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1. What Medical Services are not Covered by Original Medicare -

Original Medicare covers costs associated with doctors and hospital services that are considered medically necessary. However, it generally does not cover services that are cosmetic or alternative health treatments. Routine dental, vision and hearing services are also not covered by Original Medicare unless they are related to a medical condition. For example, routine eye exams to determine a prescription for eyeglasses are not covered. However, Original Medicare would cover an eye exam for glaucoma. If you are in a hospital, Part A will cover emergency dental procedures and some dental services, but not dentures.

The following are additional services Original Medicare does not cover:

Nursing home care – Includes help with daily personal care such as bathing, dressing, and using the bathroom.

Nonmedical services – Includes canceled appointments for which you are charged, private hospital rooms, and any other no-medical services.

Routine foot care – Routine medical care for feet, such as callus removal, is not covered. However, Original Medicare will cover foot exams or treatment if it is related to a diabetes condition, or care for such foot issues as hammertoe, bunion deformities and heel spurs.

Care in foreign countries – With few exceptions, generally not covered. However, some secondary plans, like Emblem Health, may cover the service.

Hearing aids – Original Medicare will cover ear-related medical conditions but not hearing aids or routine hearing tests.

Concierge Care – Also known as concierge medicine. Concierge doctors who accept Medicare assignments must follow the Medicare rules; however, the amount of the membership fee is NOT covered.

2. Medicare Summary Notice – If you are on Medicare, you will receive a critical document called a Medicare Summary Notice (MSN) if you had a Medicare approved service (e.g., saw a doctor or were in a hospital). The MSN will be mailed to you every 3 months and will detail the services and any supplies you received, and how much Medicare will pay. It is NOT a bill, although it will inform you how much you may be billed, the providers involved, and whether Medicare approved your claims.

Review your MSN carefully for errors, such as a claim for a service you never received. If you don't believe it is correct, or if the claim is being denied, call your provider/physician first to ensure it was submitted with the correct information. If you decide to appeal, you need to do it with 120 days of the day you receive the MSN. Appeal information is on the MSN.

Staying vigilant with the MSN will not only help you manage your healthcare costs but also helps to reduce fraud and safeguard your health.

3. Question of the Month

Q. Does Medicare still cover physical therapy?

A. Yes, providing you have met your Medicare deductible of $257, and your doctor or other healthcare provider deems the therapy medically necessary. Medicare will cover 80 % of the cost (supplement covers the other 20%), with no limit on payment for outpatient physical therapy services. It can cover physical therapy at home, in a skilled nursing facility and in outpatient rehab facilities. Medicare coverage of physical therapy does, however, have some limitations, including an annual cap on the number of services covered and meeting specific progress in therapy.

If Medicare will no longer cover your therapy, you may avail yourself of the CSA Welfare Fund's physical therapy benefit. After an annual $100 deductible, the Fund will reimburse 80% of your cost up to $2,000. The amount should cover about 10 – 15 sessions, depending on where you receive the therapy.