Medicaid Advantage Plus (MAP) appeals

If you are enrolled in a Medicaid Advantage Plus (MAP) plan and have been denied coverage for a health service or item before you received the service or item, you can appeal to ask your plan to reconsider its decision. An appeal is a formal request you make when you disagree with a coverage or payment decision.

Because you have MAP coverage, you do not need to use a separate appeal process for your Medicare and Medicaid benefits. Instead, you will use an integrated process and receive Medicare and Medicaid coverage determinations through the same appeal. To file a MAP appeal for a denial, follow the steps below.

Note: You will use a different appeal process if you are being told that you will no longer be able to receive your current level of inpatient hospital care, skilled nursing facility (SNF) care, home health services, or Comprehensive Outpatient Rehabilitation Facility (CORF) services. You will also use a different process if you have been denied coverage for a Part D-covered prescription drug.

1. Read your plan's coverage decision.

Before you can start your appeal, you will need to receive an official written decision from your plan. You are typically first told verbally that your plan will not cover a service or item when you or your doctor call to confirm coverage before the service is provided.

If you are told that the service or item will not be covered, your plan should send you a formal denial notice. If you disagree with your plan's decision, you can file an appeal by following the instructions in the formal denial notice.

2. Request a Level 1 appeal to your MAP plan.

Follow the appeal instructions on the formal denial notice you received from your plan. Make sure to file your appeal within 60 days of the date on the notice. If you plan to request aid continuing, you should file your appeal within 10 days of the postmark date on your formal denial letter or by the intended effective date of the denial, whichever is later (see #3).

Send your appeal to the address on the notice. As part of your appeal, you will need to include a letter explaining why you need the service or item that has been denied. You can also ask your provider or a friend or family member to write this letter on your behalf and generally help you through the appeal process. If a friend or family member is representing you, fill out and attach your plan's Appointment of Representative form to your appeal.

You can request a fast (expedited) appeal for coverage of a service or item you have not yet received if your doctor feels that your health would be seriously harmed by waiting the standard timeline. Your plan should also process your appeal more quickly if you have been denied coverage for a Part B-covered drug.

3. Request aid continuing, if you need it.

Aid continuing allows you to continue receiving coverage for the service or item that is being denied while your appeal is pending. To automatically receive aid continuing, you must file your appeal within 10 days of the postmark date on your formal denial letter or by the intended effective date of the denial, whichever is later. If you do not need aid continuing, file your appeal within 60 days of the date on the denial notice (see #2).

If your appeal is denied and you had aid continuing, you will not be charged for services or items received while the appeal was pending.

4. Wait for your plan's decision.

Your plan should make a decision on your appeal within 30 days of receiving it. If you filed an expedited appeal, your plan will typically make a decision within 72 hours. In some cases, your plan can extend its decision deadline up to 14 days. You should be notified if this happens.

If your appeal is successful, your service or item will be covered. If your appeal is denied, you have the right to continue appealing.

5. Get an independent review.

If your appeal is denied, you can appeal to the Integrated Administrative Hearing Office (IAHO). Your plan should automatically forward your appeal to this second level. IAHO should make a decision within 90 days of the date on your plan's denial notice. If you filed an expedited appeal, you should receive a decision within 72 hours of when IAHO receives your appeal. In some cases, IAHO can extend its decision deadline up to 14 days. You should be notified if this happens.

You can call IAHO to check on your appeal, or to provide additional information to support your appeal. Their contact information should be included on your plan level denial notice. You also have the right to ask your plan for a free copy of your case file (the information regarding your appeal).

You can choose to have your hearing with IAHO be either in-person or over the phone. If you were eligible to receive aid continuing while appealing to your plan, you should also receive aid continuing while appealing to IAHO.

6. Continue to additional levels of appeal.

If your appeal is denied at the IAHO level, you have the right to continue appealing to the Council and then to Federal Court. At each of these levels, there are separate requirements for when you must file the appeal.

Note: You can receive aid continuing through the Council level of appeal.

Appealing when you are being discharged

If you are enrolled in a MAP plan, receiving inpatient care from a hospital, SNF, home health agency, or CORF, and are told that your plan will no longer pay for your care (meaning that you will be discharged), you have the right to a fast (expedited) appeal if you do not believe your care should end. There are separate processes for hospital and non-hospital appeals. In either case, you should receive a notice explaining your rights. If you choose to appeal, follow the notice's instructions on appealing to the Quality Improvement Organization (QIO) within the given timeframe.

In some circumstances, you may be eligible for Medicaid coverage of the same services, even though the Medicare portion of your plan is denying coverage. Contact your MAP plan care manager when you receive a denial of coverage to determine the best path forward.

For more information about the inpatient care appeal processes:
https://www.medicarerights.org/fliers/Rights-and-Appeals/MA-Ending-Care-Appeals-Packet.pdf

Part D appeals

If you have been denied coverage for a prescription drug, you can choose to file a Part D appeal. The Part D appeal process is exactly the same for MAP plan members, individuals enrolled in stand-alone Part D plans, and individuals receiving coverage through Medicare Advantage Plans with Part D coverage.

For more information about the Part D appeal process:
https://www.medicarerights.org/fliers/Rights-and-Appeals/Part-D-Appeals-Packet.pdf

Tips for appealing

Below are a few tips to help you while appealing.

- Before you start your appeal, make sure to read all the letters and notices from your plan.
    - Call your MAP plan to learn why your health service or item is being denied, if the information has not been provided. Your plan's phone number should be on the back of your plan benefits card.
    - Call your provider to make sure there has not been an error before appealing. If there has not been an error, you can also ask your provider to help you with

your appeal, for instance by writing a letter as to why you need the service or item that has been denied (see #2).

- Many plans let you appeal either in writing or over the phone. A benefit of writing an appeal letter and sending it to your plan by mail or fax is that you have a record of the appeal to refer to later.
- As mentioned above, you can strengthen your appeal by including a letter from your provider in support of your appeal.
- Make sure to file your appeal in a timely manner.
    - A few days after submitting your appeal, call your plan to make sure it has received it.
    - If there is a reason you cannot submit your appeal within the designated timeframe, find out whether you are eligible for a good cause extension. Otherwise, your appeal may not be considered.
- If your plan extends its decision deadline and you believe that it should not, you can call your plan and file an expedited grievance. Your plan should respond within 24 hours.
- Keep a copy of all documents sent and received during your appeal process.
    - If possible, send your appeal by certified mail or with delivery confirmation.
    - Do not send original copies of important documents.

If you have additional questions about the MAP appeal process, contact the Independent Consumer Advocacy Network (ICAN) at 844-614-8800 for free information and assistance. For assistance with inpatient care and/or Part D appeal processes, contact the Health Insurance Information, Counseling, and Assistance Program (HIICAP) at 1-800-701-0501.