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Medicare Facts and Questions

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I. INTRODUCTION

From time to time, most Elder Law attorneys will be confronted with questions from clients concerning Medicare issues. Although the majority of Elder Law practitioners will never handle cases dealing with appeals of denial of benefits, as part of the counseling function they will need to be able to answer the basic questions that their clients may ask about benefits, and be able to spot issues concerning wrongful denials of benefits for their clients.

For many years, your author has maintained subscriptions to several publications that highlight some of the common problems with the Medicare system that beneficiaries encounter on a day-to-day basis. Most of these issues deal with information that beneficiaries have been given by various sources concerning the availability of benefits for services needed to maintain their health and well being. Many times this information is inaccurate or misleading, and clients will turn to their Elder Law attorney for advice as to what they are entitled and how they go about applying for these benefits. This paper is intended to aid the Elder Law attorney in assisting their clients in their times of need. Although citations to the pertinent law and federal regulations will be included, this paper is only meant to be a resource for providing information on basic matters. The process, and procedures for handling an appeal of denial of benefits is a complex and convoluted legal process and is outside the scope of this paper.

The idea for this paper was suggested by the format and content of these newsletters and various other publications available to all Elder Law attorneys. These publications will be listed at the end of the paper. In order to stay current in these matters, attorneys should obtain the sources and carefully study them for changes in Medicare benefits and services. Medicare continually changes the availability and scope of the benefits available to beneficiaries, and the information presented should always be checked to make sure the attorney has the most current and accurate information upon which to base advice to his or her clients.

II. HOME HEALTH

Many elderly or disabled clients will have chronic health problems that prevent them from managing many of the daily chores that most of us take for granted and mindlessly perform for ourselves. Physical limitations that result from these health problems may interfere with the ability to complete even very simple tasks. An example is an elderly person that has diabetes. As a normal result of the aging process humans lose flexibility. It can become difficult for the person to be able to do something most of us never think of as a problem-trimming our toenails for example. This is an obvious task to maintain our appearance and comfort, that most folks routinely perform without thinking about the implications. Combine the problems that

can be created by not being able to reach down to your toes, with the possible complications that can result if the person had impaired circulation to their feet from the diabetes, and you have a significant problem for that person. If the person can qualify for Medicare homecare benefits, they can have assistance with such a mundane task.

A. Qualification for Home Health Benefits

The requirements for qualification for homecare benefits under Medicare Part A and Part B are the same and are limited to four specific requirements: [i]

1. Confined to the home. The beneficiary must be confined to the home or be in an institution that is not a hospital, SNF or nursing facility.
2. Under the care of a physician. The beneficiary must be under the care of a physician who establishes the plan of care. A doctor of podiatric medicine may establish a plan of care only if that is consistent with the functions he or she is authorized to perform under state law.
3. In need of skilled services. The beneficiary must need at least one of the following skilled services as certified by a physician in accordance with the physician certification and recertification requirements for home health services under C.F.R. §424.22.

    a. Intermittent skilled nursing services that meet the criteria for skilled services and the need for skilled services found in C.F.R. §409.32. (Also see §409.33(a) and (b) for a description of examples of skilled nursing and rehabilitation services).
    b. Physical therapy services that meet the requirements of C.F.R. §409.44 (c).
    c. Speech-language pathology services that meet the requirements of C.F.R. §409.44 (c).
    d. Continuing occupational therapy services that meet the requirements of C.F.R. §409.44(c) if the beneficiary's eligibility for home health services has been established by virtue of a prior need for intermittent skilled nursing care, speech-language pathology services, or physical therapy in the current or prior certification period.

4. Under a plan of care. The beneficiary must be under a plan of care that meets the requirements for plans of care specified in C.F.R. §409.43.

5. By whom the services must be furnished. The home health services

must be furnished by, or under arrangements made by a participating home health agency.

B. Benefits

1. Skilled nursing care on a part-time or intermittent basis. Skilled nursing care includes services and care that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

2. Home health aide services on a part-time or intermittent basis. A home health aide does not have a nursing license. The aide provides services that give additional support to the nurse. These services include help with personal care such as bathing, using the bathroom, or dressing. These types of services do not need the skills of a licensed nurse. Medicare does not cover home health aide services unless you are also getting skilled care such as nursing care or other therapy. The home health aide services must be part of the home care for your illness or injury.

3. Physical therapy, speech-language therapy and occupational therapy for as long as your doctor says you need it.

    a. Physical therapy including: exercise to regain movement and strength in a body area, and training on how to use special equipment or do daily activities-like how to get in and out of a wheelchair or bathtub.
    b. Speech-language therapy (pathology services) including: exercise to regain and strengthen speech skills.
    c. Occupational therapy: to help you become able to do usual daily activities by yourself. You might learn new ways to eat, put on clothes, comb your hair, and new ways to do other usual daily activities. If ordered by your doctor, you may continue to receive occupational therapy even if you no longer need other skilled care.

4. Medical social services to help you with social and emotional concerns related to your illness. This might include counseling or help in finding resources in your community.

5. Certain medical supplies like wound dressings, but not prescription drugs or biologicals.

6. Durable medical equipment such as a wheelchair or walker.

7. FDA (Food and Drug Administration) approved injectable osteoporosis drugs in certain circumstances.

C. Advocacy Tips

There are many obstacles to obtaining and keeping these types of benefits. Many times the patient is not even given a reason other than some vague reference that Medicare will no longer pay for your care. Most of the time the reasons given for discontinuing these benefits are not a legal basis for the denial of care. Some of the more common reasons given include falsely imposed limits on the duration of home health care, or mischaracterization of the homebound requirement. Many times the termination of services happens without legally mandated notice requirements (See Exhibit A attached). The reason given for discontinuing these benefits in many cases is that the patient must be improving to continue the services. The old bromide is that the patient has plateaued and will not benefit from the continuation of therapy. If the patient no longer qualifies for therapy, then they may not qualify for home heath benefits. This is not a proper reason for denial of benefits (See attached exhibit B).

1. There is no limit on duration of services. The Code of Federal Regulations refers to the Home Health benefit in terms of "visits." To the extent that all coverage requirements specified above are met, payment may be made on behalf of eligible beneficiaries under Part A for an unlimited number of covered home health visits. All Medicare home health services are covered under hospital insurance unless there is no Part A entitlement, and then they are covered under Part B.[ii]

2. Homebound definition.[iii] The one issue that causes the most confusion concerning eligibility for home health is the definition of "homebound". This issue has some practical as well as legal implications. Some physicians have difficulty with characterizing their patients as "homebound." This problem may be the result of misunderstanding the "legal" definition of homebound, but is also a result of the psychological aspects of what the stigma of being classified as homebound may create for their patients. If you are homebound then that may imply that you are one step away from nursing home care. A physician may feel that such a disheartening designation may not be the best care they can provide for their patient. This problem may be helped by a better understanding of Medicare's definition of homebound. **The general requirement is that you must be homebound, or normally unable to leave home unassisted.** You must have an illness or injury that restricts your ability to leave home except with

the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or otherwise accredited, to furnish adult day-care services in the state shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or for a relatively short duration. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend a religious service. A trip to the grocery store of relatively short duration should not disqualify the individual.

3. Termination of services without legally mandated notice requirements. Anytime a beneficiary's care or treatment is to be discontinued or changed by a home health agency, the patient is entitled to advance notice. The notice must include information on what services are being changed or terminated, the reason for the termination, and information about the beneficiary's right to appeal the action.[iv] Because of the impact of Medicare's Prospective Payment System (PPS), home health care agencies are paid by a complex process that bases the rate they receive on the patient's level of severity, the prevailing wages of an area and the range of cases the agency handles. At least one commentator has opined that the PPS discourages home health agencies from accepting or continuing services to patients that require heavy utilization of services or have chronic conditions that require them to have increasing needs for care.[v] Alfred J. Chiplin has written an article which provides detailed advice on how to deal with cases in which the beneficiary receives inadequate or no notice of a termination of services, and therefore, is not afforded an opportunity to assert their appeal rights.

4. Must show improvement for care to continue. As mentioned above, home health care benefits are most important to

beneficiaries suffering from chronic diseases. With assistance to manage their disease, these individuals will be able to remain in the community and maintain at least some semblance of independence. Without Medicare Home Health eligibility, these individuals would deteriorate and eventually need institutional care. Many times after an acute episode, these beneficiaries will have no problem qualifying for home health care. However, as time passes and the acute problem subsides, they often lose their eligibility because the underlying problem is a chronic disease that will not get better and in many cases worsens. The Medicare contractors that are responsible for determining if Medicare will pay the bills, often place additional requirements on eligibility for services that the law does not require. **The wrongful denial is based on the requirement that unless your condition is one that has restorative potential your eligibility will be denied.** By definition, chronic care patients are suffering from diseases that will not be cured. Further, as patients age, their medical problems increase. The aging person may need more and more care to maintain the status they have today. This wrongful denial of care is not unique to home health care claims, but it impacts any beneficiary seeking to obtain ongoing therapy to maintain or slow their functional deterioration. It is a very prevalent reason for denial of skilled nursing care benefits. Advocates have railed against this problem for many years but the conventional wisdom that exists in the Medicare system is very difficult to overcome. Let me be clear about this one point. **Restorative potential is not the deciding factor in determining if skilled services, such as physical therapy, are available to the patient.**[vi] Vicki Gottlich has written an extensive article discussing the factors that have contributed to this problem and ways for advocates to deal with these wrongful denials.[vii]

II. HOSPICE BENEFITS

One of the more important but underutilized benefits available from Medicare is Hospice care. The word “Hospice” scares and confuses many families and patients. Most people experience shock when a social worker or doctor suggests that a family member might benefit from hospice care. This is an area where Elder Law attorneys can provide much needed information and counseling services to their client. Most family members, if they know anything about hospice, think it means that their loved one’s death is imminent. Because most of us are not prepared for this, the emotions we experience can cause a variety of reactions, but in most cases the result is paralysis. Family members are overwhelmed and are unable to understand the benefits that the Hospice Benefits can provide to their loved one.

A. What is Hospice?

Hospice has been described in many different ways. One description is that Hospice holds that end of life care should focus on quality of life, and on caring not curing.[viii] The goal of hospice is to provide care for people who are terminally ill to manage their pain and other symptoms, not to cure their illness. There are a multitude of services available through hospice care that are not available to other Medicare covered beneficiaries. As detailed below, homemaker services is one of the most important. The care available to hospice patients can be provided in many different settings including assisted living facilities and nursing homes, but the majority of patients' receive care through hospice in their own home. The benefit does not include expenses for room and board in care facilities. In cases where there are caregiver spouses, the ability to obtain necessary care and assistance to keep the ill spouse at home is a godsend.

Hospice can provide trained persons that are available to a patient and their family 24 hours a day seven days a week. The benefits available to a patient's family can continue for up to 13 months after the death of the patient and provide much needed bereavement counseling to the caregiver/spouse.[ix] Typically, the decision to elect hospice care is made by a family member, and that may be the person seeking advice from the attorney. A patient can receive a one-time-only hospice consultation with a hospice medical director or hospice physician to discuss care options and management of pain and symptoms. The patient does not need to choose hospice care to take advantage of this consultation service.

B. How does it work?

The patient's doctor and the hospice medical team will work with the patient and their family to create a plan of care that meets the needs of the patient. The hospice team includes specially trained medical and support staff. The plan will focus on the patient's well-being, and include the use of drugs for symptom control and pain relief, physical care, counseling, equipment, and supplies to make you as comfortable and pain free as possible. The hospice benefit allows the patient and their family to stay together in the comfort of their home. If the need arises for treatment in an inpatient hospice facility, hospital, or nursing home, the hospice medical team will make the arrangements for the inpatient care.

The plan will include the medical and support services that are available to assist in maintaining the patient's comfort. The hospice team will be a community of professionals and others such as:

- the patient and their family/caregivers
- the patient's personal physicians
- a Hospice physician or medical director
- nurses
- home health aides

- counselors and clergy
- social workers
- speech-language, physical and occupational therapists
- homemakers, and
- volunteers

C. Eligibility[x]

Medicare hospice benefits are available to anyone who is eligible for Part A Medicare (hospital insurance). The patient's doctor and the hospice medical director must certify that the patient is terminally ill and has a life expectancy of six months or less if the illness the patient has runs it normal course. The patient must sign a statement choosing hospice care instead of other Medicare covered benefits to treat the terminal illness and the care must be provided by a Medicare approved hospice program. The patient can continue to use Medicare for treatment of any of their healthcare not related to their terminal illness. [xi] In prior years many physicians were concerned with the issues related to certifying patients based on life expectancy. The Centers for Medicare and Medicaid Services (CMS) published a program transmittal on the subject in January of 2001. The transmittal has been rescinded but, the statute[xii] still contains similar language. It states that the certification must be based on clinical judgment. The statute and other CMS publications recognize that making a terminal prognosis is not always an exact science.

D. Benefits

Medicare pays for hospice services which include:

· Doctor services
· Nursing care
· Medical equipment (such as wheelchairs or walkers)
· Medical supplies (such as bandages and catheters)
· Drugs for symptom control or pain relief (may require a small (copayment)
· Home health aide and homemaker services
· Physical and occupational therapy
· Speech therapy
· Social worker services
· Dietary counseling
· Grief and loss counseling for the patient and their family
· Short-term inpatient care
· Short-term respite care (may require a small copayment)
· Any other covered Medicare services needed to manage pain and other symptoms, as recommended by the hospice team

1. <u>Respite Care</u>[xiii]

One of the more important benefits available under hospice is something called respite care. Respite care is defined by the statute as short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual. Providing care for patients can be difficult and exhausting for family members. The respite care benefit allows the caregivers/family members a break from caring for the ill person or for instances when the caregiver may need to travel or if they become ill themselves. Respite care, will be provided in a Medicare-approved facility, such as a hospice inpatient facility, hospital, or nursing home. It is only available on an "occasional" basis and is limited to five days at a time. This benefit can be invaluable to the family.

2. Home Heath Aid Services

In many instances the family member/caregiver will be an elderly spouse. The home health aide services and homemaker services may provide some of the housekeeping type services that the elderly spouse could not provide on their own. Home health aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens, light cleaning, laundering essential to the comfort and cleanliness of the patient, shaving, deodorant application, skin care with lotions and/or powder, foot care, ear care, feeding, assistance with elimination (including enemas unless the skills of a licensed nurse are required due to the beneficiary's condition, routine catheter care, and routine colostomy care), assistance with ambulation, changing position in bed, and assistance with transfers. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment as well as services to enable the individual to carry out the treatment plan.

E. Nursing Care

Another benefit available under hospice care is nursing care. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.[xiv]

All of the aforementioned services are available under the hospice benefit. Many of the services are not covered by regular Medicare or any other insurance or programs including Medicaid. These services are available during the hospice election period and the patient can continue to receive benefits under the regular Medicare program for any conditions or illness not related to their terminal illness.

III. DURABLE MEDICAL EQUIPMENT

One of the most confusing areas of Medicare benefits concerns the purchase of Durable Medical Equipment. Durable Medical Equipment is covered in most cases by Part B Medicare. Motorized wheelchairs are items that are covered under Part B and every Elder Law attorney will be confronted with questions about how and when a person can obtain one. Because of some unscrupulous providers, CMS has spotlighted the issue. Many of the problems with fraud were found in Harris County, Texas. Providers were actually submitting wrongful claims for motorized wheelchairs and in some cases not even providing the chairs after billing Medicare for them.[xv]

A. Benefits

Durable Medical Equipment is covered by Part B Medicare and benefits are available for the purchase, rental or lease of such equipment.[xvi] The benefit requires copayments and beneficiaries should obtain their equipment from suppliers who agree to accept assignment. Suppliers who agree to accept assignment on all durable medical equipment claims are called "participating suppliers." The types of equipment that can be obtained include iron lungs, oxygen tents, hospital beds, air fluidized beds, blood glucose monitors, bone growth (or osteogenesis) stimulators, canes (except white canes for the blind), commode chairs, crutches, home oxygen equipment and supplies, infusion pumps and some medicines used in them, nebulizers and some medicines used in them, patient lifts, suction pumps, traction equipment, transcutaneous electronic nerve stimulators (TENS), ventilators or respiratory assist devices, walkers and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home. It is important to note that a Skilled Nursing Facility (nursing home) cannot be considered a home. [xvii] It must meet the following criteria :

· Can withstand repeated use;
· Is primarily and customarily used to serve a medical purpose;
· Generally is not useful to an individual in the absence of an illness or injury;
· Is appropriate for use in the home.

B. Power Mobility Device

Electric wheelchairs are referred to as Power Mobility Devices (PMDs) in the Medicare regulations. Power Mobility Device is defined as a covered item of durable medical equipment that is in a class of wheelchairs that includes a power wheelchair (a four-wheeled motorized vehicle whose steering is operated by an electronic device or a joystick to control direction and turning) or a power-operated vehicle (a three or four-wheeled motorized scooter that is operated by a tiller) that a beneficiary uses in the home.[xviii]

To qualify for a power wheelchair under Medicare's rules, a beneficiary must have a health condition that makes them unable to walk on their own, be unable to operate a manual wheelchair, be able to safely operate the controls on a power wheelchair, and have a face-to-face exam and an order from the doctor treating them.

CMS has issued a National Coverage Determination (NCD) dealing with access to PMDs. The NCD states that CMS bases a decision to cover such an item on evaluation of a beneficiary's ability to engage mobility related activities of daily living such as toileting, feeding, and bathing. If the proper criteria are met then such a device will be considered a reasonable and necessary item and will be provided by Medicare.[xix]

IV. Miscellaneous Common Questions[xx]

A. I have prescription drug coverage from my former employer. Will I be able to keep it or will Medicare prescription drug coverage replace it?

Joining a Medicare drug plan is the beneficiary's choice. You aren't required to join a Medicare plan, and you shouldn't join until you are sure how it would affect your retiree coverage. In some cases, if you join a Medicare drug plan, you could lose your retiree health coverage as well as your prescription drug coverage. On the other hand, in many cases your retiree plan will work with Medicare to provide your prescription drug coverage.

For example, an employer or union might want its retirees to join a Medicare drug plan, and then the employer or union will provide additional coverage to supplement the Medicare drug plan. (This is similar to the way that employers and unions often provide health coverage to supplement Medicare doctor and hospital benefits.) Some employers and unions will make special arrangements with a particular Medicare drug plan, while others will provide coverage that supplements any Medicare drug plan their retirees choose. The total amount of drug coverage from Medicare plus this employer or union supplement may be as good as or better than the drug coverage previously provided by the employer or union alone. Your employer (or the plan that administers your retiree drug coverage) should be sending you information about how your retiree health or drug coverage will be affected if you join a Medicare plan. This information will also tell you how your retiree drug coverage compares to the new Medicare prescription drug coverage. If your retiree drug coverage will stay the same, and the coverage is as good as Medicare coverage, you can stay with your current coverage now, and you won't have to pay a penalty if you later decide to switch to Medicare drug coverage. However, if you qualify for extra help to pay for Medicare drug coverage, it is possible that you could get better coverage if you join a Medicare drug plan. The information from your retiree plan will help you understand your options. It should also tell you how to contact the plan if you have questions. If there is no information on whom to contact, contact your benefits administrator or the office that answers questions about your coverage.

Medicare is offering help to employers and unions to encourage them to keep providing high quality prescription drug coverage. If your employer or union is claiming you for the retiree drug subsidy, you should first talk to your benefits administrator

before making any changes to your current coverage. If you try to join a Medicare drug plan, your benefits administrator and/or the Medicare drug plan may contact you to confirm your choice. You may not be able to have both Medicare drug coverage and employer/retiree drug coverage if your employer is claiming you for the retiree drug subsidy. Your employer is responsible for telling you how their coverage works with Medicare.

B. What options do I have for paying my Medicare drug plan premiums?

You have three main options for paying your Medicare drug plan premiums:

1. Automatic electronic monthly withdrawal from your checking or savings bank account;
2. Receive a direct monthly bill from the plan; or
3. Automatic deduction from your monthly Social Security benefit.

If you have any other questions about these issues, contact your Medicare drug plan. Their customer service number is printed on your membership card. If you requested automatic premium deduction from your monthly Social Security benefit, it generally takes about two months from the time your Medicare drug plan submits the request for the premium deduction to start. This means that most of the time, the first time premiums are withheld from your Social Security benefit, two monthly premium payments will be withheld at the same time. Social Security will deduct only the cost of one monthly premium payment from your monthly Social Security benefit after that. It can take longer if there are problems with the request. Social Security will keep track of the number of months for which premiums are due. They will withhold the total premium amount that is due the first time they make a deduction. If your monthly Social Security benefit isn't enough to cover multiple premium payments at one time, the premiums won't be deducted. Your plan will bill you directly and you can pay them directly. You also can arrange with your plan for the premiums to be automatically withdrawn from your checking or savings bank account. You don't have to pay your monthly Medicare drug plan premiums until the automatic premium deduction begins. When your request is processed, whatever premiums you owe will be withheld from your next Social Security benefit. If you signed up for automatic deduction and after 2 months it has not begun, contact your plan to verify what your record indicates concerning your method of payment. If your Social Security automatic deduction hasn't been set up and you still want Social Security to withhold premiums, you may need to pay the first few months of your premium directly to your plan. Your plan can also help you begin withholding future premiums. If there is any question as to whether your premium is being withheld, your plan can verify this with Medicare. You can also contact Medicare directly at 1-800-MEDICARE (1-800-633-4227) and ask them if your automatic premium deduction is taking place. Generally, the payment plan you choose when you first enroll in a Medicare drug plan remains in effect for the rest of the calendar year, unless you leave that drug plan. However, if you have any problems that require you to change your premium payment choice, your drug plan can work to

help you.

If you switch to a different Medicare drug plan your enrollment in the new plan will automatically stop the premium deduction from your previous drug plan. It generally takes one to two months before the premium is no longer being withheld. When you enroll in your new Medicare drug plan, you will need to again choose how to pay your premiums. You can still choose automatic premium deduction from your Social Security benefit. The same process as when you requested premium deductions on the first plan will take place and Social Security will deduct two monthly premium payments from your Social Security Check. Social Security cannot process your request for automatic premium deduction for your new plan until the premium deduction for your previous plan is stopped. The request from your new plan will be rejected if you haven't stopped the previous premium deduction. Your plan will need to contact Medicare to find out why the new action won't take effect. If the Social Security Administration withheld the premium for your previous plan, Social Security will refund your premium. You should receive this refund as an individual payment, separate from your regular monthly benefit, within six weeks after enrolling in a new plan.

C. What is the Competitive Bidding Program?

Medicare is working with suppliers to help you save money and still obtain high quality products. You may have heard that Congress changed the way that Medicare pays for some medical equipment and supplies. You may have to use specific suppliers in your area to get certain types of Medicare-covered equipment or supplies. Starting in April 2008, this will be true in some areas of the country. This program will make the payment amount more competitive which reduces your out-of-pocket costs. The program ensures that you can obtain quality medical equipment, supplies and services, and limits fraud and abuse.

Under the new Competitive Bidding Program, medical equipment suppliers who do business in a specific area, referred to as a competitive bidding area (or CBA), are required to submit a bid for certain equipment and supplies. Suppliers who offer the best price and meet Medicare's quality and financial standards are awarded a contract. These are called "contract suppliers." In most cases, only "contract suppliers" can provide the selected items to Medicare recipients and file claims to Medicare for payment. Contract suppliers may not charge you more than the Medicare single payment amount (that is the competitive bid price) which may not exceed the current Medicare (fee schedule) allowed amount.

If the supplies or equipment ordered by your physician are included in the Competitive Bidding Program where you live, you must get your supplies or equipment from a contract supplier. However, in some cases your doctor or other health professional can supply them to you if it is part of your treatment. If you travel to or visit

an area that is included in the Competitive Bidding Program and need to get supplies or equipment that are part of the Competitive Bidding Program for that area, you must get those items from a contract supplier. You may have to change suppliers in order to receive payment from Medicare but the earliest you would have to change would be April 2008. That requirement depends upon the equipment or supply that you need. However, if you are currently renting equipment or oxygen, you may have the choice to stay with your current supplier if the supplier will continue to furnish the rented equipment.

Competitive Bidding Areas (CBAs) are defined by zip codes. The new Competitive Bidding Program applies to you if your permanent residence is in a CBA. Your permanent residence is the address where Social Security mails your benefits check. To find out if your zip code is included in a CBA, you may call 1-800-MEDICARE (1-800-633-4227) or you may search CBAs on the Supplier Directory at the Medicare.gov website. CBAs are selected based on criteria that include the size of the area in terms of total population, the amount of money spent on medical equipment and supplies by people with Medicare in your area and the number of medical equipment suppliers in your area. Texas is in Durable Medical Equipment Regional Carrier (DMERC) Region "C."

D. How do I get a new Medicare card if my card is lost, stolen, or damaged?

You can now request a replacement red, white, and blue Medicare card online on Social Security's Web site. Your card will be mailed within 30 days to the address SSA has on record. To make an online request, you will need the following information:

* Your last (exact) payment amount or the month and year you last received a payment if you have received benefits in the last 12 months.
* Your name as it appears on your most recent Social Security card
* Your Social Security Number
* Your Date of Birth
* Your phone number in case they need to contact you about your request
* Your e-mail address (optional)

You may also need:

* Your Place of Birth
* Your Mother's Maiden Name (to help identify you)

This new service can be accessed via the Social Security Administration website. If you prefer, or if you are unable to use the online request to obtain a replacement Medicare card, call Social Security's toll-free number, 1-800-772-1213. Their representatives there will be glad to help you. You can also visit a local Social Security office. For the office closest to you try their Field Office Locator on the web at SSA.gov.

E. Will Medicare pay for my flu shot every year?

Medicare will pay for the flu shot once every flu season. In some cases this may mean twice in one year. For example, if you received a shot in January 2007 for one flu

season, you could be inoculated again in October 2007 for another flu season. You can go to any licensed doctor or provider to get a flu shot. If you go to a doctor or provider who participates in Medicare, you will pay nothing for the shot. You can also go to a doctor or provider who doesn't bill Medicare. You will have to pay for the flu shot and then submit a receipt to Medicare to receive a full or partial refund of your payment.

F. What is the role of the Medicare Beneficiary Ombudsman?

The role of the Medicare Ombudsman is to make certain that Medicare effectively provides help to people with Medicare about any aspect of the Medicare program, and to make sure that beneficiaries get assistance with any Medicare question or complaint, or assistance with appeals. There are already many ways for beneficiaries to get information or have their problems resolved, and the Ombudsman is not to replace these existing mechanisms but to enhance them. The Ombudsman works within the Centers for Medicare and Medicaid Services to ensure that Medicare programs serve beneficiaries well, and that information about your rights and protections is available. The Ombudsman will work with the Medicare program to understand system-wide problems, and bring about improvements to the agency's programs for beneficiaries. If you have a particular question
or concern regarding Medicare, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for assistance.

G. I manage my parent's business affairs and would like to have their statements and routine mailings from Medicare to be sent to my address. How can this be authorized?

You should contact the Social Security Administration at 1-800-772-1213. You have two options as to how to handle this based upon the ability of your parent to handle their affairs.

1.) If your parent is unable to manage their affairs, then you should contact the Social Security Administration and apply to be your parent's Representative Payee. This will put everything for your parent in your name.

2.) If your parent is not at the level that you need to be his or her representative, then you could have your parent change their address to your address; again this would need to be done by the Social Security Administration. In this situation, your parent must make the call. Social Security will not change the address based solely on your request. If you call, Social Security will ask that your parent get on the line and agree to the change or have your parent send in a statement saying that it is ok to change their address to yours.

H. The retirement age for Social Security is increasing until it reaches age 67. Will I still get Medicare at age 65 if I'm not yet eligible for Social Security retirement benefits?

Although the retirement age is rising, 65 remains as the starting date for Medicare eligibility. You will be eligible to apply for Medicare if you have paid into Social Security for at least 10 years or you are eligible to receive Social Security benefits on your spouse's earnings. If you do not meet these requirements, you can still get Medicare hospital insurance (Part A) by paying a monthly premium if you are a citizen or a lawfully admitted alien who has lived in the U.S. for at least five years. Also, anyone who is age 65 and a citizen or a lawfully admitted alien with five years of residency in the United States can sign up for Medicare Part B medical insurance and pay a monthly premium. Be sure to sign up for Medicare about three months before you reach age 65. And remember, you do not have to be retired to enroll in Medicare. If you chose early retirement for Social Security Benefits, Medicare benefits do not begin until you are 65. If you retire at age 62, you may be able to continue to have medical insurance coverage through your employer or, if not, you can purchase coverage from a private insurance company until you turn age 65 and become eligible for Medicare. You may wish to contact your State Health Insurance Assistance Program to discuss your options. You can get their phone number in the Helpful Contacts section of the Medicare.gov Web site.

If you are at least age 62 and have worked for at least 10 years in Medicare-covered employment, your spouse can get Medicare Parts A and B at age 65. If you have worked at least 10 years in Medicare-covered employment but are not yet age 62 when your spouse turns age 65, he or she will not be eligible for premium-free Medicare Part A until your 62nd birthday. In this case, your spouse should still apply for Medicare Part B at age 65 so that he/she can avoid paying a higher Part B premium. However, if you are still working and your spouse is covered under your group health plan, he/she could delay enrollment in Part B without paying higher premiums.

Even if you keep working after you turn 65, you should sign up for Medicare Part A. If you have health coverage through your employer or union, Part A may still help pay some of the costs not covered by your group health plan. Call the Social Security Administration at 1-800-772-1213 to sign up. However, you may want to wait to sign up for Medicare Part B if you or your spouse are working and have group health coverage through you or your spouse's employer or union. You would have to pay the monthly Medicare Part B premium, and the Medicare Part B benefits may be of limited value to you as long as the group health plan is the primary payer of your medical bills. In addition, you would start your 6-month Medigap open enrollment period during a time when it will not be of most use to you. If you are age 65 or older and working for a small company (less than 20 employees), you should talk to your employee health benefits administrator before making any decision not to take Medicare Part B. If your employer has less than 20 employees, Medicare is the primary payer and your group health insurance would be the secondary payer.

I. What is Medicare Easy Pay and how do I sign up?

Medicare Easy Pay is an electronic payment option for beneficiaries who are directly billed for their Medicare premiums by the Centers for Medicare & Medicaid Services (CMS). This payment option allows beneficiaries to have their Medicare premiums automatically deducted from either their savings or checking account free of charge each month. If you are directly billed for your Medicare premiums by CMS, you can sign up for the Medicare Easy Pay at any time. To sign up for the Medicare Easy Pay program, you must complete an Authorization Agreement for Preauthorized Payment Form. This form provides the Centers for Medicare and Medicaid Services (CMS) with the information needed to set up electronic deductions (i.e., your bank account and routing number, type of account and a contact person) and permits the Medicare Premium Collection Center, also known as Mellon bank, to deduct a monthly premium from your savings or checking account. If you sign up for Medicare Easy Pay, you will receive a monthly Notice of Medicare Premium Payment Due that will show the amount of the deduction. The automatic deduction will also appear on your monthly bank statement as an Automated Clearing House (ACH) transaction. If you don't have enough money in your account to pay the Medicare premium amount when it is due, CMS will receive an insufficient funds notice from your bank. CMS will not charge you for this unprocessed transaction. However, your bank may charge you a fee for the insufficient funds transaction. After you are notified about the returned payment, you must mail your premium payment directly to the Medicare Premium Collection Center. CMS will make only one attempt to automatically deduct the premium payment from your account. In case of any change in your Medicare enrollment, you do not need to submit another easy pay application. The changes in your premium amount are made automatically. If you change your bank account information or want to cancel the automatic payment deduction, you will need to complete another Authorization Agreement for Preauthorized Payment Form indicating the stop or change.

J. What is an Advance Beneficiary Notice (ABN)?

An ABN is a written notice (the standard government form CMS-R-131), that you may receive from physicians, providers, or suppliers, before they furnish a service or item to you, notifying you:

* That Medicare will probably deny payment for that specific service or item in your case.

* The reason the physician, provider, or supplier expects Medicare to deny payment.

* That you will be personally and fully responsible for payment if Medicare denies payment.

The ABN must identify the service or item for which denial is expected, and it must clearly state the reason a Medicare denial is expected. It may include an estimate of the cost for the service or item. An ABN also gives you the opportunity to refuse to receive the service or item. The ABN protects you from unexpected financial liability in cases

where Medicare denies payment. The "bad news" is that Medicare probably will not pay. The "good news" is that you now have the opportunity to choose whether or not to receive the service or item. The ABN helps you to make an informed consumer decision about whether to obtain the service or item and be prepared to pay for it (that is, either out of your own pocket or by your other insurance coverage) or to choose not to receive it. The ABN allows you to have your claim reviewed by Medicare if you do receive the service or item. This also means that you will have the right to appeal Medicare's decision.

If you receive an ABN you must decide to receive the service or item or to not receive it. You should choose one option by checking the box provided, and then sign and date the ABN. You may choose "Option 1. YES" and receive the service or item. If you choose Option 1, your claim will be sent to Medicare. You may be billed while Medicare is making its decision. If Medicare does pay, you will be refunded any payments you made that are due to you. If Medicare denies payment, you will be personally and fully responsible for payment. You will have the right to appeal Medicare's decision. Medicare will not decide whether to pay unless you receive the service or item and have a claim submitted. You may choose "Option 2. NO" and not receive the service or item. If you choose Option 2, your claim will not be sent to Medicare. You will not be able to appeal the supplier's, physician's, or provider's opinion that Medicare won't pay. If a physician, provider, or supplier fails to give you an ABN, or gives you a defective ABN, you probably will be protected from financial liability for the cost of the service or item. However, only with respect to services and items for which your supplier, physician, or provider takes assignment of your Medicare claim, if there is any other proof that, before the services or items were furnished to you, you knew or should have known that Medicare would not pay, then you may be held liable for payment. The most likely case in which this could happen is if you received the same (or closely similar) services or items previously, and you received a Medicare denial of payment for them. In such a case, the earlier denial from Medicare can be considered as "notice" to you that Medicare will not pay. This does not apply to claims that are not assigned; in those claims, you must receive an ABN and sign it or else you are protected.

If you sign an ABN and become liable for payment, there are no Medicare charge limits which apply to the supplier's, physician's, or provider's charges. Medicare fee schedule amounts and balance billing limits do not apply. The amount of the bill in such cases, therefore, is a matter between you and the supplier, physician, or provider. Again, before signing an ABN, be sure to ask how much it will cost you.

K. What can I do if I have lost my MSN?

The Medicare Summary Notice (MSN) is an easy-to-read statement that clearly lists your health insurance claims information. The MSN lists the details of the services you received and the amount you may be billed. These notices are sent by companies

that handle bills for Medicare on a quarterly basis, unless you are due a payment check from Medicare. If you are due payment from Medicare, the MSN will be mailed to you as your claims are processed. The MSN lists all the services or supplies that were billed to Medicare for a 90-day period of time. It is important to check this notice to be sure you got all the services, medical supplies, or equipment that providers billed to Medicare. If you have any questions or if you need an MSN for a particular claim before the quarterly mailing, call the phone number listed in the Customer Service Information box on the front of the MSN. If you disagree with a claims decision, you have the right to file an appeal. Follow the instructions on the MSN to file an appeal. MyMedicare.gov lets you order a duplicate Medicare Summary Notice for finalized Part A, B and Durable Medical Equipment Regional Carrier (DMERC) claims. To do this, click on the "Order Medicare Summary Notice" link on the claim details page. You will then be asked to choose the reason (from the drop down list) for ordering the copy of your Medicare Summary Notice. Once you have given the reason, click on the "submit" button to process your request. If your request processed successfully, you will see a confirmation page telling you how long it will take to send you the Medicare Summary Notice. The Non-Covered Charges field of the Medicare Summary Notice (MSN) shows the charges for services denied or excluded by the Medicare program for which you may be billed. If a $0.00 appears in this field, it means that there were no services denied or excluded by Medicare for which you may be billed. The total amount the provider is allowed to bill you is detailed in the You May Be Billed column of your MSN. It combines the deductible, the coinsurance and any
non-covered charges. If you have supplemental insurance, it may pay all or part of this amount.

V. RESOURCES

The resources used by your author to prepare this paper come from many sources. Most of these publications are available for free or for modest subscription fees. The quickest way to obtain information on Medicare is to access the Medicare.gov website. The site is well organized for obtaining answers to most questions that clients will have. There are a tremendous number of publications that can be downloaded or ordered in pamphlet form to hand out to your clients. Much of the more technical information is available with a little digging. The policy manuals that CMS provides to its contractors are a great source of information on how the nuts and bolts of this huge system works. Additionally, CMS issues “transmittals” which are based on the latest position of CMS and usually contain clarifications of existing policies and procedures as well as instructions to contractors.

The Center for Medicare Advocacy, Inc. has numerous publications and materials on the web and for purchase that provide the legal citations as well as advocacy information for dealing with Medicare claims and the handling of appeals of denials of benefits. The Center publishes the Center News, a periodical that covers many current events and issues involving Medicare. Each issue covers a specific topic

of how certain benefits are obtained, what problems exist in seeking the benefits, and how to deal with them. Additionally, all current deducible amounts and copayment information is reported. This resource will keep you abreast of all the most important developments in the Medicare field.

Judith Stein and Alfred J. Chiplin, two of the attorneys for The Center for Medicare Advocacy, edit a book entitled the 2007 Medicare Handbook published by Aspen Publishers. Your author considers this book to be the comprehensive "Hornbook" for attorneys dealing with Medicare matters. This book covers the Medicare program in an exhaustive manner with full citations to the statutes, regulations, transmittals, and other sources of information about Medicare. Most importantly the book details the problems that exist in obtaining and keeping Medicare benefits, and provides a tremendous amount of "how to" knowledge for advocates that will be representing Medicare beneficiaries in their attempt to deal with denials of care.

The Center for Medicare Education has published many different issue briefs and newsletter type materials. The grant for the program has expired but the url for their site MedicareEd.org is incorporated into a site maintained by the Institute for Ageing Services. The "issue briefs" are a great resource for understanding problems with Medicare and how to deal with them.

The Medicare Rights Center (MRC) publishes a monthly newsletter called "Dear Marci" that each month covers a different question about Medicare benefits. It can be delivered by email and contains information on topics and questions that beneficiaries are experiencing as they deal with the Medicare program. Their website medicarerights.org has information and details on advocacy for Medicare beneficiaries. They also publish "Asclepios" "that is named for the Greek and Roman god of medicine who, acclaimed for his healing abilities, was at one point the most worshiped god in Greece". It is a weekly e-newsletter designed to "keep up-to-date with Medicare program and policy issues, and advance advocacy strategies to address them".

These resources are a very small part of the publications available to assist advocates in learning about and dealing with questions on Medicare matters. After many years of researching materials on the Medicare program, these are resources that your author has found to be timely, easy to obtain and usually effective in finding the answer to a client's questions.

VI. CONCLUSION

Obtaining and paying for healthcare is one of the most important issues facing our elderly population. The clients that Elder Law attorneys see on a daily basis have questions and concerns about a myriad of problems, but many relate to healthcare issues. Next to finding a good doctor, dealing with Medicare and obtaining coverage of their medical bills is one of the largest components of that issue. Information about the Medicare program, the nuts and bolts of available benefits and how to access the

benefits is information no Elder Law attorney can afford to be without. It is difficult to keep current on "Medicare" because the program is so large, includes many different benefits, and changes so quickly. By having quick access to the types of resources delineated in this paper and obtaining and reading some of these periodicals, it is possible to stay abreast of most of the issues that our clients will inquire about when dealing with Medicare.

CMS Pub. 11 Section 265.1 of the Home Health Manual

265.l COVERAGE OF SERVICES 07-87

265.l Notifying Patient of Noncoverage.-- If you are aware that the services to be furnished to a patient are not covered, advise the patient (or his representative) in writing prior to or at the time of start of care (or at the time the type of care changes) that the care is noncovered and that no claim for Medicare reimbursement is submitted. If the beneficiary insists that you submit a claim for payment, indicate that the bill is being submitted at the beneficiary's request, and why you consider the care to be noncovered. Use the no-payment billing procedures. (See §430.) In such a case, neither the beneficiary nor you are entitled to limitation of liability. (Such denials are not counted in determining denial rates for application of the criteria in § 263.3.)

Establish a procedure for notifying beneficiaries and physicians promptly when a decision of noncoverage is made. The procedure should provide for a written notice of noncoverage to the beneficiary or person acting on his behalf on the day that home health services were to be started or on the day you found the care to be noncovered, or on the same day the intermediary telephones a decision of noncoverage to you.

This Manual can be found at : http://www.cms.hhs.gov/Manuals

Exhibit A

RESTORATIVE POTENTIAL IS NOT A REQUIREMENT

Title 42: Public Health
PART 409—HOSPITAL INSURANCE BENEFITS
Subpart D—Requirements for Coverage of Posthospital SNF Care

§ 409.32 Criteria for skilled services and the need for skilled services.

(a) To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel.

(b) A condition that does not ordinarily require skilled services may require them because of special medical complications. Under those circumstances, a service that is usually nonskilled (such as those listed in §409.33(d)) may be considered skilled because it must be performed or supervised by skilled nursing or rehabilitation personnel. For example, a plaster cast on a leg does not usually require skilled care. However, if the patient has a preexisting acute skin condition or needs traction, skilled personnel may be needed to adjust traction or watch for complications. In situations of this type, the complications, and the skilled services they require, must be documented by physicians' orders and nursing or therapy notes.

(c) The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities. For example, a terminal cancer patient may need some of the skilled services described in §409.33.

[48 FR 12541, Mar. 25, 1983, as amended at 59 FR 65493, Dec. 20, 1994]
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Exhibit B

i. 42 C.F.R. § 409.42 *et seq.*

ii. 42 C.F.R. § 409.48 Visits

iii. 42 U.S.C. § 1395n

iv. Alfred J. Chiplin, Jr. Assuring Access to Medicare Home Health Care, (The ElderLaw Report, May 2004) p. 2

v. *id*.

vi. 42 C.F.R. § 409.32 (c).

vii. Vicki Gottlich, Medicare Coverage of Therapy Services: Are the Interests of Beneficiaries With Chronic Conditions Being Med? (November 2003) available on the Center for Medicare Advocacy website.

viii. The Medicare Hospice Benefit, Center for Medicare Education (Issue Brief Vol. 2 Number 9, 2001) available at www.MedicareEd.org.

ix. *id*. at p. 2

x. 42 C.F.R. § 418

xi. 42 C.F.R. § 418.24

xii. 42 C.F.R. § 422(b)

xiii. 42 C.F.R. § 418.204(b)

xiv. 42 C.F.R. § 418.204(a)

xv. Alfred J. Chiplin, Jr. , *supra,* at 4.

xvi. 42 C.F.R. § 410.38

xvii. 42 C.F.R. § 410.38 (b)

xviii. 42 C.F.R. § 410.38 (c)

xix. Stein,J. and Chiplin Jr. A., 2007 Medicare Handbook, Aspen Publishers (2007) p. 6-34.

xx. These questions and answers are compilations of material from the Frequently Asked Questions page of Medicare.gov. Each section encompasses numerous questions and answers. Both the questions and answers have been edited. The answers include both the law and CMS policy and procedures.