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
If Your Medicare Advantage Plan Denies a Service, You Can Appeal

If your doctor says you need a test, surgery or other service, and you’re in a Medicare private health plan (also called a Medicare Advantage Plan), you might have to ask your plan in advance whether it will cover it. This is called getting prior authorization.

If your plan says it won’t pay, you don’t have to take no for an answer. There’s a way you can try to get your plan to cover it. This is called appealing. You can appeal for a service you need.

Many people win their appeals, but it’s important to get your doctor’s support. You need your doctor to tell the plan why you need the service or specialist. Sometimes doctors will even appeal for their patients. Before you appeal, check with your doctor’s office. Find out if it will send an appeal on your behalf. You don’t need to appeal if your doctor is appealing for you.

Even if you don’t win your appeal at first, you or your doctor can continue your appeal and win at higher levels. There are several steps and deadlines to meet when you appeal. Below are the steps to appeal for care you haven’t gotten yet. Follow these steps when it’s not an emergency. If you need care right away, your doctor should call the plan for a fast (or expedited) appeal.

1. Get the plan’s denial in writing

   The plan must make an official decision before you appeal. This decision should be in writing. If your plan denied care, call and ask the plan to send you a denial notice. The plan should mail the notice in about two weeks. The notice will tell you how to appeal. It will say what information to send to the plan and where to send it.

   Sometimes a plan says it needs more than two weeks to look at your case. The plan can then take two more weeks to send you a decision. You must wait that time before you can appeal.

   If you don’t hear anything from the plan in two weeks and don’t get a denial notice, you can appeal without it. Send a letter to the plan saying it has been 14 days and you haven’t gotten a denial notice. Include a letter from your doctor saying why you need the care. This is called requesting a reconsideration, and it starts the appeal.
2. Ask for a reconsideration

You have **60 days** from the date on the denial notice to appeal. To do so, you usually need to send a letter to the plan explaining why you need the service. This is called **requesting a reconsideration** because you’re asking the plan to reconsider its decision.

Before you request a reconsideration, find out if your doctor is appealing for you. If so, you don’t need to do anything.

If your doctor isn’t appealing for you, you can send the reconsideration request. **It's best to include a supporting letter from your doctor. The letter should explain why the care is medically necessary.** It should respond to the reason on the denial notice for why the plan denied your care.

Get delivery confirmation when you mail these letters. Or fax them and keep the fax receipt.

3. Get the plan's decision

The plan must decide on your appeal, or reconsideration request, within **30 days**.

The plan can take 14 extra days to gather information. This is only if it works in your interest. The plan must notify you if it needs this extra time. If you do not hear back, call the plan.

The plan often agrees to cover your care at this point. If that happens, you’re done with the appeal. You can get the service and the plan will cover it.

4. Get an independent review

If your plan doesn’t change its decision and still denies your care, it must send your appeal to an independent group outside of the plan for review. The group is called the **Independent Review Entity (IRE)**. The IRE is the next step in the appeals process.

Medicare hires the IRE to review appeals. It’s made up of doctors and other professionals. They’re there to make sure you get quality care. The IRE must make a decision within **30 days** after it gets the appeal. You can check what’s happening with your appeal at the IRE or mail more information. MAXIMUS Federal Services is the name of the IRE. You can reach MAXIMUS at 585.425.5210
5. More levels of appeal

If the IRE denies your appeal and says the plan doesn’t have to pay for your care, then there are things you must do if you want to continue the appeal. In 2017, if the service will cost at least $160, you can appeal to the Office of Medicare Hearings and Appeals (OMHA). You have 60 days from the date on the IRE denial to do so. The IRE notice will say how to appeal to the OMHA.

If the OMHA turns you down, you can appeal to the Council. Beyond that, you can appeal to a Federal Court. If you appeal to the OMHA or beyond, it’s best to get an advocate or lawyer to help you.

If this happens during an enrollment period, another option is to switch to a different Medicare plan that covers the care you need. You can take Original Medicare or pick another Medicare Advantage Plan.
Tips for Appealing

• Don’t be afraid to appeal if you disagree with a plan’s decision. It’s your right. The process is simple.

• Plans must let you start an appeal over the phone. We recommend writing an appeal letter. The address where you send the appeal will be on the denial notice. Look below where it says “Important Information About Your Appeal Rights.”

• If the plan lets you fax your appeal, consider mailing and faxing it.

• Be brief and direct in your letter. State clearly which denied service you’re appealing.

• A doctor’s letter of support is usually key to your appeal. A sample doctor’s letter to help your doctor is enclosed.

• If you send documents as evidence with your appeal, never send the originals. Send copies.

• Don’t get stuck on one level of appeal. Make sure you go to the next level when you get a denial.

• If you missed the deadline to appeal at any level, you can ask for a Good Cause Extension. Examples of good causes include:
  □ You didn’t get the denial notice or you got it late.
  □ You were seriously ill and couldn’t appeal.
  □ An accident destroyed your records.
  □ You couldn’t get the documents you needed.
  □ You couldn’t understand the deadline.

You might have another good reason for not appealing on time. If so, request the extension. The list above doesn’t include every good reason.

• Keep good records. Keep all notices from the plan. Write down the names of representatives you speak to and when you spoke to them.

• Call the plan to make sure it got your appeal.

You can also file a formal complaint if you don’t like how your plan has treated you. This is called a grievance letter. It’s different from an appeal. Grievances don’t usually get the plan to pay for your care, but plans must respond to them. Send your grievance to the plan and to your regional Centers for Medicare & Medicaid Services (CMS) office.
[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) – You can find this on your Explanation of Benefits from the plan.]
Date/s of Service:
Total Charge: [Dollar Amount Being Denied]

Dear Sir/Madam:

I am writing to appeal [name of Medicare private plan]’s denial of coverage for [denied service]. Your denial of coverage is not reasonable because [Explain why your doctor says you need the service. Make sure to say that it’s “medically necessary.” Include personal information about your case. This includes your illness and treatment history, details about the care you got, the doctors involved, and what you feel you need now. Try to get a letter from your doctor or health care provider(s) that explains why the service is medically necessary.]

As a result, [name of Medicare plan] must cover this [denied service]. 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]