

## **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?**

- To give the provider current information such as their Medicare number, address, and phone number;
- To advise the provider about any work-related injury or auto accident;
- To inform the provider if they have employment-related insurance, Medicaid, or VA health coverage; and
- To supply the provider with any supplemental insurance information.

*By law, the provider must submit a claim to Medicare.*

### **What are the steps for processing Medicare Part A claims (services provided by a hospital, a skilled nursing facility, a home health agency, or a hospice)?**

- The provider sends Part A claims to the Medicare Administrative Contractor (MAC);
- The MAC pays the provider the Medicare Part A amount payable and sends a Medicare Summary Notice (MSN) to the person with Medicare;
- The person with Medicare mails a copy of the MSN, the itemized hospital or other bill, and a claim form to their secondary insurer (if applicable), unless their insurer has a crossover contract with Medicare Part A;
- The secondary insurer pays the provider any secondary benefit amount and sends the person with Medicare an Explanation of Benefits (EOB) detailing what benefits were paid or not paid; and
- The person with Medicare pays any remaining cost sharing amount.

### **What are the steps for processing Medicare Part B Assigned Claims?**

- For assigned claims, the provider sends the claim to the Medicare Administrative Contractor (MAC);
- The MAC sends the person with Medicare a Medicare Summary Notice (MSN) and usually pays 80 percent of the amount approved under Medicare Part B;
- Either the provider sends the MSN to the secondary insurer (if applicable) or the person with Medicare will send the MSN with a copy of the doctor’s bill and a completed claim form to the secondary insurer, unless the insurer has a crossover contract with Medicare Part B;

- The secondary insurer pays the provider any secondary benefit amount and sends the person with Medicare an Explanation of Benefits (EOB) detailing what benefits were paid or not paid; and
- The person with Medicare pays any remaining cost sharing amount.

### **What are the steps for Medicare Part B unassigned claims?**

- The person with Medicare pays the doctor;
- The provider sends the claim to the Medicare Administrative Contractor (MAC);
- The MAC sends the person with Medicare a Medicare Summary Notice (MSN) and usually pays the person with Medicare 80 percent of the amount approved by Medicare (if deductible was met);
- Either the provider or the person with Medicare sends the claim and MSN to the secondary insurer (if applicable), unless their insurer has a crossover contract with Medicare Part B;
- The secondary insurer sends the person with Medicare an Explanation of Benefits (EOB) detailing what benefits were paid or not paid; and
- The secondary insurer pays the person with Medicare any secondary benefit amount.

### **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:** Participating Medicare providers and suppliers have the same appeal rights under Part A and Part B as people with Medicare. Once an appeal request is submitted for a claim, either by a person with Medicare or by 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 signature of the person appealing (beneficiary or provider) and medical documentation or explanation to the Medicare Part A or Part B Medicare Administrative Contractor (MAC).
- The MAC will review the request and issue a decision within 60 days of the receipt of the request for redetermination.
- If the decision is upheld, then the person with Medicare or the participating provider can file for a reconsideration (within 180 days of receiving the redetermination decision). The Qualified Independent Contractor (QIC) will issue a decision within 60 days. Reconsideration can be requested regardless of the amount of the claim.
- If the reconsideration is not successful, the person with Medicare or the participating provider may request an Administrative Law Judge (ALJ) hearing or review by the Office of Medicare Hearings and Appeals (OMHA) (within 60 days from the date of the QIC decision). The ALJ or the OMHA reviewer will issue a decision within 90 days or the person appealing can request review by the Medicare Appeals Council.

- If the ALJ hearing is not successful, the 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. In certain situations, an ALJ or OMHA decision on a case may be referred to the Medicare Appeals Council on behalf of the Centers for Medicare & Medicaid Services. If the Council does not make a decision within 90 days, the person appealing can request review by the Federal District Court.
- If the Medicare Appeals Council review is not successful, the person appealing can file a request for Federal District Court review within 60 days from the Medicare Appeals Council decision.

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

- A member must ask the plan 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).
- If a member loses their case at the IRE level, they can request an Administrative Law Judge (ALJ) hearing within 60 days.
- If a member loses at the ALJ level, they can request a Medicare Appeals Council hearing within 60 days.
- Finally, if they lose at Medicare Appeals Council, they may request a Judicial Review (Federal District Court) within 60 days.

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

<https://aging.ny.gov/hiicap-notebook>

**Where can I file a complaint about quality of care?**

A quality of care issue can be addressed to Livanta, the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for New York State at 1-866-815-5440. You may use the Medicare Quality of Care Complaint Form found at this link:

<https://www.livantaqio.com/assets/file/cms10287english.pdf>

Medicare health plan members may file quality of care complaints with the BFCC-QIO, their Medicare health plan, or both.

**CLAIMS FILING AND YOUR CLIENT’S RESPONSIBILITIES**

**Your Client’s Responsibilities**

All Medicare providers, including physicians, are required to submit Medicare claims to the Medicare Administrative Contractor (MAC), the company that makes Medicare payments, on behalf of a Medicare beneficiary.

But a Medicare beneficiary has responsibilities too. Providing the appropriate information at all levels of the process will ensure 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.

- 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 or Medicare Beneficiary Identifier (MBI) is an 11-character combination of letters and numbers that is randomly generated and unique to each person with Medicare. The person with Medicare should check that the doctor or other provider either has a copy of their current 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. Be sure their doctor or other provider has their current address and telephone number. From April 2018 through April 2019, people with Medicare were mailed new Medicare cards that show the Medicare Beneficiary Identifier (MBI). If an individual with Medicare has not received a new card, they should contact the SSA at 1-800-772-1213 to confirm their address is correct in SSA's records and to request a new card. See <https://www.cms.gov/Medicare/New-Medicare-Card/> for more information.
- Inform the Social Security Administration (SSA) at 1-800-772-1213 if their mailing address or phone number changes. 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 workers' compensation), an auto accident, or an injury involving liability insurance 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 if 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 ensure proper payment.
- Know that, while legally they may refuse to supply any requested information except in relation to work injuries, auto injuries, or other liability-related insurance claims, 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). Initially, 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 Original Medicare.

**Assignment** – Assignment is an agreement between Medicare, the provider (most often a 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 Medicare-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. However, a provider cannot charge whatever he or she chooses to people with Medicare. Federal and New York State laws may limit how much a doctor may charge in excess of Medicare's approved amount.

**Beneficiary** – Any person who receives benefits. (Also referred to as a person with Medicare or Medicare Beneficiary.)

**Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)** – These 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. In New York, the BFCC-QIO is Livanta.

**Claim** – A bill requesting that medical services be paid by Medicare or by some other insurance.

**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.

**Coordination of Benefits (COB)** – The COB process ensures claims are paid correctly by identifying the health benefits available to a Medicare beneficiary, coordinating the payment process, and ensuring that the primary payer, whether Medicare or other insurance, pays first.

**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.

**Cost sharing** – A blanket term that can refer to coinsurance, copayment, or a deductible that must be paid by a person with Medicare.

**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.

**Detailed Notice of Discharge (DND)** – Medicare beneficiaries must receive this notice if they believe they are being discharged from the hospital too soon and request BFCC-QIO review. It

provides a detailed explanation of the hospital's reason for discharging them and how Medicare rules apply to their case.

**Electronic Remit Advice (ERA)** – Itemized claim and payment information sent to a provider by the Medicare Administrative Contractor (MAC) informing them of the MAC's decisions about multiple claims. This is the provider's counterpart to the Medicare Summary Notice (MSN). The paper equivalent is called a Standard Paper Remit (SPR).

**Enrollment** – The process of joining a Medicare Advantage or Medicare prescription drug plan. A member of a Medicare Advantage or Medicare prescription drug plan may be called an enrollee. Enrollment can also refer to the procedure by which eligible persons can sign up for the Medicare program and receive Medicare (Part A and Part B) coverage.

**Entitlement** – The process by which a beneficiary begins to receive Part A or Part B benefits. Entitlement decisions are made by the Social Security Administration (or more rarely by the Railroad Retirement Board).

**Employer Group Health Plan** – Health insurance offered by an employer. It can be primary coverage for the employee (or for their covered spouse) if the employee is still working at 65 for an employer with 20 or more employees.

**Employer-Sponsored Retiree Plan** – A group health insurance plan offered through your client's (or their spouse'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 by 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 providing service. For example, your client may file a grievance if they have problems with 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.

**Important Message from Medicare (IM)** – 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. They should receive a second copy when they are going to be discharged.

**Medicare Number** – A randomly-generated 11-character series of letters and numbers used on new Medicare cards to identify a Medicare beneficiary.

**Medicare Outpatient Observation Notice (MOON)** – Hospitals and Critical Access Hospitals are required to provide notification to individuals receiving observation services as outpatients for more than 24 hours explaining the status of the individual as an outpatient, not an inpatient, and the implications of such status.

**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.

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

**Notice of Medicare Non-Coverage (NOMNC)** – If a person with Medicare is enrolled in a Medicare Advantage Plan, a notice that tells them when care they are receiving from a home health agency (HHA), skilled nursing facility (SNF) or comprehensive outpatient rehabilitation facility (CORF) is ending and how they can contact the BFCC-QIO to 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** – For beneficiaries with Original Medicare: An independent review carried out by the Qualified Independent Contractor (QIC). For beneficiaries with a Medicare Advantage plan: a review of the claim by the Medicare Advantage plan.

**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 ADMINISTRATIVE CONTRACTORS (MAC)

---

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

### Medicare Part A

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

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

**Medicare Administrative Contractors (MAC)** process claims for **most Part B** services, including physician and other medical provider services. Medicare Part B MACs make payments for covered services according to the national Medicare Fee Schedule.

Physicians and other medical providers are required by law to send claims for services provided to people with Medicare to the MAC that processes Medicare payments for the location where the services were received.

Payment from the Medicare MAC goes directly *to a doctor* or other provider who accepts Medicare assignment. Your client will receive a Medicare Summary Notice (MSN) form explaining the payment made to their doctor. Payment from the MAC for a claim from a provider who does not accept assignment is sent—with the MSN—to the person with Medicare. It is then their responsibility to send the Medicare payment on to their doctor or other provider, unless they have already paid the 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 multi-state regional contractors; claims are processed by the contractor that covers the region 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), Noridian Healthcare Solutions, LLC. Certified DME suppliers submit claims directly to the DME MAC.

**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. If your client has a secondary payer, come to an agreement with the provider's billing department about which of the following will occur:
  - a. The provider submits 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 submits the claim directly to your client's Medigap 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 the 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 your client’s Medigap 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. Clients can also get MSNs online by creating an account at Medicare.gov.

**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.

1. The 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 secondary payer, come to an agreement with the 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.
  - 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.
  - c. Your client sends the following 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 Medigap 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. For example, Medicare pays 100 percent of the approved amount for lab services.

**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.

## **BENEFICIARY SUBMITTED CLAIMS**

---

If a person with Medicare is in Original Medicare, providers (for example, 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).

**NOTE: Effective April 1, 2019, only versions of the form revised January 1, 2018 or later are accepted by CMS.** The most recent version of the form was revised June 1, 2021.

A copy of the form can be found at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012949.html>

The direct link to the form can be found at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1490S-ENGLISH.pdf>. It is also available in Spanish at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1490S-Spanish.pdf>.

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 the Physician or Supplier:** Call their physician or supplier directly and ask the physician or supplier to file a Medicare claim.

**Step 2 – Contact 1-800-MEDICARE:** If their physician or supplier still does not file a Medicare claim after they have requested it, they should call 1-800-MEDICARE (1-800-633-4227). Medicare will work with the Medicare Administrative Contractor that processes their claims to contact the physician or supplier on their behalf to ensure that the physician or supplier is aware of their responsibility for filing the claim. They should also ask Medicare for the exact time limit for filing a Medicare claim for the service or supply that they 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 its share. Claims for services must be filed within one calendar year after the date of service.

**Step 3 – When They Should File a Claim:** People with Medicare should only need to file a Medicare claim in very rare situations. They should file a Medicare claim themselves when they 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 their Medicare claim. (For example, they should consider filing a Medicare claim if the physician or supplier has not filed the Medicare claim and it is close to one calendar year since they received the service or supply.)

The *Patient's Request for Medical Payment* (CMS 1490S) can be found at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1490S-ENGLISH.pdf>. People with Medicare can contact 1-800-MEDICARE if they have questions about how to complete the claim form.

If the claim is non-durable medical equipment (DME) related, send the completed claim form, the itemized bill, and any supporting documents to the Medicare contractor and explain in detail the reason for submitting the claim. The address where the form must be sent for processing depends on where the service was received. For example: If they received a service in Alabama, they need to send their claim to the address for the Medicare Administrative Contractor for Alabama. They should mail the original claim form and make copies for their records.

**Step 4** – For services received in New York State, send beneficiary submitted claims to:

National Government Services, Inc.  
P.O. Box 6178  
Indianapolis, IN 46206-6178

Refer to the table in Form CMS-1490S for mailing addresses for claims for services received elsewhere.

**Note:** For beneficiaries who live in New York State, beneficiary submitted claims for durable medical equipment and supplies should be sent to:

Noridian JA  
PO Box 6780  
Fargo, ND 58108-6780

There are generally two reasons providers refuse to submit claims:

- A.** They are not enrolled in the Medicare program, which is a requirement to submit Medicare claims. Providers must complete a Medicare enrollment application that is approved by Medicare, before any claims will be processed. If you are submitting a 1490S claim for a provider who is not enrolled in Medicare, and the provider refuses to submit a claim, check the appropriate box on the 1490S form.
- 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 provider 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 CMS-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 (that is Medicare supplement insurance) benefits will be approved. It is not necessary to file a claim in these circumstances. Benefits may possibly be paid only under the terms of non-standard, private Medicare supplemental insurance and other employer-provided insurance.

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 NPPES NPI Registry web site to search for it. The URL is <https://npiregistry.cms.hhs.gov/>.

If the NPI number is missing or the claim form has other incomplete or invalid information, the Medicare Administrative Contractor may reject the claim or will send a letter to you with an explanation of why it was returned.

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.

## **MEDICARE PART D APPEALS**

See Module 6: HIICAP Notebook; *Medicare Prescription Drug Coverage (Medicare Part D)* for information on the Part D appeals process.

---

<https://aging.ny.gov/hiicap-notebook>

## **MEDICARE APPEALS and GRIEVANCES (Complaints)**

---

### **Original Medicare**

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

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 dentures 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 of the CMS Form 20027 (Medicare Redetermination Request Form) 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.
  - <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20027.pdf>
- Attach any new evidence, which supports the belief that the claim should be Medicare-approved. If a person with Medicare requests a redetermination, the MAC will automatically notify the provider and request additional documentation.
- 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.
  - <https://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 \$180 (2023) 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 \$180 or more at issue does not include any deductible and coinsurance.

The Office of Medicare Hearings and Appeals (OMHA) is responsible for administering ALJ hearings. Submit a copy of the Reconsideration decision with a completed Form OMHA-100 (<https://www.hhs.gov/sites/default/files/OMHA-100.pdf>), “Request for an Administrative Law Judge (ALJ) Hearing or Review of Dismissal”

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 \$1,850 (2023), your client may file a lawsuit in federal court within 60 days of receiving the Appeals Council Review decision. The \$1,760 amount in dispute does not include any deductible or coinsurance.

- An attorney should represent your client. The legal aid program of the local Area Agency on Aging may be able to help the person with Medicare pursue a lawsuit.

#### **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 appeal.
- To ensure that a client's appeal is effective, advocates recommend:
  - Calling 1-800-MEDICARE or writing the Medicare Administrative Contractor (MAC) that processed your client's claim to find out exactly why the claim was denied and to 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.
  - Requesting assistance from the physician or other provider. The provider'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 appeal statement and selection of witnesses should focus on how their claim fits the rules for Medicare payment.

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

- *Medicare Appeals* (CMS Publication #11525) <https://www.medicare.gov/Pubs/pdf/11525-Medicare-Appeals.pdf?>
- <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html>
- <https://www.medicare.gov/claims-and-appeals/index.html>

---

## APPEALING A HOSPITAL DISCHARGE

---

### Original Medicare

If your client believes they are being discharged too soon from a hospital, your client has the right to an immediate review by the **Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)**. Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-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. In New York State the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) is Livanta (<https://bfccqioarea1.com/>).

BFCC-QIOs are also responsible for reviewing complaints by a person with Medicare 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.

BFCC-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 BFCC-QIO makes a decision provided the request is made according to regulations.

### How to Use the Discharge Appeal Process

Hospitals should provide patients with information about their rights around the time of admission. A guide called “Your Rights as a Hospital Patient in New York” should be provided to patients early in their stay. This guide can also be reviewed online at <https://www.health.ny.gov/publications/1449.pdf>.

The guide includes a section titled “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 their doctor and:

- Read the “**Important Message from Medicare**” 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 Livanta (New York State’s BFCC-QIO)** at 1-866-815-5440 before midnight of the day of discharge and before the beneficiary leaves the hospital. 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 (such as their name, Medicare number, physician name, etc.).



- If the patient is appealing to Livanta (BFCC-QIO), the hospital must provide the patient with a **Detailed Notice of Discharge (DND)**. 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.
- Livanta 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 Livanta 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 hospital discharge planner, hospital social worker, 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 or calling Livanta at 1-866-815-5440. 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 notices to learn how to proceed to further levels of appeal, such as Medicare Appeals Council review or a lawsuit in 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.

**Please note:** For more detailed information about the hospital discharge appeals process and discontinuation of **Skilled Nursing Facility** services or **Home Health Services**, see:

<https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/original-medicare-appeals/original-medicare-appeals-if-your-care-is-ending>

### **Medicare Health (Medicare Advantage) Plan Appeals**

Your client has the right to appeal decisions by their Medicare health plan. 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 Medicare health 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, terminates a service, 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. The health plan must provide the client with written instructions describing how to appeal. The first step is for the person with Medicare to contact his or her plan.

After the appeal is filed, the Medicare 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 in Medicare Advantage Plans**

If a person with Medicare in a Medicare Advantage plan 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 their doctor and:

- Read the “**Important Message from Medicare**” 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 Livanta (New York State’s BFCC-QIO)** at 1-866-815-5440 before midnight of the day of discharge and before the beneficiary leaves the hospital. 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 (such as their name, Medicare number, physician name, etc.).
- If the patient is appealing to Livanta (BFCC-QIO), the hospital must provide the patient with a **Detailed Notice of Discharge (DND)**. 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.
- Livanta 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 Livanta 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 hospital discharge planner, hospital social worker, 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.

The call **must be made before midnight of the day of discharge**. While the BFCC-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 BFCC-QIO decision (if not favorable). Enrollees who miss the midnight deadline for Livanta appeal may still 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 Livanta appeal process is available for **hospital discharge situations only** and does **not** include **admission denials for Medicare Advantage managed care plan enrollees**.

For non-coverage appeals, or 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 Livanta at 1-866-815-5440.

**Please note:** For more detailed information about the hospital discharge appeals process and discontinuation of **Skilled Nursing Facility** services or **Home Health Services**, if enrolled in a Medicare Advantage plan see:

<https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/medicare-advantage-appeals/medicare-advantage-appeals-if-your-care-is-ending>

Read and Learn more about the Medicare Appeals Process

- *Medicare & You 2022*, CMS Publication #10050
  - <https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf>
- <https://www.medicareinteractive.org/get-answers/medicare-rights-and-appeals>

The Medicare Rights Center provides charts that describe the appeals process for both Original Medicare and Medicare Advantage. Click on the links below to see the charts:

- Original Medicare:  
[https://www.medicareinteractive.org/pdf/OM\\_EndingCareAppeal\\_Chart.pdf](https://www.medicareinteractive.org/pdf/OM_EndingCareAppeal_Chart.pdf)
- Medicare Advantage:  
[https://www.medicareinteractive.org/pdf/MA\\_EndingCareAppeal\\_Chart.pdf](https://www.medicareinteractive.org/pdf/MA_EndingCareAppeal_Chart.pdf)

## **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 Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-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.

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

## 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 an item that you have already received, your client will be given either an Explanation of Benefits (EOB) or a notice titled Notice of Denial of Payment. 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 appeal. The appeal must be filed in writing **within 60 days** of the date on the notice.

When your client appeals 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). CMS contracts with the IRE to provide independent review activities. If your client disagrees with the IRE's decision and the amount in dispute is \$180 (2023) or more, your client has **60 days from the date of the IRE** 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 \$1,850 (2023) 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.

For details about the Medicare Advantage (MA) appeals process for pre-service denials see; <https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/medicare-advantage-appeals/medicare-advantage-pre-service-standard-appeals>

## 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 plan's 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; Boston and New York Drug and Health Plan Operations Group; 26 Federal Plaza, Rm 3810; New York, NY 10278.

## Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)

If your client's complaint is about quality of care, they can also complain **to the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) in their area**. In New York State, call Livanta (BFCC-QIO) at 1-866-815-5440.

BFCC-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. BFCC-QIOs will help write a complaint, if necessary, and will investigate complaints. In addition to the Person with Medicare Complaint Hotline, BFCC-QIOs work with the healthcare providers to improve the quality of care for all people with Medicare.

## Sources of Assistance

<b>NYS OFA HIICAP Hotline</b>	<b>1-800-701-0501</b>
<b>1-800-MEDICAR(E)</b> <a href="http://medicare.gov">medicare.gov</a>	<b>1-800-633-4227</b> <b>TTY 1-877-486-2048</b>
<b>NY Connects</b>	<b>1-800-342-9871</b>
<b>Social Security Administration</b> <a href="http://socialsecurity.gov">socialsecurity.gov</a>	<b>1-800-772-1213</b>
<b>Inpatient Appeals and Quality of Care Inquiries:</b> <b>Livanta</b> <a href="http://livantaqio.com">livantaqio.com</a>	<b>1-866-815-5440</b>
<b>Medicare Administrative Contractor (MAC)</b> <b>Medicare Part A and Part B</b> National Government Services	<b>1-800-MEDICAR(E)</b> 1-800-633-4227 <a href="http://ngsmedicare.com">ngsmedicare.com</a>
<b>Medicare Administrative Contractor (MAC) for Railroad Retirees</b> Palmetto GBA P.O. Box 10066 Augusta, Georgia 30999-0001 <a href="https://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Beneficiaries">https://www.palmettogba.com/palmetto/providers.nsf/DocsCatHome/Railroad%20Beneficiaries</a>	<b>1-800-833-4455</b> <b>TTY 1- 877-566-3572</b>
<b>Medicare Administrative Contractor (MAC)</b> <b>Durable Medical Equipment</b> Noridian Healthcare Solutions Noridian JA DME PO Box 6780 Fargo, ND 58108-6780 <a href="https://med.noridianmedicare.com/web/jadme">https://med.noridianmedicare.com/web/jadme</a>	<b>1-866-419-9458</b>
<b>Qualified Independent Contractor (QIC) for Medicare Part A Appeals</b> C2C Innovative Solutions, Inc. PO Box 45305 Jacksonville, Florida 32232-5208 <a href="https://www.c2cinc.com/QIC-Part-A-East">https://www.c2cinc.com/QIC-Part-A-East</a>	
<b>Qualified Independent Contractor (QIC) for Medicare Part B Appeals</b> C2C Innovative Solutions, Inc. – QIC Part B North PO Box 45208 Jacksonville, Florida 32232-5208 <a href="https://www.c2cinc.com/QIC-Part-B-North">https://www.c2cinc.com/QIC-Part-B-North</a>	

**Qualified Independent Contractor (QIC) for Durable Medical Equipment (DME) Appeals**

Maximus Federal Services –  
QIC DME Project  
Maximus Federal Services, Inc.  
Medicare DME  
3750 Monroe Avenue, Suite 777  
Pittsford, NY 14534  
<https://www.medicaredmeappeals.com/contact-us>

**Independent Review Entity (IRE) for Medicare Advantage**

Maximus Federal Services  
Medicare Managed Care & PACE Reconsideration Project  
3750 Monroe Avenue, Suite 702  
Pittsford, NY 14534-1302  
Phone: 585-348-3300  
<https://www.medicareappeal.com/>

**1490S Claim Form (Patient's Request for Medicare Payment)**

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012949.html>

**STUDY GUIDE MODULE 10: MEDICARE CLAIMS and 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 and Appeals module.**

- People with Medicare need to prepare themselves with a basic understanding of the language, paperwork, the participants, and the claims process.
- Appealing Medicare decisions is one of the most important rights one has as a person with Medicare.

ANSWER KEY MODULE 10: MEDICARE CLAIMS and 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. Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-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 and Appeals module.**

- People with Medicare need to prepare themselves with a basic understanding of the language, paperwork, the participants, and the claims process.
- Appealing Medicare decisions is one of the most important rights one has as a person with Medicare.