CENTERS FOR MEDICARE & MEDICAID SERVICES

How Medicare Covers Self-Administered Drugs Given in Hospital Outpatient Settings

Medicare Part B (Medical Insurance) generally covers care you get in a hospital outpatient setting, like an emergency department, observation unit, surgery center, or pain clinic. Part B only covers certain drugs in these settings, like drugs given through an IV (intravenous infusion).

Sometimes people with Medicare need "self-administered drugs" while in hospital outpatient settings. "Self-administered drugs" are drugs you would normally take on your own. Part B generally doesn't pay for self-administered drugs unless they are required for the hospital outpatient services you're getting.

If you get self-administered drugs that aren't covered by Medicare Part B while in a hospital outpatient setting, the hospital may bill you for the drug. However, if you are enrolled in a Medicare drug plan (Part D), these drugs may be covered.

What you should know about Medicare drug plans (Part D) and self-administered drugs

- Generally, your Medicare drug plan only covers prescription drugs and won't pay for over-the-counter drugs, like Tylenol® or Milk-of-Magnesia®.
- Any drug you get needs to be on your Medicare drug plan's formulary (or covered by an exception).
- You can't get your self-administered drugs in an outpatient or emergency department setting on a regular basis.
- Your Medicare drug plan will check to see if you could have gotten these self-administered drugs from an in-network pharmacy.
- Since most hospital pharmacies don't participate in Medicare Part D, you may need to pay up front and out-of-pocket for these drugs and submit the claim to your Medicare drug plan for a refund. Check with your hospital to see if they participate in Part D.

If possible, bring any drugs (or a list of drugs you are taking) with you to the hospital and show them to the staff. It helps the hospital staff to know what drugs you take at home.

Here are some common questions and answers about how Medicare drug plans (Part D) cover self-administered drugs.

What should I do if I get a bill for self-administered drugs that aren't covered by Part B in a hospital outpatient setting?

- Follow the instructions in your Medicare drug plan's enrollment materials on how to submit an out-of-network claim, or call your plan for information about how to submit a claim.
- Your plan will ask you to send certain information, like the emergency room bill that shows what self-administered drugs you were given. You may also need to explain the reason for your hospital visit. Keep copies of any receipts and any paperwork you send your plan.

What will my Medicare drug plan do?

- Your Medicare drug plan will check to see if the drug is on your Medicare drug plan's formulary; otherwise, you may need to file an exception.
- Your plan may ask you if you could have reasonably gotten any of the drugs from a participating network pharmacy. For example, if you could have taken a dose of a drug that you got from your network pharmacy before your outpatient hospital appointment, your Medicare drug plan may not pay you back for that drug.
- If the drug is covered by your Medicare drug plan, your plan may only reimburse you the in-network cost for the drug minus any deductibles, copayments, or coinsurance that you would normally be charged for the drug.

What will I have to pay for self-administered drugs that aren't covered by Part B?

- If the drug is covered by your Medicare drug plan, you may need to pay the difference between what the hospital charged and what the plan paid in addition to any deductibles, copayments, or coinsurance you would normally pay. This amount counts towards your Part D out-of-pocket costs. You must submit the claim to your plan for it to count towards your out-of-pocket costs.
- If the drug isn't covered by your Medicare drug plan, you need to pay what the hospital charges for the drug. As mentioned above, you can always request an exception if your plan tells you a drug isn't on their formulary.

Where can I get more help?

- Call your State Health Insurance Assistance Program (SHIP). Every state and territory, plus Puerto Rico, the Virgin Islands and the District of Columbia, has a SHIP with counselors who can give you free health insurance information and help. To get the telephone number for your SHIP, visit www.medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- For information on how to appeal any decision made by your Medicare drug plan, check your plan's enrollment materials or call your plan.
- Call 1-800-MEDICARE.

Medicare.gov
The Official U.S. Government Site for Medicare

Your Medicare Coverage

Is my test, item, or service covered?

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Prescription drugs (outpatient) limited coverage

How often is it covered?

Medicare Part B (Medical Insurance) covers a limited number of outpatient prescription drugs under limited conditions. Generally, drugs covered under Part B are drugs you wouldn't usually give to yourself, like those you get at a doctor's office or hospital outpatient setting. Drugs not covered under Part B may be covered under a Medicare Prescription Drug Plan (Part D).

Examples of drugs covered by Part B:

Drugs used with an item of durable medical equipment: Medicare covers drugs infused through an item of durable medical equipment, like an infusion pump or drugs given by a nebulizer.

Some antigens: Medicare helps pay for antigens if they're prepared by a physician and given by a properly instructed person (who could be the patient) under appropriate supervision.

Injectable osteoporosis drugs: Medicare helps pay for an injectable drug for women with osteoporosis who meet the criteria for the Medicare home health benefit and have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis. A doctor must certify that the woman is unable to learn how to or unable to give herself the drug by injection. The home health nurse or aide won't be covered to provide the injection unless family and/or caregivers are unable or unwilling to give the woman the drug by injection.

Erythropoisis–stimulating agents: Medicare helps pay for erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or need this drug to treat anemia related to certain other conditions.

Blood clotting factors: If you have hemophilia, Medicare helps pay for clotting factors you give yourself by injection.

Injectable and infused drugs: Medicare covers most injectable and infused drugs given by a licensed medical provider.

Oral End-Stage Renal Disease (ESRD) drugs: Medicare helps pay for some oral ESRD drugs if the same drug is available in injectable form and covered under the Part B ESRD benefit.

Parenteral and enteral nutrition (intravenous and tube feeding): Medicare helps pay for certain nutrients for people who can't absorb nutrition through their intestinal tracts or can't take food by mouth.

Intravenous Immune Globulin (IVIG) provided in the home: Medicare helps pay for IVIG for people with a diagnosis of primary immune deficiency disease. A doctor must decide that it's medically appropriate for the IVIG to be given in the patient's home. Part B covers the IVIG itself, but Part B doesn't pay for other items and services related to the patient getting the IVIG in his or her home.

Shots (vaccinations):

- Flu shots
- Pneumococcal shots
- Hepatitis B shots
- Other shots: Medicare helps pay for some other vaccines when they're directly related to the treatment of an injury or illness (like a tetanus shot after stepping on a nail).

Immunosuppressive drugs: Medicare covers immunosuppressive drug therapy if you received an organ or tissue transplant for which Medicare made payments. (Part D may cover other immunosuppressive drugs not covered by Part B, even if Medicare didn't pay for the transplant. **Note:** If you have ESRD and Original Medicare, you may join a Medicare drug plan.)

- If you're entitled to Medicare only because of permanent kidney failure, your Medicare coverage will end 36 months after the month of the transplant. Medicare won't pay for any services or items, including immunosuppressive drugs, for patients who aren't entitled to Medicare.
- Medicare will continue to pay for your immunosuppressive drugs **with no time limit** if you meet either of these conditions:
  - You were already entitled to Medicare because of age or disability before you got ESRD.
  - You became entitled to Medicare because of age or disability after getting a transplant that was paid for by Medicare, or paid for by private insurance that paid primary to your Medicare Part A (Hospital Insurance) coverage, in a Medicare-certified facility.

Note

Transplant drugs can be very costly. If you're worried about paying for them after your Medicare coverage ends, talk to your doctor, nurse, or social worker. There may be other ways to help you pay for these drugs.

Oral cancer drugs: Medicare helps pay for some oral cancer drugs you take by mouth if the same drug is available in injectable form or is a prodrug of the injectable drug. As new oral anti-cancer drugs become available, Part B may cover them.

Oral anti-nausea drugs: Medicare helps pay for oral anti-nausea drugs used as part of an anti-cancer chemotherapeutic regimen. The drugs must be administered immediately before, at, or within 48 hours after chemotherapy, and must be used as a full therapeutic replacement for the intravenous anti-nausea drugs that would otherwise be given.

Self-administered drugs in hospital outpatient settings: Medicare may pay for some self-administered drugs, like drugs given through an IV, if you need them for the hospital outpatient services you're getting.

Who's eligible?

All people with Medicare are covered under limited conditions.

Your costs in Original Medicare

For covered Part B prescription drugs you get in a doctor's office or pharmacy, you pay 20% of the Medicare-approved amount, and the Part B deductible applies. They must accept assignment for Part B drugs, so you should never be asked to pay more than the coinsurance or copayment for the drug itself.

For covered Part B prescription drugs you get in a hospital outpatient setting, you pay a copayment. If you get drugs not covered under Part B in a hospital outpatient setting, you pay 100% for the drugs, unless you have Part D or other prescription drug coverage; what you pay depends on whether your drug plan covers the drug, and whether the hospital is in your drug plan's network.

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Centers for Medicare & Medicaid Services
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