CENTERS FOR MEDICARE & MEDICAID SERVICES

Your Medicare Rights and Protections

This official government booklet has important information about the following:

- ★ **Your rights and protections in Original Medicare**
- ★ **Your rights and protections in a Medicare Advantage Plan or other Medicare health plans**
- ★ **Your rights and protections in a Medicare drug plan**
- ★ **Where you can get help with your questions**

Protect Your Medicare Number!

You should always keep your Medicare card and Medicare number as safe as you would any of your personal information. You also want to keep your plan membership card safe if you are in a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan. This will help protect against someone using your information without your knowledge.

If you need to get a new Medicare card, visit www.socialsecurity.gov, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

If you think someone is using your personal information without your consent, call any of the following numbers:

- Your local police department.
- The Federal Trade Commission's ID Theft Hotline at 1-877-438-4338 to make a report. TTY users should call 1-866-653-4261. For more information about identity theft, visit www.consumer.gov/idtheft.

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.

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

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Section 1: Medicare Basics

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. No matter how you get your Medicare, you have certain rights and protections designed to do the following:

- Protect you when you get health care
- Make sure you get the health care services that the law says you can get
- Protect you against unethical practices
- Protect your privacy

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

1. 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.

Words in blue are defined on pages 39–42.

2. 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 and prescription drug coverage for an extra cost. Costs for items and services vary by plan.
- If you want drug coverage, you must get it through your plan (in most cases). 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 are enrolled in a Medicare Advantage Plan.

3. Other Medicare Health Plans

- Plans that aren't Medicare Advantage Plans but are still part of 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.

Section 2: Rights and Protections for Everyone with Medicare

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All people with Medicare have certain guaranteed rights and protections, including the right to the following:

- **Be treated with dignity and respect at all times**

- **Be protected from discrimination**

Discrimination is against the law. Every company or agency that works with Medicare must obey the law. You can't be treated differently because of your race, color, national origin, disability, age, religion, or sex (under certain conditions).

If you think that you haven't been treated fairly for any of these reasons, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. For more information, visit www.hhs.gov/ocr.

- **Get understandable information about Medicare to help you make health care decisions, including the following:**
  - What is covered
  - How much Medicare pays
  - How much you have to pay
  - What to do if you want to file a complaint or an appeal

Words in blue are defined on pages 39–42.

- **Have your Medicare questions answered**
  - Visit www.medicare.gov.
  - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - Call your State Health Insurance Assistance Program (SHIP). To get the most up-to-date SHIP telephone numbers, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."
  - Call your plan if you are in a Medicare Advantage Plan or other Medicare health plan or a Medicare Prescription Drug Plan.

- **Get health care services in a language you understand and in a culturally-sensitive way**

For more information about getting health care services in languages other than English, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr.

- **Get emergency care when and where you need it**

If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets much worse, call 911. You can get emergency care anywhere in the United States.

To learn about emergency care in Original Medicare, call 1-800-MEDICARE.

If you have a Medicare Advantage Plan, your plan materials describe how to get emergency care. You don't need to get permission from your primary care doctor (the doctor you see first for health problems) before you get emergency care. If you're admitted to the hospital, you, a family member, or your primary care doctor should contact your plan as soon as possible. If you get emergency care, you will have to pay your regular share of the cost (copayment). Then, your plan will pay its share. If your plan doesn't pay its share for your emergency care, you have the right to appeal.

- **Learn about your treatment choices in clear language that you can understand**

You have the right to participate fully in all your health care decisions. If you can't fully participate, ask family members, friends, or anyone you trust to help you make a decision about what treatment is right for you.

- **File a complaint (sometimes called a grievance), including complaints about the quality of care**

You can file a complaint about payment, services you got, other concerns or problems you have in getting health care, and the quality of the health care you got.

If you're concerned about the quality of the care you're getting, you have a right to file a complaint or grievance. If you have Original Medicare, call the Quality Improvement Organization (QIO) in your state to file a complaint. Call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites." If you have a Medicare Advantage Plan, call your plan or the QIO.

If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD Network for your state. End-Stage Renal Disease is permanent kidney failure that requires a regular course of dialysis or a kidney transplant. To get this telephone number, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

- **Know your Medicare appeal rights**

If you disagree with a decision about your claims or services, you have the right to appeal.

For more information on appeals, you can do one of the following:

- If you have Original Medicare, see page 16.
- If you have a Medicare Advantage Plan (like an HMO or PPO) or a Medicare Prescription Drug Plan, see pages 25 or 35, and read your plan materials.
- Call the State Health Insurance Assistance Program (SHIP) in your state. To get the most up-to-date SHIP telephone numbers, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

Tip: If you need help filing an appeal, you can appoint a representative like a family member, friend, advocate, attorney, doctor, or someone else to act on your behalf. There are two ways you can do this:

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

You must send the form or letter with your appeal request. It is a good idea to make a copy of the form or letter before you send it. If you have questions about appointing a representative, call 1-800-MEDICARE.

- **Have a claim for payment filed with Medicare**

Even when your doctor says that Medicare won't pay for a certain item or service, you have a right to have the doctor file the claim with Medicare. This right is sometimes called a "demand bill." When a claim is filed, you get a notice from Medicare letting you know what it will and won't cover. This might be different from what your doctor says. You have a right to appeal the decision Medicare makes about whether or not to pay the claim, and how much to pay.

- **Have your personal and health information kept private**

To find out about these rights, you can do the following:

- If you have Original Medicare, see the "Notice of Privacy Practices for Original Medicare." You can view this notice in the "Medicare and You" handbook. Visit www.medicare.gov/Publications/Pubs/pdf/10050.pdf to view the handbook, or call 1-800-MEDICARE (1-800-633-4227) to ask for a copy. TTY users should call 1-877-486-2048.
- If you have a Medicare Advantage Plan or a Medicare Prescription Drug Plan, read your plan materials.

Section 3: Your Rights and Appeals in Original Medicare

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If you're in Original Medicare, in addition to the rights and protections described in Section 2, you have the following rights:

- **See any doctor or specialist (including women's health specialists), or go to any Medicare-certified hospital, that participates in Medicare.**
- **Get certain information, notices, and appeal rights that help you resolve issues when Medicare doesn't pay for health care.**
- **A fair, efficient, and timely process for appealing health care payment decisions. See page 16–22.**
- **Buy a Medigap (Medicare Supplement Insurance) policy**

There are certain times, including during your Medigap open enrollment period, when an insurance company must sell you a Medigap policy, even if you have health problems.

Words in blue are defined on pages 39–42.

What Is an Advance Beneficiary Notice of Noncoverage (ABN)?

If you have Original Medicare and your health care provider or supplier thinks that Medicare probably (or certainly) won't pay for an item or service, he or she may give you a written notice called an "Advance Beneficiary Notice of Noncoverage" (ABN). 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 enough information to make an informed choice about whether or not to get the care, knowing that you or your other insurer may have to pay for it.

You will be asked to sign the ABN to say that you read and understood the notice. An ABN isn't an official denial of coverage by Medicare. You could choose to get the items listed on the ABN and still ask your health care provider or supplier to submit the bill to Medicare or another insurer. If payment is denied, you can still file an appeal.

There are four types of ABNs:

1. Advance Beneficiary Notice of Noncoverage (ABN)

Used by doctors, durable medical equipment suppliers, and certain health care providers, like independent physical and occupational therapists, laboratories, and outpatient hospitals. This written notice gives you the following options:

- To get the service or item that Medicare may not pay for knowing that you are responsible to pay, but still have your provider or supplier submit the claim to Medicare
- To get the service or item that Medicare may not pay for knowing that you are responsible to pay, but not have your provider or supplier submit the claim to Medicare
- To not get the service or item

2. Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
Used by a skilled nursing facility when they believe Medicare may not continue to cover your stay. The SNFABN tells you when you're responsible for payment. 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 similar options as described in number one on the previous page.

3. Home Health Advance Beneficiary Notice (HHABN)
Given by home health agencies when they are either giving you home health care Medicare probably won't pay for, or when your home health agency will reduce or end care for other reasons. This written notice gives you similar options as described in number one on the previous page.

4. Hospital Issued Notice of Noncoverage (HINN)
Given by hospitals when they think Medicare may not pay for your inpatient hospital care. You may get an HINN before you're admitted, at admission, or at any point during your stay. This notice will tell you why the hospital thinks Medicare won't pay and what you have to pay if you keep getting services. This written notice doesn't have options like the other three types of Advance Beneficiary Notices.

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" physical exam. Medicare covers this exam if you get it within the first 12 months you have Part B.

How to Appeal if You Have Original Medicare

If you get a Medicare-covered service, you will get a Medicare Summary Notice (MSN) in the mail. MSNs are generally mailed every 3 months. The MSN shows all the services or supplies that were billed to Medicare during each 3-month period, what Medicare paid, and what you may owe the provider. Please review the entire notice carefully. If you disagree with a Medicare payment decision on the MSN, you can appeal.

The notice tells you how to file an appeal. If you appeal, ask your doctor, health care provider, or supplier for any information that might 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 or services that you got, write or call your doctor, health care provider, or supplier and ask for an itemized statement. This statement will list each Medicare item or service you got. You can also check your MSN to see if Medicare was billed.

The Appeals Process

If Medicare makes a decision you disagree with, you can file an appeal by following the process below. If you disagree with the decision made at any level of the process, you can generally go to the next level. After each level, you will be given instructions on how to proceed to the next level of appeal.

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

A redetermination is a second look at a claim. This is done by people who weren't involved with the first decision. If you disagree with the decision made on your claim, you **must** request a redetermination within 120 days from the date you got your MSN. Follow the directions on the MSN to do this. You will get a response called a "Medicare Redetermination Notice" about 60 days after the company gets your appeal request.

If you disagree with the redetermination decision in level 1, you have 180 days after you get your decision to ask for a reconsideration. This is the second level of appeal.

Level 2: Reconsideration by the Qualified Independent Contractor (QIC).

The QIC is a company that didn't take part in the level 1 decision. Follow the directions on the Medicare Redetermination Notice you got in level 1 to file a reconsideration. You will get a 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 your decision to ask for a hearing. This is the third level of appeal.

Level 3: Hearing before an Administrative Law Judge (ALJ).
Follow the directions on the Medicare Reconsideration Notice you got in level 2 to ask for a hearing before an ALJ. An ALJ hearing can be held by video teleconference, by telephone, and in some cases in person. You may also ask the ALJ to make a decision without a hearing. You will get the ALJ's decision letter about 90 days after they get your appeal request. To get an ALJ hearing, the amount of your case must meet a minimum dollar amount (the Medicare Reconsideration Notice will include a statement that tells you if your case meets this minimum dollar amount).

If you disagree with the ALJ's decision in level 3, you have 60 days after you get your decision to ask for a review by the Medicare Appeals Council. This is the fourth level of appeal.

Level 4: Review by the Medicare Appeals Council (MAC).
Follow the directions in the ALJ's decision you got in level 3 to ask for a review by the MAC. 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 your decision to file a complaint in Federal district court. This is the fifth level of appeal.

Level 5: Review by a Federal District Court.
Follow the directions in the MAC's decision in level 4 to file a complaint in Federal district court. To get a review by a Federal district court, the amount of your case must meet a minimum dollar amount.

How to Get an Expedited (Fast) Appeal in a Hospital if You Have Original Medicare

When you're admitted as an inpatient to a hospital, you have the right to get all 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 a Quality Improvement Organization (QIO) to review your case. Call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

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") that you (or your representative) must sign. If you don't get this notice, ask for it. This notice 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 services you need after you leave the hospital
- Your right to appeal a discharge decision and the steps for appealing the decision
- The circumstances in which your hospital services may be paid for during the appeal (except for any applicable coinsurance or deductibles)
- What you might pay for continuing to stay in the hospital after your discharge date
- Information on your right to get a detailed notice about why your covered services are ending

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

How do I ask for an expedited (fast) appeal?

Ask the Quality Improvement Organization (QIO) for a fast appeal. Follow the directions on the IM to do this. You must do this no later than the day you're discharged from the hospital.

If you meet this deadline, you may 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 review, you may still ask the QIO to review your case, but different rules may apply.

What will happen during the QIO's review?

When the QIO gets your request, the QIO will notify the hospital. Then, the hospital will give you (or your representative) 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
- The applicable Medicare coverage rule or policy, including information on how you can get a copy of the policy
- How the applicable coverage rule applies to your specific situation

The QIO will look at your medical information provided by the hospital and will also ask you (or your representative) for your opinion. If you met the deadline for requesting a fast review (explained above), within a day after getting all of the requested information, the QIO will decide if you're ready to be discharged.

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 review, 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 might have to pay for them. You may leave the hospital on or before that time and avoid having to pay.

If you have any questions about fast appeals in hospitals, call the Quality Improvement Organization (QIO) at the telephone number listed on the notice the hospital gives you. Or, you can call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

How to Get an Expedited (Fast) Appeal in Settings Other Than a Hospital if You Have Original Medicare

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. During a fast appeal, a QIO looks at your case and decides if your health care services need to continue.

While you are getting SNF, HHA, CORF, hospice, or hospital swing bed services, you should get a notice called, "Notice of Medicare Provider Non-Coverage" at least 2 days before covered services end that you (or your representative) must sign. 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 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 review no later than noon of the day following your receipt of 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 may still ask the QIO to review your case, but different rules may apply.

What will happen during the QIO's review?

When the Quality Improvement Organization (QIO) gets your request, the QIO 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 (or your representative) 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, or information on how you can get a copy of the policy
- How the applicable coverage rule or policy applies to your situation

If the QIO decides that you're being discharged too soon, Medicare will continue to cover your SNF, HHA, CORF, hospice, or hospital swing bed services for as long as medically necessary (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, hospice, or hospital swing bed services provided before the termination date on the "Notice of Medicare Provider Non-Coverage." If you stop getting services on or before the coverage end date on your "Notice of Medicare Provider Non-Coverage," you won't have to pay after you stop getting services. 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, hospice, or hospital swing bed services, including appealing the QIO's decision, getting notices, or learning about rights after missing the filing deadline, call the QIO at the number listed on the notice the provider gives you. You can also call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

Section 4: Your Rights and Appeals in a Medicare Advantage Plan or other Medicare Health Plan

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If you're in a Medicare Advantage Plan (like an HMO or PPO) or other Medicare health plan, in addition to the rights and protections described in Section 2, you have the rights listed below.

If you want to know more about your rights and protections, including rights and protections you may have in addition to those discussed in this booklet, read your plan's membership materials or call your plan.

You have the right to the following:

- **Choose health care providers within the plan so you can get the health care you need**

- **Get a treatment plan from your doctor**

If you have a complex or serious medical condition, a treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist without a referral within the plan for routine and preventive health care services.

- **Know how your doctors are paid**

When you ask your plan how it pays its doctors, the plan must tell you. Medicare doesn't allow a plan to pay doctors in a way that could interfere with you getting the care you need.

Words in blue are defined on pages 39–42.

- **A fair, efficient, and timely appeals process to resolve differences with your plan**

You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. See page 25.

- **File a grievance about other concerns or problems with your plan**

For example, if you believe your plan's hours of operation should be different, or there aren't enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.

- **Get a coverage decision or coverage information from your plan before getting services**

Before you get a service or supply, you can call your plan to find out if it will be covered or get information about your coverage rules. You can also call your plan if you have questions about home health care rights and protections. Your plan must tell you if you ask.

- **Privacy of personal health information**

You have the right to have the privacy of your health information protected. For more information about your rights to privacy, look in your plan materials, or call your plan.

Note about Programs of All-inclusive Care for the Elderly (PACE): To get a detailed list of your PACE rights and protections, visit www.cms.hhs.gov/pace/downloads/prtemp.pdf, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to Appeal if You Have a Medicare Advantage Plan or Other Medicare Health Plan

You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. If your plan decides not to cover a service or item, you will get an "Organization Determination" from your plan telling you that the service or item isn't covered and how to appeal.

If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours if the following applies:

- It determines your life or health could be seriously harmed if the plan took the normal 14 days to respond.
- A doctor supports your request and indicates you could be harmed if the plan takes 14 days to respond.

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

If you have a Medicare Cost Plan and you want to appeal services that were provided outside the plan's network (without the plan's involvement), you will need to follow the Original Medicare appeal process as described in Section 3.

The Appeals Process

If your plan makes a decision you disagree with, you can file an appeal by following the process below. If you disagree with the decision made at any level of the process, you can go to the next level. After each level, you will be given instructions on how to proceed to the next level of appeal.

Level 1: Request a Reconsideration from your Plan.
Follow the directions in the Organization Determination to request a reconsideration from your plan. You, your representative, or your treating doctor must request this appeal within 60 calendar days from the date of the Organization Determination. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be at risk by waiting for a standard decision. Your plan will respond within the timeframes below:

- Standard service request—30 calendar days
- Payment request—60 calendar days
- Expedited request—72 hours

If the plan decides against you, your appeal is automatically sent to level 2.

Level 2: An Independent Review Entity (IRE) Reviews Your Appeal.
The review will be expedited if the IRE determines that your life or health may be at risk by waiting for a standard decision. The IRE will send you its decision in a "Reconsideration Determination" within the timeframes below:

- Standard service request—30 calendar days
- Payment request—60 calendar days
- Expedited request—72 hours

If you disagree with the decision you get in level 2, you have 60 days after you get the IRE's reconsideration determination to ask for a hearing. This is the third level of appeal.

Level 3: Request a Hearing with an Administrative Law Judge (ALJ). Follow the directions on the IRE's Reconsideration Determination to do this.

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

If you disagree with the decision you get in level 3, you have 60 days after you get the ALJ's decision letter to ask for a review by the Medicare Appeals Council. This is the fourth level of appeal.

Level 4: Request a Review by the Medicare Appeals Council (MAC). Follow the directions in the ALJ's decision letter to do this. You will get the MAC's decision letter about 90 days after they get your appeal request.

If you disagree with the decision you get in level 4, you have 60 days after you get the MAC's decision letter to file a complaint in Federal district court. This is the fifth level of appeal.

Level 5: Request a Review by a Federal Court. Follow the directions in the MAC's decision letter to do this. To get a review by a Federal court, the projected value of your denied coverage must meet the minimum dollar amount stated in the MAC's decision.

Note: If you have drug coverage through a Medicare Advantage Plan, see Section 5.

How to Get a Fast Appeal in a Hospital if You Have a Medicare Advantage Plan or Other Medicare Health Plan

When you're admitted as an inpatient to a hospital, you have the right to get all the hospital care that is necessary to diagnose and treat your illness or injury. You have the right to ask a Quality Improvement Organization (QIO) to review your case if you think you're being discharged too soon. Call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

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") that you (or your representative) must sign. If you don't get this notice, ask for it. This notice 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
- 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 potential financial liability for continuing to stay in the hospital after your discharge date

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

How do I ask for a fast appeal?

Ask the QIO for a fast appeal. Follow the directions on the IM to do this. You must do this no later than the day you're discharged from the hospital.

How do I ask for a fast appeal? (continued)

If you meet this deadline, you may 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 Quality Improvement Organization (QIO).

If you miss the deadline for a fast appeal, you may still ask the QIO to review your case, but different rules may apply. You may also request a reconsideration from your plan, but hospital services during the reconsideration will only be covered if there is a decision issued in your favor.

What will happen during the QIO's review? When the QIO gets your request, the QIO will notify the plan and the hospital. Then, the plan or the hospital will give you (or your representative) 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 information on how you can get a copy of the policy
- How the applicable coverage rule 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 (or your representative) for your opinion. Within a 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 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, 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. You may leave the hospital on or before that time and avoid having to pay.

How do I ask for a fast appeal? (continued)

If you have any questions about fast appeals in hospitals you can do one of the following:

- Call your plan (the telephone number is in the plan materials).
- Call the Quality Improvement Organization (QIO) at the telephone number listed on the notice the hospital gives you. You can also call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

How to Get a Fast Appeal in Settings Other Than a Hospital if You Have a Medicare Advantage Plan or Other Medicare Health Plan

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, a QIO looks at your case and decides if your health care services need to continue.

While you are getting SNF, HHA, CORF services, you should get a notice called "Notice of Medicare Non-Coverage" at least 2 days before covered services end that you (or your representative) must sign. 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 on your notice
- Your right to get a detailed notice about why your covered services are ending
- How to contact the QIO in your state to request a fast appeal

How do I ask for a fast appeal?

Ask the Quality Improvement Organization (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, you may still ask the QIO to review your case, but different rules may apply. You may also request a reconsideration from your plan, but you 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, the QIO will notify the plan and the provider. Then, the plan or provider will give you (or your representative) a "Detailed Explanation of Non-Coverage" by the end of the day that includes the following information:

- Why your services are no longer covered
- The applicable Medicare coverage rule or policy, including 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 you're being discharged too soon, the plan will continue to cover your SNF, HHA, or CORF services for as long as medically necessary (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 stop getting services on or before the coverage end date on your "Notice of Medicare Non-Coverage," you can avoid having to pay after you stop getting services. If you continue to get services after the coverage end date, you may have to pay for those services.

What will happen during the QIO's review? (continued)

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 your health plan (their telephone number is in your plan materials), or call the QIO in your state. Call 1-800-MEDICARE (1-800-633-4227) to get your QIO's telephone number. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov and select "Find Helpful Phone Numbers and Websites."

Section 5: Your Rights and Appeals in a Medicare Drug Plan

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If you have Medicare prescription drug coverage, your plan will send you information that explains your rights. Read the information carefully, and keep it where you can find it when you need it. Call your plan if you have questions.

In addition to the rights described in Section 2, if you have a Medicare drug plan, you have the right to the following:

- **A fair, efficient, and timely coverage determination and appeals process to resolve differences with your plan. See pages 34–36.**
- **File a complaint (called a "grievance") with the plan. See page 37.**
- **Have the privacy of your health and prescription drug information protected. For more information about your right to privacy, look in your plan materials, or call your plan.**

Words in blue are defined on pages 39–42.

How to Request a Coverage Determination

You, your representative, or your doctor or other prescriber may request a coverage determination if your pharmacist or plan tells you one of the following:

- That a drug you believe should be covered isn't covered
- That a drug is covered at a higher cost than you think you should have to pay
- That you have to meet a plan coverage rule (such as prior authorization) before you can get the drug you requested

In some cases, you might request a coverage determination before you pay for your prescription, but in some cases, you might decide to pay for the prescription, save your receipt, and request that the plan pay you back by requesting a coverage determination.

You (or your representative), your doctor, or other prescriber may request a coverage determination by following the instructions that your plan sends you. The plan will give you its decision within 72 hours. You, your doctor, or other prescriber can call or write your plan to request that an expedited (fast) decision be made within 24 hours. Your request will be expedited 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 72 hours for a decision.

For some types of coverage determinations called "exceptions," you will need a supporting statement from your doctor or other prescriber explaining why you need the drug you're requesting. You will need this statement for the following situations:

- You're requesting that the plan cover a drug that isn't on its list of covered drugs (formulary).
- You want the plan to cover a non-preferred drug at the preferred drug price.
- Your doctor or other prescriber believes you can't meet one of your plan's coverage rules, such as a prior authorization, quantity limit, or dose limit.

Check with your plan to find out if the supporting statement is required and if it must be made in writing. If a supporting statement is required, the plan's decision-making time period begins once your plan gets the supporting statement.

The Appeals Process

If the decision on your coverage determination isn't in your favor, you can appeal the decision by following the process below:

Level 1: Request a redetermination from your plan.

You, your representative, or your doctor or other prescriber must request this appeal within 60 calendar days from the date of the coverage determination. Follow the directions in the plan's denial notice and plan materials to do this. You, your representative, your doctor, or other prescriber may request an expedited redetermination. Your request will be expedited 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 will respond in a "Redetermination Notice" within the timeframes below:

- Standard redetermination request—7 calendar days
- Expedited redetermination request—72 hours

If the plan decides against you, you have 60 days after you get the plan's Redetermination Notice to ask for a reconsideration. This is the second level of appeal.

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

Follow the directions in the plan's Redetermination Notice to do this. The review will be expedited if the IRE determines, or your doctor or other prescriber tells the IRE, that your life or health may be at risk by waiting for a standard decision. The IRE will send you its decision in a "Reconsideration Notice" within the timeframes below:

- Standard redetermination request—7 calendar days
- Expedited redetermination request—72 hours

If you disagree with the decision you get in level 2, you have 60 days after you get the IRE's reconsideration notice to ask for a hearing. This is the third level of appeal.

The Appeals Process (continued)

Level 3: Request a Hearing with an Administrative Law Judge (ALJ). Follow the directions on the IRE's Reconsideration Notice to do this.

To get an ALJ hearing, the projected value of your denied coverage must meet a minimum dollar amount. You may be able to combine claims to meet the minimum dollar amount.

If you disagree with the decision you get in level 3, you have 60 days after you get the ALJ's decision letter to ask for a review by the Medicare Appeals Council (MAC). This is the fourth level of appeal.

Level 4: Request a Review by the Medicare Appeals Council. Follow the directions in the ALJ's decision letter to do this.

If you disagree with the decision you get in level 4, you have 60 days after you get the MAC's decision letter to file a complaint in Federal district court. This is the fifth level of appeal.

Level 5: Request a Review by a Federal District Court. Follow the directions in the MAC's decision letter to do this. To get a review by a Federal district court, the projected value of your denied coverage must meet the minimum dollar amount stated in the MAC's decision.

What if I don't agree with Medicare's late enrollment penalty?

If you don't join a Medicare drug plan when you're first eligible, you may have to pay a late enrollment penalty unless you had other "creditable prescription drug coverage," which means that it met Medicare's minimum standards. In some cases, you have the right to ask Medicare to review your late enrollment penalty. This is called a "reconsideration." You might ask for a reconsideration if one of the following are true:

- You don't think Medicare counted all of your previous creditable prescription drug coverage.
- You didn't get a notice that clearly explained whether your previous drug coverage was creditable.

What if I don't agree with Medicare's late enrollment penalty? (continued)
Your Medicare drug plan will give you a reconsideration request form when it sends you the letter telling you that you have to pay a late enrollment penalty. Mail the completed form to the address, or fax it to the number listed on the form within 60 days from the date on the letter. You should also send any proof that supports your case, like information about previous creditable prescription drug coverage.

If you need more information about requesting a reconsideration of your late enrollment penalty, call your Medicare drug plan. You also may visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) for help. TTY users should call 1-877-486-2048.

How to File a Complaint about your Medicare Drug Plan
If you have a complaint, you must file it within 60 calendar days by following the instructions from your plan. 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.
- The plan doesn't give you a decision about a coverage determination (see page 34) or first-level appeal (see Appeal Level 1 on page 35) within the required timeframe.
- The plan didn't make a timely decision about a coverage determination or first-level appeal within the required timeframe and didn't send your case to the IRE.
- You disagree with the plan's decision not to grant your request for an expedited coverage determination or first-level appeal.
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.

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

Notes

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Section 6: Words to Know

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 the following:

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

You can also appeal if you are already getting coverage and Medicare or your plan stops paying.

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 or 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.

Coverage Determination (Part D)—The first decision made by your Medicare drug plan (not the pharmacy) about your drug benefits, including the following:

- Whether a particular drug is covered
- Whether you have met all the requirements for getting a requested drug
- How much you're required to pay for a drug
- Whether to make an exception to a plan rule when you request it

If the drug plan doesn't give you a prompt decision, and you can show that the delay would affect your health, the plan's failure to act is considered to be a coverage determination. If you disagree with the coverage determination, the next step is an appeal.

Exception—A type of Medicare prescription drug coverage determination. A formulary exception is a drug plan's decision to cover a drug that's not on its formulary or to waive a coverage rule. A tiering exception is a drug plan's decision to charge a lower amount for a drug that is on its non-preferred drug tier. You must request an exception, and your doctor or other prescriber must send a supporting statement explaining the medical reason for the exception.

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 are 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 may file an appeal.

Home Health Agency—An organization that provides home health care.

Home Health Care—Health care services and supplies a doctor decides you may get 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.

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 are 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 Plans—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 Summary Notice—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 provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

Medigap Open Enrollment Period—A one-time-only, 6 month period when Federal law allows you to buy any Medigap policy you want that is sold in your state. It starts in the first month that you are covered under Medicare Part B and you are age 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. Some states may have additional open enrollment rights under state law.

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.

PACE (Programs of All-inclusive Care for the Elderly)—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—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—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—A state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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Section 7: Index

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

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¿Necesita usted una copia en español? Para obtener su copia GRATIS, llame al 1-800-MEDICARE (1-800-633-4227).