



Revised March 2015

Quick Facts About Payment for Outpatient Services for People with Medicare Part B

This fact sheet explains how Medicare pays for covered hospital outpatient department services if you have Medicare Part B (Medical Insurance) and Original Medicare. If you're in a Medicare Advantage Plan (like an HMO or PPO), the plan's rules apply.

Medicare Part B pays for many of the outpatient services you get in hospitals, like X-rays and emergency department visits. Part B also pays for partial hospitalization services in hospital outpatient departments and community mental health centers under the outpatient prospective payment system.

How the outpatient prospective payment system works

Under the outpatient prospective payment system, hospitals are paid a set amount of money (called the payment rate) to provide certain outpatient services to people with Medicare. For most services, you must pay the yearly Part B deductible before Medicare pays its share. Once you meet the deductible, Medicare pays most of the total payment and you pay a copayment. For some services, you don't need to meet the yearly Part B deductible before Medicare pays (for example, screening mammography). The payment rate isn't the same for all hospitals because it's adjusted to reflect what people are paid to work in the area where the hospital is located. It's also adjusted for other factors each year.

Part B services paid for under this system include, but aren't limited to, the following:

- X-rays (radiology)
- Stitches for a cut
- The hospital charge for an emergency department or hospital clinic visit (doesn't include an amount for the doctor's services)
- Getting a cast
- Surgery that's safe to perform on an outpatient basis
- Observation to decide if you need inpatient care for an illness or injury
- The administration of certain drugs that you usually can't give yourself

Part B services paid for under this system (continued)

Medicare also uses the outpatient prospective payment system to pay for some services you get from other facilities, including the following:

- Splints, antigens, and casts you get from a home health agency if you're not under a home health plan of care
- Splints, antigens, and casts when provided for a hospice beneficiary, for a condition unrelated to his or her terminal illness and related conditions
- Partial hospitalization services you get from a hospital outpatient department or community mental health center

What you pay

For most services, you (or your supplemental coverage) pay the following:

- The yearly Part B deductible if you haven't already paid it for the year.
- A copayment amount for each service you get in an outpatient visit. For each service, this amount generally can't be more than the Part A inpatient hospital deductible. If you get hospital outpatient services in a critical access hospital, your copayment may be higher and may exceed the Part A hospital stay deductible.
- All charges for items or services that Medicare doesn't cover.

Example: Mr. Davis needs to have his cast removed. He goes to his local hospital outpatient department. The hospital charges \$150 for this procedure. His copayment amount for this procedure, under the outpatient prospective payment system, is \$20. Mr. Davis has paid \$85 of his \$155 Part B deductible. To have his cast removed, Mr. Davis must pay \$90 (\$70 remaining deductible amount + \$20 copayment amount).

The amount you pay may change each year. The amount you pay may also be different for different hospitals.

Note: If you have a Medigap (Medicare Supplement Insurance) policy, other supplemental coverage, or employer or union coverage, it may pay the Part B deductible and copayment amounts.

If you paid more than the amount listed on your Medicare Summary Notice

After Medicare gets a bill from the hospital, you will get a Medicare Summary Notice. This notice will show how much you have to pay for the services you got. It will also show how much Medicare paid the hospital for the services. If the amount you paid the hospital or community mental health center at the time of service is more than what was listed on the Medicare Summary Notice, call the provider and ask for a refund. Tell them you paid more than the amount listed on the Medicare Summary Notice.

If you paid less than the amount listed on your Medicare Summary Notice

If you paid less than the amount listed on your Medicare Summary Notice, the hospital or community mental health center may bill you for the difference if you don't have another insurer who is responsible for paying your deductible and copayments.

Your Medicare rights

If you have Medicare, you have certain guaranteed rights to help protect you. One of these is the right to appeal. You may want to appeal in any of the following situations:

- You don't agree with the amount that is paid.
- A service or item isn't covered, and you think it should be.
- A service or item is denied, and you think it should be paid.

The Medicare Summary Notice tells you how to appeal a Medicare decision. The appeals information is on the back. For more information about your rights and protections, visit www.medicare.gov to view the booklet "Medicare Rights and Protections."

If you're concerned about the quality of your care

If you think the hospital or community mental health center isn't giving you good quality care, call the Quality Improvement Organization in your state. Call 1-800-MEDICARE (1-800-633-4227) to get the telephone number. TTY users should call 1-877-486-2048.

