Tips and Tools for Tricky Casework

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How do you find answers to Medicare questions, or confirm what you believe to be true about Medicare?

- Knowing WHERE to find resources to answer questions is half the battle.
- Using trusted resources helps to reassure beneficiaries, providers, and others about the information's accuracy.
- When you have multiple resources to choose from, you want to understand WHICH resources may carry the most weight.

Information is Power!

Let’s Explore Our Medicare Resources and How We Can Apply Them to Accurately Answer Questions…

- Medicare is a program governed by laws, rules and regulations, policies, and other guidance.
- It’s complicated because every beneficiary’s situation is unique.
- Resources exist to find the appropriate answers.

Medicare Resources, in Order of Legal Significance*

- **Medicare Act - Law/Statutes (Passed by Legislators, Signed by President)**
  - Social Security Act, Title XVIII
  - United States Code, Title 42
- **Federal Regulations (Delegated Legislation by Congress to CMS Agency)**
  - 42 Code of Federal Regulations
- **Sub-Regulatory Guidance – Policies (CMS Implementation Instruction Details)**
  - Medicare Benefit Policy Manual
  - Medicare Claims Policy Manual
  - Medicare Managed Care Manual
  - Medicare Program Integrity Manual (billing)

Medicare Resources, in Order of Legal Significance*
(continued)

- **Sub-Regulatory Guidance – Medicare Coverage Database**
  - National Coverage Determinations
  - Local Coverage Determinations

- **Sub-Regulatory Guidance – Medicare Learning Network Articles, Publications, Multi-Media**

- **Some Miscellaneous Other:**
  - Published Case-Law
  - Unpublished Case-Law
  - Medicare Appeals Decisions
  - Social Security Program Operations Manual System (POMS)

* **List of resources is not exhaustive.**

Medicare Resources, in Order of Legal Significance*
(continued)

Does it Seem Overwhelming?

Finding one topical resource

will often provide cross-references

to additional resources.

It may be an easier way to locate all necessary the "threads"

Let’s Explore Five Case Studies In Which to Apply Some of These Resources…

Case Study Topics

1. Getting a Special Enrollment Period

2. Obtaining Durable Medical Equipment

3. Navigating Community Release Issues After Incarceration

4. Appealing a Home Health Discharge

5. Identifying Inappropriate Medicare Hospice Enrollment

Case Study #1
Getting a Special Enrollment Period

Ms. Green is a dually eligible individual enrolled in a Medicare Advantage plan who plans to move from New York to Florida in September.

Assuming there is no change in her dual or low-income subsidy eligible status, what resources might you use to confirm details of her various options for a Special Enrollment Period?

Getting a Special Enrollment Period

Discussion

Resources to Consult:

- The Code of Federal Regulations
- The Medicare Managed Care Manual,

  And

- The Social Security Program Operations

  Manual System

Medicare Part C
Special Enrollment Periods

42 CFR § 422.62 Election of coverage under an MA plan

- …(b) ***Special election periods (SEPs).*** An individual may at any time (that is, not limited to the annual coordinated election period) discontinue the election of an MA plan offered by an MA organization and change his or her election from an MA plan to original Medicare or to a different MA plan under any of the following circumstances:
- …(2) The individual is not eligible to remain enrolled in the plan because of a **change in his or her place of residence to a location out of the service area** or continuation area or other change in circumstances as determined by CMS but not including terminations resulting from a failure to make timely payment of an MA monthly or supplemental beneficiary premium, or from disruptive behavior. Also eligible for this SEP are individuals who, as a result of a change in permanent residence, have new MA plan options available to them.

Medicare Part C Special Election Periods

Medicare Managed Care Manual Chap. 2, section 30.4.1; and POMS HI 00208.067

SEP for *Change in Residence* for individuals who:

- Have changed permanent residence outside MA plan service area
- Were incarcerated and have now been released; *OR*
- Will have new Part C or D plans available to them as a result of a permanent move

- Enrollee is responsible for informing plan of permanent move
- SEP *begins*:
  - Month before permanent move (if plan notified in advance) *OR*
  - Month individual provides notice of the move, if already moved
- SEP *continues* for:
  - 2 months following month it began, *OR*
  - 2 months following month of move, whichever is later

Continued…

Medicare Part C
Special Election Periods

SEP for *Change in Residence* (continued):

- If plan learns individual has been out of service area over 6 months, and plan hasn't been able to confirm with enrollee, SEP starts beginning of the 6th month & ends last day of the 8th month.
- Enrollment effective date is determined by date plan receives request. Enrollee may choose an effective date up to 3 months after month MA plan receives enrollment request.
- Effective date is not earlier than date of move to new service area and receipt of enrollment request.
- Must provide a specific address for MA plan to verify residency requirements.

Medicare Part C
Special Enrollment Periods

SEP for *Change in Residence* (continued):

- ***Our Case Study*** Beneficiary is an enrollee in a New York MA plan and intends to move to Florida in September.
  - SEP exists from August 1 - November 30
  - If MA plan in FL receives enrollment request from beneficiary in August, beneficiary can choose effective date of Oct 1, Nov 1, or Dec 1.
  - If MA plan receives enrollment request in September (month of move), beneficiary can choose effective date of Oct 1, Nov 1, or Dec 1.
  - If MA plan receives enrollment request in October, beneficiary can choose an effective date of Nov 1, Dec 1, or Jan 1.
  - If MA plan receives enrollment request in November, beneficiary can choose an effective date of Dec 1, Jan 1, or Feb 1.
- ***Further MMCM Example*** Beneficiary resides in Oregon, is currently in Original Medicare and not enrolled in an MA plan. Beneficiary intends to move to Arizona in August. A SEP exists for this beneficiary from July 1 through Oct. 31.

Case Study #2
Obtaining Durable Medical Equipment

Mr. Brown has rheumatoid arthritis that significantly impacts use of his lower limbs, and he must use a wheelchair. He is currently residing in a skilled nursing facility, but he is planning to return to his home. With the help of SNF staff, he uses his upper extremities, to transfer to and from the wheelchair provided by the SNF but, when he returns home, he knows he will have difficulty reaching upper kitchen cabinets, safely accessing pots on his stove, or transferring by himself from his wheelchair to his bed.

What resources might you review to determine when Mr. Brown can get his wheelchair and if he meets the Medicare coverage criteria for a “seat elevation” feature on the wheelchair? How might he document his need for seat elevation?

Obtaining Durable Medical Equipment

Discussion

Resources to Consult:

- The Medicare Statute (also contained in the United States Code)
- The Code of Federal Regulations (C.F.R.)
- The Medicare Claims Processing Manual
- The Medicare Learning Network Fact Sheet
  Medicare DMEPOS Payments While Inpatient
- The National Coverage Analysis & Article
  Seat Elevation Coverage
- The Medicare Learning Network Booklet and Fact Sheet
  Seat Elevation Coverage
- The Program Integrity Manual

Obtaining Durable Medical Equipment

Social Security Act Section 1861(n); aka 42 U.S.C. Section 1395x

- (n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations) and eye tracking and gaze interaction accessories for speech generating devices furnished to individuals with a demonstrated medical need for such accessories; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

Obtaining Durable Medical Equipment

42 Code of Federal Regulations § 410.38

§ 410.38 Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS): Scope and conditions.

(a) *General scope.* Medicare Part B pays for durable medical equipment, including ventilators, oxygen equipment, hospital beds, and wheelchairs, if the equipment is used in the patient's home or in an institution that is used as a home.

(b) *Institutions that may not qualify as the patient's home.* An institution that is used as a home may not be a hospital or a CAH or a SNF as defined in sections 1861(e)(1), 1861(mm)(1) and 1819(a)(1) of the Act, respectively.

Obtaining Durable Medical Equipment

Medicare Claims Processing Manual, Chapter 20, Section 110.3

110.3 - Pre-Discharge Delivery of DMEPOS for Fitting and Training

The following are CMS policy and billing procedures regarding the circumstances under which a supplier may deliver durable medical equipment, prosthetics, and orthotics - but not supplies - to a beneficiary who is in an inpatient facility that does not qualify as the beneficiary's home.

Obtaining Durable Medical Equipment

Medicare Claims Processing Manual, Chapter 20, Section 110.3.1

110.3.1 – Conditions that Must be Met

1. The item is medically necessary for use by the beneficiary in the beneficiary's home.
2. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.
3. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home.
4. The supplier delivers the item to the beneficiary no earlier than two days before the day the facility discharges the beneficiary.
5. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.
6. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates.
7. The supplier does not claim payment for the item for any day prior to the date of discharge.
8. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery. 9.
9. The beneficiary's discharge must be to a qualified place of service (e.g., home, custodial facility), but not to another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home

Obtaining Durable Medical Equipment

Medicare Learning Network (MLN) Fact Sheet
Medicare DMEPOS Payments While Inpatient

- Additional information about DMEPOS Deliveries Before Inpatient Discharge, *and*
- Related Issues, including:
  - Interruptions in Period of Continuous Use of DME and Oxygen
  - Resources on Improper Medicare Payments to Suppliers for DMEPOS Provided to Beneficiaries During Inpatient Stays (HHS-OIG, Office of Audit Services)

Obtaining Durable Medical Equipment

Medicare Learning Network (MLN) Booklet
Practitioner & DMEPOS
Supplier Information on Power Mobility Devices

- Step-by-Step instructions about Practitioners and Suppliers actions (BUT, incredibly helpful to beneficiaries too), including reference to seat elevation:

Practitioners: What You Need to Do

Step 1: See the Patient Face-to-Face
Step 2: Update their Medical Record
Step 3: Write a Standard Written Order (Prescription)
Step 4: Make a Prior Authorization Request
Step 5: Complete a Home Assessment
Step 6: Review All Information to Avoid Improper Payments

DMEPOS Suppliers: What You Need to Do

Step 1: Check the Standard Written Order
Step 2: Make a Prior Authorization Request
Step 3: Complete a Home Assessment
Step 4: Keep Documents
Step 5: Review All Information to Avoid Improper Payments

Obtaining Durable Medical Equipment

National Coverage Analysis – Seat Elevation Systems as an Accessory to Power Wheelchairs (Group 3) – Decision Memo

- Details requirements to qualify for coverage
- Provides exceptions for Group 2 wheelchairs “some users may have conditions such as…rheumatoid arthritis…it is expected that they will use their upper extremities to bear weight and face the same obstacles as those patients in Group 3 PWCs.”

Obtaining Durable Medical Equipment

Program Integrity Manual – Chapter 5 – DMEPOS Items and Services Having Special DME Review Considerations, Section 5.11.2 Evidence of Medical Necessity: Wheelchair and Power Operation Vehicle Claims

- Details steps that must be taken to avoid potentially aberrant billing

Case Study #3
Navigating Community Release Issues After Incarceration

Ms. White, age 70, was imprisoned until recently, but now she is under supervised release in the community (including some support for basic living needs, but not health care). She is working full-time at a small office with no medical insurance. She would be Medicare-eligible if she was not still considered to be "in custody." State law requires her to re-pay the cost of her medical services she must get from the penal authority and enforces the requirement to re-pay.

What resources might you consult to help Ms. White to confirm if she may be Medicare-eligible?

Navigating Community Release Issues After Incarceration

Discussion

Resources to Consult:

- The Medicare Statute (also contained in the United States Code)
- The Code of Federal Regulations (C.F.R.)
- The Social Security Program Operations Manual
- The Medicare Learning Network Fact Sheet *Patients in Custody Under a Penal Authority*

Navigating Community Release Issues After Incarceration

42 U.S.C. 1395y(a)(2)

Medicare prohibits payment for services for which it has no legal obligation to pay.

[Note: Under this authority, CMS excludes individuals who are "***in custody*** *under a penal authority"* from receiving Medicare reimbursed services, based on the assumption that the correctional entity is responsible for their health services.]

Navigating Community Release Issues After Incarceration

42 C.F.R. Section 411.4(b)

Individuals who are **in custody** include, but are not limited to, individuals who are under arrest, incarcerated, imprisoned, escaped from confinement, under supervised release, on medical furlough, required to reside in mental health facilities, required to reside in halfway houses, required to live under home detention, or confined completely or partially in any way under a penal statute or rule.

Navigating Community Release Issues After Incarceration

Social Security POMS: GN 02607.840 Retirement, Survivors, and Disability Insurance (Title II) Reinstatement Policies for Prisoners

Reinstate benefits if:

- a correctional institution "officially releases" a beneficiary because they completed serving their sentence, or the institution places the beneficiary on parole or pardon (a beneficiary is "released to the streets"); **or**
- a beneficiary is serving a prison sentence, but is living outside the correctional institution **at no cost** (other than the expense of monitoring) to the correctional institution or custodial agency. The correctional institution or agency electronically maintains supervision and control over the beneficiary. The beneficiary is simply serving their prison sentence outside a correctional institution (e.g., home confinement).

Navigating Community Release Issues After Incarceration

Medicare Learning Network Factsheet
Patients in Custody Under a Penal Authority
(Cross referencing 42 C.F.R. 411.4(b))

Payment may be made for services furnished to individuals or groups of individuals who are in the custody of police or other penal authorities or in the custody of a government agency under a penal statute only if the following conditions are met:

- (1) State or local law requires those individuals or groups of individuals to repay the cost of medical services they receive while in custody.
- (2) The State or local government entity enforces the requirement to pay by billing all such individuals, whether or not covered by Medicare or any other health insurance, and by pursuing collection of the amounts they owe in the same way and with the same vigor that it pursues the collection of other debts.

Case Study #4
Appealing a Home Health Discharge

Mr. Black is 55 years old, is quadriplegic from multiple sclerosis, and needs home health care for catheter changes, therapy to prevent contractures of his upper and lower extremities, and home health aides.

His home health agency notified him that they believed Medicare-covered services were no longer considered to be reasonable and necessary and he was discharged from services after several appeals were unsuccessful. He would now like to appeal his discharge to an administrative law judge.

What resources would you use to advise him on his appeal?

Appealing a Home Health Discharge

42 CFR § 405.1200 Notifying beneficiaries of provider service terminations

- (b) ***Advance written notice of service terminations.*** Before any termination of services, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services. The provider must use a standardized notice, as specified by CMS, in accordance with the following procedures:
- (1) ***Timing of notice.*** A provider must notify the beneficiary of the decision to terminate covered services no later than 2 days before the proposed end of the services. If the beneficiary's services are expected to be fewer than 2 days in duration, the provider must notify the beneficiary at the time of admission to the provider. If, in a non-residential setting, the span of time between services exceeds 2 days, the notice must be given no later than the next to last time services are furnished.
- (2) ***Content of the notice.*** The standardized termination notice must include the following information:
- (i) The date that coverage of services ends;
- (ii) The date that the beneficiary's financial liability for continued services begins;
- (iii) A description of the beneficiary's right to an expedited determination under § 405.1202, including information about how to request an expedited determination and about a beneficiary's right to submit evidence showing that services must continue; ….

Appealing a Home Health Discharge

Process and Appeal Rights:

Social Security Act Section 1869 Determinations and Appeals

- 1869(a) Initial Determinations
- 1869(b) Hearings

42 C.F.R. § 405.1202 Expedited determination procedures

42 C.F.R. § 405.1204 Expedited reconsiderations

42 C.F.R. § 405.1000-1054 Hearings. Once an initial claim determination is made, any party to that initial determination, such as beneficiaries, providers, and suppliers – or their respective appointed representatives – has the right to appeal the Medicare coverage and payment decision.

Appealing a Home Health Discharge

42 C.F.R. 409.42 Qualifying Criteria for Home Health

Beneficiary qualifications for coverage of services. To qualify for Medicare coverage of home health services, a beneficiary must meet each of the following requirements:

(a) Confined to the home. …

(b) Under the care of a physician or allowed practitioner ...

(c) In need of skilled services …

(d) Under a plan of care. …

(e) By whom the services must be furnished.

Appealing a Home Health Discharge

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(d) Under a plan of care. …

(e) By whom the services must be furnished.

Appealing a Home Health Discharge

Medicare Benefit Policy Manual Chapter 7, Section 40.1.2.7 - Catheters

Insertion and sterile irrigation and replacement of catheters, care of a suprapubic catheter, and in selected patients, urethral catheters, are considered to be skilled nursing services. Where the catheter is necessitated by a permanent or temporary loss of bladder control, skilled nursing services that are provided at a frequency appropriate to the type of catheter in use would be considered reasonable and necessary.

Appealing a Home Health Discharge

Review the Potential Impact of
a Fully Favorable Home Health Care Decision
by an Administrative Law
for the Office of Medicare Hearings and Appeals

Case Study #5: Identifying Inappropriate Medicare Hospice Enrollment

Mr. Blue fell and broke his hip. He had a brief hospital stay, followed by an inpatient skilled nursing facility stay, and was discharged to his home with an order for physical therapy home health services. Mr. Blue sought recommendations for home health agencies though Facebook. He received a message from an organization that he thought offered home health services. He shared he had an order for services, but he couldn't locate it. The representative said it was no problem, he did not need an order, and "signed him up". Soon after, Mr. Blue received a call from his primary care provider saying his recent visit wasn't covered by his Medicare Advantage Plan because he was enrolled in hospice.

Identifying Inappropriate Medicare Hospice Enrollment

Discussion

Resources to Consult:

- The Medicare Statute (also contained in the United States Code)
- The Code of Federal Regulations (C.F.R.)
- Medicare Benefit Policy Manual, Chapter 9
- Medicare Claims Processing Manual, Chapter 11
- Model Hospice Election Statement *and* Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Identifying Inappropriate Medicare Hospice Enrollment

Hospice Enrollment Process and Coverage Criteria to Consult

- **Hospice Law:**
  - Social Security Act Sections 1812(a)(4) and (d); 1813(a)(4); 1814(a)(7); 1814(i); 1862(a)(1)(6) and (9)
  - 42 United States Code Sections 1395(d)(e) and (f)
- **Regulations:**
  - 42 Code of Federal Regulations Sections 418.1 to 418.405
- **Medicare Benefit Policy Manual** Chapter 9
- **Medicare Claims Processing Manual** Chapter 11

Identifying Inappropriate Medicare Hospice Enrollment

Model Example of Hospice Election Statement:

Model Example of Hospice Election Statement (cms.gov)

By electing hospice care under the Medicare hospice benefit, I acknowledge that:

- I was given an explanation and have a full understanding of the purpose of hospice care including that the nature of hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.
- I was provided information on what items, services, and drugs the hospice is to cover and furnish upon my election to receive hospice care.
- I was provided with information about potential cost-sharing for certain hospice services, if applicable.
- I understand that by electing hospice care under the Medicare hospice benefit, I waive (give up) the right to Medicare payments for items, services, and drugs related to my terminal illness and related conditions. This means that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected.
- I understand that items, services, and drugs unrelated to my terminal illness and related conditions are exceptional and unusual, and in general, the hospice will be providing virtually all of my care while I am under a hospice election. The items, services, and drugs determined to be unrelated to my terminal illness and related conditions will continue to be eligible for coverage by Medicare under separate benefits.

Identifying Inappropriate Medicare Hospice Enrollment

Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs":

- Model Example of "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" (cms.gov)

Purpose of Issuing this Notification The purpose of this addendum is to notify the requesting Medicare beneficiary (or representative), in writing, of those conditions, items, services, and drugs not covered by the hospice because the hospice has determined they are unrelated to your terminal illness and related conditions. If you request this notification on the effective date of the hospice election (that is, on the start date of hospice care), the hospice must provide you this form within 5 days. If you request this form at any point after the start date of hospice care, the hospice must provide you this form within 3 days. …

Right to Immediate Advocacy As a Medicare beneficiary, you have the right to contact the Medicare Beneficiary and Family Centered CareQuality Improvement Organization (BFCC-QIO) to request for Immediate Advocacy if you (or your representative) disagree with the decision of the hospice agency on items not covered because the hospice has determined they are unrelated to your terminal illness and related conditions

Thank you!

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Additional Resources at MedicareAdvocacy.org