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
Pre-Service Denials
Expedited Appeal

Appealing a Medicare Advantage Plan’s Decision to Deny Services I Need Immediately

If you need care immediately, and your health, life or ability to regain maximum function would be at risk if you were to wait the standard timeframe for your plan to review your case, you may be entitled to a fast review (expedited reconsideration).

In order to request a fast review, your plan must have officially denied you care. If your doctor will not give you a treatment because he knows your plan generally will not cover it, this is not an official denial. It may also not be an official denial if your doctor’s office calls your plan, and a representative tells them that a service will not be covered for you.

You should have your doctor’s office call your plan and ask that the service be covered for you. The doctor should request that the plan make an expedited decision because waiting the standard timeframe would endanger your health. (The plan must grant a doctor’s request for an expedited determination but does not have to do so for you.) If the plan decides it will expedite its decision, the plan must respond about whether it will cover the service within 72 hours.

Below are the steps you must take to file an expedited appeal.

Note: Plans must meet deadlines for processing requests within the timeframes stated below but are technically required by law to do so as quickly as your health requires. 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.

1. Have your doctor call or send a fax.

Have your doctor call or send a fax requesting an expedited reconsideration. You can request a reconsideration yourself, but the plan can choose whether or not to grant it. The plan must grant a doctor’s request.

2. Get the plan’s decision.

If the plan expedites the reconsideration, it must make a decision within 72 hours of your request for the appeal. (The plan has 14 extra days to gather information if it is in your best interest, but must notify you if it needs this extra time). If the plan refuses to
expedite the appeal you filed, you can file a complaint with the plan and it has 24 hours to review the complaint.

3. Get an Independent Review

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

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

4. If necessary, continue to additional levels of appeals

If the IRE says the plan does not have to pay for the care you received (upholds the plan's denial), you must take active steps to continue the appeal.

If it is during an enrollment period, you may want to consider disenrolling to take Original Medicare, or changing to another private health plan if you can find one that covers what you need.

If you choose to continue to 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 2018. You must appeal to the OMHA within 60 days of the date on the IRE's reconsideration decision.

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 Expedited Appeal Letter

[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 carrier or plan]’s denial of coverage for [denied service]. Please expedite my appeal per 42 C.F.R. § 422.584, as applying a standard timeframe for making the determination could seriously jeopardize my life, health, and/or ability to regain maximum function.

The facts of my case are as follows. [Explain why the service is medically necessary. Include personal information about illness and treatment history, details of care you received, health care providers involved, and what you feel needs to be done. If possible, get a letter from your healthcare provider/s confirming that the service is medically necessary and explaining why, and stating that an expedited appeal is necessary, as using the standard timeframe could seriously jeopardize your life, health, and/or ability to regain maximum function.]

Please review and reverse your decision to deny coverage. If you have any questions or need additional information, I can be reached at [your phone number]. Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]

Attachments: [List, if any]
[Print on your letterhead and attach copies of any relevant medical records]

[Date]

Appeals & Grievance Department
[Plan name]
[Plan address]
Fax Number:

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

Dear Sir/Madam,

I write to file an expedited appeal on behalf of my patient, [patient name].

The [treatment/service/item at issue] is medically necessary for [patient name]. [Explain patient’s medical condition and why service is medically necessary.]

Applying the standard appeals timeframe could seriously jeopardize [patient name]'s life, health, or ability to regain maximum function. For that reason, please expedite this appeal. According to the Medicare Managed Care Manual, Chapter 6, § 80.1, upon approving the request to expedite this appeal, then you must give both the enrollee and the doctor notice of your reconsideration no later than 72 hours after receiving the request. I also understand that if you deny this appeal, you will promptly forward this case to an Independent Review Entity (IRE), which will also make an expedited determination. If [patient name]'s case is forwarded to the IRE, I would like notification so that I can submit additional information if necessary.

Sincerely,

[Your Name]
[Your title]

Attachments: [List, if any]