Original Medicare and Medicare Advantage Appeals

If you were denied coverage for a health service or item, you may appeal the decision. There is more than one level of appeal, and you have the right to continue appealing if you are not successful at the first level. Be aware that at each level there is a separate timeframe for when you must file the appeal and when you will receive a decision.

How do I begin an appeal if I have Original Medicare?

Start your appeal by following the appeal instructions listed on your Medicare Summary Notice (MSN) or Redetermination Request form. This includes circling the denied service listed and filling out the shaded section at the end of the MSN. Then, 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. This will start your appeal. If your provider sends you a bill for this service, let your provider's billing office know that you are in the process of appealing Medicare's coverage 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 can move on to the next level following the instructions on the MAC denial notice.

How do I begin an appeal if I have a Medicare Advantage Plan?

If you were denied coverage for a health service or item before you received the service or item, you will first need to get an official written decision from your plan, called a Notice of Denial of Medical Coverage. Follow the instructions on the Notice of Denial of Medical Coverage and file your appeal within 60 days of the date on the notice. You will need to send a letter to your plan explaining why you need the service or item.

Your plan should make a decision within 30 days. If the appeal is successful, your service or item will be covered. If your appeal is denied, you should receive a written denial notice. Your plan should also automatically forward your appeal to the next level, the Independent Review Entity (IRE).

If you were denied coverage for a health service or item that you have already received, start your appeal by following the instructions on the notice you received from your plan. Make sure to file your appeal within 60 days of the date on the notice. You will most likely need to send a letter to the plan explaining why you needed the service you received.

Your plan 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 should receive a written denial notice. Your plan should automatically forward your appeal to the next level, the Independent Review Entity (IRE).

These materials made possible by support from the Capital District Physicians' Health Plan.

How can I strengthen my appeal?

- **Read all notices** that you received from Medicare or your plan before starting an appeal
  - If you have Original Medicare, carefully read your Medicare Summary Notice (MSN) to see what services were or were not covered.
  - If you have a Medicare Advantage Plan, carefully read your Explanation of Benefits (EOB) to see what services were or were not covered.
- **Contact your health care provider** before appealing to ensure a billing error was not made
- **Call 1-800-MEDICARE or your plan** to see why the service is not being covered
  - Your appeal letter should address the reason for denial by Medicare or your plan
- **Keep copies of all documents** sent and received during the appeal
  - Do not send original versions of important documents
  - If possible, send your appeal with certified mail or delivery confirmation
- **Include a letter of support from your health care provider**
  - This letter should explain the medical necessity of your care and support your appeal

How do I request a good cause extension for a late appeal?

A late appeal may still be considered after the deadline to appeal has passed, if you can show good cause for not filing on time. Extension requests are considered on a case-by-case basis, so there is no complete list of acceptable reasons for filling a late appeal. Some examples, however, include that you or a close family member fell ill and prevented you from handling business matters, or the notice you are appealing was mailed to the wrong address. If you think you have a good reason for not appealing on time, send in your appeal as you normally would and include a clear explanation of why your appeal is late. If the reason has to do with illness or other medical conditions, a letter or supporting documentation from your health care provider can be helpful.

When should I file a grievance instead of an appeal?

If you are dissatisfied with your Medicare Advantage or Part D prescription drug plan for any reason, you can choose to file a grievance. A grievance is a formal complaint that you file with your plan. It is not an appeal. Times when you may wish to file a grievance include if your plan has poor customer service or you face administrative problems (such as the plan taking too long to file your appeal or failing to deliver a promised refund). In some cases, you may want to file both an appeal and a grievance. To file a grievance, send a letter to your plan's Grievance and Appeals department within 60 days of the event that led to the grievance. Check your plan's website or contact them by phone for the address. Your plan must investigate your grievance and get back to you within 30 days. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan or 1-800-MEDICARE.

These materials made possible by support from the Capital District Physicians' Health Plan.