CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Appeals

This official government booklet has important information about:

- How to file an appeal if you have Original Medicare
- How to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan
- How to file an appeal if you have Medicare prescription drug coverage
- Where to get help with your questions

The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

"Medicare Appeals" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

Paid for by the Department of Health & Human Services.

Notice of Availability of Auxiliary Aids & Services

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Relay service — TTY users can call 1-877-486-2048.

Alternate formats — This product is available in alternate formats, including large print, Braille, audio, CD, or as an eBook.

To request a Medicare product in an alternate format, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. To request the Medicare & You handbook in an alternate format, visit Medicare.gov/medicare-and-you.

For all other CMS publications:

1. Call 1-844-ALT-FORM (1-844-258-3676). TTY users can call 1-844-716-3676.
2. Send a fax to 1-844-530-3676.
3. Send an email to AltFormatRequest@cms.hhs.gov.
4. Send a letter to:
   Centers for Medicare & Medicaid Services
   Offices of Hearings and Inquiries (OHI)
   7500 Security Boulevard, Room S1-13-25
   Baltimore, MD 21244-1850
   Attn: CMS Alternate Format Team

Note: Your request for a CMS publication should include your name, phone number, mailing address where we should send the publications, and the publication title and product number, if available. Also include the format you need, like Braille, large print, audio CD, or a qualified reader.

Nondiscrimination Notice

The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age. If you think you've been discriminated against or treated unfairly for any of these reasons, you can file a complaint with the Department of Health and Human Services, Office for Civil Rights by:

- Calling 1-800-368-1019. TTY users can call 1-800-537-7697.
- Visiting hhs.gov/ocr/civilrights/complaints.
- Writing: Office for Civil Rights
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

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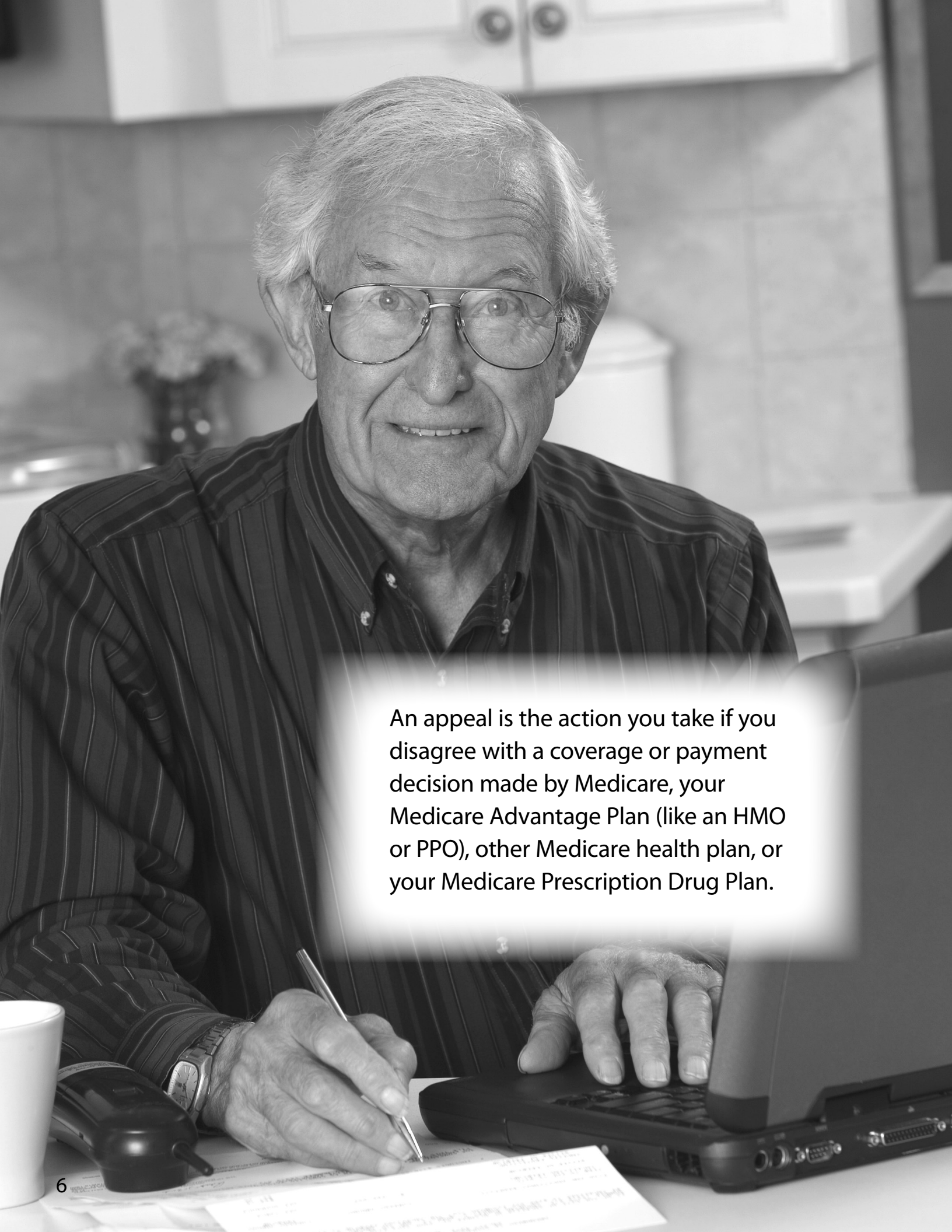


An appeal is the action you take if you disagree with a coverage or payment decision made by Medicare, your Medicare Advantage Plan (like an HMO or PPO), other Medicare health plan, or your Medicare Prescription Drug Plan.

Section 1: What can I appeal?

1

You have the right to appeal if you disagree with the decision from Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan for one of these requests:

- A request for a health care service, supply, item, or prescription drug that you think you should be able to get.
- A request for payment of a health care service, supply, item, or prescription drug you already got.
- A request to change the amount you must pay for a health care service, supply, item, or prescription drug.

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

See the sections in this booklet for information on how to file an appeal no matter how you get your Medicare. For more information, visit Medicare.gov/appeals, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Can someone file an appeal for me?

If you want help filing an appeal, you can appoint a representative. Your representative can help you with the appeals steps explained in this booklet. Your representative can be a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf.

You can appoint your representative in one of these ways:

1. Fill out an "Appointment of Representative" form (CMS Form number 1696). To get a copy, visit cms.gov/cmsforms/downloads/cms1696.pdf, or call 1-800-MEDICARE and ask for a copy.

Words in red are defined on pages 59–62.

2. Submit a written request that includes:
   - Your name, address, phone number, and Medicare number (found on your red, white, and blue Medicare card).
   - A statement appointing someone as your representative.
   - The name, address, and phone number of your representative.
   - The professional status of your representative (like a doctor) or their relationship to you.
   - A statement authorizing the release of your personal and identifiable health information to your representative.
   - A statement explaining why you're being represented and to what extent.
   - Your signature and the date you signed the request.
   - Your representative's signature and the date they signed the request.

You must send the form or written request to the company that handles claims for Medicare or your Medicare health plan. If a representative is helping with your appeal, send the form or written request with your appeal request. Keep a copy of everything you send to Medicare as part of your appeal.

If you have questions about appointing a representative, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

In some cases, your doctor can make a request on your behalf without being appointed your representative:

- If you have a Medicare Advantage Plan or other Medicare health plan:
  - Your treating doctor can request an organization determination or certain reconsiderations on your behalf, and you don't need to submit an "Appointment of Representative" form.
  - If you want your treating doctor to request a higher level of appeal on your behalf, you'll need to submit the "Appointment of Representative" form or a written request to appoint a representative as described below.
  - For more information on how to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan, see Section 3.

- If you have a Medicare Prescription Drug Plan:
  - Your doctor or other prescriber can request a coverage determination, redetermination, or reconsideration from the Independent Review Entity (IRE) on your behalf, and you don't need to submit an "Appointment of Representative" form.
  - If you want your doctor or other prescriber to request a higher level of appeal on your behalf, you'll need to submit the "Appointment of Representative" form.
  - For more information on how to appeal if you have Medicare prescription drug coverage, see Section 4.

If you want help filing an appeal, you can appoint a representative. Your representative can be a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf.

Section 2: How do I appeal if I have Original Medicare?

2

Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). If you have Original Medicare, you get a "Medicare Summary Notice" (MSN) in the mail every 3 months if you get Part A and Part B-covered items and services. If you want to get your MSNs electronically (also called "eMSNs"), visit MyMedicare.gov to sign up.

The MSN shows all your items and services that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and what you may owe the provider or supplier. The MSN also shows you if Medicare has fully or partially denied your medical claim. This is the initial determination, and it's made by the Medicare Administrative Contractor (MAC), which processes Medicare claims.

Read the MSN carefully. If you disagree with a Medicare coverage or payment decision, you can appeal the decision. The MSN contains information about your appeal rights. If you decide to appeal, ask your doctor, other health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.

If you aren't sure if Medicare was billed for the items and services you got, write or call your doctor, other health care provider, or supplier and ask for an itemized statement. This statement should list all of your items and services that were billed to Medicare. You can also check your MSN to see if Medicare was billed.

Words in red are defined on pages 59–62.

What's the appeals process for Original Medicare?

The appeals process has 5 levels:

Level 1: Redetermination by the Medicare Administrative Contractor (MAC)

Level 2: Reconsideration by a Qualified Independent Contractor (QIC)

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get a decision letter with instructions on how to move to the next level of appeal.

Level 1: Redetermination by the Medicare Administrative Contractor (MAC), the company that handles claims for Medicare

Medicare contracts with the MACs to review your appeal request and make a decision. If you disagree with the initial determination on the MSN, you can request a redetermination (a second look or review). This is done by the MACs, but by people at the company who weren't involved with the first decision. You have 120 days after you get the MSN to request a redetermination.

How do I request a redetermination?

You can request a redetermination in one of these ways:

1. Read your MSN carefully, and follow the instructions for sending an appeal:
   - Circle the item(s) and/or service(s) you disagree with on the MSN.
   - Explain in writing on the MSN why you disagree with the decision, or write it on a separate piece of paper along with your Medicare number and attach it to the MSN.

— Include your name, phone number, and Medicare number on the MSN, and sign it.

— Include any other information you have about your appeal with the MSN. Ask your doctor, other health care provider, or supplier for any information that may help your case. Write your Medicare number on all documents you submit with your appeal request.

— You must send your request for redetermination to the company that handles claims for Medicare. The company's address is listed in the "File an Appeal in Writing" section of the MSN.

2. Fill out a "Medicare Redetermination Request" form (CMS Form number 20027). To get a copy, visit cms.gov/cmsforms/downloads/cms20027.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048. Send the completed form, or a copy, to the company that handles claims for Medicare listed on the MSN.

3. Submit a written request to the MAC. The company's address is listed on the MSN. Your request must include:

   — Your name and Medicare number.

   — The specific item(s) and/or service(s) for which you're requesting a redetermination and specific date(s) of service.

   — An explanation of why you don't agree with the initial determination.

   — Your signature. If you're appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 1.

Keep a copy of everything you send to Medicare as part of your appeal. You'll generally get a decision from the Medicare contractor (either in a letter or a MSN) within 60 days after they get your request. If Medicare covered the item(s) and/or service(s), it will be listed on your next MSN.

Words in red are defined on pages 59–62.

You can submit additional information or evidence to the MAC after the redetermination request has been filed, but it may take longer than 60 days for the MAC to make a decision. If you submit additional information or evidence after filing the request for redetermination, the contractor will get an extra 14 calendar days to make a decision for each submission.

If you disagree with the redetermination decision made by the MAC in level 1, you have 180 days after you get the "Medicare Redetermination Notice" to request a reconsideration by a Qualified Independent Contractor (QIC), which is level 2.

Level 2: Reconsideration by a Qualified Independent Contractor (QIC)

A QIC is an independent contractor that didn't take part in the level 1 decision. The QIC will review your request for a reconsideration and will make a decision.

How do I request a reconsideration?

Follow the directions on the "Medicare Redetermination Notice" you got in level 1 to file a request for reconsideration. You must send your request to the QIC that will handle your reconsideration. The QIC's address is listed on the redetermination notice. You can request a reconsideration in one of these ways:

1. Fill out a "Medicare Reconsideration Request" form (CMS Form number 20033), which is included with the "Medicare Redetermination Notice." You can also get a copy by visiting cms.gov/cmsforms/downloads/cms20033.pdf, or calling 1-800-MEDICARE (1-800-633-4227) and asking for a copy. TTY users can call 1-877-486-2048.

2. Submit a written request that includes:
   - Your name and Medicare number.
   - The specific item(s) or service(s) for which you're requesting a reconsideration and the specific date(s) of service. See your redetermination notice for this information.
   - The name of the company that made the redetermination (the company that handles claims for Medicare), which you can find on the MSN and on the redetermination notice.
   - An explanation of why you disagree with the redetermination decision.
   - Your signature. If you've appointed a representative, include the name and signature of your representative. For more information on appointing a representative, see Section 1.

No matter how you choose to request a reconsideration, the request should clearly explain why you disagree with the redetermination decision from level 1. Send a copy of the "Medicare Redetermination Notice" with your request for a reconsideration to the QIC. You should also include with your request any information that may help your case. You can submit additional information or evidence after the reconsideration request has been filed, but it may take longer for the QIC to make a decision. Keep a copy of everything you send to Medicare as part of your appeal.

In most cases, the QIC will send you a written response called a "Medicare Reconsideration Notice" about 60 days after the QIC gets your appeal request. If the QIC doesn't issue a timely decision, you may ask the QIC to move your case to the next level of appeal.

Note: Some IREs call themselves "Part C QICs."

Words in red are defined on pages 59–62.

If you disagree with the reconsideration decision in level 2, you have 60 days after you get the "Medicare Reconsideration Notice" to request a hearing by an Administrative Law Judge (ALJ), which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will independently review the facts of your appeal and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing, and the ALJ may also issue a decision without holding a hearing if evidence in the hearing record supports a decision that's fully in your favor.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required amount is $160. The "Medicare Reconsideration Notice" will include a statement that tells you if your case meets the minimum dollar amount. However, it's up to the ALJ to make the final decision. You may be able to combine claims to meet the minimum dollar amount.

How do I request a hearing with an ALJ?

Follow the directions on the "Medicare Reconsideration Notice" you got from the QIC in level 2 to request a hearing before an ALJ. You must send your request to the appropriate Office of Medicare Hearings and Appeals (OMHA) Central Operations. The address is listed in the QIC's reconsideration notice. You can file a request for a hearing in one of these ways:

1. Fill out a "Request for Medicare Hearing by an Administrative Law Judge" form (CMS Form Number 20034 A/B), which is included with the "Medicare Reconsideration Notice." You can also get a copy by visiting cms.gov/cmsforms/downloads/cms20034ab.pdf, or calling 1-800-MEDICARE (1-800-633-4227) and asking for a copy. TTY users can call 1-877-486-2048.

2. Submit a written request to the OMHA office that will handle your ALJ hearing that includes:
   - Your name, address, and Medicare number. If you've appointed a representative, include the name and address of your representative.
   - The appeal number included on the QIC reconsideration notice, if any.
   - The dates of service for the items or services you're appealing. See your MSN or reconsideration notice for this information.
   - An explanation of why you disagree with the reconsideration decision being appealed.
   - Any information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.

Keep a copy of everything you send to Medicare as part of your appeal. For more information about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If the ALJ doesn't issue a timely decision, you may ask the ALJ to move your case to the next level of appeal.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (Appeals Council), which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case regardless of the dollar amount of your case.

Words in red are defined on pages 59–62.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. You must send your request to the Appeals Council at the address listed in the ALJ's hearing decision. You can file a request for Appeals Council review in one of these ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.

2. Submit a written request to the Appeals Council that includes:
   - Your name and Medicare number. If you've appointed a representative, include the name of your representative.
   - The specific item(s) and/or service(s) and the specific dates of service you're appealing. See your MSN or your ALJ hearing decision for this information.
   - A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
   - The date of the ALJ decision.
   - Your signature. If you've appointed a representative, include the signature of your representative.
   - If you're requesting that your case be moved from the ALJ to the Appeals Council because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

Keep a copy of everything you send to Medicare as part of your appeal. For more information about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE.

If the Appeals Council doesn't issue a timely decision, you can ask the Appeals Council to move your case to the next level of appeal.

Words in red are defined on pages 59–62.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council, you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the minimum dollar amount is $1,560. You may be able to combine claims to meet this dollar amount.

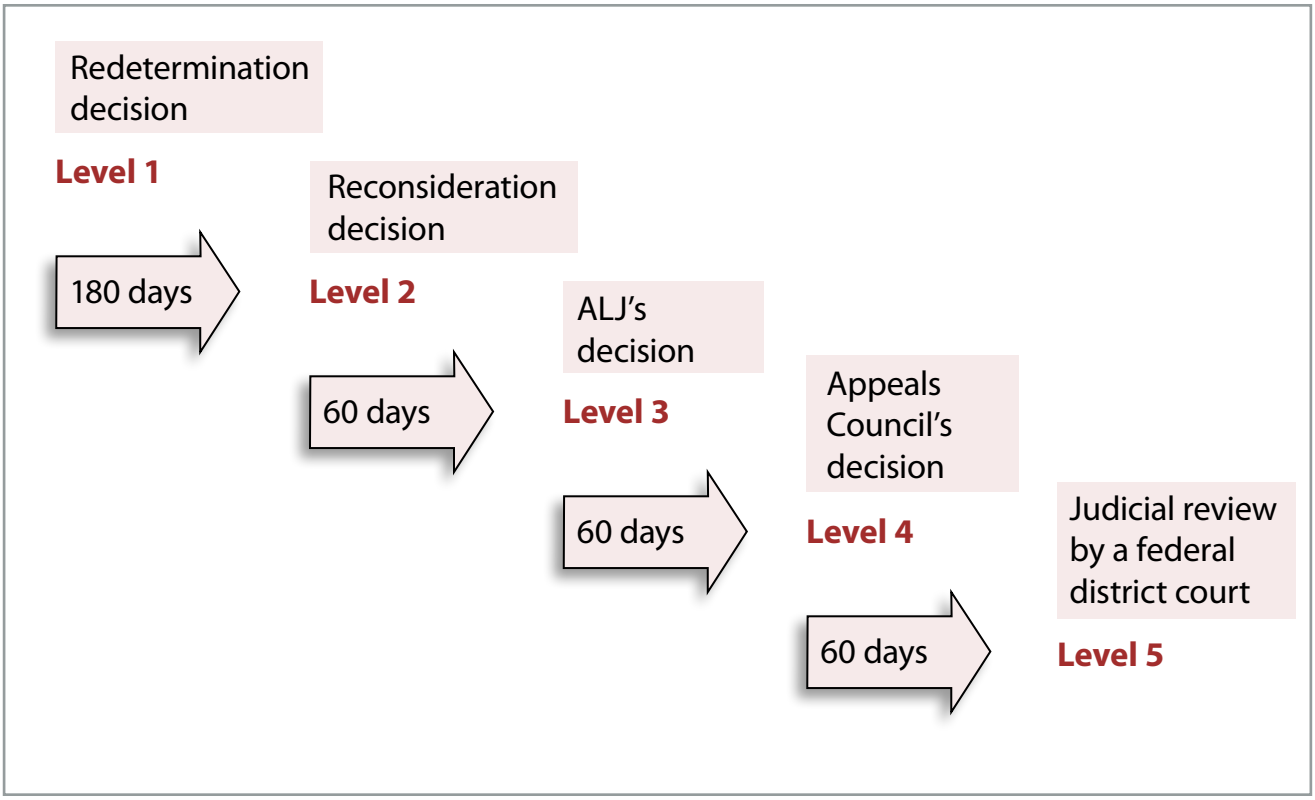
How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

For more information on the appeals process

- Visit Medicare.gov/appeals.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html for appeals forms.
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

How do I appeal if I have Original Medicare?



How do I get an expedited (fast) appeal in a hospital?

When you're admitted as an inpatient to a hospital, you have the right to get the hospital care that's necessary to diagnose and treat your illness or injury. If you think you're being discharged from the hospital too soon, you have the right to ask your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO) to review your case. To get the BFCC-QIO's phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Within 2 days of your admission, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). If you don't get this notice, ask for it. This notice lists the BFCC-QIO's contact information and explains:

- Your right to get all medically necessary hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and to know who will pay for them
- Your right to get the services you need after you leave the hospital
- Your right to appeal a discharge decision and the steps for appealing the decision
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital
- Information on your right to get a detailed notice about why your covered services are ending

If the hospital gives you the IM more than 2 days before your discharge day, it must either give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you're discharged.

How do I ask for a fast appeal?

You may have the right to ask the BFCC-QIO for a fast appeal. Follow the directions on the IM to request a fast appeal if you think your Medicare-covered hospital services are ending too soon. You must ask for a fast appeal no later than the day you're scheduled to be discharged from the hospital.

If you ask for your appeal within this timeframe, you can stay in the hospital without paying for your stay (except for applicable coinsurance or deductibles) while you wait to get the decision from the BFCC-QIO.

If you miss the deadline for a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply. For more information, contact the BFCC-QIO.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request within the fast appeal timeframe, it will notify the hospital. Then, the hospital will give you a "Detailed Notice of Discharge" by noon of the day after the BFCC-QIO notifies the hospital. The notice will include:

1. Why your services are no longer reasonable and necessary, or are no longer covered
2. The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
3. How the applicable coverage rule or policy applies to your specific situation

The BFCC-QIO will look at your medical information provided by the hospital and will also ask you for your opinion. The BFCC-QIO will decide if you're ready to be discharged within one day of getting the requested information.

If the BFCC-QIO decides that you're being discharged too soon, Medicare will continue to cover your hospital stay as long as medically necessary (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) until noon of the day after the BFCC-QIO gives you its decision. If you get any inpatient hospital services after noon of that day, you may have to pay for them.

If you have any questions about fast appeals in hospitals, call the BFCC-QIO at the phone number listed on the notice the hospital gives you. You can also visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I get an expedited (fast) appeal in a setting other than a hospital?

You have the right to a fast appeal if you think your Medicare-covered skilled nursing facility (SNF), home health agency (HHA), comprehensive outpatient rehabilitation facility (CORF), or hospice services are ending too soon.

While you're getting SNF, HHA, CORF, or hospice services, you should get a notice called the "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:

- The date that your covered services will end
- That you may have to pay for services you get after the coverage end date given on your notice
- Information on your right to get a detailed notice about why your covered services are ending
- Your right to a fast appeal and information on how to contact your BFCC-QIO to request a fast appeal

Words in red are defined on pages 59–62.

How do I ask for a fast appeal?

Ask the BFCC-QIO for a fast appeal no later than noon of the day after you get the "Notice of Medicare Non-Coverage." Follow the instructions on the notice to do this.

If you miss the deadline for requesting a fast appeal, you can still ask the BFCC-QIO to review your case, but different rules and timeframes apply. For more information, contact the BFCC-QIO. To get the BFCC-QIO's phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the provider. Then, by the end of the day that the provider gets the notice from the BFCC-QIO, the provider will give you a "Detailed Explanation of Non-Coverage." The notice will include:

- Why your Medicare services are no longer reasonable and necessary, or are no longer covered
- The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- How the applicable Medicare coverage rule or policy applies to your situation

If the BFCC-QIO decides that your services are ending too soon, Medicare may continue to cover your SNF, HHA, CORF, or hospice services (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that your services should end, you won't be responsible for paying for any SNF, HHA, CORF, or hospice services provided before the termination date on the "Notice of Medicare Non-Coverage." If you continue to get services after the coverage end date, you may have to pay for those services.

If you have questions about your rights regarding SNF, HHA, CORF, or hospice services, including appealing the BFCC-QIO's decision, getting notices, or learning about your rights after missing the filing deadline, call the BFCC-QIO at the phone number listed on the notice the provider gives you. You can also visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

What's an "Advance Beneficiary Notice of Noncoverage" (ABN)?

If you have Original Medicare and your doctor, other health care provider, or supplier thinks that Medicare probably (or certainly) won't pay for items or services, he or she may give you a written notice called an ABN. This notice is used by doctors, suppliers, and certain health care providers, like independent physical and occupational therapists, laboratories, and outpatient hospitals.

The ABN lists the items or services that Medicare isn't expected to pay for, an estimate of the costs for the items and services, and the reasons why Medicare may not pay. The ABN gives you information to make an informed choice about whether or not to get items or services, **understanding that you may have to accept responsibility for payment.**

You'll be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of these options:

- **Option 1**—You want the items or services that may not be paid for by Medicare. Your provider or supplier may ask you to pay for them now, but you also want them to submit a claim to Medicare for the items or services. If Medicare denies payment, you're responsible for paying, but since a claim was submitted, you can appeal to Medicare.
- **Option 2**—You want the items or services that may not be paid for by Medicare, but you don't want your provider or supplier to bill Medicare. You may be asked to pay for the items or services now, but because you request your provider or supplier to not submit a claim to Medicare, you can't file an appeal.

Words in red are defined on pages 59–62.

- **Option 3**—You don't want the items or services that may not be paid for by Medicare, and you aren't responsible for any payments. A claim isn't submitted to Medicare, and you can't file an appeal.

An ABN isn't an official denial of coverage by Medicare. If payment is denied when a claim is submitted, you have the right to file an appeal.

Other types of ABNs

1. **"Skilled Nursing Facility Advance Beneficiary Notice" (SNFABN)**

   A skilled nursing facility (SNF) will issue you a SNFABN if there's reason to believe that Medicare may not cover or continue to cover your care or stay because it isn't reasonable or necessary, or is considered custodial care.

   The SNFABN lets you know Medicare will likely no longer pay for your services. If you choose to get the services that may not be covered under Part A, you don't have to pay for these services until a claim is submitted and Medicare officially denies payment. However, while the claim is processed, you have to continue paying costs that you would normally have to pay, like the daily coinsurance and costs for services and supplies Medicare generally doesn't cover.

   The SNF may use the ABN and collect money from you now for Part B items or services. If Medicare pays, the SNF will refund any payments you made, except copayments or deductibles.

2. **"Hospital Issued Notice of Noncoverage" (HINN)**

   Hospitals use a HINN when all or part of your inpatient hospital care may not be covered by Medicare. This notice will tell you why the hospital thinks Medicare won't pay, and what you may have to pay if you keep getting these services.

Services & supplies Medicare generally doesn't cover

Doctors, other health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare generally doesn't cover, like:

- Dental services
- Hearing aids
- Routine eye exams
- Routine foot care

What notices are given by home health agencies?

Home health agencies are required to give people with Original Medicare written notices in these situations:

1. **"Home Health Change of Care Notice" (HHCCN)**

The HHCCN is a written notice that your home health agency should give you when your home health plan of care is changing because of one of these:

- The home health agency makes a business decision to reduce or stop giving you some or all of your home health services or supplies.
- Your doctor changed your orders, which may reduce or stop giving you certain home health services or supplies.

The HHCCN lists the services or supplies that will be changed, and it gives you instructions on what you can do if you don't agree with the change.

The home health agency isn't required to give you a HHCCN when the "Notice of Medicare Non-Coverage" (NOMNC) is issued. See page 28 for more information.

Words in red are defined on pages 59–62.

2. **"Advance Beneficiary Notice of Noncoverage" (ABN)**

When the home health agency believes that Medicare may not pay for certain home health items and services or all of your home health care, the agency should give you an ABN. See page 25 for more information on ABNs.

Home health agencies are required to give you an ABN if care is reduced or terminated, or before you get any items or services that may not be paid for by Medicare because of any of these reasons:

- They're not considered medically reasonable and necessary.
- The care is custodial.
- You aren't confined to your home.
- You don't need intermittent skilled nursing care.

Note: "The Home Health Advance Beneficiary Notice" (HHABN) has been discontinued. It was replaced by the HHCCN and the ABN in 2013.

3. **"Notice of Medicare Non-Coverage" (NOMNC)**

Your home health agency will give you a NOMNC when all of your Medicare-covered services are ending. This notice will tell you when the services will end and how to appeal if you think the services are ending too soon. The NOMNC tells you how to contact your BFCC-QIO to ask for a fast appeal. If you don't get this notice, ask for it.

If you decide to ask for a fast appeal, you should call the BFCC-QIO within the timeframe listed on the notice. After you request a fast appeal, you'll get a second notice with more information about why your care is ending. The BFCC-QIO may ask you questions about your care. To help your case, ask your doctor for information, which you can submit to the BFCC-QIO.

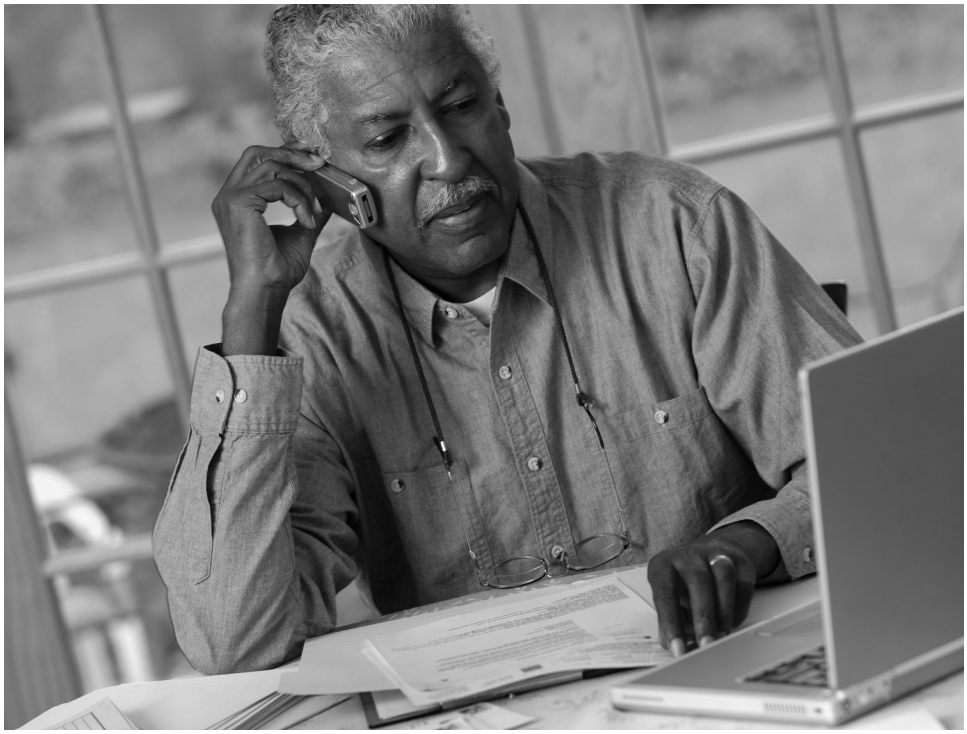
4. **"Detailed Explanation of Non-Coverage" (DENC)**

Your home health agency will give you a DENC when it's informed by the BFCC-QIO that you've requested a BFCC-QIO review of your case. The DENC will explain why your home health agency believes that Medicare will no longer pay for your home health care.

Words in red are defined on pages 59–62.

2

How do I appeal if I have Original Medicare?



Section 3: How do I appeal if I have a Medicare Advantage Plan or other Medicare health plan?

3

Medicare Advantage Plans (like HMOs or PPOs) 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 other Medicare health plan, you're still in the Medicare Program. Your Medicare Advantage Plan or other Medicare health plan will send you information that explains your rights. Call your plan if you have questions.

Medicare Cost Plans are types of HMOs that are available in certain areas of the country. You may be covered by a Medicare Cost Plan, even if you only have Part B. If you have a Medicare Cost Plan and go to a non-network provider, the services are covered under Original Medicare. You can either get your Medicare prescription drug coverage from the Cost Plan (if offered), or you can buy a Medicare Prescription Drug Plan to add prescription drug coverage. If you have a Medicare Cost Plan and want to appeal services you got outside of the plan's network, you'll need to follow the Original Medicare appeals process. See Section 2.

If you're in a PACE (Program of All-inclusive Care for the Elderly) program, your appeal rights are different. The PACE organization will provide you with written information about your appeal rights.

Words in red are defined on pages 59–62.

If you have a Medicare Advantage Plan or other Medicare health plan, you have the right to request an appeal to resolve differences with your plan. You have the right to ask your plan to provide or pay for items or services you think should be covered, provided, or continued.

If you decide to appeal, ask your doctor, other health care provider, or supplier for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

What's the appeals process for Medicare Advantage Plans or other Medicare health plans?

Request an organization determination

You have the right to ask your plan to provide or pay for items or services you think should be covered, provided, or continued. This is called an "organization determination." You, your representative, or your doctor can request an organization determination from your plan in advance to make sure that the services are covered or after payment of the services is denied.

If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask your 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 waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

If the plan won't cover the items or services you asked for, you'll get a notice explaining why your plan fully or partially denied your request and instructions on how to appeal your plan's decision by requesting a reconsideration. 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. Your plan may charge you for this copy.

If you disagree with your plan's initial decision (also known as the organization determination), you can file an appeal. The appeals process has 5 levels:

Level 1: Reconsideration from your plan

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

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions on how to move to the next level of appeal.

Words in red are defined on pages 59–62.

Level 1: Reconsideration from your plan

If you disagree with your plan's initial decision (also known as the organization determination), you or your representative can request a reconsideration (a second look or review). If your appeal is for a service you haven't gotten yet, your doctor can request a reconsideration on your behalf and must notify you about it.

You must request the reconsideration within 60 days of the date of the notice of the organization determination.

How do I request a reconsideration?

You, your representative, or your doctor must file a written standard or expedited (fast) request unless your plan allows you to file a request over the phone, by fax, or by email. You can find your plan's address in your plan materials and on the organization determination notice.

Follow the directions in the "Notice of Denial of Medical Coverage" or the "Notice of Denial of Payment" you got with your unfavorable decision to request a reconsideration from your plan. Your written reconsideration request should include:

- Your name, address, and Medicare number.
- The items or services for which you're requesting a reconsideration, the dates of service, and the reason(s) why you're appealing.
- If you've appointed a representative, include the name of your representative and proof of representation. For more information on appointing a representative, see Section 1.

You should also include any other information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

Your plan must respond to your request for an appeal within these timeframes:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

Your request will be a fast request if your plan determines, or your doctor tells your plan, that waiting for a standard service decision may seriously jeopardize your life, health, or ability to regain maximum function.

The timeframe for completing standard service and fast service requests may be extended by up to 14 days. The timeframe may be extended if, for example, your plan needs more information from a non-contract provider to make a decision about the case and the extension is in your best interest. Your plan will notify you in writing if it decided to take an extension. Your plan will notify you of the reasons for the delay and inform you of your right to file an expedited (fast) grievance if you disagree with the plan's decision to take an extension.

If the plan decides against you (fully or partially), your appeal is automatically sent to an Independent Review Entity (IRE), which is level 2.

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

You'll get a written notice from your plan about all appeal decisions. If your plan decides against you, your appeal is automatically sent to level 2. If this happens, the notice from your plan will give you the specific reason(s) for any full or partial denial.

You may send the IRE information about your case. They must get this information within 10 days after the date you get the notice telling you your case file has been sent to the IRE. The IRE's address is on the notice.

Generally, the IRE will send you its decision in a written "Reconsideration Determination" within these timeframes:

- Expedited (fast) request—72 hours
- Standard service request—30 days
- Payment request—60 days

You'll get a fast decision if the IRE determines that your life or health may be at risk by waiting for a standard decision.

Note: Some IREs call themselves "Part D QICs."

If you disagree with the IRE's decision in level 2, you have 60 days from the date of the IRE's decision to request an Administrative Law Judge (ALJ) hearing, which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will review the facts of your appeal independently before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing.

Words in red are defined on pages 59–62.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum amount is $160. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount.

How do I request a hearing?

Follow the directions in the IRE's reconsidered determination to ask for a hearing before an ALJ, or submit a written request with the information listed below within 60 days of the IRE's reconsidered determination. Note that if any of the required information is missing from your request, it can cause delays in the processing of your appeal. Your written request must include:

- Your name, address, and Medicare number. If you've appointed a representative, include the name and address of your representative.
- The document control number assigned by the IRE, if any.
- The dates of service for the items or services you're appealing.
- An explanation of why you disagree with the IRE's reconsideration or other determination being appealed.
- Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.

Keep a copy of everything you send to your plan as part of your appeal. To request an ALJ hearing, follow the instructions in the IRE's reconsideration decision. Your request for an ALJ hearing must be filed with the IRE and the IRE will forward your request and the case file to the ALJ. To learn more about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call your plan.

If the ALJ decides in your favor, the plan has the right to appeal this decision by asking the Medicare Appeals Council (Appeals Council) for a review.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Appeals Council, which is level 4.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. You must send your request to the Appeals Council at the address listed in the ALJ's hearing decision. You can file a request for Appeals Council review in one of these ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call your plan or 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.

2. Submit a written request to the Appeals Council that includes:
   - Your name and Medicare number. If you've appointed a representative, include the name of your representative.

- The specific item(s) and/or service(s) you're appealing and the specific dates of service. See your reconsideration or ALJ hearing decision for this information.
- A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
- The date of the ALJ decision.
- Your signature. If you've appointed a representative, include the signature of your representative.
- If you're requesting that your case be moved from the ALJ to the Appeals Council because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

Keep a copy of everything you send to your plan as part of your appeal. For more information about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If the Appeals Council doesn't issue a timely decision, you can ask the Appeals Council to move your case to the next level of appeal.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.

Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council (or if the Appeals Council denied your request for review), you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum claim amount is $1,560. You may be able to combine claims to meet this dollar amount.

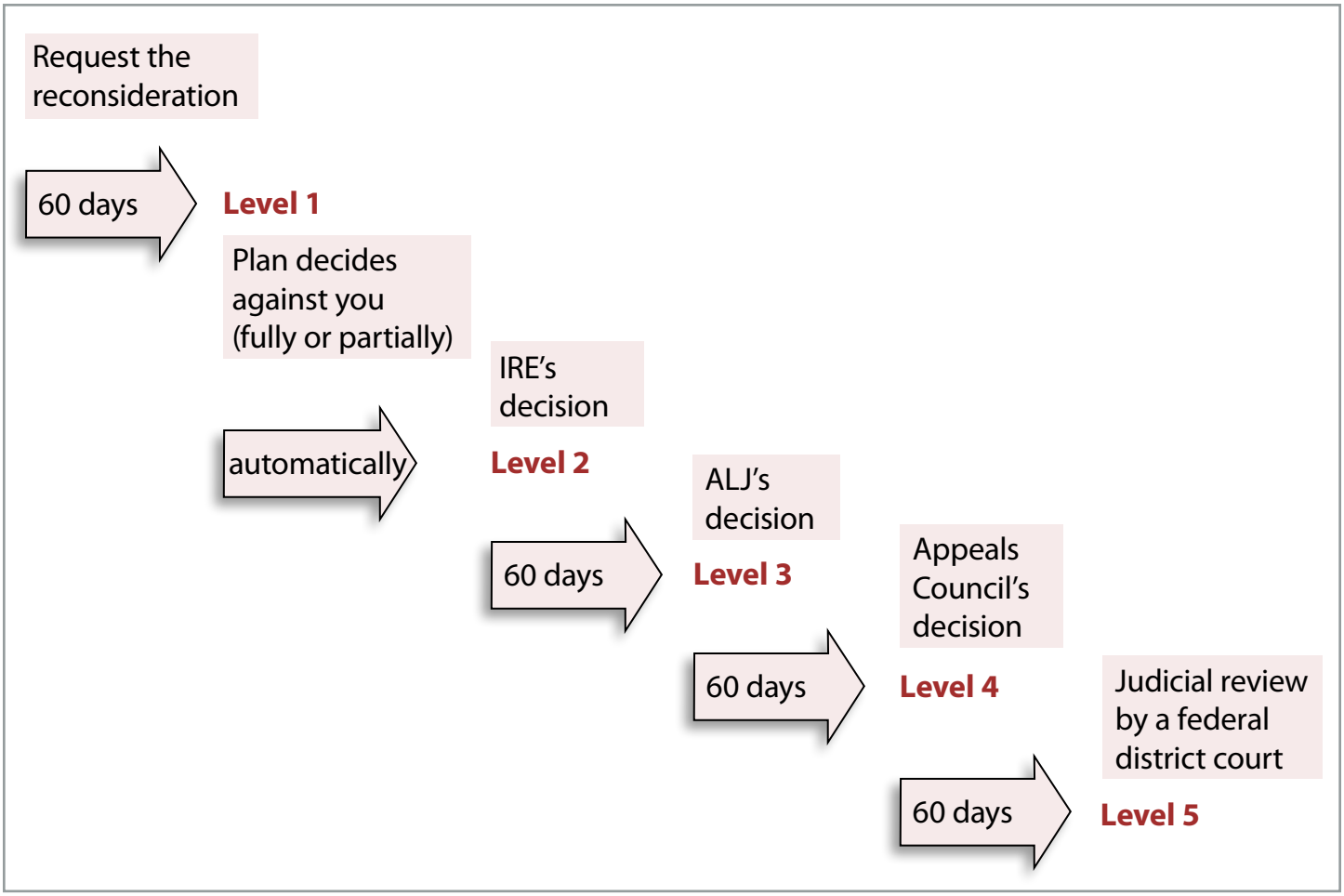
Words in red are defined on pages 59–62.

How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court.

For more information on the appeals process

- Visit Medicare.gov/appeals.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html for appeal forms.
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.



How do I get an expedited (fast) appeal in a hospital?

When you're admitted as an inpatient to a hospital, you have the right to get the hospital care that's necessary to diagnose and treat your illness or injury. If you think you're being discharged from the hospital too soon, you have the right to ask your Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to review your case. To get the BFCC-QIO's phone number, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

During your hospital stay, you should get a notice called "An Important Message from Medicare about Your Rights" (sometimes called the "Important Message from Medicare" or the "IM"). If you don't get this notice, ask for it. This notice lists the BFCC-QIO's contact information and explains:

Words in red are defined on pages 59–62.

- Your right to get all medically necessary hospital services
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services, and who will pay for them
- Your right to get services you need after you leave the hospital
- Your right to appeal a discharge decision and the steps for appealing the decision
- The circumstances under which you will or won't have to pay for charges for continuing to stay in the hospital
- Information on your right to get a detailed notice about why your covered services are ending

You should get the IM within 2 days of your hospital admission. If the hospital gives you the notice more than 2 days before your discharge day, it must either give you a copy of your original, signed IM or provide you with a new one (that you must sign) before you're discharged.

How do I ask for a fast appeal?

You have the right to a fast appeal if you think you're being discharged too soon. Ask the BFCC-QIO for a fast appeal. Follow the directions on the IM to do this. You must ask for a fast appeal no later than the day you're being discharged from the hospital.

If you meet this deadline, you can stay in the hospital after your discharge date without paying for it (except for applicable coinsurance or deductibles) while you wait to get the decision from the BFCC-QIO.

Words in red are defined on pages 59–62.

If you miss the deadline for a fast appeal, you can request an expedited (fast) reconsideration from your plan, but your Medicare health plan will only cover hospital services if there's a decision issued in your favor.

To ask for a fast appeal, contact your State Health Insurance Assistance Program (SHIP). To get the phone number for your SHIP, visit shiptacenter.org, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the plan and the hospital. Once your plan and the hospital are notified by the BFCC-QIO, you plan or the hospital will provide you a "Detailed Notice of Discharge" by noon on that day that includes:

- Why your services are no longer reasonable and necessary, or are no longer covered
- The applicable Medicare coverage rule or policy, including a citation to the applicable Medicare policy, or information on how you can get a copy of the policy
- How the applicable coverage rule or policy applies to your specific situation

You can also ask your plan for copies of any of the materials that your plan sent to the BFCC-QIO about your hospital discharge. The BFCC-QIO will look at your medical information provided by the plan and the hospital and will also ask you for your opinion. Within one day of getting that information, the BFCC-QIO will decide if you're ready to be discharged.

If the BFCC-QIO decides that you're being discharged too soon, the plan will continue to provide for your Medicare-covered hospital stay as long as medically necessary (except for applicable coinsurance or deductibles) if your plan previously authorized coverage of the inpatient admission or the inpatient admission was for emergency or urgently needed care. If your plan never authorized the inpatient admission and it wasn't for emergency or urgently needed care, you may need to appeal the denial of coverage for your plan to pay.

If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the hospital charges (except for applicable coinsurance or deductibles) incurred through noon of the day after the BFCC-QIO gives you its decision. If you get any inpatient hospital services after noon on the day that the BFCC-QIO gives you its decision, you might have to pay for them.

If you have any questions about fast appeals in hospitals, you can call the BFCC-QIO at the phone number listed on the notice the hospital gives you. You can also visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I get an expedited (fast) appeal in a setting other than a hospital?

You have the right to a fast appeal if you think your services from a Medicare-covered skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF) are ending too soon. During a fast appeal, the BFCC-QIO looks at your case and decides if your health care services need to continue.

While you're getting SNF, HHA, or CORF services, you should get a notice called "Notice of Medicare Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains:

- The date that your covered services will end
- That you may have to pay for services you got after the coverage end date indicated on your notice
- Information on your right to get a detailed notice about why your covered services are ending
- Your right to a fast appeal and information on how to contact your BFCC-QIO to request a fast appeal

How do I ask for a fast appeal?

Ask the BFCC-QIO for a fast appeal no later than noon of the first day after the day you get the "Notice of Medicare Non-Coverage." Follow the instructions on the termination notice.

If you miss the deadline for requesting a fast appeal from the BFCC-QIO, you can request an expedited (fast) reconsideration from your plan, but services will only be covered if there's a decision issued in your favor.

Words in red are defined on pages 59–62.

What will happen during the BFCC-QIO's review?

When the BFCC-QIO gets your request, it will notify the plan and the provider. You'll get a "Detailed Explanation of Non-Coverage" by the end of the day. The notice will include:

- Why your plan intends to stop covering your services
- The applicable Medicare coverage rule or policy, including citation to the applicable Medicare policy, or information on how you can get a copy of the policy your plan is using to explain why your coverage is ending
- Any applicable plan policy, contract provision, or reason on which your discharge decision was based

The BFCC-QIO will:

- Ask you why you believe coverage for the services should continue.
- Look at your medical records and the information provided by the plan.
- Make a decision by close of business the day after it gets the information it needs to make a decision.

If the BFCC-QIO decides that your services are ending too soon, your plan will continue to provide for your Medicare-covered SNF, HHA, or CORF services (except for applicable coinsurance or deductibles).

If the BFCC-QIO decides that your services should end, you won't be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the "Notice of Medicare Non-Coverage." If you continue to get services after the coverage end date, you may have to pay for those services.

If you have questions about your rights regarding SNF, HHA, or CORF services, including appealing the BFCC-QIO's decision, getting notices, or learning about your additional appeal rights after missing the filing deadline, call the BFCC-QIO at the phone number listed on the notice the provider gives you, or call your health plan (their phone number is in your plan materials). You can also visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227) to get the BFCC-QIO's phone number. TTY users can call 1-877-486-2048.

How do I file a grievance?

If you have concerns or problems with your Medicare Advantage Plan or other Medicare health plan that don't involve requests to provide or pay for items or services, you can file a "grievance."

- If your complaint involves the quality of care you got or are getting, you can file a grievance with your plan and/or your BFCC-QIO. For the phone number of the BFCC-QIO, visit Medicare.gov/contacts, or call 1-800-MEDICARE.

- You may file a grievance with your Medicare health plan if:
  - 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.
  - 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 33.
  - The plan didn't send your case to the IRE. See level 2 on page 34.
  - You disagree with the plan's decision not to grant your request for a fast appeal or you disagree with the plan's decision to extend the timeframe for making its decision.
  - The plan didn't provide the required notices.
  - The plan's notices don't follow Medicare rules.

When you join a Medicare Advantage Plan or other Medicare health plan, the plan will send you information about how to file grievances 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.

Section 4: How do I appeal if I have Medicare prescription drug coverage?

4

If you have Medicare prescription drug coverage through a Medicare Prescription Drug Plan (PDP), a Medicare Advantage Plan with prescription drug coverage (MA-PD), or other Medicare plan, your plan will send you information that explains your rights (called an "Evidence of Coverage"). Call your plan if you have questions about your "Evidence of Coverage."

You have the right to ask your plan to provide or pay for a drug you think should be covered, provided, or continued. You have the right to request an appeal if you disagree with your plan's decision about whether to provide or pay for a drug.

If you decide to appeal, ask your doctor or other health care provider for any information that may help your case. Keep a copy of everything you send to your plan as part of your appeal.

What if my plan won't cover a drug I think I need?

If your pharmacist tells you that your Medicare drug plan won't cover a drug you think should be covered, or it will cover the drug at a higher cost than you think you should have to pay, you have these options:

1. **Talk to your prescriber.**

   Ask your prescriber if you meet prior authorization or step therapy requirements. For more information on these requirements, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. You can also ask your prescriber if there are generic, over-the-counter, or less expensive brand-name drugs that could work just as well as the ones you're taking now.

Words in red are defined on pages 59–62.

2. **Request a coverage determination (including an "exception").**

   You, your representative, your doctor, or other prescriber can request (orally or in writing) that your plan cover the prescription you need. You can request a coverage determination if your pharmacist or plan tells you one of these:

   — A drug you believe should be covered isn't covered.

   — A drug is covered at a higher cost than you think you should have to pay.

   — You have to meet a plan coverage rule (like prior authorization) before you can get the drug you requested.

   — It won't cover a drug on the formulary because the plan believes you don't need the drug.

You, your representative, your doctor, or other prescriber can request a coverage determination called an "exception" if:

— You think your plan should cover a drug that's not on its formulary because the other treatment options on your plan's formulary won't work for you.

— Your doctor or other prescriber believes you can't meet one of your plan's coverage rules, like prior authorization, step therapy, or quantity or dosage limits.

— You think your plan should charge a lower amount for a drug you're taking on the plan's non-preferred drug tier because the other treatment options in your plan's preferred drug tier won't work for you.

If you request an exception, your doctor or other prescriber will need to give a supporting statement to your plan explaining why you need the drug you're requesting. Check with your plan to find out if the supporting statement is required to be made in writing. The plan's decision-making time period begins once your plan gets the supporting statement.

You can either request a coverage determination before you pay for or get your prescriptions, or you can decide to pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination. Check the "Evidence of Coverage" you get from your plan for more information on getting reimbursed for out-of-pocket costs.

You can file a standard request for any coverage determination, or if you haven't already paid for the drug yourself, you can file an expedited (fast) request. See timeframes below.

How do I file a standard coverage determination?

You, your representative, your doctor, or other prescriber can request a coverage determination (including an exception) by following the instructions that your plan sends you. Once your plan has gotten your request, it has 72 hours to notify you of its decision with respect to requests for drug benefits, and 14 calendar days for requests for payment.

You can call your plan, write them a letter, or send them a completed "Model Coverage Determination Request" form to ask your plan for a coverage determination or exception. This form is available at cms.gov/medprescriptdrugapplgriev/13_forms.asp, or call your plan and ask for a copy. Your plan must accept any written request for a coverage determination from you, your representative, your doctor, or your other prescriber.

How do I file an expedited (fast) coverage determination?

You, your representative, your doctor, or other prescriber can call or write your plan to request that a fast decision be made within 24 hours of your request. You'll get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that waiting 72 hours for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you've already paid for and gotten the drug.

Words in red are defined on pages 59–62.

You can call your plan, write them a letter, or send them a completed "Model Coverage Determination Request" form to ask your plan for a fast coverage determination or exception. This form is available at cms.gov/medprescriptdrugapplgriev/13_forms.asp, or call your plan and ask for a copy.

What if I disagree with the decision?

Your Medicare drug plan will send you a written decision. If you disagree with this decision, you have the right to appeal.

What's the appeals process for Medicare prescription drug coverage?

The appeals process has 5 levels:

Level 1: Redetermination from your plan

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

Level 3: Hearing before an Administrative Law Judge (ALJ)

Level 4: Review by the Medicare Appeals Council (Appeals Council)

Level 5: Judicial review by a federal district court

If you disagree with the decision made at any level of the process, you can generally go to the next level. At each level, you'll get instructions on how to move to the next level of appeal.

Level 1: Redetermination from your plan

If you disagree with your plan's initial denial (coverage determination), you can request a redetermination.

You must request the redetermination within 60 days from the date of the coverage determination.

How do I request a redetermination?

Follow the directions in the plan's initial denial notice and plan materials. You, your representative, your doctor, or other prescriber can request a standard or expedited (fast) redetermination.
You can't request a fast redetermination if it's an appeal about payment for a drug you already got. Standard requests must be made in writing, unless your plan allows you to file a standard request orally, like by phone. You'll get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

Your plan must accept any written request for a redetermination from you, your representative, your doctor, or other prescriber.
A written request to appeal should include:

- Your name, address, and Medicare number or member number.
- The name of the drug you want your plan to cover.
- Reason(s) why you're appealing.
- If you've appointed a representative, include the name of your representative and proof of representation. For more information on appointing a representative, see Section 1.

Send your request along with any other information that may help your case, including medical records. Your plan's address and phone number is in your plan materials and will also be in any written plan decision you get.

Your plan will respond in a "Redetermination Notice" within these timeframes:

- Expedited (fast) redetermination decision—as quickly as your health condition requires, but no later than 72 hours
- Standard redetermination decision—7 days

If you disagree with the plan's redetermination decision in level 1, you can request a reconsideration by an Independent Review Entity (IRE), which is level 2, within 60 days from the date of the redetermination decision.

Words in red are defined on pages 59–62.

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

If your Medicare drug plan decides against you in level 1, it will send you a written decision. If you disagree with the plan's redetermination, you, your representative, or your doctor or other prescriber can request a standard or expedited (fast) reconsideration by an IRE. You can't request a fast redetermination if it's an appeal about payment for a drug you already got.

How do I request a reconsideration?

To request a reconsideration by an IRE, follow the directions in the plan's "Redetermination Notice." If your plan issues an unfavorable redetermination, it should also send you a "Request for Reconsideration" form that you can use to ask for a reconsideration. If you don't get this form, call your plan and ask for a copy. This form is also available at cms.gov/medprescriptdrugapplgriev/13_forms.asp.

Send your request to the IRE at the address or fax number listed in the plan's redetermination decision letter that's mailed to you. You'll get a fast reconsideration decision if the IRE determines, or your prescriber tells the IRE, that waiting for a standard decision may seriously jeopardize your life, health, or ability to regain maximum function.

Once the IRE gets the request for review, it will send you its decision in a "Reconsideration Notice" within these timeframes:

- Expedited (fast) reconsideration decision—as quickly as your health condition requires, but no later than 72 hours
- Standard reconsideration decision—7 days

Note: Some IREs call themselves "Part D QICs."

If you disagree with the IRE's decision in level 2, you have 60 days after you receive the IRE's decision to request an Administrative Law Judge (ALJ) hearing, which is level 3.

Level 3: Hearing before an Administrative Law Judge (ALJ)

A hearing before an ALJ allows you to present your appeal to a new person who will review the facts of your appeal independently and listen to your testimony before making a new and impartial decision. An ALJ hearing is usually held by phone or video-teleconference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing, and the ALJ may also issue a decision without holding a hearing if the evidence in the hearing record supports a decision that's fully in your favor.

At the ALJ hearing, you'll have the chance to explain why your Medicare drug plan should cover your drug or pay you back. You can also ask your doctor or other prescriber to join the hearing and explain why he or she believes the drug should be covered.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2017, the required minimum amount is $160. The ALJ will decide if your case meets the minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount.

Words in red are defined on pages 59–62.

How do I request a hearing?

Follow the directions on the IRE's reconsideration notice to request an ALJ hearing. Your request must be sent to the Office of Medicare Hearings and Appeals (OMHA) address listed in the IRE's reconsideration notice. Only you or your representative can file a request in one of these ways:

1. Fill out a "Request for Hearing by an Administrative Law Judge" form (CMS Form number 20034 A/B). To get a copy visit cms.gov/cmsforms/downloads/cms20034ab.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.

2. Submit a written request to the OMHA office. Your letter must include:
   - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name, address, and phone number of your representative.
   - The appeal case number included on the reconsideration notice.
   - The prescription drug in dispute. See your redetermination or reconsideration notice for this information.
   - The reason why you disagree with the reconsideration decision.
   - Any other information that may help your case. If you can't include this information with your request, include a statement explaining what you plan to submit and when you'll submit it.
   - If you're requesting an expedited (fast) decision, include a statement that indicates this.

3. If you're requesting an expedited (fast) hearing, you can make an oral request. Follow the instructions in the IRE's decision notice to do this. The ALJ will give you a fast decision if your doctor or other prescriber indicates, or the ALJ determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you already got the drug.

Once the ALJ gets the request for review, you'll get a decision. If you request an expedited (fast) ALJ decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day your request for hearing is received by the appropriate OMHA field office, unless that time period is extended.

To learn more about the ALJ hearing process, visit hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's decision to request a review by the Medicare Appeals Council (Appeals Council), which is level 4.

Words in red are defined on pages 59–62.

Level 4: Review by the Medicare Appeals Council (Appeals Council)

You can request that the Appeals Council review your case, regardless of the dollar amount of your case.

How do I request a review?

To request that the Appeals Council review the ALJ's decision in your case, follow the directions in the ALJ's hearing decision you got in level 3. Your request must be sent to the Appeals Council at the address listed in the ALJ's hearing decision. You or your representative can file a request for Appeals Council review in one of these ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101). To get a copy, visit hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a copy. TTY users can call 1-877-486-2048.
2. Submit a written request to the Appeals Council that includes:
   - Your name, address, phone number, Medicare number, and the name of your Medicare Prescription Drug Plan. If you've appointed a representative, include the name and address of your representative.
   - The prescription drug in dispute. See your IRE reconsideration notice or your ALJ hearing decision for this information.
   - A statement identifying the parts of the ALJ's decision with which you disagree and an explanation of why you disagree.
   - The ALJ appeal case number.

— If you're requesting an expedited (fast) decision, include a statement that indicates this.

— Your signature. If you've appointed a representative, include the signature of your representative.

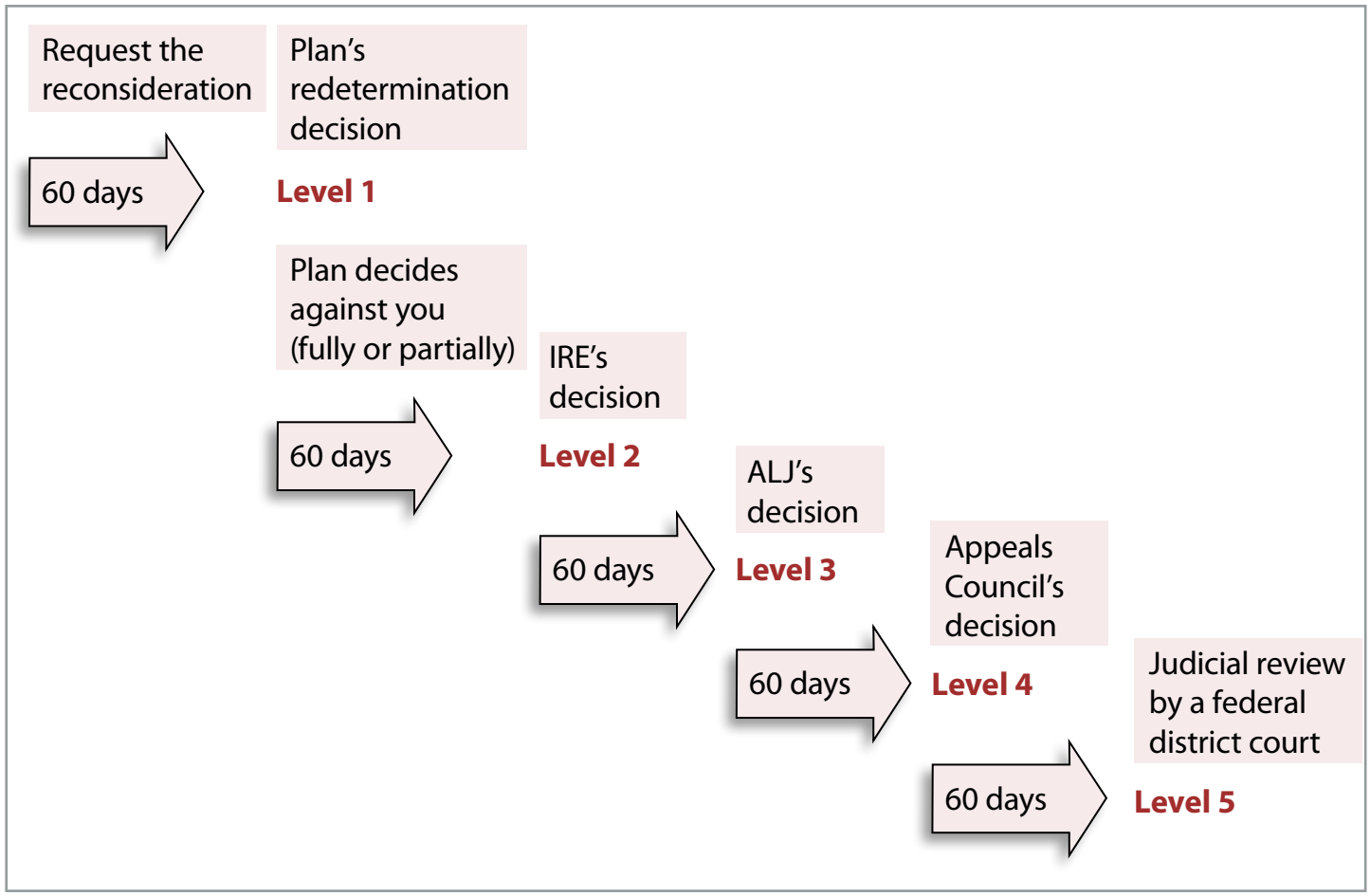
3. If you're requesting an expedited (fast) review, you can make an oral request. Follow the instructions in the ALJ's decision notice to do this. The Appeals Council will give you a fast decision if your doctor or other prescriber indicates, or the Appeals Council determines, that waiting 90 days for a decision may seriously jeopardize your life, health, or ability to regain maximum function. You can't request (and won't get) a fast decision if you already got the drug.

Once the Appeals Council gets the request for review, you'll get a decision. Expedited (fast) Appeals Council decision, you'll get a decision as quickly as your health condition requires, but generally no later than 10 days beginning on the day the Appeals Council receives the request for review, unless that time period is extended.

To learn more about the Appeals Council review process, visit hhs.gov/dab and select "Medicare Appeals Council." If you need help filing a request for Appeals Council review, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Words in red are defined on pages 59–62.

If you disagree with the Appeals Council's decision in level 4, you have 60 days after you get the Appeals Council's decision to request judicial review by a federal district court, which is level 5.



Level 5: Judicial review by a federal district court

If you disagree with the decision issued by the Appeals Council, you can request judicial review in federal district court. To get a review, the amount of your case must meet a minimum dollar amount. For 2017, the minimum dollar amount is $1,560. You may be able to combine claims to meet this dollar amount.

How do I request a review?

Follow the directions in the Appeals Council's decision letter you got in level 4 to file a complaint in federal district court. You should check with the clerk's office of the federal district court for instructions about how to file the appeal. The court location is on the Appeals Council's decision notice.

Words in red are defined on pages 59–62.

For more information on the appeals process:

- Visit Medicare.gov/appeals.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
- Visit Medicare.gov/claims-and-appeals/file-an-appeal/appeals-forms.html.
- Call your State Health Insurance Assistance Program (SHIP) for free, personalized health insurance counseling, including help with appeals. To get the phone number for the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

How do I file a grievance or complaint?

If you have a concern or a problem with your plan that isn't a request for coverage or reimbursement for a drug, you have the right to file a complaint (also called a "grievance").

Some examples of why you might file a complaint include:

- You believe your plan's customer service hours of operation should be different.
- You have to wait too long for your prescription.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to the drug plan.
- The plan didn't make a timely decision about a coverage determination in level 1 and didn't send your case to the IRE.
- You disagree with the plan's decision not to grant your request for an expedited (fast) coverage determination or first-level appeal (called a "redetermination").
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.

If your complaint involves the quality of care you got or are getting, you can file a grievance with your plan and/or your Beneficiary and Family Centered Quality Improvement Organization (BFCC-QIO). For the phone number of your BFCC-QIO, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

If you want to file a complaint:

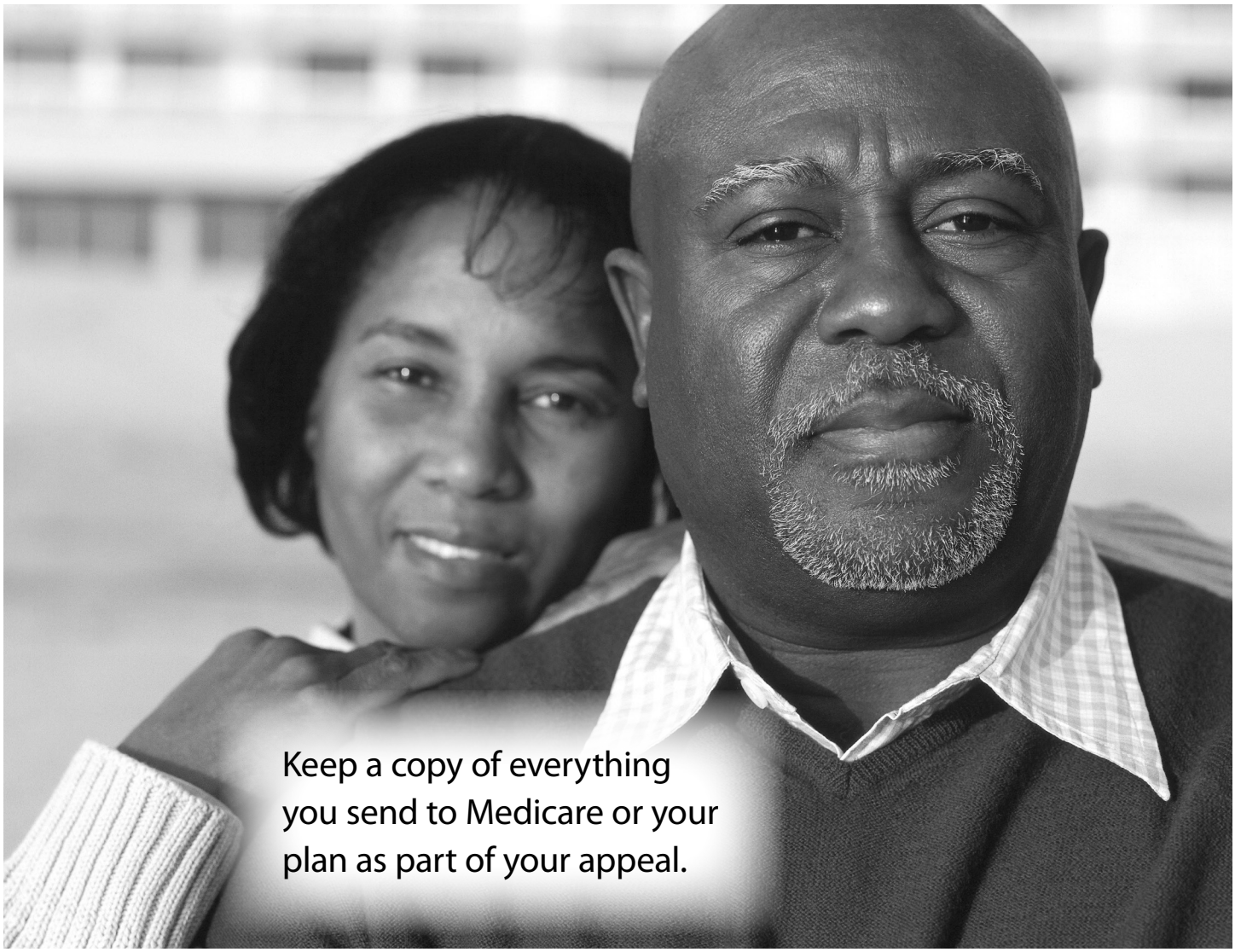
- You must file your complaint within 60 days from the date of the event that led to the complaint.
- You can file your complaint with the plan over the phone or in writing.
- You must be notified of the plan's decision generally no later than 30 days after the plan gets the complaint.
- If the complaint relates to a plan's refusal to make an expedited (fast) coverage determination or redetermination and you haven't yet purchased or received the drug, the plan must notify you of its decision within 24 hours after it gets the complaint.

If the plan doesn't address your complaint, call 1-800-MEDICARE.

More information on filing a complaint

- Visit Medicare.gov/appeals.
- Call your SHIP for free, personalized counseling and help filing a complaint. To get the phone number of the SHIP in your state, visit shiptacenter.org, or call 1-800-MEDICARE.

4 How do I appeal if I have Medicare prescription drug coverage?



Appeal—An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan. You can appeal if Medicare or your plan denies one of these:

- Your request for a health care service, supply, item, or prescription drug that you think you should be able to get
- Your request for payment for a health care service, supply, item, or prescription drug you already got
- Your request to change the amount you must pay for a health care service, supply, item or prescription drug

You can also appeal if Medicare or your plan stops providing or paying for all or part of a health care service, supply, item, or prescription drug you think you still need.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)—A type of QIO (a group of doctors and other health care experts under contract with Medicare) that uses doctors and other health care experts to review complaints and quality of care for people with Medicare. The BFCC-QIO makes sure there is consistency in the case review process while taking into consideration local factors and local needs, including general quality of care and medical necessity.

Claim—A request for payment that you submit to Medicare or other health insurance when you receive items and services that you think are covered.

Coinsurance—An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Comprehensive outpatient rehabilitation facility (CORF)—A facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation.

Copayment—An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Custodial care—Nonskilled personal care, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. In most cases, Medicare doesn't pay for custodial care.

Deductible—The amount you must pay for health care or prescriptions, before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Formulary—A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Grievance—A complaint about the way your Medicare health plan or Medicare drug plan is giving care. For example, you may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person at the plan has behaved towards you. However, if you have a complaint about a plan's refusal to cover a service, supply, or prescription, you file an appeal.

Health care provider—A person or organization that is licensed to give health care. Doctors, nurses, and hospitals are examples of health care providers.

Home health agency (HHA)—An organization that provides home health care.

Hospice—A special way of caring for people who are terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Medically necessary—Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Advantage Plan (Part C)—A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare health plan—Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans that can be offered by public or private entities and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part A (Hospital Insurance)—Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)—Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Prescription Drug Plan (Part D)—Part D adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Medicare Summary Notice (MSN)—A notice you get after the doctor, other health care provider, or supplier files a claim for Part A or Part B services in Original Medicare. It explains what the doctor, other health care provider, or supplier billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Original Medicare—Original Medicare is a fee-for-service health plan that has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Skilled nursing facility (SNF)—A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

State Health Insurance Assistance Program (SHIP)—A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Supplier—any company, person, or agency that gives you a medical item or service, except when you're an inpatient in a hospital or skilled nursing facility.

**U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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