Filling the Holes in Medicare

Coverage May Be Unjustly Denied in Many Circumstances

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Millions of seniors rely upon Medicare and supplemental Medigap policies to pay for hospital and skilled-nursing care, but many find out at the worst possible time that a big bill is due.

In particular, coverage may be unjustly denied when 1) a patient is admitted to a hospital under 'observation status' rather than as an inpatient, 2) a skilled-nursing-care facility declares that a patient has plateaued, or 3) a hospital stay exceeds 90 days for the same illness. If you or a loved one run into this type of problem, here is what you need to know.

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Observation Status

Medicare Part A covers hospital inpatient stays for 60 days and skilled-nursing-home care for the first 20 days, but only if you are discharged from a hospital after admission as an inpatient for three days. If you are admitted under observation status, you are billed as an outpatient under Medicare Part B. Although Part B may cover most of your expenses in the hospital, patients who are discharged to a nursing home without the requisite three days as an inpatient will not be covered for their nursing-home stay.

Many hospitals have increasingly admitted patients under observation status for longer stays, even though the Medicare policy manual specifies 24 hours as a benchmark. Observation status has been extended to cover multi-day stays at the hospital with tests and procedures. If this happens to you, when you are discharged to a skilled-nursing home, you will be responsible for the cost of such care, frequently running at more than $400 per day.

Here's what you can do:

- Be sure you have a healthcare proxy granting a trusted person access to your medical records and the authority to make medical decisions if you cannot do so;
- Find out your status;
- If you are classified as admitted under observation status and you believe that is incorrect, try to get your status changed by asking for a review or, if possible, a consultation with your community physician;
- If you are unsuccessful and able to safely return home, ask your hospital or community physician to order home care for you. This care will be covered by Medicare; and
- If you need skilled-nursing-home care, you will be responsible for paying privately, but, provided you have been hospitalized for at least three nights, you should initiate Medicare appeals relative to both the hospital and nursing-home stays. These appeals have been successful for people in this circumstance. Note that there is currently a federal case on appeal regarding notice and review procedures for patients placed on observation status to help prevent abuse.

Plateaued Patients

Medicare has long had a practice of denying coverage to patients in skilled-nursing homes who are not improving and have been deemed 'plateaued.' This is in spite of the fact that this 'improvement standard' does not appear anywhere in Medicare regulations or policies and is expressly contradicted, in the federal regulations, at 42 CFR 409.32(c), which states that "a patient may need skilled services to prevent further deterioration or to preserve current capabilities." The improvement-standard policy has resulted in the denial of coverage for numerous patients with chronic conditions such as Parkinson's, multiple sclerosis, arthritis, diabetes, and more.

Now, under the settlement agreement in a Vermont district-court class-action case, *Jimmo v. Sebelius*, the Center for Medicare and Medicaid Services has agreed to revise all publications and guidelines to explain that coverage will be provided to individuals who need skilled care to prevent or slow further deterioration. Nevertheless, some facilities are still using this criteria to move a patient to custodial nursing-home services, which are not covered at all by Medicare or Medigap policies.

Lifetime Days

For a hospital stay, Medicare will cover only the first 90 days for the same spell of illness under Medicare Part A. For days 1-60, you are billed a deductible, and for days 61-90, you are billed an additional co-pay. For the 91st day and beyond, you will be covered only if you have lifetime reserve days available (you get 60 lifetime reserve days that can be used at any time you go beyond the 90-day threshold).

Medicare is no help to patients who have exhausted their days during a hospital stay. This is why many people invest in a Medigap policy. These policies cover the deductibles and co-insurance payments. Also, under

Section 8.B(3) of the NAIC Model Standards for Regulation of Medicare Supplemental Insurance, Medigap policies are required to provide patients with an additional 365 lifetime reserve days for hospital care.

Medigap policies cover only Medicare-approved expenses, and Medicare will deny your claim if lifetime reserved days are available but remain unused. Providers have been known to have faulty data when it comes to knowing the exact number of lifetime reserve days that remain for a particular patient. In this environment, lifetime reserve days are not always utilized properly, resulting in unjustly denied claims.

Conclusion

Should you or a loved one get a large or unexpected summary notice due to issues with any of the matters addressed in this article, a written notice containing the reasons for termination of Medicare coverage should be requested.

An appeal might be necessary. You may want to contact a knowledgeable attorney for assistance in the appeal. ■

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