



Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal)

Medicare Advantage Plans (like an HMO or PPO) and Medicare Cost Plans are health plan options that are approved by Medicare and run by private companies. When you join a Medicare Advantage Plan or Medicare Cost Plan, you are still in the Medicare Program.

- Medicare Advantage Plans provide all of your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage and must cover all medically-necessary services that are covered under Part A or Part B. They generally offer extra benefits, and most also include Medicare prescription drug coverage (Part D).
- A Medicare Cost Plan is a type of HMO that is available in certain areas of the country. You can join even if you only have Part B. If you go to a non-network provider, the services are covered under Original Medicare. You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a stand-alone Medicare Prescription Drug Plan to add prescription drug coverage.

Filing a complaint (grievance or appeal)

You have a right to file a complaint if you have concerns or problems with your Medicare Advantage or Medicare Cost Plan. A complaint may be either a “grievance” or an “appeal.”

- You can file a **grievance** if, for example, you aren’t satisfied with how your plan or provider gave you a service.
- You can file an **appeal** if you asked your plan to provide or pay for an item or service you think should be covered, and the plan says it won’t provide or pay for the item or service.



Filing a complaint (grievance or appeal) (continued)

You must file your complaint with your plan within 60 calendar days of the date of the event that led to your complaint. Some examples of why you might file a complaint include the following:

- You believe your plan's customer service hours of operation should be different.
- You believe there aren't enough specialists in the plan to meet your needs.
- You want to report rude behavior by a doctor or nurse, or you don't think your doctor's office is clean.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to your plan.
- The plan didn't make a decision about a reconsideration within the required timeframe. See the level 1 appeal on page 4.
- The plan didn't send your case to the Independent Review Entity (IRE). See level 2 on page 5.
- You disagree with the plan's decision not to grant your request for an expedited (fast) appeal.
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.
- Your plan won't provide or pay for services you believe the plan covers.

When you join a Medicare Advantage Plan or Medicare Cost Plan, the plan will send you information about the plan's complaint procedures in its membership materials. Read the information carefully, and keep it where you can find it if you need it. Call your plan if you have questions.

Requesting an organization determination

You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. This is called an "organization determination." If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask the plan for a fast decision. The plan must notify you of its decision within 72 hours if it determines, or your doctor tells your plan, that your life or health may be seriously harmed waiting for a standard decision.



Requesting an organization determination (continued)

If the plan won't cover the item/service you asked for, the plan must tell you in writing why they won't provide or pay for the item/service and how to appeal this decision. If you appeal the plan's decision, you may want to ask for a copy of your file containing medical and other information about your case. The plan may charge you for this copy.

Note: If you have a Medicare Cost Plan and want to appeal services you got outside of the plan's network, you will need to follow the Original Medicare appeals process. For more information, visit www.medicare.gov/Publications/Pubs/pdf/11316.pdf to view the fact sheet, "How to File a Medicare Part A or Part B Appeal in Original Medicare."

Appointing a representative

If you need help, you can appoint a representative (like a family member, friend, advocate, attorney, doctor, or someone else) to act on your behalf. You can appoint someone in one of two ways:

- Fill out an "Appointment of Representative" form (CMS Form Number 1696), available at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.
- Submit a letter signed and dated by you and the person helping you. Your letter must include the same information as the "Appointment of Representative" form.

You must send the form or letter with your appeal request. It's a good idea to make a copy of the form or letter before you send it. If you have questions about appointing a representative, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If your treating doctor requests an organization determination for you, he or she doesn't have to submit the "Appointment of Representative" form or a letter. If someone else requests an organization determination for you, you must submit the form or letter appointing that person as your representative.

Your treating doctor can also request an appeal with the plan (a "reconsideration," see level 1 on page 4) for you without submitting the "Appointment of Representative" form or a letter. However, if you want your doctor to request an appeal on your behalf for a level 3 appeal or higher (as discussed on pages 5–6), you would have to submit the form or letter appointing your doctor as your representative.



Appealing decisions about your coverage

If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the decision (the “organization determination”). You will get a notice explaining why your plan denied your request and instructions on how to appeal your plan’s decision. There are **five levels** of appeal available to you. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so. After each level, you will get instructions on how to proceed to the next level of appeal.

Level 1: Appeal through your plan

The first level of appeal is called a “reconsideration.” You must request this appeal within 60 calendar days from the date of the organization determination notice. You, your treating doctor, or your representative must file a written standard request unless your plan allows you to file a request by telephone. Your plan’s address is in your plan materials and will be in the organization determination notice.

Your written reconsideration request should include the following:

- Your name, address, and the Medicare number (health insurance claim number (HICN)) shown on your Medicare card.
- The specific service and/or item(s) for which you’re requesting a reconsideration.
- The specific date(s) if applicable.
- Your reasons for appealing and any evidence you wish to attach.
- Your signature or that of your representative. If your representative is making the request, remember to attach the completed “Appointment of Representative” form or letter mentioned on page 3.

You, your representative, or your doctor can call your plan or write to them for an expedited (fast) reconsideration. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be at risk by waiting for a standard decision. Once your plan gets your request for an appeal, the plan has 30 calendar days (for a standard service request), 60 calendar days (for a payment request), or 72 hours (for an expedited request) to notify you of its decision. The time frame for completing standard service and expedited requests may be extended by up to 14 calendar days. The time frame may be extended if, for example, your plan needs more information to make a decision about the case, and the extension is in your best interest.



Appealing decisions about your coverage (continued)

Level 2: Review by an Independent Review Entity (IRE)

If the plan decides against you, your appeal is **automatically** sent to level 2. If this happens, you will get a notice from the plan. If the IRE determines that your life or health may be at risk by waiting for a standard decision, it will expedite your review.

You have the right to send the IRE information about your case. They must get this information 10 days after the date you get the IRE notice telling you they have your case file. The notice tells you where to send your information. Generally, the IRE has 30 days (for a standard service request), 60 days (for a payment request), or 72 hours (for an expedited request) to notify you of its decision. The time frame for completing standard service and expedited requests may be extended by up to 14 calendar days. The time frame may be extended if, for example, your plan needs more information to make a decision about the case, and the extension is in your best interest.

Level 3: Hearing with an Administrative Law Judge

You will get a written decision from the IRE. If you disagree with the IRE's decision, you or your representative can request an Administrative Law Judge (ALJ) hearing. Follow the directions in the IRE's decision to request a hearing. You must make the request in writing within 60 calendar days from the date of the IRE's decision.

To get an ALJ hearing, the projected value of your denied coverage or payment request must meet a minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount. If the ALJ decides in your favor, the plan has the right to appeal this decision by asking for a review by the Medicare Appeals Council.

Level 4: Review by the Medicare Appeals Council

You will get a written decision from the ALJ. If you disagree with the ALJ's decision, you or your representative can request a review by the Medicare Appeals Council (MAC). Follow the directions in the ALJ's decision to request the MAC review. You must make the request in writing within 60 calendar days from the date of the ALJ's decision.



Appealing decisions about your coverage (continued)

Level 5: Review by a Federal court

You will get a written decision from the MAC. If you disagree with the MAC's decision, you or your representative can request a review by a Federal court. Follow the directions in the MAC's decision to request a Federal court review. You must make the request in writing within 60 days from the date of the MAC's decision.

To get a Federal court review, the projected value of your denied coverage or payment request must meet the minimum dollar amount provided in the MAC's decision.

Additional appeal rights

If you are getting Medicare services from an inpatient hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility, you may have the right to a fast appeal if you think your Medicare-covered services are ending too soon. This fast appeal is also called an "expedited review" or "immediate review." You will get a notice from your provider at least 2 days before your services end. For inpatient hospital services, you will get a notice near your hospital admission. The notice will tell you when your services will end and how to ask for a fast appeal. If you don't get this notice, ask for it. With a fast appeal, the Quality Improvement Organization (QIO) in the state where the services are being provided will look at your case to decide if your services need to continue.

If you decide to file a fast appeal, remember the following:

- Ask your doctor for any information that may help your case.
- You must call your local QIO to request a fast appeal no later than noon on the day after you get the notice (or no later than the day of the discharge for inpatient hospital stays). The number for the QIO in your state should be on your notice. You can also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to get their telephone number. TTY users should call 1-877-486-2048.
- You may have other appeal rights if you miss the timeframe for filing a fast appeal. Call your plan for more information if you miss the timeframe.

You can contact your State Health Insurance Assistance Program (SHIP) for help filing a fast appeal. Visit www.medicare.gov, or call 1-800-MEDICARE to get the telephone number for your SHIP.



More information about filing a complaint

- Call your Medicare Advantage Plan or Medicare Cost Plan before you get an item, service, or supply to find out if it will be covered. Your plan must tell you if you ask. Your plan can also give you more information about its complaint (grievance and appeal) procedures.
- Visit www.medicare.gov, and select “Medicare Appeals.” You can also visit www.medicare.gov/Publications/Pubs/pdf/10112.pdf to view the booklet “Your Medicare Rights and Protections.”
- Call your State Health Insurance Assistance Program (SHIP) for free personalized counseling and help filing a complaint. Call 1-800-MEDICARE (1-800-633-4227) for their telephone number. TTY users should call 1-877-486-2048.
- Call your local Bar Association (or legal aid program if you have limited income). These offices may be able to help you with your complaint.