Helping Older Persons With Legal & Long-Term Care Problems

Medicare Coverage Of Nursing Homes: How To Identify Wrongful Denials

1. When Is Skilled Nursing Facility Care Covered By Medicare?

Skilled nursing facility (SNF) care is covered if you, the resident, have been hospitalized at least 3 consecutive days within 30 days after you were admitted to a SNF. Your doctor must order and you must receive either skilled nursing services on a daily basis or skilled rehabilitation services 5 or more days a week. If you need care that does not require a skilled professional, Medicare will not cover your SNF stay.

Traditional Medicare will cover a total of 100 days in a skilled nursing facility. Medicare will pay for all costs for your first 20 days in a SNF. However, you must pay a $157.50 co-payment (2015) for each day of days 21 through 100 of your stay. Medicare HMOs and Medicare Managed Care Organizations (MMCO) are permitted to charge co-payments from your first day in the Skilled Nursing Facility and in some cases, the daily co-payment being charged may be much more than the daily traditional Medicare co-payment.

2. Why Does Medicare Sometimes Deny Coverage?

Medicare beneficiaries are often turned down for Medicare coverage when Medicare law is interpreted too strictly. Certain reasons for denial are frequently used by skilled nursing facilities and Medicare fiscal intermediaries (usually insurance companies) to explain why they're turning down your claim. To protect yourself, become familiar with the areas of Medicare law that are often interpreted too rigidly.

3. What Should I Look For If I Am Denied Medicare Coverage?

If your Medicare coverage is incorrectly restricted, you could lose the skilled nursing care you are now receiving. Here are some wrongful coverage denials that you should be suspicious of and should challenge.

a) *"Not medically reasonable" denials*: Medicare intermediaries often use their own judgment to decide if there is a medical reason for you to receive skilled care, and how much you need. In fact, it is your own doctor who should decide what care you need and how much is reasonable. Medicare places a very high value

on the opinion of the treating physician in determining whether the care is reasonable and needed

b) *"No improvement" denials*: You are entitled to Medicare coverage even if you will not improve medically, and you need skilled care to prevent or delay more deterioration or to preserve your current capabilities.

If you need care that maintains your current abilities, your doctor should describe this need in terms of reaching a goal, such as the goal of maintaining or preventing further deterioration. It is important for your doctor to describe what you need in a way that satisfies Medicare requirements.

4. Are There Other Problems I Should Watch For?

There are areas that are often overlooked by Medicare or the skilled nursing facility. If you are receiving or need of this kind of care and are denied Medicare, contact Pro Seniors to find out if you should challenge the denial.

a) *Supervision by a skilled practitioner*: Some skilled nursing facilities make the mistake of saying that Medicare will not pay for skilled nursing or rehabilitation unless these services are directly supervised by a skilled professional.

Keep in mind that any skilled nursing or rehabilitation services that you receive do not need to be directly supervised by a registered nurse, licensed practical nurse, physical or occupational therapist, speech pathologist or audiologist in order to be covered by Medicare. General supervision, which means setting up a plan of care and evaluating it, is enough. A supervisor does not even have to be physically present or on the premises when you receive the services. Make sure that your SNF knows that it can bill Medicare for these skilled services, whether or not they are directly supervised.

b) *Coordinating a plan of care*: Your skilled nursing facility may not realize that Medicare will pay for unskilled services that SNF aides provide for you.

If you have a lot of health problems, you may need different aides to help you in different ways, from making sure that you are eating properly and getting enough exercise to monitoring your fluid intake. However, as long as a skilled professional, such as a nurse, coordinates all the aides' activities, Medicare will consider these as skilled services and will pay for them.

In cases like these, Medicare regulations say that the SNF must consider your overall condition. Skilled staff may be required to coordinate a series of tasks that, taken individually, would not need a skilled professional to perform.

c) *Observation and assessment as a skilled service*: You may be entitled to observation and assessment to make sure that you are not getting worse or having a bad reaction to your medications. Make sure that your skilled nursing facility realizes that this is a service that Medicare, and not you, should cover.

Observation and assessment is considered to be a skilled service when the skills of a technical or professional person are required to decide if you need additional medical procedures.

For example, a patient with congestive heart failure may need continuous close observation to detect signs of deterioration, water retention or side effects of medications. Likewise, patients discharged from a hospital after surgeries that are still medically unstable may need continued skilled monitoring to watch out for any post-operative complications.

5. If My Medicare Claim Is Refused, Where Can I Get Help?

Beneficiaries and Skilled Nursing Facilities (SNFs) that feel they have been unfairly turned down can contact Pro Seniors' Legal Hotline at (513) 345-4160 or 1-800-488-6070. If you are having trouble getting Medicare to pay your claims, the Pro Seniors' Health Care Consumer Rights Project will work with you to decide what steps to take.

They will

(a) investigate and appeal questionable coverage denials made by intermediaries;

(b) monitor Medicare trends as well as changes in Medicare law and policy that may affect Medicare coverage decisions; and

(c) provide free pamphlets that clearly explain Medicare law and policy and how they work.

6. How Do I Appeal A Denial?

If your nursing facility stay will not be covered by Medicare, you must be given advance written notice. In most cases, you may not be charged for services if you do not receive advance notice.

If a skilled nursing facility turns down your claim, you should appeal. It's easy and costs you nothing. Remember that wrongful denials are common. They can usually be overturned if you appeal.

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 "patient insist." The notice must provide a space so you can indicate that you want the bill submitted.

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

You can appeal a reconsideration denial to an Administrative Law Judge (ALJ) within 60 days after you receive the reconsideration denial if the bill is over $150. If the ALJ rules against you, you can appeal the decision to the Medicare Departmental Appeals Board within 60 days of the decision. If the bill is at least $1,460, you can appeal the Appeals Board's 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.

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