Dear Marci,

I am enrolled in Original Medicare. I will need to recover from an upcoming surgery in a skilled nursing facility (SNF) and I am nervous because I’ve heard of people being discharged from SNFs before they are ready to go home. What can I do if this happens?

-Rex (Louisville, KY)

Dear Rex,

If you are receiving care from a SNF and are told that Medicare will no longer pay for your care (meaning that you will be discharged), you have the right to a fast (expedited) appeal if you do not believe your care should end. There is a different process if you are enrolled in a Medicare Advantage Plan. Note that this process is different if your care is being reduced but not ending, and you do not agree with that reduction.

If you are enrolled in Original Medicare:

1. If your care is ending at a SNF 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.
   a. If you have reached the limit on your care or do not qualify for care, you do not receive this notice and you cannot appeal.
2. If you feel that your care should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with a Quality Improvement Organization (QIO) by noon of the day before your care is set to end. The QIO should make a decision no later than two days after your care was set to end. Your provider cannot bill you before the QIO makes its decision.
   a. 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.
   b. The 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.
c. If you miss the deadline for an expedited QIO review, you have up to 60 days to file a standard appeal with the QIO. If you are still receiving care, the QIO should make its decision as soon as possible after receiving your request. If you are no longer receiving care, the QIO must make a decision within 30 days.

3. If the QIO appeal is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If the 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 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 the costs incurred during the 72 hours the QIC deliberated.
   a. 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.

4. 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 your appeal is denied and your care is worth at least $170 in 2020, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level within 60 days of the date on your QIC denial letter. If you decide to appeal to 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. OMHA should make a decision within 90 days.

5. If your appeal to the OMHA level is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied, you can move to the next level by appealing to the Council within 60 days of the date on your OMHA level denial letter. There is no timeframe for the Council to make a decision.

6. If your appeal to the Council is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied and you are appealing care that is worth at least $1,670 in 2020, 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.

-Marci
Next Tuesday, July 28, is World Hepatitis Day, an annual effort to raise awareness of viral hepatitis. The World Hepatitis Alliance has compiled a list of actions you can take to raise awareness and to demand that governments commit to taking action to end hepatitis.

**Upcoming Webinar:**
Medicare Coverage for People with End-Stage Renal Disease (ESRD)

Medicare enrollment and coverage rules are different for people who have End-Stage Renal Disease (ESRD), which is kidney failure that requires transplant or dialysis. Find out the various ESRD Medicare coverage rules and how people with ESRD can avoid coverage problems.

**Date:** Thursday, August 27  
**Time:** 3:00 – 4:00 PM Eastern Time  
**Fee:** $40 per person for the live webinar and recording, or $30 per person for the recording only

**During this one-hour webinar, you will learn about:**
- ESRD Medicare eligibility and enrollment
- ESRD Medicare coverage and costs
- Medicare, ESRD, and employer insurance
- Medigap, Medicare Advantage, and Part D for people with ESRD
- Medicare coverage of immunosuppressant drugs after a kidney transplant
- ESRD and the Health Insurance Marketplaces

Register today on Medicare Interactive.