CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Appeals

This official government booklet has important information about the following:

- How to file an appeal if you have Original Medicare
- How to file an appeal if you have a Medicare Advantage Plan (like an HMO or PPO) 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 was correct when it was printed. Changes may occur after printing. Call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to get the most current information. TTY users should 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.

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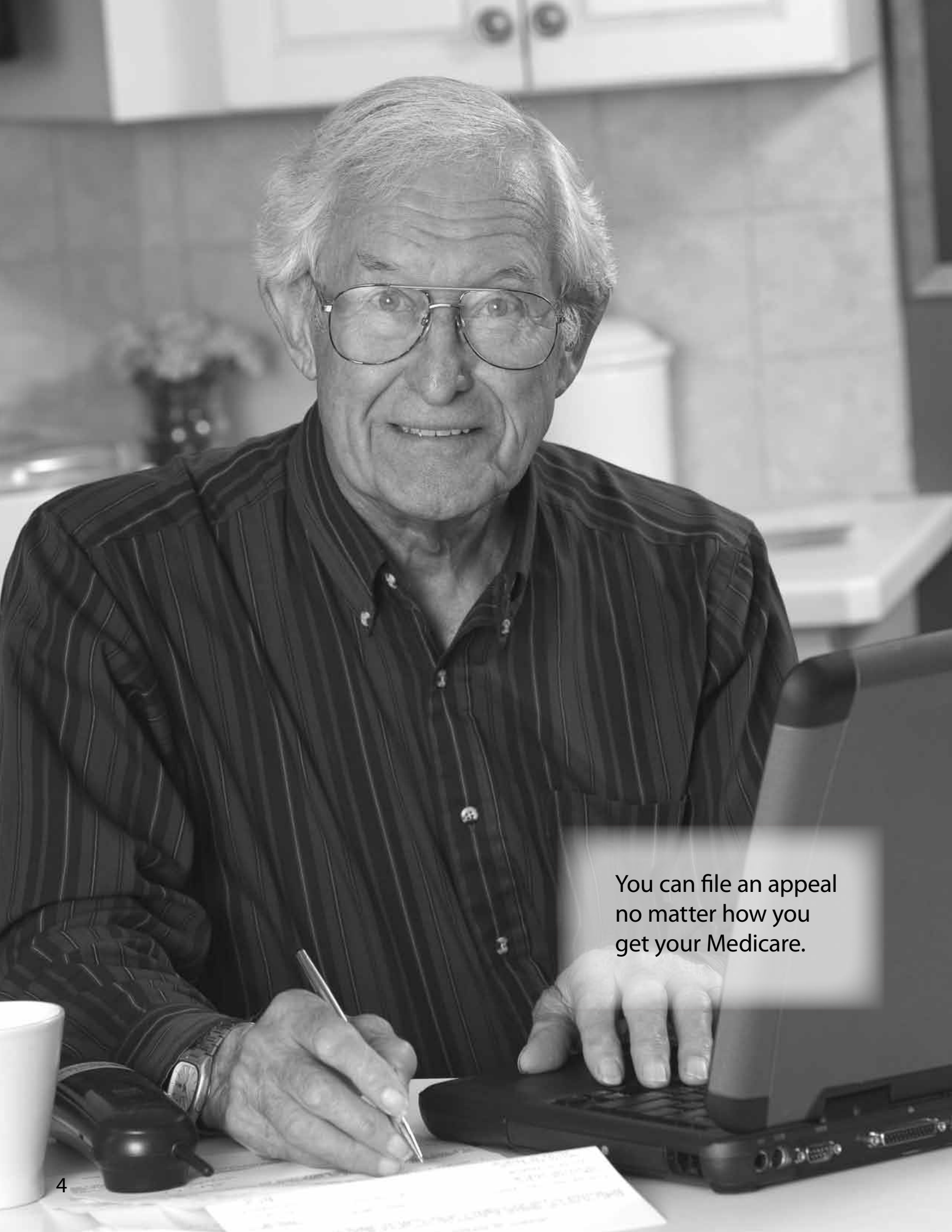
You can file an appeal
no matter how you
get your Medicare.

Section 1: Medicare Basics

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With Medicare, you can choose how you get your health and prescription drug coverage. For example, you might have Original Medicare and a Medicare Prescription Drug Plan. Or, you might have a Medicare Advantage Plan (like an HMO or PPO) that includes drug coverage.

Depending on where you live, you may be able to get your Medicare health care in one of several ways.

Original Medicare

- Run by the Federal government.
- Provides your Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage.
- You can join a Medicare Prescription Drug Plan to add drug coverage.
- You can buy a Medigap (Medicare Supplement Insurance) policy (sold by private insurance companies) to help fill the gaps in Part A and Part B coverage.

Medicare Advantage Plans (like an HMO or PPO)

- Run by private companies approved by Medicare.
- Provides your Part A and Part B coverage but can charge different amounts for certain services.
- May offer extra coverage (such as vision, dental, and/or health and wellness programs) and prescription drug coverage for an extra cost. Costs such as premiums, copayments, and coinsurance for items and services vary by plan.
- In most cases if you want drug coverage, you must get it through your plan. This is sometimes called a Medicare Advantage Prescription Drug Plan (MA-PD).
- You don't need and you can't use a Medigap policy if you're enrolled in a Medicare Advantage Plan.

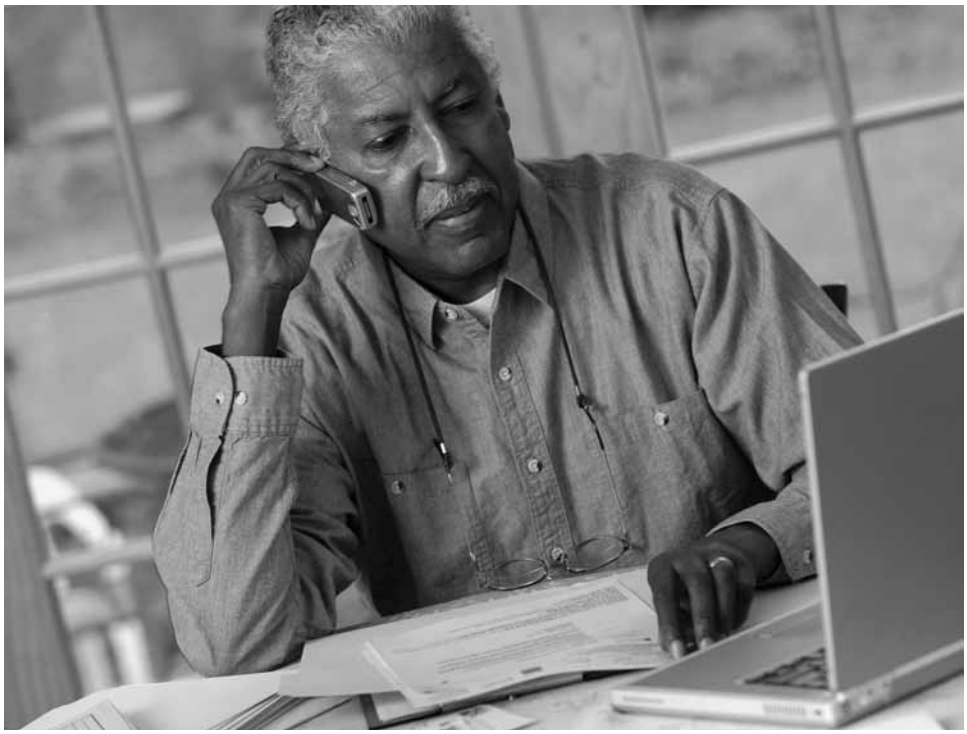
Words in red are defined on pages 51–54.

Other Medicare Health Plans

- Medicare health plans that aren't Medicare Advantage Plans but are also alternatives to Original Medicare.
- Include Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).
- Most plans provide Part A and Part B coverage, and some also provide prescription drug coverage.

You're guaranteed the right to request an appeal if you disagree with a payment or coverage decision about your health care services or prescription drug coverage. This booklet will give you information on how to file an appeal no matter how you get your Medicare. For more information on filing an appeal, visit www.medicare.gov/appeals.

You also have other guaranteed rights and protections. For more information, visit www.medicare.gov/Publications to view or print the booklet "Medicare Rights and Protections," or call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048.



Section 2: What is an Appeal?

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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), your other Medicare health plan, or your Medicare Prescription Drug Plan. You have the right to appeal if Medicare, your Medicare health plan, or your Medicare Prescription Drug Plan denies one of the following:

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

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

See Sections 3–5 for more information on how to file an appeal.

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.

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 a reconsideration 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 will need to submit this form.
  - — For more information on how to file an appeal if you have a Medicare Advantage Plan or other Medicare health plan, see Section 4.

Words in red are defined on pages 51–54.

- If you have a Medicare Prescription Drug Plan:
  - — Your doctor or other prescriber can request a coverage determination or redetermination 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 an appeal on your behalf from the Independent Review Entity (IRE) or at a higher level of appeal, you will need to submit this form.
  - — For more information on how to appeal if you have Medicare prescription drug coverage, see Section 5.

You can appoint your representative in one of the following ways:

1. Fill out an "Appointment of Representative" form (CMS Form Number 1696) available at www.cms.gov/cmsforms/downloads/cms1696.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048.
2. Submit a letter that includes the following:
   - — Your name, address, and phone number
   - — Your 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 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
   - — Your signature and the date you signed the letter
   - — Your representative's signature and the date they signed the letter

You must send the form or letter to the company that handles bills for Medicare or, if appealed, 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.

Section 3: How do I Appeal if I have Original Medicare?

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Original Medicare includes Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). Original Medicare covers certain items and medical services in hospitals and outpatient care settings.

When you get Medicare-covered items or services, you will get a "Medicare Summary Notice" (MSN) in the mail. MSNs are generally mailed every 3 months by the company that handles bills for Medicare.

The MSN shows the items and services that were billed to Medicare during each 3-month period, what Medicare paid, and what you may owe. The MSN will also tell you if Medicare has fully or partially denied your medical claim. This is the initial determination, which is made by people at the company that handles bills for Medicare.

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, 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.

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

Words in red are defined on pages 51–54.

What is the appeals process?

The appeals process has five levels. 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 will be given instructions in the decision letter on how to move to the next level of appeal.

Level 1: Redetermination by the company that handles claims for Medicare

If you disagree with the initial determination on the MSN, you can request a redetermination (a second look or review). This is done by people at the company that handles bills for Medicare 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 must send your request for redetermination to the company that handles bills for Medicare. The company's address is listed in the "Appeals Information" section of the MSN. Read your MSN carefully and follow the instructions on the back. You can request a redetermination in one of the following ways:

1. Follow the instructions on your MSN:
   - — Circle the items you disagree with on the MSN.
   - — Write an explanation of why you disagree with the decision on the MSN or write it on a separate piece of paper and attach it to the MSN.
   - — Include your name, phone number, and Medicare number on the MSN and sign the notice.
   - — Include any other information you have about your appeal with the MSN. Ask your doctor, 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.
   - — Keep a copy of everything you send to Medicare as part of your appeal.

Words in red are defined on pages 51–54.

2. Fill out a "Medicare Redetermination Request Form" (CMS Form Number 20027) available at www.cms.gov/cmsforms/downloads/cms20027.pdf, or call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048. Send the completed form, or a copy, to the company that handles bills for Medicare listed on the MSN.

You will 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 will cover the item(s), it will be listed on your next notice.

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

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 the following ways:

1. Fill out a "Medicare Reconsideration Request Form" (CMS Form Number 20033) available at www.cms.gov/cmsforms/downloads/cms20033.pdf, or call 1-800-MEDICARE and ask for a free copy.

2. Submit a letter that includes the following:
   - — Your name and Medicare number.
   - — The items or services for which you're requesting a reconsideration and the dates of service. See your redetermination notice for this information.
   - — The name of the company that made the redetermination (the company that handles bills 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 2.

No matter how you choose to request a reconsideration, the request should clearly explain why you disagree with the redetermination (the 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 any other information that may help your case with your request. You can submit additional information 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 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).

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 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.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2011, the required amount is $130. 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.

Words in red are defined on pages 51–54.

How do I request a hearing?

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) field office. The address of the appropriate field office is listed in the QIC's reconsideration notice. You can file a request for a hearing in one of the following ways:

1. Fill out a "Request for Hearing by an Administrative Law Judge" form (CMS Form Number 20034 A/B) available at www.cms.gov/cmsforms/downloads/cms20034ab.pdf, or call 1-800-MEDICARE and ask for a free copy.

2. Submit a letter to the OMHA office that will handle your ALJ hearing that includes the following:
   - Your name, address, and Medicare number. If you've appointed a representative, include the name and address of your representative.
   - The document control 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.
   - 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 will submit it.

For more information about the ALJ hearing process, visit www.hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE.

In most cases, the ALJ will send you a written decision within 90 days of getting your request. 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 (MAC).

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

You can request that the MAC review your case. You can request a review for a claim of any amount of money.

How do I request a review?

To request that the MAC 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 MAC at the address listed in the ALJ's hearing decision. You can file a request for MAC review in one of the following ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-01) available at www.hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE and ask for a free copy.
2. Submit a letter to the MAC that includes the following:
   - Your name and Medicare number. If you've appointed a representative, include the name and address of your representative.
   - The items or services and 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 or dismissal, if any.
   - 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 MAC because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

For more information about the MAC review process, visit www.hhs.gov/dab and select "Medicare Operations Division." If you need help filing a request for MAC review, call 1-800-MEDICARE.

Words in red are defined on pages 51–54.

In most cases, the MAC will send you a written decision within 90 days of getting your request. If the MAC doesn't issue a timely decision, you can ask the MAC to move your case to the next level of appeal.

If you disagree with the MAC's decision in level 4, you have 60 days after you get the MAC's decision to request judicial review by a Federal district court.

Level 5: Judicial review by a Federal district court

If you disagree with the decision issued by the MAC, 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 2011, the minimum dollar amount is $1,300. You may be able to combine claims to meet this dollar amount.

How do I request a review?

Follow the directions in the MAC's decision letter you got in level 4 to file a complaint in Federal district court.

For more information on the appeals process:

- Visit www.medicare.gov/appeals.
- Call 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. To get the phone number for the SHIP in your state, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

How do I get a 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 is 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 the Quality Improvement Organization (QIO) to review your case. To get the QIO's phone number, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

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 QIO's contact information and explains the following:

- 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.

Words in red are defined on pages 51–54.

How do I ask for a fast appeal?

You may have the right to ask the 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 QIO.

Words in red are defined on pages 51–54.

If you miss the deadline for a fast appeal, you can still ask the QIO to review your case, but different rules and timeframes apply. For more information, contact the QIO. To get the QIO's phone number, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

What will happen during the QIO's review?

When the 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 QIO notifies the hospital. The notice will include the following information:

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

The QIO will look at your medical information provided by the hospital and will also ask you for your opinion. The QIO will decide if you're ready to be discharged within 1 day of getting the requested information.

If the 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 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 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 QIO at the phone number listed on the notice the hospital gives you. You can also visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the QIO's phone number.

How do I get a 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 "Notice of Medicare Provider Non-Coverage" at least 2 days before covered services end. If you don't get this notice, ask for it. This notice explains the following:

- 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 the QIO in your state to request a fast appeal

How do I ask for a fast appeal?

Ask the QIO for a fast appeal no later than noon of the day after you get the "Notice of Medicare Provider 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 QIO to review your case, but different rules and timeframes apply. For more information, contact the QIO. To get the QIO's phone number, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

What will happen during the QIO's review?

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

- 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

Words in red are defined on pages 51–54.

If the 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 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 Provider 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 QIO's decision, getting notices, or learning about your rights after missing the filing deadline, call the QIO at the phone number listed on the notice the provider gives you. You can also visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the QIO's phone number.

What is an "Advance Beneficiary Notice of Noncoverage?"

If you have Original Medicare and your doctor, 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 "Advance Beneficiary Notice of Noncoverage" (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 explains what Medicare won't pay for, the reasons why Medicare won't pay, and also gives an estimate of costs. The ABN helps to give 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 will be asked to choose an option box and sign the notice to say that you read and understood it. You must choose one of the following options:

- To get the items or services that Medicare may not pay for and agree to pay if Medicare doesn't. Your provider or supplier will submit a claim to Medicare for the items or services. If Medicare denies payment, you can still file an appeal.
- To get the items or services that Medicare may not pay for and agree to pay out of pocket at that time. You request that no claim be submitted to Medicare. You won't be able to appeal because no claim will be filed.
- To not get the items or services, no claim is filed, and you aren't responsible to pay. You won't be able to appeal because no claim will be filed.

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 Advance Beneficiary Notices

1. **"Skilled Nursing Facility Advance Beneficiary Notice"**

   The "Skilled Nursing Facility Advance Beneficiary Notice" (SNFABN) is issued to you by a SNF if there is a reason to believe that Medicare may not cover or continue to cover your stay because it isn't reasonable or necessary, or is considered custodial care. The SNFABN tells you the date when Medicare will likely no longer pay for your services. If you choose to get the services that may not be covered, you don't have to pay for services until a claim is filed 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 never covers. This written notice gives you choices similar to the ABN (see above).

2. **"Home Health Advance Beneficiary Notice"**

   The "Home Health Advance Beneficiary Notice" (HHABN) is issued to you by an HHA before you get items or services that may not be paid for by Medicare. This written notice give you choices similar to the ABN (see above). The HHABN notice is also used without the option boxes to alert you to a change in your home health care plan. Read the notice carefully so that you're aware of the changes in your care.

3. **"Hospital Issued Notice of Noncoverage"**

   The "Hospital Issued Notice of Noncoverage" (HINN) is a notice issued by hospitals 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 services.

Services and supplies Medicare never covers

Doctors, health care providers, and suppliers don't have to (but still may) give you an ABN for services that Medicare never covers, such as the following:

- Dental services
- Hearing aids
- Routine eye exams
- Routine foot care
- Routine physical exams (Note: Medicare Part B covers a one-time "Welcome to Medicare" preventive visit if you get it within the first 12 months you have Medicare Part B, as well as yearly "Wellness" visits. For more information on preventive services, visit www.medicare.gov/Publications to view or print the booklet "Your Guide to Medicare's Preventive Services," or call 1-800-MEDICARE and ask for a free copy.

Words in red are defined on pages 51–54.

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How do I Appeal if I have Original Medicare?

Section 4: How do I Appeal if I have a Medicare Advantage Plan or other Medicare Health Plan?

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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.

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 include Medicare prescription drug coverage (Part D).

Medicare Cost Plans are types of HMOs that are 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 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 will need to follow the Original Medicare appeals process. See Section 3.

Your Medicare Advantage Plan or other Medicare health plan will send you information that explains your rights. Call your plan if you have questions.

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, 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.

Words in red are defined on pages 51–54.

4

How do I Appeal if I have a Medicare Advantage Plan or other Medicare Health Plan?

What is the appeals process?

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.

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 your life or health may be seriously harmed waiting for a standard decision.

If the plan won't cover the items or services you asked for, the plan must tell you in writing why it won't provide or pay for the items or services and how to appeal this decision. You will get a notice explaining why your plan fully or partially denied your request and instructions on how to appeal your plan's 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. Your plan may charge you for this copy.

If you disagree with the organization determination (your plan's initial decision), you can file an appeal. The appeals process has five levels. 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 will be given instructions on how to move to the next level of appeal.

Level 1: Reconsideration from your plan

If you disagree with the initial decision (organization determination) from your plan, you, your representative, or your treating doctor can request a reconsideration (a second look or review).

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

How do I request a reconsideration?

You or your doctor must file a written standard request, unless your plan allows you to file a service request over the phone, by fax, or by email. Your plan's address is listed 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 the following:

- Your name, address, and the Medicare number (health insurance claim number (HICN)) shown on your Medicare card.
- The items or services for which you're requesting a reconsideration and the dates of service.
- 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 2.

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 will respond to your request for an appeal within the timeframes below:

- Standard service request—30 days
- Payment request—60 days
- Fast request—72 hours

Your request will be a fast request 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.

The timeframe for completing standard service and fast requests may be extended by up to 14 days. The timeframe 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.

If the plan decides against you (fully or partially), your appeal is automatically sent to level 2.

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

You will 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 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 IRE's address is listed on the notice.

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

- Standard service request—30 days
- Payment request—60 days
- Fast request—72 hours

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

The timeframe for completing standard service and fast requests may be extended by up to 14 days. The timeframe may be extended if, for example, the IRE needs more information to make a decision about the case, and the extension is in your best interest.

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.

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 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.

To get an ALJ hearing, the amount of your case must meet a minimum dollar amount. For 2011, the required amount is $130. The "Reconsideration Determination" will include a statement that tells you if your case meets this 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?

Follow the directions in the IRE's reconsideration decision to ask for a hearing before an ALJ. You can instead submit a written request with the information listed below. 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 the Medicare number (health insurance claim number (HICN)) shown on your Medicare card. 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.
- 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 will submit it.

Send your written request to the appropriate Office of Medicare Hearings and Appeals (OMHA) field office specified in the reconsideration or the reconsidered determination.

To learn more about the ALJ hearing process, visit www.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 for a review by the Medicare Appeals Council (MAC).

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 MAC.

Words in red are defined on pages 51–54.

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

You can request that the MAC review your case. You can request a review for a claim of any amount of money.

How do I request a review?

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

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101) available at www.hhs.gov/dab/divisions/dab101.pdf, or call your plan or 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should call 1-877-486-2048.
2. Submit a letter to the MAC that includes the following:
   - Your name and Medicare number. If you've appointed a representative, include the name and address of your representative.
   - The items or services you're appealing and 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 or dismissal, if any.
   - Your signature. If you've appointed a representative, include the signature of your representative.
   - If you're requesting that your case by moved from the ALJ to the MAC because the ALJ hasn't issued a timely decision, include the hearing office in which the request for hearing is pending.

You will get the MAC's decision letter about 90 days after it gets your appeal request.

If you disagree with the MAC's decision in level 4, you have 60 days after you get the MAC's decision to request judicial review by a Federal district court.

Level 5: Judicial review by a Federal district court

If you disagree with the decision issued by the MAC, 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 2011, the required claim amount is $1,300. You may be able to combine claims to meet this dollar amount.

How do I request a review?

Follow the directions in the MAC's decision letter you got in level 4 in order to file a complaint in Federal district court.

For more information on the appeals process:

- Visit www.medicare.gov/appeals.
- Call 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. To get the phone number for the SHIP in your state, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

Words in red are defined on pages 51–54.

How do I get a 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 is 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 the QIO review your case. To get the QIO's phone number, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

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 QIO's contact information and explains the following:

- 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
- When your services will end
- Your right to get services you need after you leave the hospital
- Your right to appeal a discharge decision and have your hospital services paid for during the appeal (except for any applicable coinsurance or deductibles)
- Your right to ask for a fast appeal
- What you may pay for continuing to stay in the hospital after your discharge date

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.

Words in red are defined on pages 51–54.

How do I ask for a fast appeal?

You may have the right to a fast appeal if you think you're being discharged too soon. Ask the 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 QIO.

If you miss the deadline for a fast appeal, you can request a reconsideration from your plan, but hospital services will only be covered if there is a decision issued in your favor.

To ask for a fast appeal, contact your SHIP. To get the phone number for your SHIP, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

What will happen during the QIO's review?

When the QIO gets your request, it will notify the plan and the hospital. You will get a "Detailed Notice of Discharge" by noon on that day that includes the following information:

- 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

The QIO will look at your medical information provided by the plan and the hospital and will also ask you for your opinion. Within 1 day of getting that information, the QIO will decide if you're ready to be discharged.

If the 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 the 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 QIO gives you its decision. If you get any inpatient hospital services after noon on the day that the 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 QIO at the phone number listed on the notice the hospital gives you. You can also visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the QIO's phone number.

How do I get a 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), or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. During a fast appeal, the QIO looks at your case and decides if your health care services need to continue.

Words in red are defined on pages 51–54.

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 following:

- 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 the QIO in your state to request a fast appeal

How do I ask for a fast appeal?

Ask the QIO for a fast appeal no later than noon of the day before the date that your Medicare-covered services end. Follow the instructions on the "Notice of Medicare Non-Coverage" to do this.

If you miss the deadline for requesting a fast appeal from the QIO, you can request a reconsideration from your plan, but will have to pay for services if you don't win your appeal.

What will happen during the QIO's review?

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

- Why your services are no longer covered
- 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
- Any applicable plan policy, contract provision, or reason on which your discharge decision was based

The QIO will ask you why you believe coverage for the services should continue. The QIO will also look at your medical records and the information provided by the plan. The QIO will make a decision by close of business the day after it gets the information it needs to make a decision.

If the 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 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 QIO's decision, getting notices, or learning about your additional appeal rights after missing the filing deadline, call the QIO at the phone number listed on the notice the provider gives you your call your health plan (their phone number is in your plan materials). You can also visit www.medicare.gov/contacts or call 1-800-MEDICARE to get the QIO's phone number.

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 the QIO in your state. For the phone number of the QIO, visit www.medicare.gov/contacts or call 1-800-MEDICARE.

Other reasons you may file a grievance include:

- 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 pages 26–27.
- The plan didn't send your case to the IRE. See level 2 on page 28.
- 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.

Words in red are defined on pages 51–54.

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.

4

How do I Appeal if I have a Medicare Advantage Plan or other Medicare Health Plan?

Section 5: How do I Appeal if I have Medicare Prescription Drug Coverage?

5

If you have Medicare prescription drug coverage through a Medicare Prescription Drug Plan, 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 request an appeal to resolve differences with your plan. You have the right to ask your plan to provide or pay for a drug you think should be covered, provided, or continued.

Words in red are defined on pages 51–54.

If you decide to appeal, ask your doctor or 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 the following 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 www.medicare.gov/Publications to view or print the fact sheet "How Medicare Prescription Drug Plans and Medicare Advantage Plans with Prescription Drug Coverage (MA-PDs) Use Pharmacies, Formularies, and Common Coverage Rules," or call 1-800-MEDICARE (1-800-633-4227) and ask for a free copy. TTY users should 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.

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 the following:

- 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 (such as 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.

Words in red are defined on pages 51–54.

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, such as 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 and if it must 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.

You can either file a standard request or a fast request for the coverage determination. 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 its decision.

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 www.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 doctor, or your other prescriber.

How do I file a 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 will get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that your life or health may be at risk waiting 72 hours for a decision. You won't get a fast decision if you've already paid for and gotten the drug.

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 www.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 is the appeals process?

The appeals process has five levels. 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 will be given 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, 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 to do this. You, your representative, your doctor, or other prescriber can request a standard or fast redetermination. Standard requests must be made in writing, unless your plan allows you to file a standard request by phone. You will get a fast decision if your plan determines, or your doctor or other prescriber tells your plan, that your life or health may be at risk by waiting for a standard decision.

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 the following:

- Your name, address, and the Medicare claim number (your Medicare number) shown on your Medicare card.
- The name of the drug you want your plan to cover.
- Reason(s) why you're appealing.
- 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 2.

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 the timeframes below:

- Standard redetermination decision—7 days
- Fast redetermination decision—72 hours

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

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 can request a standard or fast reconsideration by an IRE.

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 www.cms.gov/MedPrescriptDrugApplGriev/13_Forms.asp.

Important: If you want your doctor, other prescriber, or another person to request a reconsideration from the IRE for you, you will need to submit an "Appointment of Representative" form or other documentation to show that the person has the authority to act on your behalf. For more information on appointing a representative, see Section 2.

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 will get a fast reconsideration decision if the IRE determines, or your prescriber tells the IRE, that your life or health may be at risk by waiting for a standard decision.

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

- Standard reconsideration decision—7 days
- Fast reconsideration decision—72 hours

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.

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-tele-conference, or in some cases, in person. You can also ask the ALJ to make a decision without a hearing.

At the ALJ hearing, you will 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 2011, the required amount is $130. The "Reconsideration Notice" will include a statement that tells you if your case meets this 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?

Follow the directions on the IRE's reconsideration notice to request a hearing before an ALJ. Your request must be sent to the appropriate Office of Medicare Hearings and Appeals (OMHA) field office. The address of the appropriate field office is listed in the reconsideration notice. You or your representative can file a request in one of the following ways:

1. Fill out a "Request for Hearing by an Administrative Law Judge" form (CMS Form Number 20034 A/B) available at www.cms.gov/cmsforms/downloads/cms20034ab.pdf, or call 1-800-MEDICARE and ask for a free copy.
2. Submit a letter to the OMHA office that will handle your ALJ hearing. Your letter must include the following:
   - 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 appeal case number included on the reconsideration notice.
   - The prescription drug in dispute. See your redetermination or reconsideration notice for this information.
   - An explanation of 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 will submit it.
   - If you're requesting a fast decision, include a statement that indicates this.
3. If you're requesting a 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 your life or health may be at risk waiting 90 days for a decision. You won't get a fast decision if you already got the drug.

Words in red are defined on pages 51–54.

Once the ALJ gets the request for review, you will get a decision within the timeframes below:

- Standard ALJ decision—90 days
- Fast ALJ decision—10 days

To learn more about the ALJ hearing process, visit www.hhs.gov/omha and select "Coverage and Claims Appeals." If you need help filing an appeal with an ALJ, call 1-800-MEDICARE.

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 (MAC).

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

You can request that the MAC review your case. You can request a review for a claim of any amount of money.

How do I request a review?

To request that the MAC 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 MAC at the address listed in the ALJ's hearing decision. You or your representative can file a request for MAC review in one of the following ways:

1. Fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form (DAB-101) available at www.hhs.gov/dab/divisions/dab101.pdf, or call 1-800-MEDICARE and ask for a free copy.
2. Submit a letter to the MAC that includes the following:
   - 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.

Words in red are defined on pages 51–54.

— A statement identifying the parts of ALJ's decision with which you disagree and an explanation of why you disagree.

— The ALJ appeal case number.

— If you're requesting a 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 a fast review, you can make an oral request. Follow the instructions in the ALJ's decision notice to do this. The MAC will give you a fast decision if your doctor or other prescriber indicates, or the MAC determines, that your life or health may be at risk waiting 90 days for a decision. You won't get a fast decision if you already got the drug.

Once the MAC gets the request for review, you will get a decision within the timeframes below:

- Standard MAC decision—90 days
- Fast MAC decision—10 days

To learn more about the MAC review process, visit www.hhs.gov/dab and select "Medicare Appeals Council." If you need help filing a request for MAC review, call 1-800-MEDICARE.

If you disagree with the MAC's decision in level 4, you have 60 days after you get the MAC's decision to request judicial review by a Federal district court.

Level 5: Judicial review by a Federal district court

If you disagree with the decision issued by the MAC, 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 2011, the minimum dollar amount is $1,300. You may be able to combine claims to meet this dollar amount.

How do I request a review?

Follow the directions in the MAC's decision letter to file you got in level 4 in order to 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 will be listed in the MAC's decision notice.

For more information on the appeals process:

- Visit www.medicare.gov/appeals.
- Call 1-800-MEDICARE.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized health insurance counseling. To get the phone number for the SHIP in your state, visit www.medicare.gov/contacts 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"). You must file your complaint within 60 days of the date of the event that led to the issue.

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 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.

Words in red are defined on pages 51–54.

- 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 a 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.

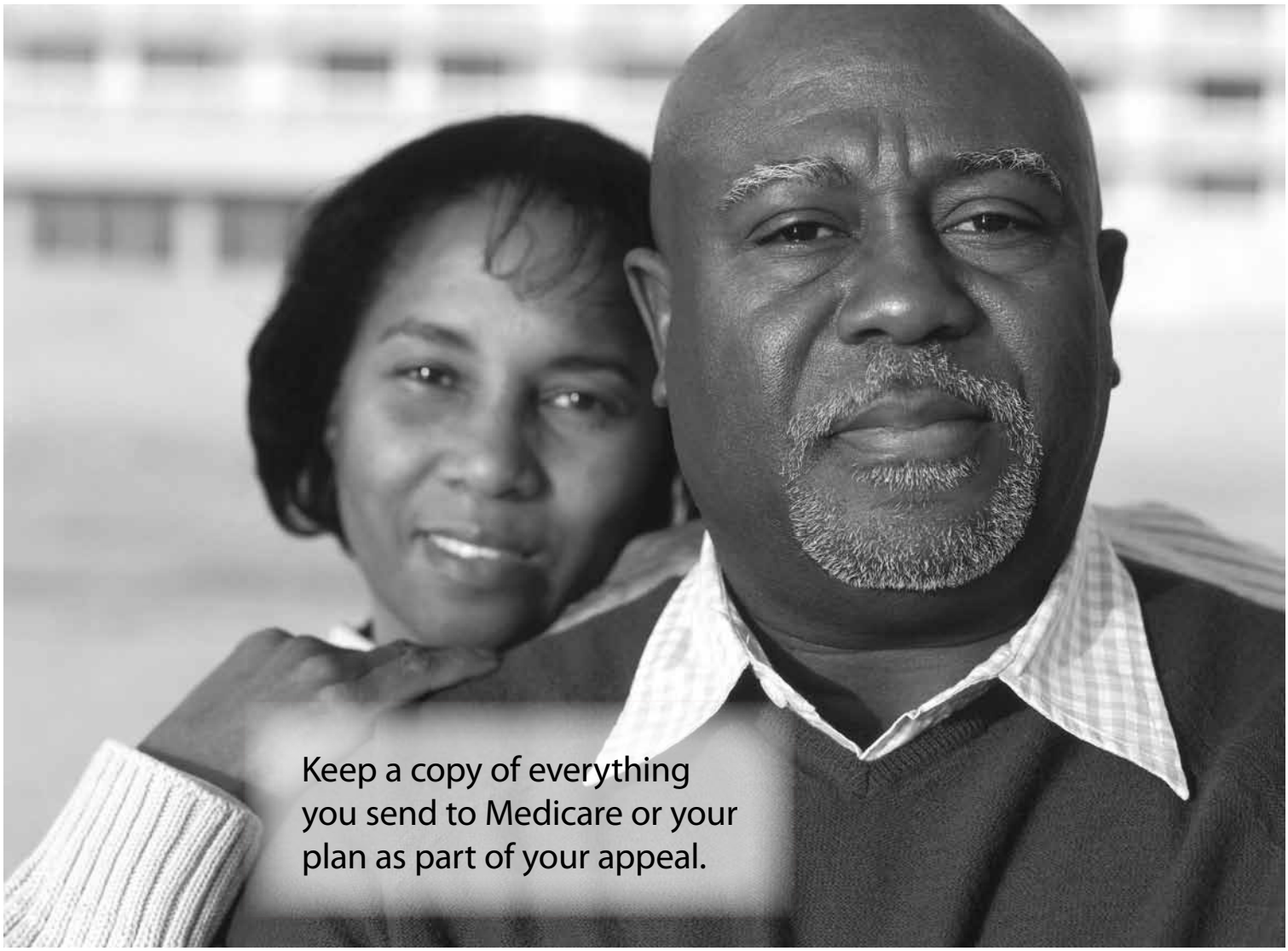
If you want to file a complaint, you should know the following:

- 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 decision generally no later than 30 days after the plan gets the complaint.
- If the complaint relates to a plan's refusal to make a fast coverage determination or redetermination and you haven't yet purchased or received the drug, the plan must notify you of its decision no later than 24 hours after it gets the complaint.
- If you think you were charged too much for a prescription, call the company offering your plan to get the most up-to-date price.

If the plan doesn't take care of your complaint, call 1-800-MEDICARE.

For more information on filing a complaint:

- Visit www.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, call 1-800-MEDICARE or visit www.medicare.gov/contacts.


Keep a copy of everything
you send to Medicare or your
plan as part of your appeal.

Section 6: Definitions

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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—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. 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.

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.

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—An organization that provides home health care.

Home Health Care—Health care services and supplies a doctor decides you may receive in your home under a plan of care established by your doctor. Medicare only covers home health care on a limited basis as ordered by your doctor.

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 as well.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare—The Federal health insurance program for people who are age 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 Medicare 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 Cost Plan—A type of Medicare health plan available in some areas. In a Medicare Cost Plan, if you get services outside of the plan's network without a referral, your Medicare-covered services will be paid for under Original Medicare (your Cost Plan pays for emergency services, or urgently needed services).

Medicare Health Plan—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, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

Medicare Prescription Drug Plan (Part D)—A stand-alone drug plan that 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 or provider files a claim for Part A or Part B services in Original Medicare. It explains what the doctor or provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare—Original Medicare is fee-for-service coverage under which the government pays your health care providers directly for your Part A and/or Part B benefits.

Premium—The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Programs of All-Inclusive Care for the Elderly (PACE)—A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically-necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Quality Improvement Organization (QIO)—A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to people with Medicare.

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

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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