MEDICARE RIGHTS CENTER
Getting Medicare right

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 an Original Medicare denial of service. You have the right to appeal, which is a formal request that Medicare review its initial decision. In most cases, you can appeal any time you believe that Medicare'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 Original Medicare appeal, including:

Overview of appeals process
Appeals chart

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

Sincerely,

Helpline Counselor

If you are receiving care from a hospital, skilled nursing facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), hospice, or home health agency and are told that Original Medicare will no longer pay for your care (meaning that you will be discharged), you have the right to a fast (expedited) appeal if you do not believe your care should end. There are separate processes for hospital and non-hospital appeals. You can file an appeal to extend your care as long as you feel that continued care is medically necessary.

Inpatient hospital appeal

If you are an inpatient at a hospital, you should receive a notice titled Important Message from Medicare within two days of being admitted. This notice explains your patient rights, and you will be asked to sign it. If your inpatient hospital stay lasts three days or longer, you should receive another copy of the same notice before you leave the hospital. This notice should arrive up to two days, and no later than four hours, before you are discharged.

If the hospital says you must leave and you disagree, follow the instructions on the Important Message from Medicare to file an expedited appeal to the Quality Improvement Organization (QIO). You must appeal by midnight of the day of your discharge. The QIO should call with its decision you within 24 hours of receiving all the information it needs.

1. If you are appealing to the QIO, the hospital must send you a Detailed Notice of Discharge. This notice explains in writing why your hospital care is ending and lists any Medicare coverage rules related to your case.
2. The QIO will request copies of your medical records from the hospital. It can be helpful to ask the hospital for your own copy (a copying charge may apply). The QIO will usually call you to get your opinion on the discharge, but you can also send a written statement.
3. If your appeal to the QIO is unsuccessful, you will not be held responsible for the cost of the 24-hour period while you waited for the QIO to make a decision. If you remain in the hospital after that period, you may be responsible for the cost of your care if you do not win at a higher level of appeal.

SNF, HHA, CORF, and hospice appeals

If your care is ending at a SNF, CORF, hospice, or home health agency because your provider believes Medicare will not pay for it, you should receive a Notice of Medicare Non-Coverage. You should get this notice no later than two days before your care is set to end. If you receive home health care, you should receive the notice on your second to last care visit. If you have reached the limit in your care or do not qualify for care, you do not receive this notice and you cannot appeal.

If you feel that your care should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with the Quality Improvement Organization (QIO) by noon of the day before your care is set to end. The QIO should make a decision no later than two days after your care was set to end. Your provider cannot bill you before the QIO makes its decision.

1. Once you file the appeal, your provider should give you a Detailed Explanation of Non-Coverage. This notice explains in writing why your care is ending and lists any Medicare coverage rules related to your case.
2. The QIO will usually call you to get your opinion. You can also send a written statement. If you receive home health or CORF care, you must get a written statement from a physician who confirms that your care should continue.
3. If you miss the deadline for an expedited QIO review, you have up to 60 days to file a standard appeal with the QIO. If you are still receiving care, the QIO should make its decision as soon as possible after receiving your request. If you are no longer receiving care, the QIO must make a decision within 30 days.

Further appeals

Subsequent levels of appeal are the same for hospital and non-hospital care that is ending.

If the QIO appeal is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If the QIO denies your appeal, you can choose to move to the next level by appealing to the Qualified Independent Contractor (QIC) by noon of the day following the QIO's decision. The QIC should make a decision within 72 hours. Your provider cannot bill you for continuing care until the QIC makes a decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the 72 hours the QIC deliberated.

1. If you miss the QIC deadline, you have up to 180 days to file a standard appeal with the QIC. The QIC should make a decision within 60 days.

If the appeal to the QIC is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied and your care is worth a certain amount, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level 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 this is not required. OMHA should make a decision within 90 days.

If your appeal to the OMHA level is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied, you can move to the next level by appealing to the Council within 60 days of the date on your OMHA level denial letter. There is no timeframe for the Council to make a decision.

If your appeal to the Council is successful, you should continue to receive Medicare-covered care, as long as your doctor continues to certify it. If your appeal is denied, you can choose to appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision.

Original Medicare Appeals: Ending Care

	Hospital Discharge Appeal	SNF/HHA/CORF/Hospice Discharge Appeal
Initial Decision	Receive notice titled Important Message from Medicare	Receive Notice of Medicare Non-Coverage
	File by midnight day of discharge	File by noon day before care ends
First Level of Appeal	Appeal to Quality Improvement Organization (QIO) -Decision within 24 hours-	Appeal to Quality Improvement Organization (QIO) -Decision by two days after your care was set to end-
	File by noon day following denial	File by noon day following denial
Second Level of Appeal	Appeal to Qualified Independent Contractor (QIC) -Decision within 72 hours-	
	60 days to file	
Third Level of Appeal	Appeal to Office of Medicare Hearings and Appeals (OMHA) -Decision within 90 days-	
	60 days to file	
Fourth Level of Appeal	Appeal to Council -No decision timeframe-	
	60 days to file	
Final Level of Appeal	Appeal to Federal District Court -No decision timeframe-	

Note: This appeals process is for when your care is ending and you have Original Medicare. Click here to learn more about this process. Keep in mind that there are different appeals processes for Medicare Advantage Plans and Part D prescription drug plans.