Medicare Advocacy for Guardians

Michigan Guardianship Association
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I. Ensuring Proper Medicare Coverage[1]

Appendix A contains the 2014 Medicare premium and co-pay information, as well as the eligibility levels for the various Medicare Savings Programs (i.e., Medicaid for Medicare).

A. Who is eligible for Medicare?

Medicare may be available to individuals 65 and over, individuals who have been receiving Social Security Disability (SSDI) for 24 months, and individuals with End Stage Renal Disease. Importantly, Medicare *is not* available for those just receiving Supplemental Security Income (SSI) under the age of 65.

The 24-month wait for disabled individuals to receive Medicare begins when a person is entitled to disability benefits, not from when he or she begins receiving benefits. Because of the delay in processing Social Security disability applications (and the time for potential appeals), a client will often be eligible for Medicare sooner than he or she thinks. There is no waiting period if an individual has ALS (Lou Gehrig's disease).

B. An individual is eligible for Medicare. How do I make sure he or she has proper coverage?

Good Medicare advocacy begins with good Medicare coverage. Guardians need to ensure that an individual has the best Medicare coverage possible given his or her resources.

Most individuals with a guardian are eligible for Medicaid. If an individual is eligible for full Medicaid (AD-Care), he or she is also automatically eligible for the Medicare Savings Program (enrollment handled by DHS) and Extra Help with Prescription Drugs (enrollment handled by Social Security). This will provide very comprehensive Medicare coverage for the individual. *We generally do not recommend signing an individual up for a managed care plan as long as it can be avoided.*

[1] Some of the content for these materials came from various presentations that we have made over the years. Attorney Sanford Mall joined us for many of those presentations and we want to acknowledge his contributions towards these materials.

Even if an individual has Medicaid and Medicare, he or she will still need to sign up for a Part D Prescription Drug Plan. You should review and sign up for Part D plans at Medicare.gov. Medicare.gov provides an excellent search tool to review and choose plans. When an individual has Medicaid, you are usually looking for the most comprehensive plan that is under the Extra Help premium benchmark ($32.46 in 2014), which means the individual pays no premium for his or her prescription drug plan. *Importantly, if an individual has Medicaid, he or she can switch plans every month. So, if you find that an individual's prescriptions needs have changed, you can change the plan right then.*

If an individual is not eligible for Medicaid, you will need to decide what additional coverage he or she may need. Medigap or Medicare Supplemental plans remain the benchmark for comprehensive coverage. Historically, in Michigan, we relied on the Blue Cross Blue Shield Legacy Medigap plans (those $122.86 plans). These plans are still available to us until July 2016. However, because of recent legislation that converted Blue Cross Blue Shield of Michigan to a non-profit mutual insurance company, these plans will probably not be available to us after that date.

When the BCBSM Legacy plans go away (and there is no current legislation that would prevent them from going away), a lot of individuals will either no longer be able to afford a Medigap plan or will not be able to get a plan because of medical underwriting. Unfortunately, these individuals probably have to look towards Medicare Advantage plans. Like Prescription Drug Plans, you should shop for Medicare Advantage plans at Medicare.gov. You will also need to review these plan each year between October 15th and December 7th.

II. Medicare Advocacy in the Hospital

Appendix B contains a sample Care Plan Meeting Agenda. Appendix C contains a Medicare Beneficiary Hospital Patient Advocacy Checklist.

A. Why is being "admitted" to the hospital so important?

You would think knowing whether an individual has been admitted to the hospital would be obvious. Unfortunately, it is not. As advocates are increasingly aware, hospitals often provide "observation" services instead of formally admitting patients to the hospital. Making matters worse, hospitals have been known to override a doctor's admission order and retroactively change an individual's admission status before submitting a bill to Medicare (commonly known as Condition Code 44).

Observation status can harm individuals in several ways. The greatest concern is that someone may be denied Medicare's post-hospital skilled nursing benefits because they were not "admitted" to the hospital for three nights. In addition to this, a client may face higher co-pays under Part B and be responsible for the cost of prescription (and even routine, over-the-counter) drugs received in the hospital. Also, a client on observation status *may* not be entitled to the full range of hospital services, including, but not limited to, discharge and post-hospital services.

For these reasons, it is important to vocally advocate for hospital admission. Make notes of all evidence suggesting that a patient was admitted in case you need to appeal. Engage the doctor and get (and document) his or her assurances that a patient has been admitted. If a hospital insists that an individual is simply at the hospital for observation, ask it to issue a Hospital-Issued Notice of Noncoverage (called a HINN). This will provide you with what you need to appeal immediately. If you believe the hospital wrongfully changed your client's status from inpatient to outpatient (i.e., Code 44), you can always try to appeal based on a number of factors, including the fact that your client did not receive any notice of noncoverage.

The Center for Medicare Advocacy has a great self-help packet at: http://www.medicareadvocacy.org/self-help-packet-for-medicare-observation-status/.

B. How is the hospital paid and how may that impact my advocacy?

Hospitalizations are a critical time for guardians to not only ensure that individuals receive quality medical care in the hospital, but also that they have a safe and quality transition out of the hospital. Unfortunately, Medicare's payment system gives hospitals a profit incentive to get individuals out of the hospital as soon as possible.

Since 1983, Medicare has paid hospitals based on a prospective payment system (PPS). Each hospital stay is classified by a Diagnosis-Related Group (DRG) code and Medicare pays the hospital the average overall cost associated with a patient with that diagnosis. Even if a hospital can convince Medicare that a patient needs much more care than the average patient, any "outlier" payments only amount to 60% of the average daily cost to care for that diagnosis.

This makes a hospital's profit equation simple. If the hospital can deliver care for less than the amount associated with the DRG code, it makes money. If it takes longer, the hospital loses money. Thus, hospital professionals are under extreme pressure to discharge individual at the earliest opportunity, which can be at conflict with what may be in the best interest of the individual.

Largely because of this payment system, approximately 1 out of 5 patients are readmitted to the hospital. The Affordable Care Act attempts to address by penalizing hospitals if an excessive number of patients are readmitted to a hospital within a certain period (currently 30 days) after discharge for certain conditions. Currently, those conditions are heart attacks, heart failure, and pneumonia, but the number of covered conditions is expected to expand modestly in 2015. If an individual has one of the focused conditions, the hospital may be more apt to listen to you discharge concerns.

In addition to inpatient hospitals, skilled nursing, home health, hospice, and outpatient hospital services also have variations of the prospective payment system. Drug treatment and psychiatric hospitals generally do not use the prospective payment system.[2]

C. How does a hospital make a discharge decisions?

Medicare covers an inpatient hospital service or procedure if "such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose."[3] In short, is inpatient hospital treatment medically necessary?

A hospital will usually make an initial decision to discharge a patient. Every hospital that participates in Medicare must have a Utilization Review Committee. The Utilization Review Committee is made up of physicians and hospital administrators and is tasked with monitoring and determining whether a hospital admission or continued stay is medically necessary.

A Utilization Review Committee can decide to terminate a continued hospital stay.[4] However, before issuing a discharge notice, the hospital must technically obtain the concurrence of the treating physician in writing.[5] (A hospital can unilaterally deny coverage at the time of admission.) If the treating physician does not agree with the discharge, the hospital is supposed to automatically refer the case to the Quality Improvement Organization (currently MPRO in Michigan) on its own initiative for review. Thus, it is extremely important to engage the treating physician as an ally as early as possible in the process.

D. How do I know a hospital discharge is being planned?

The key discharge notice given to a patient is entitled "Important Message from Medicare (IM)." An Important Message from Medicare must be given to a patient upon being admitted to the hospital.[6] Additionally, if the discharge does not occur within two days of receiving the initial IM, a follow-up copy of the IM must be given no sooner than two days prior to the scheduled discharge.[7]

The Important Message from Medicare must be delivered to the beneficiary. However, if the beneficiary is unable to comprehend the notice, it shall be delivered to the beneficiary's representative. A hospital can deliver the copy of the Important Message from Medicare on the date of discharge, but regulations require that the hospital give an individual at least

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[2] Judith A. Stein and Alfred J. Chiplin, 2013 Medicare Handbook, Wolters Kluwer, pp. 2-21, 22. (Referred hereafter as 2013 Medicare Handbook.)
[3] 42 U.S.C. §1395f(a)(3).
[4] 42 CFR §482.30(d).
[5] 42 CFR §412.42(c)(2).
[6] 42 CFR §405.1205(b)(1).
[7] 42 CFR §405.1205(c).

4 hours to consider his or her appeal rights. Hospitals are not supposed to make a habit of waiting until the day of discharge to give this notice.

The Important Message from Medicare simply states that the hospital or the doctor will inform the patient of the discharge date. In practice, many hospitals will write the discharge date on the IM or provide some other written notification.

E. I believe an individual needs more hospital care. What do I do?

If it is not medically safe for the individual to leave the hospital, then demand a care meeting to discuss why an individual needs additional care. A sample agenda for the care meeting is attached as Appendix B.

Unfortunately, the Important Message from Medicare form will not tell you anything about the basis for the discharge. Try to first gather this information at the care meeting. However, if you cannot get this information (or have insufficient time to get it), consider appealing to the QIO. In this process, the hospital must provide the patient with a Detailed Notice of Discharge no later than noon the day after the hospital is notified of an expedited appeal.[8] The hospital is also supposed to provide you with additional documentation needed to support your appeal upon request.

An individual can request an expedited review of a hospital discharge if he or she makes the request to the QIO (i.e., currently MPRO) no later than the day of discharge. According to the 2013 Medicare Handbook, CMS states that an expedited request is timely filed if done before midnight on the day of discharge.[9] However, it is safest to make the appeal as soon as practical.

A timely appeal is important because it ensures that the appeal will be expedited and it will delay financial liability for the hospital stay until noon of the calendar day after the beneficiary receives notification of the determination by the QIO.[10] Thus, even an unsuccessful appeal may buy necessary time to finalize a better discharge plan.

Initiating an appeal involves a painless telephone call to the QIO (i.e., currently MPRO) as outlined in the Important Message from Medicare that the individual received. From there, the QIO will notify the hospital that a request for an expedited determination has been made and will request the pertinent information from the hospital.[11] The hospital is then required to provide the patient with a Detailed Notice of Discharge and must provide the patient with all information sent to the QIO if requested.[12] Theoretically, the hospital bears the burden of proof in an appeal.[13]

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[8] 42 CFR §405.1206(e).
[9] 2013 Medicare Handbook, pp. 2-34.
[10] 42 CFR §405.1206(f)(2).
[11] 42 CFR §405.1206(d).
[12] 42 CFR §405.1206(e).
[13] 42 CFR §405.1206(c).

After the QIO receives all the pertinent information, the QIO must make its determination within one calendar day.[14] The QIO will notify the individual of its determination by telephone and will follow-up the telephone call with a written letter.[15] If the patient receives an unfavorable decision, financial liability begins at noon the day following the decision.[16] Thus, at worst, a hospital appeal should allow an individual to stay an extra day in the hospital.

If you lose, an individual can still request an expedited reconsideration no later than noon the day after your client receives the QIO decision. However, at this point in the appeal process, the individual would be financially liable for the additional days if he or she loses. Only the very rare case gets appealed further than this second reconsideration appeal level, but there are additional levels of appeal available if necessary.

F. The hospital is discharging an individual. The discharge is probably medically appropriate, but there is not a good transition plan in place. What do I do?

The transition from one care setting (or level of care) to another can be traumatic and even dangerous. The overriding objective of discharge advocacy is to ensure that an individual has the best possible chance of receiving a safe, appropriate, and fully coordinated care transition. A proper discharge plan will assure a safe and appropriate setting with all necessary post discharge services fully coordinated to optimize the patient's quality of care. Anything less should be questioned and even appealed.

If an individual is being discharged and an appropriate transition plan is not in place, request a meeting with the hospital to discuss a discharge plan.

There are technically two parts to a discharge planning process. It begins with a discharge evaluation that must be done if a guardian requests it.[17] If an evaluation has not been done, request it. A formal discharge plan will be created if the discharge planning evaluation indicates a need for a plan *or* if the physician orders it.[18] However, hospitals are encouraged to do a discharge plan for every patient and increasingly hospitals are doing this.

Often a guardian simply requesting a discharge plan meeting will provide the necessary time you need to get a discharge plan in place. However, if that does not work, you can appeal the hospital discharge to the QIO (currently MPRO in Michigan) because there is not a proper discharge plan in place. While we certainly discourage meritless appeals, if time is legitimately needed to get a safe discharge plan in place, the appeal may provide crucial time.

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[14] 42 CFR §405.1206(d)(6)(i).
[15] 42 CFR §405.1206(d)(8).
[16] 42 CFR §405.1206(f)(2).
[17] 42 CFR §482.43(b).
[18] 42 CFR §482.43(c)(1)-(2). See also Interpretative Guideline A-0819.

G. What must a hospital discharge plan contain?

In May 2013, the Centers for Medicare & Medicaid Services (CMS) substantially revised its "interpretative guidelines" regarding discharge planning.[19] The new guidelines emphasize the importance of person-centered discharge planning with the "preferred goal" of an individual returning to the setting that the person was in when her or she transferred to the hospital. Under the interpretive guidelines, a discharge plan must:

- Actively consider input from the guardian, family, friends, and other support persons. The plan must be tailored to the individual and written in plain English. A patient's preferences and goals should be incorporated into a discharge plan. Although a hospital does not have an obligation to implement unrealistic goals and preferences, the fact that a patient's preferences are more time consuming to implement does not itself make the plan unrealistic.[20]

- Give a wide range of post-hospital options and *not* just direct the person to services that the hospital has a financial interest in. (And a hospital must disclose any provider that it has a financial interest in.) "Hospitals are expected to have knowledge of the capabilities and capacities of not only of long-term care facilities, but also of the various types of service providers in the area . . . ."[21] This includes:

    - Knowing an individual's ability to pay for services and, if applicable, the community resources (such as Medicaid) that might be able to assist.

    - "[F]amiliarity with available Medicaid home and community-based services (HCBS), since the State's Medicaid program plays a major role in supporting post-hospital care for many patients."

    - If the patient is enrolled in a managed care plan, working to limit the list of possible facilities or agencies to those that are within the plan. If a hospital cannot make arrangements with a patient's preferred provider, the hospital must document the reasons it cannot.

- Consider the individual's ability to pay for these services and make sure an individual is aware what those services will cost. The hospital should make the patient aware of what might be owed out of pocket and discuss the patient's ability to pay out of pocket expenses.[22]

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[19] State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning ("Interpretive Guidelines").
[20] Interpretive Guidelines §482.43(c) (A-0818; A-0820).
[21] Interpretive Guidelines §482.43(b) (A-0806).
[22] Interpretive Guidelines §482.43(b) (A-0806).

- Ensure any non-professionals who will provide care are properly trained to provide that care. Any written instructions must be easy to understand.[23]

- Begin implementing a discharge plan, which includes arranging transfers. When transferring, the hospital must provide sufficient medical information to the transferor and to the referring facility to ensure a safe transition. If the transfer is to the patient's home, the hospital must provide the information to the individual's physician.[24]

Again, sometimes just requesting a discharge plan or care planning meeting will give you the time you need to arrange a safe and appropriate transfer. However, if a hospital insists on a discharge before an appropriate transition plan is in place, advocates have successfully used these guidelines to appeal inappropriate discharges to Quality Improvement Organizations (currently MPRO in Michigan). Do not be afraid to do this if necessary.

III. Medicare Advocacy in the Skilled Nursing Facility

Appendix D contains additional advocacy tips for skilled nursing facilities. Appendix E contains a checklist for nursing home residency advocacy.

A. Why should I care about Medicare in a skilled nursing facility if a client has Medicaid?

If a client is not on Medicaid, the importance of Medicare covered nursing days is obvious. But why should you care about Medicare if an individual is on Medicaid? The practical reality is that the individual will most likely receive a higher quality of care and more care options with Medicare than just Medicaid. Providers will appreciate Medicare's higher reimbursement rate and placement will often be easier if an individual enters with Medicare than Medicaid alone.

With this said, the Nursing Home Reform act applies to any facility that provides Medicare or Medicaid services and certain services must be provided regardless of payer source. *Attached as **Appendix D** is an expanded explanation of this act and an individual's rights under it.*

B. An individual is now in a skilled nursing facility. What do I do?

A nursing facility must complete a full assessment of a resident's condition within 7 days for a Medicare beneficiary and within 14 days after his or her admission, at least once every 12 months thereafter, and "promptly after a significant change in the resident's

[23] Interpretative Guidelines §482.43(c)(5) (A-0820);
[24] Interpretative Guidelines §482.43(c)(3) (A-0820); §482.43(d) (A-0837).

physical or mental condition."[25] The plan should be designed to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of [the] resident."[26]

A sample care plan meeting agenda is again attached as Appendix B.

This assessment includes completing a Minimum Data Set (MDS) that complies with CMS's regulatory requirements. There are 18 topics that must be included in the MDS. The assessment must be done on a Resident Assessment Instrument (RAI) that comports to Michigan requirements. We recommend obtaining this documentation as soon as you are able.

The care plan can be essential to maximizing the Medicare benefit in the nursing facility and guardians should participate in these meetings when practical. Care plan meetings should be interactive and nursing home staff assumptions can, and often should be, challenged. A written care plan should be result of such meeting with appropriate goals in place. A resulting care plan should be individualized; it should not just be a cookie-cutter plan by the facility for many patients.

Take these two examples where an effective care plan meeting can make a difference:

- An 87-year-old woman who is confused and disoriented after hospital discharge is admitted to a nursing home. The nursing home assesses her level of functioning and determines she is not ambulatory. The physical therapy goal is set at "unassisted transfer from bed to chair and use of walker for toileting." At the care plan meeting family members inform the therapist that their loved one was living alone, driving, shopping and caring for herself independently only 2 weeks earlier. As a result, physical therapy goals were adjusted because pre-hospital functioning allowed the physical therapist to predict a more functional outcome. From a beneficiary advocacy standpoint, this means that rehabilitation services will likely be extended as will Medicare payment for the nursing home stay.

- An 82-year-old man is refusing to participate in therapy. The nursing home planned to discharge him from Medicare for lack of cooperation. At a care plan meeting the family discussed strategies to encourage the man to participate. For example, they identified that he did not respond well when the therapist communicated in a condescending manner (i.e., "ok, honey") and responded much better when the PT addressed him as "Mr. Smith…" By discussing strategy with nursing home staff and working as a team, the resident continued therapy and received continued Medicare coverage.

[25] 42 USC §1395i-3(b)(3)(C)(i); 42 CFR §483.20(b)(2).
[26] 42 CFR §483.20(b).

C. What do I need to know about a person's Medicare coverage in a skilled nursing facility?

To understand how much Medicare will cover, you need to gather the following information:

- Did the individual have a prior hospitalization? If so, when was he or she hospitalized? When was he or she discharged to the nursing facility?
- What Medicare coverage does the individual have?
- Is Medicare covering the individual in the facility? If so, what skilled care or therapy is the individual receiving that qualifies for it being a Medicare stay? If not, should the individual be receiving skilled care or therapy that would qualify for Medicare days?
    - Note: Generally, if the individual is not receiving skilled care or therapy immediately after being admitted to the skilled nursing facility, he or she can only then start receiving Medicare coverage within 30 days of the hospital discharge unless it was medically inappropriate to begin an active course of treatment in the SNF immediately.[27]

Medicare provides coverage for up to 100 days of skilled nursing care. You will want to look at when skilled nursing Medicare coverage began and figure out when the 100 days would be up. However, even if an individual has 100 days, only the first 20 days are fully covered unless the individual has Medicaid or appropriate supplemental coverage. If an individual does not have supplemental Medicare coverage, he or she will pay $152/day in 2014 for days 21-100 (or, if a Medicare Advantage plan, whatever the Medicare Advantage plan states). Thus, it is very important to know an individual's Medicare coverage because that might impact your advocacy decisions.

The 100 days is per "spell of illness." A "spell of illness" ends when an individual has spent 60 consecutive days without being in the hospital or skilled nursing facility or Medicare has not been paying for the stay in the nursing facility for 60 consecutive days. Thus, an individual could remain in a nursing facility (either on Medicaid or private pay), have a three-day qualifying hospitalization, and have another 100 Medicare days so long as the individual had 60 days without Medicare paying for the stay.

D. I believe the individual needs more skilled care or therapy, but the facility (or worse, the insurance company) says Medicare coverage is ending. What do I do?

This can be a delicate situation for guardians. Many of you have good relationships with facilities and need their assistance in placing difficult clients. If you have the time, it is always a good idea to request a care meeting to see why they are ending Medicare coverage and to see if you can convince them to extend coverage. You will likely be successful more times than not.

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[27] Medicare Benefit Policy Manual, Ch. 8.

As a guardian, you must receive notice that Medicare coverage is ending. Ideally, that notice is given directly to you in writing at least two days in advance of Medicare coverage ending. The facility can call you to tell you that the coverage is ending, but in that telephone call they must tell you his or her appeal rights (and follow-up with a written notice). Facilities mishandle notices all the time and you can win on appeal for lack of notice alone. However, be careful. If a facility loses an appeal based on invalid notice, the facility is liable for the additional days it takes to give proper notice. This is an easy way to sour a good relationship.

It is also important to educate facilities that Medicare appeals do not have to be adversarial. If the facility is concerned that they may later be audited, a successful appeal will make sure that the facility will get paid (at Medicare's higher reimbursement rate) without issue. Although some facilities do not like to be questioned, enlightened facilities will realize that an appeal can be a true win-win.

To take advantage of an expedited appeal, you must call the Quality Improvement Organization (currently MPRO in Michigan) by noon the day before the discharge. ***If an individual has a Medicare Advantage plan, it is essential to call before this deadline or you lose the right to appeal to the QIO. You will then have to appeal to the plan itself.***

This is not an intimidating call. The QIO will ask for information regarding the individual and why you believe the discharge is inappropriate. From there, you can either fax in additional information and evidence or just let the QIO decide.

E. The facility states that an individual has "plateaued" or is failing to show "improvement." What should I do?

For years, facilities have stated that an individual's Medicare days were ending because he or she has "plateaued" or is "failing to improve." Although this has always been an incorrect terminology, facilities should certainly not be using this language after a recent court settlement in *Jimmo v. Sebelius.*[28] However, we still hear it and it should raise red flags when used as an explanation to end skilled services.

The settlement in *Jimmo v. Sebelius* required CMS to update their manuals to reflect the correct standard. CMS transmitted these changes in December 2013 and stated the following:[29]

> **SUMMARY OF CHANGES:** In accordance with the Jimmo v. Sebelius Settlement Agreement, the Centers for Medicare & Medicaid Services (CMS) has agreed to issue revised portions of the relevant chapters of the program manual used by Medicare

[28] No. 11-cv-17 (D.Vt.), filed January 18, 2011

[29] The most updated transmittal is CMS Transmittal 179 (Pub 100-02) dated January 14, 2014, and available at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R179BP.pdf.

contractors, in order to clarify that coverage of skilled nursing and skilled therapy services "…does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care." Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition.

It is important to emphasize that *Jimmo* applies to all skilled services under Medicare. Thus, in addition to skilled nursing facilities, *Jimmo* applies to home health services, inpatient rehabilitation facilities, and outpatient coverage.

Practitioners have had modest success informally asking providers to reevaluate a denial using the correct *Jimmo* standard and, when necessary, appealing a denial on the basis of *Jimmo*. The revised manual certainly does not guarantee skilled services, but it can be helpful.

F. The nursing facility has already stopped coverage or it is after noon the day before discharge. What can I do?

Technically, you can still appeal, but the individual will be financially liable if he or she loses the appeal and the appeal can take longer.

In some instances, a facility can resume the skilled care or therapy within 30 days after it stopped. To do this, there would ideally be a reason for why the skilled services or therapy stopped. For example, the individual had the flu, there was a change in medications, and so forth.

G. The opportunity for Medicare skilled nursing days passed. The individual has Medicaid coverage, but I believe he or she could use more therapy. What can I do?

As stated above, a skilled nursing facility is supposed to provide the therapy regardless of payer source. In practice, you are much more likely to get better and more services if Medicare will pay. Even if Medicare is no longer paying for room and board, an individual residing in a nursing facility still can get coverage under Medicare Part B.[30]

IV. Medicare Advocacy for Home Health Benefits

For your convenience, a Medicare Benefit Home Health Checklist is provided as Appendix F.

A. What are the requirements to receive home health services?

To receive Medicare home health coverage, a client must meet very specific requirements. Specifically, the individual must be: (1) confined to a home; (2) in need of skilled nursing

[30] Medicare Claims Processing Manual, Chapter 7, §10.1; Medicare Benefit Policy Manual, Chapter 15, §250.

care on an intermittent basis or physical therapy or speech-language pathology or have a continuing need for occupational therapy; and (3) be under the care of a physician and receiving services under a plan of care established and periodically reviewed by a physician.

Confined to a home ("homebound"). There are two main components to beins consider homebound: (1) an individual's condition restricts the ability to leave the home (a "homebound condition") and (2) any absences from the home are medically related, infrequent, or of relatively short duration. It includes situations where: "an illness or injury that restricts their ability to leave their place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated." Contraindicated simply means not medically advisable.

The Medicare Benefit Policy Manual (MBPM Ch. 7, §30.1.1) offers many more specific examples of what would be considered "homebound." Importantly,
a patient with a psychiatric illness that is manifested in part by a refusal to leave home (or it would not be safe to leave the home unattended), would qualify even if he or she has no physical limitations. But simply being old or feeble alone is not sufficient to be considered confined to the home.

A person can also be homebound in an assisted living facility or a group home, but not in a skilled nursing facility.[31] If the facility is required by law or contract to provide certain services, Medicare will not duplicate those services.

In addition to requiring a homebound condition, Medicare may look at an individual's actions to determine if a person is truly confined to the home. Short and infrequent absences should not be counted as evidence against an individual. Specifically, short absences for these activities should not disqualify an individual: religious services, medical treatment (e.g., dialysis or cancer treatment), attendance at adult-day care facility, an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event."[32]

In need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy. Usually, what constitutes a need for physical or speech therapy is fairly straightforward. Most discussion usually revolves around the "need of skilled nursing care on an intermittent basis." There is a great deal of subjectivity in what is considered skilled and it generally takes into consideration "the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice."[33] A patient's overall condition is a critical factor in determining what is skilled.

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[31] Medicare Benefit Policy Manual Ch. 7, §30.1.2.
[32] Medicare Benefit Policy Manual Ch. 7, §30.1.1.
[33] 42 CFR 409.44(b)(1)(i).

But simply needing skilled services is not enough. You also must show that the services will be intermittent. Intermittent means skilled care that is either provided or needed on fewer than 7 days each week, or less than 8 hours each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).[34] Once you meet this the eligibility hurdle, skilled nursing and home health aide services can be furnished "any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week)." However, just because a beneficiary can receive this many hours, does not mean that it is common or typical.

Under the care of a physician and receiving services under a plan of care established and periodically reviewed by a physician. Obtaining home health services involves a surprising amount of required documentation. Before home health services can begin, a physician must certify that: (1) a patient is homebound, (2) the patient needs the intermittent skilled services or therapy, (3) the services are furnished under the care of a physician, (4) a plan of care is established (see below), and (5) there was a face-to-face encounter with the patient.

The face-to-face encounter is a new requirement under the Affordable Care Act (i.e., Obamacare). The physician can delegate this requirement to certain non-physician practitioners (e.g., nurse practitioners or physician assistants).[35] The encounter must occur no more than 90 days before home health care occurs or within 30 days of the start of care. Although meant to be a measure to prevent fraud, this requirement has had the unfortunate effect of making many of our homebound patients struggle to find ways to meet with a physician in person.

To receive home health coverage, a qualified physician must sign a plan of care and must recertify the plan every 60 days.[36]. There is no limit to the number of 60-day periods.[37]

The plan of care for home health services should be viewed like a prescription for drugs—if you want those services, it needs to be on the plan of care. The plan of care is an underutilized advocacy tool. There is a lot of subjectivity in determining the appropriate home health services and, thus, a lot of room to advocate for services to be on the plan of care. Encouraging a client to advocate for the entire range of services to be on a plan of care can be an invaluable and critical service to individuals.

B. What services can home health provide?

Once a patient qualifies for home health services, patients are entitled to all reasonable and necessary services. Those services can include:

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[34] 42 USC 1395x(m)(7)(b).
[35] Medicare Benefit Policy Manual, Ch. 7, §30.5.1.1.
[36] 42 CFR §424.22; Medicare Benefit Policy Manual Ch. 7, §30.5.2.
[37] Medicare Benefit Policy Manual Ch. 7, §30.5.2.

- Part-time or intermittent skilled nursing care;
- Part-time or intermittent home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Medical supplies (excluding drugs and biological other than a covered osteoporosis drug;
- Durable medical equipment while under the plan of care established by physician;
- Medical services provided by an intern or resident-in-training under an approved teaching program; and
- Services at hospitals, skilled nursing facilities, or rehabilitation centers when they involve equipment too cumbersome to bring to the home.[38]

Home health aides can be available: "to provide hands-on personal care of the patient or services needed to maintain the patient's health or to facilitate treatment of the patient's illness or injury."[39] The range of services that a home health aide can provide is quite extensive and can include a range of services from basic assistance with ADLs to changing bed linens. A home health aide can also provide services such as light cleaning and meal preparation if these services are incidental to the home visit. This is certainly not 24 hours a day and 7 days per week custodial care, but it can be a crucial component to a client's care plan if you can provide a home health agency willing to offer these services.

C. Why am I having trouble getting home health services and what can I do?

The biggest advocacy issue is often getting home health services to begin with. One of the biggest challenges with home health benefits is ensuring that a home health agency will get paid. Medicare contractors will not make a decision regarding the appropriateness of a home health payment until services are actually received. Not only might the home health agency not get paid, it may also face penalties for submitting an improper claim.

Compounding this issue, a Medicare beneficiary cannot appeal a denial of a home health claim until services are delivered! Thus, our clients may be put in a terrible situation: a home health agency will not provide the services and our client cannot appeal without incurring financial liability. Paying for services and filing an appeal is usually not an option for most guardians.

If an individual is in the hospital, the hospital discharge planning process may be the best place to ensure the initiation of services. By insisting that appropriate home health services be committed to and in place as part of a discharge plan, you may be best positioned to ensure that all appropriate services are provided. Also, if the hospital fails to

[38] Medicare Benefit Policy Manual Ch. 7, §30.5.1.1.
[39] Medicare Benefit Policy Manual Ch. 7, §50.2.

help arrange the home health services, you arguably have an expedited appellate right as an inappropriate hospital discharge.

As with most aspects of Medicare advocacy, getting the support of the attending physician can be a critical help to getting services both initially and upon appeal. A persuasive letter from a physician may assist in convincing the home health agency to begin services.

If none of the above options are viable, try another home health agency. If that is also not an option, determine if it is possible to adjust the plan of care in a way that may pose less of a risk to the agency.

If all else fails, file a complaint about the home health agency with the QIO (currently MPRO in Michigan at 1-800-365-5899).

D. The home health agency is cutting services. What can I do?

Receiving notices from home health agencies has been historically problematic. Home health agencies are supposed to provide notice during certain triggering events such as when an agency is reducing or discontinuing care.

While notices are nice, they are practically useless in most home health situations because an individual typically has no recourse without first taking on the potential financial liability for the service! In many instances, your only option will be to shop for other home health providers to see if they will provide the services or discuss revising the plan of care.

The only exception to the above is when a home health agency is terminating *all* Medicare covered home health care. In that instance, the agency should issue a Notice of Medicare Non-Coverage and an individual has expedited appeal rights. The notice is the same generic notice given in a skilled nursing facility.

But again, as a practical matter, if you are not receiving the home health services you think an individual is entitled to receive, your best recourse may be shopping for another home health provider. Also, patient satisfaction scores and patient complaints can impact a home health agency's reimbursement rate. While a complaint should be done with great caution (or risk souring your relationship with the agency), even the threat of a complaint may move a home health agency to action.

E. Why do I need to calendar a home health matter for every 60 days?

Like hospitals, Medicare reimburses home health agencies based on a patient's diagnosis and condition known as a HHRG score and not the care actually received. Because the reimbursement is based on the HHRG score, this is the time for an individual to overstated his or her abilities. Presumably, the higher the reimbursement to the home health agency, the more services the home health agency will be willing to provide. Home health agencies are then paid for a 60-day period and the agency must cover nearly all the expenses associated with that patient's care for that rate.

Medicare allows for continuous 60-day recertifications. However, the reimbursement rate to the home health agency may be reduced each 60-day period under the theory that the agency should be providing the care more efficiently as time goes by. A home health agency may determine that an individual uses an excessive amount of services or non-routine medical supplies (i.e., he or she is not profitable). The agency may then use various excuses for why another 60-day period cannot be renewed or services should be reduced.

Thus, you should engage the home health agency a week or two before the end of each 60-day period and try to prevent a reduction in services. As discussed above, there are limited recourses if the agency cuts services. If the provider is terminating all services, you may demand a Notice of Medicare Non-Coverage and appeal. Otherwise, your only options may be to risk incurring financial liability for the services, shopping other home health agencies, or seeing if you can revise the plan of care.

F. How do I find home health providers?

Knowing your local home health agencies and what they provide is crucial. As discussed above, if a home health agency is not providing the services that you need, your only real recourse may be shopping different home health agencies to see if they will provide the services. Additionally, Medicare has a great website called Home Health Compare (http://www.medicare.gov/homehealthcompare/search.html) that offers a list of home health agencies with various evaluations regarding the quality of their services.

V. Medicare Advocacy for Hospice

Appendix G contains a Medicare Hospice Benefit Home Checklist.

A. When is a client eligible for hospice?

The hospice benefit is different from all other Medicare benefits because it does not provide for the curative treatment of illness/injury.[40] Medicare covers hospice care for those who have been diagnosed as terminally ill. Terminally ill means a client has medical prognosis that his/her life expectancy is less than 6 months if the illness runs its normal course.[41] The beneficiary must be certified as being terminally ill by the hospice doctor and the client's attending doctor.[42]

[40] 42 USC §1395y(a)(1)(A).
[41] 42 CFR §418.3.
[42] 42 CFR §418.22(c).

B. How does a client elect hospice?

One can receive hospice benefits under Medicare only after specifically opting into the hospice benefit and thereby opting out of Medicare coverage for services related to the terminal illness. This election is made by filing an election statement with a hospice of the client's choice. An election statement may be filed by the client himself or by a legal representative.[43] Electing hospice care does not mean that all curative treatment is waived. Beneficiaries who elect hospice may still receive Medicare coverage for medically reasonable and necessary treatment unrelated to their terminal illness.[44]

If beneficiary has not yet elected the hospice benefit, Medicare will pay for the consultation visit with hospice medical directors. If a Medicare Advantage does not cover hospice, the beneficiary may elect hospice care to be covered under traditional Medicare.

C. What services will hospice provide?

Any services to be provided to a Medicare hospice patient must be included in a written plan of care.[45] The plan must be reviewed or revised as the patient's condition requires, but no less frequently than every 15-calendar days.[46] Hospice services can include:

- Nursing Care: Hospice must provide nursing care that ensures that the nursing needs of the patient are met as identified in the patient's initial assessment. Nursing care may be provided on a continuous basis for 24 hours during a period of crisis. Period of crisis is one in which the patient requires continuous care to achieve application or management of acute medical symptoms.[47]

- Counseling Services: Must be available to the patient and family to assist the patient and family in minimizing stress and problems. Hospice must provide an assessment of the patient's and family's spiritual needs. Hospice must make reasonable efforts to facilitate visits from local clergy or other individuals who can support the patient's spiritual needs.[48]

[43] 42 CFR §418.24.
[44] 42 CFR §418.24.
[45] 42 CFR §418.56.
[46] 42 CFR §418.56(d).
[47] 42 CFR §418.204(a).
[48] 42 CFR §418.64(d).

- Homemaker Services: Must be coordinated and supervised by a member of the interdisciplinary group. Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.[49]

- Inpatient Care: To receive payment for general inpatient care under the Medicare hospice benefit, beneficiaries must require an intensity of care directed towards pain control and symptom management that cannot be managed in other settings. Medicare rarely covers room and board in an inpatient setting (except for respite care below).

- Respite Care: Inpatient care for respite purposes is provided to the hospice patient when necessary to relieve the beneficiary's caregivers. Respite care may be provided only on an occasional basis and is limited to no more than five consecutive days at a time.[50] The daily coinsurance amount for respite care can be no more than 5 percent of the payment made by CMS for the respite day. Respite services can be a critical benefit if a client is being discharged from the hospital, but the family needs some time to get organized (e.g., to get a house ready for the patient or to get caregivers in place).

Medicare beneficiaries who receive care under the MI Choice Waiver Program may continue to receive those benefits after they elect the hospice benefit. The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit.[51]

D. Can an individual revoke hospice?

Yes, at any time.[52] To revoke the election of hospice care, the individual or his or her representative must file a statement with the hospice. The statement must include a signature by the beneficiary or legal representative and the date of revocation. Upon revocation, the beneficiary is no longer covered under Medicare for hospice care and the beneficiary resumes Medicare coverage for benefits previously waived.[53]

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[49] 42 CFR §418.76(k)(2).
[50] 42 CFR §418.204(b)(1); 42 CFR §418.204(b)(2).
[51] 42 CFR §418.76(i); 42 CFR §418.76(i)(3).
[52] 42 CFR §418.28.
[53] 42 CFR 418.28(c)(1); 42 CFR 418.28(c)(2).

E. Can an individual select a different hospice provider?

A beneficiary may change, once each election period, the designation of the particular hospice from which care will be received. Change of designated hospice is not a revocation of election of hospice benefits. In order to change the designated hospice, the beneficiary or representative must file (with the current and future hospice provider) a signed statement indicating the name of each hospice and the effective date of the change.[54] This change can be made only once during the election period. If an additional change were desired during a single election period, the beneficiary would have to revoke the hospice coverage and then reelect hospice coverage using a new election period.

F. Can an individual really be discharged from hospice?

Yes, an individual can be discharged from hospice for reasons other than death. And more people are being discharged. The number of individuals being discharged by hospice has increased by 50% in the last 10 years. What is causing this? CMS is increasingly cracking down on hospices searching for long-term, relatively healthy (a.k.a., profitable) patients. Hospices now must show auditors more objective data demonstrating that a patient's disease is progressing.[55] As a result, more hospice patients are being discharged.

VI. Appendices

- Appendix A: 2014 Medicare by the Numbers
- Appendix B: Care Plan Agenda
- Appendix C: Medicare Beneficiary Hospital Patient Advocacy Checklist
- Appendix D: Advocacy in Skilled Nursing Facilities
- Appendix E: Medicare Beneficiary Nursing Home Advocacy Checklist
- Appendix F: Medicare Home Health Benefit Checklist
- Appendix G: Medicare Hospice Benefit Checklist

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[54] 42 CFR §418.30.

[55] Paula Span, Bounced From Hospice, The New Old Age Blog, NY Times (January 7, 2014), available at http://newoldage.blogs.nytimes.com/2014/01/07/bounced-from-hospice/.

Appendix A
2014 Medicare by the Numbers

Part B Premium = $104.90 / month
Part A Premium = $426 / month (if an individual does not have enough credits)
Michigan Part D "Benchmark" Premium = $32.46 / month (For "Extra Help" premiums.)

Premiums at Higher Incomes (Based on 2012 Tax Returns):

Individual	Joint	Part B Premium	Part D Adjustment
$85k - $107k	$170k - $214k	$146.90	$12.10
$107k - $160k	$214k - $320k	$209.80	$31.10
$160k - $214k	$320k - $428k	$272.70	$50.20
Above $214k+	Above $428k	$335.70	$69.30

Standard Part D Benefit

-$310 deductible -> 'donut hole' hit at $2,850 in total prescription costs (all payment sources).
- 52.5% brand discount and 28% generic discount in 'donut hole' for 2013.
- Catastrophic coverage begins at $4,550 paid out-of-pocket.

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Medicare Savings Programs[1]

	Individual		Couple	
	Income[2]	**Assets**	**Income**[2]	**Assets**
QMB	$993	$7,160	$1,331	$10,750
- Premiums, copays, and deductibles.				
SLMB	$1,187	$7,160	$1,593	$10,750
- Part B premium.				
ALMB	$1,333	$7,160	$1,790	$10,750
- Part B premium, limited budget allocation.				

[1]RFT 242 has not been updated to reflect these numbers.
[2]Includes $20 income disregard.

Part D Low-Income Subsidy / "Extra Help"

	Individual		Couple	
	Income[1]	**Assets**	**Income**[1]	**Assets**
Full Extra Help	$1,333	$8,660	$1,789.63	$13,750
- No premium, $2.55 to $6.35 co-pays; no co-pay after $6,455 in total drug costs. - NOTE: $1.20 - $3.60 co-pays at or below $993/$1,333 incomes.				
Partial Extra Help	$1,479	$13,440	$1,986	$26,860
- 15% co-pays.				

[1]Includes $20 income disregard.

Sample Part A Costs

Hospital	**Skilled Nursing**
- $1,216 Deductible (Days 1-60). - $304 daily co-pay (Days 61-90) - $608 daily co-pay (Lifetime Reserve Days – 91-150)	- $0 (Days 1-20) - $152 (Days 21-100) 100% Thereafter

Appendix B

Care Plan Meeting Agenda

Client: _____
Date: _____

Nursing Home / Hospital Staff in Attendance**:**

_____ _____

_____ _____

1. Overview of the needs identified in care plan. List evaluations completed.

2. ____ Obtain copy of written care plan. Date of plan _____.

3. What goals have been set, by whom?

4. What approaches are being used to meet patient's identified needs?

5. What is in place to assure that patient will receive care according to plan?

Specifics: Admission date and diagnoses: _____

_____

	ADL Assessment	Independent	Needs Assistance	Dependent
1	Bathing - sponge, bath, or shower			
2	Dressing			
3	Toilet Use			
4	Transferring			
5	Urine and Bowel Continence			
6	Eating			

Care Plan Meeting Agenda
Client: _____
Date: _____

Care Needs:
Activities

Therapies (amount, duration, scope, goals)
OT

PT

Speech / Cognitive

RT

Other

Personal Schedule – best time, worst time, preferences

Medications
Current list

Note changes – why

Other Nursing Care Needs

Emotional Needs

Prognosis

Future Care Planning Required

Appendix C

Medicare Beneficiary Hospital Patient Advocacy Checklist

General Information for Advocacy File

_____ Appointment of Agent /Advance Directives.
_____ HIPAA Release.
_____ Fee Agreement.
_____ Purpose of admission – scheduled or emergency.
_____ Begin assessing discharge needs / request for discharge evaluation.
_____ Patient history.
_____ Care planning summary.

Health Care Coverage

_____ Obtain copy of Medicare Cards.
_____ Obtain copy of other health care insurance cards.
_____ Obtain copy of recent premium statement for private insurance.

A. Medicare
_____ Traditional Medicare.
_____ Medicare Advantage (HMO).
Obtain a copy of the HMO contract and limitations.
_____ Received "Important Message from Medicare."

B. Private Health Care Insurance
_____ Identify type of private insurance.
Name of company: _____
Type of coverage: _____

C. Benefit Available
_____ When did the patient first go into the hospital? (Date) _____
_____ Is this the patient's first hospitalization? _____

Care Planning - Inpatient Status vs. Outpatient Observation

_____ **Inpatient status** (formal admission to hospital)
If the hospital's Utilization Review committee disagrees with the inpatient status, Code 44 allows the hospital to change status if the following criteria are met:
_____ Change in status occurs prior to release.
_____ No claim submitted to Medicare by hospital.
_____ Physician concurs with the UR committee's decision.

[1] This was adapted from the materials of Sanford Mall who presented on Hospital Benefits Advocacy at the 2007 NAELA Advanced Elder Law Institute in Memphis, Tennessee.

_____ Physician's concurrence is well documented in medical record.

_____ Did change in status occur? _____

_____ Request Care Plan Meeting.

_____ Request Admission Notice of Non-coverage to trigger appeal right.

NOTE: If unsure about Admit / Observation status request Admission Notice of Non-coverage and a Care Plan Meeting.

_____ **Observation status** (outpatient, although may be in an inpatient bed).

_____ Request Admission / Pre-admission Notice of Non-coverage.

_____ Contact physician if patient should have "admit" status.
(if not "admitted," may cause additional issues re: coverage/services).

_____ Request a Care Plan Meeting.

Discharge Planning

_____ Request a discharge planning evaluation if patient has not already been identified by the hospital as at risk for adverse health consequences if no discharge plan [42 CFR §482.43(b); 42 USC s1395x)(ee)].

_____ Is the discharge evaluation developed, or developed under supervision, by a registered nurse, social worker or other appropriately qualified personnel?

_____ Did the evaluation ask about the patient's living situation prior to hospital stay?

_____ Did the evaluation ask about the patient's ability to perform ADL's?

_____ Did the patient/patient representative participate in the evaluation?

_____ Is the evaluation part of the patient's medical record?

_____ Did the evaluation indicate the need for a formal discharge plan? [42 CFR §482.43(c)(1)].

_____ Does the discharge plan adequately address post-hospitalization needs?

_____ Did the patient/representative participate in the discharge plan? Indicate care preferences to the discharge planner.

_____ Does the discharge plan adequately address the needs identified in the discharge evaluation?

_____ Was there an assessment of the need for skilled nursing care facility?

_____ If so, did the QIO/hospital determine whether there is a bed available to the patient in a skilled nursing facility in the community or local geographic area?
[42 CFR §§424.13(b)(1), 412.42(c)(1)].

_____ If an available placement is identified, determine what information was provided to the facility re: needs of the individual.

_____ Did someone research & visit the skilled nursing facility to determine if it is appropriate, safe & able to meet the individual's needs including payment source (i.e., Medicaid)?

_____ Are all other continuing care needs identified, including scope, frequency & duration? (e.g., home health care, hospice care, outpatient rehabilitation).

_____ Does the discharge plan address both medical and social service needs?

_____ Did the hospital arrange for the initial implementation of the discharge plan? [42 CFR §482.43(c)(3)].

_____ What information was provided for the referral of services?

_____ Is there a schedule indicating when care services will begin?

_____ Is there a list of medications and instructions provided?

_____ Any diet restrictions or special diet requirements?

_____ Is there a schedule of any follow-up appointments needed?

_____ Is there sufficient information provided regarding Medicare coverage and payment for hospital stay and post-care services?

_____ Is the discharge plan and services identified safe & appropriate? The Patient has a right to refuse placement/services if unsafe or inappropriate.

_____ Did the hospital reassess the discharge plan if there are factors (e.g., changes in condition) that may affect continuing care needs or appropriateness of the discharge plan? [42 CFR 482.43(c)(4)].

_____ If the discharge planning evaluation did not indicate need for a formal discharge plan, will the physician request one? [42 CFR §482.43(c)(2)].

_____ If no request for discharge plan, appeal to QIO to review denial of discharge plan.

_____ Are there any other ancillary service needs identified? (e.g., Meals-On-Wheels, caregiver resources).

_____ Are there any custodial care needs (other needs besides skilled nursing & rehabilitation)?

_____ Identify need / eligibility for any additional benefits after discharge from hospital (e.g., Medicaid, Veterans Aid & Attendance benefits).

Discharge Appeal Rights for Traditional Medicare

_____ Is the discharge appropriate? Discharge date must be determined solely based on medical needs.

_____ Did patient receive An Important Message from Medicare?

_____ Is the name and contact information for QIO included?

_____ Did the hospital follow proper discharge procedures?

_____ Hospital determined that the beneficiary no longer needs inpatient care and notifies the patient in writing[42 CFR §412.42(c)(1). (c)(3)], **and**

_____ Attending physician agrees, in writing [42 CFR §412.42(c)(2)],

- OR -

_____ QIO review and concurrence with hospital decision if the attending physician disagrees [42 CFR §412.42(c)(3)], **and**

_____ Hospital notified the beneficiary in writing that patient not longer requires inpatient care [42 CFR §412.42(c)(3)]:

_____ When did patient receive the An Important Message from Medicare or other notice? _____

_____ Is appeal to QIO proper? (Regarding discharge from hospital or discharge plan; to buy time for further discharge planning)

_____ Appeal to the QIO in writing or by telephone was timely (usually by midnight the day of discharge)

_____ Did the QIO complete and send a written notice to the patient / family / advocate within three (3) working days if:
- patient is still an inpatient when request was made
- determination relates to institutional services for which admission is sought, determination made before the patient was admitted to the institution, and request was submitted timely

_____ Did the QIO complete and send a written notice to the patient within ten (10) working days after request was made when the patient is still an inpatient in a skilled nursing facility for the stay in question

_____ Did QIO complete and send a written notice to the patient within thirty (30) working days if:
- initial determination concerns ambulatory or non-institutional services;
- patient is no longer an inpatient in a hospital or SNF for the stay in question; or
- patient does not submit a timely request for expedited reconsideration.

Discharge Rights for Patients with Medicare Advantage *(Note: this checklist only highlights some of the major differences. Confirm provisions in the patient's specific health care plan)*

_____ Did the managed care organization (MCO) or hospital provide written notice of non-coverage when the patient indicates disagreement with the discharge decision?
NOTE: Written notice *only* required if advised of patient's disagreement with the discharge decision

_____ Exercise notice and appeal rights even if the MCO or hospital is not discharging the individual, but refusing to continue coverage of inpatient stay. [42 CFR §422.620(a)(i)-(ii)]

_____ Before issuing a written notice of non-coverage, concurrence with the physician is obtained. [42 CFR 422.620(b)]

_____ Does the notice of non-coverage provide specific information regarding [42 CFR §422.622(c)]:

_____ Reason why inpatient hospital care is no longer needed;

_____ Effective date and time of patient's liability for continued inpatient care

_____ Appeal rights

_____ Additional information specified by CMS

_____ The patient will receive coverage until at least noon the day after written notice is required. [42 CFR §422.620(a)(2)]

_____ If a review is requested, request must be in writing or by telephone.

_____ If a review is requested, the QIO must make a determination and notify the patient, MCO & hospital by close of business of the first working day after it receives all necessary information for the determination.

Appendix D

ADVOCACY IN SKILLED NURSING FACILITY

The Nursing Home Reform law applies to any nursing facility which accepts Medicare or Medicaid reimbursement. 42 USC 1395i-3, 1396r. This law was passed in 1987. The focus of the law is whether an individual resident receives necessary care. Under the law, each resident must receive the care that s/he needs to "attain or maintain the highest practicable physical, mental, and psychosocial well-being." 42 USC 1395i-3(b)(2), 1396r(b)(2); 42 CFR 483.25.

Advocacy starts immediately once the resident is admitted to the facility. A nursing facility must complete a full assessment of the resident's condition within 14 days after his/her admission, at least once every 12 months thereafter, and "promptly after a significant change in the resident's physical or mental condition." 42 USC 1395i-3(b)(3)(C)(i), 1396r(b)(3)(C)(i); 42 CFR 483.20(b)(2). "Significant change" is defined as:

> a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both.

42 CFR 483.20(b)(2)(ii). The assessment must include information as required by CMS. The information is referred to as the Minimum Data Set (MDS). Federal regulations list 18 topics that must be included in the MDS. These required topics include resident's customary routine, cognitive patterns, communication, mood and behavior patterns, psychosocial well-being, physical functioning, skin condition, and discharge potential. See 42 USC 1395i-3(b)(3)(A)(ii), 1396r(b)(3)(A)(ii), 42 CFR 483.315(e). The assessment must be done on a Resident Assessment Instrument (RAI). The nursing home staff must assess a resident's condition regarding a wide array of subject matters and then mark the assessment accordingly. For example, the section pertaining to cognitive skills for daily decision-making, the staff is to enter "0" if the resident is independent, the number "1" if the resident has modified independence, the number "2" if the resident is moderately impaired, and the number "3" if the resident is severely impaired. The CMS has issued a number of Operation Manuals that are quite readable on defining MDS and completing a RAI. The bottom line is that the assessment is to be used to identify potential problems and to develop a proper care plan for the resident. The law further requires that the nursing facility "examines each resident no less frequently than once every three months and revise the resident's assessment to ensure continuing accuracy of the assessment".

A comprehensive care plan must be prepared within 7 days after the completion of the full assessment. Accordingly, a Care Plan Meeting must be conducted within 21 days of the admission of a resident to a nursing home. 42 USC 1395i-3(b)(2), 1396r(b)(2); 42 CFR 483.20(k)(2)(i). This must be an "individualized" care plan. The care plan is to be reviewed and, if necessary, revised every 3 months. A care plan is prepared by a team of individuals at the nursing home besides the resident and/or the resident's

representative (Guardian). A care plan should reflect the resident's needs and preferences. The care plan must set forth the services that are to be furnished for the resident to attain or maintain highest practicable physical, mental, and psychosocial well-being, and must list measurable objectives and timetables. 42 CFR 483.20(k)(1)(i). Care plans are the cornerstone of the Nursing Home Reform Law.

Be careful of a "cookie cutter" care plan which essentially reads the same from one resident to another resident. Each care plan is supposed to be individualized. The care plan meeting should ensure that the resident's needs and preferences are documented in the care plan. Experience states that nursing home staffs tend to produce the same type of care plan. It is important that the plan is based on individual needs and objectives. These care plans can be key documents especially in whether the facility is meeting appropriate standards for the resident and can assist when the nursing facility considers terminating or decreasing services to the resident.

As previously stated, the law requires that a resident receive therapy necessary for her/him to reach or maintain highest practicable level of functioning. These types of services include but are not limited to physical therapy, speech therapy, occupational therapy, and mental health rehabilitative services. Therapy must be provided under a doctor's written order. 42 CFR 483.45(b). If therapy has been ordered, a facility is legally obligated to provide therapy. Most importantly, therapy cannot be dependent on a resident's reimbursement source. 42 USC 1395i-3(c)(4), 1396r(c)(4)(A); 42 CFR 483.12(c)(1). According to CMS, required therapy services must be provided to Medicaid eligible residents even if the facility receives no more than the Medicaid per diem rate for care of that resident. According to a CMS Surveyor's Guidelines,

> Specialized rehabilitative services are considered facility services and are, thus, included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State [Medicaid] plan.

Despite these provisions, discrimination is most noticeable when a resident's reimbursement source switches from Medicare to Medicaid. Often, the basis is that Medicare reimbursement for care only lasts 100 days during a benefit period. It is common that a resident's therapy ceases on the exact date that the Medicare reimbursement stops even if the resident requires therapy services. It is a **myth** that "Medicaid doesn't pay for therapy". The advocate should press the doctor for on-going orders even if Medicare is not paying for the service as long as the resident needs therapy as previously outlined.

There are a wide range of services that a nursing home facility must provide a resident. One key service is making sure that a sedentary resident should be moved or shifted frequently. If resident nonetheless develops pressure sores, the facility must ensure that resident receives appropriate treatment.

Besides the Medicare and Medicaid laws that have codified assessments and care plans, the Michigan Administrative Code has also taken such steps. Nursing care is based on an assessment and a care plan based on that assessment. MAC Rule 325.20709(1). The nursing home shall make reasonable efforts to discuss the care plan with the Guardian so parties can contribute to the plan's development and implementation. MAC Rule 325.20709(5). Rehabilitative nursing care is to be provided by the nursing home which is to restore and maintain the resident's optimum level of independence and specifically in terms of activities of daily living. MAC Rule 325.20708.

Appendix E

Medicare Beneficiary Nursing Home Resident Advocacy Checklist

General Information for Advocacy File

_____ Appointment of Agent /Advance Directives.
_____ HIPAA Release.
_____ Fee Agreement.
_____ Why is the patient being admitted to nursing home?
_____ Is the patient in a "Medicare bed"?
_____ Patient history.
_____ Care planning summary including prospective discharge options.
_____ Nursing home certification _____ Medicare _____ Medicaid.
Note if partially certified.

Health Care Coverage

_____ Obtain copy of Medicare Cards.
_____ Obtain copy of other health care insurance cards.
_____ Obtain copy of recent premium statement for private insurance.

A. Medicare
_____ Traditional Medicare
_____ Medicare Advantage
Obtain a copy of the contract and limitations.
_____ Was a three day hospital stay required to be eligible for SNF benefits?

B. Private Health Care Insurance
_____ Identified type of private insurance
Name of company: _____
Type of coverage: _____

C. Benefit Available
_____ When was the patient last hospitalized or in a SNF?
(Date)_____

_____ Is this admission from a prior or new spell of illness?

_____ What were the dates that the patient was in the hospital (three day qualifying stay)? _____

Nursing Home Admissions Issues

See Nursing Home Admissions Contract Review Checklist

Care Planning

_____ Has the nursing home completed a comprehensive care plan for the patient upon admission (within 7 days) [42 CFR §483.20(k)]?

_____ Did the patient and/or patient's representatives participate in the care plan?

_____ Does the plan document measurable objectives for the patient?

_____ Does the plan document a timeline to meet those objectives?

_____ Obtain a copy of the written care plan.

_____ Is the discharge evaluation developed, or developed under supervision, by a registered nurse, social worker or other appropriately qualified personnel?

_____ Is Care Plan Meeting needed? If so, request.

Discharge from Medicare in the Nursing Home

_____ Is the discharge (from Medicare coverage and from skilled nursing / rehabilitation services) appropriate?

_____ Does the patient have remaining Medicare days?

_____ Is there a need for skilled care services?

- Skilled rehabilitation services may be continued for maintenance therapy [42 CFR §409.33(c)], even if the patient has shown no improvement or has "plateaued."
- Skilled nursing services, including observation and assessment may be continued, even if there has been no change in the patient's status [42 CFR §409.33(a)(2)].

_____ Did patient receive written Notice of Non-coverage for early termination of Medicare benefits?

_____ Is the name & contact information for QIO included?

_____ Is the substance of the Notice proper?

_____ Did the patient request a "Demand Bill" be sent to Medicare after the facility made the decision of non-coverage? [Sarassat v Sullivan, 1989 WL 20844 (N.D. Cal 1989)].

_____ Has the QIO issued a formal determination of the resident's coverage?

_____ Is the patient eligible for an expedited review process?

_____ Has the nursing home set a date for discharge?
When? _____

_____ Has the nursing home given the written Notice at least two days prior to discharge?

_____ Has the resident filed an expedited appeal to the QIO?
_____ By noon on the day that notice is received?

_____ Did the QIO inform the nursing home of the appeal?

_____ Did the nursing home provide the patient with a more detailed notice of non-coverage?

_____ Has the QIO made a determination of coverage?
_____ When? (QIO has 72 hours to make a determination).

Discharge Rights for Patients with Medicare Advantage *(Review MCO contract for any special considerations that may modify the above noted advocacy process).*

Appendix F
Medicare Home Health Benefit Checklist

[Note: Home Health Care = any provider of home care services]

General Information

_____ Appointment of Agent/Advanced Directives
_____ HIPAA Release for Advocates
_____ Coordination of benefits (Medicare/Medicaid; Older Americans Act)
_____ Eligibility for other benefits? (e.g. VA aid & attendance)

Arranging for Home Care Generally

_____ Determine whether the agency is Medicare/Medicaid Certified
_____ Look up Home Health Agencies using Medicare's Home Health Compare website at http://www.medicare.gov/homehealthcompare/search.html.
_____ Review health care coverage benefits – scope & duration
_____ Review Services Contract/ Fee Agreement
_____ Determine policy re: staffing coverage for "no-shows"
_____ Determine policy for abuse, neglect & exploitation by staff
_____ Determine whether agency & staff are bonded
_____ Determine staff training requirements, especially aides & direct care staff
_____ Ensure significant follow-up & involvement by family, neighbors & advocates to prevent abuse, exploitation & neglect
_____ Ensure that all valuable and goods are not easily accessible in the home

Medicare Home Health Agencies (HHAs)

_____ Meets eligibility for home health
- _____ Requires skilled care (RN, OT, PT, SLP), physical, speech, or occupational therapy.
- _____ Homebound
  - _____ Leaving home takes considerable and taxing effort
  - _____ Absences are infrequent
  - _____ The patient is under a plan of care by a physician

_____ Provider is Medicare Certified

_____ Written or Oral notice when Medicare will not pay for services and when there is a change – called a "home health advanced beneficiary notice" (HHABN).

_____ Outcome and Assessment Information Set (OASIS) completed and identifies clinical severity, functional severity and services utilization.

_____ Information re: care & treatment is provided by the HHA

_____ Complete information in advance of changes in care or treatment that may affect the individual's well-being

_____ Right to participate in care and treatment planning or changes in care plans

_____ Individuals must be provided explanation of circumstances when the individual can a demand bill submitted & right to appeal.

_____ Termination of services:

- _____ Provider must provide 2 days written notice before total loss of services
- _____ Expedited appeal with a QIO on noon of the day they receive notice from provider
- _____ QIO informed provider of appeal and provide must supple beneficiary with more detailed notice regarding decision to discharge
- _____ QIO makes determination in 72 hours.

_____ Contact Michigan Department of Community Health Bureau of Health Systems for complaints

Appendix G

MEDICARE HOSPICE BENEFIT CHECKLIST

IMPORTANT NOTES

1) A beneficiary may qualify for an unlimited number of six-month election periods provided that he or she continues to meet medical certification eligibility requirements (42 CFR 418.21).

2) Beneficiaries who elect the hospice benefit still receive Medicare coverage for medically reasonable/necessary treatment unrelated to terminal illness (42 CFR 418.24).

3) Beneficiaries receiving long-term care under the Medicaid Waiver Program can continue receive those benefits after electing the hospice benefit (42 CFR 418.76(i)).

Eligibility for Medicare Hospice Benefit

_____ Client must be enrolled in Medicare Part A to receive hospice services paid for by Medicare.

_____ Must obtain certification by the hospice doctor and attending doctor that the client is terminally ill (42 CFR 418.22(c)).

_____ Doctor must include a brief narrative explanation of the clinical findings that support a life expectancy of six months or less.

_____ The doctor's certification cannot contain check boxes or standard language used for all patients (42 CFR 418.22(b)(3).

_____ Certification is filed with the hospice (42 CFR 418.22).

_____ Prior to each new election period: obtain re-certification from hospice doctor that patient remains terminally ill.

Electing the Hospice Benefit

_____ File election statement with hospice of client's choice. (42 CFR 418.24(a)).

_____ Identify in the statement the hospice that will provide the beneficiary's care.

_____ Include an acknowledgement that beneficiary understands that he or she is waiving Medicare coverage for *curative* services related to the terminal illness. (42 CFR 418.24(d)(2)).

_____ Include the effective date of the election, which in no event can be prior to the date of the election statement.

_____ Insure that the election statement is signed by beneficiary or his/her legal representative.

Choosing a Hospice Provider

_____ Hospice must be a Medicare provider in good standing and must comply with Medicare's conditions of participation (42 CFR 418.52, 42 CFR 418.116).

Patient Rights

_____ Obtain statement of patient's rights and responsibilities from hospice during the initial assessment visit. (42 CFR 418.52(a)(1)).

_____ Statement must include, at a minimum, the following rights (42 CFR 418.52(c)):

- _____ To have his or her property and person treated with respect.
- _____ To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice.
- _____ Not to be subject to discrimination or reprisal for exercising his or her rights.
- _____ To be involved in developing his or her hospice plan of care.
- _____ To refuse care or treatment.
- _____ To choose his/her attending physician.
- _____ To have a confidential clinical record.
- _____ To be free from mistreatment, neglect, or abuse.
- _____ To receive a written copy of the Plan of Care.

_____ Insure that the hospice immediately investigates all alleged violations of patient's rights involving anyone furnishing services on behalf of hospice. (42 CFR 418.52(b)(4)).

_____ Insure that hospice takes appropriate corrective action in accordance with state law if the alleged violation is verified by hospice administrator. (42 CFR 418.52(b)(4)).

_____ Insure that the verified violations are reported to state and local bodies having jurisdiction. (42 CFR 418.52(b)(4)).

Hospice Services

_____ A Plan of Care must be created in collaboration with the patient's attending doctor, the patient/representative, and the primary caregiver (42 CFR 418.56(b)).

_____ The Plan of Care must, at a minimum, include (42 CFR 418.56(c)):

- _____ A detailed statement of the scope and frequency of services necessary to meet the specific patient needs.

_____ Measurable outcomes anticipated.
_____ Drugs and treatment necessary.
_____ Medical supplies and appliances necessary.

_____ The Plan of Care must be reviewed/revised as the patient's condition requires, but no less frequently than every 15 calendar days (42 CFR 418.56(d)).

Changing Hospice Providers

NOTE: A beneficiary may change designated hospice providers, only one time during each election period.

_____ File a signed statement with current and future hospice a listing the name of each hospice and the effective date of the change (42 CFR 418.30).

_____ If client wants to change provider more than once during a single election period, revoke the hospice benefit and then reelect hospice coverage using a new election period.

Hospice Revocation

_____ To revoke the election of hospice care, individual or representative must file a statement with the hospice (42 CFR 418.28(b)).

_____ Contact the hospice to obtain its pre-printed revocation statement.

_____ Statement must indicate that client revokes his/her election of Medicare coverage for hospice care for the remainder of that election period (42 CFR 418.28(b)(1)).

_____ Statement must be signed by beneficiary/representative and include the effective date of revocation. (42 CFR 418.28(b)(2)).

Appealing Hospice Discharge

(a) For Cause

NOTE: If provider complies with the requirements noted below, there are no appeal rights for a hospice patient who is discharged for cause (i.e. where hospice determines that the patient's behavior is disruptive, abusive, or uncooperative to the extent that the delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. (42 CFR418.26(a)).

_____ Verify that the hospice provider has done the following prior to discharge of the client for cause (42 CFR 418.26(a)(3)):

_____ Advised patient that discharge for cause is being considered.
_____ Made a serious effort to resolve the problem presented by the patient's behavior.
_____ Ascertained that the patient's proposed discharge is not due to the patient's use of necessary hospice services.
_____ Documented the problem and efforts made to resolve it and entered this documentation into the client's medical record.

(b) Due to Determination of Non-Terminal Status

NOTE: A beneficiary who is discharged due to non-terminal status has a right to review within 72 hours of a request (Fed. Reg. 11,419 (March 8, 2005), (42 CFR 405.1202)).

_____ Verify that hospice has obtained a doctor's discharge order from the hospice medical director (42 CFR 418.26(b)).

_____ Verify that the hospice has issued a standardized termination notice (42 CFR 405.1200).

_____ Verify that the termination notice contains the following:
- _____ Indicates that Medicare coverage for hospice care is ending.
- _____ The date coverage ends.
- _____ The beneficiary's financial liability for continued service.
- _____ How to appeal the discharge (42 CFR 405.1200).

_____ Obtain a letter from the client's attending doctor that lists specific clinical findings and includes supporting documentation suggesting the client's limited life expectancy.

_____ Submit a request for determination to the Quality Improvement Organization (QIO) in the state in which client is receiving services.

_____ Submit the request in writing or by telephone by no later than noon of the calendar day following receipt of the provider's notice of termination (42 CFR 405.1202(b)).