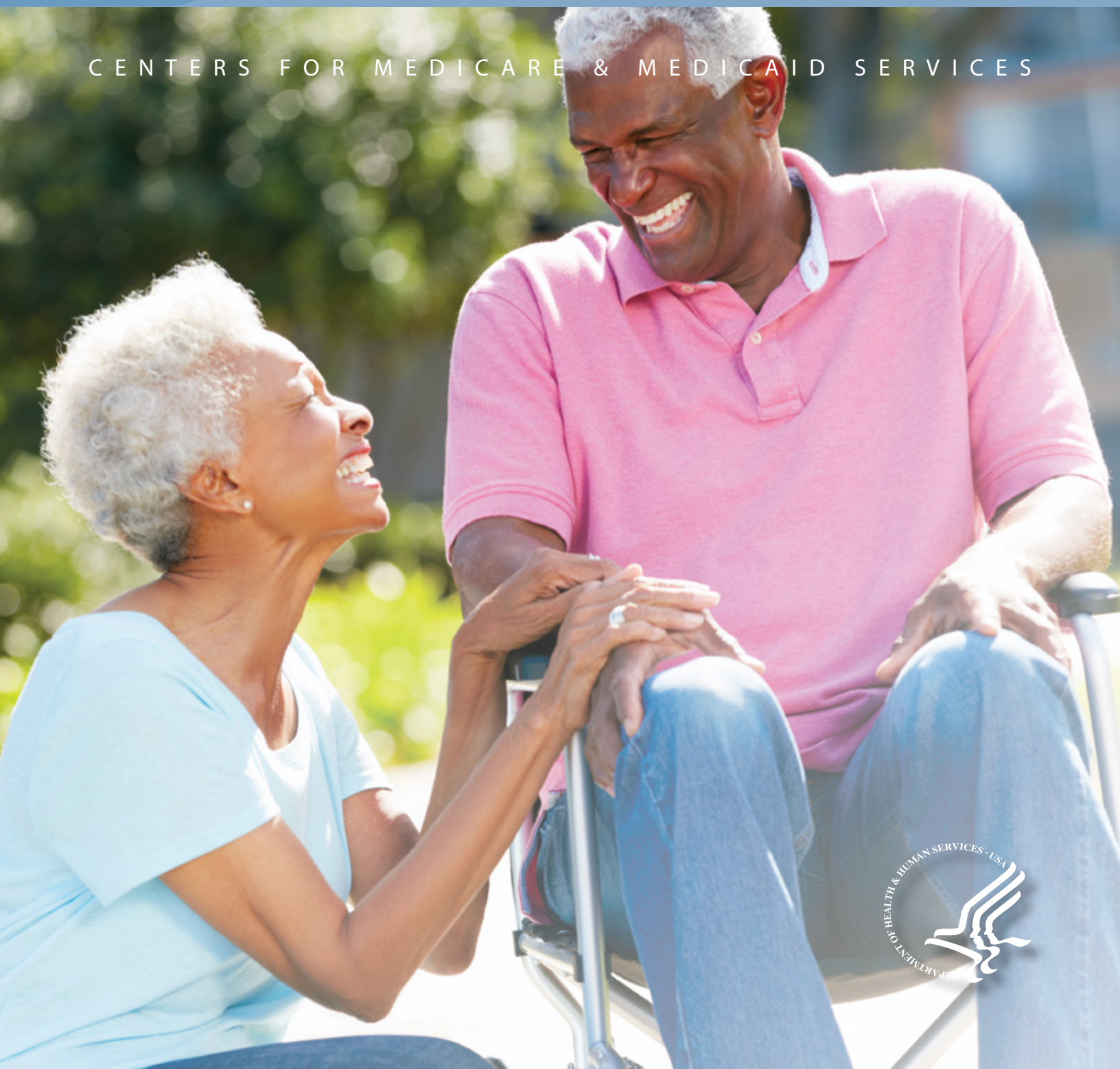
Medicare Coverage of Cancer Treatment Services

CENTERS FOR MEDICARE & MEDICAID SERVICES



If you or a loved one has been diagnosed with cancer, you may be concerned about which oncology (cancer treatment) supplies, services, and prescription drugs Medicare will cover.

This booklet explains Medicare coverage of medically necessary cancer treatment supplies, services, and prescription drugs in Original Medicare (Part A and Part B), Medicare Advantage Plans (Part C), and Medicare Prescription Drug Plans (Part D). For more information, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Medicare Coverage of Cancer Treatment Services isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

The information in this booklet describes the Medicare program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

What Medicare covers

Medicare Part A (Hospital Insurance)

Generally, Part A covers medically-necessary cancer-related services and treatments that are provided while you're an inpatient in a hospital.

Part A covers:

- Inpatient hospital stays, including cancer treatments you get while you're an inpatient in the hospital. You may be in a hospital and still be considered an outpatient (called observation status). If you're unsure if you're an inpatient, ask the hospital staff.
- Skilled nursing facility care (following a 3-day related hospital stay).
- Home health care (like rehabilitation services for physical therapy, speech-language pathology therapy, occupational therapy, or skilled nursing care).
- Hospice care.
- Blood.
- Some costs of clinical research studies while you're an inpatient in the hospital.
- Surgically-implanted breast prostheses after a mastectomy if the surgery takes place in an inpatient setting.

Medicare Part B (Medical Insurance)

Part B covers many medically-necessary cancer-related services and treatments provided on an outpatient basis. You may be in a hospital and still be considered an outpatient (observation status). Part B also covers some preventive services for people who are at risk for cancer. For some services, you must meet certain conditions.

Part B covers:

- Doctors' visits.
- Many chemotherapy drugs that are administered through your vein in an outpatient clinic or a doctor's office.
- Some oral chemotherapy treatments.
- Radiation treatments given in an outpatient clinic.
- Diagnostic tests like X-rays and CT scans.
- Durable medical equipment (DME) like wheelchairs and walkers.
- Outpatient surgeries.
- Mental health services, including services that are usually provided outside a hospital (like in a clinic, doctor's office, or therapist's office) and services provided in a hospital's outpatient department.
- Nutritional counseling if you have diabetes or kidney disease.
- Certain preventive and screening services.
- Enteral nutrition equipment (feeding pump) as DME that your doctor prescribes for use in your home, and certain nutrients if you can't absorb nutrition through your intestinal tract or you can't take food by mouth.
- Some costs of clinical research studies while you're an outpatient.
- Breast prostheses (external breast prostheses, including a post-surgical bra) after a mastectomy. Part B covers surgically implanted breast prostheses after a mastectomy if the surgery takes place in an outpatient setting.
- In some cases, a second opinion for surgery that isn't an emergency, and a third opinion if the first and second opinions are different.

What you pay for services

Copayments, coinsurance, or deductibles may apply for each service. Talk to your doctor or other health care provider to find out how they charge for a specific test, item or service and how much it will cost. The specific amount you'll owe may depend on several things, like whether your doctor or other health care provider accepts assignment, the type of facility, other insurance you may have, and the location where you get your test, item, or service.

Medicare may have maximum payment amounts on certain types of services and may not provide coverage for some services. Your doctor or other health care provider may recommend you get services more often than Medicare covers. Or, they may recommend services that Medicare doesn't cover. If this happens, you may have to pay some or all of the costs. It's important to ask questions so you understand why your doctor is recommending certain services and whether, or how much, Medicare will pay for them.

Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get cost information. TTY users can call 1-877-486-2048.

Medicare doesn't cover:

- Room and board in assisted living facilities.
- Adult day care.
- Long-term nursing home care.
- Medical food or nutritional supplements (except enteral nutrition equipment).
- Services that help you with activities of daily living (like bathing and eating) that don't require skilled care.

Medicare coverage other than Original Medicare

Medicare Advantage Plans (Part C)

Medicare Advantage Plans (like HMOs or PPOs) combine Part A, Part B, and sometimes, Part D (prescription drug coverage) coverage. If you're in a Medicare Advantage Plan or another type of Medicare health plan, your plan must give you at least the same coverage as Original Medicare, but it may have different rules and costs. Because these services may cost more if the provider doesn't participate in your health plan, ask if your provider accepts your plan when scheduling your appointment. Read your plan materials, or call your plan for more information about your benefits.

Medicare coverage other than Original Medicare (continued)

Medicare prescription drug coverage (Part D) for chemotherapy and other cancer-related drugs and supplies

Medicare offers prescription drug coverage to everyone with Medicare. To get drug coverage, you must be enrolled in a Medicare Prescription Drug Plan (or belong to a Medicare Advantage Plan with Part D coverage). Medicare prescription drug coverage isn't automatic.

Part D covers most prescription medications and some chemotherapy treatments and drugs. If Part B doesn't cover a cancer drug, your Part D plan may cover it. It's important to check with your plan to make sure your drugs are on the plan's formulary (list of covered drugs) and to check the tier in which the drug is listed. This affects your out-of-pocket costs. Read your plan materials, or call your plan for more information about your drug coverage.
Visit Medicare.gov/find-a-plan to compare Medicare drug plans.

These cancer drugs may be covered under Part D:

- Prescription drugs for chemotherapy only available to be taken by mouth
- Anti-nausea drugs
- Other prescription drugs used in the course of your cancer treatment, like pain medication

Medigap (Medicare Supplement Insurance) Policies

If you have other insurance that supplements Original Medicare, like a Medigap (Medicare Supplement Insurance) policy or a group health plan, it may pay some of the costs for the services and supplies described in this booklet. Medigap policies are sold by private companies and help pay certain out-of-pocket costs, like deductibles, coinsurance, and copayments. For more information about Medigap, visit Medicare.gov/supplement-other-insurance or contact your plan.

Changing Medicare coverage

After getting a cancer diagnosis, speaking with your health care providers, and reviewing your current Medicare coverage, you may want to look at other health coverage options based on your needs. However, it's important to remember that there are certain limitations on what changes you can make and when. Each year, you have a chance to make changes to your Medicare health and prescription drug coverage. for the following year. Each year, plans can change in cost and benefits. It's in your best interest to compare the plans available in your area each year to ensure you have the plan that best meets your needs. Visit Medicare.gov/find-a-plan to compare plans.

Changing Medicare coverage (continued)

1. **During the Medicare Open Enrollment Period (October 15 – December 7 each year with coverage starting January 1 of the following year)**
   - **What can I do?**
     - Change from Original Medicare to a Medicare Advantage Plan.
     - Change from a Medicare Advantage Plan back to Original Medicare.
     - Switch from one Medicare Advantage Plan to another Medicare Advantage Plan.
     - Switch from a Medicare Advantage Plan that doesn't offer drug coverage to a Medicare Advantage Plan that offers drug coverage.
     - Switch from a Medicare Advantage Plan that offers drug coverage to a Medicare Advantage Plan that doesn't offer drug coverage.
     - Join a Medicare Prescription Drug Plan.
     - Switch from one Medicare Prescription Drug Plan to another Medicare Prescription Drug Plan.
     - Drop your Medicare prescription drug coverage completely.
2. **Medicare Advantage Disenrollment Period (January 1–February 14)**
   - **What can I do?**
     - If you're in a Medicare Advantage Plan, you can leave your plan and switch to Original Medicare.
     - If you switch to Original Medicare during this period, you'll have until February 14 if you want to also join a Medicare Prescription Drug Plan, adding drug coverage. Your coverage will begin the first day of the month after the plan gets your enrollment form.
   - **What can't I do?**
     - Switch from Original Medicare to a Medicare Advantage Plan.
     - Switch from one Medicare Advantage Plan to another.
     - Switch from one Medicare Prescription Drug Plan to another.
     - Join, switch, or drop a Medicare Medical Savings Account (MSA) Plan.
     - Join, switch, or drop a Medicare Prescription Drug Plan unless you dropped a Medicare Advantage Plan during this period.

   For more information on enrolling in Medicare or changing plans, visit Medicare.gov/sign-up-change-plans.

Appealing coverage and payment decisions

An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You have the right to appeal if Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan denies one of these:

- A request for a health care service, supply, item, or prescription that you think you should be able to get
- A request for payment of a health care service, supply, item, or a prescription drug you already got
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug

You can also appeal if Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Medicare health and drug plans will also have a transition process in place if you're new to the plan and taking a drug that isn't on the plan's formulary. The plan must let you get a 30-day temporary supply of the prescription (a 91-day supply if you're a resident of a long-term care facility). This gives you time to work with your prescribing doctor to find a different drug that's on the plan's formulary. If an acceptable alternative drug isn't available, you or your doctor can request an exception from the plan, and you can appeal denied requests. Visit Medicare.gov/appeals for more information on how to file an appeal.

For more information

- Visit Medicare.gov to:
  - Learn more about what Medicare covers
  - Find and compare doctors, hospitals, and other providers
  - Find suppliers of durable medical equipment (DME) and medical supplies
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Look at topic-specific publications at Medicare.gov/publications.
- Call your State Health Insurance Assistance Program (SHIP) to get free personalized health insurance counseling. To get the phone number for your state, visit shiptacenter.org, or call 1-800-MEDICARE.

Definitions

Assignment: An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance: An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Copayment: An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Deductible: The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Durable medical equipment (DME): Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Exception: A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its drug list or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that's on its non-preferred drug tier. You or your prescriber must request an exception, and your doctor or other prescriber must provide a written supporting statement explaining the medical reason for the exception.

Hospice: A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Medicare Advantage Plan (Part C): A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Prescription Drug Plan (Part D): Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Original Medicare: Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Tiers: Groups of drugs that have a different cost for each group. Generally, a drug in a lower tier will cost you less than a drug in a higher tier.

Notice of Availability of Auxiliary Aids & Services

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Relay service — TTY users can call 1-877-486-2048.

Alternate formats

- To request other Medicare publications in alternate formats, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. To request the Medicare & You handbook in an alternate format, visit Medicare.gov/medicare-and-you.
- For all other CMS publications:
  - Call 1-844-ALT-FORM (1-844-258-3676). TTY users can call 1-844-716-3676.
  - Send a fax to 1-844-530-3676.
  - Send an email to AltFormatRequest@cms.hhs.gov.
  - Send a letter to: Centers for Medicare & Medicaid Services Offices of Hearings and Inquiries (OHI), 7500 Security Boulevard, Room S1-13-25, Baltimore, MD 21244-1850, Attn: CMS Alternate Format Team

Note: Your request for a CMS publication should include your name, phone number, mailing address where we should send the publications, and the publication title and product number, if available. Also include the format you need, like Braille, large print, audio CD, or a qualified reader.

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- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing:

  Office for Civil Rights
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

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