Cancer Legal Resource Center
A DRLC PROGRAM

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Navigating Medicare Appeals

Ideally, your health insurance provider should process all claims correctly. However, insurers can and do make mistakes. If you believe that your Medicare plan has wrongly refused to cover a medication, service, or other charge, you have the right to appeal this decision.

Where can I see which of my medical expenses my Medicare plan has been covering?
If you have Original Medicare (Part A and/or Part B), you will receive a Medicare Summary Notice (MSN) in the mail every three months. You may also sign up to receive your MSN monthly by email at MyMedicare.gov. Your MSN will list all the items and services that were billed to your Medicare plan during the 3-month period, what Medicare paid, and what you still owe. Your MSN will also show if Medicare has fully or partially denied any medical claims. If you have a Medicare Advantage or Medicare Prescription Drug Coverage plan, you will also receive a regularly scheduled summary of charges and coverage, but how and how often you receive this summary may vary depending on your plan.

If Medicare has denied coverage or payment for a treatment or item that you received, you have the right to appeal this decision. You may appeal any denial of:

- your request for a health care service, supply, item, or prescription drug that you need;
- your request for payment for a health care service, supply, item, or prescription drug that you have already received; or
- your request to change the amount you pay for a health care service, supply, item, or prescription drug.

How do I appeal a denial from my Original Medicare, Medicare Advantage, or Medicare Prescription Drug Coverage plan?
To appeal a denial from your Original Medicare or Medicare Prescription Drug Coverage plan, you can:

1. fill out a Redetermination Request Form (available on cms.gov) and send it to the address listed on your MSN;
2. follow the instructions on your MSN for sending in an appeal; or
3. send a signed, written request including your name and Medicare number, the name of the item or service you are appealing, and the reason you are requesting an appeal to the address listed in the “Appeals Information” section of your MSN.

If you have a Medicare Advantage plan, you can find your plan’s appeal procedure online or in materials explaining your benefits. For most Advantage plans, you will have to submit a written request for an appeal.

When should I file an appeal? How long does the appeals process take?
If you are appealing an Original Medicare or Medicare Prescription Drug Coverage denial, you must file your appeal within 120 days of receiving your MSN or other notification of denial of coverage. After you file your initial request, you will receive a decision within 60 days. If you are appealing a Medicare Advantage denial (referred to as an "organization determination"), you must file an appeal within 60 days after receiving the organization determination.

When will I hear back from Medicare about my appeal?
After you submit your request for an appeal with Original Medicare, your file will be reviewed by a an administrative contractor, and they will inform you of their decision within 72 hours or 60 days, depending on the urgency of your request.

If you have Medicare Advantage, your plan will conduct an internal review of the denial and issue a decision within 72 hours, 30 days, or 60 days depending on the urgency of the request. If your plan again decides against you, it will automatically forward your case file and any supporting evidence to an Independent Review Entity for review. An Independent Review Entity is a separate agency which contracts with Medicare to have qualified people examine your claim and determine whether Medicare made an appropriate decision. The Independent Review Entity that reviews most Medicare decisions is called MAXIMUS.

What can I do if I am still denied coverage or payment after I appeal? Can I appeal again?
The Original Medicare and Medicare Prescription Drug Coverage appeals process has five levels, and each level has its own deadlines and requirements. These levels are:

1. Redetermination by a Medicare Administrative Contractor
2. Reconsideration by a Qualified Independent Contractor
3. Hearing with an Administrative Law Judge
4. Review by the Medicare Appeals Council
5. Review by a federal district court

If you have a Medicare Advantage plan, the appeals process is slightly different:

1. Health Plan Reconsideration
2. Reconsideration by an Independent Review Entity
3. Hearing with an Administrative Law Judge
4. Review by the Medicare Appeals Council
5. Review by a federal district court

If you disagree with a decision reached at any level in this process, you may be able to appeal the decision to the next level.

What documents will I need for an appeal?
As a rule, you should save every document relating to your Medicare appeal. These documents may include Medicare Summary Notices, medical bills, copies of forms you filled out or letters you wrote as part of the appeals process, and any correspondence you received from Medicare. Every time you prepare any documents to give to Medicare, you should make a copy for your own records. Keep these documents together in one place so that you can find them easily if you ever need to verify any information for your appeal.

My situation is urgent and I cannot wait 60 days for a decision. Can I receive a quicker decision on my appeal?
If you believe that your health could be seriously harmed by waiting the typical amount of time to receive a decision about your coverage, you or your doctor may ask the plan to make an urgent decision. *If the plan agrees that you need an expedited decision*, it must make a decision within 72 hours of your request. This is true for all Medicare plans.

May I have someone help me with the appeals process?
Yes. If you would like to appoint someone to complete the appeals forms for you, you may submit an "Appointment of Representative" form available at cms.gov/cmsforms/downloads/cms1696.pdf. Your representative may be a family member, attorney, friend, doctor, or anyone else you trust. Send the completed form to the company that handles claims for Medicare or your Medicare health plan. The person you choose may serve as your representative for one year before you will need to submit a new form giving them permission to continue acting on your behalf. If you have a Medicare Advantage Plan or Medicare Prescription Drug Coverage, your doctor can request certain appeals for you without needing to complete an Appointment of Representative form.[1]

You may also contact your state's State Health Insurance Assistance Program (SHIP) or Health Insurance Counseling and Advocacy Program (HICAP) for further assistance and counseling. These agencies provide free, confidential consultation and education services for people with questions about their Medicare coverage.

Is there an external or independent appeals process? Can I have my appeal decided by someone who does not work for Medicare?
Under the five-step appeals process for Medicare plans, your appeal may be reviewed by parties such as an independent review entity, an administrative law judge, and a federal district court.

Can I appeal a decision about being discharged from a hospital or skilled nursing facility?
If you believe that you are being discharged from a hospital or skilled nursing facility before you are ready and able to go home, you are entitled to have your release immediately appealed by your Original Medicare or Medicare Advantage plan. Your discharge will be reviewed by your plan's Beneficiary and Family Centered Care Quality Improvement Organization. While they are reviewing your case, you will be allowed to continue to stay in the hospital for no charge.

When your appeal request is received, the hospital or facility will be notified. Within one day, the hospital or facility must provide you with a "Detailed Explanation of Non-Coverage" explaining why it believes your services will no longer be covered. After you receive this explanation, the Quality Improvement Organization reviewing this appeal will ask you why you believe coverage should continue for your services, and will make a decision by the end of the day.

[1] For more information on the situations in which your doctor can act as your representative in the appeals process without submitting additional paperwork, see https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf

How do I file a complaint about a doctor or medical facility?
Any complaint about your health care that is not related to the coverage of a specific item or service is known as a *grievance*. You can file a grievance about any complaints about your care by a doctor or hospital, including the way you were treated or even your satisfaction with a piece of durable medical equipment. You can find detailed instructions about how to file different types of grievances here: https://www.medicare.gov/claims-and-appeals/file-a-complaint/complaint.html You will receive a response to your grievance no more than 30 days after you submit it.

How do I file a grievance about my Medicare Advantage or Medicare Prescription Drug Coverage plan?
In some situations, you may wish to file a grievance about your plan itself rather than about any one decision your plan has made. These grievances may include concerns about your plan's customer service, access to specialists, availability of information, or other complaints. You may file a grievance about these issues by filling out a Medicare Complaint Form (available here: https://www.medicare.gov/MedicareComplaintForm/home.aspx) or by following the instructions in your plan's membership materials. You must file these grievances within 60 days of the event leading to the complaint. You will be notified of the decision that Medicare reaches regarding your grievance no more than 30 days after you submit it.

Resources

- To look up and contact your state's State Health Insurance Assistance Program (SHIP) or Health Insurance Counseling and Advocacy Program (HICAP): https://www.medicare.gov/Contacts
- For personalized assistance with Medicare questions, contact the Medicare Rights Center at https://www.medicarerights.org
- For a more detailed look at the Medicare appeals process, see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf
- For information about Medicare Advantage Plan appeals, visit: www.medicareappeal.com

