



Getting Medicare right

Date: _____

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 Original Medicare. You have certain appeal rights under Medicare law. You can appeal any time you believe that medically necessary care or coverage has been wrongly denied, reduced or terminated. An appeal is a formal request asking Medicare to cover your health care or drugs.

Enclosed is the information we discussed regarding your Medicare 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



Original Medicare Post-Service Denials

Appealing Medicare's decision to deny payment

If Original Medicare will not pay for care you received and you think the care you received is medically necessary, you should not take no for an answer.

If you are in Original Medicare, the appeals process for Part A and Part B denials is as follows:

1. Get a Medicare Summary Notice

When Original Medicare processes a claim for health care services you received, the claim is detailed in a Medicare Summary Notice (MSN). The MSN is a summary of claims for health care services Medicare processed for you during the previous three months. The MSN is not a bill.

MSNs are mailed four times a year and contain information about submitted charges, the amount that Medicare paid, and the amount you are responsible for.

If Original Medicare will not pay for care you received, you will find this out when you receive your Medicare Summary Notice (MSN).

2. Request a Redetermination (Appeal)

If the MSN you received denies payment for a service you think was medically necessary, you have the right to appeal.

The MSN will have instructions for how to appeal. Follow these instructions. If the MSN lists several items and you are not disputing all of them, circle the one you want to appeal. Write "Please Review" on the bottom and sign the back. Make a copy for your files. Then mail the signed original to Medicare at the address on the MSN.

Make sure you mail your appeal within 120 days of receiving the MSN.

If possible, get a letter from your health care provider saying that you needed the service and why. Send this with your MSN.



Getting Medicare right

3. Get Medicare's Decision

The company that handles your bills for Medicare (Medicare Administrative Contractors or MACs) will send you a written decision within 60 days of getting your request for redetermination (appeal).

4. Get an Independent Review

If the Medicare carrier or intermediary denies your initial appeal, you can ask for a reconsideration (review by a Qualified Independent Contractor). The amount in question does not matter.

You must request a reconsideration within 180 days (six months) of receiving the decision on your initial appeal. The Qualified Independent Contractor generally has 60 days to issue a decision.

5. Continue to Additional Levels of Appeals

If the Qualified Independent Contractor upholds Medicare's denial, you must take active steps to continue the appeal.

You can appeal to an Administrative Law Judge (ALJ), if the cost for the service in dispute is at least \$150 in 2016. You must appeal to the Administrative Law Judge within 60 days of the date on the Qualified Independent Contractor's decision. The notice will contain instructions on how to appeal to the Administrative Law Judge.

If you are turned down at the Administrative Law Judge level, you can appeal to the Medicare Appeals Council (MAC) and then to Federal Court.

If you plan to appeal at the Administrative Law Judge level or higher, you may want to find an advocate or lawyer to help you.



Getting Medicare right

Tips for Appealing

- Do not be afraid to appeal if you disagree with Medicare's decision. You have the right to appeal and the process is fairly simple.
- Even if you sign an Advance Beneficiary Notice (ABN) that stated that you agree to pay for care if Medicare will not, you can still appeal.
- Sometimes, you have the option of starting an appeal by writing or over the phone. **We recommend writing an appeal letter.** The address you should send it to should be on the redetermination denial letter. If not, call 1-800-MEDICARE to find out the address you should send your reconsideration form to.
- If you have the option to fax an appeal, consider both mailing and faxing your appeal. **Keep photocopies and records of all communication**, whether written or oral, with Medicare concerning your denial. Send your appeal certified mail or delivery confirmation.
- 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 Medicare Summary Notice showing the denial, or received it late
 - You were seriously ill and as a result, were unable to appeal
 - 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 Medicare and write down the names of any representatives you speak to and when you spoke to them.
- After a reasonable amount of time, call Medicare (or the independent review agency) to make sure they received your appeal.



Getting Medicare right

Sample General Appeal Letter

[Date]
[Your Name]
[Your Address]

Appeals & Grievance Department
[Address on MSN]

Re: **[Your Name]**
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 Medicare's denial of coverage for **[denied service]**. Your denial of coverage is not reasonable because **[Explain why the service is medically necessary. Include personal information about your case, including illness and treatment history, details of the care you received, the 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.]**

As a result, Medicare 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]**



Getting Medicare right

Sample Physician's Appeal Letter

[Print on your letterhead, attach copies of any relevant medical records and return to client]

[Date]

Appeals & Grievance Department

[Address on MSN]

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]**