LEGAL EASE

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Know your rights as a Medicare beneficiary

Medicare is medical insurance to which most Americans are entitled at age 65 years. However, many Medicare beneficiaries and their families do not fully understand Medicare, and all of the benefits to which they are entitled. A recent article in Elder Law Answers (www.elderlawanswers.com; "*Seniors Often Must Fight for Medicare Home Health Benefits"*) points out the importance of understanding the coverage for home health care.

Home health care for Medicare beneficiaries can be extremely important. This benefit, when properly utilized, can make the difference between being able to stay at home, even with serious health issues, and ending up in a hospital or nursing home. In order to qualify for full home health benefits under Medicare, the Medicare beneficiary must meet the following requirements:

- Be confined to the home, that is, if leaving to receive services would require "considerable and taxing effort";
- A physician must order the services;
- At least some element of the services ordered must be skilled, such as skilled nursing care, physical therapy, or speech therapy;
- Services must be provided by a certified home health agency.

If an element of skilled care is provided as part of the written care plan, then the beneficiary is also entitled to Social Services, home health aide services, and necessary medical supplies and equipment. Home health benefits require no payment, but supplies and equipment may be subject to a 20 percent co-payment. Medicare is required by law to cover home health services with no time limit on the amount of time the beneficiary is covered, as long as the requirements mentioned above are met. Additionally, the beneficiary is entitled to 35 hours of service per week. The care is "intermittent" in that 24/7 care is not covered.

Nevertheless, according to the Elder Law Answers article, few beneficiaries receive the level of service that the law mandates, and many find that their services are cut off prematurely. If a Medicare beneficiary's home health services are stopped or reduced, and the beneficiary (and his or her doctor) feels that the benefit should continue, an appeal is necessary. In the appeal stage, 81 percent of the beneficiaries are successful when the case is taken to an administrative law judge.

If the beneficiary is able, he or she should pay privately for services during the appeal process. Remember, you are not appealing termination of service, but the denial of Medicare payment for service. To have the best chance of a successful appeal, ask the home health care agency to explain the cutback in service in writing. Ask your doctor to call the home health agency urging them not to cut back on service, followed by a letter from your physician explaining the level of care that is needed. Consult with a Medicare assistance agency or an attorney as to the likelihood of success for an appeal. If appealing, do so as soon as possible, and continue to pay privately for services in the meantime.

Knowing your rights as a Medicare beneficiary and fighting to keep services that are clearly necessary can make all the difference in your recovery.