Medicare Minute Teaching Materials — February 2024
Ending Care Appeals

1. What should I do if my care ends too soon?
If you are receiving care in a hospital or non-hospital setting and you learn that your care is going to end, you have the right to a fast, or expedited, appeal to request continued care.

The distinction between hospital and non-hospital settings is made in these materials because there are different steps in the appeal process depending on whether hospital or non-hospital care is ending. Non-hospital facilities include skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), hospice settings, and home health agencies. Note that hospital and non-hospital settings can overlap. For example, a hospital building may also include a skilled nursing facility. Although they are in the same building, the type of care they provide is different.

In both hospital and non-hospital settings you can file an appeal to challenge your provider's decision to end your care if you think that they are wrong about whether Medicare will cover your services. If you are unable to appeal, a family member or other representative can appeal for you. If your appeal is unsuccessful at the first level, you can continue to appeal by following instructions on the denial notices you receive.

Expedited appeals have tight deadlines, so it is important to pay attention to the timeframes for appealing at each level. Keep copies of any appeal paperwork you send out, and if you speak to someone on the phone, get their name and write down the date and time that you spoke to them. It is helpful to have all of your appeal documents together in case you run into any problems and need to access documents you already mailed.

2. What notices will I receive when I am receiving care in a hospital or non-hospital setting?
If you are an inpatient at a hospital, you should receive a notice titled Important Message from Medicare within two days of being admitted. This notice explains your patient rights, and you will be asked to sign it. If your inpatient hospital stay lasts three days or longer, you should receive another copy of the same notice before you leave the hospital. This notice should arrive up to two days, and no later than four hours, before you are discharged.

If your care is ending in a non-hospital setting (at a skilled nursing facility [SNF], comprehensive rehabilitation facility [CORF], hospice, or home health agency) because your provider believes Medicare will not pay for it, you should receive a Notice of Medicare Non-Coverage. You should get this notice no later than two days before your care is set to end. If you receive home health care, you should receive the notice on your second to last care visit. If you have reached the limit in your care or do not qualify for care, you do not receive this notice and you cannot appeal.

3. How do I start an appeal for inpatient <u>hospital</u> care that is ending?
If the hospital says you must leave and you disagree, follow the instructions on the Important Message from Medicare to file an expedited appeal to the Beneficiary and Family Centered Care- Quality Improvement Organization (BFCC-QIO). You must appeal by midnight of the day of your discharge. If you are appealing to the BFCC-QIO, the hospital must send you a Detailed Notice of Discharge. This notice explains in writing why your hospital care is ending and lists any Medicare coverage rules related to your case. The BFCC-QIO will

request copies of your medical records from the hospital. It can be helpful to ask the hospital for your own copy (a copying charge may apply). The BFCC-QIO will usually call you to get your opinion on the discharge, but you can also send a written statement.

The BFCC-QIO should call you with its decision within 24 hours of receiving all the information it needs. If the appeal to the BFCC-QIO is successful, your care will continue to be covered. If the BFCC-QIO decides that your care should end, you will be responsible for paying for any care you receive after noon of the day after the BFCC-QIO makes its decision. If you stay in the hospital after that period, you may be responsible for the cost of your care, unless you appeal to a higher level of appeal and win there. See question 4 to learn how to continue if the BFCC-QIO denies your first request for continued hospital care.

If you leave the hospital or miss the deadline to file an expedited appeal to the BFCC-QIO, you have 30 days from your original discharge date to request a post-service BFCC-QIO review. The BFCC-QIO will send a written decision letter once it receives all the information it needs from you and the hospital.

4. What happens if the BFCC-QIO denies my appeal to continue my hospital care?
Your next steps depend on whether you have Original Medicare or a Medicare Advantage Plan:

Original Medicare
If your appeal to the BFCC-QIO is denied, you can file an appeal with the Qualified Independent Contractor (QIC). You have until noon of the day following the BFCC-QIO's denial to file this appeal. The QIC should make a decision within 72 hours. If you continue to stay in the hospital, you cannot be billed until the QIC makes its decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the 72 hours the QIC deliberated.

If you left the hospital or missed the deadline to appeal, you can follow the standard appeal process that gives you up to 180 days to file an appeal with the QIC. The QIC should make a decision within 60 days. If the QIC appeal is successful, your hospital care will continue to be covered. If the QIC denies your appeal, you can continue to appeal to the third level (see question 7).

Medicare Advantage
If your appeal to the BFCC-QIO is unsuccessful, you will not be held responsible for the cost of the 24-hour period while you waited for the BFCC-QIO to make a decision. If you remain in the hospital after that period, you may be responsible for the cost of your care if you do not win at a higher level of appeal.

If your appeal is denied, you can file an appeal with the BFCC-QIO a second time. A different set of staff will review your appeal and reconsider whether care should be continued. You have 60 days following the BFCC-QIO's initial denial. The BFCC-QIO should issue a second decision within 14 days of getting the appeal. If you continue to stay in the hospital, you cannot be billed until the BFCC-QIO makes its decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the time the BFCC-QIO deliberated. If the second appeal to the BFCC-QIO is successful, your hospital care will continue to be covered.

If the QIC denies your appeal, you can continue to appeal to the third level (see question 7).

5. How do I start an appeal for non-hospital care that is ending?

If you learn that your non-hospital care is ending and you feel that your care should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with the Quality Improvement Organization by noon of the day before your care is set to end. Once you file the appeal, your provider should give you a Detailed Explanation of Non-Coverage. This notice explains in writing why your care is ending and lists any Medicare coverage rules related to your case. The BFCC-QIO will usually call you to get your opinion. You can also send a written statement. If you receive home health or CORF care, you must get a written statement from a physician who confirms that your care should continue.

If you have Original Medicare, the BFCC-QIO should make a decision no later than two days after your care was set to end. If you have a Medicare Advantage Plan, the BFCC-QIO should make a decision no later than the day your care is set to end. Your provider cannot bill you before the BFCC-QIO makes its decision.

If you miss the deadline for an expedited BFCC-QIO review, you have up to 60 days to file a standard appeal with the BFCC-QIO. If you are still receiving care, the BFCC-QIO should make its decision as soon as possible after receiving your request. If you are no longer receiving care, the BFCC-QIO must make a decision within 30 days.

If the BFCC-QIO appeal is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. See question 7 to learn how to continue your appeal if the BFCC-QIO denies your first request for continued care.

6. What happens if the BFCC-QIO denies my appeal for continued non-hospital care?

Your next steps depend on whether you have Original Medicare or a Medicare Advantage Plan:

Original Medicare

If the BFCC-QIO denies your appeal, you can choose to move to the next level by appealing to the Qualified Independent Contractor (QIC) by noon of the day following the BFCC-QIO's decision. The QIC should make a decision within 72 hours. Your provider cannot bill you for continuing care until the QIC makes a decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the 72 hours the QIC deliberated. If you miss the QIC deadline, you have up to 180 days to file a standard appeal with the QIC. The QIC should make a decision within 60 days. If the appeal to the QIC is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If the QIC denies your appeal, you can continue to appeal to the third level (see question 7).

Medicare Advantage

If your appeal is denied, you can file an appeal with the BFCC-QIO a second time. A different set of staff will review your appeal and reconsider whether care should be continued. You have 60 days following the BFCC-QIO's initial denial. The BFCC-QIO should issue a second decision within 14 days of getting the appeal. If you continue to stay in the hospital, you cannot be charged until the BFCC-QIO makes its decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the time the BFCC-QIO deliberated. If the second appeal to the BFCC-QIO is successful, your hospital care will continue to be covered. If the BFCC-QIO denies your appeal, you can continue to appeal to the third level (see question 7).

7. What are the rest of the steps in the appeal process?
The last three levels of the Original Medicare and Medicare Advantage appeal processes are the same for hospital and non-hospital care that is ending.

If the QIC or BFCC-QIO denies your appeal at the second level and your care is worth at least $180 in 2024, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) within 60 days of the date on your denial letter. If you decide to appeal at the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required. The OMHA should make a decision within 90 days.

If your appeal to the OMHA is successful, your care will be covered. If your appeal is denied, you can choose to appeal to the Council within 60 days of the date on your OMHA level denial letter. There is no deadline for the Council to make its decision.

If your appeal to the Council is successful, your care will be covered. If your appeal is denied and you are appealing care that is worth at least $1,840 in 2024, you can choose to appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision about your appeal.

8. What if my care from a skilled nursing facility (SNF) or home health care is being reduced, but not ending?
The appeal process is different if your care is being reduced but not ending, and you do not agree with that reduction. You have rights if your skilled nursing facility (SNF) or home health agency (HHA) decides to reduce your care because it believes Medicare will no longer cover it. Be aware that the process is slightly different depending on whether you have Original Medicare or a Medicare Advantage Plan.

If you have Original Medicare, and your SNF or HHA decides to reduce services prescribed by your doctor because it believes that Medicare will no longer cover these services, it should give you a notice explaining why services are being reduced. If you are in a SNF, you should receive a notice indicating that Medicare may deny part of your care. This notice is often called a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). If you are receiving care from an HHA, you should receive a Home Health Advance Beneficiary Notice (HHABN). Each notice will ask you to choose one of the following three options:

- Request care and ask the SNF or HHA to bill Medicare (demand bill). If Medicare denies coverage, you have the right to file an appeal. If your appeal is unsuccessful, you may be responsible for the cost of care. A SNF or HHA may refuse to demand bill.
- Request care but agree to pay for the care out of pocket.
- Turn down care. You can look for another SNF or HHA that might cover the needed care.

Remember, you have the right to a demand bill if your care is being reduced because your SNF or HHA doesn't believe Medicare will cover it. Be aware that demand billing rules are slightly different, depending on the kind of care you are receiving. If you ask a SNF to demand bill Medicare, you cannot be billed until Medicare makes a coverage decision. However, if you ask an HHA to demand bill Medicare, the HHA can bill you for home health services while Medicare makes its decision.

If you are receiving home health care, there are situations when you may receive an HHABN but do not have the right to request a demand bill. For example, if:

- Your doctor reduces the amount of care in your plan of care. In this case, you will need to get your doctor to change their mind, get another doctor to certify that you need to continue getting the same amount of services, or go without these services.
- The HHA reduces your care for staffing reasons, or they do not think it is safe for you to stay at home. You will need to find another HHA to get home health care, investigate other care options in your community, or go without these services.

If you have a Medicare Advantage Plan and your SNF or HHA is reducing your home health services because it believes that Medicare will no longer cover these services, you typically have to appeal to ask your plan for a fast (expedited) review of this decision.

You can contact your State Health Insurance Assistance Program (SHIP) or 1-800-MEDICARE (633-4227) for more information on appealing a reduction in care from a skilled nursing facility or home health care. Contact information for your local SHIP is on the last page of this document.

9. What is a good cause extension?
When initially filing an appeal and for each subsequent level, you have a limited amount of time to file. That said, after the deadline has passed, if you can show good cause for not filing on time, your late appeal may be considered. You can request a good cause extension at any level of appeal, and it is available for Original Medicare, Medicare Advantage, and Part D appeals. Extension requests are considered on a case-by-case basis, so there is no complete list of acceptable reasons for filing a late appeal. Some examples include:

- The notice you are appealing was mailed to the wrong address.
- A Medicare representative gave you incorrect information about the claim you are appealing.
- Illness—either yours or a close family member's—prevented you from handling business matters.
- The person you are helping appeal a claim is illiterate, does not speak English, or could not otherwise read or understand the coverage notice.

If you think you have a good reason for not appealing on time, send in your appeal as you normally would and include a clear explanation of why your appeal is late. If the reason has to do with illness or other medical conditions, a letter or supporting documentation from your health care provider can be helpful.

10. Can someone else appeal on my behalf?
If you cannot appeal on your own, you can choose a representative to appeal for you. This can be a family member, friend, advocate, attorney, or doctor, among others. To appoint a representative, you and the representative will have to fill out a Medicare Appointment of Representative form, form CMS-1696. Call 1-800-MEDICARE (633-4227) to request this form or download it online. Send this form in at any stage in the appeal process.

You can also submit a written request with your appeal that includes:
- Your name, address, phone number, and Medicare number
- A statement assigning someone as your representative and their name, address, and phone number

- The relationship between you and the representative
- A statement giving the representative permission to access your health information
- A statement explaining why you're being represented
- Your signature and the representative's signature

Call 1-800-MEDICARE (633-4227) or contact your local State Health Insurance Assistance Program (SHIP) if you have any questions about choosing a representative. Contact information for your local SHIP is on the last page of this document.

11. How can I prevent, detect, and report Medicare fraud related to a SNF stay?
Medicare fraud can occur when a provider or facility bills for services you did not receive or were not medically necessary. Examples of potential skilled nursing facility (SNF) fraud could include:

- Learning that your Medicare was charged for:
  - Services that your doctor did not deem medically necessary
  - Services that you never received
  - More expensive services than what you received
  - A greater quantity of services than what you received
  - SNF services for dates after you were released from the SNF
- Being forced to stay in a SNF until your benefits have expired, even though your condition has improved, and you wish to transition to home health care services.

You can stop SNF fraud by:

- Reading your Medicare statements to compare the services you received with the services Medicare was charged by your providers.
- Reporting any charges on your Medicare statements that are not accurate to your local Senior Medicare Patrol (SMP).
- Working with your doctor to enroll in SNF services.
- Not accepting gifts or money in return for choosing a SNF.
- Signing forms only once you have understood them.
- Reporting quality-of-care complaints to your local Senior Medicare Patrol (SMP).

You can find contact information for your local SMP on the final page of this document.

12. Who can I contact if I have more questions?

Medicare: The federal government has a toll-free number, 1-800-MEDICARE (633-4227), and a website www.Medicare.gov that provides basic information. You can contact Medicare with questions about the appeal process.

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about how to appeal or if you need help appealing. SHIP counselors provide unbiased Medicare counseling and assistance. Contact information for your local SHIP is on the final page of this document.

Senior Medicare Patrol (SMP): Contact your SMP if you believe you have experienced potential fraud, errors, or abuse. Contact information for your local SMP is on the final page of this document.

Your Beneficiary and Family Centered Care- Quality Improvement Organization (BFCC-QIO): There are two BFCC-QIOs that are responsible for various regions of the country. Find which BFCC-QIO is responsible for your region here. You can submit ending care appeals or quality-of-care complaints to your BFCC-QIO.

- KEPRO: www.keproqio.com, 888-315-0636
- Livanta: www.livantaqio.com, 877-588-1123

SHIP case example

Jonathon is 72 years old and has Original Medicare. He recently had surgery after falling and breaking a hip. After his stay in the hospital, Jonathon was admitted to a skilled nursing facility (SNF). Jonathon later learned that he would be leaving the SNF and going home in two days. He is not sure he is ready to go home, though. His wife Rosa is also worried about his coming home too early and getting hurt again. Rosa wants to help extend Jonathon's stay but is not sure what to do.

What should Rosa do?

- Rosa should contact her State Health Insurance Assistance Program (SHIP) to learn about the expedited appeal process. She can visit www.shiphelp.org or call 877-839-2675 if she does not know how to contact her SHIP.
- Rosa should locate her husband's Notice of Medicare Non-Coverage or ask the SNF for another copy. She should read this carefully and follow the instructions on how to appeal. She should also keep this document for her records.
- Rosa should contact the BFCC-QIO at the number listed to file an expedited appeal by noon of the day before Jonathon's care is set to end. Rosa should also include an Appointment of Representation form with his appeal, which will allow her to file an expedited appeal on her husband's behalf.
- If possible, Rosa should also speak with Jonathon's doctor at the SNF to see if they can provide a letter of support that includes medical documentation showing he needs continued SNF care.
- Rosa should expect a decision no later than two days after Jonathon's care was set to end. If the BFCC-QIO appeal is successful, Jonathon should continue to receive Medicare-covered care, as long as his doctor continues to certify it. If the BFCC-QIO decides his care should end, he will be responsible for paying for any care he receives after the end date on the Notice of Medicare Non-Coverage if Rosa does not win at a higher level of appeal.
- If Rosa decides to continue appealing, she will follow the instructions on the denial notice to do so.

SMP case example

Lily's husband Jamal recently had surgery and is now staying at a SNF. Lily visits Jamal daily. After a week at the SNF, Lily sees that Jamal is growing increasingly exhausted from the frequency of physical therapy, much of which seems unrelated to his surgery. Jamal says he expressed his feelings to the staff, who said he would never recover from his surgery if they adjusted his physical therapy. Lily is worried that her husband is receiving excessive therapy that is not beneficial for him.

What should Lily do?

- Lily can contact Jamal's doctor and ask what kind and frequency of physical therapy would be beneficial for recovering from the kind of surgery he had.
- Lily should contact her Senior Medicare Patrol (SMP) for assistance.
  - If Lily does not know how to contact her SMP, she can call 877-808-2468 or visit www.smpresource.org.
- The SMP team member can help gather more information from Lily about Jamal's surgery, details provided by their doctor, their experience at the SNF, and any other relevant information.
- If the SMP determines there could be potential fraud or abuse, they will report it to the proper authorities and other referral sources as needed.
- The SMP team member can help inform Lily about how to be on the lookout to prevent Medicare fraud, errors, and abuse. Lily should continue to remember her and her husband's right to refuse unwanted or excessive care and be on alert for possibly fraudulent practices.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: 800-247-4422 **SHIP email:** idahoshiba@doi.idaho.gov **SHIP website:** shiba.idaho.gov **To find a SHIP in another state:** Call 877-839-2675 and say "Medicare" when prompted or visit www.shiphelp.org.	**SMP toll-free:** 800-247-4422 **SMP email:** idahoshiba.doi.idaho.gov **SMP website:** https://aging.idaho.gov/stay-safe/senior-medicare-patrol-fraud-prevention **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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SHIP Technical Assistance Center: 877-839-2675 | www.shiptacenter.org | info@shiptacenter.org
SMP Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org