Medicare Minute Teaching Materials – April 2016
Medicare Notices and Appeals

1) What is a Medicare Summary Notice (MSN)?
An MSN is a summary statement from Medicare provided to individuals enrolled in the Original Medicare Program that lists services you received from doctors, hospitals, and other health care providers. **An MSN is not a bill.** MSNs are mailed quarterly. You can also sign up for electronic MSNs at www.MyMedicare.gov.Your MSN lists services you have received and tells you whether they were covered, Medicare's approved amount for the services, and the amount you may still owe the provider. An MSN is divided into four sections. The initial summary page lists your deductible status, the names of the providers you've used in the past three months, and the total amount you owe for care received during that time. Section 2, "Making the Most of Your Medicare," contains tips to understand the MSN and lists additional resources for more information. Section 3 details claims for care you've received during the last quarter, including how much the provider billed Medicare, what Medicare actually paid the provider, and the amount you owe for the care. This section will also indicate if Medicare has denied coverage for any of your care and may include short notes that give reasons for a denial or other administrative action. Finally, Section 4 provides instructions, addresses, and deadlines for filing an appeal if Medicare denied coverage for any services or items you received.

Keep in mind that Medicare often provides separate MSNs for Part A- and Part B-covered services. For example, inpatient hospital, Skilled Nursing Facility (SNF), and hospice care will have their own MSN separate from the MSNs for Part B outpatient services and durable medical equipment (DME). If you have Original Medicare and a stand-alone Part D drug plan, you will also receive an Explanation of Benefits (EOB) from your Part D plan for any medications received (see question 2).

2) What is an Explanation of Benefits (EOB)?
Like an MSN, an EOB is a summary of health care services you have received over a period of time, and how much you may owe for them. You can receive an EOB from:

- Part D plans – If you have a Medicare Part D prescription drug plan, you will receive a Part D EOB monthly listing the medications you filled in the prior month and what you paid for them. You will receive a Part D EOB whether you have Original Medicare with a stand-alone Part D plan or you get your Part D coverage through a Medicare Advantage Plan. In addition to the drugs you have filled, the EOB will tell you which phase of drug coverage you are in for the year—the deductible, initial coverage, coverage gap, or catastrophic phase—and your total out-of-pocket costs and drug costs to date. It will also indicate any mid-year formulary changes that may affect you.

- Medicare Advantage Plans – This kind of EOB applies if you get your Medicare benefits through a Medicare Advantage Plan. Your Medicare Advantage Plan has different options for how frequently it provides EOBs: some plans choose to send EOBs on a monthly basis while others send an EOB after each claim and then a quarterly summary of all claims that quarter. Your Medicare Advantage EOB tells you what your provider billed your plan, the approved amount that the plan will pay, and what you may have to pay.

Like an MSN, **an EOB is not a bill.** It is simply a summary of the services you have received and how much you may owe for them. The Medicare Advantage EOB will also state the amount you have paid that counts toward your yearly out-of-pocket maximum. While all EOBs provide the same basic information, the layout and other specifics may vary based on your plan. If your EOB shows that an item or service is not being covered, look for a section that includes notes, comments, or remarks to find out the reason why. You may have to look on the next page to find them.

3) What is an appeal?

An appeal is when you ask Original Medicare or your health insurance plan to reconsider its denial of coverage of an item, service, or medication. Before you start your appeal, make sure you carefully read your Medicare notices. If a claim was denied, first contact your provider's office to make sure there was not a billing error leading to the denial. If the reason for the denial is not provided in your MSN, contact 1-800-Medicare to inquire further. If the reason for denial is not provided in your EOB, contact your plan for that information. The reason for denial will help determine your next steps. You can appeal a decision:

- If Medicare denies coverage of a health care service, item, or drug you need
- If Medicare or your plan stops paying for all or part of a health care service, item, or medication that your doctor thinks you still need
- If you want to request that you pay less for a drug you need
- If you are currently receiving certain kinds of care and your provider wants to end this care

There are two types of **Original Medicare** appeals. First, there are standard appeals that you file after you have already received care. These appeals follow a standard timeline. There are also expedited appeals that you file if your hospital, skilled nursing, home health, outpatient rehabilitation, or hospice care is set to end due to Medicare coverage rules. It is important to be aware of deadlines for expedited appeals because they move more quickly than standard ones.

If you have a **Medicare Advantage Plan** you can file a standard or expedited appeal with your plan. Standard appeals can be filed either before or after you receive care. There are two circumstances when you may file an expedited appeal. If you need care right away, you can file an expedited appeal. If your plan approves your request to expedite, it should issue a decision within 72 hours. You can also file an expedited appeal if you receive care from a hospital, skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), hospice, or home health agency and are told that your Medicare Advantage Plan will no longer pay for your care.

Your State Health Insurance Assistance Program (SHIP) can help you understand the appeals process and answer questions about the charges you wish to appeal. See the last page of this document for information about how to contact your SHIP.

4) When can you appeal?
You can appeal a denial immediately upon receipt of a notice indicating coverage is denied. If your appeal is approved, your health service or item will be covered, and you do not have to proceed in the appeal process. If Medicare or your plan denies your appeal, you can continue appealing by following the instructions on your denial notice. Make sure you follow the steps and stay within the timeframe of the appeal process that applies to your case. If you do not follow these rules, your appeal may not be considered. Note: the approval or denial of appeals will be sent to you in a letter.

5) What if I miss the deadline to appeal?
Submitting your appeal by the deadline will ensure that your appeal is fully considered. However, if you miss the deadline, you may be able to extend it by asking for a Good Cause Extension. You can receive a Good Cause Extension if you have a valid reason for not appealing in time. Reasons for a Good Cause Extension include, but aren't limited to:

- You were seriously ill and unable to file an appeal
- Documentation to support your appeal was difficult to obtain
- You lacked the ability to understand the timeframe for requesting an appeal

To request a Good Cause Extension, send the documentation supporting your reason for a late filing along with your appeal information to Original Medicare, your Part D plan, or your Medicare Advantage Plan.

6) Can someone file an appeal on my behalf?
A loved one, social worker, caregiver, or other chosen party may file an appeal for you. However, you may need to fill out a form saying that the person you select is your authorized representative. You can appoint your representative by completing an "Appointment of Representative" form (CMS Form number 1696). To get a copy, visit www.cms.gov/cmsforms/downloads/cms1696.pdf, or call 1-800-MEDICARE.

7) What is the difference between a denial, billing error, and Medicare fraud?
Sometimes Medicare denials are the result of a mistake or billing error rather than a decision not to cover a service, item, or medication. If you receive a health service denial from Original Medicare or your Medicare Advantage Plan, always call your doctor's office to ensure they did not make a billing mistake before proceeding with an appeal. If you receive a drug denial, call your plan to check for potential errors before requesting a formal denial notice.

If you do not recognize or remember receiving the service, item, or medication that was denied, call your provider or pharmacist to ensure a billing error did not take place. Help to protect yourself from Medicare fraud by only giving your information to trusted individuals, such as doctors and pharmacists. You also may want to keep a record/journal of all the medications you purchase and services you receive.

You may detect fraud by reviewing your **Explanation of Benefits (EOB)**, if you have a Medicare Advantage or Part D plan, or **Medicare Summary Notice (MSN)**, if you have Original Medicare. Compare these notices to your records. Make sure there are no suspicious additional charges or claims

for medications or services you never received. Also make sure that you were not billed multiple times for an item or service. If you receive an unsatisfactory answer or you are uncomfortable talking to your plan or pharmacist, report suspicious charges to the Senior Medicare Patrol (SMP) (see last page for contact information).

SHIP Case Study
Mai is 75 years old and has Original Medicare. She received a Medicare Summary Notice (MSN) that indicated she was denied coverage for her home health care based upon not being considered homebound. Mai is confused about why the care was denied and worries that she will not be able to pay her bill. She is not sure of her rights.

What should Mai do?

- For more information about understanding Medicare's home health coverage and her appeal rights, Mai should contact her State Health Insurance Assistance Program (SHIP).
- If Mai does not know how to contact her SHIP, she can visit www.shiptacenter.org or call 877-839-2675.

- A SHIP counselor will discuss Mai's unique circumstances and provide her with the information she needs to take the next step, including an appeal, if it appears her home health should indeed have been covered.

SMP Case Study
Penny is 67 years old and recently selected a new primary care physician. This month, she received a bill from this new doctor for her Annual Wellness Visit. Penny was confused because she knew that her Medicare Advantage Plan should cover the full cost of this visit. When Penny contacted her plan, she learned that this visit had been denied because her former primary care physician had already billed the plan for it. Penny has not visited her former primary care physician at all this year. She worries that she may be the victim of fraudulent billing.

What should Penny do?

- Penny should contact her former primary care physician to see if their office made a billing mistake.
- If her previous doctor's office is not willing to address the incorrect charges, she should contact her state Senior Medicare Patrol (SMP) for assistance.
- If she does not know how to contact her local SMP, she should visit www.smpresource.org or call 877-808-2468.
- The SMP representative will discuss Penny's case, reinforce the importance of addressing suspicious charges as she has done, and refer her case to the proper authorities.
- The SMP will also help Penny address the charges she is receiving from her new physician's office while her case is being reviewed by Medicare and other authorities.
- Medicare will determine if billing fraud, errors, or abuse occurred, based on the information Penny and the SMP provided.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 or visit www.shiptacenter.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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