



CMA WEEKLY ALERT, APRIL 28, 2005 (1 of 2)

## **NEW CHALLENGES FOR ADVOCATES REPRESENTING MEDICARE BENEFICIARIES**

At a time when Medicare beneficiaries may need more assistance than ever to navigate the new Medicare appeals system, the new appeals rules issued by the Centers for Medicare & Medicaid Services (CMS) have also made it more difficult for beneficiaries to get the independent representation they need. CMS has created new requirements for appointment of representation forms and has imposed, for the first time, limitations on fees that can be charged for representation.

### **Appointment of Representation Form**

A valid Appointment of Representation form must:

- Be in writing and signed and dated both by the beneficiary and the representative.
- Authorize the representative to act on behalf of the beneficiary and authorize the adjudicator to release identifiable health information to the representative.
- Include an explanation of the purpose and scope of the representation.
- Include the name, phone number and address for the beneficiary and the representative.
- Include the beneficiary's Medicare health insurance claim number.
- Include the representative's professional status or relationship to the beneficiary.
- Be filed with the entity processing the party's initial determination or appeal.

If a form is defective, the representative will be given an opportunity to correct the defect. Otherwise, the representative will not have the authority to act on behalf of the beneficiary or to receive health information.

CMS limits the duration of the Appointment of Representation form to one year. A duly appointed representative may file multiple appeals on behalf of an individual beneficiary during the course of that year, but must submit a copy of the original appointment form with each additional appeal filed. Once an Appointment of Representation form has been filed in a case, the appointment lasts for the duration of the appeal unless it is revoked, even if the appeal lasts longer than one year.

Although the Appointment of Representation form applies to initial determinations (i.e., original claims submissions) as well as to appeals, CMS has determined that the initial determination notice will be sent only to the beneficiary. The initial determination is generally the Medicare Summary Notice (MSN). CMS alleges that a beneficiary's privacy interests may be violated if the initial determination is sent to the representative because the MSN often contains information about multiple health claims.

CMS also says that privacy concerns prevent an appointed representative from delegating the appointment to another person without the beneficiary's consent. Thus, a family member who already serves as an appointed representative cannot delegate that appointment to an advocate for purposes of pursuing an appeal unless the beneficiary signs a written notice. A signed statement is not required where both the appointed and new representatives are attorneys (but not paralegals) in the same law firm or organization. When a beneficiary lacks the capacity to sign an appointment of representation form or form acknowledging delegation of the appointment, state law determines who has authority to authorize representation on his or her behalf.

### **New Rules on Appointed Representative Fees**

Under the new regulations, a beneficiary's appointed representative (but not a provider or supplier's representative) who wishes to charge a fee for services at the administrative law judge (ALJ) and Medicare Appeals Council (MAC) levels of review must obtain approval of the fee from the Secretary of the Department of Health and Human Services (HHS). The regulations also say that no award of fees or costs may be made against the Medicare trust fund, and that limitations on the amount of fees that apply in Social Security and SSI disability cases do not apply to Medicare appeals.

The regulations do not contain any standard by which fee requests will be judged. However, the preamble indicates that guidelines for the application of Equal Access to Justice Act (EAJA) claims before HHS may be applicable to Medicare appeals. CMS states that HHS will review the guidelines to determine whether they need to be changed in light of the new provision.

The provision requiring beneficiary advocates to seek approval of their fees is contrary to an August 2000 response the Center for Medicare Advocacy requested and received from the Medicare Agency to an inquiry about the applicability of the Social Security fee limitation to Medicare cases. The preamble justifies the policy change by saying that a change in the Medicare Act makes provisions concerning approval of fee arrangements from back awards of Social Security disability benefits applicable to Medicare appeals. CMS goes on to acknowledge however, that, unlike Social Security cases, there is no back award of benefits from which attorneys can be paid, and that the limitation on Social Security attorneys' fees does not apply.

Questions may be raised about a policy that requires HHS to approve and regulate fee activities that do not involve the Medicare trust fund. Further, CMS bases its authority to review fee arrangements on a provision concerning fees that come out of back awards, while acknowledging that "Medicare appeals do not involve past-due cash benefits..."

*Advocates who have questions about the new rules for appointed representatives may contact Alfred Chiplin ([achiplin@medicareadvocacy.org](mailto:achiplin@medicareadvocacy.org)) or Vicki Gottlich ([vgottlich@medicareadvocacy.org](mailto:vgottlich@medicareadvocacy.org)) in the Center for Medicare Advocacy's Washington D.C. office at 202-216-0028.*



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## **GRANDDAUGHTER'S GRADUATION? GRANDSON'S WEDDING? YOU CAN LEAVE THE NURSING HOME!**

Residents of skilled nursing facilities can leave their facility to attend a family graduation or wedding without losing their Medicare coverage! The Medicare Benefit Policy Manual recognizes that although most beneficiaries are unable to leave their facility,

an outside pass or short leave of absence for the purpose of attending a special religious service, holiday meal, family occasion, going on a car ride, or for a trial visit home, is not, by itself evidence that the individual no longer needs to be in a SNF for the receipt of required skilled care.

Medicare Benefit Policy Manual, Pub. 100-02, Ch. 8, '30.7.3.

Remember this section of the Manual next Thanksgiving and at the holiday season.

A facility should not notify patients that leaving the facility will lead to loss of Medicare coverage. Such a notification is "not appropriate," says the Manual.