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What to Do When Medicare Nursing Home Coverage is Terminated

Video Transcript

Milwaukee SHIP Collaborative

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Video Link: What to Do When Medicare Nursing Home Coverage is Terminated

Transcript

Hi, and welcome to "What to Do When Medicare Nursing Home Coverage is Terminated," part of a 2021 Medicare informational video series sponsored by the Milwaukee SHIP Collaborative. I am Matthew Hayes, SeniorLAW Project Director at Legal Action of Wisconsin. We are a member of the Milwaukee SHIP collaborative led by Milwaukee County. The collaborative brings together federal, state, and local agencies to provide you with timely, accurate, and unbiased information to assist you with Medicare costs, Medicare appeals, and Medicare fraud prevention. SeniorLAW provides free legal services and benefit counseling to individuals who reside in Milwaukee County and are age 60 or over. Today, I am going to speak about what you can do if Medicare decides to end your coverage while you are in a nursing home.

When someone has an illness or injury that causes them to go to the hospital, it is not uncommon for that person to be sent to a nursing home to get rehab before returning home. Medicare will often cover a stay in a nursing home — but generally only when the facility thinks that you will get better and go home.

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When you are in a nursing home, the facility may decide that you have stopped improving and no longer need what they call skilled care. You may be told that you have "plateaued," or are "maintenance only," or that you require only "custodial care." Once this happens, your stay at the nursing home will no longer be paid for by Medicare.

Medicare, like most health insurance providers does not cover what is called long-term care, services that help people with a variety of activities of daily living with an assumption that those services are likely to continue for the foreseeable future.

If the nursing home believes Medicare will no longer cover your stay in the facility, they must issue a written notice at least two days prior to the last day of covered care. Once Medicare coverage ends, and if you stay in the nursing home, you will be responsible for very high medical costs, so that two-day period will allow you to appeal the facilities' decision as well as decide the best course of action before you become responsible for the nursing home bill.

The notice you receive will generally be called a Notice of Non-Coverage. This notice will explain the date that coverage of care ends, the date you will become financially responsible for a continued stay at the nursing home, and a description of your right to an expedited or fast appeal.

To appeal the decision, you have to call a phone number provided on the notice. It is very important to review the notice and make the call as soon as possible in order to get a review of the facility's decision before the two-day notice period ends.

You may also be given a choice about filing Medicare claims with regard to the end of your Medicare coverage. This choice may be provided to you on the notice of non-coverage or on a separate form.

It is important to decide how you will respond to this notice if you plan to stay in the nursing home, because the wrong choice could affect your ability to get Medicare payment if they decide that you are still receiving skilled care.

You will see something like this and will be expected to choose one of three options:

OPTIONS: Check only one box. We can't choose a box for you.

☐ **Option 1**. I want the care listed above. I want Medicare to be billed for an official decision on payment, which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, but I can appeal to Medicare by following the directions on the MSN.

☐ **Option 2**. I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed.

☐ **Option 3**. I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay.

It is important to choose option 1 if you plan to stay in the facility because option 2 does not allow you to appeal Medicare's decision. Option 3 would be checked off if you plan to leave the facility. So option 1, if you're planning to stay in the facility, is the best option for indicating that you want the facility to file a claim, and that's very important in order to have the option to get paid down the road.

Ultimately, if you need continue to need nursing care after Medicare coverage ends, you will want to look into your options for long-term care.

Because Medicare and other health insurance does not cover long-term care, you may have to pay out of your own pocket or get some type of Medicaid/Title 19/Medical Assistance coverage to help with LTC-related costs. This involves a close review of your financial situation and can be a complex process.

Luckily, we can help. Not only you can contact SeniorLAW for help with your Medicare nursing home appeals, but SeniorLAW can also help you understand your options for paying for long-term care services.

Call us at (414) 278-1222, for assistance with your Medicare issues.

Also, keep in mind there are Medicare Savings Program which can help you pay your Medicare premiums, deductibles, and co-payments. These programs can help you keep more money in your pocket and balance your expenses. To learn if you are eligible, call the Aging Resource Center at (414) 289-6874.