



News Flash – A new publication titled Medicare Outpatient Therapy Billing is now available in downloadable format from the Medicare Learning Network® at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Outpatient_Therapy_Billing_ICN903663.pdf on the CMS website. This publication provides information about Medicare outpatient physical therapy, occupational therapy, and speech-language pathology (therapy services) coverage requirements; calendar year 2010 therapy codes and dispositions; and billing measures for therapy services.

MLN Matters® Number: MM7224

Related Change Request (CR) #: 7224

Related CR Release Date: November 19, 2010

Effective Date: January 1, 2011

Related CR Transmittal #: R65GI

Implementation Date: January 3, 2011

Update to Medicare Deductible, Coinsurance and Premium Rates for 2011

Note: This article was updated on September 4, 2012, to reflect current Web addresses. All other content remains the same.

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Impact on Providers

This article is based on Change Request (CR) 7224 which provides the Medicare rates for deductible, coinsurance, and premium payment amounts for Calendar Year (CY) 2011.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

Background

2011 Part A - Hospital Insurance (HI)

A beneficiary is responsible for an inpatient hospital deductible amount, which is deducted from the amount payable by the Medicare program to the hospital for inpatient hospital services furnished in a spell of illness.

When a beneficiary receives such services for more than 60 days during a spell of illness, he or she is responsible for a coinsurance amount that is equal to one-fourth of the inpatient hospital deductible per-day for the 61st-90th day spent in the hospital.

Note: An individual has 60 lifetime reserve days of coverage, which they may elect to use after the 90th day in a spell of illness. The coinsurance amount for these days is equal to one-half of the inpatient hospital deductible.

In addition, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible per day for the 21st through the 100th day of Skilled Nursing Facility (SNF) services furnished during a spell of illness. **The 2011 inpatient deductible is \$1,132.00.** The coinsurance amounts are shown below in the following table:

Hospital Coinsurance		Skilled Nursing Facility Coinsurance
Days 61-90	Days 91-150 (Lifetime Reserve Days)	Days 21-100
\$283.00	\$566.00	\$141.50

Most individuals age 65 and older (and many disabled individuals under age 65) are insured for Health Insurance (HI) benefits without a premium payment. In addition, The Social Security Act provides that certain aged and disabled persons who are not insured may voluntarily enroll, but are subject to the payment of a monthly Part A premium. Since 1994, voluntary enrollees may qualify for a reduced Part A premium if they have 30-39 quarters of covered employment. When voluntary enrollment takes place more than 12 months after a person's initial enrollment period, a 2-year 10% penalty is assessed for every year they had the opportunity to (but failed to) enroll in Part A. The 2011 Part A premiums are as follows:

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.

Voluntary Enrollees Part A Premium Schedule for 2011	
Base Premium (BP)	\$450.00 per month
Base Premium with 10% Surcharge	\$495.00 per month
Base premium with 45% Reduction (for those with 30-39 quarters of coverage)	\$248.00 (for those who have 30-39 quarters of coverage)
Base premium with 45% Reduction and 10% surcharge	\$272.80 per month

2011 Part B - Supplementary Medical Insurance (SMI)

Under Part B, the Supplementary Medical Insurance (SMI) program, all enrollees are subject to a monthly premium. In addition, most SMI services are subject to an annual deductible and coinsurance (percent of costs that the enrollee must pay), which are set by statute. Further, when Part B enrollment takes place more than 12 months after a person’s initial enrollment period, there is a permanent 10% increase in the premium for each year the beneficiary had the opportunity to (but failed to) enroll.

For 2011, the standard premium for SMI services is \$115.40 a month; the deductible is \$162.00 a year; and the coinsurance is 20%. The Part B premium is influenced by the beneficiary’s income and can be substantially higher based on income. The higher premium amounts and relative income levels for those amounts are contained in CR 7224, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R65G1.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Additional Information

The official instruction, CR 7224, issued to your carriers, DME MACs, FIs, A/B MACs, and RHHIs regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R65G1.pdf> on the CMS website.

If you have any questions, please contact your carriers, DME MACs, FIs, A/B MACs, or RHHIs at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

Disclaimer
 This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2009 American Medical Association.