Original Medicare post-service denials

Date: _____

Dear helpline caller:

The Medicare Rights Center is a national, nonprofit organization. We help older adults and people with disabilities with their Medicare problems. We support caregivers and train professionals. We also teach people about Medicare and advocate for policy reform. The Medicare Rights Center is not part of Medicare or the government. We aren't connected to any insurance company or plan.

You recently called the Medicare Rights helpline for assistance with a denial from Original Medicare. You have certain appeal rights under Medicare law. You can appeal any time you believe that medically necessary care or coverage has been wrongly denied, reduced or terminated. An appeal is a formal request asking Medicare to cover your health care or drugs.

Enclosed is the information we discussed regarding your Original Medicare appeal. In this packet, you will find information about how to file an appeal. The following information is included:

- Overview of appeals process
- Tip sheet
- Sample appeals letter
- Sample doctor's letter

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

Sincerely,

Helpline Counselor

Appealing Medicare's decision to deny payment

If you have Original Medicare 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 an Original Medicare appeal for a Part A or Part B denial, follow the steps below.

1. Read your Medicare Summary Notice (MSN).

The Medicare Summary Notice (MSN) is a summary of health care services and items you have received during the previous three months. The MSN is not a bill.

MSNs are usually mailed four times a year (quarterly) and contain information about charges billed to Medicare, the amount that Medicare paid, and the amount you are responsible for. Note that you may receive additional MSNs if you receive reimbursement for a bill you paid.

Your MSN also lists any **non-covered charges**. This field shows the portion of charges for services that are denied or excluded (never covered) by Medicare. A $0.00 in this field means that there were no denied or excluded services. A charge in this field means you are responsible for paying it. If you disagree with a non-covered charge, you should file an appeal.

2. Request a redetermination (appeal).

Follow the appeal instructions listed on your MSN or Redetermination Request form:

- Circle the denied service
- Fill out the shaded section at the end of the MSN

Send your appeal to the Medicare Administrative Contractor (MAC) within 120 days of the date on your MSN. The MAC's name and address are listed in the shaded section of your MSN.

If possible, 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 noting that it was medically necessary. Send this letter with your appeal.

3. Get Medicare's decision.

The MAC 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 Qualified Independent Contractor (QIC) within 180 days of the date listed on the MAC denial letter. The QIC may go by a different name in your area. Follow the instructions on the MAC denial notice to file your appeal.

The QIC should make a decision within 60 days. If your QIC appeal is successful, your service or item will be covered. If it is denied, you have the right to continue appealing.

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 QIC 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 Medicare.
    - Call 1-800-MEDICARE (633-4227) to learn why your health service or item is being denied, if the information was not provided. Your appeal letter should address the reason(s) for denial stated by Medicare.
    - If your MSN says that Medicare 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 Medicare and write down the names of any representatives you speak to, the date and time you spoke, and what you spoke about.
- 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.
    - 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.
- You can also appeal if you signed an **Advance Beneficiary Notice (ABN)**. Before appealing, make sure that Medicare was billed and that you received a denial.
- 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 Medicare's coverage decision.

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
[Address on MSN]

Re: **[Your name]**
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 Medicare's denial of coverage for eyeglasses obtained after cataract surgery.

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 Medicare's procedures, subsequent to this surgery.

Because I meet the conditions for coverage of these eyeglasses, Medicare 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
[Address on MSN]

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]**