

Section V.12. Medicare Advocacy Project (MAP) Procedures

The purpose of the Medicare Advocacy Project procedures is to insure full utilization of Medicare nursing facility benefits.

1. New applicants, who require Choices for Care (CFC), VT Long-Term Care Medicaid as a payer source for nursing facility care, will be referred to the Department of Disabilities, Aging and Independent Living (DAIL).
2. DAIL staff determines clinical eligibility and completes the Clinical Certification form (CFC form 803) including hospital admission and payer source information.
3. DAIL staff sends a copy of the Clinical Certification form to the Department for Children and Families (DCF).
4. When an active CFC nursing facility resident has readmission from a hospital the nursing facility provider submits a Change Report Form (CFC 804B) DCF and DVHA. Changes include:
 - a. Re-admission from a three-day hospital stay,
 - b. Change in payer source
5. DCF/Economic Services Division changes information on the LONG panel which is relayed to the HP system.
6. DVHA tracks to see if Economic Services Division information matches LONG panel in ACCESS system. If changes need to be made, DVHA will make those changes to the HP system.
7. DVHA will send the report to MAP in cases where an individual was admitted or readmitted to a nursing facility and who had a three-day hospital stay prior to the admission and who did not utilize the full 100 days of Medicare coverage.
8. MAP will verify with DVHA through ACCESS that the individual has Long-Term Care Medicaid coverage. MAP will follow up with a phone call to the nursing facility provider to confirm or clarify the information, as necessary. They will look to determine how many days of Medicare were used in this spell of illness.
9. After MAP verifies individual in a nursing facility who has had a three-day hospital stay and did not receive the full 100 days of Medicare and is on Long-Term Care Medicaid, MAP sends a letter to the individual and his/her patient representative which asks that the individual sign an authorization for MAP to represent the person in a Medicare appeal. Once the signed form is received, the appeal process is started.

NOTE: Utilization review of Medicare covered services by the Home Health Agencies will be done on a retrospective basis quarterly by MAP.