

Medicare Minute Script – February 2015 The Medicare Appeals Process

There may come a time when you disagree with a coverage or payment decision made by Original Medicare, your Medicare Advantage (private health) plan, or your Medicare Part D (prescription drug) plan. If so, you have the right to an appeal.

1) What is a Medicare appeal?

An **appeal** is a request you make to Medicare or your private health plan when you disagree with a coverage or payment decision on a health care service, item, or medication. There are three main types of appeals: Original Medicare health appeals, Medicare Advantage health appeals, and Part D drug appeals. How you file an appeal depends on the type of Medicare coverage you have, and the health care service, item, or medication in question. In order to appeal, you must:

- Receive a Medicare notice indicating your insurance will not pay for a health care service, item, or medication
- Determine whether you should complete a standard or expedited appeal
- Follow appeal instructions on the notice you receive
- Appeal in a timely manner

Filing a grievance is different from filing an appeal. In some cases, you may want to do both. A grievance is a complaint you make against your Medicare Advantage or Part D plan because you are dissatisfied with the quality of service you have received. However, if you disagree with your plan's refusal to cover a service, item, or prescription, you file an appeal.

2) Important Medicare notices

The notices you receive from Medicare or Medicare private plans are important documentation for each stage of the appeal process. Follow the instructions on the notices you receive to appeal decisions, and be sure to stay within the timeframe of each appeal process. If you do not follow these rules, your appeal may not be considered. Notices you receive **before receiving a service**, indicating that your Medicare coverage may not or will not cover the service:

- **Advance Beneficiary Notice (ABN):** Also known as a waiver of liability, this is a notice you receive when a provider or supplier offers you a service or item they believe Medicare will not cover. ABNs only apply if you have Original Medicare.
- **Notice of Denial of Medical Coverage:** An official written decision from your Medicare Advantage plan explaining that it will not cover a service or item.
- **Notice of Denial of Prescription Drug Benefits (Coverage Determination):** An official written decision from your Part D plan explaining that it will not cover a specific drug.

Notices you receive **after receiving a service**, indicating your summary of charges:

- **Medicare Summary Notice (MSN):** A summary of health care services received. MSNs only apply if you have Original Medicare.
- **Explanation of Benefits (EOB)/Notice of Denial of Payment:** A summary of health care services or prescriptions received and whether your plan paid for them. These are sent to you by your Medicare Advantage plan or Part D drug plan.

Understand which next steps to take when you are denied. For instance, for a pharmacy counter denial, you typically must call your Part D plan to request the **Notice of Denial of Prescription Drug Benefits** after your plan refuses to pay for your drug at the pharmacy counter. When you call your plan, ask why they did not pay for the prescription and whether you can reverse the coverage decision with the help of your doctor. For both health and drug denials, speak with your health care provider about helping you with your appeal. An appeal is strengthened when you include a doctor's letter stating that your service, item, or medication is medically necessary.

3) Know the difference between a denial, a billing error, and Medicare fraud

Sometimes Medicare denials can be the result of a mistake or billing error rather than a decision not to cover a service, item, or medication. If you receive a health service denial from Original Medicare or your Medicare Advantage plan, always call your doctor's office to ensure they did not make a billing mistake before proceeding with an appeal. If you receive a drug denial, call your plan to check for potential errors before requesting a formal denial notice. If you need help understanding and navigating the appeals process, contact your State Health Insurance Assistance Program.

If you do not recognize or remember receiving the service, item, or medication that was denied, call your provider or pharmacist to ensure a billing error did not take place. If your provider or pharmacist is uncooperative, call your local SMP or the SMP Resource Center at 877-808-2468.

Take Action: Always file an appeal if you have been denied coverage for a health service or item, after you've checked with your provider to ensure a billing error has not occurred. During an appeal, make sure you follow the steps listed on your denial notices and stay within the timeframes of the appeal process also listed on your notice.