# Navigating Original Medicare and Medicare Advantage Appeals

# Medicare Rights Center

The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through

Counseling and advocacy

Educational programs

Public policy initiatives

# National Council on Aging

This toolkit for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) was made possible by grant funding from the National Council on Aging.

The National Council on Aging is a respected national leader and trusted partner to help people aged 60+ meet the challenges of aging. They partner with nonprofit organizations, government, and business top provide innovative community programs and services, online help, and advocacy.

# Learning objectives

- Recognize when someone has received a coverage denial
- Know how one can start an appeal
- Understand the appeals process and its various levels
- Recommend tips for making a strong appeal

# Medicare basics

# What is Medicare?

- Federal program that provides health insurance for those 65+, those under 65 receiving Social Security Disability Insurance (SSDI) for a certain amount of time, and those under 65 with kidney failure requiring dialysis or transplant
  - No income requirements
- Two ways to receive Medicare benefits:

**Original Medicare**

Traditional program offered directly through federal government

**Medicare Advantage**

Private plans that contract with federal government to provide Medicare benefits

# Parts of Medicare

- Medicare benefits administered in three parts:
  - Part A – Hospital/inpatient benefits
  - Part B – Doctor/outpatient benefits
  - Part D – Prescription drug benefit
- Original Medicare includes Part A and Part B
  - Part D benefits offered through stand-alone prescription drug plan
- What happened to Part C? → Medicare Advantage Plans (e.g., HMO, PPO)
  - Way to get Parts A, B, and D through one private plan
  - Administered by private insurance companies that contract with federal government
  - Not a separate benefit: everyone with Medicare Advantage still has Medicare

# Medicare appeals

# Appeals

- Appeal: Formal request for review of a coverage decision
  - Beneficiaries can appeal Medicare's or their plan's decision to deny coverage
  - There are multiple levels in the appeals process
  - If an appeal is denied, one can appeal to the next level

**Health appeals**
Original Medicare and Medicare Advantage Plan appeals

**Drug appeals**
Stand-alone prescription drug plan and Medicare Advantage drug plan appeals

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# Starting the appeals process

- Appeal process begins when beneficiary receives denial notice
  - **Original Medicare:** Medicare Summary Notice (MSN)
  - **Medicare Advantage:** Denial notice
    - » Can be combined with Explanation of Benefits (EOB)

# Sample MSN

This is the total amount that the provider can bill the beneficiary. They will receive a separate bill from their provider for any charges they owe. The MSN is not a bill.

**January 21, 2022**
**Craig L. Secosan, M.D., (555) 555-1234**
Looking Glass Eye Center PA, 1888 Medical Park Dr., Suite C, Brevard, NC 28712

| Service Provided & Billing Code | Service Approved? | Amount Provider Charged | Medicare-Approved Amount | Amount Medicare Paid | Maximum You May Be Billed | See Notes Below |
|---|---|---|---|---|---|---|
| Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (92014) | Yes | $143.00 | $107.97 | $86.38 | $21.59 | |
| Destruction of skin growth (17000) | **NO** | $68.56 | 0.00 | 0.00 | $68.56 | A |
| Total for Claim #02-10195-592-390 | | $211.56 | $107.97 | $86.38 | $90.1 | |

This column tells the beneficiary whether their claim was approved or denied.

Use this column to refer to footnotes at the bottom of the page for explanations of the services received.

**Notes for Claims Above**
**A This service was denied.** The information provided does not support the need for this service or item.

# Sample EOB

This column shows how much the beneficiary owes toward their deductible.

**Provider: Main Street Cardiology** **Claim Number: 87765**

**Patient Account Number: 25303540**

| Date of service | Type of service | Notes | Amount billed | Your Plan Paid | Deductible | Copay | Non-covered | Your Share |
|---|---|---|---|---|---|---|---|---|
| 1/10/20 | Office visit | | $150 | $80 | $0.00 | $50 | $0.00 | $50 |

This column includes reference to notes section, when applicable. For example, if the plan did not approve coverage, this column would refer to section that explains why.

If plan denied coverage for the service, this column would list the amount that the plan did not pay for, and the beneficiary may be responsible for that cost.

This column shows how much the beneficiary owes for the cost of the service.

# Starting the appeals process

- Before starting, check to make sure the denial is not an error
  - Sometimes the bill that the doctor sent Medicare is filed incorrectly, resulting in a denial of services
    - » Doctor’s office can correct the error by contacting the company that processed the Medicare claim

# Check-in question #1

Robert sees on his MSN that one of his services was denied. He doesn't know why, though. What can he do to better understand?

**Share your ideas!**

# Check-in question #1

Robert sees on his MSN that one of his services was denied. He doesn't know why, though. What can he do to better understand?

**Share your ideas!**

Possible answers:

- Read the shaded notes section of the MSN
- Call his doctor to ensure a mistake wasn't made
- Call 1-800-MEDICARE to learn more about coverage rules and his denial

# Original Medicare appeals

# Types of Original Medicare appeals

- Original Medicare appeals are generally for services or items the beneficiary already received
- Beneficiary can file an appeal if:
  - Medicare denied payment because the service was not medically necessary or was experimental
  - Medicare denied payment because the service was given too frequently

# Starting an appeal

- Beneficiary begins appeal by filling out shaded grey area on the last page of the MSN
  - Make a copy (keep the original)
  - Mail copy to address indicated by the date indicated on the last page
- Beneficiary should also attach a letter from their health care provider stating why the service was medically necessary

# Appeal timeline

**Receive MSN that says Medicare denied payment for care received**

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**Request redetermination by <u>Medicare Administrative Contractor (MAC)</u>**
-Request within 120 days of receiving MSN
- MAC has 60 days to respond

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**Request reconsideration by <u>Qualified Independent Contractor (QIC)</u>**
- Request within 180 days of date on MAC's decision
-QIC has 60 days to respond

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Service or item must be worth at least $180 to request OMHA review

**Request review by <u>Office of Medicare Hearings and Appeals (OMHA)</u>**
- Request within 60 days of date on QIC's decision
- OMHA has 90 days to respond

# Appeal timeline

**Request review by <u>Office of Medicare Hearings and Appeals (OMHA)</u>**
- Request within 60 days of date on QIC's decision
- OMHA has 90 days to respond

**Request review by <u>Medicare Appeals Council (Council)</u>**
-Request within 60 days of date on OMHA denial letter
- There is no timeframe for the Council to make a decision

Service or item must be worth at least $1,760 to request Federal District Court review

**Request review by the <u>Federal District Court</u>**
-Request within 60 days of date on Council denial letter
- There is no timeframe for the Federal District Court to make a decision

# Check-in question #2

At the first level of appeals, where should an Original Medicare beneficiary send their appeal? How could they find out if they weren't sure?

**Share your ideas!**

# Check-in question #2

At the first level of appeals, where should an Original Medicare beneficiary send their appeal? How could they find out if they aren't sure?

**Share your ideas!**

Possible answers:

- The Medicare Administrative Contractor (MAC), within 120 days of receiving the MSN
- Check the last page of the MSN for MAC address
- Call 1-800-MEDICARE for MAC contact information

# Medicare Advantage appeals

# Types of Medicare Advantage appeals

- **Pre-service appeals**
  - Plan denies coverage for health service or item before the beneficiary received the service or item
  - Standard and expedited appeals (different timelines)
- **Post-service appeals**
  - Plan denies payment for service or item the beneficiary already received

# Starting a pre-service appeal

- Beneficiary contacts plan to see if it will cover health care service or item before they receive it
- Plan decides not to cover service or item and sends beneficiary a Notice of Denial of Medical Coverage
- Beneficiary begins appeal by sending letter to plan's grievances and appeals department that explains why they need the service or item
  - They should ask doctor to write a letter of support that explains why they need the care and addresses the plan's denial reason
  - Keep copies of letters; do not send originals

# Requesting expedited pre-service appeal

- Beneficiary or doctor may request fast appeal if their health could be seriously harmed by waiting the standard timeline
  - Plan should grant expedited appeal requests from beneficiary's provider

# Standard pre-service appeal

**Receive denial notice from plan that care will not be covered**

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**Request reconsideration by plan**
- Request within 60 days of receiving denial notice
- Plan has 30 days to respond

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**Plan auto-forwards appeal to Independent Review Entity (IRE)**
- IRE has 30 days to respond

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Service or item must be worth at least $180 to request OMHA review

**Request review by Office of Medicare Hearings and Appeals (OMHA)**
- Request within 60 days of date on IRE's decision
- There is no timeframe for OMHA to make a decision

# Expedited pre-service appeal

**Receive denial notice from plan that care will not be covered**

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**Request reconsideration by plan**
- Plan has 72 hours to respond (plus 14 days if in beneficiary's best interest)

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**Plan auto-forwards appeal to Independent Review Entity (IRE)**
- IRE has 72 hours to respond (plus 14 days if in beneficiary's best interest)

↓

Service or item must be worth at least $180 to request OMHA review

**Request review by Office of Medicare Hearings and Appeals (OMHA)**
- Request within 60 days of date on IRE's decision
- There is no timeframe for the OMHA to make a decision

# Starting a post-service appeal

- Beneficiary receives care
- Plan sends beneficiary notice that explains it is not covering health care service or item
  - Notice can be part of Explanation of Benefits or Notice of Denial of Payment
- Beneficiary should send a letter to plan's grievances and appeals department explaining why they need the service or item
  - They should ask doctor to write a letter of support explaining why they need the care and addressing the plan's concerns
  - Keep copies of letters; do not send originals

# Post-service appeal timeline

**Receive denial notice that says plan denied payment for care received**

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**Request reconsideration by <u>plan</u>**
- Request within 60 days of receiving denial notice
- Plan has 60 days to respond

↓

**Plan auto-forwards appeal to <u>Independent Review Entity (IRE)</u>**
- IRE has 60 days to respond

↓

Service or item must be worth at least $180 to request OMHA review

**Request review by <u>Office of Medicare Hearings and Appeals (OMHA)</u>**
- Request within 60 days of date on IRE's decision
- There is no timeframe for the OMHA to respond

# Additional levels of appeal

- If OMHA appeal is denied, beneficiary can choose to appeal to the **Council**
  - Request review within 60 days of the date on OMHA denial letter
  - There is no timeframe for the Council to make a decision
- If Council appeal is denied, beneficiary can choose to appeal to the **Federal District Court**
  - Service or item must be worth at least $1,760 to appeal
  - Request review within 60 days of the date on Council denial letter
  - There is no timeframe for the Federal District Court to make a decision

# Right to emergency and urgent care

- Beneficiaries have right to receive urgent or emergency care anywhere in the U.S
  - Does not matter if the doctor or hospital is not in-network
  - No referral is necessary
  - Plan must pay even if the situation reasonably seemed to be an emergency, but it turns out not to be
  - If denied coverage, appeal

# Check-in question #3

A beneficiary appeals to their Medicare Advantage Plan, but the appeal is denied. What should the beneficiary do next to continue the appeals process?

**Share your ideas!**

# Check-in question #3

A beneficiary appeals to their Medicare Advantage Plan, but the appeal is denied. What should the beneficiary do next to continue the appeals process?

**Share your ideas!**

Possible answers:

- Wait for their plan to auto-send the appeal to the IRE
- Call their plan to learn why the appeal was denied
  - Understanding could help the beneficiary file a more successful appeal at higher levels

# Important notes on appeals

# Good cause extensions

- If the beneficiary misses a deadline to appeal, they can request a good cause extension
- Extensions are granted on a case-by-case basis
- Filed by appealing as normal and including a clear explanation of why the appeal is late
- Examples:
  - Illness
    - » including proof is helpful
  - Denial notice sent to the wrong address
  - Beneficiary could not read or otherwise understand the coverage notice
    - » For example, the beneficiary received notices in English but does not speak or read English

# Appointing a representative

- A beneficiary can appoint a representative to appeal on their behalf
- Must complete the Appointment of Representative form and mail it to either:
  - The MAC (if the appeal is with Original Medicare)
  - The Medicare Advantage Plan (if the appeal is with a plan)
- Can alternatively submit a written request alongside your appeal (see Medicare.gov for the elements this written request must include)

# Advance Beneficiary Notice (ABN)

- Given if provider thinks Medicare will likely deny payment for care that is normally covered
  - Beneficiary does not meet Medicare's medical necessity requirements
- **Only for Original Medicare beneficiaries**
- Providers not required to give ABN for excluded services
- Rights depend on if beneficiary received ABN
  - If beneficiary signs ABN, they are responsible for the full cost of services if Medicare denies coverage
    - » **Beneficiary may appeal**
  - If beneficiary does not receive ABN, they are not responsible for costs of services

# Tips for a strong appeal

- Beneficiaries appealing should:
  - Read all relevant notices carefully and reach out for help if they do not understand any
  - Meet appeal deadlines or request a good cause extension
  - Include a letter or supporting documentation from their health care provider
  - Keep a copy of all documents sent and received and do not send originals
  - Send the appeal with certified mail or delivery confirmation
  - Write down the names of any representatives they speak with, the date and time of the conversation, and what they discussed

# Filing a grievance

- Grievance: a formal complaint that you file with a Medicare Advantage Plan or Part D plan
- Examples of when one might file a grievance:
  - Poor customer service
  - Made to pay an incorrect copayment amount
  - Disenrolled from the plan involuntarily
  - Have not received a promised reimbursement
  - **Plan fails to return a coverage determination or appeal decision on time, according to Medicare guidelines**
- If a plan does not respond to a grievance in a timely manner, file a grievance

# Check-in question #4

Sylvia received a denial notice from her Medicare Advantage Plan. She called the plan, and a representative told her she had 120 days to appeal. She later learned that she only had 60 days to appeal, and she missed the deadline. What can she do?

**Share your ideas!**

# Check-in question #4

Sylvia received a denial notice from her Medicare Advantage Plan. She called the plan, and a representative told her she had 120 days to appeal. She later learned that she only had 60 days to appeal, and she missed the deadline. What can she do?

**Share your ideas!**

Possible answers:

- Appeal and include a good cause extension request
  - Include notes from the call if possible, such as the date and name of the representative
- File a grievance with the plan

# Review

# Review

- Medicare notices should include important information, such as why care was denied, who to appeal to, and how to do so
- Appeals should be filed in a timely manner, as each level of appeal has a set timeframe in which one must file the appeal and when they will receive a decision
- If someone is unsuccessful at the first level, they can continue appealing
- A letter of support and documentation from a doctor can be helpful in creating a strong appeal

# Resources for information and help

**State Health Insurance Assistance Program (SHIP)**

- www.shiphelp.org

**Social Security Administration**

- 800-772-1213
- www.ssa.gov

**Medicare**

- 1-800-MEDICARE (633-4227)
- www.medicare.gov

**Medicare Rights Center**

- 800-333-4114
- www.medicareinteractive.org

**National Council on Aging**

- www.ncoa.org

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# Medicare Interactive

- www.medicareinteractive.org

- Web-based compendium developed by Medicare Rights for use as a look-up guide and counseling tool to help people with Medicare
  - Easy to navigate
  - Clear, simple language
  - Answers to Medicare questions and questions about related topics
  - 3+ million annual visits

# Medicare Interactive Pro (MI Pro)

- Web-based curriculum that empowers professionals to better help clients, patients, employees, retirees, and others navigate Medicare
  - Four levels with four to five courses each
  - Quizzes and downloadable course materials
- Builds on 30 years of Medicare Rights Center counseling experience
- For details, visit www.medicareinteractive.org/learning-center/courses

# Thank you!