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 your Medicare private health plan.

There are different types of Medicare private health plans, also called Medicare Advantage Plans. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Private-Fee-for-Service Plans (PFFS) are the most common. Regardless of what type of Medicare Advantage Plan you’re in, you have certain appeal rights under Medicare law. An appeal is a formal request asking your plan to cover your health care or drugs.

Enclosed is the information we discussed regarding your Medicare Advantage Plan 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 a Medicare Advantage Plan’s Decision to Deny Payment

If your plan is refusing to pay for care you already received, you have the right to appeal. There are several stages to the process and deadlines you must meet.

Below are the steps you must take to file a standard appeal if your plan will not pay for care you already received.

1. Get a Denial Notice

The plan must send you a written denial notice before you can start the appeal. By law, you are supposed to receive notice of a denial of payment within 30 days of when the doctor or hospital has requested payment from the plan.

The notice will tell you what information you need to send to the plan to start an appeal.

2. Request a Reconsideration

You have 60 days from the date on your denial notice to appeal to the plan (request a reconsideration).

In most cases, you will need to send a letter to the plan explaining why you needed the service. Ideally, you should also include a supporting statement from your doctor explaining why you needed the care (medical necessity).

3. Get the Plan’s Decision

Once you appeal, the Medicare Advantage Plan must make a decision within 60 days. If you do not hear back, call the plan.

* Note: If your plan will not approve care that you need and have not yet gotten, you are entitled to a faster appeal.
4. Get an Independent Review

If your plan still does not change its decision, it must automatically forward your request to the next level of appeal—the Independent Review Entity (IRE). The IRE is an independent group of doctors and other professionals that contracts with Medicare to review the plan decision.

The IRE must decide your case within **60 days**.

If your request is forwarded on to the Independent Review Entity and you wish to check on the status of your case or mail them additional information, you can contact the IRE at:

Maximus Federal Services  
Phone: 585-425-5210

5. Continue to Additional Levels of Appeals

If the IRE upholds the plan’s denial, you must take active steps to continue the appeal.

You can appeal to the **Office of Medicare Hearings and Appeals (OMHA)**, if the cost for the service in dispute is at least $160 in 2017. You must appeal to the OMHA within 60 days of the date on the IRE’s decision. Your notice from the IRE will contain instructions on how appeal to the OMHA.

If you are turned down at the OMHA level, you can appeal to the **Council** and then to **Federal Court**.

If you plan to appeal at the OMHA level or higher, you may want to find an advocate or lawyer to help you.
Tips for Appealing

- Do not be afraid to appeal if you disagree with a plan’s decision. You have the right to appeal and the process is fairly simple.

- Many plans give the option of starting an appeal by writing or over the phone. **We recommend writing an appeal letter.** The address for the Plan’s Appeal and Grievance Department can be found in your Explanation of Benefits letter underneath “Important Information About Your Appeal Rights.”

- If the plan gives you the option to fax an appeal, consider both mailing and faxing your appeal.

- Be brief and concise in your appeal letter. Clearly state which denied service you are appealing.

- In most cases, having a doctor’s letter of support is essential to your appeal. We have enclosed a sample doctor’s letter to help your physician with the process.

- If you are sending documents as evidence along with your appeal, never send the original copies.

- If you have missed the deadline for any level appeal, you can request a Good Cause Extension. Examples of good causes include:
  - You did not receive the Explanation of Benefits showing the denial, or received it late
  - You were seriously ill and as a result, were unable to appeal
  - An accident destroyed your records
  - Documentation to support your appeal was difficult to obtain
  - You lacked the ability to understand the time frame for requesting a reconsideration

  If you have a good reason for not appealing in a timely way but it is not on this list, request the extension anyway. The list above is not comprehensive.

- Keep good records. Make sure to keep any notices you receive from the plan and write down the names of any representatives you speak to and when you spoke to them.

- After a reasonable amount of time, call the plan to make sure they received your appeal.

If you feel that your plan has treated you poorly, consider writing a grievance letter, both to the plan, and your regional Centers for Medicare and Medicaid (CMS) office.
Sample Appeal Letter for Denial of Eyeglasses After Cataract Surgery

[Date]
[Your Name]
[Your Address]

Appeals & Grievance Department
[Name of Medicare private 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 plan]’s denial of coverage for eyeglasses obtained after cataract surgery.

The law requires private Medicare health plans, such as [name of Medicare 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 plan]’s procedures, subsequent to this surgery.

Because I meet the conditions for coverage of these eyeglasses under Original Medicare, [name of Medicare plan] must reimburse me for this item. Further, [name of Medicare plan] must send me payment within 60 days of receiving this request for reconsideration. 42 C.F.R. § 422.618(a).

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 Physician’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].

[Name of patient] has been under my care for [amount of time]. [S/he] is diagnosed with [diagnosis/es]. In order to appropriately treat [name of patient]’s medical condition, I have [ordered/performed] [treatment/item/service (CPT #)].

[Name of service] is medically necessary for [name of patient] because [reasons]. If [s/he] 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]