CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Advantage Plans and Medicare Cost Plans: How to File a Complaint (Grievance or Appeal)

Medicare Advantage Plans (like an HMO or PPO) and Medicare Cost Plans are health plan options that are approved by Medicare and run by private companies. When you join a Medicare Advantage Plan or Medicare Cost Plan, you are still in the Medicare Program. These plans often have networks, which means you may have to see doctors who belong to the plan or go to certain hospitals to get covered services. Some of these plans require referrals to see specialists.

Medicare Advantage Plans provide all of your Part A (Hospital Insurance) and Part B (Medical Insurance) coverage and must cover medically-necessary services. They generally offer extra benefits, and many include Medicare prescription drug coverage (Part D). Medicare Advantage Plans include the following:

- Medicare Health Maintenance Organization (HMO) Plans
- Medicare Preferred Provider Organization (PPO) Plans
- Medicare Private Fee-for-Service (PFFS) Plans
- Medicare Special Needs Plans (SNP)
- Medicare Medical Savings Account (MSA) Plans

Medicare Cost Plans are a type of HMO that are available in certain areas of the country. You can join a Medicare Cost Plan anytime it's accepting new members. In a Medicare Cost Plan, you can join even if you only have Part B. If you go to a non-network provider, the services are covered under the Original Medicare Plan. You pay the Medicare Part A and Part B coinsurance and deductibles. You can either get your Medicare prescription drug coverage from the plan (if offered), or you can buy a stand-alone Medicare Prescription Drug Plan to add prescription drug coverage.

Filing a Complaint (Grievance or Appeal)

You have a right to file a complaint if you have concerns or problems with your plan. A complaint may be either a "grievance" or an "appeal." You can file a "grievance" if, for example, you aren't satisfied with how your plan or provider gave you a service. You can file an "appeal" if you asked your plan to provide or pay for an item/service you think should be covered and the plan says it won't provide or pay for the item/service.

You must file your complaint with your plan within 60 calendar days of the date of the event that led to your complaint. Some examples of why you might file a complaint include the following:

- You believe your plan's customer service hours of operation should be different.
- You believe there aren't enough specialists in the plan to meet your needs.
- You want to report rude behavior by a doctor or nurse or have issues with doctor office cleanliness.
- The company offering your plan is sending you materials that you didn't ask to get and aren't related to your plan.
- The plan didn't make a decision about a reconsideration (see the first level of appeal on the next page) within the required timeframe.
- The plan didn't send your case to the Independent Review Entity (IRE).
- You disagree with the plan's decision not to grant your request for an expedited appeal.
- The plan didn't provide the required notices.
- The plan's notices don't follow Medicare rules.
- Your plan won't provide or pay for services you believe are covered by the plan.

Check your plan's membership materials, or call your plan for specific instructions on how to file a complaint.

Requesting an Organization Determination

You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. This is called an organization determination. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must notify you of its decision within 72 hours if it determines your life or health could be seriously harmed or if a doctor supports your request and indicates that you may be harmed by waiting the normal 14 days the plan has to notify you of its decision.

If the plan won't cover the item/service you asked for, the plan must tell you in writing why they won't provide or pay for the item/service, and how to appeal this decision.

TIP: Any person you appoint, such as a family member or your doctor, may help you request an organization determination or an appeal. Call your plan to learn how to appoint a representative.

Appealing Decisions about Your Coverage

TIP: When you join a Medicare Advantage Plan or Medicare Cost Plan, the plan will send you information about the plan's appeal procedures. Read the information carefully and keep it where you can find it when you need it. Call your plan if you have questions.

If you ask your plan (for an organization determination) to provide or pay for a service and your request is denied, you can appeal the decision. There are **five levels** of appeal available to you. **You should follow the order listed below.**

1. Appeal through your plan (called a "reconsideration")

You must request this appeal within 60 calendar days from the date of the notice of the organization determination. You or your appointed representative must file a written standard request unless your plan allows you to file a request by telephone. Your plan's address is in your plan materials and will be in the notice containing any unfavorable organization determination decision.

Your written reconsideration request should include the following:

- Your name, address, and the health insurance claim (HIC) number shown on your Medicare card
- The specific service and/or item(s) for which a reconsideration is being requested
- The specific date(s) if applicable
- Your reasons for appealing and any evidence you wish to attach
- Your signature or that of your appointed representative. If the individual making the request isn't the person enrolled in the plan, attach documentation that shows the individual's authority to act on behalf of the person in the plan, such as a completed "Appointment of Representative" form (Form CMS-1696). This form is available at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf on the web.

Appealing Decisions about Your Coverage (continued)

1. Appeal through your plan (called a "reconsideration") (continued)

You, your appointed representative, or your doctor can call your plan or write to them for an expedited reconsideration. Your request will be expedited if your plan determines, or your doctor tells your plan, that your life or health may be seriously jeopardized by waiting for a standard decision. Once your plan receives your request for an appeal, the plan has 30 calendar days (for a standard service request), 60 days (for a payment request), or 72 hours (for an expedited request) to notify you of its decision. The time frame for completing standard service and expedited requests may be extended by up to 14 calendar days.

2. Review by an Independent Review Entity

If the plan again decides against you, your appeal is **automatically** sent to an Independent Review Entity (IRE) for review. The review will be expedited if the IRE determines that your life or health may be seriously jeopardized by waiting for a standard decision.

You have the right to send the IRE information about your case. They must get this information 10 days after the date you get the IRE letter telling you they have your case file. You can have someone such as a family member, friend, or doctor help you write this information. You must send your information to the location specified in the IRE's letter.

The IRE has 30 days (for a standard service request for coverage), 60 days (for a payment request), or 72 hours (for expedited requests for coverage) to notify you of its decision. The time frame for completing standard service and expedited requests may be extended by up to 14 calendar days.

3. Hearing with an Administrative Law Judge

If you disagree with the IRE's decision, you or your appointed representative can request a hearing with an Administrative Law Judge (ALJ). You must make the request in writing within 60 calendar days from the date of the notice of the IRE decision. You must send your request to the location specified in the IRE's reconsideration notice. To get an ALJ hearing, the projected value of your denied coverage or payment request must meet a minimum dollar amount (you may be able to combine claims to meet the minimum dollar amount). If the ALJ decides in your favor, the plan has the right to appeal this decision by asking for a review by the Medicare Appeals Council.

4. Review by the Medicare Appeals Council

If you disagree with the ALJ's decision, you or your appointed representative can request a review by the Medicare Appeals Council (MAC). You must make the request to the MAC in writing within 60 calendar days from the date of the notice of the ALJ's decision. You must send your request to the location specified in the ALJ's decision notice. The MAC doesn't review every case it receives. If the MAC decides not to review your case, you or the plan may ask for a review by a Federal court.

Appealing Decisions about Your Coverage (continued)

5. Review by a Federal court

If you disagree with the MAC's decision, you or your appointed representative can request a review by a Federal court. You must make the request in writing within 60 days from the date of the notice of the MAC's decision. You must send your request to the location specified in the MAC's decision notice. To receive a review by a Federal court, the projected value of your denied coverage or payment request must meet a minimum dollar amount. The MAC's decision will include the amount.

Additional Appeal Rights

If you are getting Medicare services from an inpatient hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility, you may have the right to a fast appeal if you think your Medicare-covered services are ending too soon. This fast appeal is also called an expedited review or immediate review. You will get a notice from your facility or provider that will tell you how to ask for a fast appeal. If you decide to file a fast appeal, ask your doctor for any information that may help your case. The Quality Improvement Organization (QIO) in the state where the services are being provided will look at your case to decide if your services need to continue. You can also contact your State Health Insurance Assistance Program (SHIP) for help filing an appeal. Visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227) to get the telephone number for your SHIP. TTY users should call 1-877-486-2048. You may have other appeal rights if you miss the timeframe for filing a fast appeal.

For More Information

- Call your Medicare Advantage Plan or Medicare Cost Plan before you get an item/service or supply to find out if it will be covered. Your plan must tell you if you ask. Your plan can also give you more information about its complaint (grievance and appeal) procedures.
- Visit www.medicare.gov on the web. Select "Medicare Appeals." You can also look at or print a copy of the booklet "Your Medicare Rights and Protections." Under "Search Tools," select "Find a Medicare Publication." You can also call 1-800-MEDICARE (1-800-633-4227) to find out if a free copy can be mailed to you. TTY users should call 1-877-486-2048.
- Call your State Health Insurance Assistance Program (SHIP) for free personalized counseling. To get their telephone number, visit www.medicare.gov on the web. Under "Search Tools," select "Find Helpful Phone Numbers and Websites." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Call your local Bar Association or legal aid program if you have limited income. These offices may be able to help you with your complaint.

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