

Medicare Minute Script – June 2019

Original Medicare and Medicare Advantage Standard Appeals

Today we will learn how to appeal denials of payment for health services or items.

Point 1: Know what to do if you are denied coverage for a health care service or item.

If you receive a denial from Original Medicare or your Medicare health or drug plan, you have the right to appeal. An appeal is a formal request for review of a decision made by Original Medicare, or by your Medicare Advantage or Part D plan. If you were denied coverage for a health service or item, you may appeal the decision. There is more than one level of appeal, and you have the right to continue appealing if you are not successful at the first level. Make sure to file each appeal in a timely manner. At each level, there is a separate timeframe for when you must file the appeal and when you will receive a decision. If there is a reason you cannot submit your appeal on time, see whether you are eligible for a good cause extension. Otherwise, your appeal may not be considered. Keep in mind that an appeal is different from a grievance. A grievance is a formal complaint that you file with your plan.

Point 2: Understand how to start a standard appeal for an Original Medicare denial.

To find out if Original Medicare has covered or denied the health care services you have received, check your Medicare Summary Notice (MSN). The MSN is a summary of health care services and items you have received during the previous three months. The MSN is not a bill. MSNs contain information about charges billed to Medicare, the amount that Medicare paid, and the amount you are responsible for. If your MSN says that Medicare did not pay for a service, and you think it should, call your doctor to make sure that there was not a billing error before appealing. To start your appeal, you should follow the instructions listed on your MSN or Redetermination Request form. This includes circling the description of the denied service listed and filling out the shaded section at the end of the MSN. Send your appeal to the Medicare Administrative Contractor, or “MAC,” within 120 days of the date on your MSN. The MAC’s name and address are listed in the shaded section of your MSN. The MAC should make a decision within 60 days. If your appeal is successful, your service or item will be covered. If your appeal is denied, you can move on to further levels of appeal.

Point 3: Understand how to start a pre-service or post-service appeal for a Medicare Advantage Plan.

Pre-service appeals: If you have a Medicare Advantage Plan and you are denied coverage for a health service or item before you receive it, you can appeal to ask the plan to reconsider its decision. Before you start your appeal, you will need to get an official written decision from your plan, called a Notice of Denial of Medical Coverage. You can start your appeal by following the instructions on the Notice of Denial of Medical Coverage. Make sure to file your appeal within 60 days of the date on this notice. You will need to send a letter to your plan explaining why you need the service or item. You may also want to ask your doctor to write a letter of support. Your plan should make a decision within 30 days. If your appeal is successful, your service or item will be covered. If your appeal is denied, you can continue on to further levels of appeal.

SHIP National Technical Assistance Center: 877-839-2675 | www.shiptacenter.org | info@shiptacenter.org

SMP National Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org

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Post-service appeals: If your plan denies coverage for a service or item that you have already received, you can ask your plan to reconsider its decision. You should receive a written notice from your plan stating that it is not covering your health service or item. This can either be an Explanation of Benefits (EOB) or a Notice of Denial of Payment. This is not a bill. Start your appeal by following the instructions on the notice you received from your plan. File your appeal within 60 days of the date on the notice. Your plan should make a decision within 60 days. If your appeal is successful, your service or item will be covered. If your appeal is denied, you can move on to further levels of appeal.

Take Action:

1. Call 1-800-MEDICARE for help understanding the costs and coverage rules for Original Medicare-covered services and items or to request a copy of your Medicare Summary Notice (MSN).
2. Contact your Medicare Advantage Plan to learn about costs and coverage of health services and items or to request a copy of your Explanation of Benefits (EOB).
3. Contact your State Health Insurance Assistance Program (SHIP) if you need help appealing a denial.
4. Contact your Senior Medicare Patrol (SMP) if you suspect fraud or abuse because of services listed on your MSN or EOB that you do not think you received.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free: SHIP email: SHIP website:</p> <p>To find a SHIP in another state: Call 877-839-2675 or visit www.shiptacenter.org.</p>	<p>SMP toll-free: SMP email: SMP website:</p> <p>To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>
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