Medicare Minute Script – April 2016
Medicare Notices and Appeals

Medicare notices help you understand your coverage, inform you about Medicare's coverage decision, monitor your out-of-pocket costs, and identify billing errors or suspicious charges.

Point 1: Know what to do if your health service or item is denied by Medicare or your plan.
If you have been denied coverage for a health service or item you may file an appeal. An appeal is formal request to ask Medicare to reconsider its coverage decision. How you appeal depends on whether you have coverage under Original Medicare or a Medicare Advantage Plan. If you have Original Medicare you can file a standard appeal if you have already received care. You can file an expedited appeal if your hospital, skilled nursing, home health, outpatient rehabilitation, or hospice care is set to end because of Medicare coverage rules. If you have a Medicare Advantage Plan, a standard appeal can be filed either before or after you receive care, and there are two circumstances when you may file an expedited appeal. First, you can file one before you receive care if you need a faster decision than that offered in the standard appeals process. Second, you can file one if your hospital, skilled nursing, home health, outpatient rehab, or hospice care is set to end because of the plan's or provider's interpretation of Medicare coverage rules.

Point 2: Understand the notices you should receive about your coverage.
Medicare notices contain information about the care you have received, its costs, your appeal rights, and who to contact for more information and assistance. If you have Original Medicare, you may receive the following notices:

- **Advance Beneficiary Notice (ABN):** An ABN is the notice you receive when a provider or supplier offers you a service or item they believe Medicare will not cover. Note that an ABN is not required for items or services that Medicare **never** covers, such as cosmetic surgery, acupuncture, routine foot care, and dentures.
- **Medicare Summary Notice (MSN):** An MSN is a quarterly summary of your health care services, not a bill. The MSN lists your services, shows if Medicare has paid for them, and shows how much you may owe your provider. If your MSN shows Medicare did not pay for a service you think it should have, call your provider to make sure there was not a billing error before appealing the decision.

If you have a Medicare Advantage or Part D plan, you may receive the following notices:

- **Notice of Denial of Medical Coverage:** This is an official written decision from your Medicare Advantage Plan explaining that it will not cover a service or item.
- **Notice of Denial of Prescription Drug Benefits (Coverage Determination):** This is an official written decision from your Part D plan explaining that it will not cover a specific drug.
- **Explanation of Benefits (EOB):** An EOB is a summary of health care services or prescriptions you have received and whether your plan paid for them, not a bill. EOBs are sent to you by your Medicare Advantage Plan or Part D drug plan, typically every month or after you have received services. If your EOB says that your plan did not pay for a service, call your provider to make sure there was not a billing error before appealing the decision.

Point 3: Know how to start an appeal.
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. In your request for an appeal, you should respond to the reason for the denial. For example, if Medicare or your plan denies coverage of a health care service due to lack of medical necessity, you will want to include information from your provider about why you need this care.

Take Action:
1) Review your notices carefully for accuracy.

2) File an appeal if your health service or item is denied, and stay within the timeframe of the appeal process.

3) If you need help understanding the appeals process, contact your State Health Insurance Assistance Program (SHIP)

4) If you notice suspicious charges on your MSN or EOB, contact your Senior Medicare Patrol (SMP) to discuss potential abuse or fraud.

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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