Medicare Appeals

Original Medicare Appeals

Original Medicare Appeals: There are two types of Original Medicare health appeals. The first type is a post-service **standard appeal.** This is an appeal you file if you already received a health care service or item and your Medicare Summary Notice (MSN) indicates that Medicare did not pay for the service you received.

The second type of appeal is an ending care **expedited appeal.** This is filed if your care from a hospital, skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), hospice, or home health agency is about to end.

Medicare Advantage Appeals

Medicare Advantage Appeals: If your Medicare Advantage plan denies a health service or item before or after you received it, you can appeal to ask your plan to reconsider its decision. If you need care right away, you can file a fast-track (**expedited**) request. If your plan approves your request to expedite, it should issue a decision within 72 hours.

You can also file an appeal if you receive care from a hospital, skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), hospice, or home health agency and are told that your Medicare Advantage plan will no longer pay for your care.

Part D Drug Appeals

Part D Drug Appeals: If your Medicare Part D prescription drug plan won't cover a drug you need, you should file an appeal to ask your Part D plan to reconsider its coverage decision. Common reasons for appealing are:

- The drug you need is not on your plan's list of covered drugs (**formulary**).
- Your drug plan only covers a limited amount of the drug you need (**quantity limits**).
- Your plan wants you to try other drugs first (**step therapy**).
- You must get special permission from the plan in advance before it will cover your drug (**prior authorization**).
- Your plan is charging more for your drug than for similar drugs on its formulary.

Note: You must call your plan to get a denial notice and to request an exception (see Terms to Know). Your plan's refusal to pay at the pharmacy counter does not count as a denial.

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Terms to Know

Appeal: A formal request to Medicare, your Medicare Advantage private plan, or your Part D prescription drug plan to review a health service or item coverage decision.

Exception Request: A formal request that you make to your Medicare prescription drug plan (Part D plan), asking to cover your drug if it is not listed on the plan's formulary; move a covered drug to a lower cost tier so you can pay less for that drug; or to override coverage restrictions placed on covered drugs.

Explanation of Benefits (EOB): A summary of the services or items you have received and how much you may owe for them. It tells you how much your provider billed, the approved amount your plan will pay, and how much you have to pay. The EOB is not a bill. You only receive an EOB if you have a Medicare Advantage plan or a Part D plan.

Formulary: The list of prescription drugs covered by your plan. Drugs not on the formulary are generally not covered.

Grievance: A complaint or dispute filed with your Medicare private health plan (Part C) or Medicare private drug plan (Part D) about any part of the plan's operations, behavior or activities. You must file a grievance orally or in writing within 60 days of the event or incident.

Important Message from Medicare: A formal notice from your **hospital** indicating that your care will end soon, because your Medicare Advantage plan will not cover continued care.

Medicare Summary Notice (MSN): A summary of claims made by Original Medicare for health care services processed for you during the previous three months. The MSN is not a bill. MSNs are mailed four times a year and contain information about submitted charges, the amount Medicare paid, and the amount you are responsible for. If Original Medicare will not pay for care you received, you will find this out when you receive your Medicare Summary Notice (MSN).

Notice of Medicare Non-Coverage: A formal notice from your **provider** indicating that your care will end soon, because your Medicare Advantage plan will not cover continued care.

Tips for Appealing

- Plans must let you start an appeal over the phone. We recommend writing an appeal letter. The address where you send the appeal will be on the denial notice. Look below where it says "Important Information About Your Appeal Rights."
- Be sure to submit a letter from your doctor indicating why care is medically necessary.
- Keep a copy of everything you send to your plan and detailed records of everyone you talk to.
- Keep the receipts if you pay out of pocket for your drug. You will be reimbursed if you win your appeal.
- If you are not initially successful with your appeal, continue to the next level.
- If you missed the deadline to appeal at any level, you can ask for a Good Cause Extension. Examples of good causes include (this is not an exhaustive list):
  - ☐ You did not get the denial notice or you got it late.
  - ☐ You were seriously ill and could not appeal.
  - ☐ An accident destroyed your records.
  - ☐ You could not get the documents you needed.
  - ☐ You could not understand the deadline.

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