Chapter 4

Medicare

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§ 4:1 History and Overview
§ 4:2 Program Administration and Sources of Law
§ 4:3 Eligibility and Enrollment
§ 4:3.1 Eligibility
§ 4:3.2 Application
§ 4:3.3 Enrollment
[A] Initial Enrollment Period
[B] General Enrollment Period
[C] Working Elderly and the Special Enrollment Period
[D] Failure to Enroll
[E] Appeals
§ 4:4 Medicare Appeals Process
§ 4:4.1 Redeterminations
§ 4:4.2 Reconsideration
§ 4:4.3 Administrative Hearings
§ 4:4.4 Summary of Part A Appeals Process
§ 4:4.5 Summary of Part B Appeals Process
§ 4:5 Part A: Hospital Services
§ 4:5.1 Coverage and Qualifying Criteria
[A] Benefit Periods
[B] Covered Benefits
[C] Standard for Coverage

§ 4:5.2 Rehabilitation Hospitals
§ 4:5.3 Reimbursement Structure and Coverage Issues
[A] Admission Denials
[B] Premature Discharges
[C] Observation Status
§ 4:5.4 Beneficiary's Right to Discharge Planning
§ 4:5.5 Coverage Denials and Appeals
Chart 4-1 Medicare Hospital Coverage Determination and Appeals Process
§ 4:5.6 Which Medicare Denials for Inpatient Hospital Care Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases
[A] Additional Advocacy Tips
§ 4:5.7 Which Medicare Denials for Inpatient Hospital Rehabilitation Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases
[A] Additional Advocacy Tips
§ 4:6 Part A: Skilled Nursing Facility Coverage
§ 4:6.1 Coverage and Qualifying Criteria
[A] Benefit Periods
[B] Beneficiary Copayment Obligation
[C] Covered Services
§ 4:6.2 Reimbursement Structure and Coverage Issues
[A] Provider Decisions
[B] MAC Decisions
[B][1] Initial Admissions
[B][2] Approved Admissions
[B][3] Redeterminations
§ 4:6.3 Terminations
§ 4:6.4 Appeals Overview
Chart 4-2 Medicare Skilled Nursing Facility Claims Submission and Appeals Process
§ 4:6.5 Which Medicare Denials for Skilled Nursing Facility Care Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases
[A] Other Important Points
§ 4:7 Home Health Coverage
§ 4:7.1 Coverage and Qualifying Criteria
[A] Homebound Rule
[B] Skilled Nursing Care on an Intermittent Basis
[C] Skilled Therapy Services
[D] Part-Time or Intermittent Services
[E] Chronic, Stable, and Maintenance-Level Patients

§ 4:7.2 Claims Submission and Reimbursement Structure
§ 4:7.3 Notice Requirements
[A] ABN at Initiation
[B] ABN for Reductions
[C] ABN for Terminations
[D] Other Insurance
[E] Completion of ABN
[F] Exceptions
[G] HHCCN
§ 4:7.4 Terminations
§ 4:7.5 Appeals Overview
Chart 4-3 Medicare Home Health Claims Submission and Appeals Process
§ 4:7.6 Which Medical Denials for Home Health Services Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases
[A] Additional Advocacy Tips
§ 4:8 Part A: Hospice Coverage
§ 4:8.1 Coverage and Qualifying Criteria
§ 4:8.2 Deductibles and Coinsurance for Non-Hospice Care
§ 4:8.3 Election of the Hospice Benefit
[A] Who May Make an Election for Hospice Care
[B] How the Election Is Made and How It Is Revoked
[C] Changing the Hospice That Is Providing Care
§ 4:8.4 The Appeals Process
§ 4:8.5 Which Medicare Denials for Hospice Care Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases
[A] Additional Advocacy Tips
§ 4:9 Part B
§ 4:9.1 Covered Services
§ 4:9.2 Approved Charges and Balance Billing
§ 4:9.3 Advance Beneficiary Notice
§ 4:9.4 Ambulance Services
[A] Coverage Rules
[B] Non-emergency Services
[C] Physician Certification Rules
[D] Levels of Service
[E] Destination Requirements
[F] Fee Schedule and Mandatory Assignment
§ 4:9.5 Part B: Appeals
§ 4:10 Medicare and Medicaid
§ 4:11 Medicare As Secondary Payer

§ 4:11.1 When Medicare Is a Secondary Payer
[A] Automobile and Liability Insurance
[B] Employer Group Health Plan: End-Stage Renal Disease
[C] Employer Group Health Plan: Older Employees and Spouses
[D] Employer Group Health Plan: Disabled Individuals and Family Members
[E] Administration of Medicare As a Secondary Payer Issue
§ 4:11.2 Filing Secondary Payer Claims
§ 4:12 Private Contracts
§ 4:12.1 Private Contract Requirements
§ 4:12.2 Private Contract Affidavit
§ 4:12.3 Private Contract Not Required
§ 4:12.4 Appeals for Private Contracts
§ 4:13 Medicare Managed Care
§ 4:13.1 Medicare Advantage Plan Options
[A] Benefits
[B] Continuation Area
§ 4:13.2 Medicare Advantage Plans
[A] Health Maintenance Organizations
[B] Provider Sponsored Organizations
[C] Preferred Provider Organizations
[D] Private Fee-for-Service Plans
[E] Religious Fraternal Benefit Society Plans
[F] Point of Service Options
[G] Education Campaign
§ 4:13.3 Election Periods
[A] Initial Coverage Election Periods
[B] Annual Election Periods
[C] Medicare Advantage Open Enrollment Period
[D] Special Election Periods for Newly Eligible Medicare Advantage Individuals
[E] Special Election Periods
§ 4:13.4 Disenrollment by the Medicare Advantage Plan
§ 4:13.5 Disclosure Requirements
§ 4:13.6 Access to Services
[A] Emergency and Urgent Care Services
[B] Urgently Needed Services
[C] Post-Stabilization Care
[D] Gag Orders
§ 4:13.7 Termination of Medicare Advantage Coverage
§ 4:13.8 Appeals
[A] Organization Determinations

§ 4:13.9 Non-Expedited Organization Determinations
[A] Requests for Services
[B] Requests for Payment
[C] Written Notification by Practitioners
§ 4:13.10 Expedited Organization Determinations
[A] Written Notification
§ 4:13.11 Non-Expedited Reconsiderations
[A] Requests for Services
[B] Requests for Payment
§ 4:13.12 Expedited Reconsiderations
§ 4:13.13 Further Appeal Rights
§ 4:13.14 Appeals of Hospital Coverage
§ 4:13.15 *Grijalva* Court Case
[A] Advance Notice of Service Terminations
[B] Fast-Track Appeal
[C] Reconsideration
§ 4:13.16 Grievances
§ 4:14 Medicare Prescription Drug, Improvement and Modernization Act of 2003
§ 4:14.1 Background
§ 4:14.2 Eligibility
§ 4:14.3 Enrollment and Disenrollment Periods
§ 4:14.4 Penalty for Late Enrollment
§ 4:14.5 Structure of Medicare Part D Drug Benefit
§ 4:14.6 Formularies
§ 4:14.7 Excluded Drugs
§ 4:14.8 Low-Income Subsidy Assistance
§ 4:14.9 EPIC
§ 4:14.10 Appeals
[A] Coverage Determinations
[B] Redetermination
[C] Reconsideration
[D] Further Appeals
§ 4:15 Advocacy Issues
Appendix 4A Medicare Beneficiary Costs
Appendix 4B Medicare Preventive Services
Appendix 4C Enrollment and Disenrollment Periods for Medicare Advantage Plans
Appendix 4D Medicare Advantage Plan Appeals
Appendix 4E Medicare Drug Benefit
Appendix 4F Medicare Drug Benefit for Dual Eligible and Other Low-Income Beneficiaries

§ 4:1 History and Overview

Medicare is our only national health insurance program.[1] Individuals entitled to Social Security retirement insurance who are sixty-five years of age or older and individuals entitled to Social Security disability benefits for not less than twenty-five months are eligible to participate in Medicare. Passed in 1965 as title 18 of the Social Security Act,[2] Medicare was intended to pay some of the cost of some health care services in order to ensure access to a basic level of health care for the aged.[3] Medicare was always intended as a health insurance program. It was, and continues to be, based upon a private health insurance model. Medicare requires deductibles and copayments by the insured and it pays only a portion of the cost of certain services for certain patients. Claims must be submitted to an insurance company or other entity for approval prior to payment and payments are often made directly to the health care provider.

Unlike Medicaid (title 19 of the Social Security Act),[4] neither Medicare eligibility nor program payment is predicated upon the income or assets of the beneficiary. It is not a welfare program. Both programs are overseen by the Centers for Medicare and Medicaid Services (CMS), a component of the U.S. Department of Health and Human Services. Medicaid, however, is a shared state-federal program, paid in part by both entities, and administered by state departments of social services. Medicare, on the other hand, is entirely a federal program and benefits are paid with federal sources of income. Since Medicare is a national program, Medicare procedures and qualifying criteria should not vary significantly from state to state. When they do, advocates should be alert to be certain that there are valid reasons for the discrepancies.

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1. Portions of this text appeared originally in HULIN, KEENAN, PLEBANI & STEIN, MEDICARE PRACTICE MANUAL (Legal Counsel for the Elderly—AARP 1990) [hereinafter MEDICARE PRACTICE MANUAL]. Copies are available from LCE/AARP, P.O. Box 19269-K, Washington, D.C. 20036, (202) 833-6720.
2. 42 U.S.C. §§ 1395 *et seq*. See *infra* Appendix 4A for Medicare deductibles, as well as coinsurance and premium amounts.
3. Whitman v. Weinberger, 382 F. Supp. 256 (E.D. Va. 1974). Coverage for certain individuals deemed permanently disabled for twenty-four months was added in 1972. Social Security Amendments of 1972, § 201(a) (1972).
4. 42 U.S.C. §§ 1396 *et seq*.

Medicare has four parts, Part A, Part B, Part C, and Part D. Part A covers inpatient hospital care, inpatient care in a skilled nursing facility (SNF), home health care services, and hospice care.[5] Part B covers medical care and services provided by physicians and other medical practitioners, durable medical equipment, a variety of outpatient care services, and home health services not otherwise covered under Part A.[6] Part C, the Medicare Advantage program, provides alternative health plan options to Medicare beneficiaries and is discussed later in this chapter.[7] Part D is the outpatient prescription drug benefit that started in 2006.

Part A of the program is financed largely through federal payroll taxes paid into Social Security by employers and employees. Part B is financed by monthly premiums paid by Medicare beneficiaries and by general revenues from the federal government. In addition, Medicare beneficiaries themselves share the cost of the program through copayments and deductibles that are required for many of the services covered under both Parts A and B. Part C is not separately financed, while Part D is funded by general revenues, beneficiary premiums, and state payments.

Since its enactment in 1965, Medicare has been revised several times by Congress to increase coverage. In 1972, for example, coverage was extended to the disabled.[8] Also in 1972, coverage was extended to SNF patients needing skilled rehabilitation rather than only to those in need of skilled nursing.[9] In 1980, Congress removed the requirement that home health patients have a prior hospitalization in order to receive Medicare coverage; Congress also removed the 100-visit limitation on coverage.[10] In 2006, prescription drug coverage was added.

As a general rule, Medicare coverage is not available for routine office visits (except during the first twelve months of Medicare eligibility, and the annual wellness visit),[11] comfort items, or respite care, but Medicare covers many preventive services (see Appendix 4B below). The act allows coverage only when the services received

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5. 42 U.S.C. §§ 1395c, 1395d.
6. *Id*. §§ 1395j, 1395k.
7. Pub. L. No. 105-33, 111 Stat. 251, 270 (1997).
8. Social Security Amendments of 1972, § 201(a) (1972).
9. *Id*. § 238(a).
10. Omnibus Budget Reconciliation Act of 1980, § 930(b), (g), 94 Stat. 2599, 2631 (1980).
11. *See infra* Appendix 4B.

are medically "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[12] Medicare coverage is further excluded by statute for custodial care, except in the case of hospice services.[13] These requirements, that the care be medically reasonable and necessary for treatment or diagnosis and that the care be "skilled," are strictly interpreted by those who administer the Medicare program. They create the most frequent obstacles to coverage.

This chapter is designed to present the advocate with an overall understanding of the Medicare program, including issues of enrollment and eligibility, the Medicare appeals process, and related issues such as the role of Medicare reimbursement when the beneficiary has other health insurance. In addition, more detailed information regarding coverage criteria and reimbursement structure in specific health care settings, for example, hospitals, long-term care facilities, and home health care situations, is provided. Finally, this chapter explores the area of Medicare and managed care, a subject that should be of great interest to advocates and their clients.

§ 4:2 Program Administration and Sources of Law

The Medicare program is administered by the CMS under the direction of the Secretary of the Department of Health and Human Services. CMS has ten regional offices throughout the country that oversee the program for their areas.

CMS contracts with private organizations, usually insurance companies, to review claims and make payment. These entities are known as Medicare Administrative Contractors (MACs) for Part A SNF, home health, and hospice cases, "Quality Improvement Organizations" (QIOs), formerly Peer Review Organizations (PROs), for hospital cases, and MACs for all Part B cases. These entities review coverage decisions issued by providers under their authority and then issue subsequent notices known as initial determinations from which a beneficiary can appeal.

MACs make initial determinations and issue payments when Medicare coverage is available. In hospital cases, QIOs make the initial determinations but do not issue payment; instead, they

12. *Id.* § 1395y(1)(A).
13. *Id.* § 1395y(9).

authorize the appropriate intermediary to issue payment when coverage criteria are met. QIOs and MACs are all responsible for making decisions in the first stage of the appeal process, known as redetermination for Part A and Part B.

CMS guides the claim review, decision, and payment process by issuing health insurance coverage manuals as well as various transmittals, bulletins, memoranda, and other instructions. These writings purport to interpret the statute and regulations, but sometimes go beyond interpretation and create criteria that are more restrictive than the Medicare Act. Practically, the manuals and other directives from CMS form the basis for the coverage decisions that affect most beneficiaries.[14]

Advocates should be alert to discrepancies between standards established by CMS and those established by the Medicare Act and regulations. Where detrimental discrepancies exist, they may be the grounds for appeals or federal court challenges. Importantly, administrative law judges (ALJs) are bound by national coverage determinations, but not local coverage determinations.[15] Federal judges rely on the Medicare statute and regulations, not on CMS's guidelines. Thus, many cases are won on appeal to an ALJ that were denied initially and at reconsideration based on CMS rules. Furthermore, CMS's restrictive criteria have been successfully challenged in the federal courts as violative of the Due Process Clause of the Fifth Amendment to the U.S. Constitution, the Medicare Act and regulations, and the Administrative Procedure Act.[16]

Advocates should also watch for discrepancies that may exist between standards enforced by CMS's regional offices. Since Medicare is a federal program, beneficiaries should not be subject to more restrictive criteria in one region of the country than in another.

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14. *See* CMS, MANUALS, www.cms.hhs.gov/manuals/. *See also* Transmittals Overview Page, www.cms.hhs.gov/Transmittals/01_overview.asp.
15. 42 C.F.R. § 405.1060–.1062.
16. *See, e.g.*, Linoz v. Heckler, Medicare & Medicaid Guide (CCH) ¶ 35,876 (9th Cir. 1986); Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988); Fox v. Bowen, 656 F. Supp. 1236 (D. Conn. 1987); Hooper v. Sullivan, Medicare & Medicaid Guide (CCH) ¶ 37,985 (D. Conn. 1989); Sarrassat v. Bowen, No. C88-20161 (RPA) (N.D. Cal. 1989).

§ 4:3 Eligibility and Enrollment

§ 4:3.1 Eligibility

Individuals entitled to Social Security retirement insurance who are sixty-five years of age and older,[17] and individuals entitled to Social Security disability benefits for not less than twenty-five months are eligible to participate in Medicare.[18] Individuals entitled to Railroad Retirement benefits or Railroad Retirement disability benefits[19] and individuals suffering from end-stage renal disease are also eligible to participate.[20] Certain federal, state, and local government employees who are not eligible for Social Security retirement or disability benefits may be eligible for Medicare benefits if they worked and paid the hospital insurance portion of their FICA taxes for a sufficient period of time.[21] Federal employees became subject to the hospital insurance portion of FICA in January 1983.[22] Most newly hired state and local employees, not otherwise covered under Social Security, started paying the hospital insurance portion as of April 1986.[23] Individuals who are not otherwise eligible for Medicare, but who are over age sixty-five, may purchase coverage by paying a monthly premium.[24]

Medicare eligibility for Social Security and Railroad Retirement beneficiaries begins on the first day of the first month in which the individual attains age sixty-five. This is also the date upon which individuals not otherwise eligible for Medicare are entitled and may purchase coverage.[25]

Individuals receiving Social Security or Railroad Retirement disability benefits become eligible for Medicare coverage in the twenty-fifth month of receiving those benefits.[26] Individuals who have end-stage renal disease become eligible on the first day of the third month of a course of renal dialysis treatments, or the month in which they

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17. 42 U.S.C. §§ 426(a)(1)(2)(A), 1395o; 42 C.F.R. § 406.10(a)(1).
18. 42 U.S.C. § 426(b)(1)(2)(A); 42 C.F.R. § 406.12(a)(1).
19. 42 U.S.C. § 426-1(a); 42 C.F.R. § 406.10(a)(2).
20. 42 U.S.C. § 426-1(b); 42 C.F.R. § 406.13(c)(1).
21. 42 U.S.C. § 418(v); 42 C.F.R. § 406.15(a).
22. 42 U.S.C. § 418(v); 42 C.F.R. § 406.15(f)(2).
23. 42 U.S.C. § 418(v); 42 C.F.R. § 406.15(f)(3).
24. 42 U.S.C. § 1395*i*-2(a); 42 C.F.R. § 406.20(a) and (b), § 406.5(b).
25. 42 U.S.C. § 426(a); 42 C.F.R. § 406.10(b)(1).
26. 42 U.S.C. § 426(b)(2); 42 C.F.R. § 406.12(a)(1) and (2).

begin a program of self-dialysis, or the month in which they receive a kidney transplant, whichever occurs first.[27]

§ 4:3.2 Application

An application for Social Security or Railroad Retirement benefits will trigger automatic enrollment in both Medicare Part A and Part B.[28] However, since participation in Part B is voluntary and requires the payment of a monthly premium, a beneficiary is offered the opportunity to decline enrollment in this part of the program.[29]

A person not entitled to Medicare by virtue of Social Security or Railroad Retirement benefits must make a separate application for Medicare and agree to pay monthly premiums.[30] (See Appendix 4A for premium amounts.) A person may elect not to apply for Social Security or retirement benefits at age sixty-five and still be entitled to Medicare coverage. In this case, a separate application for Medicare benefits is required.[31] Application for benefits can be made at any Social Security office or online. Railroad Retirement beneficiaries should contact the Railroad Retirement Board to enroll.

§ 4:3.3 Enrollment

[A] Initial Enrollment Period

Individuals should enroll in Medicare three months prior to the first month in which they would be eligible for benefits and for three months after their first month of eligibility. This period is referred to as the "initial enrollment period."[32]

Enrollment during the first three months of the initial enrollment period will result in coverage beginning on the first day of the first month in which the individual attains age sixty-five.[33] Enrollment during the month in which the individual attains age sixty-five will result in coverage beginning in the following month.[34]

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27. 42 U.S.C. § 426-1(b)(1)(A); 42 C.F.R. § 406.13(e)(2).
28. 42 U.S.C. § 426(a)(1); 42 C.F.R. § 406.10(a).
29. 42 U.S.C. § 1395q(b); 42 C.F.R. § 407.17(b).
30. 42 U.S.C. § 1395r(e)(B)(ii); 42 C.F.R. §§ 406.5(b), 406.20(a).
31. 42 U.S.C. § 426(a); 42 C.F.R. § 406.6(a).
32. 42 U.S.C. § 1395p(d); 42 C.F.R. § 406.21(b).
33. 42 U.S.C. § 1395q(a)(2)(A); 42 C.F.R. § 406.22(a)(1).
34. 42 U.S.C. § 1395q(a)(2)(B); 42 C.F.R. § 406.22(a)(2).

Enrollment during one of the three remaining months of the initial enrollment period will result in coverage beginning on the first day of the second month following the month in which the individual enrolls.[35]

For example, an individual attains age sixty-five in May. Her initial enrollment period will be February 1 through August 31 of that year. Depending upon the month in which she enrolls, her coverage period would be as follows:

Enrolls In	Coverage Begins
February	May 1
March	May 1
April	May 1
May	June 1
June	August 1
July	September 1
August	October 1

[B] General Enrollment Period

There is also a "general enrollment period" that occurs in the first three months of each year.[36] An individual who fails to enroll during his or her initial period of eligibility can enroll in Part B of Medicare only during this general period (and may be required to pay a premium surcharge for late enrollment), unless he falls under the provisions of the working elderly discussed below or if he is eligible for payment of the Part B premium by one of the Medicare Savings Programs. (See chapter 6.)[37] Medicare Part B coverage will not start until July for individuals who enroll in the General Enrollment Period. Enrollment in Part A can take place at any time and coverage can be retroactive up to six months unless the individual must purchase Part A coverage.[38] If an individual must purchase coverage, enrollment in Part A can only occur during the initial or general

35. 42 U.S.C. § 1395q(a)(2)(C); 42 C.F.R. § 406.22(a)(3).
36. 42 U.S.C. § 1395p(e); 42 C.F.R. § 406.21(c).
37. 42 U.S.C. § 1395p(i)(2); 42 C.F.R. § 406.24.
38. 42 U.S.C. § 1395p(i)(3); 42 C.F.R. § 406.6(d)(4).

enrollment period and coverage will begin on July 1 of that year.[39] Enrollment is generally handled by the Social Security Administration through their local offices. Railroad Retirement beneficiaries should contact the Railroad Retirement Board to enroll.

[C] Working Elderly and the Special Enrollment Period

At the time the Medicare program was established in 1965, most people retired at sixty-five, and automatically began their participation in the program at that age. However, as people began to work past the age of sixty-five, and as Medicare began to try to contain costs, Medicare coverage and enrollment policy changed.

In the early 1980s, several pieces of legislation were passed that made Medicare benefits secondary to benefits payable under an employer group health plan (EGHP) for employees and their spouses age sixty-five and older.[40] Furthermore, employers were prohibited from offering a different health plan to Medicare-eligible employees and their spouses than that offered to other employees.[41] Employers with fewer than twenty employees are exempt from these laws but may participate voluntarily.[42]

These changes led to the establishment of an additional "special enrollment period" for the working elderly.[43] Individuals over the age of sixty-five who are covered by an EGHP by virtue of their own or a spouse's employment[44] have the option to enroll in Medicare past age sixty-five without incurring a premium surcharge. Since their EGHP is the primary payer, many workers may not want to pay for Medicare coverage that might be duplicative. The special enrollment period for this group includes any month during which an employee is covered by the EGHP and ends eight months from the date the individual is no longer enrolled in the group health plan.[45] Failure to enroll during

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39. 42 U.S.C. § 1395q(a)(2)(E); 42 C.F.R. § 406.21(c)(3).
40. 42 U.S.C. § 1395y(b)(2); 42 C.F.R. § 411.100.
41. 42 U.S.C. § 1395y(b)(A)(i)(I); 42 C.F.R. §§ 411.102, 411.108.
42. 42 U.S.C. § 1395y(b)(1)(A)(iii).
43. 42 U.S.C. § 1395p(i)(2); 42 C.F.R. § 406.24.
44. 42 U.S.C. § 1395r(b). An EGHP for a retired worker, or spouse of a retired worker, is not a factor in the special enrollment period provisions. When the EGHP coverage continues into retirement, the date of termination of the employment relationship determines the date the special enrollment period begins for the worker and his or her spouse, age sixty-five or older.
45. 42 U.S.C. § 1395p(i)(3)(A); 42 C.F.R. § 406.24(a)(4).

this "special enrollment period" may result in a premium surcharge and the individual may not be allowed to enroll until the next general enrollment period.[46]

Enrollment during the first month of the "special enrollment period" (SEP) will result in Part B coverage effective on the first day of that month or, at the individual's option, on the first day of any of the three following months.[47] Enrollment during the last seven months of the SEP will result in Part B coverage effective on the first day of the month after the month of enrollment.[48] Therefore, in order to avoid any gaps in coverage it is advisable to enroll immediately upon termination of EGHP coverage.

[D] Failure to Enroll

There can be serious implications for individuals who fail to enroll in Medicare during their proper enrollment period. There is the surcharge of 10% per year assessed on the Part B premium for each year that an individual fails to enroll.[49] What can be more serious is that failure to enroll during the initial or special enrollment period will result in the individual's not being allowed to enroll in Medicare Part B until the general enrollment period, which falls during the first three months of each year.[50] Coverage for Part B benefits then would not begin until July of that year.[51] As a result, there may be several months when an individual, having no Part B Medicare coverage, may be vulnerable to costly out-of-pocket medical expenses.

It is important to note that an individual entitled to Social Security or Railroad Retirement benefits may enroll in Part A at any time and receive up to six months' retroactive coverage without penalty.[52] It is only Part B coverage that is subject to enrollment period restrictions and to a surcharge. An exception to this is those individuals not entitled to Part A coverage but who elect to pay the premium and participate voluntarily. They will be subject to the enrollment restrictions and the surcharge.[53]

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46. 42 U.S.C. § 1395r(b); 42 C.F.R. § 406.21(c)(2).
47. 42 U.S.C. § 1395q(e)(1); 42 C.F.R. § 406.24(e)(1).
48. 42 U.S.C. § 1395q(e)(2); 42 C.F.R. § 406.24(e)(2).
49. 42 U.S.C. § 1395r(b); 42 C.F.R. §§ 408.22, 406.32(d).
50. 42 U.S.C. § 1395p(g)(3); 42 C.F.R. § 406.21(c)(1).
51. 42 U.S.C. § 1395q(a)(2)(E); 42 C.F.R. § 406.21(c)(3).
52. 42 C.F.R. § 406.6(d)(4).
53. 42 U.S.C. § 1395p; 42 C.F.R. §§ 406.21, 406.32(d).

[E] Appeals

A decision to deny Medicare coverage, for whatever reason, can always be appealed to the Social Security Administration or the Railroad Retirement Board. When a person's enrollment rights have been prejudiced because of the action, inaction, misrepresentation, or error on the part of the federal government, the person cannot be penalized or caused hardship.[54] If an individual can demonstrate this to be the case, the decision to deny Medicare coverage or the imposition of a penalty surcharge may be reversed. Appeals are handled by the local Social Security office.

§ 4:4 Medicare Appeals Process

Because of the size and complexity of the Medicare program and because of the desire to contain costs, Medicare coverage is often denied when it should be granted. Sometimes these denials are a result of errors; sometimes they are a result of policy that places cost containment concerns over the needs of individual beneficiaries. Whatever the underlying reasons for the denial, the Medicare program includes an appeals system that is designed, at least in theory, to reverse erroneous denials and to correct mistakes.[55]

If the patient's attending physician feels the care in question is medically necessary and the care is not simply excluded from coverage (for example, hearing aids, dentures), the patient should appeal. In the majority of cases, appeal results are either fully or partially in favor of the claimant.

The following section provides a general overview of the Medicare appeals process as it applies to all settings. The advocate will face some unique issues in each care setting, but the detailed conduct of appeals in each care setting is beyond the scope of this chapter and is covered in great depth elsewhere.[56]

§ 4:4.1 Redeterminations

The first stage of appeal, known as the "redetermination" for Part A and Part B claims, is performed by the entity that issued the initial

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54. 42 U.S.C. § 1395p(h); 42 C.F.R. § 406.38(a).
55. *See* 42 U.S.C. §§ 1395ff *et seq.*; 42 C.F.R. §§ 405.701 *et seq.*, §§ 405.801 *et seq.*
56. *See, e.g.*, MEDICARE PRACTICE MANUAL, *supra* note 1.

determination denying benefits: the MAC for Part A SNF, home health, hospice and Part B claims, and the QIO for hospital claims. Generally, these appeals simply entail submitting a written request (forms are available at Social Security offices, but requests may also be made in writing without the form). If at all possible, the claimant should attach a copy of the denial issued by the health care provider and a supporting letter and/or documentation from the treating physician to the reconsideration or review request. (Assistance from the attending physician is always the key to a successful appeal.)[57] Also, it is always important to keep copies of all appeal requests and all supporting data.

It is not unusual to wait many months for a decision from this first appeal stage. Unfortunately, it is also not unusual for meritorious claims to be denied at the redetermination stage. However, many of these decisions do result in additional benefits, and this step is a prerequisite to further appeals.

In both Part A and Part B cases, patients may request a reconsideration by the Qualified Independent Contractor (QIC) after receipt of an adverse redetermination decision.

§ 4:4.2 Reconsideration

The next level of an appeal is a reconsideration held by the QIC.[58] Beneficiaries and other parties have 180 days to request a reconsideration by MAXIMUS Federal Services, the QIC for New York and other parts of the country. Providers, but not beneficiaries, are required to submit *all* evidence to the QIC that they want considered at the QIC or later appeal stages; any evidence not submitted cannot be considered at an ALJ hearing or further appeal unless "good cause" is established for the subsequent submission.

This stage is a paper review; the QIC makes a determination based on evidence in the case record. The QIC is supposed to complete its reconsideration within sixty days of the reconsideration request. If a QIC does not issue a timely decision, the party can request that the appeal be escalated to the next level of review.

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57. *See* Pilsums v. Harris, Medicare & Medicaid Guide (CCH) ¶ 30,908 (D. Conn. 1981).
58. 70 Fed. Reg. 11,420–99.

§ 4:4.3 Administrative Hearings

The ALJ hearing represents the beneficiary's best chance to win Medicare coverage previously denied. At the hearing, for the first time, the claimant has an opportunity to receive consideration of the claim in accordance with the Medicare statute and regulations (in contrast to the less formal and more restrictive guidelines and directives used by MACs and peer review organizations at their decision levels). The different nature of the hearing evaluation is reflected by the nationwide win rates in most cases. Appeals taken to ALJ hearings are successful in about 80% of all cases. For this reason, it makes sense for an advocate to expend the greatest time and energy at the hearing stage, where vigorous representation will often lead to satisfying results.

ALJ hearings are required to be conducted by video teleconferencing (VTC) if the VTC technology is available, but individuals can have an in-person hearing if they demonstrate "good cause." The ALJ may also offer to conduct a hearing by phone if a telephone hearing may be more convenient for the parties. In addition, individuals can waive their right to a hearing and request that the ALJ issue a decision based on the record. If the ALJ does not make a decision within ninety days of the hearing request, the provider or beneficiary may bring the case before the Medicare Appeals Council.

If the ALJ decision is not satisfactory, however, further appeal is possible to the Medicare Appeals Council and then, in some cases, to federal court.

§ 4:4.4 Summary of Part A Appeals Process

Usually, the first notice a Medicare beneficiary receives that care will not be covered by Medicare is from the health care provider. Before they can charge a beneficiary, providers who participate in the Medicare program must first issue a written notice to the patient informing him or her that Medicare coverage will not be available. Providers have a financial incentive to issue denial notices because they may have to absorb the cost of the care they provide if they erroneously inform the beneficiary that the care *will* be covered but not if they erroneously deny coverage.

Notices from providers, however, do not form the basis for an appeal. The beneficiary must receive another notice, called the "initial

determination," from the appropriate QIO or MAC in order to proceed with an appeal.[59]

Patients who receive denials from a provider should, therefore, request that a claim for payment be submitted to Medicare nonetheless so that an initial determination will be issued by the QIO or MAC that can then be appealed. (Also, occasionally, the initial determination does grant coverage that was denied by the provider.) If the beneficiary or representative requests a provider to submit a claim to Medicare, the provider is required to do so.[60] If a hospital inpatient receives a denial from the hospital, a review should be requested immediately to avoid being charged by the hospital until the QIO issues an initial determination, which it must do within three days.

Generally, a request for redetermination must be filed within 120 days of receipt of the initial determination unless "good cause" can be shown. Hospital *inpatients* denied Medicare during their stay may request an "expedited review" of a Medicare denial. These expedited requests must be decided by the QIO within three working days.

The redetermination process was created by legislation, which also established it as a prerequisite to a reconsideration by the QIC.[61] The Medicare statute provides that beneficiaries dissatisfied with a Medicare reconsideration concerning Part A benefits are entitled to a hearing before an ALJ of the Social Security Administration.[62] In order to be entitled to a hearing, SNF, hospice, and home health patients must have $160 in controversy (where reconsideration decisions have been issued by QICs); hospital patients must also have $160 in controversy (where reconsiderations are issued by peer review organizations).

Hearing requests must be made within sixty days of receipt of the notice of the reconsideration decision. Late filing of a request for hearing may be accepted where good cause for the delay is shown. Examples of good cause include illness that prevents the beneficiary from making hearing requests on time; the loss of important records

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59. 42 C.F.R. §§ 405.702–.710, 466.83.
60. HEALTH CARE FIN. ADMIN. (HCFA), MEDICARE INTERMEDIARY MANUAL [hereinafter MEDICARE INTERMEDIARY MANUAL] § 3439.1; Sarrassat v. Bowen, No. C88-20161 (RPA) (N.D. Cal. 1989); Program Memorandum Transmittal No. A-99-52 (Dec. 1999).
61. Pub. L. No. 106-554, 114 Stat. 2763A–463 (2000).
62. *Id*.

by fire or other accidental cause; and incorrect information given by the contractor concerning the requirements for a timely filing of a hearing request. The hearing request should be made in writing and filed with the entity specified in the QIC's reconsideration.

If the hearing request is unsatisfactory, a beneficiary may request a review from the Medicare Appeals Council. The request must be made within sixty days of receipt of the hearing decision. If the required amount remaining in controversy after the hearing is $1,630, the case may proceed to federal district court. The federal court complaint must be filed within sixty days of receipt of the Medicare Appeals Council decision.

§ 4:4.5 Summary of Part B Appeals Process

A Medicare Summary Notice (MSN) must be obtained before a beneficiary has a right to appeal a Part B denial. This Initial Determination is the written notice that briefly explains what Medicare will pay on a Part B claim and is prepared by the MAC. Many claims are denied in whole or in part because of insufficient information and mistakes. Determinations that find that the medical service was not medically necessary and, therefore, not covered under Medicare should be closely examined. Errors are often made. If the claimant does not think Medicare is allowing a sufficient reimbursement amount, the claimant should also question the determination.

It may be useful to telephone the MAC to question why Medicare benefits were denied. Often the claimant will discover that inadequate information or documentation was mailed to the MAC and that the coverage denial can be resolved by providing better documentation.

If the claimant remains dissatisfied, a redetermination may be requested. The redetermination is the first formal appeal stage for Medicare Part B claims. The request for redetermination must be filed within 120 days of receipt of the MSN.

If the redetermination decision is unsatisfactory, the beneficiary may request a reconsideration by the QIC. If $160 still remains in controversy after the reconsideration decision, the case may finally proceed to an ALJ hearing. The ALJ hearing request must be made within sixty days of receipt of the unsatisfactory QIC decision. If this decision is unsatisfactory and $160 still remains in controversy, the case may be further appealed to the Medicare Appeals Council within sixty days of receipt of the ALJ decision. If the claimant still remains

dissatisfied after the Medicare Appeals Council decision, and $1,600 remains in question, a complaint may be filed in federal court within sixty days of receipt of the adverse Medicare Appeals Council decision.[63]

§ 4:5 Part A: Hospital Services

An advocate's role where Medicare hospital coverage is concerned is, first, to make sure the patient receives the care required, and second, to ensure that the patient is not charged for services that should be covered by Medicare. Access to Medicare hospital coverage, and the vital hospital care that coverage pays for, is a legal right crucial to the financial and physical well-being of millions of aged and disabled Americans. Unfortunately, the enormous institutional pressure to restrain Medicare expenditures has created economic incentives to deny hospital admission, limit high-technology care, and discharge patients too early. On the other hand, notice and appeal procedures exist that enable an advocate—whether patient, family member, or professional—to oppose unfair coverage denials and protect the hospital coverage granted by Congress.

Often, the cogent arguments of the well-prepared advocate can persuade decision makers (who are, after all, usually physicians) to make a more professional evaluation of a patient's need for medically appropriate hospital care.

§ 4:5.1 Coverage and Qualifying Criteria

[A] Benefit Periods

In any benefit period, a Medicare beneficiary is entitled to sixty fully paid days of hospital care, subject only to an initial deductible amount. After sixty days, a beneficiary must pay a daily coinsurance amount equal to one-fourth of the initial deductible. After ninety days, the beneficiary is entitled to sixty "lifetime reserve" days, which may be used only once during the beneficiary's lifetime.

An example of how benefit periods work follows. Imagine that Mrs. Brown entered the hospital on January 1 and stayed for 200 days. Mrs. Brown then returns home for thirty days before she is rehospitalized. The Medicare hospital coverage available to Mrs. Brown may be described as follows: Mrs. Brown first pays the deductible

63. 42 C.F.R. § 405.1130 (2005).

due before any Medicare coverage is paid. (See Appendix 4A for deductible and coinsurance amounts.) She then receives sixty days of hospital coverage without coinsurance. Mrs. Brown is next responsible for coinsurance each day between days 61 and 90. On day 91, Mrs. Brown begins to use her lifetime reserve days (assuming that she has not used any of these days in prior hospital stays). The lifetime reserve days require a daily coinsurance payment. After the lifetime reserve days are exhausted on the 150th day, Mrs. Brown will have exhausted her Medicare coverage for her current benefit period.

When Mrs. Brown returns to the hospital after thirty days at home, she will be entitled to *no additional* Medicare coverage. A beneficiary is entitled to a maximum of 150 days of hospital coverage in any one "spell of illness." A spell of illness ends, and a new spell of illness, complete with additional hospital coverage, becomes available, only after the beneficiary has gone sixty consecutive days during which he or she has been neither an inpatient of a hospital nor an inpatient of an SNF.[64] To be a hospital or SNF "inpatient," a beneficiary must receive a level of care coverable by the Medicare program. Because Mrs. Brown was at home for only thirty days, she continues in the same spell of illness and her benefits remain exhausted.

[B] Covered Benefits

Covered benefits under Part A include nearly all services, except for luxuries (such as a telephone or television), generally provided during the hospital stay, including room and board in a semiprivate room, nursing services, operating and recovery room costs, drugs and medical supplies furnished in the hospital, laboratory tests, radiological services billed by the hospital, rehabilitation services, and blood.[65] Significantly, however, the Medicare hospital benefit does not include coverage for physicians' services while in the hospital. For example, the surgeon and anesthesiologist will bill the patient separately (the cost of the physicians' services may be covered by Part B of the Medicare program).

[C] Standard for Coverage

The substantive standard for Medicare coverage for general hospital services (also called acute hospital care) is one of "medical

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64. Social Security Act § 1861(a); 42 U.S.C. § 1395x(a).
65. Social Security Act § 1861(b); 42 U.S.C. § 1395x(b) (1982).

necessity." A physician must certify that hospital "services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required. . . ."[66] The regulations provide that inpatient hospital care includes cases where a beneficiary needs an SNF level of care but, under Medicare criteria, a SNF-level bed is not available.[67] In addition, the statute explicitly excludes from coverage any expenses incurred for items or services "not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. . . ."[68]

§ 4:5.2 Rehabilitation Hospitals

Medicare imposes additional coverage requirements for care received in rehabilitation hospitals. Rehabilitation hospital care may be covered where it is provided in a freestanding rehabilitation hospital, or in a distinct rehabilitation unit of an acute care hospital. If they meet certain requirements regarding staffing, patient mix, and type of care provided, rehabilitation hospitals and distinct rehabilitation units are paid based on a prospective payment system, which pays hospitals at a predetermined, specific rate for each discharge.[69]

For rehabilitation hospitalization to be covered, the following requirements must be satisfied:

- the physician must certify that the patient needs inpatient hospital rehabilitation;
- the hospital must be a Medicare-certified facility;
- the patient must require a relatively intense (in relation to services available at a lower level of care), multidisciplinary rehabilitation program provided by a coordinated team of physical therapists, occupational therapists, speech language pathologists, rehabilitation nurses, and/or other professionals supervised by a physician with experience or training in rehabilitation medicine;
- the goal of the rehabilitation program must be to upgrade the patient's ability to function as independently as possible; and

66. 42 U.S.C. § 1395f(a)(3).
67. 42 C.F.R. § 412.42(c)(1); *see also* 42 C.F.R. § 424.13(b).
68. Social Security Act § 1862(a)(1)(A); 42 U.S.C. § 1395y(a)(1)(A).
69. 66 Fed. Reg. 41,315–30 (Aug. 7, 2001).

- the care must be reasonable and necessary and not actually available at a lower level of care.[70]

§ 4:5.3 Reimbursement Structure and Coverage Issues

Part A of the Medicare program is financed by the Hospital Insurance Trust Fund, which in turn is funded through a mandatory Social Security payroll tax imposed on all wage earners.[71]

Since its inception in 1965, the Medicare program has consistently proven to be more expensive than anticipated, and program payouts have increased precipitously from year to year. Total Medicare expenditures, for example, rose from $4.6 billion in 1967 to $702 billion in 2017.[72] Not surprisingly, there has been tremendous pressure to restrict the growth of Part A expenditures.

Prior to 1983, the Medicare program paid hospitals on a retrospective basis in an amount equal to the reasonable cost of covered services. In other words, Medicare paid a hospital what it cost the hospital to deliver the service involved. Since October 1, 1983, hospitals have been paid under a prospective payment system (PPS).[73]

The prospective payment system applies only to acute care and rehabilitation hospitals; alcohol and drug treatment, psychiatric, and children's hospitals are not included in the prospective system, nor

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70. 42 C.F.R. §§ 412.23(b), 412.29; MEDICARE INTERMEDIARY MANUAL, *supra* note 60, § 3101.11; CMS, MEDICARE HOSPITAL MANUAL § 211. Note that for many years the Health Care Financing Administration (HCFA) interpreted "relatively intense" to mean that the patient had to require and receive at least three hours per day of physical and/or occupational therapy in order to qualify for Medicare coverage for hospital-level rehabilitation. This interpretation, found in HCFA's Intermediary and Hospital Manuals, was found by the U.S. District Court in Hooper v. Sullivan, Medicare & Medicaid Guide (CCH) ñ 37,985 (D. Conn. 1989), to be an arbitrary rule of thumb and thus not usable to deny coverage. In *Hooper*, the Secretary was ordered to revise the manual provisions to reflect the fact that Medicare determinations are to be made based on an individual assessment of each patient's needs and to prohibit denials based on the three-hour rule or any other rule of thumb.
71. Social Security Act § 1817, 42 U.S.C. § 1395i(a).
72. KAISER FAMILY FOUND., THE FACTS ON MEDICARE SPENDING AND FINANCING (June 2018).
73. Social Security Amendments of 1983, § 601(e) (codified as amended at 42 U.S.C. § 1395ww(d)).

are units in acute care hospitals that provide alcohol and drug treatment, psychiatric, or pediatric services.[74]

Under the prospective payment system, acute care hospitals are paid a prospectively determined amount for each Medicare discharge. All patient discharges are classified according to a list of diagnosis-related groups (DRGs). The list includes approximately 500 DRGs. Each DRG is assigned a particular value based on the average cost of caring for patients with similar diagnoses in the past.[75] The DRG for a stroke, for example, might be $6,000. For every patient discharged from the hospital after treatment for a stroke, the hospital would receive $6,000 in Medicare reimbursement even if the patient's care had actually cost the hospital less, or more, than $6,000 to deliver.

Only when a beneficiary has a medically necessary stay that is much longer or more expensive for the hospital than an average case covered by the appropriate DRG can the hospital receive additional Medicare coverage called "outlier payments."

[A] Admission Denials

As described above, if Medicare coverage is granted, the hospital will generally receive a predetermined DRG amount. The QIO, which functions as a watchdog agency seeking to ensure that the hospital does not claim Medicare coverage for medically unnecessary care, will sometimes retroactively deny coverage in certain types of cases. When such a retroactive denial occurs, the hospital loses the entire DRG payment. Moreover, because the hospital had, until the issuance of the QIO denial, considered the case to be covered by Medicare, it has not complied with the required denial notice process, and therefore may not charge the patient for the cost of care.[76]

[B] Premature Discharges

Because the hospital usually receives only the single predetermined DRG amount for a given hospital discharge, the hospital comes under severe pressure to discharge patients at the earliest possible time, thereby maximizing profit or minimizing loss. Available evidence

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74. 42 U.S.C. § 1395ww(d)(1)(B); 42 C.F.R. § 412.20–.32.
75. Social Security Amendments of 1983, § 601(e) (codified as amended at 42 U.S.C. § 1395ww(e)).
76. Social Security Act § 1879; 42 U.S.C. § 1395pp; 42 C.F.R. § 411.400–.406.

demonstrates that this pressure is so extreme that it has resulted in a deterioration in the quality of hospital services. Patients are, therefore, advised to utilize the appeals process (see section 4:5.5 below).

[C] Observation Status

It has become more common that individuals go to the hospital and, instead of being admitted, they are placed under "observation" status. This is an important distinction, because out-of-pocket costs differ between under observation status and hospital admission, and the number of days an individual is under observation status doesn't count toward the "3-day prior hospital stay" requirement for Medicare to cover a skilled nursing facility stay.

New York State law[77] requires hospitals to inform patients who are assigned to observation status that they are not admitted to the hospital, but are under observation status. Oral notice and written notice are required within twenty-four hours of assignment to observation status. The written notice must be signed by the patient or the patient's legal representative to acknowledge receipt.

At a minimum, the written notice must include that observation status may affect the patient's Medicare, Medicaid, and/or private insurance coverage for the current hospital stay, including medications and other pharmaceutical supplies, as well as coverage for any subsequent discharge to a skilled nursing facility, home, or community-based care. The written notice must encourage the patient to contact his or her insurance plan for more specific information on coverage.

Since March 2017, hospitals have also been required to issue the Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries to advise them that they have been assigned to observation status (https://www.cms.gov/Medicare/Medicare-General-information/Bni/). While the MOON instructions allow a thirty-six-hour time frame to provide the notice to Medicare beneficiaries, New York State law and regulation require all notices of observation status, including the MOON, to be given within twenty-four hours of the patient's assignment to observation. Hospitals in New York State must follow the more stringent requirement and provide the notice within twenty-four hours.

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77. N.Y. PUB. HEALTH LAW § 2805-w.

§ 4:5.4 Beneficiary's Right to Discharge Planning

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) established for the first time a discharge planning process for identifying and planning for the post-hospital care needs of Medicare patients.[78]

The problem with the right to discharge planning established by OBRA-86 is the fact that it is not self-executing. That is, the Secretary is required to publish regulations or other guidelines and standards to implement the statutory protections. In December 1994, the Secretary published regulations to implement the statutory discharge planning rights. The regulations establish procedures for determining when a discharge plan is required but are not specific about penalties if the discharge plan is not in fact put in place.[79] In May 2013, CMS issued revisions to State Operations Manual, Hospital Appendix A—Interpretative Guidelines for 42 C.F.R. § 482.43, Discharge Planning.[80]

As noted above, the hospital is required to give a patient on admission a notice entitled "An Important Message from Medicare."[81] The hospital is also required to give the patient a notice of discharge appeal rights when and if the hospital attempts to charge the patient privately for the cost of care involved. In addition, if the QIO issues an initial determination, the patient must be notified in writing and offered the opportunity to appeal.[82] Unfortunately, none of these notification protections requires the hospital or the QIO to notify the patient concerning his or her right to the detailed discharge planning process provided by OBRA-86. Accordingly, it is important that advocates be aware of these discharge rights and insist upon their actual availability.

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78. CMS, PEER REVIEW ORGANIZATION MANUAL § 2050(5)(A), (B) (2003) [hereinafter PEER REVIEW ORGANIZATION MANUAL].
79. 42 C.F.R. § 482.43.
80. Letter from Director, Survey and Certification Group, Center for Clinical Standards and Quality/Survey & Certification Group, to State Survey Agency Directors, Regarding Revision to State Operations Manual (SOM), Hospital Appendix A—Interpretive Guidelines for 42 C.F.R. § 482.43, Discharge Planning (May 17, 2013), http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf.
81. Social Security Act § 1866(a)(1)(M); 42 U.S.C. § 1395cc(a)(1)(M); 42 C.F.R. § 466.78(b)(3); PEER REVIEW ORGANIZATION MANUAL, *supra* note 78, §§ 2000, 2005.
82. 42 C.F.R. § 473.12(b)(1).

In November 2006, CMS issued a final rule that revises the "An Important Message from Medicare" (IM) form and changes when it has to be given to a hospital patient.[83] Since July 2007, hospitals have been required to deliver the revised IM at or near admission, but no later than two days after the beneficiary's admission to the hospital, and to obtain the signature of the beneficiary or a representative. The IM includes a statement of patients' rights, information about when a beneficiary will and will not be liable for charges for a continued stay in a hospital, as well as a more detailed description of the QIO appeal rights.

Hospitals are also required to deliver a copy of the signed IM to each beneficiary before discharge unless the initial IM was delivered and signed within two days of the discharge. Beneficiaries who request an appeal of their discharge by the QIO will be given a more detailed notice, called a Detailed Notice of Discharge. The notice explains why services are no longer necessary and describes relevant Medicare coverage rules, instructions, or other policy.[84]

§ 4:5.5 Coverage Denials and Appeals

As previously noted, a detailed discussion of the appeals process in individual care settings is beyond the scope of this chapter. However, Chart 4-1 summarizes the coverage determination and appeals process in Medicare hospital cases.

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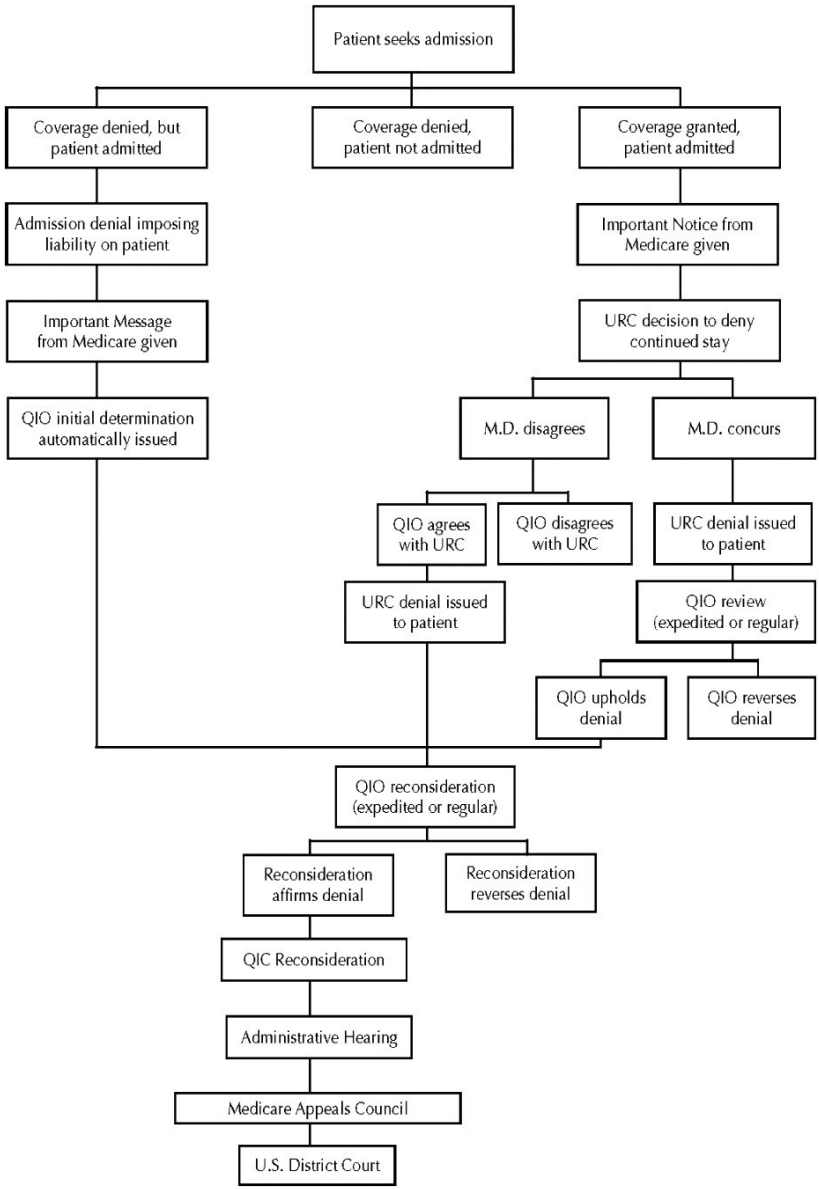
83. 71 Fed. Reg. 68,708–25. For the revised State Operations Manual Hospital Appendix A, see Ctrs. for Medicare & Medicaid Servs., Memorandum on Revision to State Operations Manual (SOM), Hospital Appendix A—Interpretive Guidelines for 42 CFR 482.43, Discharge Planning (May 17, 2013), https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-13-32.pdf.

84. For a copy of both notices, see CMS, HOSPITAL DISCHARGE APPEAL NOTICES, http://www.cms.gov/Medicare/Medicare-GeneralInformation/BNI/HospitalDischargeAppealNotices.html.

Chart 4-1
MEDICARE HOSPITAL COVERAGE DETERMINATION AND APPEALS PROCESS



§ 4:5.6 Which Medicare Denials for Inpatient Hospital Care Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases

Medicare claims for inpatient hospital care are suitable for coverage, and for appeal if they have been denied, if they meet the following test: The patient's condition must have been such that the care the patient required could only have been provided in a hospital, or the patient required an SNF level of care and no SNF bed was actually available in a Medicare-certified SNF in the patient's geographic area. (Note: A SNF level of care means that the patient required skilled services—from a physical therapist or a registered nurse, for example—on a daily basis.)

[A] Additional Advocacy Tips

- ✔ The opinion of the attending physician is the most important element in the patient's case. If the physician believes that it was medically necessary for the patient to receive care in the hospital, or that the patient needed at least an SNF level of care but no skilled nursing facility bed was actually available, the case will probably be won.
- ✔ Get the attending physician to put his or her favorable opinion in writing, explaining with as much detail as possible why the coverage standard described above is met in the patient's case.
- ✔ Usually a Medicare denial means not that the patient must leave the hospital, but that any further stay will be at the patient's own expense. Remember, however, that the patient cannot be required to pay unless the patient has been given a written notice of denial of coverage, and once a written denial is delivered the patient cannot be charged until the third day following the notice. For example, if a denial notice is delivered on Monday, the patient cannot be charged for the stay until Thursday.
- ✔ Appeal as quickly as possible. In some cases the patient is entitled to expedited review, which may include additional time in the hospital before charges accrue, if the request for review is made immediately.

§ 4:5.7 Which Medicare Denials for Inpatient Hospital Rehabilitation Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases

Medicare claims for inpatient hospital rehabilitation are suitable for appeal if they meet the following criteria:

(1) the patient's physician certifies that inpatient hospitalization for rehabilitation is medically necessary;

(2) the patient requires a relatively intense, multidisciplinary rehabilitation program;

(3) the rehabilitation program is provided by a coordinated, multidisciplinary team;

(4) the goal of the rehabilitation program is to upgrade the patient's ability to function as independently as possible; and

(5) the care is provided in a Medicare-certified facility.

[A] Additional Advocacy Tips

✔ Ignore arbitrary caps on coverage imposed by the QIO. For example, do not accept assertions that Medicare coverage cannot be gained if the patient needs less than three hours per day of physical and occupational therapy, or that hospital rehabilitation for certain conditions (for example, below-the-knee amputations or upper extremity paralysis) is not coverable. The Medicare statute and regulations include no such restrictions. In practice, ALJs will grant coverage if it can be shown that the patient needed a multidisciplinary, coordinated rehabilitation program provided by a team of professionals that was not actually available at an SNF or on an outpatient basis.

✔ It will be helpful to succeed on appeal if the patient needs close medical supervision, that is, twenty-four-hour-a-day availability of a physician and/or nurse with training or experience in rehabilitation.

✔ The attending physician is always the key to obtaining Medicare benefits. If possible, obtain a statement from the patient's physician explaining why inpatient hospital rehabilitation is medically necessary and that the rehabilitation

program the patient needs is not actually available at an SNF or on an outpatient basis.

✔ Do not be satisfied with a Medicare determination unreasonably limiting your client's coverage and do not let the client forego the medical care he or she needs. Appeal for the benefits he or she deserves. It will take some time but the patient will probably win benefits in the end.

§ 4:6 Part A: Skilled Nursing Facility Coverage

The Medicare SNF benefit is important and provides valuable health care benefits for Medicare beneficiaries. However, it is one of the most misunderstood areas that Medicare covers. Many people mistakenly believe that Medicare does not cover nursing home care at all. Others believe that Medicare covers extensive nursing facility services. Some people realize there is limited coverage but do not understand that the level of care (for example, skilled versus custodial) affects coverage.

The Medicare SNF benefit is significant, yet limited in duration. The level of care the patient receives is extremely important. The following basic requirements must be addressed when evaluating the availability of the Medicare SNF benefit:

- Only post-hospital admissions are covered.
- Ordinarily, post-hospital transfer and skilled services must begin within thirty days after leaving the hospital.
- Only skilled nursing or rehabilitation care is covered.
- The skilled services must be provided on a daily basis.
- A maximum of 100 days per spell of illness may be covered.
- As a practical matter, the skilled care has to be provided on an inpatient basis.

§ 4:6.1 Coverage and Qualifying Criteria

[A] Benefit Periods

Medicare Part A provides payment for post-hospital care in SNFs for up to 100 days during each spell of illness.[85] If Medicare coverage

85. 42 U.S.C. §§ 1395x(i), 1395d(2)(A), 1395e(a)(3).

requirements are met, the patient is entitled to full coverage of the first twenty days of SNF care. From the twenty-first through the 100th day, Medicare pays for all covered services except for a daily coinsurance amount.[86] The SNF patient will not be entitled to any Medicare coverage unless he or she was hospitalized for at least three days prior to the SNF admission and, generally, was admitted to the SNF within thirty days of the hospital discharge.

It is possible that a beneficiary could have two spells of illness during the same year. However, there must be a sixty-day break in hospitalization or nursing home services at a SNF level of care to end the first spell of illness. Because of this requirement, it is rare that a beneficiary ever receives more than 100 days of coverage per year. For example, Mrs. Jones is admitted to the hospital and then transferred to the SNF on March 25. Upon admission Medicare coverage is granted for 100 days through July 3. She receives a custodial level of care through August 28 and is then readmitted to the hospital. Upon readmission to the SNF she cannot be covered by Medicare, because her spell of illness was only broken by fifty-eight days from July 3 to August 28. Mrs. Jones would have to receive a custodial level of care for sixty consecutive days and be re-hospitalized in order for further SNF coverage to be available.

[B] Beneficiary Copayment Obligation

Medicare covers the first twenty days in full; however, there is a copayment for the next eighty days. The daily copayment is equal to one-eighth of the hospital deductible amount.[87] Accordingly, for a 100-day stay, the patient will be responsible for a significant amount of money, which either comes out of the beneficiary's pocket or is covered by Medicaid or a Medigap insurance policy.[88] Although the Medigap insurance policy may cover the SNF copayment, the beneficiary must pay premiums for this private supplemental insurance coverage. Also, long-term care insurance policies are offered in many states. (Medigap and long-term care insurance policies are discussed in detail in chapter 5.)

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86. 42 U.S.C. § 1395e(a)(3).
87. 42 C.F.R. § 409.85; *see also* Appendix 4A.
88. Medigap insurance is private insurance coverage that is designed to integrate with Medicare coverage and fill in some of the gaps not covered by Medicare. *See* 42 C.F.R. §§ 403.200 *et seq.*; *see also* chapter 5.

[C] Covered Services

SNF coverage includes the services generally available in a SNF: nursing care provided by registered professional nurses, bed and board, physical therapy, occupational therapy, speech therapy, social services, medications, supplies, equipment, and other services necessary to the health of the patient.

There are certain requirements that must be met in order for a patient to receive Medicare coverage. These requirements include:

(1) A physician must certify that the patient needs SNF care.

(2) The patient must have been hospitalized for at least three days prior to the admission to the SNF and must generally have been admitted to the SNF within thirty days of the hospital discharge.

(3) The beneficiary must require daily skilled nursing or rehabilitation.

(4) The care needed by the patient must, as a practical matter, be available only in an SNF on an inpatient basis.

(5) Patient is treated for a condition in the nursing home similar to the condition treated in the hospital.

§ 4:6.2 Reimbursement Structure and Coverage Issues

Upon transfer from the hospital, the patient is almost always taken to the SNF by ambulance. After arriving at the SNF, the patient is usually taken directly to his or her room. The necessary paperwork is usually completed by a relative of the patient. The SNF staff often deal with a relative rather than the patient because they feel the patient is unable to fully understand what is going on because of his or her medical condition, both physiological and psychological. This is often a correct assessment.

For the Medicare patient, the most important function of the SNF admission process is the determination as to whether the stay will be covered by Medicare.

Since July 1, 1998, SNFs have been paid through per diem prospective case adjusted payment rates called resource utilization groups (RUGs).[89]

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89. Pub. L. No. 105-33, § 4432, 111 Stat. 251, 414 (1997).

[A] Provider Decisions

At the initial stage this critical decision is performed by the SNF provider. Once admitted to an SNF and to a Medicare-certified bed, the patient must have his or her medical needs assessed to determine whether skilled services are required on a daily basis. SNFs must issue a notice—the Advance Beneficiary Notice of Non-coverage (ABN)—before it can transfer potential financial liability in most cases to the patient.

The SNF provider performs this initial screening process for two reasons. First, the Medicare statutes and regulations require providers to have in place utilization review plans. The purpose of utilization review is to make certain that medical services are necessary and that services are being efficiently utilized. As a condition of participation, the provider must perform this function.

Second, the provider is concerned with its waiver-of-liability status. Basically, Medicare law provides that nonskilled custodial care may be covered by Medicare when neither the provider nor the patient had reason to know the services were not medically necessary.[90] The provider is allowed a certain percentage of wrong determinations before each admission decision is closely scrutinized by the MAC. Up to that point, the provider is held harmless for wrong determinations and is not held liable for the costs. Accordingly, it is important for a provider to maintain this favorable status.

The standards for making these determinations are set forth in the policy manuals of CMS. The manuals provide guidelines to the MACs and providers concerning the definitions of skilled services.[91] These manual provisions are CMS's interpretation of the law but are not necessarily correct as a matter of law. The advocate should always refer to the statutes and regulations as the proper sources for establishing Medicare coverage determinations.

In addition to making admission determinations, the SNF provider will also make decisions about continuing Medicare coverage. For

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90. 42 U.S.C. § 1395pp; 42 C.F.R. §§ 411.400 *et seq.*; MEDICARE INTERMEDIARY MANUAL, *supra* note 60, § 3430.

91. MEDICARE INTERMEDIARY MANUAL, *supra* note 60, §§ 3130 *et seq*. It should be noted that providers use the CMS, SKILLED NURSING FACILITY MANUAL, as opposed to the MEDICARE INTERMEDIARY MANUAL. However, the sections of the MEDICARE INTERMEDIARY MANUAL cited here and below are exactly the same as those in the SKILLED NURSING FACILITY MANUAL.

example, a rehabilitation patient may be denied continued Medicare coverage after four weeks of physical therapy services. This decision is made by the SNF through its utilization review committee (URC). Technically, the URC is made up of at least two physicians, a registered nurse, and perhaps an administrator. It is the function of the URC to review the medical records and determine the appropriate level of care for each patient. However, in practice it is usually the nurse who makes the determination, at admission and upon continuing review, and then presents the assessments to the URC. The usual course is for the URC to approve the nurse's determinations in brief review sessions. Although the patient's attending physician has the opportunity to meet with the URC and support the need for Medicare coverage, this does not often happen. In short, the usual URC function might be described as perfunctory with actual decisions being made by one or two non-physician SNF staff persons.

[B] MAC Decisions

[B][1] Initial Admissions

The SNF provider must submit a billing to the MAC in order to obtain an "official" denial of coverage. The initial denial notice provided by the provider is not a true denial of coverage. A bill must be submitted and the MAC will then issue a denial notice to the beneficiary. Accordingly, it is most important that the bill be submitted to the MAC even when the SNF provider believes that services will not be covered. This procedure is referred to as no-payment billing. All beneficiaries have the right to have bills submitted to Medicare and SNF providers are obligated to submit the bills.[92] The settlement in *Sarrassat v. Bowen* specifically provides that a SNF provider cannot bill the patient or a third party until a Medicare intermediary (now MAC) denial has been issued.[93] This case also reinforces patients' rights to have no-payment bills submitted. The *Sarrassat* decision affects all Medicare patients throughout the country. Pursuant to the stipulated judgment, all Medicare SNF provider denials must state that the beneficiary has the right to

92. MEDICARE INTERMEDIARY MANUAL, *supra* note 60, § 3630.
93. Medicare & Medicaid Guide (CCH) ¶ 38,504, at 22,841 (N.D. Cal. 1989).

have the bill submitted to Medicare. Furthermore, the SNF cannot bill the beneficiary until the MAC issues a formal claim determination.

Although it is the MAC that performs the first official assessment of a patient's level of care, in actuality the MAC merely rubber-stamps the SNF provider denial. Therefore, if the provider issues a notice of non-coverage, the MAC will also issue a notice of non-coverage. However, this practice is not reciprocated for approved admissions.

[B][2] Approved Admissions

A MAC, through random audit, will review SNF provider admissions of covered Medicare stays. At this point, the MAC often reverses the SNF provider's decision to grant Medicare coverage. However, the patient is protected by the waiver-of-liability provision of the law because written notice of non-coverage was not given.

The MAC determination process is cursory at best. The medical records that are available at the time of admission usually consist only of the hospital discharge summary, patient transfer report, and assessment done at the SNF.[94] As noted previously, it is unusual for the attending physician to submit any supporting documentation at this point. However, the MAC also performs the reconsideration process, which is the first step of appeal.

[B][3] Redeterminations

The redetermination is a review done after the patient has been denied Medicare coverage. Accordingly, there are many more medical records available to document the services that now have been provided. The advocate should note the importance of this retrospective as opposed to prospective view. Now the MAC can look back over the records to determine the level of care, as opposed to looking ahead to determine what care a patient will require. This is quite true also for a coverage denial of continuing care after Medicare coverage was initially granted. Although there is a period of coverage with medical records, the denial is for a case that will no longer be covered in the future.

The medical records are reviewed by a staff person who was not involved in the initial decision. A recommendation is made to uphold or reverse the initial decision. The file is then reviewed by a

94. The area of relevant medical records is discussed in more detail below.

physician or registered nurse acting as a medical consultant, who either agrees or disagrees with the recommendation. A written decision is then issued to the beneficiary.

§ 4:6.3 Terminations

CMS also requires that an expedited review notice be given to Medicare beneficiaries whenever a SNF (in addition to a home health agency, hospice, or comprehensive outpatient rehabilitation facility (CORF)) plans to *terminate* services or discharge a patient in Medicare fee-for-service. This notice requirement applies only to complete terminations of service and does not apply to any reduction of service or termination of a specific service within a course of treatment. The form, "Notice of Medicare Non-Coverage," must be issued no later than *two days before* the proposed end of services.

If beneficiaries disagree with the provider that services should be terminated, they can request an expedited determination by the QIO. Beneficiaries must submit a request to the QIO, in writing or by telephone, no later than noon on the calendar day following receipt of the provider's notice of termination. On the day that the QIO receives the request, the QIO must notify the provider that a request for an expedited determination has been made and determine whether the provider delivered a valid notice to the beneficiary.

Once the QIO notifies the provider that the beneficiary has requested an expedited determination, the provider must send a second notice, "Detailed Explanation of Non-Coverage," to the beneficiary by the close of business on the day of the QIO's notification. That notice must include a detailed explanation as to why services are no longer reasonable and necessary or are no longer covered, and a description of any applicable Medicare coverage rule, instruction, or other Medicare policy.

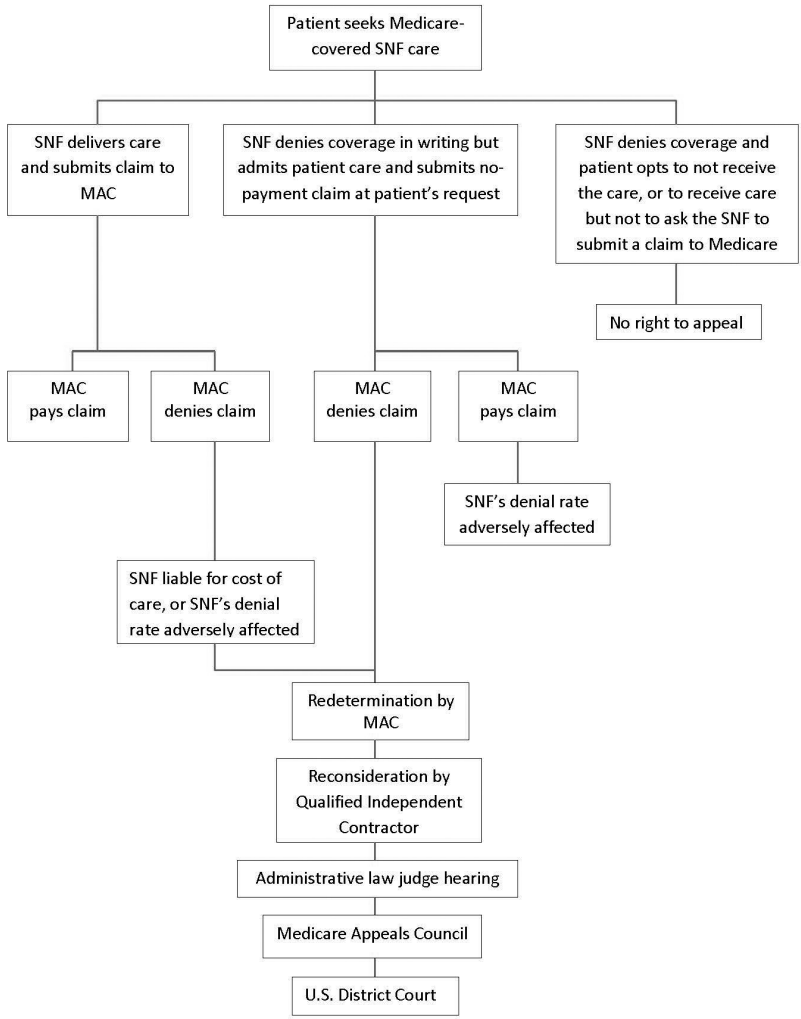
In making its determination, the QIO must solicit the views of the beneficiary and the service provider and, where appropriate, determine whether the physician certification requirement has been met. The QIO expedited determination must be made within seventy-two hours after receipt of the beneficiary's request. In evaluating the request, the burden of proof rests with the provider to demonstrate that termination of coverage is the correct decision on the basis of either medical necessity or other Medicare coverage policies.

A beneficiary who is dissatisfied with the QIO's expedited determination may request an expedited *reconsideration* by the appropriate QIC. The reconsideration process follows a timetable and structure similar to that of the QIO expedited determination. The beneficiary must request an expedited reconsideration by the QIC in writing or by telephone, no later than noon on the calendar day following initial notification of the QIO's expedited determination. If the beneficiary receives an adverse QIC determination, further appeal rights are available.

§ 4:6.4 Appeals Overview

Chart 4-2 gives an overview of the SNF claims submission and appeals process.

Chart 4-2
MEDICARE SKILLED NURSING FACILITY CLAIMS SUBMISSION AND APPEALS PROCESS



§ 4:6.5 Which Medicare Denials for Skilled Nursing Facility Care Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases

A Medicare SNF claim suitable for appeal should meet the following criteria:

(1) The patient must have been hospitalized for at least three days, and, in most cases, must have been admitted to the SNF within thirty days of hospital discharge.

(2) A physician must certify that the patient needs SNF care.

(3) The beneficiary must require "skilled nursing or skilled rehabilitation services, or both, on a daily basis." Skilled nursing and skilled rehabilitation services are those that require the skills of technical or professional personnel, such as registered nurses, licensed practical nurses, physical therapists, and occupational therapists. In order to be deemed skilled the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(4) The SNF must be a Medicare-certified facility.

[A] Other Important Points

(1) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed.[95]

(2) The management of a plan involving only a variety of "custodial" personal care services is skilled when, in light of the patient's condition, the aggregate of those services requires the involvement of skilled personnel.

(3) The requirement that a patient receive "daily" skilled services will be met if skilled rehabilitation services are provided five days per week.

(4) Examples of skilled services include overall management and evaluation of care plan; observation and assessment of the patient's changing condition; Levin tube and gastrostomy feedings; ongoing assessment of rehabilitation needs and

95. Jimmo v. Sebelius, No. 5:11-CV-17-CR (D. Vt. Oct. 16, 2012).

potential; therapeutic exercises or activities; and gait evaluation and training.

(5) If the nursing home issues a notice saying Medicare coverage is not available and the patient seems to satisfy the criteria above, ask the nursing home to submit a claim for a formal Medicare coverage determination. The home must submit a claim if the patient or representative requests; the patient is not required to pay until he or she receives a formal Medicare determination.

(6) Do not be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the patient deserves. It will take some time, but you will probably win your case.

§ 4:7 Home Health Coverage

Traditionally, Medicare covers home health services in full, with no required deductible or copayments from the beneficiary if coverage criteria are met, with no limit on the length of time for which coverage is available, and no requirement that the patient be institutionalized prior to receiving home care.

The Balanced Budget Act of 1997 modified and shifted costs for home care services for beneficiaries enrolled under *both* Part A and Part B by adding a prior institutionalization requirement, establishing a "home health spell of illness" benefit period, and providing a 100-visit coverage limitation per spell of illness under Part A. These changes were effective January 1, 1998, and were phased in over six years. Additional coverage for home health care services that do not meet the Part A coverage criteria and visit limitation are available under Part B. This post-institutional and 100-visit limitation does *not* apply to beneficiaries enrolled *only* in Part A or Part B.

Post-institutional home care is home health services furnished to an individual and initiated within fourteen days of discharge from (a) a hospital or rural primary care hospital in which the individual was an inpatient for at least three consecutive days, **or** (b) an SNF in which the individual was provided post-hospital extended care services.

The home health spell of illness is defined as: a period of consecutive days (a) beginning with the first day (not included in a previous spell of illness) on which an individual is furnished post-institutional home health services and which occurs in a month in which the individual is

entitled to benefits under Part A, **and** (b) ending with the close of the first period of sixty consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of an SNF, nor provided home health services.[96]

The purpose of this change was to facilitate payment for home care benefits out of Part B funds rather than exclusively out of the Medicare trust fund which pays for Part A services. This payment shift was not supposed to have any direct effect on beneficiaries.

§ 4:7.1 Coverage and Qualifying Criteria

Medicare covers home health services when the care is medically necessary and reasonable and the following criteria are met:

(1) patient must be confined to the home (homebound); patient must either:

  (a) because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their residence; OR

  (b) have a condition such that leaving one's home is medically contraindicated.

If the patient meets one of these criteria, then the patient must also meet two additional requirements:

- there must exist a normal inability to leave the home, AND leaving home must require a considerable and taxing effort;

(2) physician has seen the patient up to ninety days prior to start of home care or within thirty days after the start of care, and has documented the need for Medicare home care;

(3) services are furnished under a physician's plan of care (also known as a physician order) and reviewed every two months;

(4) services are received from a certified home health agency;

(5) patient needs "intermittent skilled nursing services" OR physical therapy, speech therapy, or has a continued need for occupational therapy; and

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96. Pub. L. No. 105-33, § 4611(a)–(f), 111 Stat. 251, 472 (1997).

(6) intermittent skilled nursing services are defined as less than seven days a week OR seven days a week up to seven hours per day for twenty-one days or less (with extensions in certain cases).

If the triggering conditions described above are met, the beneficiary is entitled to Medicare coverage for home health services. Home health services include:

(1) "part time or intermittent" skilled nursing care and home health aide services up to seven days a week for less than eight hours a day and provided for up to twenty-eight hours (thirty-five hours in exceptional cases) per week;

(2) physical, speech and occupational therapy;

(3) medical social services; and

(4) medical supplies and equipment.

No deductible or copayment for home health services is required.

In practice, the requirement that a patient be confined to his or her home (usually called the "homebound" rule) and the requirement that he or she need intermittent skilled nursing care or physical or speech therapy assume fundamental importance. Generally, if these two preconditions can be met, the beneficiary can establish eligibility for home health coverage.

[A] Homebound Rule

The requirement that a patient be homebound is described in detail in the Medicare statute:

> [A]n individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is contraindicated. While an individual does not have to be bedridden to be considered "confined to home," the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose

> of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.[97]

This amendment, made in 2000, expanded the list of allowed absences from the home to include adult day-care, when the beneficiary is participating in therapeutic, psychosocial, or medical treatment and absences for religious services. It did not change the existing homebound guidelines and it did not imply that Medicare coverage has been expanded to include adult day-care.[98] Furthermore, CMS issued instructions in 2002 to reassure chronically disabled homebound Medicare beneficiaries that they can continue to receive home health care even if they leave their homes for special nonmedical purposes. The instructions made clear that absences from the home that are infrequent and for short periods of time for events such as family reunions, graduations, or funerals do not jeopardize homebound status.[99]

There are still, however, unresolved questions regarding the homebound definition. For example, a patient is considered confined to his or her home if the patient is unable to leave home "except with the assistance of another individual or the aid of a supportive device." On the other hand, the "condition of the individual should be such that there exists a normal inability to leave home." The question often arises whether a patient in a wheelchair is homebound even though the patient leaves home in the wheelchair on a regular basis. Unavoidably, advocates often find themselves quoting one section of the statute, while Medicare decisionmakers attempt to justify denials with different language.

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97. *Id*. § 1395n(a) (as amended by § 507 of the Beneficiary Improvement and Protection Act (BIPA) of 2000).
98. PROG-MEM HCFA Pub. 60A, Trans. A-01-21, Feb. 6, 2001.
99. MEDICARE BENEFIT POLICY MANUAL, ch. 7, Home Health Services (rev. 233, Feb. 24, 2017) [hereinafter MEDICARE BENEFIT POLICY MANUAL], § 30.1.

The CMS Home Health Agency Manual provides some examples of homebound patients that should be of use to advocates attempting to establish homebound status. According to the manual, the following patients qualify as homebound:

(1) a beneficiary paralyzed from a stroke who is confined to a wheelchair or who requires the aid of crutches in order to walk;

(2) a beneficiary who is blind or senile and requires the assistance of another person in leaving his or her place of residence;

(3) a beneficiary who has lost the use of his or her upper extremities, is thus unable to open doors, use handrails on stairways, and the like, and therefore requires the assistance of another individual in leaving his or her place of residence;

(4) a patient with a psychiatric problem if the patient's illness is manifested in part by a refusal to leave his or her home environment or is of such a nature that it would not be considered safe for the patient to leave the home unattended, even if the patient has no physical limitations; and

(5) a patient in the late stages of amyotrophic lateral sclerosis (ALS) or other neurodegenerative disability.

The manual instructs that in determining whether the patient has a general inability to leave home, and leaves the home only infrequently or for short duration, it is necessary to look at the patient's condition over a period of time rather than for short periods within the home health stay. Thus, a few special trips outside the home when family visit would not disqualify an otherwise homebound patient.[100]

[B] Skilled Nursing Care on an Intermittent Basis

The second principal criterion for home health coverage under Medicare is the requirement that the patient need skilled nursing care on an intermittent basis or physical or speech therapy. If the patient requires physical or speech therapy, the analysis is easy; the test is satisfied. More often, however, an attempt to establish home health coverage is defeated by the beneficiary's inability to show a need for

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100. MEDICARE BENEFIT POLICY MANUAL, *supra* note 99.

intermittent skilled nursing care; either the patient requires no skilled care or the patient requires skilled nursing care exceeding the intermittent level.

While the statute does not contain a detailed definition of "skilled care" for home health purposes, federal regulations do.[101] The regulations specifically adopt the definition and examples of skilled nursing care stated in the SNF regulations.[102] The SNF regulations provide that a skilled service "must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel."[103] Put another way, skilled services are those that must be performed or supervised by a professional person if they are to be fully safe and effective. The SNF regulations also contain numerous examples of skilled services.[104] The skilled services listed there include overall management and evaluation of the patient's care plan, observation and assessment of the patient's changing condition, and specific skilled treatments such as injections, tube feedings, and physical therapy services.[105]

The federal regulations do define physical, speech, and occupational therapy for home care.[106] Importantly, the regulations state that physical therapy may be covered by Medicare as skilled care if the therapy is necessary "to perform a safe and effective maintenance program."[107]

The CMS Home Health Agency Manual defines skilled home health care in a way that parallels the SNF regulations. The manual also provides numerous guidelines and examples to help in determining whether patients require skilled care:[108]

- A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of the nurse. Where a service can be safely and effectively performed by the average nonmedical person, this service cannot be regarded as skilled although a skilled nurse actually provides the service.[109]

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101. 42 C.F.R. §§ 409, 484.
102. 42 C.F.R. § 409.44(b).
103. 42 C.F.R. § 409.32(a).
104. *Id.* § 409.33.
105. *Id.*
106. 42 C.F.R. § 409.44(c).
107. 42 C.F.R. § 409.44(c)(2)(iii).
108. MEDICARE BENEFIT POLICY MANUAL, *supra* note 99, § 40.1.1.
109. *Id.*

- A service that, by its nature, requires the skill of a licensed nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient's family, or other caregivers. For example, the administration of injections of insulin is a skilled service, even when it is taught to a family member.[110]
- A beneficiary's diagnosis should never be the sole factor in deciding that a service the beneficiary needs is either skilled or nonskilled.[111]
- The determination whether a beneficiary needs skilled nursing care should be based solely upon the beneficiary's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or stable.[112]
- Observation and assessment of a patient's condition constitutes a skilled nursing service when the likelihood of change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the beneficiary's treatment regimen is essentially stabilized.[113]
- Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary, and covered under the Medicare program where underlying conditions or complications require that only a registered nurse can ensure that essential nonskilled care is achieving its purpose.[114]

Although a need for skilled nursing care may be identified, if the patient does not require skilled therapy, the question remains whether the patient needs intermittent skilled nursing care as required by the statute. For many years Medicare claims were routinely denied on the basis that the patient involved required more than intermittent skilled nursing care. The meaning of the term "intermittent" was nowhere adequately described. Finally, on August 1, 1988, the U.S. District Court for the District of Columbia issued a decision

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110. *Id.* § 40.1.2.4.
111. *Id.* § 40.1.1.
112. *Id.*
113. *Id.* § 40.1.2.1.
114. *Id.* § 40.1.2.2.

clarifying this point.[115] The case establishes that intermittent means "less than daily."[116]

The term was further clarified in the 1997 Balanced Budget Act defining "intermittent" for qualifying purposes as: "skilled nursing care that is needed or provided on fewer than seven days each week, or less than eight hours of each day for periods of twenty-one days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable)."[117]

In other words, a patient will need intermittent skilled care if he or she needs skilled care visits on six or fewer days per week. If the patient requires daily skilled care on a seven-day-per-week basis, however, the patient will be found to not meet the intermittent rule, and will be considered ineligible for continued home health coverage unless the patient can show that he or she will require daily skilled care for less than eight hours a day for a relatively short period of time (twenty-one days, for example), or that the need for daily skilled care will end at a certain predictable time in the future.[118]

[C] Skilled Therapy Services

A patient's need for physical therapy services will, assuming the patient is homebound, trigger home health coverage even where the patient does not require skilled nursing services. In order to qualify, therapy must be skilled. The CMS Home Health Agency Manual provides that the service of a physical, speech, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the supervision of a skilled therapist.[119] To be considered reasonable and necessary, the therapy must be consistent with the nature and severity of the illness or injury and the beneficiary's particular medical needs. The amount, frequency, and duration of the services must be reasonable, and the services must be considered, under accepted standards of medical practice, to be specific and effective treatment for the patient's condition.[120]

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115. Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).
116. *Id.* at 1511.
117. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4612, 111 Stat. 251, 474 (1997). This provision, effective October 1, 1997, essentially codifies the language defining "intermittent services" found in CMS's policy manual.
118. MEDICARE BENEFIT POLICY MANUAL, *supra* note 99, § 40.1.3.
119. *Id.* § 40.2.1.
120. *Id.*

The following types of skilled therapy are covered by the home health benefit:[121]

- assessment by a physical therapist to determine a beneficiary's rehabilitation needs and potential, or to develop and implement a physical therapy program;
- therapeutic exercises that must be taught by or under the supervision of a qualified physical therapist to ensure the safety of the beneficiary and the effectiveness of the treatment;
- gait training furnished a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality; and
- range-of-motion tests, and range-of-motion exercises, if they are part of an active treatment for a specific disease, illness, or injury that has resulted in a loss or restriction of mobility.

[D] Part-Time or Intermittent Services

Once a patient has satisfied the requirements that he or she be homebound and needs skilled nursing care on an intermittent basis or physical or speech therapy, home health coverage under Medicare is available for the therapy and for the part-time or intermittent services of a home health aide or nurse. As discussed above, intermittent services are services delivered less than daily, that is, less than seven days per week. "Part-time or intermittent" for coverage purposes is defined as "skilled nursing and home health aide services furnished any number of days per week as long as the combined services are less than eight hours per day and provided for twenty-eight or fewer hours per week or (subject to review) up to thirty-five hours per week."[122] Thus, even using the government's own guidelines, application of the part-time or intermittent rule should allow for very extensive coverage of home health nursing and aide services.

Advocates should be aware that although Medicare home health coverage may theoretically by available for extended periods of home health aide care, the Medicare reimbursement system works to discourage the actual delivery of long periods of aide care. Accordingly, advocates will frequently encounter resistance from home health

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121. *Id.* § 40.2.2.
122. *Id.* § 50.7.

agencies fearing inadequate reimbursement for the extended aide visits the advocate wishes the patient to receive.

[E] Chronic, Stable, and Maintenance-Level Patients

Fiscal intermediaries (now MACs) have routinely denied coverage to patients deemed chronic, stable, in need of care to "maintain" their conditions, or who otherwise are not getting better or worse at a rapid pace. In fact, however, neither the Medicare statute nor the regulations employ the words "chronic" or "stable" to describe non-coverable care. Restoration should not be the decisive factor in determining a patient's entitlement to coverage. Furthermore, as the U.S. District Court for the District of Connecticut has ruled in *Fox v. Bowen*, a federal class action concerning Medicare coverage for SNF care, the Secretary of Health and Human Services shall not deny Medicare coverage on the basis of "arbitrary rules of thumb."[123] Instead, as the court ruled in *Fox*, each claimant should receive an individualized assessment of his or her need for care based on the facts and circumstances of the particular case.

A patient afflicted with multiple sclerosis, for example, may well be homebound and require intermittent skilled nursing care, even though the patient is not likely to experience an improvement in his or her medical condition. The CMS Home Health Manual, however, is inconsistent on the availability of home health coverage for patients who are not expected to improve. The manual does specify that chronic or stable patients may be entitled to coverage.[124] Moreover, the manual provides that coverage may be available in some cases for physical therapy intended to "maintain" a patient's condition.[125] On the other hand, the manual also requires that therapy must be provided with the expectation, based on the assessment made by the physician of the beneficiary's rehabilitation potential, that the condition of the beneficiary will improve in a reasonable and generally predictable period of time. The manual's ambiguity on this point leaves home health agencies unsure whether coverage is available to patients unable to recover. In order to avoid the financial penalties associated with a claim submission that is eventually denied

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123. Fox v. Bowen, 656 F. Supp. 1236 (D. Conn. 1986).
124. MEDICARE BENEFIT POLICY MANUAL, *supra* note 99, § 40.1.1.
125. *Id.* § 40.2.1.

by the MAC, most agencies deny coverage themselves and decline to submit a claim unless the patient insists.

Moreover, the Medicare fiscal intermediaries (now MACs) have denied coverage on the basis of a beneficiary's having "a long-standing condition with no significant improvement" or some similar basis. The advocate should be aware of this continued practice and should not hesitate to appeal such denials.

The *Jimmo v. Sebelius* lawsuit[126] challenged the "Improvement Standard" applied by Medicare to home health (HH), skilled nursing facility (SNF), and outpatient therapy (OPT) services.

Under the settlement, Medicare manuals have been revised to clarify that HH and SNF "coverage of nursing care does not turn on the presence or absence of an individual's potential for improvement from the nursing care, but rather on the beneficiary's need for skilled care."

Furthermore, the manual revisions clarify that, under the SNF, HH, and OPT maintenance coverage standards, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist ("skilled care") are necessary for the performance of a safe and effective maintenance program to maintain the patient's current condition or to prevent or slow further deterioration.

The agreement does, however, include one limitation in coverage, by providing that Medicare will not cover maintenance services when there is **not** a need for skilled care, including when "the maintenance program does not require the skills of a therapist because it could be safely and effectively accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers . . . ." In addition, the agreement does not change other existing eligibility criteria for HH (and SNF and OPT) benefits, such as the homebound requirement.

The new guidelines are applicable to fee-for-service Medicare as well as Medicare Advantage managed care plans. It is unknown how many patients are affected by the settlement, or how any changes in practice culminating from this settlement will affect Medicare spending.

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126. Jimmo v. Sebelius, No. 5:11-CV-17-CR (D. Vt. Oct. 16, 2012). Additional information can be obtained at the plaintiff's website, http://www.medicareadvocacy.org.

CMS is required to deploy an education campaign for contractors, providers, suppliers, and other stakeholders about the new guidelines, the enforcement of which depends upon application and an embracement by contractors who process Medicare claims.[127]

§ 4:7.2 Claims Submission and Reimbursement Structure

The home health claims submission process is complex, and is described below, along with notice requirements.

When a beneficiary desires Medicare home health coverage, the beneficiary must approach a home health agency certified by Medicare and request Medicare-covered services. Typically, the agency will evaluate the patient and determine whether coverage will be available for the needed care. If the agency believes that coverage will be granted by the MAC (an insurance company acting as Medicare's agent), the agency will deliver the services and then submit a claim for coverage to the MAC.[128] The claims are usually submitted at two-month intervals.

§ 4:7.3 Notice Requirements

The complexity of this system often leaves the beneficiary unaware of the claims submission process and subsequent appeal rights. A class action case, *Healey v. Shalala*,[129] challenged CMS's failure to provide Medicare home health beneficiaries with timely and adequate notices when home health services are denied, reduced, or terminated by home health agencies. Since the *Healey* case, CMS has instructed home health agencies to provide Home Health Advance Beneficiary Notices (HHABNs) to beneficiaries in certain cases when home care is denied, reduced, or terminated.

Since December 9, 2013, CMS has required that home health agencies (HHAs) use the Advance Beneficiary Notice of Non-coverage (ABN) instead of the HHABN Option Box 1 form for beneficiary liability notices, and the Home Health Change of Care Notice (HHCCN) instead of the HHABN Option Box 2 and Option Box 3

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127. CMS Transmittal 179 (Jan. 14, 2014), http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Download/R179BP.pdf; https://www.cms.gov/Center/Special-Topic/Jimmo-Center.html.
128. 42 C.F.R. § 424.33.
129. Healey v. Shalala, Civil No. 3:98CV00418 (DJS) (D. Conn., filed Mar. 4, 1998).

forms for change of care notifications.[130] These forms apply to services delivered to patients in Medicare fee-for-service (FFS).

The ABN is issued prior to providing an item or service which the HHA believes Medicare will not cover. This form may be required at the initiation, reduction, or termination of services. These scenarios are described below.

[A] ABN at Initiation

Initiations occur at the start of home health care and may also occur when a service is added to an existing home health plan of care (POC). An ABN must be issued to the beneficiary prior to receiving care that is usually covered by Medicare, but, in particular instances, is not covered or may not be covered by Medicare due to the following extenuating reasons:

- the care is not medically reasonable and necessary;
- the beneficiary is not confined to his or her home (not considered homebound);
- the beneficiary does not need skilled nursing care on an intermittent basis; or
- the beneficiary is receiving custodial care only.

[B] ABN for Reductions

Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care, provided by the HHA and/or care that is part of the POC. If a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges, the HHA must issue the ABN prior to providing the non-covered items or services. Technically, this is an initiation of non-covered services following a reduction of services.

[C] ABN for Terminations

A termination is the cessation of all Medicare covered services provided by the HHA. If the patient wants to continue receiving care from the HHA that will not be covered by Medicare for any of the

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130. CMS, Beneficiary Notices Initiative, Fee For Service ABN (last modified Sept. 18, 2013), http://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

previously listed reasons (see the bulleted items in section 4:7.3[A] above) and a physician orders the services, an ABN must be issued to the beneficiary in order for the HHA to charge the beneficiary or secondary insurer. If the beneficiary won't be getting any further home care after discharge, there is no need for ABN issuance.

When all Medicare-covered home health care is terminated, HHAs may sometimes be required to deliver the Notice of Medicare Non-Coverage (NOMNC).[131] The NOMNC informs beneficiaries of the right to an expedited determination by a Quality Improvement Organization if they feel that termination of home health services is not appropriate (see section 4:7.4 below).

[D] Other Insurance

If a beneficiary is eligible for both Medicare FFS and another payor (such as Medicaid or another program), ABN requirements still apply. CMS has clarified that for patients dually eligible for Medicare and Medicaid, if the state Medicaid office does not want a claim filed with Medicare prior to filing a claim with Medicaid, the patient should choose Option 2 on the ABN. If Option 2 is chosen, but the HHA is aware that the state sometimes asks for a Medicare claim submission at a later time, then CMS requires the HHA to add a statement in the 'Additional Information' box such as 'Medicaid will pay for these services. Sometimes, Medicaid asks us to file a claim with Medicare. We will file a claim with Medicare if requested by your Medicaid plan.'

[E] Completion of ABN

Option 1 allows the beneficiary to receive the items and/or services, and requires the HHA to submit a claim to Medicare. This will result in a payment decision that can be appealed. Beneficiaries who need to obtain an official Medicare decision in order to file a claim with a secondary insurance should choose Option 1.

Option 2 allows the beneficiary to receive the non-covered items and/or services, and pay for them out of pocket. No claim will be filed and Medicare will not be billed. Thus, there are no appeal rights associated with this option.

Under Option 3, the beneficiary is indicating that he or she does not want the care in question. By checking this box, the beneficiary

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131. CMS, Beneficiary Notices Initiative, FFS ED Notices (last modified Nov. 20, 2013), http://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html.

understands that no additional care will be provided and thus, there are no appeal rights associated with this option.

HHAs must make a good-faith effort to insert a reasonable estimate for all of the items or services listed in the ABN. In general, CMS expects that the estimate should be within $100 or 25% of the actual costs, whichever is greater.

[F] Exceptions

ABN issuance is **not** required in the following situations:

- initial assessments (in cases where beneficiaries are not admitted) for which HHAs do not charge;
- care that is never covered by Medicare under any circumstances (that is, an HHA offers complimentary hearing aid cleaning and maintenance);
- telehealth monitoring used as an adjunct to regular covered home health care; or
- non-covered items/services that are part of care covered in total under a Medicare bundled payment (for example, home health prospective payment system episodic payment).

[G] HHCCN

HHAs must provide the HHCCN whenever they reduce or terminate a beneficiary's home health services due to physician/provider orders or limitations of the HHA in providing the specific service (such as a lack of staff or unsafe home environment for staff visiting the patient). Notification is required for covered and non-covered services listed in the POC.

Reductions involve any decrease in items and/or services, such as frequency, amount, or level of care, provided by the HHA. When care that is listed on the POC or provided by the HHA is reduced, the beneficiary must receive the HHCCN listing the items/services being reduced and the reason for the reduction, regardless of who is responsible for paying for that service. When a reduction occurs because the HHA decides to stop providing the service for administrative reasons or because of a physician's order, the HHCCN must be issued.

Examples of reductions that require the HHCCN due to physician orders are when the POC lists wound care daily and the doctor writes a new order to decrease wound care to every other day, or the POC

includes wound care twice a week and the doctor writes a new order to discontinue all wound care. Cases that require an HHCCN due to agency reasons include a POC listing physical therapy (PT) services four times a week, but the HHA has an unexpected staffing shortage and can only provide such services twice a week, or PT services are ordered four times a week, and the HHA has lost PT staff and can no longer provide any PT services.

Some important points about the HHCCN:

- HHCCN requirements apply only when home health services are expected to be partially or fully covered by Medicare. When a beneficiary is not receiving services that are expected to be covered under the Medicare home health benefit, the HHCCN is not required. For example, if a dual-eligible beneficiary (having both Medicare and Medicaid) is not receiving any Medicare covered home health services, HHCCN issuance wouldn't be required when changes of care occur. However, HHAs are required to issue the ABN to dual eligible beneficiaries when applicable (see 4:7.3[D] above).
- When multiple care changes occur due to simultaneous order changes and agency-specific reasons for change, the HHA must give the beneficiary two separate HHCCNs so that she or he can identify the reason that corresponds to each change. Only one check box indicating the reason for change can be marked on each HHCCN.
- HHAs may list multiple change-of-care scenarios on a preprinted HHCCN. If multiple scenarios are listed, the beneficiary should be able to clearly identify the information that pertains to his or her case. HHAs may use checkboxes to indicate information applicable to the beneficiary. Alternatively, applicable items can be circled, or items that do not apply can be crossed out.
- An ABN is issued (and not the HHCCN) if a reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges.
- The NOMNC must be issued to the beneficiary when all Medicare covered services are ending based on the physician's orders. Since the NOMNC provides written notification of the forthcoming termination of all home health care, it satisfies the

regulatory requirement for change of care advisement (HHCCN issuance). Thus, when the NOMNC is issued as required, a separate HHCCN does **not** need to be issued.

The HHCCN is **not** required when changes in care include:

- increase in care;
- changes in HHA caregivers or personnel as decided by the HHA;
- changes in expected arrival or departure time for HHA staff as determined by the HHA;
- changes in brand of product (that is, the same item produced by a different manufacturer) as determined by the HHA;
- change in the duration of services that has been included in the POC and communicated to the beneficiary by the HHA (that is, shorter therapy sessions as health status improves, such as a reduction from an hour to forty-five minutes);
- lessening the number of items or services in cases where a range of services is included in the POC;
- changes in the mix of services delivered in a specific discipline (for example, skilled nursing) with no decrease in frequency with which that discipline is delivered;
- changes in the modality affecting supplies employed as part of specific treatment (for example, wound care) with no decrease in the frequency with which those supplies are provided; or
- changes in care that are the beneficiary's decision and are documented in the medical record.

§ 4:7.4 Terminations

CMS also requires that an expedited review notice be given to Medicare beneficiaries whenever a home health agency (in addition to a SNF, hospice, or CORF) plans to *terminate* services or discharge a patient in Medicare fee-for-service. This notice requirement applies only to complete terminations of service and does not apply to any reduction of service or termination of a specific service within a course of treatment. The form, "Notice of Medicare Non-Coverage," must be issued no later than *two days before* the proposed end of services.

If beneficiaries disagree with the provider that services should be terminated, they can request an expedited determination by the QIO. Beneficiaries must submit a request to the QIO, in writing or by telephone, no later than noon of the calendar day following receipt of the provider's notice of termination. On the day that the QIO receives the request, the QIO must notify the provider that a request for an expedited determination has been made and determine whether the provider delivered a valid notice to the beneficiary.

Once the QIO notifies the provider that the beneficiary has requested an expedited determination, the provider must send a second notice, "Detailed Explanation of Non-Coverage," to the beneficiary by the close of business on the day of the QIO's notification. That notice must include a detailed explanation why services are no longer reasonable and necessary or are no longer covered, and a description of any applicable Medicare coverage rule, instruction, or other Medicare policy.

In making its determination, the QIO must solicit the views of the beneficiary and the service provider, and, where appropriate, determine whether the physician certification requirement has been met. The QIO expedited determination must be made within seventy-two hours after receipt of the beneficiary's request. If the QIO determination is adverse, the beneficiary may request an expedited *reconsideration* by the appropriate QIC. Should the beneficiary receive an adverse QIC determination, further appeal rights are available.

Since October 1, 2000, Medicare has been paying all home health agencies under a prospective payment system.[132] Medicare pays providers for each covered sixty-day episode of care. As long as beneficiaries continue to remain eligible for home health services, they may receive an unlimited number of medically necessary episodes of care. The system includes 153 home health resource utilization groups that serve as the basis of determining the episode payment. Medicare makes payment adjustments for patients with greater needs or those requiring four or fewer visits per episode.

§ 4:7.5 Appeals Overview

Chart 4-3 gives an overview of the home health care claims submission and appeal process.

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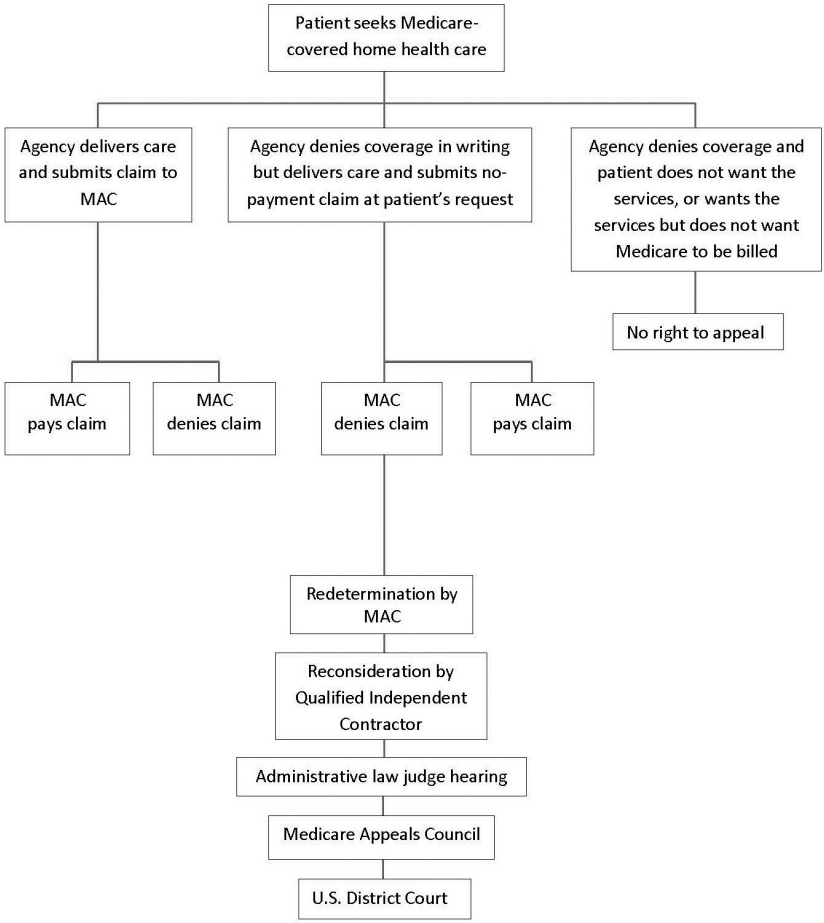
132. The change was mandated by the Balanced Budget Act of 1997 and amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1998 and the Balanced Budget Refinement Act of 1999.

Chart 4-3
MEDICARE HOME HEALTH CLAIMS SUBMISSION AND APPEALS PROCESS



§ 4:7.6 Which Medical Denials for Home Health Services Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases

A home health claim suitable for appeal should meet the following criteria:

(1) A physician has signed or will sign a care plan.

(2) The patient has had a face-to-face encounter with the physician that certifies the home health plan of care in the ninety days prior to, or within thirty days of, the start of services.

(3) The patient is or will be homebound. This criterion is met if the patient needs personal assistance, or the help of a wheelchair, crutches, etc., in order to leave the home. Occasional but infrequent "walks around the block" are allowable.

(4) The patient needs or will need skilled nursing care on an intermittent basis or physical or speech therapy.

(5) The care must be provided by, or under arrangements with, a Medicare-certified provider.

[A] Additional Advocacy Tips

- It makes no difference whether the patient's condition is chronic or stable. Restorative potential is not necessary.
- Ignore arbitrary caps on coverage imposed by the MAC. For example, do not accept MAC assertions that aide services in excess of nine hours per week are not covered, or that daily nursing visits cannot be covered. In practice, ALJs will grant home health coverage for daily nursing services (at least where it can be shown that the need for daily nursing will not continue indefinitely) as well as aide services totaling as many as thirty-five hours per week.
- In order to be able to appeal a Medicare denial, the home health agency must have filed a Medicare claim for the patient's care. The patient or representative should request, in writing, that the home health agency file a Medicare claim even if the agency told the patient that Medicare will deny coverage.
- Do not be satisfied with a Medicare determination unreasonably limiting coverage; appeal for the benefits the patient

deserves. Appeals take some time, but they often result in additional benefits.

§ 4:8 Part A: Hospice Coverage

Medicare hospice benefit[133] is different from all other Medicare programs in that it does not provide for the treatment of illness or injury.[134] Rather, it is designed for the palliation and management of terminal illness,[135] and covered hospice services must be reasonable and necessary for that purpose. As a result, both eligibility for the hospice benefit and the services that can be obtained under it differ from other Medicare benefits. In addition, one can receive hospice benefits under Medicare only after specifically opting into the hospice benefit and thereby opting out of all other Medicare Part A services not provided by the hospice or by arrangement with the hospice.[136] Health maintenance organizations are not required to provide hospice services to Medicare beneficiaries. Those Medicare beneficiaries enrolled in a health maintenance organization must, like other Medicare beneficiaries, opt into the hospice benefit.[137]

Medicare hospice services must be provided by a Medicare-certified hospice program.[138] The hospice must meet various conditions of participation in order to become Medicare certified.

§ 4:8.1 Coverage and Qualifying Criteria

The Medicare hospice benefit is provided under Part A of the Medicare program. Therefore, in order to be eligible for hospice benefits, one must be enrolled in Medicare Part A. Unlike other Medicare programs, however, a beneficiary who chooses to receive hospice benefits must be certified by the individual's attending physician and/or a physician associated with the hospice[139] as

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133. Social Security Act § 1861(dd); 42 U.S.C. § 1395x(dd).
134. Social Security Act § 1862(a)(1)(A); 42 U.S.C. § 1395y(a)(1)(A).
135. Social Security Act § 1862(a)(1)(C).
136. 42 C.F.R. § 418.24.
137. *Id.* § 417.414.
138. *Id.* §§ 418.50 *et seq.*
139. Both the hospice physician and the patient's attending physician (if the patient has an attending physician) must certify that the patient is terminally ill for the first ninety-day election period. For subsequent election periods, only one physician is required to certify that the patient is terminally ill. 42 C.F.R. § 418.22(c)(1)(i), (ii).

terminally ill.[140] The written certification must state that the individual's medical prognosis is such that his or her life expectancy is six months or less.[141] The certification is filed with the hospice. If a physician provides a verbal certification to the hospice within two days of the initiation of the patient's care, the physician may provide the written certification within eight days after the patient's care is initiated.

The Medicare hospice benefit covers the following services:

- nursing care provided by or under the supervision of a registered nurse;
- medical social services provided by a social worker under the direction of a physician;
- physician's services;
- counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home;
- short-term inpatient care for symptom control, and for respite care not to exceed five consecutive days, provided in a participating hospice inpatient unit or in a participating hospital or nursing facility;
- medical appliances and supplies, including drugs and biologicals;
- home health aide services;
- homemaker services; and
- physical therapy, occupational therapy, and speech-language pathology services provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.[142]

Any services that are to be provided to a Medicare hospice patient must be included in a written plan of care established by the attending physician, the medical director of the hospice or the director's

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140. Social Security Act § 1814(a)(7); 42 U.S.C. § 1395f(a)(7); 42 C.F.R. § 418.20.
141. 42 C.F.R. § 418.22(b).
142. 42 C.F.R. §§ 418.202, 418.204.

physician-designee, and the hospice interdisciplinary group.[143] The plan must include an assessment of the patient's needs and must identify the services (including the management of discomfort and symptom relief) to be provided, and it must state in detail the scope and frequency of services needed to meet the patient's and family's needs.[144] The plan must also specify the drugs and biologicals that will be administered to the patient and the persons authorized to administer each.[145] The written plan of care must be reviewed and updated at intervals specified in the plan itself and the hospice must document these reviews and updates.[146]

§ 4:8.2 Deductibles and Coinsurance for Non-Hospice Care

The hospice patient is liable for coinsurance amounts only for respite care and drugs and biologicals. No other services provided by the hospice for the palliation and management of the patient's terminal illness may be billed to the patient.

The patient, however, may be liable for deductibles, coinsurance amounts, and part of the difference between actual charges and approved amounts on unassigned claims for services not considered hospice care. Examples of services not considered hospice care and consequently subject to these various charges are services furnished before or after a hospice election; services of the individual's attending physician, if the attending physician is not an employee of or working under arrangements with the hospice; and Medicare services received for the treatment of an illness or injury not related to the individual's terminal condition.[147]

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143. Each hospice must establish an interdisciplinary group composed of individuals who provide or supervise the care and services offered by the hospice. The interdisciplinary group must include at least a physician, a registered nurse, a social worker, and a pastor or other counselor. The group is responsible, in addition to establishing the written care plan, for provision or supervision of the hospice care and services and for periodic review and updating of the plan of care for each individual receiving hospice care, as well as establishing policies governing the day-to-day provision of hospice care and services. 42 C.F.R. § 418.56.
144. 42 C.F.R. § 418.54.
145. *Id.*
146. *Id.* § 418.54(d).
147. *Id.* § 418.402.

§ 4:8.3 Election of the Hospice Benefit

[A] Who May Make an Election for Hospice Care

Ideally, an election of the hospice benefit is made by the patient. However, sometimes a patient may be so incapacitated that the patient is unable to make the election. Medicare regulations provide that an election may be filed by either the beneficiary or the beneficiary's representative. A representative means a person who is, because of the beneficiary's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual.[148]

[B] How the Election Is Made and How It Is Revoked

An election to receive hospice care is made by filing an election statement with a hospice of choice.[149] An election statement may be filed by either the beneficiary or his or her representative.[150] As noted above, once a beneficiary has elected to receive the hospice benefit, he or she waives all rights to Medicare payments for services that are related to the treatment of the terminal condition or a related condition except for services provided by the designated hospice or by another provider under arrangements made by the designated hospice, or by the individual's attending physician.

An election can be made for two ninety-day benefit periods of hospice care, followed by an unlimited number of sixty-day periods.[151]

A patient who is expected to enter a third benefit period (after 180 days) or a subsequent sixty-day benefit period must be seen in person by a hospice physician or hospice nurse practitioner to gather information that supports the patient's continuing eligibility for hospice care.[152]

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148. *Id.* § 418.3.
149. *Id.* § 418.24(a).
150. *Id.* § 418.3.
151. 42 C.F.R. § 418.21.
152. *Id.* § 418.22(a)(1), (4).

The election for any period lasts until it lapses by time or until the beneficiary revokes the election. If the beneficiary voluntarily revokes the election, he or she forfeits any remaining days in the period.[153] A patient who has elected the ninety-day period and then revokes that election would have no remaining hospice days.

For example, assume that Mrs. Jones is electing to use her first ninety-day hospice period. If she elects hospice coverage to commence on February 4, she will have hospice coverage until May 4, a total of ninety days. On May 4, she could elect another period of hospice coverage. However, if she were to revoke her election on March 9, she would have used only thirty-four days of the period and would forfeit the remaining fifty-five days of that period. At a later date, however, she could elect to commence a new ninety-day period of hospice coverage.

An individual may revoke the election at any time during an election period by filing with the hospice a signed statement revoking Medicare hospice coverage for the remainder of the period. The statement must include the date the revocation is to be effective, but in no event can this be earlier than the date on which the revocation is made. Upon the revocation of hospice coverage, the beneficiary resumes Medicare coverage of the benefits previously waived.[154]

As a practical matter, each hospice usually has designed and printed its own election and revocation statements for the use of the beneficiary. The patient or advocate should contact the hospice for such forms.

[C] Changing the Hospice That Is Providing Care

Once each election period, a beneficiary may change the designation of the particular hospice from which the care will be received. The change of the designated hospice is not a revocation of the election of hospice benefits. In order to change the designated hospice, the beneficiary or representative must file with both the old hospice and the new hospice a signed statement indicating the name of each hospice and the effective date of the change.[155]

Note that such a change may be made only once during each election period. If an additional change is desired, the beneficiary

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153. *Id.* § 418.28(c).
154. *Id.* § 418.28(b), (c).
155. *Id.* § 418.30.

must revoke the hospice election, thereby forfeiting any days remaining in the period, and elect hospice coverage with a different hospice using a new election period.

§ 4:8.4 The Appeals Process

Hospice patients are afforded the same appeal rights as those granted to other recipients of services under Part A of Medicare.

As a practical matter, denials of coverage in the hospice area seem to occur with much less frequency than denials of coverage to patients receiving care in other settings.

§ 4:8.5 Which Medicare Denials for Hospice Care Should Be Appealed: A Quick Screen to Aid in Identifying Coverable Cases

A Medicare hospice claim suitable for appeal should meet the following criteria:

(1) The patient has remaining hospice election periods available. Patients are entitled to two ninety-day election periods, and an unlimited number of sixty-day periods. The two ninety-day periods must be used before the sixty-day period.

(2) The attending physician and a physician associated with the hospice (in the case of the first ninety-day election period) have certified that the patient is terminally ill. For subsequent election periods, only one physician need certify that the patient is terminally ill.

(3) The patient or his or her representative has signed and filed a hospice election form with the hospice of choice.

(4) The hospice of choice is Medicare-certified.

(5) The services for which Medicare coverage has been denied were provided for the palliation and management of the terminal illness and were included in the written plan of care established by the attending physician, a hospice physician, and the hospice interdisciplinary group.

[A] Additional Advocacy Tips

✔ The attending physician is always the key to obtaining Medicare benefits. Obtain a statement from the patient's physician

stating that the patient was terminally ill, that the services provided were reasonable and necessary for the palliation and management of the terminal illness, and that the services were included in the written plan of care. In situations where coverage has been denied for inpatient services, have the physician state that the inpatient care was reasonable and necessary and that the care could not have been provided in anything other than an inpatient setting.

✔ The requirement that a patient be terminally ill will be met if the physician certifies that the patient's life expectancy is six months or less.

§ 4:9 Part B

Part B of Medicare is intended to fill some of the gaps in medical insurance coverage left under Part A. Part B has an annual deductible ($185 in 2019). Each year, before Medicare pays anything, the patient must incur medical expenses sufficient to meet the deductible, based on Medicare's "approved charge," not on the provider's actual charge.

§ 4:9.1 Covered Services

The major benefit under Part B is payment for physicians' services. In addition, durable medical equipment, outpatient therapy, diagnostic X-rays, laboratory tests, and preventive services are also covered. The following items and services can be covered under Part B:

- physicians' services;
- services and supplies, including drugs and biologicals that cannot be self-administered, furnished incident to physicians' services;
- diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests;
- x-ray therapy, radium therapy, and radioactive isotope therapy;
- surgical dressings and splints, casts, and other devices used for fractures and dislocations;
- durable medical equipment;
- prosthetic devices;
- braces, trusses, artificial limbs, and eyes;

- ambulance services;
- outpatient and ambulatory surgical services;
- outpatient hospital services;
- physical therapy services;
- occupational therapy;
- outpatient speech therapy;
- CORF services;
- rural health clinic services;
- institutional and home dialysis services, supplies, and equipment;
- ambulatory surgical center services;
- antigens and blood-clotting factors;
- pneumococcal vaccination, influenza vaccine, and hepatitis B vaccine;
- screenings for hepatitis C;
- annual screening mammograms for women age forty and older;
- annual screening pap smear and pelvic exams for women at high risk of cervical or vaginal cancer (once every two years for women not at risk);
- screenings for colorectal cancer;
- screenings for prostate cancer;
- screenings for glaucoma;
- screenings for lung cancer;
- bone mass measurement;
- outpatient diabetes self-management training and blood glucose monitors and testing strips for all diabetes;
- medical nutrition therapy services;
- qualified psychologist services;
- therapeutic molded shoes for diabetics;

- depression screening;
- screening and counseling for alcohol misuse;
- cardiovascular disease risk reduction;
- screening and counseling for obesity; and
- other preventive services.

Medicare Part B is fairly comprehensive but far from complete. Certain items and services are excluded from coverage:

- services that are not medically reasonable or necessary;
- custodial care;
- personal comfort items and services;
- care that does not meaningfully contribute to the treatment of illness, injury, or a malformed body member;
- routine physical checkups, except annual wellness visits;
- eyeglasses or contact lenses in most cases;
- eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lenses;
- hearing aids and examinations for hearing aids;
- immunizations except for pneumococcal, influenza, and hepatitis B vaccine;
- orthopedic shoes and other supportive devices for the foot unless intended as an instrumental part of a leg brace;
- cosmetic surgery;
- most dental services; and
- routine foot care.

Medicare Part B is optional. It is financed in part by premiums paid by individuals enrolled in the program. See Appendix 4A for premium amounts. Participants usually have this premium automatically deducted from their Social Security checks.

Individuals receiving Social Security retirement benefits, individuals receiving Social Security disability benefits for twenty-four months, and individuals otherwise entitled to Medicare Part A are automatically enrolled in Part B unless they decline coverage. Others

must enroll in Part B by filing a request at the Social Security office during certain designated periods.

One problem with Medicare Part B for beneficiaries in Medicare fee-for-service is the difference between the cost of medical items or services, particularly physicians' services, and the Medicare-approved charge.

§ 4:9.2 Approved Charges and Balance Billing

When an item or service is determined to be coverable under Medicare Part B, it is reimbursed at 80% of a payment rate approved by Medicare known as the "approved charge"; the patient is responsible for the remaining 20%. Unfortunately, the "approved charge" is often substantially less than the actual charge. The obvious result of this reimbursement system is that Medicare payment, even for items and services covered by Part B, is often inadequate. The patient is left with out-of-pocket expenses. When a physician accepts "assignment," he or she agrees to accept the Medicare-approved charge as full payment for the services provided. Medicare pays 80% of the approved charge. Either the patient or supplemental insurance pays the remaining 20% copayment. No further payment is due to the physician.

When a physician does not accept assignment, however, he/she may "balance bill" the patient above the Medicare-approved charge. "Balance bill" refers to a physician's charge above the Medicare-approved rate. In New York State, the amount doctors can charge in excess of Medicare's approved charge is limited by state law.[156] For most services, state law mandates that physicians who do not accept assignment can charge no more than 5% above the Medicare-approved charge. For example: Dr. Blanc performs anesthesia services during an operation. She does not accept assignment. Medicare approves $400 for the procedure and pays 80%, or $320, to the patient. The most that Dr. Blanc can bill her patient is $420 (105% of $400).

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156. N.Y. PUB. HEALTH LAW § 19. The constitutionality of this law was upheld in Med. Soc'y of the State of N.Y. v. Cuomo, 777 F. Supp. 1157 (S.D.N.Y. 1991), *aff'd*, No. 91-9364 (2d Cir. Sept. 24, 1992). The law was also challenged in state court based on the wording of the statute, which refers to the federal "reasonable charge" rather than the new federal relative value scale. This challenge was upheld at the trial court level but reversed on appeal. Med. Soc'y of the State of N.Y. v. N.Y. State Health Dep't, Index No. 2358-92 (N.Y. Sup. Ct. Albany Cty. 1992), *rev'd*, No. 66610 (App. Div. 3d Dep't 1993).

The state limit on balance billing does not apply to selected home and office visits for basic medical examinations. These visits include services which can be identified by codes 99201 to 99215 (routine office visits), 99341 to 99353 (routine home visits), 99375, and 99376 on the MSN. For selected home and office visits not covered by New York State law, federal law sets a limit, known as the "limiting charge," on the amount a physician may balance bill. A physician cannot bill a patient more than 115% of the approved charge on an unassigned claim.[157]

For example, assume the patient goes to a doctor who does not accept assignment. The doctor's actual charge is $600, but the Medicare-approved charge is only $400. The doctor's total bill may not exceed $460 (115% of $400); this is the limiting charge. Medicare will pay $320 (80% of the $400 approved charge) directly to the patient. The patient's out-of-product expense is $140 ($460 minus Medicare payment of $320). If the doctor bills above $460, he is billing above the limiting charge and is violating federal law.

Individuals can compute the maximum amount that physicians can charge them by (1) reviewing the approved charge on the MSN received from the Medicare carrier; and (2) multiplying the approved charge by the appropriate percentage (105% or 115%). Individuals who believe they have been overcharged and have not been able to receive a refund from their physician can contact the New York State Department of Health by calling 518-408-1245 (ask for the staff member who handles balance billing complaints).

The New York State limit or the federal limiting charge applies only to physician services and other services paid pursuant to the Medicare physician fee schedule, for example, the services of an independent physical therapist. Neither the state limit nor the federal limiting charge, however, applies to other items and services such as durable medical equipment. Specific limiting charge information can be obtained by calling the number listed on the MSN.

Medicare beneficiaries can locate physicians who always accept assignment by obtaining names of participating providers. Such providers have signed an agreement with Medicare to accept Medicare assignment from all Medicare patients. For information on participating providers, individuals can call 1-800-MEDICARE.

Doctors who are not participating providers are allowed to accept assignment on a case-by-case basis, and thus patients should always

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157. 42 U.S.C. § 1395w-4(g).

ask if their doctor accepts assignment. Furthermore, all providers must accept assignment for their Medicare patients who are also enrolled in Medicaid or the "buy-in" program.[158]

Medicare beneficiaries who require elective surgery are specifically protected from excessive balance billing. A physician who performs elective surgical procedures costing $500 or more must provide a written disclosure concerning the actual costs to the beneficiary.[159] The written disclosure must show the estimated actual charge, the estimated Medicare-approved charge, the excess of the actual charge and the Medicare 20% coinsurance amount. Disclosure of this information allows the beneficiary to make an informed decision concerning the surgery. If a physician fails to disclose this information in writing, the patient can be charged only the Medicare-approved rate. Even when proper disclosure is made, a physician may not charge above the limiting charge level described above.

When multiple surgical procedures are performed during a single operative session, Medicare reimbursement is decreased. Medicare policy requires that MACs must establish "guidelines" which allow reimbursement for only the major procedure or the major procedure and partial amounts of the secondary procedure.[160] CMS policy is to pay at 100% of the Medicare allowance for the highest valued procedure and 50% for the second, third, fourth, and fifth procedures.[161]

§ 4:9.3 Advance Beneficiary Notice

Medicare Part B protects beneficiaries from having to pay for some services that are denied because they are considered "not reasonable and necessary." In such cases, if the beneficiary could not have been expected to know that the services would not be covered, the beneficiary is not held liable, and the provider may not bill the beneficiary. To protect themselves from liability, providers are allowed to provide notices, known as Advance Beneficiary Notices of Noncoverage (ABNs), to Medicare beneficiaries before Medicare Part B services are furnished if they believe that Medicare will not pay for all

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158. *See infra* section 6:5.4.
159. 42 U.S.C. § 1395u(m).
160. MEDICARE CLAIMS PROCESSING MANUAL § 40.5.
161. EMPIRE MEDICARE SERVICES, HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM IMPLEMENTATION INSTRUCTIONS (May 2000); EMPIRE MEDICARE SERVICES, MEDICAL POLICY BULLETIN: MULTIPLE SURGICAL PROCEDURES (Jan. 1, 1996).

or part of the services because the services are not medically reasonable and necessary.

The Part B ABN must include a detailed explanation in lay language explaining why the provider believes that Medicare will deny payment for the service and an estimated cost for the service. If the beneficiary is not given an ABN or the notice does not meet certain delivery and format requirements, the beneficiary is not responsible for paying the provider if Medicare denies payment. Providers are *not* required, however, to give ABNs to beneficiaries before providing Medicare Part B *excluded* services, which include routine physicals and certain screening tests, cosmetic surgery and personal comfort items. Beneficiaries who have been given an ABN, have exercised the option for billing Medicare, and have received a denial from Medicare should still be encouraged to appeal Medicare's denial of payment.[162]

§ 4:9.4 Ambulance Services

[A] Coverage Rules

Medicare pays for ambulance services when three requirements are met: "medical necessity," "destination" rules, and provision by an approved ambulance supplier. Generally, Medicare covers ambulance services only if they are furnished to a beneficiary "whose medical condition is such that other means of transportation would be contraindicated." Some examples of conditions for which ambulance transportation is considered medically necessary include: an emergency situation (that is, an accident, injury, or acute illness); unconsciousness; severe hemorrhage; or shock.

Medicare categorizes ambulance services as "emergency" or "nonemergency." An emergency service is defined as "one that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(i) placing the beneficiary's health in serious jeopardy;

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162. For more information on ABNs, see CMS, Beneficiary Notices Initiative Overview Page, http://www.cms.hhs.gov/bni.

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

[B] Non-emergency Services

Non-emergency services refer to all ambulance trips that do not meet the emergency criteria. Non-emergency transportation will be covered if *either*: the beneficiary is "bed-confined" and it is documented that other means of transportation are contraindicated; *or* the beneficiary's medical condition, regardless of bed confinement, requires ambulance transportation. For a beneficiary to be considered bed-confined, *all* of the following must be met:

(i) the beneficiary is unable to get up from bed without assistance;

(ii) the beneficiary is unable to ambulate; *and*

(iii) the beneficiary is unable to sit in a chair or wheelchair.

[C] Physician Certification Rules

In addition to the above criteria, additional rules apply to non-emergency services. For *scheduled, repetitive* services, Medicare will only cover non-emergency services if the ambulance supplier, *before* furnishing the service, obtains a written order or certification from the beneficiary's attending physician certifying that the trip is medically necessary. The physician's certification must be dated no earlier than *sixty days* prior to the date of the ambulance trip.

For *unscheduled* services or services that are scheduled on a non-repetitive basis, Medicare only pays for non-emergency ambulance trips under the following circumstances:

- for residents of a facility who are under the care of a physician if the ambulance supplier obtains a written order from the beneficiary's attending physician, within *forty-eight hours after* the trip, certifying that the trip was medically necessary; or
- for a beneficiary residing at home or in a facility who is not under the care of a physician (without a requirement for physician certification of medical necessity).

If the ambulance supplier is unable to obtain the required certification from the beneficiary's attending physician, a signed certification

from certain staff who are employees of the attending physician will suffice. In situations where the ambulance supplier is unable to obtain the required certification within *twenty-one calendar days* following the date of service, the supplier must document its attempts to obtain the certification and may then submit the claim.

[D] Levels of Service

Medicare covers the following levels of ambulance service:

- Basic life support (BLS): transportation by ground ambulance vehicle, medically necessary supplies and services, and provision of BLS ambulance services.
- Advanced Life Support, level 1 (ALS1): transportation by ground ambulance vehicle, medically necessary supplies and services, and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.
- Advanced Life Support, level 2 (ALS2): either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications intravenously or by continuous infusion; or transportation, medically necessary services and supplies, and the provision of at least one of the following ALS procedures: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway or intraosseous line.
- Paramedic ALS Intercept (PI): Emergency Medical Technician-Paramedic services furnished by an entity that does not furnish the ground ambulance transport.
- Specialty Care Transport (SCT): inter-facility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level beyond the scope of the Emergency Medical Technician-Paramedic.
- Fixed Wing (FW) air transport: transportation by an aircraft that is certified as a fixed wing air ambulance and such services and supplies as may be medically necessary.

- Rotary Wing (RW) air transport: transportation by a helicopter that is certified as an ambulance and such services and supplies as may be medically necessary.

[E] Destination Requirements

Ambulance transport is allowed to the nearest facility unless necessary services are not available locally. In cases where services are not available locally, transportation to the nearest facility furnishing those services is covered. Medicare pays for transportation:

- from any point to the nearest hospital, critical care access hospital (CAH), or SNF that is capable of furnishing the required level of care;
- from a hospital, CAH, or SNF to the beneficiary's home;
- from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, and back to the SNF;
- from the home of a patient receiving renal dialysis to the nearest facility that furnishes renal dialysis, and back home;
- from a hospital or SNF to a physician's office to obtain medically necessary diagnostic or therapeutic services *not* available at the institution where the beneficiary is an inpatient (and which are less costly than bringing to the patient); or
- to a physician's office on the way to a hospital made because of the beneficiary's dire need for professional attention, and immediately thereafter, the ambulance continues to the hospital.

[F] Fee Schedule and Mandatory Assignment

Ambulance services are paid a pre-established fee for each different service provided (a fee schedule) and ambulance suppliers are required to accept assignment; that is, to accept the Medicare-approved fee as their full payment.[163] This means beneficiaries only have to pay 20% of the Medicare-approved amount after they have met their annual Medicare Part B deductible (unless they have other insurance that reimburses for the 20% coinsurance).

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163. 67 Fed. Reg. 9100–35 (Feb. 27, 2002).

§ 4:9.5 Part B: Appeals

The Part B appeals process is similar to Part A. Following the initial determination (the MSN), there is a "redetermination," which is the counterpart to a Part A redetermination. The next steps in the administrative appeals process are the reconsideration by the QIC and the ALJ hearing. There must be at least $160 in controversy to request an ALJ hearing. Following the ALJ hearing, there is an appeal to the Medicare Appeals Council when there is $160 or more in controversy and to federal district court where there is at least $1,630 in controversy.[164] Multiple claims may be aggregated in order to meet the $160 amount in controversy.[165]

§ 4:10 Medicare and Medicaid

Medicare is title 18 and Medicaid is title 19 of the Social Security Act.[166] Although these two health coverage programs are both part of the Social Security Act, they are very different. Medicare is an "insurance program . . . [that] provides basic protection against the costs"[167] of medical services, while Medicaid's purpose is "to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services."[168] The basic difference, then, is that Medicare is an insurance program and Medicaid is an entitlement or welfare program for the indigent. Two other points should be kept in mind:

- Medicaid provides more comprehensive medical benefits than Medicare.
- Medicaid pays for more than 50% of all nursing home care nationally.

It is particularly important to know that many individuals are dually eligible for both Medicare and Medicaid. Most often a Medicare beneficiary will become eligible for Medicaid coverage because of excessive medical costs that have caused the beneficiary to become impoverished.

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164. 42 U.S.C. § 1395ff(b).
165. 42 C.F.R. § 405.817.
166. *See* 42 U.S.C. §§ 1395 *et seq*.
167. 42 U.S.C. § 1395c.
168. *Id*. § 1396.

Many states, including New York, provide Medicare "buy-in" for their Medicaid recipients. This means that the state Medicaid agency pays the Medicare premiums, deductibles, and coinsurance payments for dually eligible beneficiaries.[169]

(The specific income and resource requirements for New York's buy-in program can be found in chapter 6, in the section on the Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary and Qualified Individuals-1 Programs.)

For Medicare Part B services, first Medicare will pay 80% of the approved charge (after the annual deductible is met). Effective July 1, 2015, Medicaid will not pay 20% of the approved charge (and any part of the deductible that has not been met) to physicians and some other providers participating in the Medicaid program if the Medicare payment is more than the Medicaid fee or rate for that service.[170] Providers must accept assignment for such individuals; that is, they cannot charge more than Medicare's approved charge.

For Medicare Part A services, providers participating in both Medicare and Medicaid will first receive reimbursement from Medicare and then can submit bills to Medicaid for deductibles and copayments not paid by Medicare.

§ 4:11 Medicare As Secondary Payer

In most instances, Medicare is the primary payer of medical services. Secondary payment usually comes from other sources (for example, Medigap insurance and Medicaid). However, there are instances when another payment source is primary and Medicare becomes a secondary payer.

§ 4:11.1 When Medicare Is a Secondary Payer

Medicare becomes the secondary payer under the following specific circumstances:

- workers' compensation plans;[171]
- automobile and liability insurance coverage;[172]

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169. *Id.* §§ 1396a(a)(10)(E), 1396d(p) (effective Jan. 1, 1989).
170. Ambulances, psychologists, and certain clinics will still receive 20% of Medicare's approved charge from Medicaid.
171. 42 U.S.C. § 1395y(b)(2)(A)(ii).
172. *Id.*

- employer group health plan coverage to beneficiaries with end-stage renal disease;[173]
- employer group health plan coverage to elderly employees and spouses;[174] and
- employer large group health plan coverage to disabled individuals and family members.[175]

[A] Automobile and Liability Insurance

Medicare is precluded from paying for services that will be made under automobile liability or no-fault insurance. The Medicare beneficiary is responsible for obtaining payment from a no-fault insurer.[176] A conditional Medicare payment may be made when a claim is pending before a liability or no-fault insurance carrier, or if the beneficiary failed to file a claim because of physical or mental incapacity.[177] The beneficiary is expected to complete a Report to Medicare of Automobile or Liability Insurance Coverage[178] and file it with the Medicare intermediary and/or carrier.[179]

[B] Employer Group Health Plan: End-Stage Renal Disease

This provision of the law pertains to beneficiaries eligible for Medicare solely on the basis of being a dialysis patient. When such a beneficiary is also covered by an employer group health plan (EGHP), Medicare is the secondary insurer for a period of up to thirty months.[180] Medicare will make a conditional primary payment if the EGHP denies the claim or if no claim is filed because of physical or mental incapacity.[181] Conditional payments will not be made if the EGHP alleges it is secondary to Medicare or limits payments to Medicare beneficiaries.[182]

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173. *Id.* § 1395y(b)(1)(C).
174. *Id.* § 1395y(b)(1)(A).
175. *Id.* § 1395y(b)(1)(B).
176. 42 C.F.R. § 411.51.
177. *Id.* §§ 411.52, 411.53.
178. Form HCFA-L365.
179. 63 Fed. Reg. 14,506 (1998).
180. Pub. L. No. 105-33, § 4631, 111 Stat. 251, 486 (1997).
181. 42 C.F.R. § 411.165(a)(2).
182. *Id.* § 411.165(b).

[C] Employer Group Health Plan: Older Employees and Spouses

If an employer medical insurance plan covers at least twenty employees, the EGHP must be the primary payer of medical services for the beneficiary and spouse who are sixty-five years old.[183] However, if the employee refuses the EGHP coverage, Medicare becomes the primary payer and the plan may not offer that individual coverage complementary to Medicare.[184] Medicare will make primary payments for services not covered by the EGHP, or where the beneficiary has exhausted benefits under the EGHP.[185] Conditional primary payments also may be made as noted in the previous subsection.[186]

[D] Employer Group Health Plan: Disabled Individuals and Family Members

If an employer plan covers at least 100 employees, the EGHP has to be the primary payer for "disabled active individuals." Such plans are referred to as large group health plans (LGHPs). MSP status for a disabled Medicare beneficiary is determined by the existence of LGHP coverage based on the individual's or a family member's current employment status. An individual has "current employment status" with an employer if the individual is an employee, is the employer (employer self-employed persons), or is associated with the employer in a business relationship.[187]

For those individuals who have LGHP coverage as a result of their own or a family member's current employment status, Medicare will continue to be the secondary payer. For those disabled individuals who do not have LGHP coverage as a result of their own or a family member's current employment status, Medicare is implemented similarly to the Medicare working aged provisions.

[E] Administration of Medicare As a Secondary Payer Issue

In administration of the Medicare secondary payer issues, there are general provisions that apply to each of the above-referenced topics. For example, after CMS has made a conditional primary payment,

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183. *Id.* §§ 411.100(a)(i), 411.170.
184. *Id.* § 411.172(c).
185. *Id.* § 411.175(a).
186. *Id.* § 411.175(b).
187. 42 U.S.C. § 1395y(b)(1)(B).

steps will be taken to recover this payment from the appropriate third-party payer.[188] The Medicare beneficiary is obligated to cooperate in the recovery process and may incur personal liability for refusing to cooperate.[189] Third-party payers are obligated to notify CMS, when Medicare has made payments, that the third party has made or should have made primary payment.[190] CMS is granted subrogation rights to any person or entity that is entitled to payment from the third-party payer.[191] However, CMS may waive recovery or settle a claim for less than the full amount paid.[192]

Third-party payment for inpatient psychiatric hospitalization and SNF care, however, is not counted against the inpatient days available to the beneficiary.[193] Medicare payments are secondary even if state law or the third-party plan provides otherwise. Medicare will make secondary payments to supplement the third-party primary payment.[194] The amount of the Medicare secondary payment is computed pursuant to a specific formula contained in the regulations.[195]

§ 4:11.2 Filing Secondary Payer Claims

Part A secondary payer claims are submitted by the provider of services, and all Part B claims are submitted by the provider. When a claim is identified as a secondary payer claim, it should first be submitted to the appropriate third-party payer and then to the Medicare intermediary or carrier. The third-party payers would be:

- an EGHP;
- an LGHP;
- auto insurance carrier;
- liability insurance carrier;

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188. 42 C.F.R. § 411.24.
189. *Id.* § 411.23; *see The Medicare as Secondary Payer Program: New Cost Containment Measures Present Questions of Fairness*, 22 CLEARINGHOUSE REV. 3 (1988); 63 Fed. Reg. 14,506 (1998).
190. 42 C.F.R. § 411.25.
191. *Id.* § 411.26.
192. *Id.* § 411.28.
193. *Id.* § 411.30.
194. *Id.* § 411.32; *see* Smith v. Midwestern Indem. Co. [1989 Transfer Binder], Medicare & Medicaid Guide (CCH) ¶ 38,328 (M.D. Fla. 1989) (federal secondary payer provisions clearly preempted state collateral source rule).
195. 42 C.F.R. § 411.33.

- workers' compensation agency or insurance carrier;
- U.S. Department of Labor (federal employee); or
- Federal Black Lung Program.

After the claim has been processed by the primary payer, it should be submitted to Medicare for secondary payment consideration. The claim should include a copy of the third-party notice of payment or denial. In the case of potential liability insurance coverage, the claim should be sent to Medicare first and then developed later.

§ 4:12 Private Contracts[196]

Since January 1, 1998, physicians and other practitioners have been allowed to "opt-out" of Medicare and sign private contracts with Medicare beneficiaries. Under these contracts, such providers can charge unlimited fees, but neither they nor their patients are allowed to obtain any reimbursement for these services from Medicare or Medigap insurance plans. Those providers allowed to sign such contracts include doctors of medicine and osteopathy and the following practitioners: clinical social workers, clinical psychologists, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse anesthetists, certified nurse midwives, and registered dieticians and nutrition professionals. Prior to this change, any provider who agreed to treat Medicare patients on a fee-for-service (FFS) basis had to abide by fee limits and submit claims for all eligible patients to Medicare for reimbursement. FFS patients then received payment from Medicare and their private supplemental insurance plans.

Physicians or practitioners who sign private contracts will not be allowed to submit claims to Medicare for reimbursement for any patients for a two-year period. In other words, physicians who sign private contracts with Medicare beneficiaries are not allowed to opt-out of Medicare for some Medicare beneficiaries but not others; or for some services but not others. Medicare beneficiaries who sign private contracts with providers, however, can still obtain Medicare-reimbursed services from other providers who have not signed such contracts. In addition, Medicare beneficiaries can obtain services that Medicare does not cover, such as cosmetic surgery and routine

196. HFCA Pub. 14-3, Transmittal No. 1639, May 1, 1999; 42 C.F.R. § 405.400–.450.

foot care, from Medicare providers without having to sign a private contract.

§ 4:12.1 Private Contract Requirements[197]

Private contracts must be in writing, signed by both parties, and a copy must be given to the beneficiary before services can be furnished under the contract terms. There is no requirement, however, that mandates how far in advance of the service the provider must inform the beneficiary of the private contract arrangement. Thus, the provider can request that the beneficiary sign a private contract on the same day that services are to be provided. Patients should, therefore, ask the doctor's office staff if the doctor has opted out of Medicare before scheduling an appointment and again before going to the doctor.

Private contracts must state the starting date and expiration date of the opt-out period. The contract cannot be signed by the beneficiary when the Medicare beneficiary requires emergency or urgent care services.

Private contracts must clearly indicate that by signing them, the beneficiary or the beneficiary's legal representative:

(1) agrees not to submit, or to ask the provider to submit, a claim to Medicare even if the items or services would otherwise be Medicare-covered;

(2) agrees to be responsible for payment for all services furnished by the provider and understands that no reimbursement will be provided under Medicare;

(3) acknowledges that no limits will apply to amounts that can be charged for all items or services under the contract;

(4) acknowledges that Medigap plans will not, and other supplemental insurance may not, make payments because Medicare will not make payment; and

(5) acknowledges that the beneficiary has a right to receive Medicare-reimbursed items and services provided by other physicians or practitioners who have not opted out of Medicare.

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197. 42 C.F.R. § 405.415.

§ 4:12.2 Private Contract Affidavit[198]

For the private contract to be valid, the provider must file an affidavit with all Medicare insurance carriers (to which they would otherwise submit Medicare claims) within ten days of signing the contract. The affidavit must state that during the opt-out period:

(1) the provider will not submit a claim, nor permit any entity acting on his or her behalf, to submit a claim to Medicare for any service furnished to a Medicare beneficiary except for emergency or urgent care services;

(2) the provider understands that he or she may not receive Medicare payment for services furnished to Medicare "privately contracted" beneficiaries;

(3) the provider acknowledges that his or her services are not covered by Medicare and that no Medicare payment may be made to any entity for his or her services, directly or on a capitated basis; and

(4) the provider agrees to be bound by the terms of both the affidavit and the private contracts that have been signed.

Since June 2015, opt-out affidavits automatically renew every two years. Those providers who don't want their opt-out to automatically renew may cancel the renewal by notifying all MACS with which they filed an affidavit in writing at least thirty days prior to the start of the new two-year opt-out period.[199]

If a provider opts out of Medicare, no payment may be made by Medicare or by any Medicare Advantage plan to the provider or to any entity to which the provider reassigns his or her right to receive payment for those services. The provider, however, may still order, certify the need for, or refer a beneficiary for Medicare-covered items and services, provided the provider is not paid for such ordering, certifying, or referring services.

When a provider who has opted out of Medicare furnishes emergency or urgent care services to a Medicare beneficiary with whom the provider has not previously entered into a private contract, the provider must submit a claim to Medicare. In those cases, physician

198. 42 C.F.R. § 405.420.
199. Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10.

may collect up to the limiting charge from the beneficiary; a practitioner may only collect the deductible and coinsurance.

§ 4:12.3 Private Contract Not Required

Physicians and practitioners who furnish services to a Medicare beneficiary do not have to submit claims to Medicare in the following cases (and do not have to sign a private contract):

(1) the beneficiary is not enrolled in Medicare Part B (Medicare limiting charge rules do not apply);

(2) the beneficiary refuses to authorize the provider to submit a claim for a covered service to Medicare (Medicare limiting charge rules do apply);

(3) the service is "categorically non-covered," such as hearing aids and meals on wheels (Medicare limiting charge rules do not apply); and

(4) the service is not covered because the beneficiary is enrolled in a Medicare risk health maintenance organization (HMO) and the HMO will not pay for the service because the provider is outside of the HMO's network (Medicare limiting charge rules do not apply).

If a doctor believes that Medicare will not cover a service because it is "not reasonable and necessary" (that is, multiple nursing home visits), the doctor can give the patient a written notice (known as an ABN) prior to service explaining the reason(s) that Medicare will not cover it.[200] The patient should still request the doctor submit the claim to Medicare. If Medicare denies payment, the patient should request an appeal, but if the appeal is lost, the patient will be responsible for paying the doctor whatever he or she charges. In this situation, no private contract has to be signed by the doctor and patient for the patient to be responsible for the full charges.

§ 4:12.4 Appeals for Private Contracts[201]

The following determinations by CMS are considered initial determinations and are subject to appeals: (i) a provider has failed to privately contract, to properly opt out, maintain opt-out, timely

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200. *See supra* section 4:9.3.
201. 42 C.F.R. § 405.450.

renew opt-out, or properly terminate opt-out; and (ii) no payment can be made to a beneficiary for the services of a physician who has opted out.

§ 4:13 Medicare Managed Care

§ 4:13.1 Medicare Advantage Plan Options

The Balanced Budget Act of 1997 substantially changed the Medicare program in an effort to reduce costs and provide Medicare beneficiaries with a variety of options for services. One of the biggest changes was the establishment of the Medicare+Choice program.[202] The "Medicare Prescription Drug Improvement and Modernization Act of 2003" changed the name of Medicare+Choice to Medicare Advantage.[203] Every individual entitled to Medicare Part A and enrolled in Medicare Part B (except those with end-stage renal disease) is eligible to receive Medicare benefits through two options: the existing FFS system or through a Medicare Advantage plan.[204] Medicare+Choice introduced the possibility for an array of services delivery options including: HMOs; provider sponsored organizations (PSOs); preferred provider organizations (PPOs); private FFS contracts, religious fraternal benefits plans or medical savings accounts (MSAs).[205] All Medicare Advantage enrollees must continue to pay their Part B premium, but other out-of-pocket expenses, such as additional premiums, deductibles, coinsurance and copayments, can vary depending upon the kind of plan selected.

[A] Benefits

All Medicare Advantage plans must provide enrollees with coverage of "basic benefits,"[206] defined as "all Medicare-covered benefits, except hospice services." The Advantage plans may also provide supplemental benefits, which may be "mandatory supplemental

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202. Pub. L. No. 105-33, §§ 1851–59, 111 Stat. 251, 276–327 (1997); 63 Fed. Reg. 34,968 (1998); 63 Fed. Reg. 52,610 (1998); 64 Fed. Reg. 7968 (1999); 42 C.F.R. § 422.
203. Pub. L. No. 108-173, 117 Stat. 2066 (2003).
204. 42 C.F.R. § 422.50.
205. 42 C.F.R. § 422.4.
206. 42 C.F.R. §§ 422.2, 422.100–.101.

benefits" or "optional supplemental benefits."[207] Mandatory supplemental benefits are services not covered by Medicare that an enrollee must purchase as part of the plan and pay for in premiums or cost-sharing. Optional supplemental benefits are health benefits not covered by Medicare that an enrollee may purchase by paying higher premiums or cost-sharing. A Medicare Advantage plan may, subject to approval by CMS, require enrollees to purchase mandatory supplemental benefits. CMS will approve mandatory supplemental benefits if it determines that imposition of the mandatory benefits will not substantially discourage Medicare beneficiaries from enrolling in the plan.

[B] Continuation Area[208]

A Medicare Advantage organization may offer a continuation of enrollment option to enrollees when they no longer reside in the plan's service area and move into another area (known as the continuation area) within which the organization furnishes or arranges for services. An organization that wishes to offer a continuation of enrollment option must:

(i) obtain CMS's approval;

(ii) ensure access to services; and

(iii) make the option available to all enrollees residing in the continuation area.

§ 4:13.2 Medicare Advantage Plans

[A] Health Maintenance Organizations

Prior to the Balanced Budget Act of 1997, the only managed care option available to most Medicare beneficiaries was a health maintenance organization (HMO). An HMO is a combination health care provider and insurance company that arranges with a network of health care professionals to provide care to its members. Most HMOs have a "risk contract" and all HMOs that requested CMS approval to offer services to Medicare beneficiaries since August 1997 must have a risk contract. Under a risk contract, the HMO receives a monthly

207. 42 C.F.R. §§ 422.2, 422.102.
208. 42 C.F.R. § 422.54.

capitation payment from CMS for each of its enrollees. In return, the plan agrees to provide or arrange for the full range of Medicare-covered services through an organized system of affiliated physicians, hospitals, and other providers. Beneficiaries must obtain all covered services through the HMO, except in cases of emergencies or urgently needed care. Members select a primary care provider (referred to as a gatekeeper) who is responsible for coordinating all care, including referrals for tests and specialists. HMO enrollees' out-of-pocket expenses can include any plan premiums and copayments for services. Risk plans are also allowed to offer point-of-service (POS) options in which enrollees can go out of plan for services, or utilize non-network providers without obtaining advance authorization, and face additional out-of-pocket expenses (see POS section for more information).

[B] Provider Sponsored Organizations[209]

Provider sponsored organizations (PSOs) are entities organized by health care providers or a group of affiliated providers (that is, doctors and hospitals) that will contract with Medicare to provide health care services to Medicare enrollees. PSOs differ from other managed care organizations in that the providers of services own and operate the organization. Affiliated providers are expected to share "substantial financial risk" and have at least a majority financial interest in the PSO. "Substantial financial risk" can include:

(1) agreement by a health care provider to accept capitation payments for each Medicare enrollee or to accept a predetermined percentage of the PSO premium or the PSO's revenue; or

(2) the PSO's use of significant financial incentives for its affiliated providers with the aim of achieving utilization management and cost containment goals, including agreement to a withholding of a significant amount of compensation to be used for covering the PSO's or other providers' losses.

PSOs will operate under a state license or can, in limited cases, obtain a federal waiver from state licensure requirements. PSO enrollees are expected to get a referral from their primary care provider

209. 42 C.F.R. § 422.350–.390.

to receive coverage for tests or a doctor outside the PSO. Enrollees' out-of-pocket expenses can include any plan premiums and copayments for services.

[C] Preferred Provider Organizations

Preferred provider organizations (PPOs) are groups of physicians and hospitals who contract with an insurance company to serve a group of enrollees on a FFS basis at lower rates than charged to non-enrollees. PPO members are allowed to visit any doctor in the network without a referral (no gatekeeper) and to choose doctors and other services outside of the provider network (for higher out-of-pocket expenses). PPOs achieve savings by negotiating discounted rates with a panel of providers. PPOs are similar to Medicare FFS because payments are made each time services are delivered. PPO enrollees' expenses can include any plan premiums and copayments.

[D] Private Fee-for-Service Plans[210]

Private fee-for-service (PFFS) plans are private health insurance plans that contract with Medicare to provide services on a FFS basis to members of the plan. The plan receives a set monthly payment for each Medicare beneficiary from CMS to provide Medicare services to plan members. The PFFS plan:

(1) pays providers of services at rates determined by the plan on a FFS basis without placing the provider at financial risk (for example, providers cannot receive less payment due to the amount of referrals to specialists);

(2) does not vary the rates for a provider based on the utilization of that provider's services; and

(3) does not restrict enrollee's choices among providers as long as they are authorized to provide services and agree to accept the plan's terms and conditions of payment.

While CMS's contribution to a PFFS plan is limited to the Medicare Advantage payment amount, there is no limit on the premiums that PFFS plans can charge enrollees for basic or supplemental benefits.

PFFS enrollees are not limited to using contracting providers and do not need a referral to visit a specialist. PFFS plans must allow

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210. 42 C.F.R. §§ 422.2, 422.4(a)(3), 422.114, 422.216.

enrollees to obtain services from any entity that is authorized to provide services under Medicare and agrees to provide services under the terms of the plan. Any provider who has not entered into a contract with a PFFS plan can thus receive payment from a PFFS plan if the provider, prior to furnishing the service, is informed that the beneficiary is enrolled in the plan and is informed about the terms and conditions of payment under the plan.

The insurance company offering the PFFS plan sets the amount that will be paid for each service. Contracting providers (doctors, hospitals, etc.) are allowed to charge enrollees up to 15% above the plan's payment rate in addition to charging for deductibles, coinsurance, and copayments. Non-contracting providers can charge enrollees for deductibles, coinsurance, and copayments similar to those faced by Medicare FFS enrollees, but cannot charge amounts in excess of the plan's payment (no balance billing is allowed) for services rendered to a plan member.

Hospitals that charge PFFS enrollees balance billing of $500 or more (for any inpatient or outpatient service) must provide patients with a written notice stating:

(1) balance billing is permitted;

(2) an estimate of the balance billing amount; and

(3) the amount of any deductibles, coinsurance, or copayment amounts, before furnishing any services.

PFFS plans must provide to enrollees, for each claim filed by them or a provider, an explanation of their liability for deductibles, coinsurance, copayments, and balance billing amounts.

PFFS plans are not required to offer a basic plan in addition to offering plans that contain additional benefits and charge a higher premium. In addition, certain "waiver of liability" protections for Medicare FFS beneficiaries do not apply to PFFS enrollees and thus they may face liability when the plan denies payment (because the service is "not medically necessary") after a service has been provided. PFFS enrollees' out-of-pocket expenses can include any plan premiums, deductibles, coinsurance, copayments, and balance billing amounts.

There were about 200,000 beneficiaries enrolled in PFFS plans in 2017.[211]

[E] Religious Fraternal Benefit Society Plans[212]

Religious fraternal benefit societies can receive Medicare payments for providing a managed care plan to members of the church, convention, or group with which the society is affiliated. One requirement to participate is that the society does not impose limitations on membership based on health factors.

[F] Point of Service Options[213]

A point of service (POS) option allows the beneficiary of a managed care plan to utilize non-network providers or network providers without obtaining advance authorization by paying additional costs, such as additional premiums, deductibles, and copayments. A Medicare Advantage coordinated care plan (HMO, PPO, or PSO) may offer a POS option as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit after receiving approval from CMS. A network MSA plan may only offer this option as an optional supplemental benefit. The disclosure requirements outlined later apply to organizations offering a POS benefit, and in addition, the plan must provide written information to beneficiaries that specifies all costs to the enrollee, including:

(i) premiums and cost-sharing;

(ii) annual limits on out-of-plan benefits; and

(iii) maximum out-of-pocket expenditures for plan members who reach the annual plan limit for use of out-of-plan providers.

[G] Education Campaign

CMS is required to hold a special education and publicity campaign in the fall of each year to educate Medicare beneficiaries about their Medicare FFS and Medicare Advantage options. The information is intended to help beneficiaries compare benefits provided under Medicare FFS to coverage offered by Medicare Advantage plans in

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211. KAISER FAMILY FOUND., MEDICARE ADVANTAGE 2017 SPOTLIGHT: ENROLLMENT MARKET UPDATE (JUNE 2017).
212. 42 C.F.R. §§ 422.2, 422.57.
213. 42 C.F.R. §§ 422.2, 422.105.

their area and enrollment procedures. Information must be mailed to each beneficiary at least fifteen days before the "annual election period" (see below) and to newly eligible Medicare beneficiaries prior to their initial Medicare eligibility.

Every fall, CMS mails handbooks entitled "Medicare & You" to all Medicare beneficiaries. The handbook contains basic information on Medicare FFS benefits, Medigap insurance and managed care plans, and organizations to contact. CMS provides a toll-free number (1-800-633-4227) for beneficiaries in any state to call for general information on managed care or information on specific plans in their county. In addition, CMS has established a website for information on the Medicare Advantage plans (www.medicare.gov). Another helpful website is: www.hiicap.state.ny.us.

§ 4:13.3 *Election Periods*[214]

[A] Initial Coverage Election Periods

Individuals are eligible to enroll in a Medicare Advantage plan or FFS during their initial coverage election period. This period starts three months before their entitlement to both Medicare Part A and Part B and ends the last day of the month preceding the month of entitlement. For those who enroll during the initial coverage election period, coverage will start the first day of entitlement to both Medicare Part A and Part B.

[B] Annual Election Periods

Beneficiaries are offered an annual election period, from October 15 through December 7, during which they can change from FFS to a Medicare Advantage plan, from a Medicare Advantage plan to FFS, or from an Advantage plan to a different Advantage plan, with coverage starting the first day of the following January. Beneficiaries already enrolled in FFS or a Medicare Advantage plan who do not make an election keep their respective coverage.

[C] Medicare Advantage Open Enrollment Period

Beneficiaries enrolled in a Medicare Advantage plan have one opportunity to switch back to Medicare FFS or to switch to another

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214. HFCA Operational Policy Letter (OPL 132) (Apr. 25, 2001); 42 C.F.R. §§ 422.60, 422.62, 422.68, 422.74. *See* Appendix 4B.

Medicare Advantage plan from January 1 to March 31 of each year. If they switch back to Medicare FFS, they can purchase a stand-alone prescription drug plan.

[D] Special Election Periods for Newly Eligible Medicare Advantage Individuals

Medicare beneficiaries who join a Medicare Advantage plan during the initial enrollment period (the period beginning three months before and ending three months after their sixty-fifth birthday) can also return to Medicare FFS once any time during the first three months after the effective date of their enrollment. If they choose to disenroll from the Medicare Advantage plan during this period, they will be enrolled into Medicare FFS the month after the month the disenrollment request is received.

[E] Special Election Periods

In addition, special election periods are available in which beneficiaries can disenroll from their Medicare Advantage plan and return to Medicare FFS or enroll into a different Medicare Advantage plan if:

(1) CMS has terminated the Medicare Advantage plan's contract or the Advantage plan has terminated or discontinued coverage;

(2) the beneficiary has permanently moved out of the plan's service area; or

(3) the beneficiary has demonstrated that the plan violated its contract by failing to provide medically necessary services on a timely basis, failing to provide medical services in accordance with applicable quality standards, or by materially misrepresenting the plan's provisions in marketing practices.

Plans do not have to enroll these beneficiaries if they have reached their capacity limit.

§ 4:13.4 Disenrollment by the Medicare Advantage Plan[215]

A Medicare Advantage plan may disenroll an individual if the individual has:

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215. 42 C.F.R. § 422.74.

(1) not paid on a timely basis any monthly basic and supplementary premiums, subject to a grace period for late payment;

(2) engaged in "disruptive behaviors" (the behavior is disruptive, unruly, abusive, or uncooperative to the extent that continued enrollment seriously impairs the plan's ability to furnish services to either the particular individual or other enrollees); or

(3) provided fraudulent information on the election form or permitted abuse of the enrollment card.

If the disenrollment is for any of these reasons, the Medicare Advantage plan must give the individual a written notice of the disenrollment with an explanation of the reasons for disenrollment and the right to a hearing under the organization's grievance procedures.

A Medicare Advantage plan must disenroll an individual if:

(1) the individual no longer permanently resides in the plan's service area or has left the service area for more than six months;

(2) the individual loses entitlement to Medicare Part A or Part B; or

(3) the plan terminates its contract with CMS or reduces its service area.

If the disenrollment is due to a move outside of the service area, the individual is still entitled to a written notice and a right to a hearing under the grievance procedures.

If the disenrollment is due to non-payment of premiums, disruptive behavior, fraud or abuse, or loss of Medicare Part A or Part B, the individual is deemed to have elected Medicare FFS. If the disenrollment is due to plan termination, area reduction, or the enrollee's move out of the area, the individual is entitled to a "special election period" during which enrollment into another Medicare Advantage plan or Medicare FFS is allowed.

§ 4:13.5 Disclosure Requirements[216]

A Medicare Advantage plan must disclose certain information to each enrollee electing an Advantage plan. This information includes:

(1) the plan's service area and any enrollment continuation area;

(2) the plan's benefits, including any conditions and limitations, premiums and cost-sharing (deductibles, copayments, etc.), and any other conditions associated with receipt or use of benefits;

(3) benefits offered under Medicare FFS;

(4) the availability of hospice benefits and any approved hospices in the service area;

(5) the number, mix and addresses of providers, any out-of-network coverage or POS option, and any supplemental premium;

(6) any out-of-area coverage;

(7) rules for coverage of emergency services;

(8) any mandatory or optional supplemental benefits and the premium for those benefits;

(9) prior authorization and review rules;

(10) grievance and appeals procedures;

(11) quality assurance programs; and

(12) disenrollment rights and responsibilities.

A Medicare Advantage organization must provide certain information to an individual eligible to elect an Advantage plan upon the request of that individual. This information includes most of the above and also the:

(1) procedures to control utilization of services and expenditures;

(2) number of grievances and appeals;

(3) disenrollment rates for the past two years;

(4) satisfaction of enrollees with the plan;

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216. 42 C.F.R. § 422.111.

(5) health outcomes of enrollees;

(6) way doctors are paid; and

(7) financial condition of the organization.

§ 4:13.6 Access to Services[217]

A Medicare plan (excluding PFFS) must have procedures for identification of individuals with complex or serious medical conditions, assessment of those conditions, and establishment and implementation of a treatment plan. The Advantage plan must establish written standards for:

(1) timeliness of access to care;

(2) policies and procedures (that is, coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations; and

(3) provider consideration of beneficiary input into the provider's proposed treatment plan.

In addition, the Medicare Advantage organization must ensure:

(1) the hours of operation are convenient to the enrollees;

(2) services are provided in a culturally competent manner to all enrollees, including those with limited English or reading skills, and diverse cultural and ethnic backgrounds;

(3) continuity of care and integration of services; and

(4) coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services.

[A] Emergency and Urgent Care Services[218]

The Medicare Advantage plan must cover emergency and urgently needed services regardless of whether the services are obtained within or outside the plan and without requiring prior authorization. Emergency services means covered inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services

217. 42 C.F.R. § 422.112.
218. 42 C.F.R. § 422.113.

and are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a *prudent layperson* could reasonably expect that the absence of immediate medical attention would result in serious jeopardy to that person's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

[B] Urgently Needed Services[219]

Urgently needed services are covered services that are not emergency services provided when an enrollee is temporarily absent (for not more than twelve months) from the plan's service or continuation area (or under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the plan's providers are temporarily unavailable or inaccessible) when such services are medically necessary and immediately required: (i) as a result of an unforeseen illness, injury, or condition; and (ii) it was not reasonable to obtain the services through the Advantage plan.

The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge and that decision is binding on the Medicare Advantage plan. For emergency services obtained outside the Advantage plan's network, the enrollee can be charged the lesser of $50 or what the plan would charge if such services were obtained through the plan.

[C] Post-Stabilization Care[220]

An Advantage plan must pay for "post-stabilization" care provided by non-contracting providers that were pre-approved by the plan or were not pre-approved because the plan did not respond to the post-stabilization care services provider's request for pre-approval within one hour after being requested to approve such care, or the plan could not be contacted for approval. Post-stabilization care is medically necessary non-emergency services (following an emergency) needed to ensure that the enrollee remains stabilized or to improve or resolve the enrollee's condition from the time that the treating hospital requests authorization from the Advantage plan until:

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219. *Id.*
220. 42 C.F.R. §§ 422.100(b)(iii), 422.113.

(1) the enrollee is discharged;

(2) a plan physician with privileges at the treating hospital assumes responsibility for the enrollee's care;

(3) a plan physician assumes responsibility for the enrollee through transfer; or

(4) the treating physician and plan reach an agreement concerning the enrollee's care.[221]

[D] Gag Orders[222]

A Medicare Advantage plan can not prohibit or restrict a health care professional from advising, or advocating on behalf of, an enrollee about:

(i) the patient's health status, medical care, or treatment options;

(ii) the risks, benefits, and consequences of treatment or non-treatment; or

(iii) the opportunity to refuse treatment and to express preferences about future treatment decisions.

This prohibition does not require counseling or a referral to a service by the health care professional if there is an objection based on moral or religious grounds, and the Medicare Advantage plan fulfills certain notification requirements to prospective and current enrollees.

§ 4:13.7 Termination of Medicare Advantage Coverage

Medicare beneficiaries whose coverage is ending will automatically be returned to Medicare FFS effective January of the following year unless they choose to enroll in another Medicare Advantage plan (if one was available in their area). Medicare beneficiaries who face termination of their Medicare Advantage coverage and want to select another plan in their area can disenroll from their existing plan and enroll in another plan from October 15 through December 7, with coverage in the new plan effective January 1 of the following year.

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221. 42 C.F.R. § 422.113(c)(3).
222. 42 C.F.R. § 422.206.

§ 4:13.8 Appeals[223]

[A] Organization Determinations[224]

Each Medicare Advantage plan must have a procedure for making timely "organization determinations" regarding the benefits an enrollee is entitled to receive, including basic benefits, mandatory and optional supplemental benefits, and the amount that the enrollee is required to pay for a health service.

An organization determination is any determination made by a Medicare Advantage plan involving:

(1) payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

(2) payment for any other health services furnished by a non-affiliated Medicare Advantage provider that the enrollee believes are covered by Medicare or, if not covered by Medicare, should have been furnished, arranged for, or reimbursed by the Medicare Advantage plan;

(3) the Medicare Advantage plan's refusal to provide or pay for services, in whole or in part, including the type or level of services that the enrollee believes should have been furnished or arranged for by the plan;

(4) discontinuation of a service (such as an SNF discharge), if the enrollee believes that continuation of the service is no longer medically necessary;[225] or

(5) failure of the Medicare Advantage plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or failure to provide timely notice of an adverse determination, such that a delay would adversely affect the enrollee's health.

Organization determinations can be appealed, and organization determinations defined in (3) and (4) in the previous sentence are subject to an expedited appeal.

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223. 42 C.F.R. §§ 422.560–.626.
224. 42 C.F.R. § 422.566.
225. 42 C.F.R. § 422.566(b).

Some examples of organization determinations include:

(1) a doctor does not prescribe covered treatments or tests, does not refer the patient to specialists, or does not admit the member for hospital services;

(2) the Medicare Advantage plan refuses to authorize or provide tests, treatments, or referrals recommended by the primary doctor;

(3) the plan does not authorize a second opinion on the need for surgery;

(4) the Medicare Advantage plan or doctor decides to reduce or terminate services the patient is already receiving, such as home health or therapy services, or decides to discharge the patient from a nursing home;

(5) the patient encounters an unreasonable delay or difficulty in arranging for surgery, hospitalization, tests, doctor's visits, or any other needed services, and the member believes this is a way of denying needed care; or

(6) a decision is made to discharge a hospital patient before the member believes he or she is ready to be discharged.

§ 4:13.9 Non-Expedited Organization Determinations[226]

[A] Requests for Services

When an enrollee or an authorized representative has made a request for a service, the Medicare Advantage plan must notify the enrollee of its determination "as expeditiously as the enrollee's health condition requires, but no later than fourteen calendar days" from the date the request is received. The fourteen days can be extended by up to fourteen calendar days, if requested by the enrollee, or if the plan justifies a need for additional information on why the delay is in the interest of the enrollee.

226. 42 C.F.R. § 422.568.

[B] Requests for Payment

When an enrollee or an authorized representative has made a request for payment for a service, the plan must make a determination within sixty calendar days from receipt of the payment request. Most "clean" claims, however, must be paid within thirty calendar days of receiving the payment request. Clean claims are claims that have no defect or impropriety, do not lack any required substantiating documentation, and do not require special treatment that prevents timely payment.

[C] Written Notification by Practitioners[227]

If an enrollee requests that a Medicare Advantage plan provide a notice of a practitioner's decision to deny a service in whole or in part, or if a Medicare Advantage plan decides to deny service or payment in whole or in part, the plan must give the enrollee written notice of the determination. The notice must:

(1) state the reason for the denial in understandable language;

(2) inform the enrollee of the right to a reconsideration; and

(3) describe both the standard (non-expedited) and expedited reconsideration processes and the rest of the appeal process.

When a Medicare Advantage plan fails to provide the enrollee with timely notice of an organization determination, this failure is considered an adverse determination and may be appealed by requesting a reconsideration.

§ 4:13.10 Expedited Organization Determinations[228]

An enrollee, authorized representative, or a physician, regardless of whether the physician is affiliated with the Medicare Advantage organization, can request orally or in writing an "expedited" organization determination involving the plan's refusal to provide or pay for services or discontinuance of a service. Requests for payment for a service are not subject to expedited organization determinations. Medicare Advantage plans are required to issue an expedited determination "as expeditiously as the enrollee's health condition requires," but within seventy-two hours of receiving the request if it

227. 42 C.F.R. § 422.568(c)–(e).
228. 42 C.F.R. § 422.570–.572.

determines that applying the standard time frame could "seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function."

The plan may extend the seventy-two-hour deadline by up to fourteen calendar days if the enrollee requests the extension or if the plan justifies the need for additional information on why the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may reverse a Medicare Advantage plan's adverse determination). The Medicare Advantage plan must grant the request of a physician, regardless of whether the physician is affiliated with the plan, to issue an expedited determination; plans, however, are not required to grant an enrollee's request for an expedited determination.

[A] Written Notification

If the plan agrees to make an expedited determination, the plan may first notify the enrollee of the determination orally, but also must send written notification within three calendar days of the oral notification. When the plan denies the request for an expedited determination, the plan must give the enrollee "prompt" oral notice of the denial and deliver, within three calendar days, a written letter explaining that the determination will be made within fourteen calendar days of receiving the request. The enrollee can resubmit a request for an expedited determination with any physician's support and the enrollee can file a grievance with the plan when disagreeing with the decision to deny the expedited determination.

§ 4:13.11 Non-Expedited Reconsiderations[229]

[A] Requests for Services

Enrollees, their authorized representatives, or certain providers who do not agree with the Medicare Advantage plan's determination have sixty calendar days from the date of the determination notice to request a reconsideration (additional time is available due for "good cause"). If the plan makes a reconsideration determination (concerning a request for services) that is completely favorable to the enrollee, the plan must authorize or provide the service as expeditiously as the enrollee's health condition requires but no later than thirty calendar

229. 42 C.F.R. §§ 422.582, 422.590, 422.592.

days from the date of receiving the request. This time frame may be extended by up to fourteen calendar days if the enrollee requests the extension or if the plan justifies a need for additional information and why the delay is in the interest of the enrollee.

If the Advantage plan makes a reconsideration determination that is wholly or partially unfavorable to the enrollee, it must send the case file to MAXIMUS Federal Services as expeditiously as the enrollee's health condition requires, but no later than thirty calendar days, with an additional fourteen-calendar-day extension in certain situations described earlier, from the date of the request for a reconsideration. MAXIMUS Federal Services is a private contractor that reviews reconsideration determinations that are not completely favorable to enrollees. The enrollee must be notified by the plan if the case is referred to MAXIMUS Federal Services.

MAXIMUS Federal Services must conduct its review as expeditiously as the enrollee's health condition requires but no later than thirty calendar days from receipt of the case, with extensions in certain cases. MAXIMUS Federal Services must send the enrollee (and CMS) a written notice of its determination, stating the reasons for the determination and, if the decision is adverse, how to file an appeal. Should MAXIMUS Federal Services rule in favor of the enrollee, the plan must authorize the service within seventy-two hours from the date the plan receives notice from MAXIMUS Federal Services reversing its determination or provide the service as expeditiously as the enrollee's health condition requires, but no later than fourteen calendar days from the date the plan receives notice reversing its organization determination.

Information on MAXIMUS and appeals is at https://medicareappeal.com/.

[B] Requests for Payment

If the plan makes a reconsidered determination (concerning payment for services) that is completely favorable to the enrollee, the plan must issue its determination and pay for the service within sixty calendar days from the date it receives the request for reconsideration. When the plan makes a reconsidered determination that is partially or completely unfavorable to the enrollee, it must send the case file to MAXIMUS Federal Services within sixty calendar days from the date it receives the reconsideration request (and notify the enrollee). MAXIMUS Federal Services must conduct its review as expeditiously as the enrollee's health condition requires, but no later than sixty

calendar days from receipt of the case, with extensions in certain cases. If MAXIMUS Federal Services decides in favor of the enrollee, the plan must pay for the service no later than thirty calendar days from the date the plan receives notice reversing its organization determination.

§ 4:13.12 Expedited Reconsiderations[230]

Enrollees, their authorized representative or physicians may request an "expedited" reconsideration of a determination involving a plan's refusal to provide services or discontinuance of a service (expedited reconsiderations are not available for payment cases).

A Medicare Advantage plan must provide an expedited reconsideration if it determines that applying the standard time frame could "seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." Medicare Advantage plans are required to issue an expedited reconsideration as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours after receiving the request. This time period may be extended by up to fourteen calendar days if the enrollee requests the extension or if the plan justifies a need for additional information and why the delay is in the interest of the enrollee. The plan can first notify the enrollee orally, but must mail a written notice within three calendar days. If the plan issues an expedited reconsideration that is completely favorable, the plan must authorize or provide the service as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours from the date the plan received the reconsideration request.

A Medicare Advantage plan must grant the request of any physician for an expedited reconsideration but does not have to grant requests by an enrollee. If the Medicare Advantage plan denies the request for an expedited reconsideration, it must give the enrollee prompt oral notice and follow up, within three calendar days, with a written notice that:

(1) the request for expedited reconsideration was denied;

(2) the reconsideration determination will be made within thirty calendar days of receiving the request;

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230. 42 C.F.R. §§ 422.584, 422.590, 422.592.

(3) the enrollee can file a grievance with the plan if he or she disagrees with the denial; and

(4) the enrollee can resubmit a request for an expedited reconsideration with any physician's support.

If the plan issues an expedited reconsideration that is partially or wholly unfavorable to the enrollee, it must submit the case file to MAXIMUS Federal Services as expeditiously as the enrollee's health condition requires, but not later than twenty-four hours of its determination (and notify the enrollee). MAXIMUS Federal Services must make a decision as quickly as the enrollee's condition requires, or within seventy-two hours, with extensions in certain cases. MAXIMUS Federal Services must mail a written notice of its determination to the enrollee (and CMS), stating the reasons for the determination and, if it is an adverse decision, how to appeal. Should MAXIMUS Federal Services rule in favor of the enrollee, the plan must authorize or provide the service as expeditiously as the enrollee's health condition requires, but no later than seventy-two hours from the date the plan receives notice reversing its organization determination.

For all reconsiderations, the Medicare Advantage plan must utilize persons who were not involved in making the organization determination. Also, when the issue is a denial of coverage based on medical necessity, the reconsideration must be made by a physician with expertise in the field of medicine that is appropriate for the denied services.

§ 4:13.13 Further Appeal Rights[231]

If MAXIMUS Federal Services issues a reconsideration that is not completely favorable to the enrollee, the enrollee has the right to request an ALJ hearing when the amount in controversy is at least $160. If the ALJ decision is unfavorable, the enrollee can request review by the Medicare Appeals Council (MAC). For cases where the Appeals Council rules against the enrollee and the amount in controversy is at least $1,630, judicial review is available.

If MAXIMUS Federal Services' determination is reversed by the ALJ or at a higher level of appeal, the Medicare Advantage plan must

231. 42 C.F.R. §§ 422.600, 422.602, 422.608, 422.612.

pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than sixty calendar days from the date it receives notice reversing the determination. However, when a Medicare Advantage organization requests MAC review of an ALJ decision, the organization may await the outcome of the review before paying for, authorizing, or providing the service under dispute.

§ 4:13.14 Appeals of Hospital Coverage[232]

Medicare Advantage enrollees have the right to immediate review of a determination by the Advantage plan or hospital that inpatient care is no longer necessary. The review must be requested by phone or in writing and made by noon of the first working day after receipt of the written determination from the organization or hospital. The review is decided by the Quality Improvement Organization (QIO), an organization selected by CMS to handle such appeals and monitor quality of care in hospitals and other settings. The enrollee who requests an immediate review may remain in the hospital without additional financial liability until noon of the calendar day following the day the QIO notifies the enrollee of an adverse decision (enrollees who appeal an adverse QIO decision and win would not face financial liability for longer hospital stays). These financial protections do not apply if the Medicare Advantage plan never approved the hospital admission.

An enrollee who fails to request immediate review within the required time frame may request expedited reconsideration by the Advantage plan, but if the plan's decision is upheld, the enrollee will face liability retroactive to the date of the initial notice of noncoverage.

§ 4:13.15 Grijalva *Court Case*[233]

CMS established *new* notice and appeal procedures for Medicare (managed care) enrollees who face *termination* of services by home health agencies (HHAs), SNFs, CORFs, or hospitals. This does *not* change the appeals procedures for other types of Medicare managed care plan determinations. The procedure is part of a negotiated

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232. 42 C.F.R. §§ 422.620, 422.622.

233. Grijalva v. Shalala, 153 F.3d 115 (9th Cir. 1998), *vacated and remanded*, 119 S. Ct. 1573 (1999). *See also* 42 C.F.R. § 422.626.

settlement CMS reached with Medicare managed care enrollees after suit was brought against the federal government (*Grijalva v. Shalala*) for its failure to provide meaningful procedural protections when enrollees' services were denied, reduced, or terminated. Under this procedure, CMS has contracted with organizations, called independent review entities (the review entity), to handle appeals concerning termination of the services listed above.

[A] Advance Notice of Service Terminations

Under these appeal procedures, when a Medicare managed care plan decides to terminate HHA, SNF, or CORF services, their providers are required to give a brief written notice to the Medicare managed care enrollee no later than *two days before* services will end. In non-institutional cases where the amount of time between services is more than two days, the notice should be given no later than the next to last time services are furnished. The notice must include the following information:

(i) the date that covered services will end;

(ii) the date that the enrollee will start to be liable for continued services;

(iii) a description of the enrollee's right to a "fast-track" appeal to the review entity, including information about how to contact the review entity, an enrollee's right to submit evidence showing that services should continue, and the availability of other appeal procedures if the deadline for a fast-track appeal is not met; and

(iv) the enrollee's right to receive detailed information (explained below).

[B] Fast-Track Appeal[234]

Medicare managed care enrollees can request a fast-track appeal of a Medicare managed care plan's decision to *terminate* HHA, SNF, or CORF services if they submit a request to the review entity by phone or in writing by *noon of the first day after the day* that the termination notice was delivered to them. (Enrollees who fail to make a timely request to the review entity for a fast-track appeal can still request an

234. 42 C.F.R. § 422.626.

"expedited" reconsideration to the Medicare managed care plan.) On the date that the review entity receives an enrollee's request for a fast-track appeal, the review entity must immediately notify the Medicare managed care plan that the enrollee has filed such a request and that the plan is required to supply any information needed for the review entity to make a decision. This information must be given to the review entity by the *close of the business day* that the review entity has notified the Medicare managed care plan of the appeal request. When the review entity notifies a Medicare managed care plan that an enrollee has requested a fast-track appeal, the Medicare managed care plan must send a *detailed* notice to the enrollee by close of that business day. The notice must include an explanation why services are either no longer covered or "reasonable and necessary," a description of any applicable Medicare coverage rule or other Medicare policy, and a statement of any applicable Medicare managed care plan policy, contract provision, or rationale upon which the termination decision was based. The enrollee can also request any documentation sent by the plan to the review entity that holds the fast-track appeal.

The review entity must make a decision on the fast-track appeal and notify the enrollee, the Medicare managed care plan, and the provider of services by *close of the business day after* it receives the information necessary to make a decision. If the review entity's decision is delayed because the Medicare managed care plan does not timely supply necessary information or records, the managed care plan must pay for any additional coverage.

If the review entity reverses the Medicare managed care plan's termination decision, the enrollee is entitled to continued services and the plan must issue a new notice before terminating services in the future. If the review entity upholds the Medicare managed care plan's termination decision and the review entity's decision was not delayed, the enrollee will be responsible for paying for any services received starting *three days after* receipt of the termination notice. An enrollee may face a maximum of one day of financial liability if the review entity upholds the termination decision.

[C] Reconsideration

Enrollees whose appeals are denied by the review entity can request a reconsideration within *sixty days* of being notified of the review entity's decision. The review entity is responsible for issuing its

reconsideration determination as "expeditiously as the enrollee's health condition requires," but no later than *fourteen days after* receiving the enrollee's reconsideration request. If the review entity reaffirms its decision, further appeals can be made to an ALJ, the Departmental Appeals Board, and to federal court.

Enrollees who do not request either a fast-track or an expedited appeal will have services terminated *two days after* they receive a termination notice. Enrollees may waive their right to two days of continued services and choose to be discharged sooner.

§ 4:13.16 Grievances

A determination that is not an organization determination is considered a grievance and Medicare Advantage enrollees can utilize a grievance procedure.[235] CMS requires that each Medicare Advantage plan must provide "meaningful procedures" for timely hearing and resolution of grievances. A Medicare Advantage organization must respond to an enrollee's grievance within *twenty-four hours* if the complaint involves the organization's: (i) decision to extend the time frame for issuing an organization determination or reconsideration; or (ii) refusal to grant an enrollee's request for an expedited organization determination or an expedited reconsideration.[236] For all other cases, the Medicare Advantage organization must notify the enrollee of its decision as expeditiously as the case requires, but no longer than thirty days after receiving the grievance.

Grievances include complaints about waiting times, physician behavior, quality of care, and adequacy of the HMO's facilities. Sometimes what appear to be grievances, such as a complaint about not receiving care on a timely basis or poor quality of care, are complaints about receipt or denial of services (for example, patient had to wait so long for a service that he or she went out-of-plan for the service; doctor did not authorize surgery or other medical services) and should be considered an organization determination subject to the appeal, not the grievance procedures. In addition, certain grievance issues, particularly about quality of care, should also be brought to the attention of the QIO (1-866-815-5440), the State Health

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235. 42 C.F.R. §§ 422.561, 422.564.
236. *Id.*

Department office covering the region (call 518-474-5515 for location), and CMS:

Centers for Medicare and Medicaid Services—Region 2
Health Plans Branch
26 Federal Plaza, Room 3800
New York, NY 10278

§ 4:14 Medicare Prescription Drug, Improvement and Modernization Act of 2003[237]

§ 4:14.1 Background

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 established a prescription drug benefit for Medicare beneficiaries starting January 1, 2006. Medicare beneficiaries are able to obtain Medicare Part D prescription drug coverage through private Medicare plans, including "stand-alone" prescription drug plans or Medicare Advantage managed care plans. The legislation also implemented a Medicare drug discount card program that expired at the end of 2005 and changed the name of the Medicare+ Choice managed care program to Medicare Advantage.

§ 4:14.2 Eligibility[238]

All individuals who are entitled to Medicare Part A or enrolled in Medicare Part B and live in a plan's service area (national plans cover the entire country) are eligible to receive the Medicare drug benefit.

§ 4:14.3 Enrollment and Disenrollment Periods[239]

Individuals are eligible to enroll in a Medicare drug plan during an initial enrollment period. This includes a seven-month period—the three months prior to their sixty-fifth birthday, the month they turn sixty-five, and three months after their sixty-fifth birthday.

Individuals can also enroll into or disenroll from a Medicare drug plan and enroll in another plan during the October 15–December 7 annual coordinated election period. In addition, they may disenroll or

237. Pub. L. No. 108-173, 117 Stat. 2066 (2003).
238. 42 C.F.R. § 423.30 (2005).
239. 42 C.F.R. § 423.38 (2005).

enroll during a special enrollment period for the following reasons: (i) they involuntarily lose other drug coverage that is comparable to the Medicare drug benefit ("creditable coverage"); (ii) they were not adequately informed that they lost creditable coverage, that their coverage was not creditable or is no longer creditable; (iii) they also receive Medicaid and want to switch Medicare plans; (iv) they moved out of the plan's service area; (v) they belong to a plan that violated a material provision of its contract; (vi) their enrollment or non-enrollment occurred because of an error by a federal employee; or (vii) the Medicare drug plan is terminated by the sponsoring organization or CMS.

§ 4:14.4 Penalty for Late Enrollment[240]

Individuals who do not enroll in a Medicare drug plan during their initial enrollment period and do not have "creditable coverage" will face a penalty of about 1% for every month that they were eligible to, but did not, enroll. Individuals who choose not to enroll in a Medicare drug plan because they have creditable coverage will not face a penalty if they enroll at a later date within sixty-three days of losing their creditable coverage. Creditable coverage includes the following as long as the benefits are comparable to or better than the Medicare drug benefit: Medicaid, a group health plan, some state pharmaceutical assistance programs (not including New York's Elderly Phamaceutical Insurance Coverage (EPIC)), and military coverage under TRICARE.[241] Medigap policies H, I, and J (see section 5:2) that offer some drug benefits are not considered creditable coverage. Individuals, therefore, who continue these policies and choose to enroll in a Medicare drug plan at a later date will face a penalty.

§ 4:14.5 Structure of Medicare Part D Drug Benefit

The standard Medicare drug benefit for 2019 includes premiums, deductibles, coinsurance, gaps in coverage, and copayments. Beneficiaries will have to satisfy an annual deductible of $415. After meeting the $415 deductible, Medicare beneficiaries will pay 25% of drug costs between $415 and $3,820, and Medicare will pay the remaining 75%. Medicare beneficiaries whose drug costs exceed $3,820 will have to pay all of their expenses between $3,820 and

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240. 42 C.F.R. §§ 423.46, 423.286 (2005).
241. 40 C.F.R. § 423.56 (2005).

$7,653.75 ($5,100 in out-of-pocket costs); after they have paid $5,100 in drug expenses, beneficiaries will have to pay the greater of 5% of the cost of each drug or a $3.40 copayment for each generic drug and an $8.50 copayment for each brand-name drug, and the Medicare drug plan will pay the remaining amount.[242] Plans are allowed to provide benefits in addition to those in the standard plan.

§ 4:14.6 Formularies

Each Medicare drug plan includes a list of covered drugs known as a formulary. Formularies must include at least two drugs in each therapeutic category (that is, antidepressants, anti-inflammatories, cholesterol-lowering drugs) or in each class.[243] CMS approves and monitors all formularies. Plans cannot change a class or category of covered drugs during the year unless new drugs or uses appear. If plans intend to remove a drug from their formulary, they must give a sixty-day advance notice to members taking that drug. Plans can use utilization management tools including tiered formularies, prior authorization, step therapy, and quantity limits.

Plans were required to include every drug in certain classes that were available on January 1, 2006, for individuals already stabilized on those drugs. These classes included: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, antineoplastics, and immunosuppressants. Those not stabilized on these drugs may be limited to certain drugs or utilization management tools. These limits do not apply to HIV/AIDS drugs.

All Medicare drug plans must have a "transition process" for new enrollees who are transitioning from other drug coverage, including Medicaid, and whose drug therapies may not be included in the new plan's formulary or situations in which enrollees are stabilized on formulary drugs that require prior authorization or step therapy. Generally, plans are required to provide an approved month's supply for such drugs within the first ninety days of coverage under a new plan.

§ 4:14.7 Excluded Drugs

Certain drugs are excluded from Medicare drug coverage. These include drugs for anorexia, weight loss or weight gain, or fertility;

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242. For similar information in a chart, see Appendix 4E.

243. The United States Pharmacopeia has model guidelines, http://www.usp.org/hqi/mmg. *See also* www.cms.hhs.gov/PrescriptionDrugCovContra/03_RxContracting_FormularyGuidance.asp.

drugs for cosmetic purposes or hair growth; prescription drugs for symptomatic relief of coughs and colds; prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations); non-prescription drugs; and drugs covered under Medicare Part A or B. States can receive federal matching funds for Medicaid recipients for all of these except non-prescription drugs or drugs covered under Medicare Part A or Part B. In New York, Medicaid continues to pay for non-prescription drugs that it formerly covered and barbiturates when prescribed for indications not covered by Medicare Part D.

§ 4:14.8 Low-Income Subsidy Assistance

Individuals dually eligible for Medicare and Medicaid ("dual eligibles"), including those in institutions, are not eligible for Medicaid drug coverage but have to join a private Medicare drug plan to obtain their prescription drug coverage. They do not face the above-mentioned premiums, deductibles, or gaps in coverage but have to pay a small copayment for each drug (those institutionalized do not have any copayments) and are limited to drugs on the plan's formularies or list of covered drugs. Individuals not on Medicaid but with incomes below 150% of the poverty level receive low-income subsidies in the form of either a reduced monthly premium and deductible or none at all, have no gap in coverage, and have to make copayments for each drug (see Appendix 4F for further information).

Individuals on Medicaid or one of the Medicare Savings Programs (see section 6:5.4) are automatically eligible for low-income subsidies without filing an application. All others who want to receive assistance with their Medicare drug plan's premiums, deductibles, coinsurance, and gaps in coverage must file the "Application for Help with Medicare Prescription Drug Plan Costs" with their local Social Security office and also select a Medicare drug plan.

To ensure that there is no gap in coverage for Medicaid recipients who have to obtain their drug coverage from a private Medicare plan, CMS randomly "auto enrolls" Medicaid recipients into a Medicare drug plan if they do not select one on their own. They are auto-enrolled into plans for the month after they are determined eligible for Medicaid and New York sends their names to CMS. If they are not satisfied with their Medicare drug plan, they can disenroll and join another plan at any time.

Medicaid spenddown recipients who incur medical expenses equal to their spenddown amount or pay that amount directly to their county Medicaid office for at least one month in a calendar year are automatically eligible for low-income subsidies for the rest of the year. Their names will be forwarded by New York to CMS and they will be auto-enrolled into a Medicare drug plan. Duals with employer or retiree coverage (that pays for drugs) may keep their third-party insurance if they can document that they face termination of such insurance if they enroll in a Medicare drug plan and their county determines that it is cost-effective for them to continue their private insurance.

CMS will "facilitate" the enrollment of Medicare Savings Program recipients who do not select a Medicare drug plan by randomly enrolling them into a drug plan.

§ 4:14.9 EPIC

The Elderly Pharmaceutical Insurance Coverage (EPIC) program is a New York State program for seniors administered by the Department of Health. It helps more than 250,000 income-eligible seniors aged sixty-five and older to supplement their out-of-pocket Medicare Part D drug plan costs. Seniors can apply for EPIC at any time of the year and must be enrolled or eligible to be enrolled in a Medicare Part D drug plan to receive EPIC benefits and maintain coverage.

EPIC provides secondary coverage for Medicare Part D and EPIC-covered drugs purchased **after any Medicare Part D deductible is met**. EPIC also covers approved Part D–excluded drugs once a member is enrolled in Part D.

EPIC helps pay the premiums for certain Medicare Part D drug plans for members with income up to $23,000 if single, or $29,000 if married. Higher-income members are required to pay their own Part D premiums, but EPIC provides premium assistance by lowering their EPIC deductible.

EPIC has two plans based on income. The Fee Plan is for members with income up to $20,000 if single or $26,000 if married. Members pay an annual fee to EPIC ranging from $8 to $300 based on their prior year's income. **After any Part D deductible is met**, Fee Plan members only pay the EPIC copayment for drugs. Copayments range from $3 to $20, based on the drug cost not covered by Part D.

The Deductible Plan is for members with incomes ranging from $20,001 to $75,000 if single, or $26,001 to $100,000 if married. After members meet any Part D deductible, out-of-pocket drug costs for

covered Part D and EPIC medications will be applied to the EPIC deductible. Once the EPIC deductible is met, members only pay the EPIC copayment amounts, which range from $3 to $20.

For more information on EPIC application and contact information, see the EPIC website[244] or call 1-800-332-3742.

§ 4:14.10 Appeals

[A] Coverage Determinations[245]

Enrollees can appeal many of their Medicare drug plan's coverage determinations, including: (i) non-provision or payment of a drug because it is not on the formulary, is determined to be not medically necessary, is furnished by an out-of-network pharmacy, or is not a drug for which Medicare will pay; (ii) failure to provide a coverage determination in a timely manner when that delay would adversely affect the enrollee's health; (iii) rejection of an exception request; and (iv) the copayment amount required for a drug. Plans must have an exceptions process for beneficiaries to request that a formulary drug be provided at a lower tier for cost sharing and that a non-formulary drug be covered.

When enrollees request a drug, plans must notify them of a coverage determination as expeditiously as the enrollee's health condition requires, but no later than *seventy-two hours* after receiving a request. Enrollees or their physicians can request an expedited coverage determination if applying the standard seventy-two-hour time frame may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. A plan that approves a request for an expedited determination must make its determination and notify the enrollee and physician, if appropriate, as expeditiously as the enrollee's health condition requires, but no later than *twenty-four hours* after receiving the request.

[B] Redetermination[246]

An enrollee who has received an adverse coverage determination may request either a standard or an expedited redetermination within

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244. N.Y. STATE DEP'T OF HEALTH, ELDERLY PHARMACEUTICAL INSURANCE COVERAGE (EPIC) PROGRAM (last modified Dec. 2018), http://www.health.ny.gov/health_care/epic/.
245. 42 C.F.R. §§ 423.566, 423.568, 423.570, 423.572, 423.576.
246. *Id.* §§ 423.580, 423.582, 423.584, 423.586, 423.590.

sixty days of the coverage determination. For standard redeterminations involving requests for covered drugs, the plan must notify the enrollee as expeditiously as the enrollee's health condition requires, but no later than *seven calendar days* (fourteen calendar days for payment requests) from the request for the redetermination. A plan that approves a request for an expedited redetermination must complete its redetermination and give the enrollee and physician notice as expeditiously as the enrollee's health condition requires, but no later than *seventy-two hours* after receiving the request. If the plan reverses its coverage determination, it must authorize or provide the medication as expeditiously as the enrollee's health condition requires, but no later than *seven calendar days* (or *seventy-two hours* for expedited redeterminations) after the plan received the request for redetermination.

[C] Reconsideration[247]

An enrollee who is dissatisfied with a redetermination decision can file a standard or expedited reconsideration with an independent review entity (IRE) within sixty days of the redetermination. The IRE must complete its reconsideration within *seven calendar days* for standard reconsiderations for requests for covered drugs, *fourteen calendar days* for payment requests, and *seventy-two hours* for expedited reconsiderations. If the IRE reverses the plan's decision, the plan must authorize or provide the medication as expeditiously as the enrollee's health condition requires, but no later than *seventy-two hours* (or *twenty-four hours* for expedited reconsiderations) from the date the plan received the reconsideration request.

[D] Further Appeals

Enrollees who are not satisfied with the reconsideration determination have further appeal rights, including an ALJ hearing, MAC review, and judicial review.

§ 4:15 Advocacy Issues

Many advocates who represent Medicare Advantage enrollees find that the system is fraught with problems. Language describing plan benefits is hard to understand and benefits vary from plan to plan, making comparisons difficult. Written and timely notices of determi-

247. 42 C.F.R. §§ 423.590, 423.600, 423.602, 423.604.

nations are not issued, appealable issues are treated as grievances, appeals take a long time to be resolved, eligibility rules for home care and nursing home benefits are interpreted more strictly than in FFS, and many enrollees do not understand their plan's benefits, exclusions, and procedures for obtaining plan approval for services. Lastly, many enrollees wonder if their plan will provide the same benefits year to year or will even terminate their coverage. All of these problems are expected to increase as additional Medicare beneficiaries enroll in Medicare Advantage plans to obtain prescription drug coverage.