June 2021 Medicare Minute: Original Medicare and Medicare Advantage Appeals
Question and Answers

Question: Is there a time limit to appeal an Original Medicare denial?
Answer: Yes, you should file an appeal within 120 days of the date listed on the Medicare Summary Notice (MSN).

Question: Are MSNs applicable to Medicare Advantage Plans?
Answer: MSNs are just for Original Medicare. The Medicare Advantage Plan notice you receive after getting health care services or items is called an Explanation of Benefits (EOB).

Question: If my doctor doesn't accept Medicare can I get any sort of reimbursement?
Answer: If your doctor has opted out of Medicare, meaning they have signed an agreement to be excluded from the Medicare program, then you cannot receive reimbursement for any services that doctor provides. When you see an opt-out provider you should be asked to sign a private contract describing the doctor's charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.

If your doctor accepts Original Medicare but did not bill Medicare, follow these troubleshooting tips to get your provider to bill Medicare.

If you have a Medicare Advantage Plan and your doctor is not in-network for your plan, you may be able to get some reimbursement depending on the type of plan you have. For example, PPOs can provide some out-of-network coverage. Contact your plan to learn more about out-of-network coverage.

Question: Where do you get your updates from the Medicare Administrative Contractor (MAC)? Is it on the beneficiaries Medicare account?
Answer: Generally, you should contact the MAC directly for any updates on the status of an appeal.

Question: I find it difficult to understand much information in an MSN. For example, payment may not be made in full and there is a footnote indicating that the item was

paid under a "special payment method," but I have no way to understand what that even means.
Answer: Without seeing the MSN, it's hard to say for sure what that's specifically referring to, but my guess is that the special payment method is referring to something on the back end about how the provider got paid by Medicare. The MSN contains a lot of technical information and not all of it is as relevant to you as the patient. The important columns for you to look at are the ones that show the maximum you can be billed and whether your service was approved.

Question: My wife received what I believe to be an MSN for her COVID vaccination, though she has a Medicare Advantage Plan. Is that weird?
Answer: Original Medicare is paying for the COVID vaccination for everyone—even people who have Medicare Advantage Plans—so that's why your wife received an MSN for the vaccine. Normally, though, people with Medicare Advantage Plans get EOBs, not MSNs, the COVID vaccination is an exception.

Question: What about appeals if someone is in the hospital?
Answer: There is a different appeal process for when someone is in the hospital and their hospital care is set to end. You can learn more about Original Medicare ending care appeals and Medicare Advantage Plan ending care appeals on Medicare Interactive.

Question: How do I appeal if the appeal is related to ambulance denial and no doctor is involved? The patient had COVID and was transported to the hospital; the patient was then admitted and stayed three weeks and the bill was denied for payment by Medicare.
Answer: You can file an appeal with a letter of support from one of the attending doctors at the hospital. You file an appeal by following the instructions on the Medicare Summary Notice (if you have Original Medicare) or Explanation of Benefits (if you have a Medicare Advantage Plan). What you'll write in the appeal letter and the likelihood of a successful appeal depends on the reason why the ambulance ride was denied, though. For counseling specific to your situation, please contact the Medicare Rights Center helpline at 800-333-4114. Our helpline hours are Monday-Friday, 10am-3pm EST.

Question: How do I appeal a Part D denial?
Answer: Here is more information about Part D appeals on Medicare Interactive.

Question: My doctor and I are appealing a Medication denial to the administrative law judge (ALJ). Any advice about what to provide the judge with that might help him approve the medication?

Answer: You should include a letter of support from your doctor that directly addresses the denial reason and provides proof that the medication is medically necessary. More specific advice depends on the reason why your drug was denied, like whether you are appealing a tiering exception, a coverage restriction, or asking for a formulary exception, among other things. You can call the Medicare Rights Center helpline for counseling specific to your situation: 800-333-4114. Our helpline hours are Monday-Friday, 10am-3pm EST.

Question: Do offer any assistance with Part D questions and concerns?
Answer: Yes, you can call the Medicare Rights Center helpline at 800-333-4114 for personalized assistance with your Medicare questions. Our helpline hours are Monday-Friday, 10am-3pm EST.

Question: I have a beneficiary who went to skilled nursing facility (SNF) from a hospital stay. She did not stay the full three days before transfer but it is my understanding that she did not need to due to COVID waiver rules. The SNF refused to bill Medicare so the beneficiary's daughter submitted the bill directly to Medicare as the beneficiary has passed away. They denied coverage but we are appealing, is this the same appeals process for Original Medicare detailed in the presentation?
Answer: Yes, that would be the same Original Medicare appeals process as described in this presentation. You will be appealing to ask Medicare to cover services that the beneficiary already received. In the appeal letter, I recommend referencing the SNF waiver (see page 16).

Question: I have my Medicare Advantage Plan telling me Medicare only pays one amount one time and another amount for the same service. How do I find out Medicare procedure code pay amounts?
Answer: There aren't always set amounts for how much a Medicare Advantage Plan pays for a service. If you owe a copayment then your out-of-pocket cost should be fixed, regardless of how much your plan pays. If you owe a coinsurance (a percentage of the full amount) then your out-of-pocket cost may vary because the full amount that a service costs can change. You should speak with your doctor and your plan to learn an estimate of how much a service may cost and what you might owe.

Question: What do you do if you doctor won't submit your bill to Medicare?
Answer: Here are some troubleshooting tips for this situation on Medicare Interactive.