Medicare Advantage post-service denials

Date: _____

Helpline caller:

The Medicare Rights Center is a national, nonprofit organization. We help older adults and people with disabilities through education, advocacy, and counseling. We are not a government agency, nor are we connected to any insurance plan or company.

You recently called our helpline for assistance with a Medicare Advantage denial of service. You have the right to appeal, which is a formal request that your plan review its initial decision. In most cases, you can appeal any time you believe that your plan's decision to deny, reduce, or terminate medically necessary care was incorrect.

This packet contains additional information we discussed in our phone call regarding your Medicare Advantage appeal, including:

- An overview of the appeal process
- Tip sheet
- Sample appeal letter
- Sample provider letter

If you have more questions or concerns, please call us again at 800-333-4114.

Sincerely,

Helpline counselor

Appealing your plan's decision to deny payment

If you have a Medicare Advantage Plan and your health service or item was denied, you have the right to appeal. An appeal is a formal request you make if you disagree with a coverage or payment decision. To file a Medicare Advantage appeal for a Part A or Part B denial, follow the steps below.

1. Read your Explanation of Benefits (EOB).

An Explanation of Benefits is the notice that your Medicare Advantage Plan typically sends you after you receive medical services or items. An EOB is not a bill.

EOBs are usually mailed once per month and contain a summary of the services and 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 provider.

Your EOB also shows any items or services that were not covered (in this case, you may receive a noticed titled Notice of Denial of Payment). Look for a section that includes notes, comments, footnotes, and/or remarks to find out the reason why, and contact your plan if you need more information. If you disagree with a non-covered charge, you should file an appeal. The notice should explain what you need to do to appeal.

2. Request a redetermination (appeal).

Follow the appeal instructions on the notice you received from your plan. Send your appeal to the address written on your EOB or Notice of Denial of Payment. Make sure to file your appeal within 60 days of the date on the notice.

You will most likely need to send a letter to the plan explaining why you needed the service you received. If possible, also speak to your provider and ask for their help with the appeal process. Ask for a letter of support explaining why you needed the denied health service or item and that it was medically necessary.

3. Get your plan's decision.

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 have the right to continue appealing.

4. Get an independent review.

If your appeal is denied, you can move on to the next level by appealing to the Independent Review Entity (IRE) within 60 days of the date listed on your plan denial notice. Your plan should automatically forward your appeal to the IRE. The IRE should make a decision within 60 days of the date on your plan denial notice.

You can call the IRE to check on your appeal, or to mail more information. The IRE is also known as MAXIMUS Federal Services, and their phone number is 585-348-3300.

Note: If your plan misses the 60-day decision deadline, your appeal will be considered denied, and your plan should automatically forward your appeal to the IRE.

5. Continue to additional levels of appeal.

If your appeal is denied and your health service or item is worth a certain amount, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level. You must file your OMHA level appeal within 60 days of the date on your IRE denial letter.

If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal–but that is not required.

If your appeal is denied, you have the right to continue appealing to the Council and then to Federal District Court. Be aware that at each level there are separate requirements for when you must file the appeal and how much the health service or item must be worth to appeal.

Tips for appealing

Below are a few tips to help you while you are appealing.

- Before you start your appeal, make sure you fully read all the letters and notices sent by your plan.
    - Call your Medicare Advantage Plan to learn why your health service or item is being denied, if the information was not provided. Their phone number should be on the back of your plan benefits card. Your appeal letter should address the reason(s) for denial stated by the plan.
    - If your EOB says that your plan did not pay for a service, and you think it should, call your doctor to make sure there was not a billing error before appealing.
    - Keep any notices you receive from your plan and write down the names of any representatives you speak to, the date and time you spoke, and what you spoke about.
- Many plans let you appeal either in writing or over the phone. We recommend writing an appeal letter and sending it to your plan by mail or fax.
- You can strengthen your appeal by including a letter from your doctor in support of your appeal.
- Make sure you file each appeal in a timely manner.
    - Call your plan to make sure it got your appeal.
    - If there is a reason you cannot submit your appeal within the timeframe, see whether you are eligible for a **good cause extension**. Otherwise, your appeal may not be considered.
- Keep a copy of all documents sent and received during the process.
    - If possible, send your appeal certified mail or delivery confirmation.
    - Do not send the original copies of important documents.
- If your provider sends you a bill for the denied service or item, let your provider's billing office know that you are in the process of appealing your plan's coverage decision.

Note: If your plan has poor customer service, you face administrative problems (such as the plan taking too long to file your appeal or failing to deliver a promised refund), or you run into other issues, you can choose to file a grievance (a formal complaint). To file a grievance, contact your plan and send a letter to their Grievance and Appeals department.

If you have additional questions about the appeal process, there are resources to help you understand your rights. Contact your State Health Insurance Assistance Program (SHIP) for free information and assistance. To find your SHIP's helpline number, visit https://www.shiptacenter.org/.

Sample appeal letter for denial of eyeglasses after cataract surgery

[Date]
[Your name]
[Your address]

Appeals & Grievance Department
[Name of Medicare Advantage Plan]
[Plan address]

Re: **[Your name]**
Medicare plan:
Medicare number:
Provider:
Claim number: **[Claim number for denied service/s]**
Date/s of service:
Total charge: **[Amount being denied]**

Dear sir/madam:

I am writing to appeal **[name of Medicare Advantage Plan]**'s denial of coverage for eyeglasses obtained after cataract surgery.

The law requires private Medicare health plans, such as **[name of Medicare Advantage Plan]**, to provide enrollees with "benefits under the Original Medicare [sic] fee-for-service option", which means that plans must cover "those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B, or an actuarially equivalent level of cost-sharing as determined in this part." 42 U.S.C. § 1395w-22(a)(1). Private Medicare plans may, however, offer enrolled beneficiaries benefits above and beyond those provided for in parts A and B. 42 U.S.C. § 1395w-22(a)(3).

Original Medicare covers one pair of conventional eyeglasses or conventional contact lenses furnished after each cataract surgery with insertion of an intraocular lens (Centers for Medicare and Medicaid Services Medicare Benefit Policy Manual, Chapter 15 § 120B).

I received cataract surgery with insertion of an intraocular lens on **[date]**. I have requested coverage of one pair of conventional eyeglasses, which I obtained by following **[name of Medicare Advantage Plan]**'s procedures, subsequent to this surgery.

Because I meet the conditions for coverage of these eyeglasses under Original Medicare, **[name of Medicare Advantage Plan]** must reimburse me for this item. Please review your decision. If you have any questions or need additional information, please contact me at **[your number]**. Thank you for your prompt attention to this matter.

Sincerely,
[Your name]

Attachments: **[List, if any]**

Sample provider's appeal letter

[Print on your letterhead, attach copies of any relevant medical records, and return to client]

[Date]

Appeals & Grievance Department
[Plan name]
[Plan address]

Re:**[Patient name and date of birth]**
Date/s of service:
Total cost of services:

Dear sir/madam,

I write on behalf of my patient, **[patient name]**.

[Patient name] has been under my care for **[amount of time]**. They are diagnosed with **[diagnosis/es]**. In order to appropriately treat **[patient name]**'s medical condition, I **[ordered/performed] [treatment/item/service (CPT #)]**.

[Name of service] is medically necessary for **[patient name]** because **[reasons]**. If they cannot receive this treatment, **[consequences of not receiving treatment]**.

Accordingly, please reconsider your denial of coverage for this medically necessary **[treatment/service/item]**.

Please contact me should you require any additional information. I can be reached at **[phone number]**.

Sincerely,

[Your name]
[Your title]

Attachments: **[List, if any]**