MODULE 10: MEDICARE CLAIMS AND APPEALS

Objectives

Below are the objectives for Module 10: Medicare Claims and Appeals. HIICAP counselors will learn how to assist people with Medicare in the appeals process.

At the end of this module are the Study Guide Test and Answer Key.

Medicare Claims Processing, what is the person with Medicare's responsibility?

- By law, the provider of service must submit a claim to Medicare;
- The person with Medicare must give the provider current information such as their address and phone number;
- Advise the provider of service about any work-related injury or auto accident;
- The person with Medicare must inform the provider if they have employment-related insurance, Medicaid, or VA health coverage; and
- The person with Medicare must supply the provider with their supplemental insurance information

What are the steps for processing and receiving Medicare Part A claims (services in hospital, skilled nursing facility, home health agency or hospice)?

- The provider sends the claim to Medicare Part A;
- Medicare Part A pays provider and sends a Medicare Summary Notice (MSN) to the person with Medicare;
- The person with Medicare mails a copy of MSN, itemized hospital bill, and claim form to their secondary insurer unless their insurer has a crossover contract with Medicare Part A;
- The secondary insurer sends the person with Medicare an Explanation of Benefits (EOB); and
- Person with Medicare pays remainder of bill

What are the steps for Medicare Part B Assigned Claims?

- For assigned claims provider sends claim to Medicare;
- Medicare sends the person with Medicare a Medicare Summary Notice (MSN) and usually pays 80 percent of the amount approved by Medicare Part B;
- Either the provider sends the MSN to the secondary insurer or the person with Medicare will send the MSN with a copy of the doctor's bill and a completed claim form unless the insurer has a crossover contract with Medicare Part B;
- The secondary insurer sends the person with Medicare an Explanation of Benefits (EOB); and
- The person with Medicare pays remainder of the bill

What are the steps for Medicare Part B nonassigned claims?

- The person with Medicare pays the doctor;
- The doctor sends claim to Medicare;

- Medicare sends the person with Medicare the Medicare Summary Notice (MSN) and usually pays them 80 percent of the amount approved by Medicare (if deductible was met);
- Either the doctor or the person with Medicare sends the claim and MSN to the secondary insurer unless their insurer has a crossover contract with Medicare Part B; and
- The secondary insurer sends the person with Medicare an Explanation of Benefits.

What is the Medicare Appeals Process for Part A and Part B?

- If a person with Medicare is dissatisfied with a Medicare decision, appealing a claim is one of the most important rights they have.

Note: Medicare providers and suppliers have the same appeal rights, as people with Medicare. Once an appeal request is submitted for a claim, either by a person with Medicare or a provider, that is the only appeal available. An unfavorable decision on a provider initiated appeal is binding on the person with Medicare.

- For both Part A and Part B, a person with Medicare must request a redetermination within 120 days of notification of the original claim determination (120 days of the date on the Medicare Summary Notice (MSN)).
- Submit a copy of the MSN with the person with Medicare's signature and medical documentation or explanation to the Medicare Part A or Part B Medicare Administrative Contractor (MAC).
- The MAC will review and issue a decision within 60 days.
- If decision is upheld, then a person with Medicare can file for a reconsideration (within 180 days of redetermination decision). The Qualified Independent Contractor (QIC) will issue a decision within 60 days. The person with Medicare is entitled to a reconsideration regardless of the amount of the claim.
- If the reconsideration is not successful, the person with Medicare may request an Administrative Law Judge Hearing (within 60 days from the date of the QIC decision). There must be $140 (2013) or more in controversy. The Administrative Law Judge (ALJ) will issue a decision within 90 days.
- If the ALJ hearing is not successful, person with Medicare may request a Medicare Appeals Council review within 60 days from the ALJ decision. The Medicare Appeals Council will issue a decision within 90 days.
- If the Medicare Appeals Council review is not successful, the person with Medicare can file a request for Federal Court Review within 60 days from the Medicare Appeals Council decision. There must be at least $1,400 (2013) in controversy.

Can a member of a Medicare Advantage (MA) plan appeal a decision?

- A member must ask for a reconsideration within 60 days of the initial determination
- If the MA plan does not rule in the person with Medicare's favor, the MA plan automatically forwards their case to the Independent Review Entity (IRE), currently Maximus
- If a member loses their case at the IRE level, they can request an Administrative Law Judge (ALJ) hearing within 60 days. There must be at least $140 (2013) in dispute.
- If a member loses at the ALJ level, they can request a Medicare Appeals Council (MAC) hearing within 60 days.

- Finally, if they lose at MAC, they may request a Judicial Review (Federal District Court) within 60 days. There must be $1,400 (2013) or more in dispute.

Note: For information on Medicare Part D appeals, see Module 6: Medicare Prescription Drug Coverage (Medicare Part D)

Where can I file a complaint about quality of care?

A quality of care issue can be addressed to IPRO, the Quality Improvement Organization (QIO) for New York State at 1-800-331-7767.

CLAIMS FILING AND YOUR CLIENT'S RESPONSIBILITIES

"Claims filing is a lot like motherhood. It's a career for which there is no training, no job description, no handbooks and no end in sight," wrote Erma Bombeck in a 1991-syndicated article. But there is preparation! People with Medicare must ready themselves to tackle this necessary part of health insurance after age 65 with:

1. an awareness of their primary responsibilities
2. a basic understanding of the language, the paperwork, the participants and the process
3. a tracking tool, the Insurance Claims Record, to guide and organize their efforts

Your Client's Responsibilities

Since September 1, 1990, all Medicare providers, including physicians, are required to submit Medicare claims to the Medicare contractor, the insurance company that makes Medicare payments, on behalf of a person with Medicare.

But a person with Medicare has responsibilities too. Providing the appropriate information at all levels of the process will insure the fewest possible glitches. That's not to say that problems won't occur. But at least a person with Medicare has done everything possible to guard against it.

- **First, supply the doctor or other provider with correct information**
  Incorrect information is a primary reason for delay and denial of payment. A person with Medicare should check with each doctor or other provider to see that their correct Medicare number is on file and being used. A person with Medicare should be sure not to confuse their Medicare number with their Social Security number. The Medicare number usually has a letter at the end. The person with Medicare should check that the doctor or other provider has either a copy of their Medicare card or in some other way knows whether they have both Parts A and B or only one. A person with Medicare should always give their name exactly as it is shown on their Medicare card as nicknames confuse the computer! Be sure their doctor or other provider has their current address and telephone number. Sometimes Medicare will need to contact a person with Medicare for additional information.
- Be sure to show and refer to their Medicare Advantage plan identification card if they are in a Medicare Advantage plan. They do not need to show their red, white, and blue Medicare card if they are in a Medicare Advantage plan.
- Let their doctor or other provider know if their injury or illness is the result of a work-related incident (for worker's compensation), an auto accident, or injury involving liability or homeowner's insurance. Federal law requires that a claim include this information.

- Inform their doctor or other provider if they have other health benefits such as employer-sponsored retiree insurance, Medicaid, or VA related health care coverage
- Give doctors or other providers their private Medicare supplement (Medigap) or other insurance policy numbers.
- Be certain to inform doctors or other providers if they are over age 65 and continuing to work, or their spouse is currently working. If your client has a qualified employer health plan, it may be their primary payer.
- Be aware that federal law authorizes Medicare to ask for medical information if it is necessary to identify a person with Medicare, to determine their Medicare eligibility, to determine their coverage or to insure proper payment
- Legally, your client may refuse to supply any requested information except in relation to work injuries, auto injuries, or other liability-related insurance claims, but be aware that withholding information may result in slow payment or no payment.

MEDICARE LANGUAGE

Speaking the language of Medicare and health insurance claims is a prerequisite for mastering the process. Become familiar with the following terms:

Advance Beneficiary Notice of Noncoverage (ABN) – A notice that a doctor or supplier may give a person with Medicare if he or she provides a service that Medicare does not consider medically necessary or that he or she believes Medicare will not pay for. The person with Medicare may sign the notice indicating that they will assume financial responsibility if Medicare does not pay, or they can elect to forego the service.

Appeal – An appeal is a special kind of complaint your client can make if they disagree with the initial claim determination (for example, if Medicare doesn't pay for a service your client received.) This complaint is made to your client's Medicare Advantage plan or to the Medicare Administrative Contractor (MAC) that processed the claim for those in the Original Medicare Plan.

Assignment – Assignment is an agreement between Medicare, the provider (most often the physician) and the person with Medicare. Accepting assignment means that the provider accepts Medicare's approved amount as payment in full. The provider is paid directly by Medicare, usually 80 percent of the approved amount. The person with Medicare usually owes 20 percent of the approved amount. Not accepting assignment means the provider does not accept Medicare's approved amount as payment in full. A provider cannot, however, charge whatever he or she chooses to people with Medicare. Federal and New York State laws limit how much a doctor may charge in excess of Medicare's approved amount.

Claim – A request to a Medicare Administrative Contractor (MAC) or to a private insurance company for payment of health care benefits.

Coinsurance – A specified dollar amount or percentage of covered expenses, which a person with Medicare must pay toward medical bills. For example, Medicare Part A Hospital Insurance requires that a person with Medicare pay a daily coinsurance amount for hospital days 61-90, while Medicare Part B requires that a person with Medicare pay a coinsurance of 20 percent of Medicare's approved amount for physician services.

Copayment – Like a coinsurance, it is the amount you pay for covered services. A copayment is a flat fee. For example, in an HMO you may pay $20 every time you see your primary care physician.

Deductible – The amount of money that a person with Medicare must pay before Medicare or other insurance payments begin.

Denial – A decision by Medicare or another insurer that a person with Medicare's claim for benefits is not approved and will not be paid.

Employer Group Health Plan – Employee plan in business with 20 or more employees that offers health insurance. It can be primary coverage if one spouse is still working.

Employer-Sponsored Retiree Plan – A group health insurance policy offered through your client's former employer. At age 65, it usually becomes second payer after Medicare.

Explanation of Benefits (**EOB)** – A statement sent to your client to describe what benefits were paid or not paid by their employer-sponsored retiree plan or by their Medigap or other private health insurance. Usually, the reasons for claim denial are listed on the EOB.

Fast Track Appeal – An appeal right for Medicare Advantage enrollees who have been advised that services provided in a Skilled Nursing Facility, Home Health Agency or Comprehensive Outpatient Rehabilitation Facility may be terminated and they disagree. There are also expedited appeals in Original Medicare for termination of similar Part A benefits.

First (or Primary) Payer – The insurance coverage that has primary responsibility for your client's health care claims. For most people age 65 and older, Medicare is the first payer.

Grievance – A complaint about the way that your client's Medicare health plan is giving care. For example, your client may file a grievance if they have problems with the cleanliness of the health care facility, calling the plan, staff behavior, or operating hours. A grievance is not the same as an appeal, which is a way to deal with a complaint about a treatment decision or a service that is not covered.

Hospital Issued Notice of Non-coverage (HINN) – A notice that clients may receive if the hospital determines they may no longer be at a Medicare covered level of care. (In other words, Medicare will no longer pay for their care.) If they wish to appeal their discharge they must ask for the notice in writing to file an appeal.

Important Message From Medicare – A notice your clients should receive at or near the time of admission to a hospital that describes their rights should they wish to appeal their discharge.

Medigap – A privately purchased insurance policy specifically designed to pay some of the major benefit gaps in Medicare, such as deductibles and coinsurance.

Medicare Summary Notice (MSN) – A statement sent from Medicare to a person with Medicare to explain the Medicare benefits they used and to describe Medicare's payment for these services.

Notice of Discharge and Medicare Appeal Rights (NODMAR) - Medicare Advantage enrollees must receive or request this notice if they feel they are being discharged too soon in order to file an appeal.

Premium – A monthly payment for Medicare and/or private insurance that a person with Medicare pays regardless of whether they use the service.

Reconsideration – An independent review carried out by the Qualified Independent Contractor (QIC).

Redetermination – An independent review carried out by the Part A or Part B Medicare Administrative Contractor (MAC).

Second (or Secondary) Payer – When a person with Medicare has more than one type of insurance, this insurance coverage pays only after their first payer has done so. For many people age 65 and older, a Medicare supplement policy or a retiree health plan from their former employer is the second payer.

MEDICARE CONTRACTORS

Private insurance companies who have contracts (thus the name contractors) with the Centers for Medicare & Medicaid Services (CMS) handle processing and payments of Medicare Claims.

Medicare Part A

Contractors, who process claims for **Part A** services, including hospital, skilled nursing facility, home health and hospice services, are known as **Medicare Administrative Contractors (MAC).**

For all Medicare Part A services, the provider of services will submit your client's claims to the MAC for payment. A person with Medicare is not responsible for submitting Medicare claims.

The MAC will then send the payment directly to the hospital or other provider. Your client will receive a Medicare Summary Notice (MSN) to let them know that Medicare Part A has processed a claim on their behalf.

The MAC also processes claims for *outpatient* hospital services. However, outpatient hospital services are actually part of Medicare Part B benefits. Any part of the deductible applied to these services helps satisfy the annual Medicare Part B deductible.

Medicare Part B

Contractors, which process claims for most Part B services, including physician services, are known as **Medicare Administrative Contractors (MAC)**. Medicare Part B MACs make payments for covered services according to a national Medicare Fee Schedule. Payments are based on a relative value scale that considers the time and resources a doctor devotes to each procedure. The payment also considers the doctor's overhead according to the area of the country where the doctor practices. *Physicians and other medical providers are required by law to send claims for services rendered to people with Medicare to the MAC who handles Medicare payments where the services were received.*

Payment from the Medicare MAC goes directly *to a doctor* who accepts Medicare assignment. Your client will receive a Medicare Summary Notice (MSN) form explaining the payment made to their doctor. Payment from the Medicare MAC for a claim from a doctor who does not accept assignment is sent–with the MSN–to the person with Medicare. It is their responsibility to send the Medicare payment on to their doctor or other provider.

Note: National Government Services (NGS) is the Part A and Part B Medicare Administrative Contractor (MAC) for the entire state of New York.

Part B claims for Durable Medical Equipment (DME) are processed by one of four Regional Contractors; claims will be processed by the contractor where the person with Medicare establishes residence at least six months and one day out of the year. If the person with Medicare's permanent residence is in the Northeast, their claims for durable medical equipment, prosthetics, orthotics, and supplies will be processed by the Jurisdiction A Durable Medical Equipment Medicare Administrative Contractor (DME MAC), NHIC. Certified DME suppliers submit claims.

Note: It is the provider's legal responsibility to submit claims to Medicare. The provider is not permitted to charge a person with Medicare for this claims processing service.

MEDICARE CLAIMS PROCESS

Steps for Medicare Part A Claims

For services received from a hospital, skilled nursing facility, home health care agency or hospice:

1. The provider sends claims to Medicare Part A.
2. Medicare Part A pays the provider directly. Medicare Part A sends a Medicare Summary Notice to the person with Medicare.
3. Come to an agreement with the provider-billing department about which of the following will occur:
   a. The provider mails the claim directly to your client's Medigap or retiree plan. Your client's insurance company will send payment to the provider.
   b. The provider mails the claim directly to your client's Medicare supplement or retiree plan. Your client's insurance company will send payment to your client unless your client signed an agreement with the provider for them to be paid directly.
   c. Your client mails the following to their Medigap or retiree plan insurer:
      - a copy of the Medicare Summary Notice
      - a copy of the itemized hospital bill (if required)
      - a completed claim form (if required)
      - your client's secondary insurer may require one or more of these three forms (learn insurer's claim requirements before your client sends their first claim)
4. Your client's insurer sends an EOB and payment to your client (except as noted in 3a or 3b). A Medigap policy usually pays the Medicare Part A deductible and coinsurance. A retiree plan may pay part or all of the Medicare Part A deductible and coinsurance; it depends on the retiree plan.
5. Your client pays the provider. Your client is responsible for the following:
   - amounts paid to your client by Medicare and your client's Medicare Supplement Insurance or retiree plan
   - deductible and coinsurance amounts not paid by your client's insurance
   - charges for items not covered by Medicare or your client's insurance such as telephone and television.
   - Call 1-800-MEDICARE for a copy of the Medicare Summary Notice (MSN) for your client's hospital stay if your client does not receive one in the mail.

Note: Most Medigap and other secondary insurers have an automatic crossover arrangement with Medicare, where once Medicare processes the claim, the information is forwarded electronically to the other insurer, eliminating the need to submit a separate claim. Check with the secondary insurer to see if this service is available.

Steps for Medicare Part B Assigned Claims

(Medicare-participating doctors always accept assignment. Medicare non-participating doctors may choose to accept assignment on a claim-by-claim basis.) Refer to the assigned MSN example that follows.

1. Doctor's (or other provider's) office sends the claim to Medicare Part B.
2. Medicare sends your client the MSN and pays the provider 80 percent* of the amount approved by Medicare if your client has already met their Part B deductible.
3. If your client has a second payer, come to an agreement with their doctor's billing staff as to which of the following will occur:
   a. Medicare Part B sends the claim directly to your client's Medigap insurer. Your client's Medigap insurer usually pays the doctor the remaining balance or...
   b. The doctor's office mails the claim directly to your client's Medigap or retiree plan insurer. The insurer will send payment to your client unless your client signed an agreement with the doctor provided for them to be paid directly or...
   c. Your client sends to their Medigap or retiree plan insurer:
      - a copy of the MSN
      - a copy of the itemized doctor's bill (if required)
      - a completed claim form (if required).
4. Advise your client to keep copies of all forms for their records!
5. Your client's insurer sends an EOB and payment to your client (except in option 3a or 3b, above). A Medigap policy usually pays 20 percent of Medicare's approved amount. A retiree plan may pay all or part of the 20 percent not paid by Medicare.
6. Your client pays the doctor. Your client is responsible for the following:
   - amounts paid to your client by Medicare and their Medicare Supplement Insurance or retiree plan
   - deductible and coinsurance amounts not paid by their insurance
   - charges for items not covered by Medicare or their insurance.

- For most covered services, Medicare pays 80 percent of the approved amount. However, there are exceptions: e.g., Medicare pays 100 percent for lab services and 65 percent (2013) of the approved amount for outpatient mental health services.

BENEFICIARY SUBMITTED CLAIMS

If a person with Medicare is in the Original Medicare Plan, providers (e.g., hospitals, skilled nursing facilities, home health agencies, and physicians) and suppliers are required by law to file claims for covered services and supplies that they receive. However, if the provider does not submit a claim form on a beneficiary's behalf, the beneficiary may need to submit a CMS claim form called *Patient's Request for Medicare Payment*, (CMS 1490S). See page 11 for a copy of the form.

Medicare cannot pay its share of the bill until a Medicare claim is filed. People with Medicare should take the following steps if their doctor or supplier does not file the Medicare claim in a timely manner.

Step 1 – Contact Your Physician or Supplier: Call your physician or supplier directly and ask the physician or supplier to file a Medicare claim.

Step 2 – Contact 1-800-Medicare: If your physician or supplier still does not file a Medicare claim after you have requested it, you should call 1-800-Medicare (1-800-633-4227). Medicare will work with the Medicare contractor that processes your claims to contact the physician or supplier on your behalf to ensure that the physician or supplier is aware of the responsibility for filing the claim. Also ask Medicare for the exact time limit for filing a Medicare claim for the service or supply that you received.

IMPORTANT: There is a time limit for filing a Medicare claim. If a claim is not filed within the time limit, Medicare cannot pay you its share. Claims for services on or after January 1, 2010, must be filed within one calendar year after the date of service.

Step 3 – When You Should File a Claim: You should only need to file a Medicare claim in very rare situations. You should contact 1-800 Medicare and ask for the forms to file a Medicare claim yourself when you have completed steps 1 and 2 above; AND the physician or supplier still has not filed the Medicare claim; AND it is close to the time limit for filing your Medicare claim. (For example, for dates of services January 1, 2010 and after, you should consider filing a Medicare claim if the physician or supplier has not filed the Medicare claim and it is close to 12 months since you received the service or supply).

To file a Medicare claim yourself, call 1-800-Medicare and ask for the proper form for a Medicare beneficiary to file a claim. The form is called *Patient's Request for Medical Payment* (CMS 1490S). 1-800-Medicare can answer your questions about how to complete the claim form.

Step 4 – In New York State send claims to:

National Government Services Inc.
Medicare Part B Claims
P.O. Box 6178
Indianapolis, IN. 46206-6178

Note: Beneficiary claims for durable medical equipment and supplies should be sent to:

DME Jurisdiction A Claims
P.O. Box 9165
Hingham, MA 02043-9165

There are generally two reasons providers refuse to submit claims:

A. They do not have a National Provider Identifier (NPI) which is a requirement to submit Medicare claims. Providers must apply for and receive an NPI before any claims will be processed. If you are submitting a 1490S claim form for a provider who does not have an NPI, and the provider refuses to submit a claim, add the following statement to the claim form: **"Doctor Refuses to File Claim"**

B. The Provider has "Opted-Out" of the Medicare program, Section 1802 of the Social Security Act, as amended by Section 4507 of the Balanced Budget Act of 1997, permits a doctor or practitioner to "opt-out" of Medicare and enter into private contracts with Medicare

beneficiaries if specific requirements are met. By "opting-out", a doctor or practitioner has decided not to provide services through the Medicare program and not bill for any services or supplies they provide to any Medicare beneficiary for a period of at least 2 years.

If you are submitting a 1490S claim form because your provider has opted out of the Medicare program and you want to be able to submit to your secondary insurer, add the following statement to the claim form "**Submitted for Denial Purpose Only"**

If a person with Medicare receives services from an Opt-out provider, you are agreeing that no Medicare or standard "Medigap" (Medicare supplement) benefits will be approved. It is not necessary to file a claim in these circumstances. Benefits may be paid only under the terms of the non-standard, private Medicare supplemental insurance and other employer provided insurance.

C. Send the completed claim form, your itemized bill, and any supporting documents to the Medicare contractor and explain in detail your reason for submitting the claim. The address where you need to return the form for processing depends on where the service was received. For example: If you received a service in Alabama, you need to send your claim to the address for Alabama.

When you submit your own claim to Medicare, you will need to ask your provider for his or her National Provider Identifier (NPI) number or you can go to the Web site to search for it. The URL is https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do.

If the NPI number is missing or the claim form has other incomplete or invalid information, the Medicare contractor may reject the claim or will send a letter to you with an explanation of why it was returned. You should mail the original claim form and make copies for your records. Please allow at least 60 days for Medicare to receive and process your request.

Tip: Be your own best consumer advocate and ask if the provider will participate in Medicare and bill Medicare for you.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT – SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

Your Medicare Carrier
If you need help, call 1-800-MEDICARE
(1-800-633-4227)

1 Name of Beneficiary from Health Insurance Card
(Last) (First) (Middle)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box – Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number
(Include Area Code)
(___ ___ ___)
___ ___ ___–___ ___ ___ ___

4 Describe the illness or injury for which patient received treatment

4b Condition was related to:
A. Patient's employment
☐ Yes ☐ No
B. Accident
☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5
a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No
b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No
c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policyholder's Name:

Policy or Medical Assistance No.

Note: If you DO NOT want payment information on this claim released, put an (X) here ☐

6 I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND CENTERS FOR MEDICARE & MEDICAID SERVICES OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

HOW TO FILL OUT THIS MEDICARE FORM

Medicare will pay you directly when you complete this form and attach an itemized bill from your doctor or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Medicare to process this claim. Mail your completed claim form to the Medicare Carrier responsible for processing your claim. If you do not know the address of your carrier, call 1-800-MEDICARE (1-800-633-4227).

FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of this form.

Block 1. Print your name shown on your Medicare Card (Last Name, First Name, Middle Name).

Block 2. Print your Health Insurance Claim Number including the letter at the end **exactly** as it is shown on your Medicare card. Check the appropriate box for the patient's sex.

Block 3. Furnish your mailing address and include your telephone number in Block 3b.

Block 4. Describe the illness or injury for which you received treatment. Check the appropriate box in Blocks 4b and 4c.

Block 5a. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where you are currently working.

Block 5b. Complete this Block if you are age 65 or older and enrolled in a health insurance plan where your spouse is currently working.

Block 5c. Complete this Block if you have any medical coverage other than Medicare. Be sure to provide the Policy or Medical Assistance Number. You may check the box provided if you do not wish payment information from this claim released to your other insurer.

Block 6. Be sure to sign your name. If you cannot write your name, make an (X) mark. Then have a witness sign his or her name and address in **Block 6** too.

If you are completing this form for another Medicare patient you should write (By) and sign your name and address in **Block 6.** You also should show your relationship to the patient and briefly explain why the patient cannot sign.

Block 6b. Print the date you completed this form.

B. Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service

Doctor's Office	Independent Laboratory	Outpatient Hospital
Nursing Home	Patient's Home	Inpatient Hospital

- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Doctor's or supplier's name and address. Many times a bill will show the names of several doctors or suppliers. IT IS VERY IMPORTANT THE ONE WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed **Block 4** of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a Medicare claim.
- If the patient is deceased, please contact your Social Security office for instructions on how to file a claim.
- Attach an Explanation of Medicare Benefits notice from the other insurer if you are also requesting Medicare payment.

COLLECTION AND USE OF MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872 and 1875 of the Social Security Act, as amended.

The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information to a hospital or doctor about the Medicare benefits you have used.

With one exception, which is discussed below, there are no penalties under Social Security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether worker's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 16 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

MEDICARE APPEALS & GRIEVANCES (Complaints)

In the Original Medicare Plan

If your client is dissatisfied, they have the right to **appeal** any decision concerning Medicare-covered services in the Original Medicare Plan.

Appealing Medicare decisions is one of the most important rights one has as a person with Medicare. Your client can file an appeal if he or she believes Medicare incorrectly denied payment or did not pay enough for services. Your client's appeal rights will be detailed on the back of the Medicare Summary Notice (MSN) that is mailed to them.

There is seldom a good reason not to appeal a Medicare denial, unless the services are excluded from Medicare coverage, such as for acupuncture or a hearing aid. A good practice is to examine the reason for denial. For example, if the service was denied as not medically reasonable or necessary, additional documentation on appeal may change the outcome.

The patient, or anyone they choose to be their "representative," may appeal a denial of coverage. The patient need not be actively involved in the appeal and does not have to attend any hearings.

MEDICARE PART A AND PART B APPEALS PROCESS

Level 1: Redetermination

Your client can request a Redetermination regardless of how much money is involved in a claim. After a claim is submitted, your client will receive a Medicare Summary Notice (MSN) from the Medicare Part A or Part B Medicare Administrative Contractor (MAC). The MSN states whether the claim was Medicare approved in full or part or was denied. If your client is dissatisfied with the decision, the appeal process begins. Submit a copy ***(not the original)*** of the MSN with "Please Review" written across the top along with your client's signature to the Medicare Part A or Part B Medicare Administrative Contractor (MAC) that processed the claim within 120 days of the date the MSN was processed.

- Submit A Copy of the CMS Form 20027 (Medicare Redetermination Request Form)
  - http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/CMS20027a.pdf
- Attach any new evidence, which supports the belief that the claim should be Medicare-approved.
- You may want to send the request "return receipt" so you have proof of when it was received.
- Keep a copy for your client's records.
- The MAC will review the initial claim, any new evidence and any medical records that are found in the course of review.
- The MAC will issue a second decision, either upholding or correcting its original decision, giving reasons for the decision.

Level 2: Reconsideration

When a redetermination is not successful, your client may request a reconsideration from the Qualified Independent Contractor (QIC) **within 180 days** of the date on the redetermination decision letter, regardless of how much money is involved in a claim.

To request a reconsideration:

- Submit a copy of the Redetermination decision with a completed CMS Form-20033 (Medicare Reconsideration Request Form) to the QIC.
  - http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf
- Attach any new evidence, which supports the belief that the claim should be Medicare-approved.
- The QIC will send your client a written decision either upholding or correcting the second decision.

Level 3: Administrative Law Judge Hearing

When a reconsideration is not successful and the amount at issue is $140 (2013) or more, your client may request a Hearing before an Administrative Law Judge (ALJ) ***within 60 days*** of the date on the Reconsideration letter. The $140 or more at issue does not include any deductible and coinsurance.

Submit a copy of the Reconsideration decision with a completed CMS Form-20034 (http://www.cms.gov/cmsforms/downloads/cms20034ab.pdf), "Request for Medicare Hearing by an Administrative Law Judge."

Attach any new evidence, which supports the belief that the claim should be Medicare-approved.

Level 4: Medicare Appeals Council Review

- When an Administrative Law Judge Hearing is not successful your client may request a Medicare Appeals Council Review from the Department of Appeals Board (DAB) **within 60 days** of the Administrative Law Judge Hearing decision.
- If the Appeals Council grants a review, it may give your client the opportunity to provide additional evidence, after which it will issue a decision.
- This level of appeal is necessary if your client intends to take their case to court.

Level 5: Judicial Review in Federal District Court

When a Medicare Appeals Council Review is not successful and the amount in dispute exceeds $1,400 (2013), your client may file a lawsuit in federal court within 60 days of receiving the Appeals Council Review decision. The $1,400 amount in dispute does not include any deductible or coinsurance**.**

- An attorney must represent your client. The local Legal Aid Services for the Area Agency on Aging may be able to help the person with Medicare pursue a lawsuit.
- To insure that a client's appeal is effective, advocates recommend:
- Calling or writing the Medicare Administrative Contractor (MAC) that processed your client's claim to find out exactly why the claim was denied or paid at such a low rate and request copies of the rules that were applied to denying the claim. It may be as simple as needing more

documentation from your client's physician to prove that the service they received was medically necessary.

- Request assistance from the physician. The physician's statement disputing the reason for the claim's denial may be the most important piece of evidence in your client's case.
- After your client understands why the claim was denied, prepare the case. The focus of the appeal statement and selection of witnesses should be based on how their claim fits the rules for Medicare payment.

Medicare Appeal Tips

- Always submit appeals with supporting documentation from a physician
- Continue the appeal process if denied at Level 1.
- The majority of appeals are decided in favor of the person with Medicare or the provider of services, so it is worthwhile to pursue.

Read and Learn more about the Medicare Part A and Part B Appeals Process:

- *Medicare Appeals* (CMS Publication #11525) June 2011 (http://www.medicare.gov/Publications/Pubs/pdf/11525.pdf).

APPEALING A HOSPITAL DISCHARGE

In the Original Medicare Plan

If your client believes they are being discharged too soon from a hospital, your client has the right to an immediate review by the Quality Improvement Organization. **Quality Improvement Organizations (QIOs)** are groups of practicing doctors and health care professionals paid by the federal government to monitor care given to Medicare patients and to protect the admission and discharge rights of hospitalized people with Medicare.

QIOs are also responsible for reviewing a person with Medicare's complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare Advantage Plans and ambulatory surgical centers.

QIOs provide inpatient appeals for hospitalized people with Medicare. A person with Medicare who uses the appeal process **can** stay in the hospital at no charge and cannot be discharged before the QIO makes a decision provided the request is made according to regulations.

How to Use the Discharge Process

Hospitals should provide patients with information about their rights around the time of admission. A guide called "The New York State Patients' Handbook" should be provided to patients early in their stay.

This guide includes "An Important Message from Medicare." This notice describes how to appeal decisions about discharge should your client feel they are being sent home too soon.

People with Medicare and/or their representatives should ask for this information if they do not receive it.

Steps in the Inpatient Hospital Appeal Process for Original Medicare

If the patient or their representative has been told that they are being discharged because they appear to no longer need acute hospital care and they disagree with this decision, they should speak to the doctor and:

- Ask for a notice in writing called a **Hospital Issued Notice of Noncoverage (HINN).** This states that the kind of care the patient currently needs or is receiving could be safely provided at home or in another setting and that Medicare may not continue coverage if the patient stays in the hospital after the date indicated on the form.
- Read the form carefully. If the patient or his or her representative does not understand the notice, ask for the hospital patient representative to assist in starting the appeal.
- **Call IPRO (New York State's QIO) at 1-800-331-7767** before noon of the day after your client receives the notice. Patients or representatives must be ready to state reasons why they feel they should remain in the hospital as well as to provide the necessary information to begin the appeal (i.e., name, Medicare number, physician name, etc.).
- IPRO reviews the patient's medical record to determine if the patient is or is not at a Medicare covered level of care. While the first review is being done, the patient may remain in the hospital at no additional cost until noon of the day after IPRO returns the decision. At that point, the hospital may begin to bill the patient if the patient appeal was not successful.
- People with Medicare and their representatives should be advised to work with the discharge planner and/or social services so that a safe discharge plan can be put in place. All patients must be provided with a written discharge plan before leaving the hospital.

Additional Appeal Rights

- Patients and/or their representatives may request an immediate reconsideration if their first appeal is not successful. People with Medicare should understand that they could be held financially responsible for days of care while the second appeal or reconsideration is being completed.
- If the patient or his/her representative loses the reconsideration appeal, they should proceed with planning for discharge but can request an Administrative Law Judge hearing by writing IPRO at 1979 Marcus Avenue, Lake Success, NY 11042 or calling 1-800-446-2447. This level of appeal may take place long after the hospitalization but all people with Medicare may access this process. It does not require an attorney.
- Read all appeal decision outcomes to learn how to proceed to the next level of appeal, i.e., Departmental Appeal Board Hearing or even Federal District Court.

Although appealing a Medicare hospital decision is a person with Medicare's right, the patient may not feel well enough to exercise that right or may not be informed about discharge rights.

Emphasize the need for people with Medicare to choose someone before admission to assist them or act on their behalf should problems or questions arise during the hospital stay. People with Medicare should choose a friend or family member to be their health care proxy.

Note: People with Medicare who do not request an appeal while in hospital and later wish to do so should call IPRO at 1-800-446-2447 to discuss their request. IPRO's hotline for people with Medicare (1-800-331-7767), where the appeals are actually performed, is also an excellent resource for appeals questions.

Note: There are also similar appeal rights in the Original Medicare Plan for discharge from Skilled Nursing Facilities and termination of home health services. All are expedited and go to the QIO for the first level of appeal.

In Other Medicare Health (Medicare Advantage) Plans

Your client has the right to appeal decisions concerning their Medicare health plans. If your client has any concerns or problems with their plan, they also have the right to file a grievance (complaint).

Your client has these rights regardless of the type of plan in which your client is enrolled. To participate in Medicare, each health plan must have an appeal and grievance process for its members. Consult the health plan's membership materials or contact your client's health plan for details about their rights and how to file a Medicare appeal and complaint.

Your client may file an appeal if their health plan denies a service, or terminates or refuses to pay for services that your client believes should be covered. Your client may be eligible for an expedited decision (issued within 72 hours) if they believe that waiting the amount of time for a standard decision could seriously harm their health or ability to function. (Refer to Medicare Advantage (MA) Managed Care Appeals and Grievance Procedures chart on page 10-20 for details on the appeals process.)

The health plan must provide to a person with Medicare written instructions on how to appeal. The first step is for the person with Medicare to contact his/her plan.

After the appeal is filed, the health plan reviews its original decision to deny coverage. Then, if the health plan does not decide in your client's favor, the appeal automatically goes to the Independent Review Entity (IRE) that contracts with Medicare.

Note: If a decision is not rendered within the required timeframe, it is considered an adverse decision and must also be automatically sent to the IRE.

How to Use the Inpatient Appeal Process for People with Medicare in Medicare Advantage Plans

- If a person with Medicare in a Medicare Advantage plan believes that they are being discharged too soon from a hospital, they have a right to request an immediate QIO review.
- They should first speak to their doctor.
- The patient or her designated representative must ask for a notice in writing. Medicare Advantage plan members receive a notice called **Notice of Discharge and Medicare Appeal Rights (NODMAR).** This notice provides details about how to begin the appeal.

The patient or his or her representative should call IPRO at **1-888-880-9976** and request an immediate review. The call **must be made before noon of the day after** the notice is received. While the QIO appeal is being processed, the health plan will continue to be responsible for paying the costs of the stay until noon of the calendar day after the QIO decision (if not favorable). Enrollees who miss the noon deadline for IPRO appeal may request a fast appeal from the health plan. However, there is **no automatic financial protection during** the course of the appeal. This means the enrollee could be responsible for paying the costs of hospital care beginning the date specified on the discharge form.

The IPRO appeal process is available for **hospital discharge situations only** and does **not** include **admission denials for Medicare Advantage managed care plan enrollees**.

As with Original Medicare, if your client is enrolled in a Medicare Advantage plan and believes they are being discharged too soon from a hospital, your client has the right to immediate review by the Quality Improvement Organization (QIO) in New York State. During the immediate QIO review, a patient may be able to stay in the hospital at no charge and the hospital cannot discharge the patient before the QIO reaches a decision.

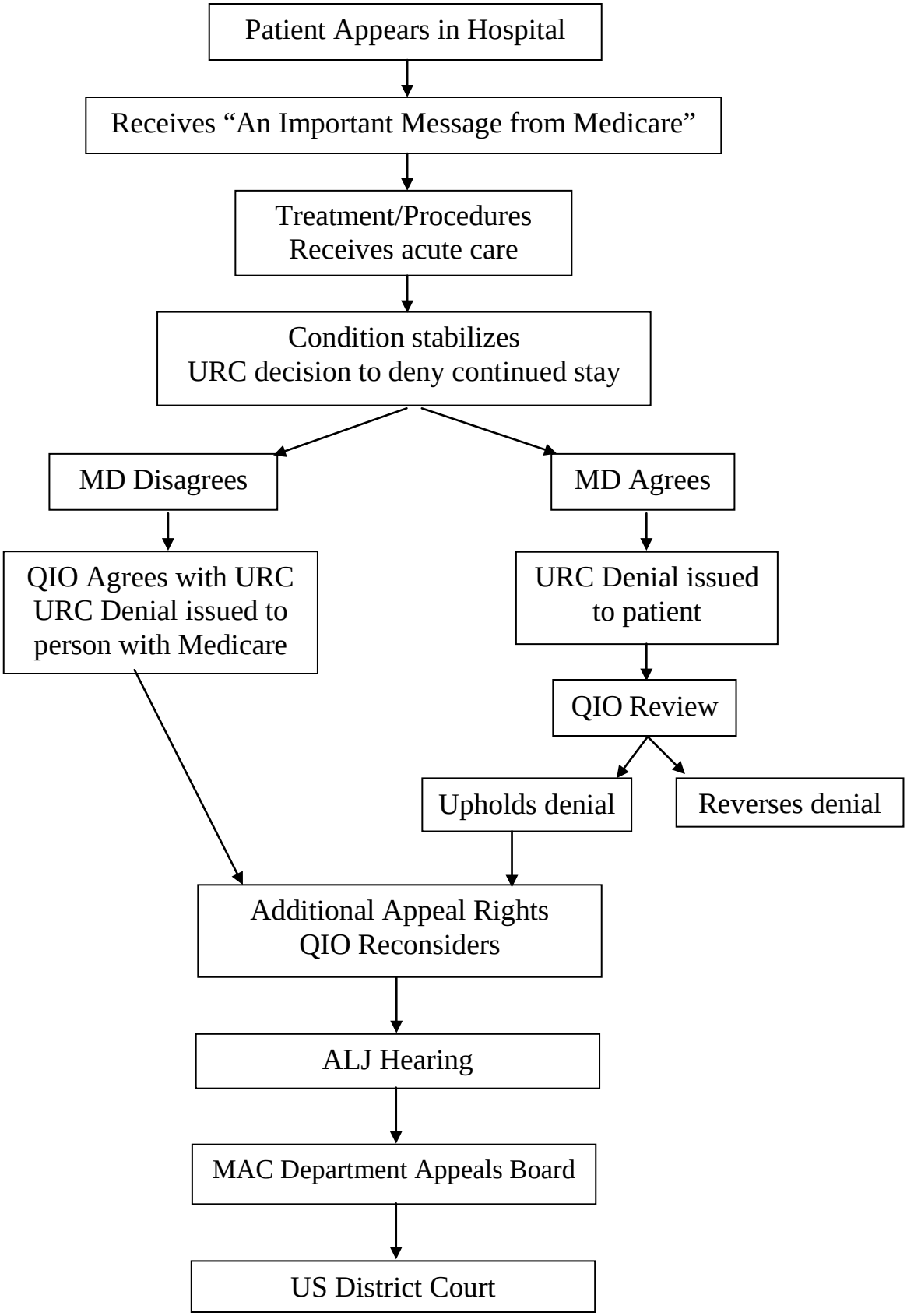
In New York State, the designated QIO is Island Peer Review Organization (IPRO). For non-coverage appeals, call 1-800-446-2447. For inquiries about the quality of Medicare-covered services which a person with Medicare has received or is receiving in a hospital, nursing facility, outpatient department, home health agency, or through a Medicare Advantage plan, call the Hotline for People with Medicare at 1-800-331-7767.

Please note: To request appeals about discontinuation of **Skilled Nursing Facility** services or **Home Health Services,** the person with Medicare or representative should request the provider to submit a demand bill for services provided to Medicare for a coverage determination.

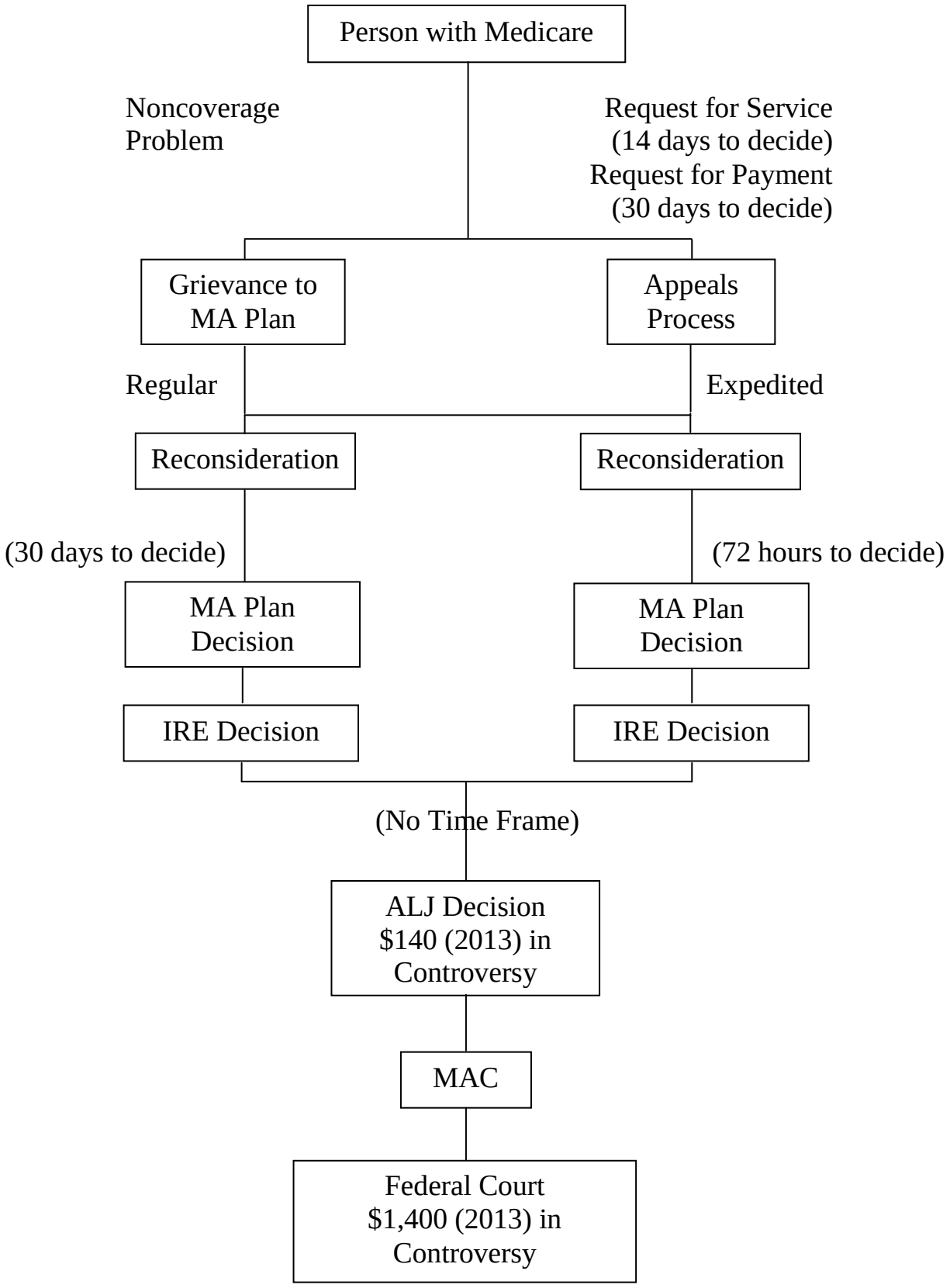
Read and Learn more about the Medicare Appeals Process

- *Medicare & You 2013*, CMS Publication #10050, September 2012
- *Medicare Hospital Patient's Rights*, IPRO

Original Medicare Hospital Appeals Continued Stay HINNS Process



Medicare Advantage (MA) Managed Care Appeals and Grievance Procedures



MEDICARE ADVANTAGE MANAGED CARE PLAN COMPLAINTS

Your client has the right to complain when they feel that their Medicare Advantage (MA) Managed Care Plan has not provided Medicare-covered services, has not performed up to their expectations, or has not met plan or CMS requirements.

There are three types of procedures available to use to resolve complaints. Each procedure covers specific types of complaints. The procedures are:

- The Medicare appeals procedure
- The plan's internal grievance procedure
- The **Quality Improvement Organization (QIO)** procedures

The plan's written materials must explain all complaint procedures. These materials should clearly distinguish between grievance and appeals issues. They must describe all steps of the plan's internal grievance procedure and the Medicare appeals procedure. Time limits, amount requirements, and procedures must be included.

(Refer to Medicare Advantage (MA) Managed Care Appeals and Grievance Procedures chart on page 10-20 for details on the appeals process, including time limits.)

Note: MA plans may also choose to implement more stringent time limits.

Medicare Appeals Procedure

A member should use the Medicare appeals procedure if their Medicare Advantage (MA) plan refuses to provide or pay for a service. The MA plan's claims department will usually make decisions about coverage and payment for services.

If the claims department denies payment for Medicare-covered services or refuses to provide Medicare-covered supplies requested, your client will be given a "Notice of Initial Determination." That notice will include an explanation of appeal rights. If your client believes that the decision their MA plan made was not correct, your client has the right to ask for a "Reconsideration." This request must be filed in writing **within 60 days** of when the "Notice of Initial Determination" is received or your client may simply make a copy of the notice from the MA plan, write, "please reconsider" on it, sign their name and date it, then mail it to your client's MA plan.

When your client asks in writing, the MA plan must reconsider its initial determination to deny payment or services. If your client's MA plan does not rule in their favor, the case is automatically referred to the Independent Review Entity (IRE), currently Maximus. CMS has a contract with Maximus to provide independent review activities. If your client disagrees with Maximus' decision and the amount in dispute is $140 (2013) or more, your client has **60 days from receipt** of the decision to request a hearing before an Administrative Law Judge. Your client may represent him or herself or appoint someone to represent them. If the case involves $1,400 (2013) or more, your client can eventually appeal to a Federal Court. If their appeal goes as far as this judicial review, your client will need to be represented by an attorney.

Internal Grievance Procedure

The Medicare Advantage (MA) plan's internal grievance procedure may be used if your client has a complaint about the quality of care your client received that is not related to payments. The complaint procedure is in the Member Handbook or your client can contact Member Services.

If your client has a complaint about deceptive or misleading advertising, questionable enrollment or marketing practices, your client should also file their complaint with the Centers for Medicare & Medicaid Services Region II, Room 3800, 26 Federal Plaza, Federal Building, New York, NY 10278.

Quality Improvement Organization (QIO)

If your client's complaint is about quality of care, they can also complain to the **Quality Improvement Organization (QIO)** in their area. In New York State, write or call the **Island Peer Review Organization (IRPO)**, 1979 Marcus Ave., 1st Floor, Lake Success, NY 11042-1002. The telephone number is 1-800-331-7767 or 1-516-326-7767.

QIOs are groups of practicing doctors and other health care professionals paid by the Federal government to monitor the quality of care provided to Medicare patients by hospitals, skilled nursing facilities, home health agencies, ambulatory surgical centers, and Medicare Advantage plans. QIOs will help write a complaint, if necessary, and will investigate complaints. In addition to the Person with Medicare Complaint Hotline, QIOs work with the healthcare providers to improve the quality of care for all people with Medicare.

Read and Learn more about the Medicare Appeals Process

- *Medicare & You 2013*, CMS Publication #10050, September 2012
- Your client may also obtain information by calling 1-800-633-4227 (1-800-MEDICAR(E)).

Sources of Assistance

NYS OFA HIICAP Hotline **1-800-701-0501**

1-800-MEDICAR(E) **1-800-633-4227**
www.medicare.gov

State Office for Aging Senior Hotline **1-800-342-9871**

Social Security Administration **1-800-772-1213**
www.socialsecurity.gov

Medicare Administrative Contractor (MAC): Part A
National Government Services **1-800-MEDICAR(E)**
1-800-633-4227
TTY 1-877-486-2048

Inpatient Appeals and Quality of Care Inquiries:
Quality Improvement Organization (QIO)
Island Peer Review Organization (IPRO) **(NY only): 1-800-331-7767**
(Inpatient and admission denials)
1979 Marcus Avenue, 1st Floor **(out-of-state, call collect): 1-516-326-7767**
Lake Success, New York 11042
www.ipro.org

Medicare Administrative Contractor (MAC)
(Entire State of New York)
Medicare Part B/National Government Services **1-800-MEDICAR(E)**
www.ngsmedicare.com **1-800-633-4227**
TTY 1-877-486-2048

Counselor Contacts: Kathy Dunphy **718-989-0981**
Ronnie Hauser **914-329-9779**

Carrier: Railroad Retirees **1-800-833-4455**
Palmetto GBA **TTY 877-566-3572**
P.O. Box 10066, Augusta, Georgia 30999-0001
http://www.palmettogba.com/palmetto/palmetto.nsf/DocsCat/Home

Medicare Administrative Contractor
Durable Medical Equipment **1-800-MEDICAR(E)**
National Heritage Insurance Company (NHIC) **1-800-633-4227**
P.O. Box 9146,
Hingham, MA 02043-9146
http://www.medicarenhic.com/dme/index.asp

STUDY GUIDE MODULE 10: MEDICARE CLAIMS & APPEALS

1. MEDICARE CLAIMS PROCESSING

Group Activity: Using the information from *Module 10*. Discuss the steps for:

1. Medicare Part A Claims
2. Medicare Part B Assigned Claims
3. Medicare Part B Unassigned Claims

2. MEDICARE APPEALS PROCESS

a. PART A and PART B APPEALS: List the 5 levels of this process.

1.
2.
3.
4.
5.

b. The most important document to provide the Administrative Law Judge in a hearing is a _____ from a person with Medicare's _____ explaining the medical necessity for the services he or she received.

c. A person with Medicare will always need an _____ to begin the Medicare appeal process.

3. MEDICARE ADVANTAGE PLAN COMPLAINTS

There are three types of procedures available to use to resolve complaints. Each procedure covers specific types of complaints. List the 3 procedures and types of complaints they cover.

1.
2.
3.

In Summary: Consider what your client has learned in this Medicare Claims & Appeals module.

- People with Medicare need to prepare themselves with:
  - a basic understanding of the language, paperwork, the participants and the claims process
  - a tracking tool, the Insurance Claims Record, to guide and organize their efforts
- Appealing Medicare decisions is one of the most important rights one has as a person with Medicare

ANSWER KEY MODULE 10: MEDICARE CLAIMS & APPEALS

1. MEDICARE CLAIMS PROCESSING

Group Activity: Using the information from *Module 10*. Discuss the steps for:

1. Medicare Part A Claims
2. Medicare Part B Assigned Claims
3. Medicare Part B Unassigned Claims

2. MEDICARE APPEALS PROCESS

a. PART A and PART B APPEALS: List the 5 levels of this process.

1. *Redetermination*
2. *Reconsideration*
3. *Administrative Law Judge Hearing*
4. *Medicare Appeals Council Review*
5. *Federal Court Review*

b. The most important document to provide the Administrative Law Judge in a hearing is a *letter* from a person with Medicare's *physician* explaining the medical necessity for the services he or she received

c. A person with Medicare will always need an *MSN* to begin the Medicare appeal process.

3. MEDICARE ADVANTAGE PLAN COMPLAINTS

There are three types of procedures available to use to resolve complaints. Each procedure covers specific types of complaints. List the 3 procedures and types of complaints they cover.

1. *Medicare appeals - when a Medicare Advantage managed care plan refuses to provide or pay for a service.*
2. *Internal Grievance Procedure - when a member has a complaint about the quality of care they received that is not related to payments.*
3. *Quality Improvement Organization (QIO)- if a member feels that they are being discharged from a hospital too soon.*

In Summary: Consider what your client has learned in this Medicare Claims & Appeals module.

- People with Medicare need to prepare themselves with:
  - a basic understanding of the language, paperwork, the participants and the claims process
  - a tracking tool, the Insurance Claims Record, to guide and organize their efforts
- Appealing Medicare decisions is one of the most important rights one has as a person with Medicare