Helping Older Persons With Legal & Long-Term Care Problems

Appealing Medicare Coverage Denials

What To Do When You Are Turned Down For Medicare Coverage

1. When does Medicare cover my hospital stay?

Your inpatient hospital stay is covered when you meet these requirements:

(a) your physician prescribes the hospital stay;
(b) your hospital stay is medically necessary for your treatment or diagnosis;
(c) the hospital Utilization Review Committee (URC) or the Quality Improvement Organization (QIO) approves your hospital stay; and
(d) the hospital is a Medicare participant.

2. What are some common denials?

They include:

***(a) Pre-admission denial notices*:** The hospital's Utilization Review Committee (URC) must decide whether Medicare will cover you before you are admitted to the hospital. If you are turned down, the denial must be in writing. You can request that the URC's denial be appealed.

The written denial notice must include (1) why your claim was denied; (2) how to request an appeal; and (3) where you can file your appeal.

(b) Admission and continued stay denial notices: The hospital's URC must decide whether your medical services are necessary. They can decide before, during or after you are admitted to the hospital. Continued stay reviews take place after you have been admitted and receive services. If the URC thinks that you don't need inpatient hospital care, and the attending physician agrees, the hospital must give a written notice of their Medicare non-coverage decision to you. If the attending physician does not agree, then the hospital must request a review by the QIO.

All denial notices must be in writing. Medicare Managed Care Organizations (HMOs) are required to give this same written notice and they are also subject to the same appeal process. If you receive a continued stay denial, then you must be informed that you have a right to appeal this decision. You must also be advised how to file your appeal.

If you are denied coverage, ask that the decision be reconsidered. Wrongful denials are common. If you appeal, there is a good chance you will win.

3. How do I appeal a hospital stay denial?

You can appeal the proposed *non-coverage* **discharge** *to the Quality Improvement Organization (QIO). You can ask for this appeal* **by calling 1-800-589-7337.**

You should then confirm your telephone appeal by writing the QIO at KePRO, Inc. PEPP/Review Dept., Rock Run Center, Suite 100, 5700 Lombardo Center Drive, Seven Hills, Ohio 44131.

If you do not request an appeal, the hospital may bill for the cost of your stay beginning on the third day after you receive the written hospital notice of non-coverage.

If your doctor agrees with the hospital, that your continued hospital stay is no longer necessary, you may **request that the QIO review this decision by noon of the first workday after you receive the written notice of non-coverage.** Even if the QIO reviews and agrees with the discharge notice of noncoverage, you will only be held financially responsible for the cost of your continued stay **if you do not leave the hospital by noon of the day after you received the QIO's decision on your appeal.**

You can appeal a QIO reconsideration denial to an Administrative Law Judge (ALJ) within 60 days if the bill is over $200. The ALJ decision may be appealed to the Departmental Appeals Board within 60 days. If the bill is at least $2000, you can appeal the Appeals Board decision to Federal District Court.

4. What if I am turned down for coverage of home health services?

Request an evaluation from a home health agency (HHA) if the following conditions are met:

(a) you need skilled nursing care, physical therapy or speech therapy;
(b) you are confined to your home, which means that you need help from someone else or a supportive device (like crutches or a wheelchair) to leave home; and
(c) your doctor thinks that you need home health care. If the home health agency feels that the services you need would not be covered by Medicare, it must notify you in writing before or when your care starts.

If services are provided and then cut off by the home health agency, demand that the agency still submit a request to Medicare for coverage. An appeal is easy and costs you nothing. Wrongful denials occur frequently. They can usually be overturned if you appeal.

5. How do I request an appeal for home health care coverage?

You can get an administrative review if you ask the home health agency to submit a request for services to Medicare. These are called "demand billings" or "private insists." If Medicare denies coverage, you can request a reconsideration within 4 months of the decision.

If you still receive a denial after the reconsideration, you can request a hearing before an Administrative Law Judge (ALJ) within 60 days if the amount of your denied claim is more than $100. If the ALJ also denies your claim, you can appeal it before the Medicare Departmental Appeals Board within 60 days of the negative decision. If the amount is $1,000 or more, you can appeal the negative Departmental Appeals Board's decision to Federal District Court within 60 days.

6. What if I am denied coverage for a skilled nursing facility stay?

You are entitled to skilled nursing facility care if (a) you have been in the hospital for at least 3 consecutive days; (b) you are admitted to the nursing facility within 30 days after a hospital discharge; (c) your doctor orders skilled nursing or rehabilitation services for you; and (d) you receive skilled nursing services daily, or skilled rehabilitation five or more days a week. Medicare pays for the first 20 days in a skilled nursing facility (SNF). You, the patient, pay a $105.00 co-payment (2003) for each day of days 21 through 100.

Ask questions if your services are reduced (which means that you'll lose your Medicare coverage) on or around day 21 of your nursing facility stay, especially if your health hasn't changed much. If your skilled services are reduced or completely cut on day 21, appeal this decision immediately. You must be given advance written notice that your nursing facility stay will not be covered by Medicare. You cannot be charged for services if you do not receive advance notice.

The notice must state that the facility will not bill Medicare for the stay unless you demand that Medicare be billed for the services. This is known as a "demand billing" or "private insist." The notice must provide a space where you can indicate that you want the bill submitted.

You should appeal an initial denial by a skilled nursing facility. It's easy and doesn't cost you anything. Remember that wrongful denials are common. They can often be overturned if you appeal.

7. How do I appeal a skilled nursing facility denial?

After the skilled nursing facility submits a claim to Medicare, you will receive a written notice from Medicare indicating whether services are covered. If coverage is denied, you can challenge the decision by requesting a reconsideration within 4 months of the denial notice.

You can appeal a reconsideration denial before an Administrative Law Judge (ALJ) within 60 days after you receive the denial if the amount of your denied claim is over $100. If the ALJ rules against you, you can appeal the decision before the Social Security Appeals Council within

60 days of the decision. If the denied coverage is at least $1,000, you can appeal the Appeals Council decision to Federal District Court.

Pro Seniors' Legal Hotline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

Pro Seniors, Inc.
7162 Reading Rd.
Suite 1150
Cincinnati, Ohio 45237

Switchboard: 513.345.4160
Clients Toll-free: 800.488.6070
Fax: 513.621.5613
TDD: 513.345.4160

E-mail: proseniors@proseniors.org
Web Site: www.proseniors.org