

MEDICARE APPEALS & GRIEVANCES

APPEALS

WHAT IS AN APPEAL?

An appeal is the action patients and providers can take if they disagree with a coverage or payment decision made by Medicare or the Medicare plan. Patients and providers have the right to appeal any decision about the patient's Medicare services. An appeal can be made if Medicare or the plan denies:

- A request for a healthcare service, supply, or prescription that the patient or provider thinks the patient should be able to get
- A request for payment for healthcare services or supplies or a prescription drug the patient has already received and was then was denied
- A request to change the amount the patient must pay for a prescription drug

Patients and providers can also appeal if Medicare or the plan stops *providing or paying for all or part of* an item or service the patient or provider thinks the patient still needs. Once the decision is made to file an appeal, the patient and provider should work together to collect any information that may help the case.

FILING AN APPEAL UNDER THE ORIGINAL MEDICARE PROGRAM

Get the *Medicare Summary Notice* (MSN) that shows the item or service that is being appealed.

Appeals must be filed within 120 days of the date the patient receives the MSN. Appeals can be filed in one of two ways:

1. By following the instructions on the back of the MSN.
2. By filling out the *Redetermination Request Form*, and sending it to the Medicare contractor at the address listed on the MSN.

Generally, a decision from the Medicare contractor (either in a letter or a Medicare Summary Notice) will be received within 60 days after they get the request.

FILING AN APPEAL UNDER A MEDICARE HEALTH PLAN

The steps for filing an appeal can be found in the materials the plan sends the patient each year. Another option is for the patient or provider to call the plan directly.

FINANCIAL ADVOCACY NETWORK

FILING AN APPEAL UNDER A MEDICARE PRESCRIPTION DRUG PLAN

Patients and providers have the right to do all of the following—even before they buy a certain drug:

- Get a written explanation (called a “coverage determination”) from the Medicare drug plan. A coverage determination is the first decision made by the Medicare drug plan (not the pharmacy) about patient benefits, including whether a certain drug is covered, whether the patient has met the requirements to get a requested drug, how much the patient pays for a drug, and whether to make an exception to a plan rule when the patient or provider requests it.
- Ask for an exception if the patient or provider believes the patient need a drug that isn’t on the plan’s formulary.
- Ask for an exception if the patient or provider believes that a coverage rule, such as prior authorization, should be waived.
- Ask for an exception if the patient or provider thinks the patient should pay less for a higher tier (more expensive) drug because the patient or provider believes the patient cannot take any of the lower tier (less expensive) drugs for the same condition.

The patient or provider must contact the plan to ask for a coverage determination or an exception. If the network pharmacy cannot fill a prescription, the pharmacist will show the patient or provider a notice that explains how to contact the Medicare drug plan to make the request.

The patient or provider may make a standard request by phone or in writing, if asking for prescription drug benefits not yet received. If asking to get paid back for prescription drugs already bought, the patient or provider must make the standard request in writing.

The patient or provider can call or write the plan for an expedited (fast) request. Requests will be expedited if the patient has not yet received the prescription and the plan determines—or the prescriber tells the plan—that the patient’s life or health may be at risk by waiting.

If requesting an exception, the provider must provide a statement explaining the medical reason why the exception should be approved.

FINANCIAL ADVOCACY NETWORK

WHAT IF THE PATIENT THINK SERVICES ARE ENDING TOO SOON?

If patients are getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and they think their Medicare-covered services are ending too soon, they have the right to a fast appeal. Providers give patients a written notice before their services end that tells them how to ask for a fast appeal. Patients and providers should work together on this appeal.

CAN SOMEONE HELP A PATIENT FILE AN APPEAL?

If a patient's provider cannot help, the patient should contact his or her *State Health Insurance Assistance Program (SHIP)* for help filing an appeal.

GRIEVANCES

A grievance is any complaint or dispute (other than an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested.

The enrollee must file the grievance either orally or in writing no later than 60 days after the triggering event or incident precipitating the grievance. Listed below are some examples of problems that are typically dealt with through the plan grievance process

- Problems getting an appointment, or having to wait a long time for an appointment
- Disrespectful or rude behavior by doctors, nurses, or other plan clinic or hospital staff

Each plan must provide meaningful procedures for timely hearing and resolving both standard and expedited grievances between enrollees and the Medicare health plan or any other entity or individual through which the Medicare health plan provides health care services. The Medicare health plan must include in its grievance procedures:

- The ability to accept any information or evidence concerning the grievance orally or in writing not later than 60 days after the event; and
- The requirement to respond within 24 hours to an enrollee's expedited grievance whenever:
 1. A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
 2. A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration.

FINANCIAL ADVOCACY NETWORK

Plans must notify all concerned parties upon completion of the investigation as expeditiously as the enrollee's case requires based on the enrollee's health status, but not later than 30 days after the grievance is received.

For more information about the grievance process, see section 20.3 in Chapter 13 of the Medicare Managed Care Manual. A copy of the model notice plans may use to notify enrollees about their right to an expedited grievance is located in Appendix 5. Click on the "**Downloads**" section below to access Chapter 13.

Grievances about Part D prescription drugs are not processed using these procedures. For information on how to file a grievance about prescription drugs, click on the link to Chapter 18 of the Prescription Drug Benefit Manual under the "**Downloads**" section below.

Quality of care grievances (complaints about the quality of care received in hospital or other provider settings) may be reported through the plan's grievance procedures, the enrollee's Quality Improvement Organization (QIO), or both.

For more information about filing a grievance with the QIO, click on Medicare publication - Your Medicare Rights and Protections.