

Medicare Rights, Common Mistakes, and Healthy Aging

Rounding out the Medicare Fundamentals series, this course addresses what beneficiaries are entitled to when things go wrong, including the appeals process and how disputes are reviewed. It also highlights the most common and costly Medicare mistakes so advisors can help clients steer clear of them. A final look at staying healthier beyond age 65 adds a practical wellness dimension. This course is ideal for professionals who want to be well-rounded Medicare resources for their clients.

CREDIT HOURS 2 | FIELD OF STUDY BUSINESS | EXAM QUESTIONS 10

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LEARNING ASSIGNMENTS AND OBJECTIVES

Assignment

- Study the full course materials included here.
- Complete the review questions after each chapter.
- Answer 10 final exam questions.
- Final exam is scored immediately, 70% or better passes.
- Certificate of completion is available in your account.
- Failed exams can be retaken free of charge.

Course Objectives

- Identify your legal rights concerning Medicare coverage.
- Identify the top 10 mistakes often made when using Medicare.

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Chapter 1: KNOWING YOUR RIGHTS

Chapter Objective

After completing this chapter, you should be able to:

- Identify your legal rights concerning Medicare coverage.

Sooner or later you may have some kind of issue over your Medicare coverage. Note that I'm saying *may*, not *will*. But just in case it happens, keep in mind that you have every right to challenge a decision you don't agree with — whether it's made by Medicare, Social Security, a Medicare Advantage plan, or a Part D drug plan — or to file a complaint about the kind of care you receive. You can try to resolve a variety of problems through different procedures, from making a simple request to pursuing a full-blown appeal. In this chapter, I walk you through those procedures and suggest ways to seek free professional help in making appeals. But first, I consider a very basic right that isn't always addressed: your right to accurate information.

UNDERSTANDING YOUR RIGHT TO ACCURATE INFORMATION

A major reason for writing this course is my deep concern about how often people receive information about Medicare that's just plain wrong. If it comes from family, friends, doctors, insurance agents, employers' benefits administrators, and so on — well, it's not their fault because none of them can be regarded as reliable sources on Medicare's complexities. But sometimes the inaccurate information comes from Social Security and Medicare officials themselves, whose job is to help Medicare beneficiaries understand the law and navigate its maze of regulations. I hear about some new incident almost every week — and surely that's just the tiniest tip of the iceberg.

As I know for sure, many officials go out of their way to be helpful, and very often the information they provide is reliable. What's more, I can't blame them for not being able to keep in their heads the whole multitude of rules and regulations; there are just too many of them. However, I do fault officials who, convinced that they do know it all, don't bother to check the rules. That's what the POMS manual — the Program Operations Manual System, Social Security's "bible" of guiding instructions — is there for. Medicare officials also have a whole raft of references in their manual system, with regulations on every aspect of coverage, payment, *coordination of benefits*, and many more topics. That's why, in this course, I sometimes quote the reference for the appropriate official instruction or regulation — especially a fairly new one — so that, if necessary, you can arm yourself with that authority to convince an official who seems not to know of it. The following sections describe strategies that can help you in the quest for accurate information.

Knowing whom to call

For historical reasons, the administration of Medicare is divided between two federal agencies: the **Social Security Administration (SSA)** and the Centers for Medicare & Medicaid Services (CMS). So putting your questions to the appropriate officials may be half the battle. The following sections note which agency to contact about Medicare issues in different circumstances.

Social Security Administration

Contact the SSA (800-772-1213 or TTY 800-325-0778) or go to its website (www.ssa.gov) about:

- Eligibility for Medicare
- Medicare enrollment and disenrollment
- Applying for low-cost drug coverage under the Extra Help program
- Paying higher-income premiums and requesting waivers
- Paying Part B late penalties
- Reporting a change of address or a death
- All questions about Social Security retirement and survivor benefits, disability benefits (SSDI), and Supplemental Security Income (SSI)

Centers for Medicare & Medicaid Services

Contact the CMS through the Medicare help line (800-633-4227 or TTY 877-486-2048) or go to its website (www.medicare.gov) about:

- Medicare coverage for medical services and supplies
- Choosing a Medicare Advantage plan or Part D drug plan
- Choosing *Medicare supplemental insurance (Medigap)*
- Billing and payment questions
- Obtaining a replacement Medicare card
- Finding doctors who accept Medicare patients in your area
- Finding a Medicare-approved medical equipment supplier in your area
- Comparing the quality of hospitals, nursing homes, and home health agencies in your area
- Appealing a payment or coverage decision you don't agree with
- Reporting fraud

Seeking a second opinion

The call lines for both Social Security and Medicare are staffed by customer service representatives who have a certain amount of training but aren't equipped to answer every question that comes in.

If they don't know the answer, they should consult a supervisor, but they don't always do so. And sometimes they confidently provide an answer that isn't actually accurate.

Remember

If you have doubts about an answer, sometimes the simplest solution is to hang up and call again. You'll get a different person and maybe a different answer. In that case, ask to speak to a supervisor yourself and, if necessary, ask them to look up the specific regulation related to your query. Always note the date and time of your call, the name of the person you talk to, and the citation for the regulation in question (if you're told it).

Another way of seeking a second opinion on whether the information you receive is for real or not is to call your State Health Insurance Assistance Program (SHIP), which has trained counselors to personally answer questions on Medicare at no charge. You can find contact information for each SHIP in the Appendix.

ASKING FOR AN INVESTIGATION

In some circumstances, you may not need to go through a formal appeals process (which I describe later in this chapter). If you think that a mistake has been made, you may be able to have the incident looked into and possibly resolved without further ado. This section explains several ways of doing so depending on the situation.

Requesting equitable relief

Equitable relief is an obscure concept that few people have ever heard of. It allows Social Security to investigate cases and reverse decisions if it finds they were caused by a federal employee's making a mistake, giving faulty information, or failing to give correct information and may result in situations that cost beneficiaries money, especially from

- Missing the appropriate deadline for Part B enrollment
- Being hit with Part B late penalties

Federal employees include any official from Social Security or Medicare or anybody acting on these agencies' behalf, such as a customer service representative or an employee of a Part D plan or a Medicare Advantage plan.

According to the official instruction on this process (POMS HI 00805.170, "Conditions for Equitable Relief"), you may also qualify for relief "if the evidence shows" that you were misinformed by somebody else (such as your employer or insurance company) who in turn had been misinformed by an employee or agent of the federal government. If Social Security investigates and finds

evidence that you received faulty information, it can reverse its original decision, allowing you immediate enrollment or reinstatement in Part B and waiving any late penalties.

Warning

Be aware, though, that the evidence has to be pretty convincing. Social Security says it doesn't even consider opening an investigation unless you can provide the name of the official who misinformed you, plus the place and date when the conversation took place. (This situation is where keeping notes about every interaction you have with federal officials pays off.) Therefore, *equitable relief* is awarded quite rarely. Some people have obtained it only after asking their members of Congress to intervene. But other people have been successful on their own, so it's well worth a try.

To apply for equitable relief, write a letter to your local Social Security office (call SSA's main number, 800-772-1213, or the TTY number, 800-325-0778, for the address), being as specific as possible about the details. The Medicare Rights Center offers guidance on applying and a specimen letter at www.medicarerights.org/PartB-Enrollment-Toolkit/Equitable-Relief.pdf. Or call 800-333-4114 for a copy.

Contacting an ombudsman

An *ombudsman* is a person appointed to investigate and resolve complaints in a particular situation. Two types are especially useful for people in Medicare:

- **The Medicare Beneficiary Ombudsman's office:** This office receives and looks into complaints, helps resolve them, and, if it identifies any trends behind them, makes recommendations for changes of policy. You can't normally contact this office directly, but you can ask for complaints to be sent there by calling the Medicare help line (800-633-4227 or TTY 877-486-2048) or going through your State Health Insurance Assistance Program (for SHIP contact info, see the Appendix).
- **Long-term-care ombudsmen:** These folks are appointed to look after the interests of people in nursing homes and other long-term-care (LTC) facilities, act as their advocates, and troubleshoot problems on their behalf. Each state, the District of Columbia, Puerto Rico, and Guam have LTC ombudsmen. For contact info, go to theconsumervoice.org/get_help or call your local Agency on Aging (see the state pages of your local phone book).

Reaching out regarding quality of service

If you have an issue with the quality of a medical service you receive under Medicare — from a doctor, a hospital, or any other health provider — you have the right to contact your *Beneficiary and Family Centered Care Quality Improvement Organization* (BFCC-QIO) directly and file a complaint. The BFCC-QIO is an independent review panel of doctors and other healthcare experts who are trained

to monitor the care that Medicare beneficiaries receive. It also hands down decisions in cases where coverage is terminated. (For example, you'd call the BFCC-QIO if you think the hospital is discharging you too soon, as explained in Chapter 1 of course 81457E.) Medicare contracts with BFCC-QIOs in every state, plus the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. For the address and phone number of your BFCC-QIO, call the Medicare help line at 800-633-4227 or TTY 877-486-2048 or visit qioprogram.org/locate-your-bfcc-qio.

Getting ahold of your plan

If you're enrolled in a Medicare Advantage plan or a Part D prescription drug plan, very often the simplest and quickest way of dealing with a concern is to call the plan, using the customer service number on your membership card.

Remember

But be aware that the plan may categorize your complaint as an inquiry, a grievance, or a coverage determination, depending on what you complain about:

- **One of the plan's policies in general terms:** In this case, the plan can treat your complaint as an inquiry and respond with a simple explanation of the policy. It need not do anything more.
- **How a policy affects you personally:** In this case, the plan must treat your complaint as a grievance or (if it concerns coverage or payment) as a coverage determination and take appropriate action.

Filing a grievance

A *grievance* covers many types of complaints that you can bring against your Medicare Advantage or Part D drug plan — but *not* those that have anything to do with coverage or payment. Instead, it can focus on any aspect of a plan's service or quality of care that requires some action from the plan to resolve. Situations when you may want to file a grievance include

- **Poor or unsatisfactory customer service:** Plan representatives leave you on hold for ages or disconnect your call, don't respond to your questions satisfactorily, give wrong or inadequate answers, or are rude.
- **Misleading information:** You choose a plan on the basis of information that turns out, after enrollment, to be untrue.
- **Absence of important notifications:** The plan doesn't send you notices required by law — such as its *Annual Notice of Change* (see Chapter 2 of course 81457E) — or you find the wording of its messages difficult to understand.

- **Problems at the pharmacy:** A pharmacy in your plan's network gives you the wrong meds or makes other mistakes in dispensing your drugs.
- **Poor quality of care for medical services:** You can't easily get appointments or have to wait too long for them. You have a problem with your care from doctors, nurses, hospitals, or other providers in the plan's network — including rude behavior and facility cleanliness.
- **Tardy responses or decisions:** The plan fails to respond to your request for a coverage determination or an appeal, or it doesn't give you its decision within the required time frame.

To file a grievance, you can call or write to the plan about your complaint. Look at the informational materials your plan sent you when you enrolled. These documents give the appropriate phone numbers and address for filing a grievance, as well as instructions for how to go about it. You can also find this info on your plan's website.

You must file the complaint within 60 days of the incident that prompted it. (You can request an extension for a good reason, such as illness or a family crisis. Send your plan an explanation in writing, even if the 60-day deadline has passed.) The plan must respond to your complaint within 30 days of receiving it, or up to 14 days more if the plan needs longer to investigate.

Remember

If the plan decides that no action is needed — in other words, it doesn't think your complaint is justified —you can't appeal any further. (An exception is if it's a quality-of-care issue. In that case, you have the right to take it up with your BFCC-QIO, as explained earlier in the section “**Reaching out regarding quality of service.**”) Alternatively, if the plan decides your complaint should be handled as a coverage determination (which I explain later in this chapter), it must tell you how to go about doing that.

TAKING STEPS TOWARD AN APPEAL

A Medicare appeal is a formal process that can begin only after certain steps have been taken:

- If your issue involves the original Medicare program or a Medicare Advantage plan, you must first receive a formal denial of coverage or payment.
- If the issue is about Part D drug coverage — whether it's provided through a stand-alone drug plan or a Medicare Advantage plan — you first need to request a coverage determination; if the plan turns you down, you can then proceed to an appeal.

In this section, I explain how either of these triggers works, depending on the kind of challenge you want to make. I also suggest a plan of attack that will help your case if you decide to continue with an appeal.