National Medicare
TRAINING PROGRAM

Module 2

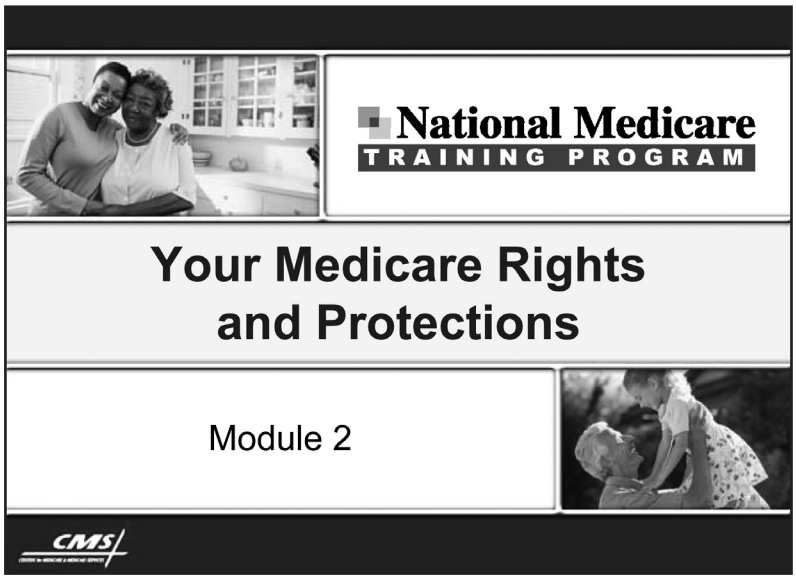
Your Medicare Rights and Protections

Training Workbook

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Revised: March 2008

Module 2: Your Medicare Rights and Protections



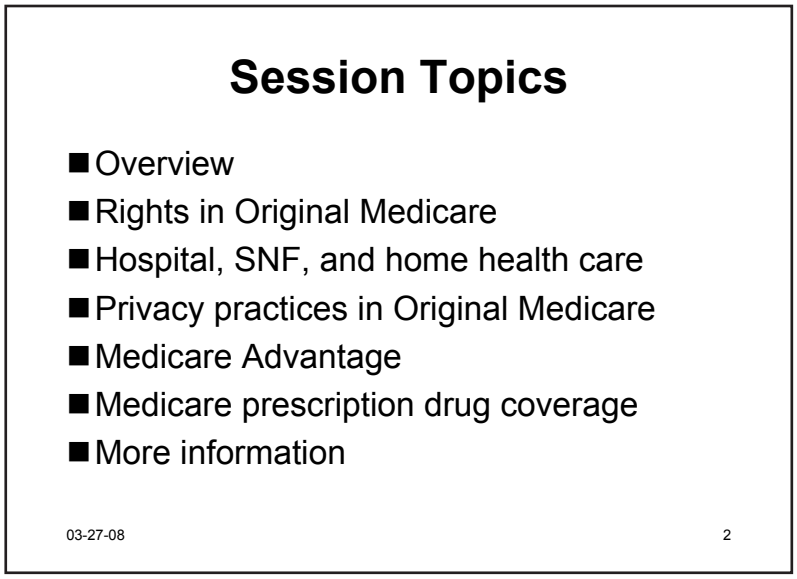
In this module, *Your Medicare Rights and Protections*, we'll be talking about your right to get the health care services you need; your right to file a complaint; and where you can get help with your questions. (Reference: *Your Medicare Rights and Protections*, CMS Publication 10112)

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare and Medicaid. The information in this module was correct as of March 2008. To check for an updated version of this training module, visit ***www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp*** on the web.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

My Health.
My Medicare.

Module 2: Your Medicare Rights and Protections

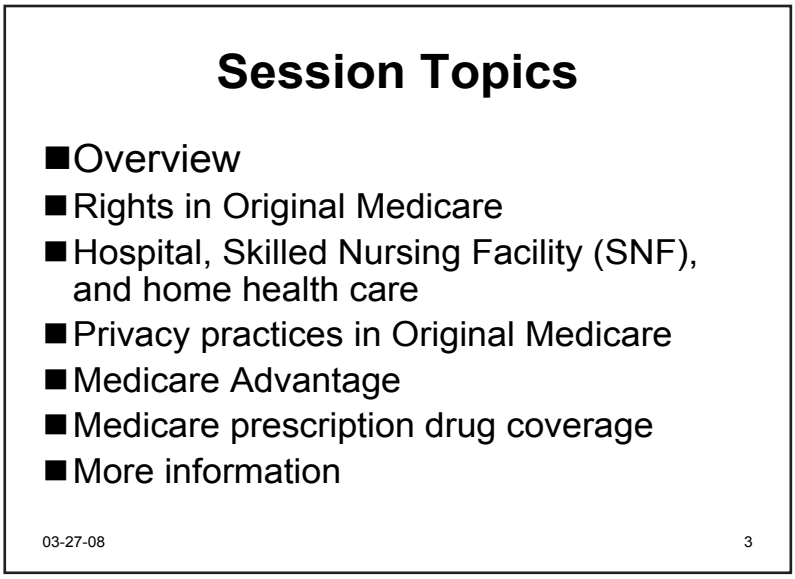


As a person with Medicare, you have certain guaranteed rights and protections that we'll be discussing throughout this module. The topics we will cover include:

- An overview of Medicare rights and protections
- Your rights and protections in Original Medicare
- Hospital, skilled nursing facility, and home health care rights
- Privacy practices in Original Medicare
- Your rights and protections in a Medicare Advantage Plan
- Your rights and appeals in a Medicare Prescription Drug Plan
- Where to get more information

My Health. My Medicare.

Module 2: Your Medicare Rights and Protections



Let's begin with an overview of your Medicare rights and protections.

My Health. My Medicare.

Module 2: Your Medicare Rights and Protections

If you have Medicare, you have certain guaranteed rights. You have them whether you are in Original Medicare, in a Medicare Advantage or other Medicare plan, have a Medicare Prescription Drug Plan, or have a Medigap (Medicare Supplement Insurance) policy. These rights protect you when you get health care; make sure you get the health care services the law says you can get; protect you against unethical practices; and protect your privacy.

Original Medicare is a "fee-for-service" plan. You are in Original Medicare unless you join a Medicare Advantage or other Medicare plan. Some people in Original Medicare buy a Medigap policy to help cover the costs Medicare doesn't pay.

Medicare Advantage includes Medicare Health Maintenance Organization (HMO) Plans, Preferred Provider Organization (PPO) Plans, Special Needs Plans, Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans. Other Medicare plans include Medicare Cost Plans, demonstrations, and Programs of All-Inclusive Care for the Elderly (PACE).

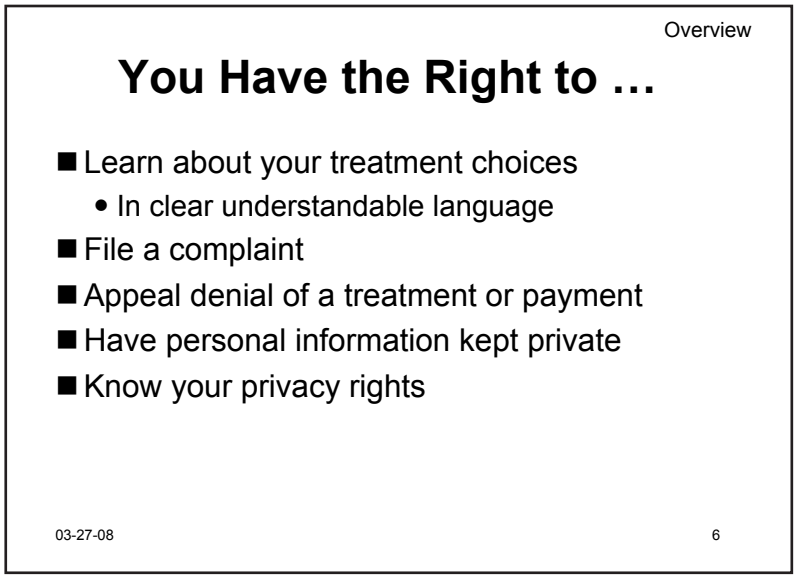
My Health.
My Medicare.

Module 2: Your Medicare Rights and Protections

As a person with Medicare, you have certain guaranteed rights. You have the right to:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Get information about Medicare you can understand to make health care decisions
  - This includes information on what is covered, what costs are paid, how much you have to pay, and what to do to file a complaint
- Get your questions about Medicare answered
  - You can call 1-800-MEDICARE or contact your State Health Insurance Assistance Program. Their numbers are listed in the *Medicare & You* handbook.
- Get culturally competent services in a language you can understand and in a culturally sensitive way
- Get emergency care when and where you need it

My Health. My Medicare.



You also have the right to:

- Learn about treatment choices in clear, understandable language
  - This right means that Medicare health plans cannot prevent your doctor from telling you what you need to know about your treatment choices.
- File a complaint about payment, services, or other problems, and the quality of your health care
- Appeal decisions relating to your treatment or benefits
- Have the personal information that Medicare collects about you kept private
- Know your privacy rights.

Let's talk about some of these rights in more detail.

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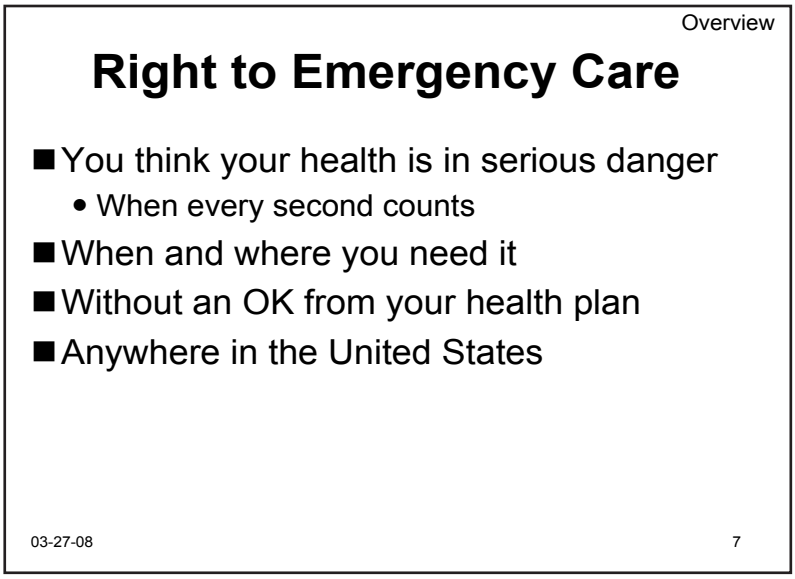
My Medicare.



Emergency care is care given for a medical emergency when you think your health is in serious danger—when every second counts.

You have the right to get emergency care when and where you need it. You don't need an OK from your health plan. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

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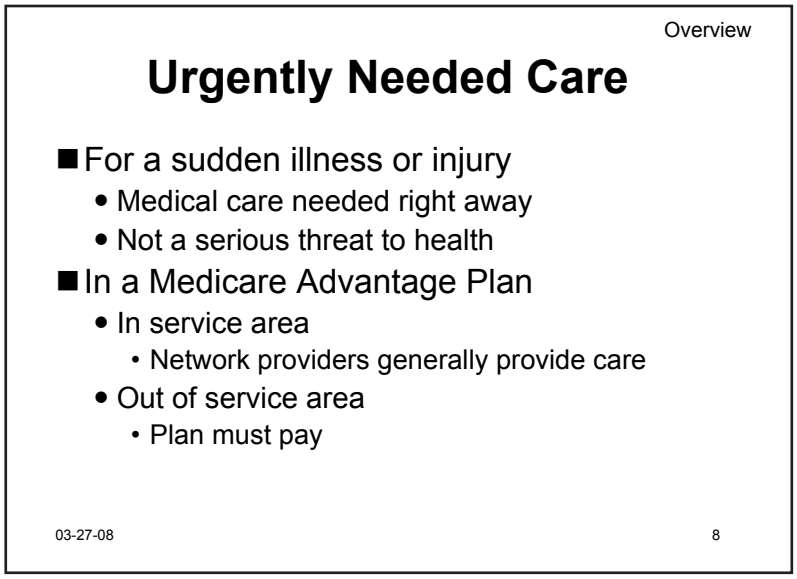

Urgently needed care is care that you get for a sudden illness or injury that needs medical care right away, but is not a serious threat to your health. If you are in a Medicare Advantage Plan or a Medicare plan other than Original Medicare, health care providers in the plan's network generally provide care if you are in the plan's service area. If you are out of your plan's service area for a short time (less than 6 months) and cannot wait until you return home, the health plan must pay for urgently needed care.

Medicare drug plans are required to provide convenient access to pharmacies including out-of-network pharmacies in case of emergency.

My Health.
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You cannot be discriminated against (treated unfairly) because of your race, color, national origin, disability, age, religion, or gender (generally limited to complaints of discrimination filed against providers of health and social services who receive Federal financial assistance). If you think you have been discriminated against for any of these reasons, call the Office for Civil Rights in your state for information about submitting a complaint about discrimination. You can call 1-800-MEDICARE (1-800-633-4227) to get the number or look on **www.medicare.gov** under "Helpful Contacts."

You can also call the Office for Civil Rights at the U.S. Department of Health and Human Services toll-free at 1-800-368-1019. (TTY users should call 1-800-537-7697.)

My Health.
My Medicare.

You have the right to file a complaint about payment, services you received, and other concerns or problems you have in getting health care, and the quality of the health care you received under any Medicare plan. There are two kinds of complaints: appeals and grievances.

An **Appeal** is a request for a review of certain decisions about health care payment or services, or prescription drug coverage.

You have the right to appeal any official decision about your Medicare services. If Medicare does not pay for a covered item or service you have been given, or does not pay enough for an item or service, or if you are not given a Medicare-covered item or service you think you should get (if you're in a Medicare Advantage Plan), you can appeal. For more information on filing an appeal, call your Medicare Advantage Plan, your Medicare Prescription Drug Plan, the State Health Insurance Assistance Program (SHIP) in your state, or 1-800-MEDICARE (1-800-633-4227).

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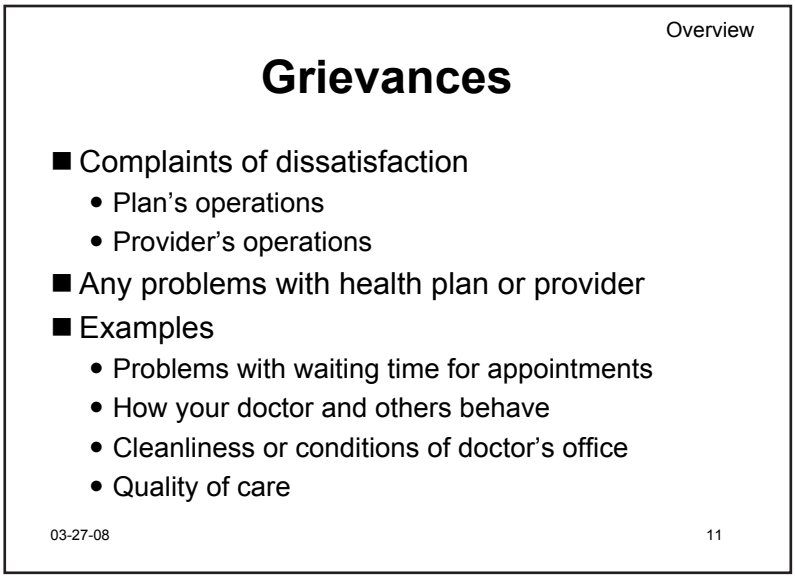

Grievances are complaints of dissatisfaction with any aspect of a plan's or provider's operations, including quality of care.

You have a right to file a grievance about any problems you have with your health plan or your providers. For example, you could file a grievance if you have a problem with things such as the waiting times for appointments, the way your doctor or others behave, the cleanliness or condition of the doctor's office, or the quality of your care.

If you want to file a grievance about the quality of health care you have received, call your health plan or the Quality Improvement Organization (QIO) in your state. You can get the number by calling 1-800-MEDICARE (1-800-633-4227) or going to **www.medicare.gov/Contacts** on the web.

Although Original Medicare doesn't have a grievance process, people in Original Medicare can call their QIO if they are dissatisfied with any aspect of a provider's operations, including quality of care.

My Health.
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So far in this module, we've talked about your rights as a person with Medicare. These include the right to:

- Get information
- File a complaint, whether it is regarding payment or coverage or quality of care
- Emergency care and urgent care
- Non-discrimination

Let's talk about your specific rights in Original Medicare.

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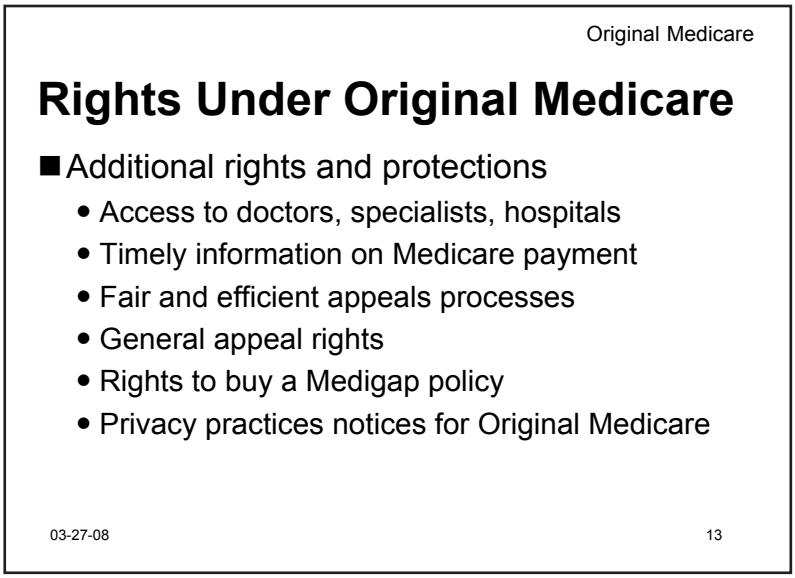

In addition to the rights we talked about earlier, you have additional rights when you are enrolled in Original Medicare. They include:

- Access to doctors, specialists (including women's health specialists), and hospitals. You can see any doctor or specialist, or go to Medicare-certified hospitals that participate in Medicare.
- Certain information, notices, and appeal rights that help you resolve issues when Medicare doesn't pay for health care, including timely information on Medicare payment and a fair, efficient, and timely appeals process. (We'll go into more detail on appeals in a few minutes.)
- Rights to buy a Medigap policy
- The Notice of Privacy Practices for Original Medicare.

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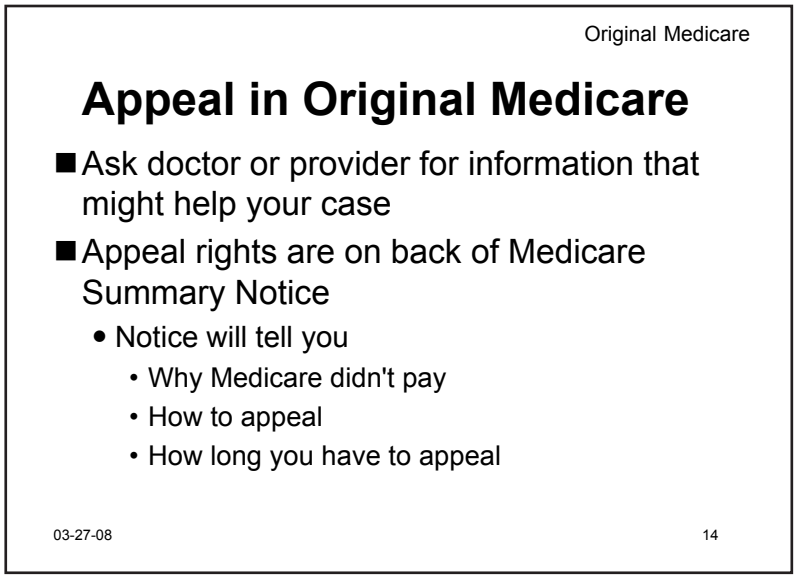

If you are in Original Medicare, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Medicare Summary Notice (MSN) that is mailed to you by the company that handles your Medicare bills. The notice will also tell you why Medicare didn't pay your bill and how you can appeal. It will also tell you the time limit for filing your appeal.

When you appeal a claim, you should state:

- Why you want a review
- What you want reviewed
- Who the review is for
- Dates of service
- Any additional documentation

You should keep a copy of everything you send to Medicare as part of your appeal.

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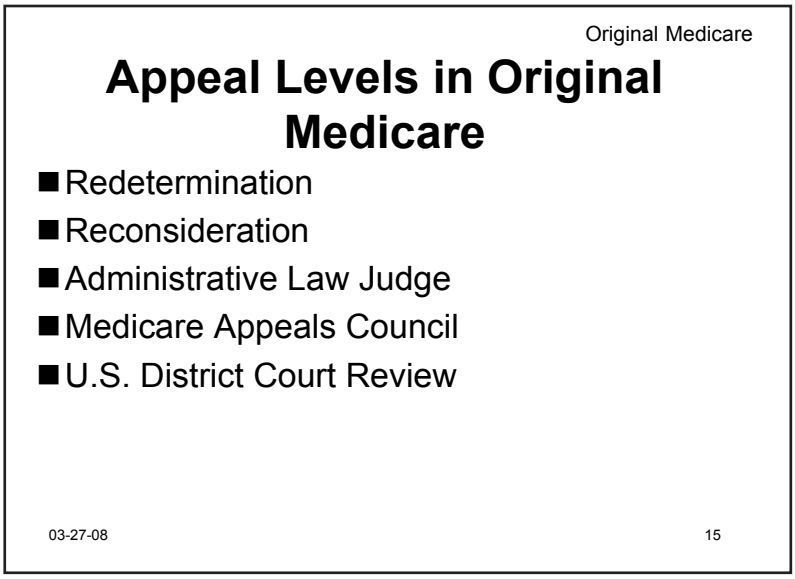

There are five levels in the appeals process in Original Medicare:

1. You can request a **redetermination** by sending a written request to the company that handles your claims for Medicare **within 120 days** from the initial determination. Details of how to file are on the Medicare Summary Notice. You will get a decision within about 60 days.
2. If you aren't satisfied with the redetermination decision, you can request a **reconsideration by a Qualified Independent Contractor (QIC)** (a contractor that didn't take part in the first decision). Your request must be made in writing **within 180 days** of getting the redetermination notice. You should get a decision in about 60 days, or if the QIC can't issue a decision on time, you will get a letter asking if you want to skip to the next level of appeal.
3. If you aren't satisfied with the reconsideration decision, you can request a **hearing by an Administrative Law Judge (ALJ)**. To get an ALJ hearing, your case must meet a **minimum dollar amount, $120 in 2008**. (The amount is adjusted each year for inflation.) You must make the request in writing within 60 days from the date you receive the reconsideration notice. In most cases, the ALJ will issue a decision within 90 days after getting your request, or will send you a letter asking if you want to skip to the next level of appeal.
4. If you disagree with the judge's decision, you can request a **review by the Medicare Appeals Council (MAC)**, part of the Health and Human Services Departmental Appeals Board. Your request must be made in writing **within 60 days** from the date you receive the hearing decision. The MAC will generally make a decision within 90 days after getting your request, or will send you a letter asking if you want to skip to the next level of appeal.
5. If you disagree with the decision by the MAC, you can request a review by **the U.S. District Court**.To get a review by a Federal court, the amount of your case must meet a **minimum dollar amount, $1,180 in 2008** (adjusted each year for inflation). You have 60 days from the date you receive the MAC decision.

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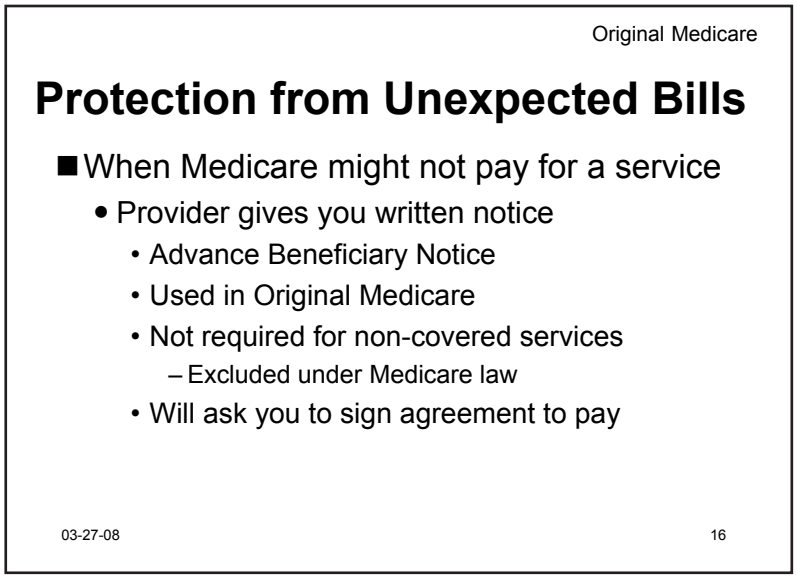

You are protected from unexpected bills. If a doctor or supplier of health care services expects that Medicare won't pay for certain items or services, in many situations he or she will give you a notice that says Medicare probably (or certainly) won't pay. This is called an Advance Beneficiary Notice (ABN). The Advance Beneficiary Notice is used in Original Medicare, but not in Medicare Advantage Plans.

Doctors and suppliers are not required to give you an Advance Beneficiary Notice for services Medicare never covers (i.e., excluded under Medicare law), such as routine physical exams, routine eye exams, dental services, hearing aids, and routine foot care.

If you still want to get the service, you will be asked to choose an option and sign an agreement to pay for the service yourself if Medicare does not pay for it. You will be asked to sign a Waiver of Liability for these services and products. You will be responsible for paying for the services you received.

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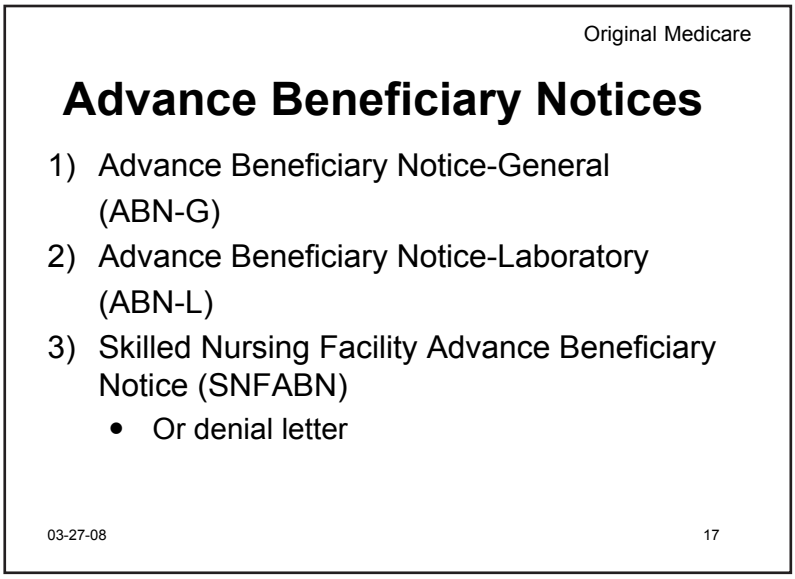

There are five types of Advance Beneficiary Notices:

1. **Advance Beneficiary Notice-General (ABN-G)** The ABN-G is used by doctors, durable medical equipment suppliers, and certain health care providers (for example, independent physical and occupational therapists and outpatient hospitals).
2. **Advance Beneficiary Notice-Laboratory (ABN-L)** The ABN-L is used only for laboratory services. The ABN-L has two options that are very similar to those of the Advance Beneficiary Notice-General.
3. **Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or denial letters** The SNFABNs or denial letters are used only for skilled nursing facility care. The SNFABN gives you options to choose from, like the Advance Beneficiary Notice-General. The skilled nursing facility denial letters aren't notices like the SNFABN, and don't have options to check off, but they give you similar information, and you must sign and date these letters. You will get either a SNFABN or a denial letter when you have used all the skilled nursing facility care that Medicare will pay for.

   NOTE: The SNFABN will be revised in the near future and will replace the denial letter, the ABN-G for Part B items and services, and the NEMB-SNF).

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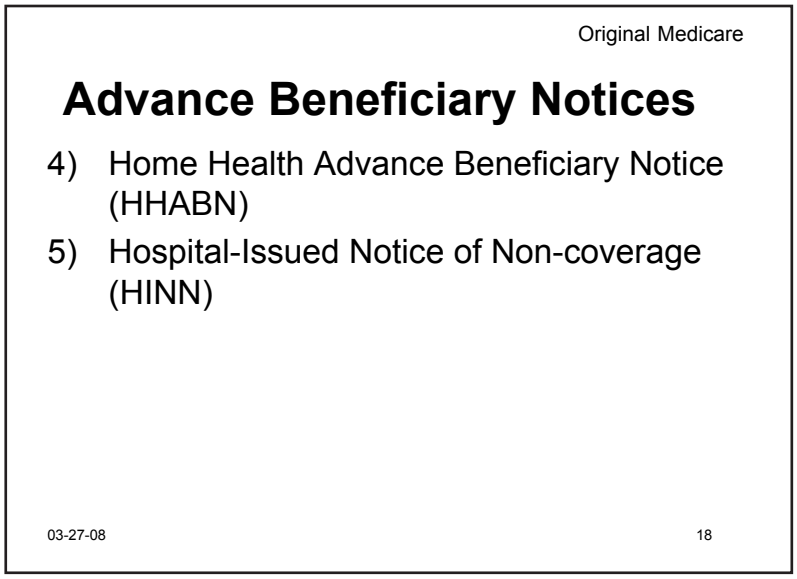

4. **Home Health Advance Beneficiary Notice (HHABN)** This notice is used only by home health agencies. The HHABN is given in most instances where your home health agency is either giving you home health care Medicare won't pay for, or when your home health agency will reduce or end care for other reasons.
5. **Hospital Issued Notice of Non-coverage (HINN)** If you are getting inpatient hospital care, you may get a notice called a Hospital Issued Notice of Non-coverage (HINN) when the hospital thinks Medicare may not pay for your care. You may get one of these notices before you are admitted, at admission, or at any point during your hospital stay. These notices will tell you why the hospital thinks Medicare won't pay, what you have to pay if you keep getting services, and what rights you have to appeal the hospital's decision. This notice is in the form of a letter, so it doesn't have options to check off like Advance Beneficiary Notices, although you will sign and date this letter to show that you understand your options.

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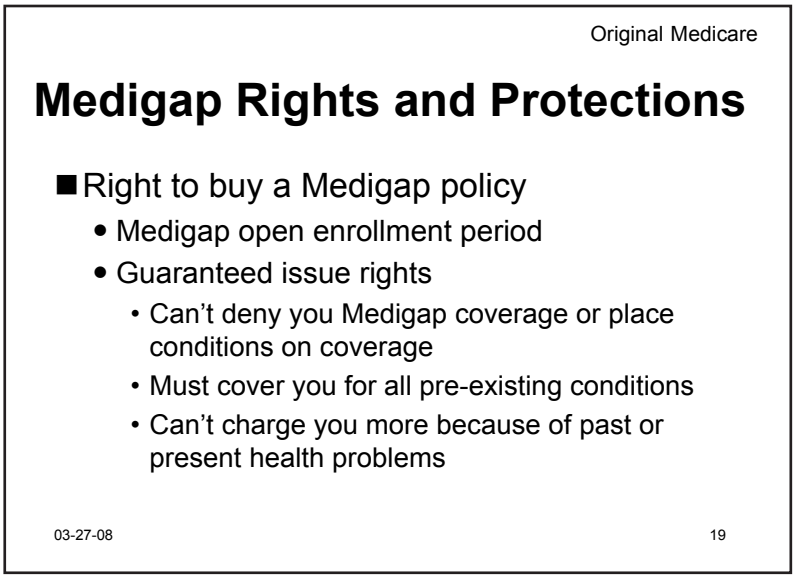

In some situations, you have the right to buy a Medigap policy. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps"in Original Medicare Plan coverage, such as coinsurance amounts.

Medigap policies must follow Federal and state laws that protect you. There are 12 standardized Medigap policies called "Plan A"through "Plan L." The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." Each Medigap Plan A through L has a different set of benefits.

You have the right to buy a Medigap policy during your Medigap open enrollment period and when you have guaranteed issue rights. There are a number of situations in which an insurance company must issue you a Medigap policy you want to buy. In these situations, the company:

- Can't deny you Medigap coverage or place conditions on your policy
- Must cover you for all pre-existing conditions
- Can't charge you more for a policy because of past or present health problems

(Module 3, *Medigap*, describes these situations.)

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My Health. My Medicare.

Next let's talk about your rights when you are in the hospital, in a skilled nursing facility, or receiving home health care.

If you are admitted to a hospital or skilled nursing facility, or you are receiving home health care, you are guaranteed certain rights and protections. Many of these rights and protections are the same whether you are in Original Medicare or a Medicare Advantage Plan. Let's take a few minutes to understand them.

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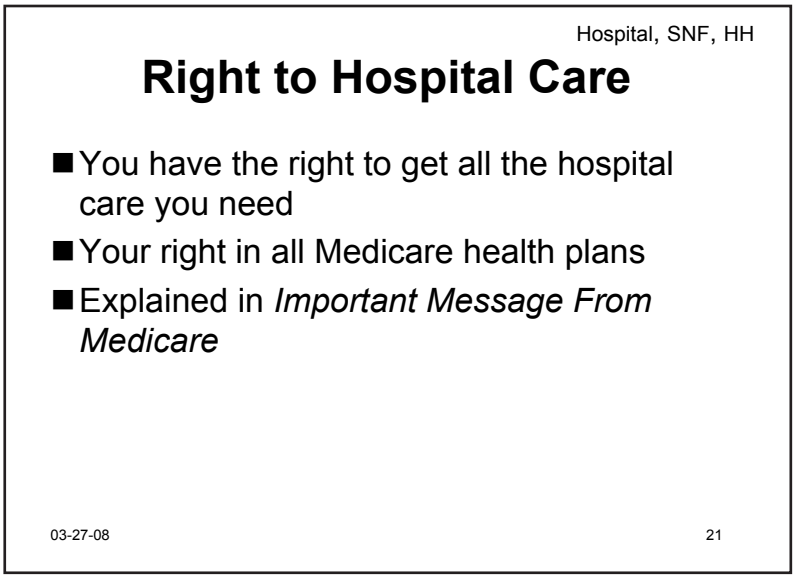

All people with Medicare, including those in a Medicare Advantage Plan or other Medicare plan, have the right to get all of the hospital care they need, including any follow-up care they need after leaving the hospital.

When you are admitted to the hospital, you must be given a copy of the *Important Message From Medicare* notice. The hospital must explain why you are receiving this notice, answer any questions you may have regarding its content, and ask you to sign the notice.

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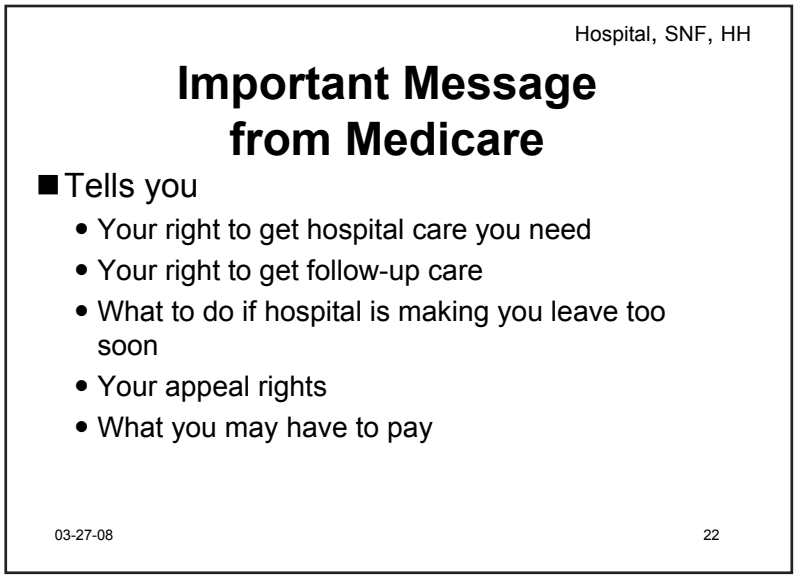

The *Important Message From Medicare* explains your rights as a hospital patient.

The *Important Message From Medicare* notice tells you:

- That you have the right to get all of the hospital care you need, and any follow-up care that is covered by your Medicare plan after you leave the hospital
- What to do if you think the hospital is making you leave too soon
- What your appeal rights are, and
- What you may have to pay.

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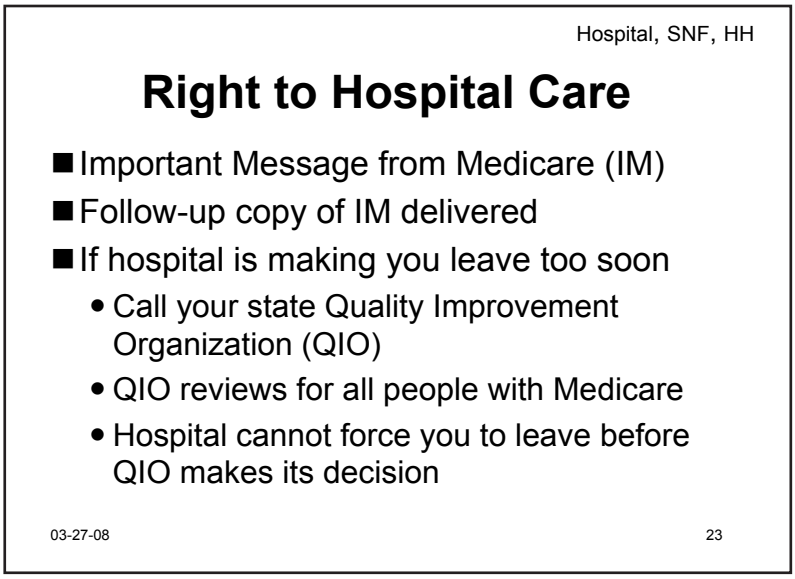

When the hospital or your plan thinks you no longer need inpatient care and you disagree, it will give you a follow-up copy of the Important Message from Medicare (IM) you received at or near admission if more than two days have passed since receiving the original IM.

If you have questions about this notice or think the hospital is making you leave too soon, call your Quality Improvement Organization (QIO), or call your Medicare Advantage Plan if you miss the deadline to appeal to a QIO. Each state has a QIO. QIOs are groups of practicing doctors and other health care experts who are paid by the Federal government to check on and improve the care given to Medicare patients, including those enrolled in Medicare Advantage Plans.

Call 1-800-MEDICARE (1-800-633-4227) or visit **www.medicare.gov/Contacts** on the web to get the number for your QIO. The number should also be on the IM the hospital gave you. The phone numbers can also be found in the booklet *Your Medicare Rights and Protections*. You may be able to stay in the hospital at no charge while the QIO reviews your case if you file an appeal by the day of discharge. The hospital cannot force you to leave before the QIO makes its decision.

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My Health.
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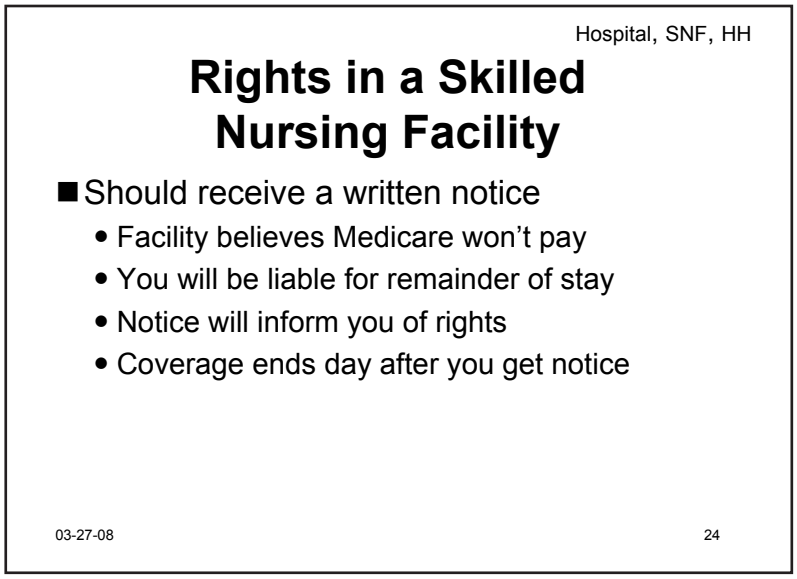

If you are in Original Medicare or a Medicare Advantage Plan and don't have any remaining, or no longer qualify for, a Skilled Nursing Facility (SNF) Part A covered days, you should receive a written notice informing you that you will be liable for the remainder of your stay in the facility. Depending on the notice you receive, you'll have different rights. The purpose of this notice is to let you know that the facility believes you no longer qualify to have Medicare pay for the facility's services. If someone is acting on your behalf, the facility must notify that person in writing.

Your Medicare coverage ends the day after you get the notice.

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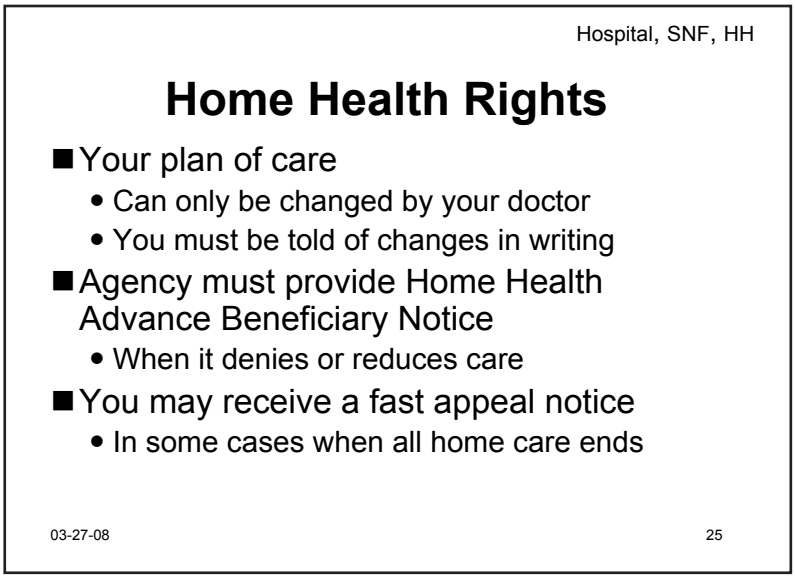

If you are in Original Medicare or a Medicare Advantage Plan, you have rights to home health care. Only your doctor can change your plan of home health care. Your home health agency cannot change your plan of care without getting your doctor's approval. You must be told in writing of any changes in your plan of care. If you have a question about your care, you should call your doctor. If your agency changes your plan of care without your doctor's approval, you should contact the local Quality Improvement Organization (QIO). Visit **www.medicare.gov** or call 1-800-MEDICARE to get the telephone number.

If a home health agency denies or reduces care because it believes that Medicare will not pay for the home health care services that the doctor has ordered, then the home health agency must provide a *Home Health Advance Beneficiary Notice*. (Applies to Original Medicare).

When all home care ends, you may also have the right to a fast appeals process.

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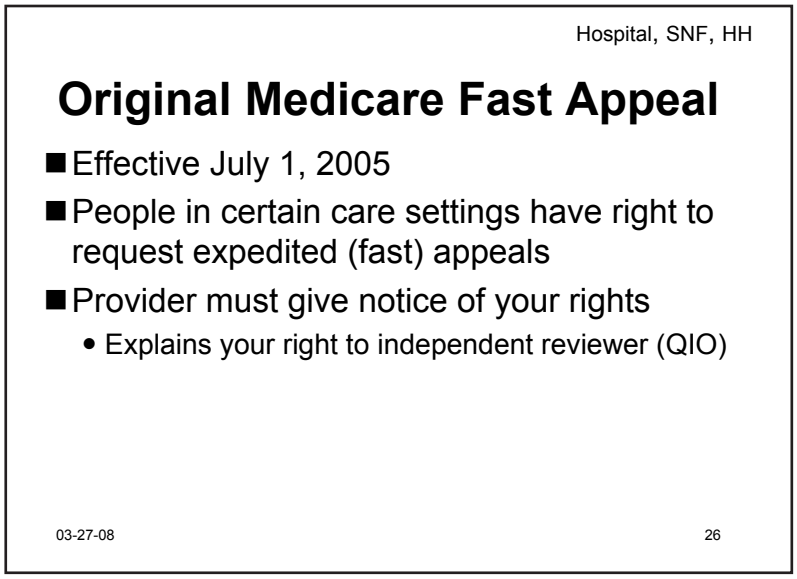

The Medicare expedited determination or fast appeal process became effective July 1, 2005. It allows people with Medicare in specific care settings—home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), skilled nursing facility (SNF) and swing bed hospital care—the right to file an appeal with a Quality Improvement Organization (QIO) to review your provider's decision to end your covered care. Your provider must give you notice of your right to an expedited review.

This process is similar to the QIO review of inpatient hospital discharges that has existed for some time.

In short, the expedited review process gives you the right to appeal your provider's decision to discharge you.

(If you disagree with a decision to deny payment for a claim, rather than a decision to discharge you, you can use the standard appeal process.)

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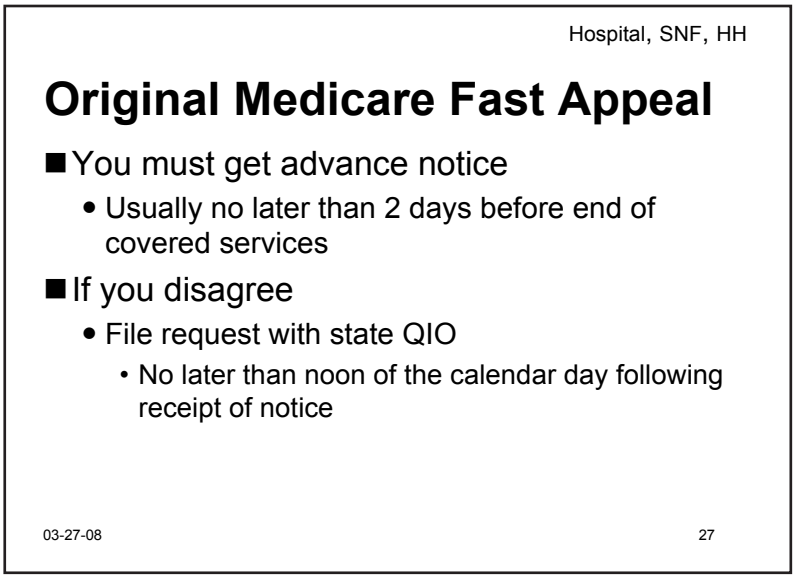
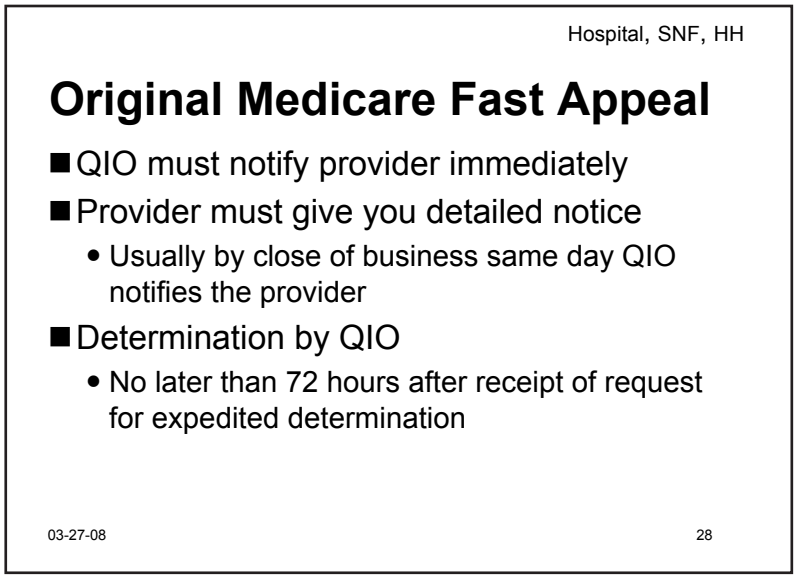


In Original Medicare, the following timeframes apply for expedited determinations and reviews:

- **Advance notice of Medicare non-coverage**. The provider must give you this notice usually no later than 2 days before the proposed end of covered services. If services are for fewer than 2 days, you must be given notification at the time of admission, or for nonresidential providers, the next-to-last time services are furnished.
- **Request to state QIO**. You must make your request to the QIO no later than noon of the calendar day following your receipt of the generic notice. Once you request the fast appeal process, the provider cannot bill you until the QIO determines if coverage can continue. **NOTE:** No matter when the notice is given, you still have until the day before coverage ends to request QIO review, or until 24 hours after the generic notice is given when coverage ends suddenly.

[continued]

My Health. My Medicare.



On the day the QIO receives your timely request for expedited redetermination, it must immediately notify the provider.

The provider must give you a detailed notice, usually by close of business the same day the QIO notifies the provider you have requested an expedited redetermination.

No later than 72 hours after receiving the request for the expedited redetermination, the QIO must make its decision. Notification may initially be by telephone but must be followed by a written notice, which includes information on reconsideration options. The QIO may make a decision even if not all the requested information has been received. The QIO will try to contact you to discuss your concerns with the termination or discharge.

You have the right to file for an expedited reconsideration with the Qualified Independent Contractor (QIC) if you are dissatisfied with the results of the expedited redetermination by the QIO. The request must be filed by noon of the calendar day following notification of the QIO expedited redetermination decision.

It is important to note that you must make a timely contact with the appropriate QIO as directed on the notice to receive a timely expedited review.

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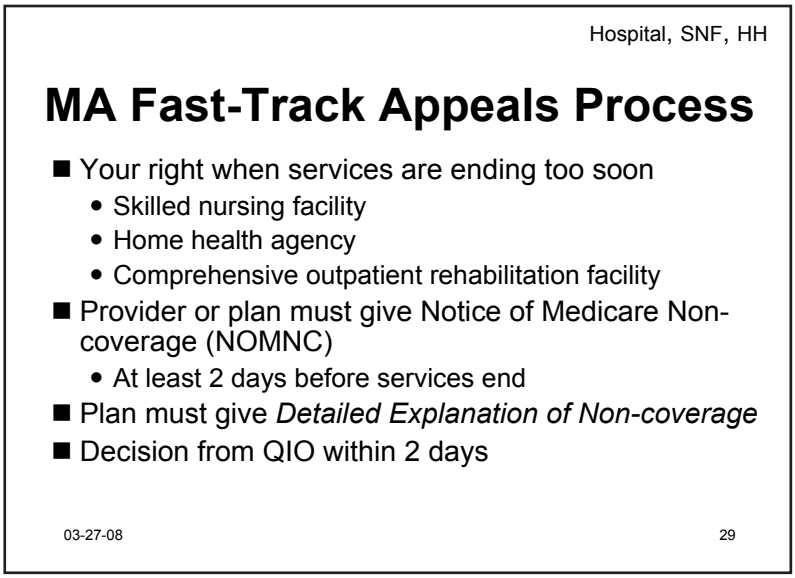
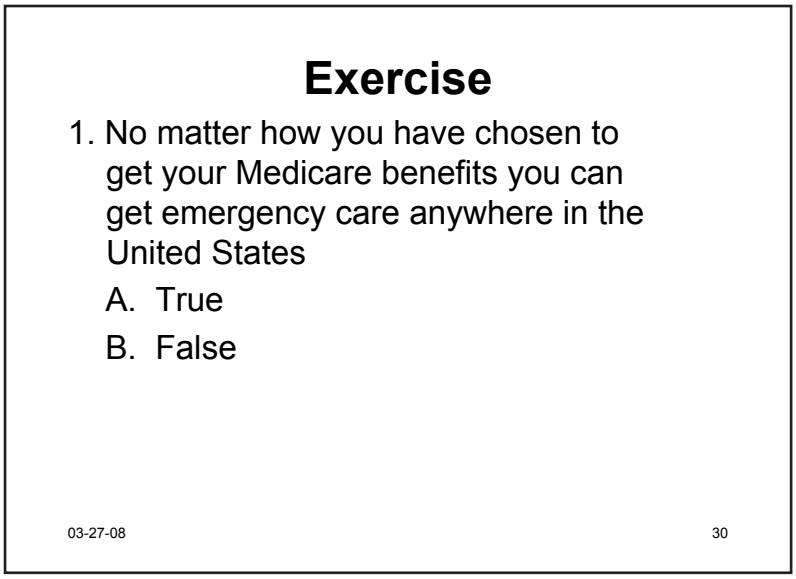


You also have the right to a fast-track appeals process if you are in a Medicare Advantage Plan. This process is available when you believe your services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. The provider or plan must give you a Notice of Medicare Non-coverage (NOMNC) at least 2 days before your services are expected to end. If you appeal, the plan must give you a *Detailed Explanation of Non-coverage*.

In general, you will get a decision within approximately 2 days from the QIO that will decide if your services need to continue.

My Health. My Medicare.

Exercise



1. No matter how you have chosen to get your Medicare benefits you can get emergency care anywhere in the United States.
   A. True
   B. False

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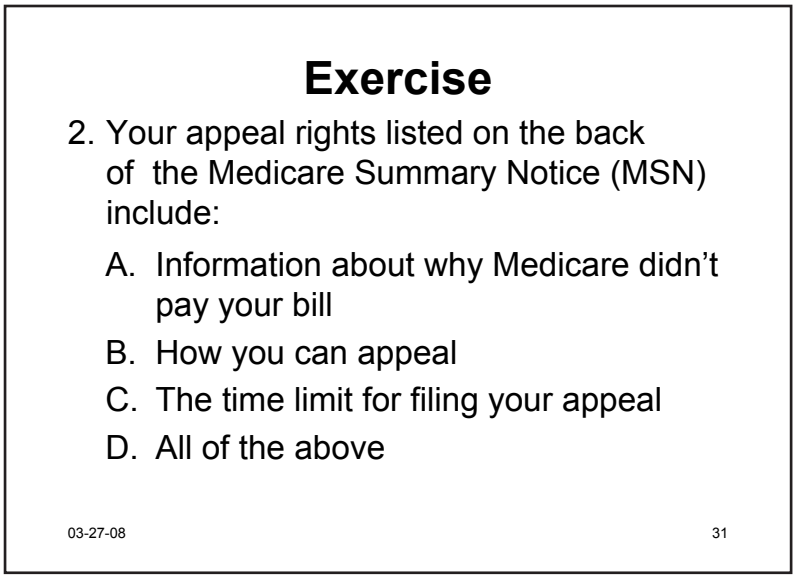
ANSWER: A. True

My Health.
My Medicare.

Exercise



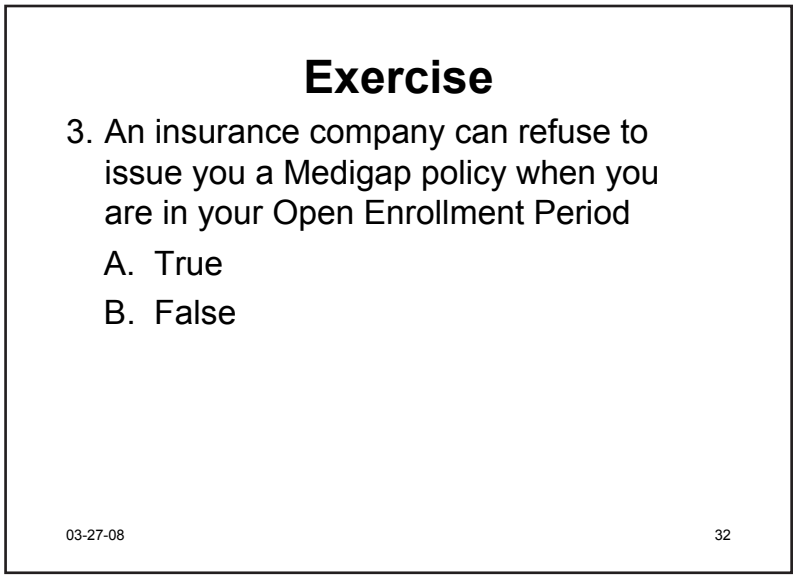
2. Your appeal rights listed o the back of the Medicare Summary Notice (MSN) include:
   A. Information about why Medicare didn't pay your bill
   B. How you can appeal
   C. The time limit for filing your appeal
   D. All of the above

NOTES:

ANSWER: D. All of the above

My Health. My Medicare.

Exercise



3. An insurance company can refuse to issue you a Medigap policy when you are in your Open Enrollment Period
   A. True
   B. False

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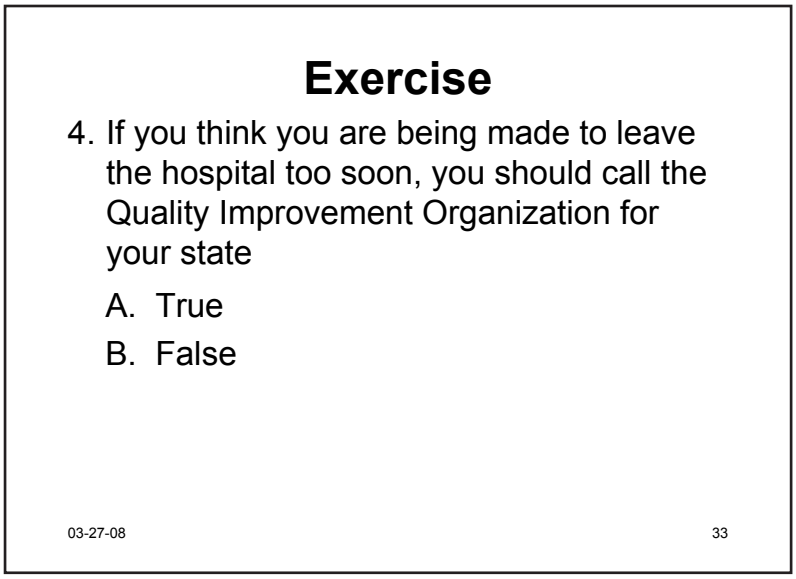
Answer: B. False

My Health.
My Medicare.

Exercise

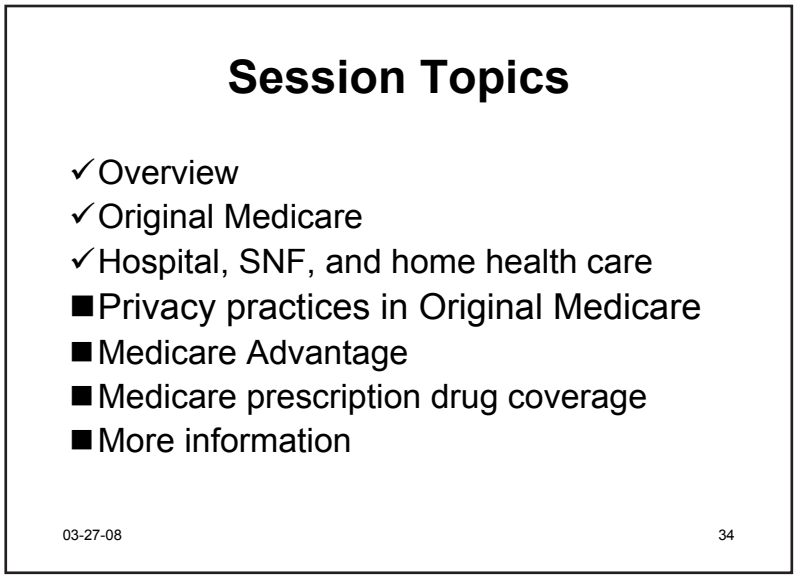


4. If you think you are being made to leave the hospital too soon, you should call the Quality Improvement Organization for your state
   A. True
   B. False

NOTES:

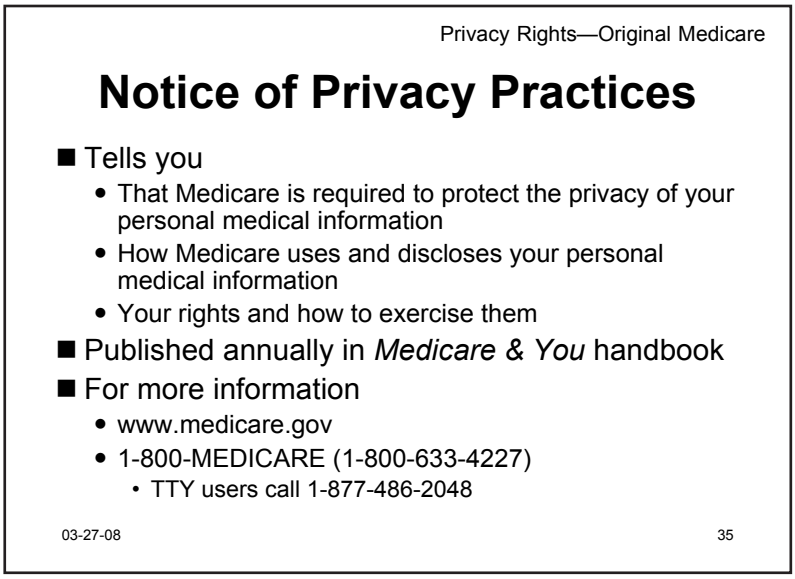
ANSWER: A. True

My Health. My Medicare.



Medicare has special rules that protect your privacy. You are probably aware of some of these rules when you visit the doctor or pick up a prescription. Let's take a few minutes and discuss what these rights mean to you.

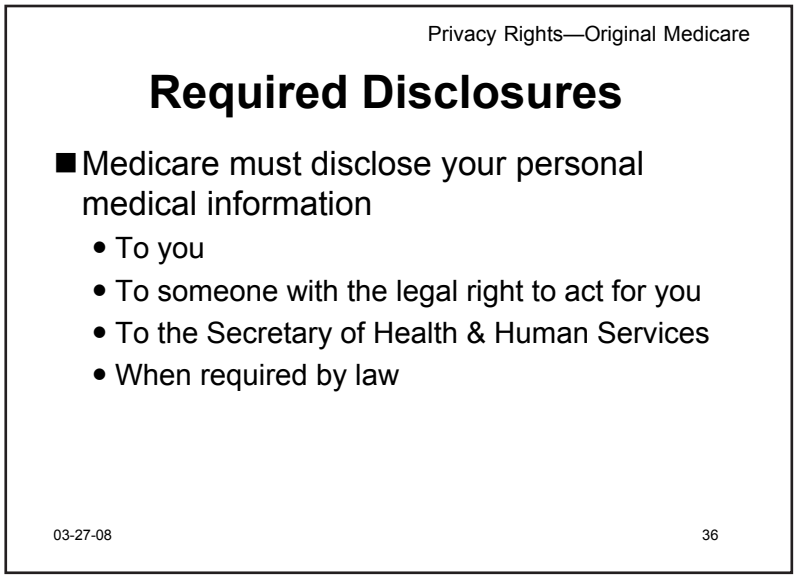
My Health.
My Medicare.



Medicare is required to protect your personal medical information. The *Notice of Privacy Practices for Original Medicare* describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you are enrolled in a Medicare Advantage Plan or other Medicare plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

The Notice of Privacy Practices is published annually in the *Medicare & You* handbook. For more information, go to **www.medicare.gov** or call 1-800-MEDICARE (1-800-633-4227). You can also order a free copy of *Your Medicare Rights and Protections* (CMS Pub. No. 10112).

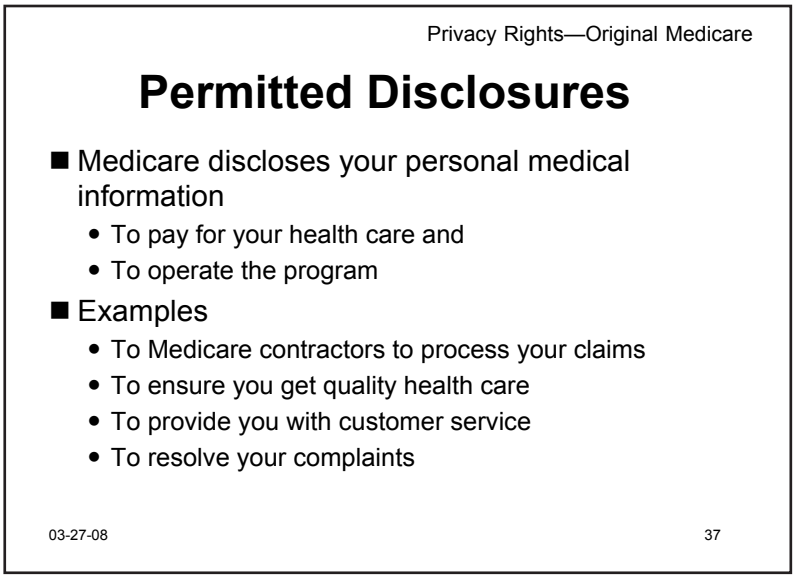
My Health. My Medicare.



There are situations where Medicare **must** disclose your personal medical information, including:

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of Health and Human Services, if necessary, to make sure your privacy is protected, and
- Where required by law.

My Health.
My Medicare.

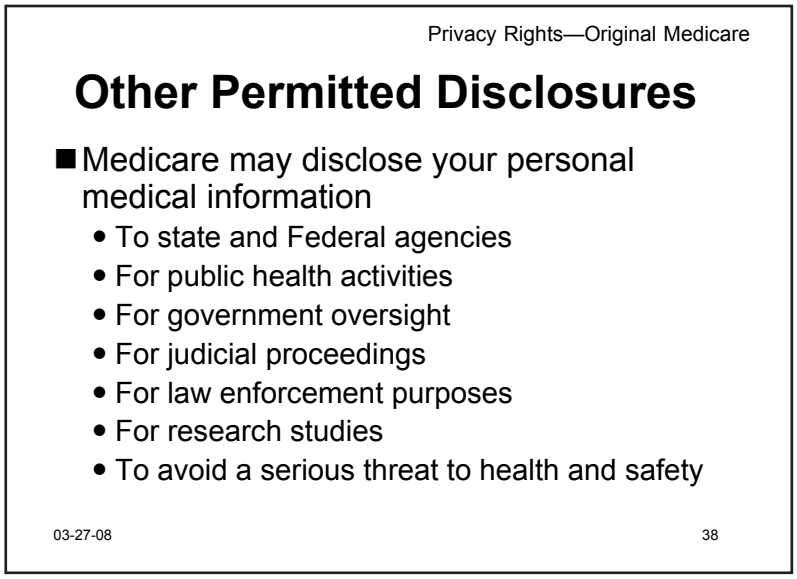


Basically, Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare program.

For example:

- Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your Medicare Summary Notice.
- Medicare may use your personal medical information to make sure you and other people with Medicare get quality health care, to provide customer services to you, or to resolve any complaints you have.

My Health. My Medicare.



Medicare also may use or give out your personal medical information for the purposes shown here, under limited circumstances.

- To state and other Federal agencies that have the legal right to receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs)
- For public health activities (such as reporting disease outbreaks)
- For government health care oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing limited information to locate a missing person)
- For research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability)
- To avoid a serious threat to health or safety

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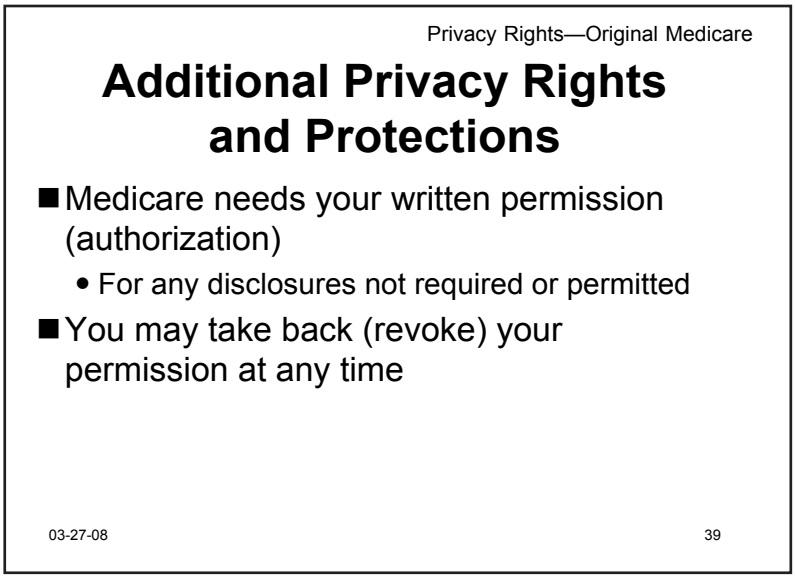
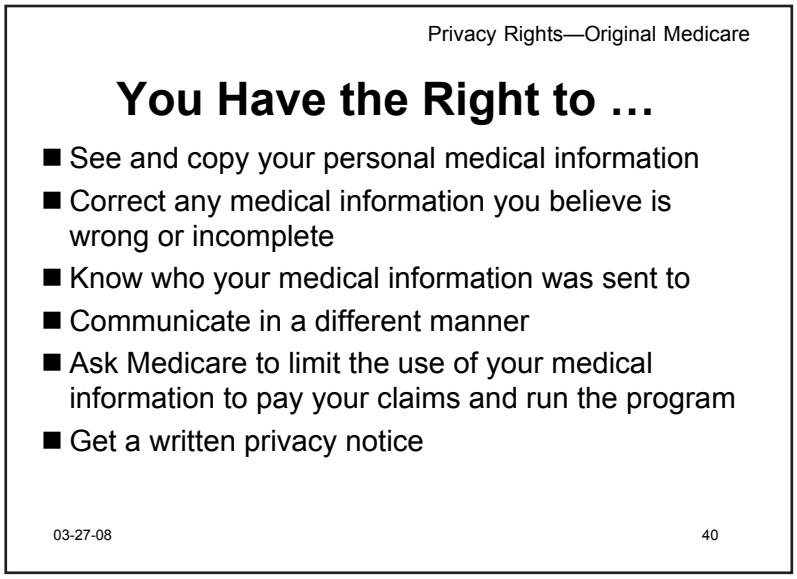
My Health.
My Medicare.



By law, Medicare must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

My Health. My Medicare.



You have the following privacy rights. You may:

- See and copy your medical information held by Medicare
- Correct any incorrect or incomplete medical information
- Find out who received your medical information for purposes other than paying your claims or running the Medicare program
- Ask Medicare to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. box instead of your home address)
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare Program. Please note that Medicare may not be able to agree to your request
- Ask for a separate paper copy of these privacy practices

If you want information about the privacy rules, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

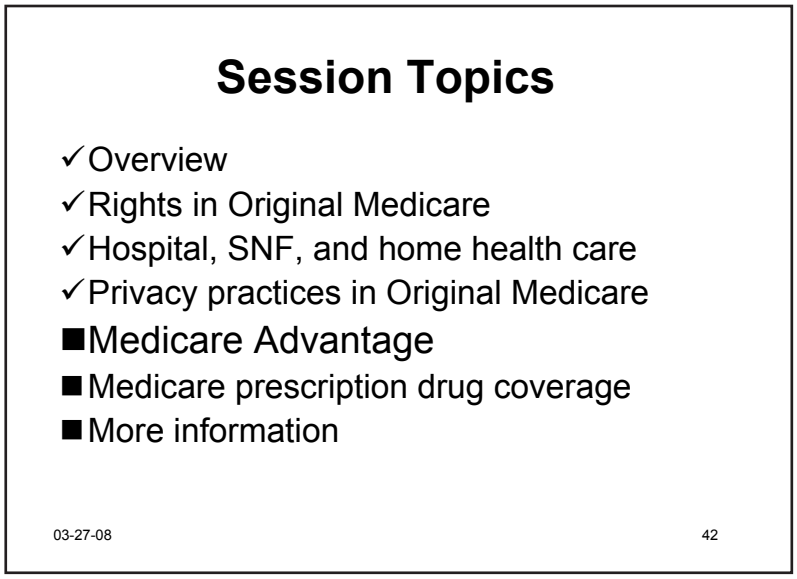
My Health.
My Medicare.

If you believe Original Medicare has violated your privacy rights, you may file a complaint. Your complaint will not affect your benefits under Medicare.

You can file a complaint by:

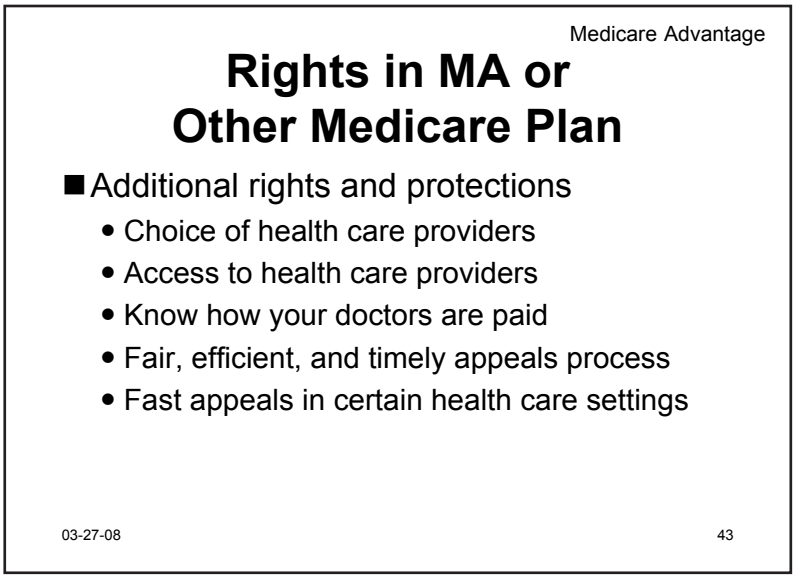
- Calling 1-800-MEDICARE (1-800-633-4227) and ask to speak with a customer service representative. TTY users should call 1-877-486-2048.
- Contacting the HHS Office for Civil Rights at **www.hhs.gov/ocr/hipaa** or by calling 1-866-627-7748. TTY users should call 1-800-537-7697.

My Health. My Medicare.



So far, we've primarily discussed your rights and protections under Original Medicare and the *Notice of Privacy Practices* for Original Medicare. Now, let's discuss your rights and protections if you are in a Medicare Advantage Plan.

My Health. My Medicare.



In addition to the rights we talked about at the beginning of this presentation, you have additional rights when you are enrolled in a Medicare Advantage Plan.

- You have the right to choose health care providers within the plan so you can get the health care you need.
- If you have a complex or serious medical condition, you have the right to get a treatment plan that lets you see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist within the plan for routine and preventive health care services.
- When you ask your health plan how it pays its doctors, the health plan must tell you. Medicare doesn't allow a health plan to pay doctors in a way that wouldn't let you get the care you need.
- You have the right to a fair, efficient, and timely process to resolve differences with your health plan This process includes the initial decision made by the plan, an internal review, and an independent external review. You have the right to ask your plan to provide or pay for a service you think should be covered, provided, or continued. We'll talk about the appeals process in more detail in a few minutes.
- As we mentioned earlier, you also have the right to a fast appeals process whenever you are getting services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.

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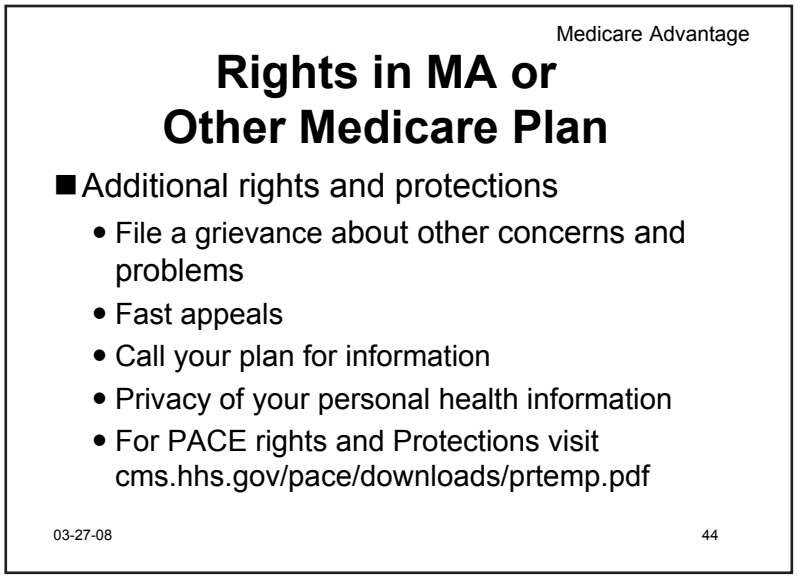
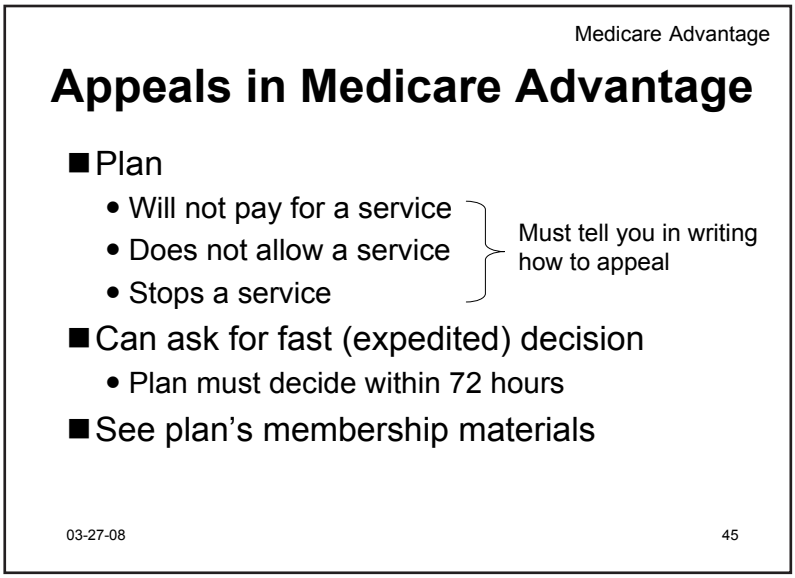
My Health. My Medicare.



- You also have the right to file a grievance about other concerns or problems. For example, if you believe there are not enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.
- You can call your Medicare Advantage Plan to find out if a medical service or supply will be covered.
- You have the right to have your health information kept private.

NOTE: You can get a list of your PACE rights and protections by visiting **www.cms.hhs.gov/pace/downloads/prtemp.pdf** on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have a Medicare cost plan, you will need to follow Original Medicare appeal process for any services you receive outside the plan's network.

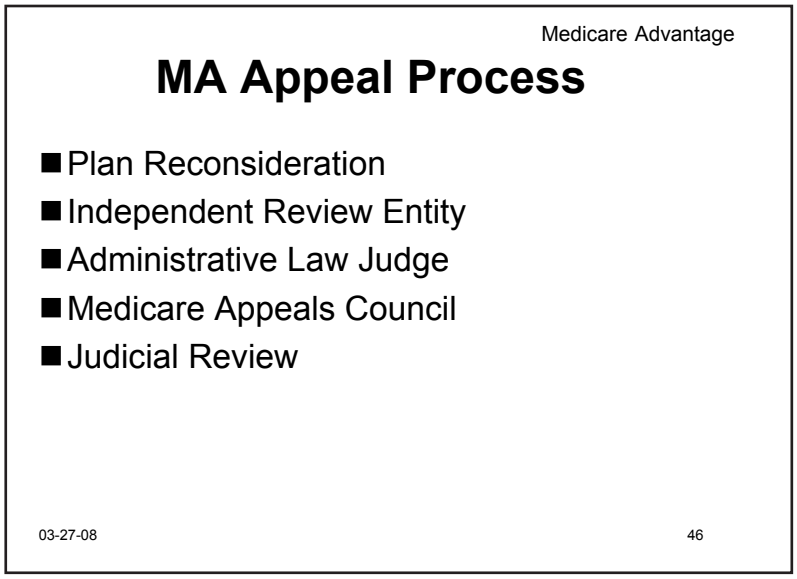
My Health. My Medicare.



The plan must tell you in writing how to appeal. If you are in a Medicare Advantage Plan or other Medicare plan, you can appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for an expedited appeal decision.

If your request for an expedited decision is requested or supported by a doctor, the plan must make a decision within 72 hours. You or the plan may extend the time-frame up to 14 days to get more medical information. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, an independent organization that works for Medicare—not for the plan—reviews the decision. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

My Health. My Medicare.



This slide outlines the appeals process in a Medicare Advantage Plan

- **Plan Reconsideration:** must be filed within 60 days of the date of the determination notice; no minimum amount in controversy needed; health plan has jurisdiction.
- **Independent Review Entity:** automatic if Plan Reconsideration does not change initial determination; no minimum amount in controversy needed; Independent Review Entity has jurisdiction.
- **Administrative Law Judge (ALJ)** hearing: must be filed within 60 days of the date of Independent Review Entity decision; minimum amount $120 in 2008, this amount is adjusted annually based on inflation.
- **Review by the Medicare Appeals Council (MAC):** Must be made in writing within 60 days from the date of receiving the unfavorable ALJ decision. The MAC generally has 90 days to make a decision after receiving the request for review. Jurisdiction Department of Health and Human Services Departmental Appeals Board (DAB).
- **Judicial Review:** must be filed within 60 days of receipt of MAC decision/ declination; minimum amount in 2008 is $1,180, to be adjusted annually; jurisdiction of U.S. District Court.

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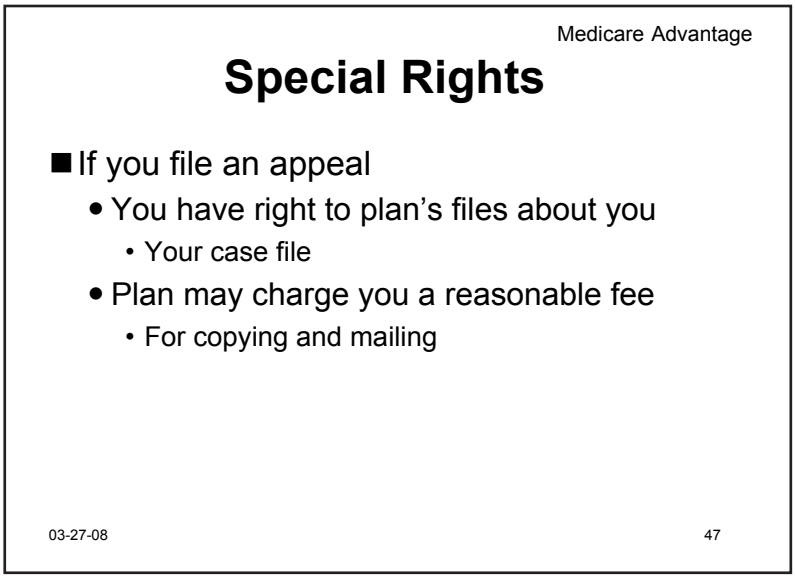
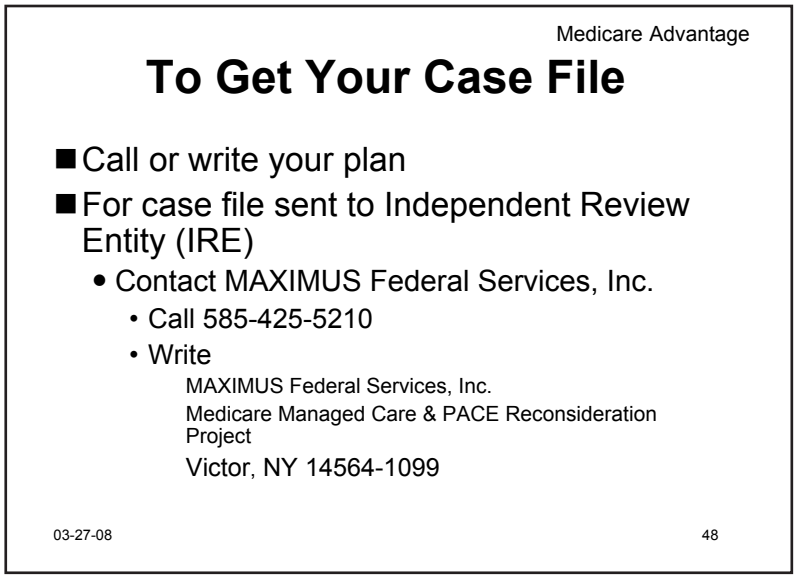


If you are in a Medicare Advantage Plan or Other Medicare Plan and you are filing an appeal, you have special rights. You have the right to ask your plan for a copy of the file that contains your medical and other information regarding your appeal.

The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it will cost based on the number of pages contained in the file, plus normal mail delivery.

My Health. My Medicare.

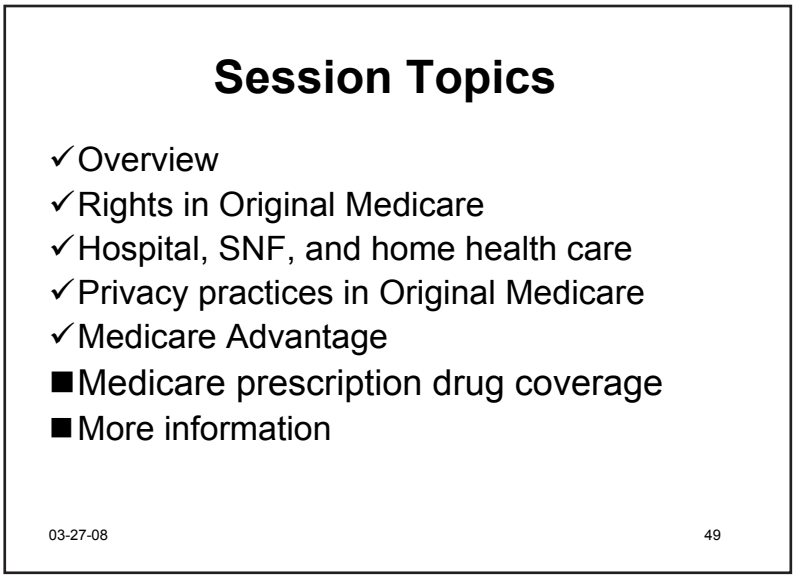


You may want to call or write your plan and ask for a copy of your file. Look at your *Evidence of Coverage*, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.

You may also ask to receive a copy of the case file the plan sent to the Independent Review Entity (IRE), currently MAXIMUS Federal Services, Inc. You may call MAXIMUS at 585-425-5210, or you may send a letter to:

MAXIMUS Federal Services, Inc.
Medicare Managed Care
& PACE Reconsideration Project
Victor, NY 14564-1099

My Health. My Medicare.



Medicare works with private drug plans to provide people with Medicare with the high-quality, cost-effective drug coverage they need. All Medicare drug plans must make sure that the people in their plan, their enrollees, have access to medically necessary drugs to treat their conditions.

If you are enrolled in a Medicare Prescription Drug Plan, you are guaranteed certain rights and protections. These rights and protections are the same whether you are in Original Medicare with stand-alone prescription drug plan or a Medicare Advantage Plan with prescription drug coverage. Let's take a few minutes to understand what they are.

My Health. My Medicare.

Every Medicare drug plan must establish and maintain procedures for:

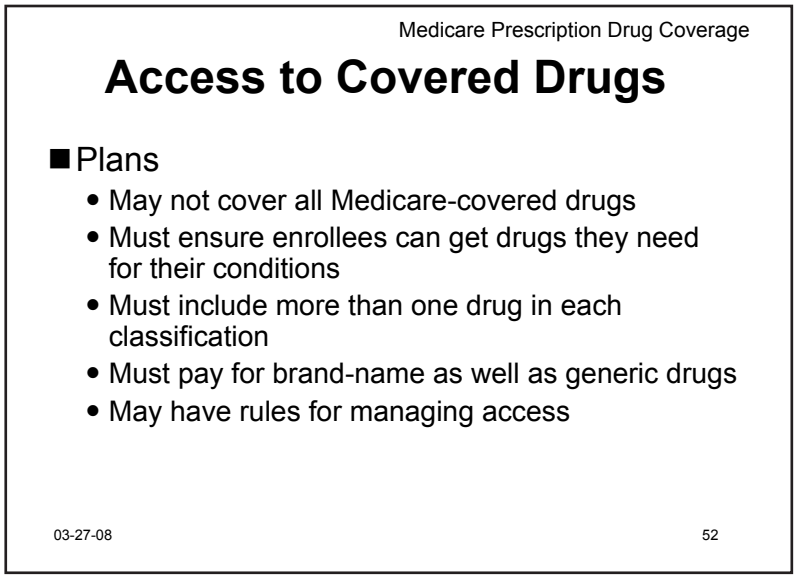
- Standard and expedited coverage determinations;
- Standard and expedited appeals; and
- Standard and expedited grievances.

My Health.
My Medicare.

The plan also must give you written information about its grievance, coverage determination, and appeal procedures at the following times:

- Grievance procedure—at initial enrollment, upon involuntary disenrollment initiated by the plan sponsor, upon denial of a request for expedited review, upon your request, and once a year.
- Coverage determination and appeals procedures, including the right to expedited review—at initial enrollment, upon notification of an adverse coverage determination or denial, and once a year. If a plan changes its formulary or the cost-sharing status of a drug you are taking, the plan must give you written information about the grievance and appeal procedures.
- Quality of care complaint process available through the Quality Improvement Organization (QIO)—at initial enrollment and once a year.

My Health.
My Medicare.



Medicare drug plans work to provide people with Medicare with the high-quality, cost-effective drug coverage they need. All Medicare drug plans must make sure that the people in their plan, their enrollees, can get medically necessary drugs to treat their conditions.

A plan's formulary may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.

Plans must pay for both brand-name and generic drugs.

Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin, such as syringes, needles, alcohol swabs, and gauze, are also covered.

Some of the methods plans use to manage access to certain drugs include:

- Formularies
- Prior authorization
- Step therapy
- Quantity limits

Becoming familiar with these terms will help you make choices about your coverage.

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My Health.
My Medicare.

CMS requires Medicare drug plans to cover "all or substantially all" medications in six categories:

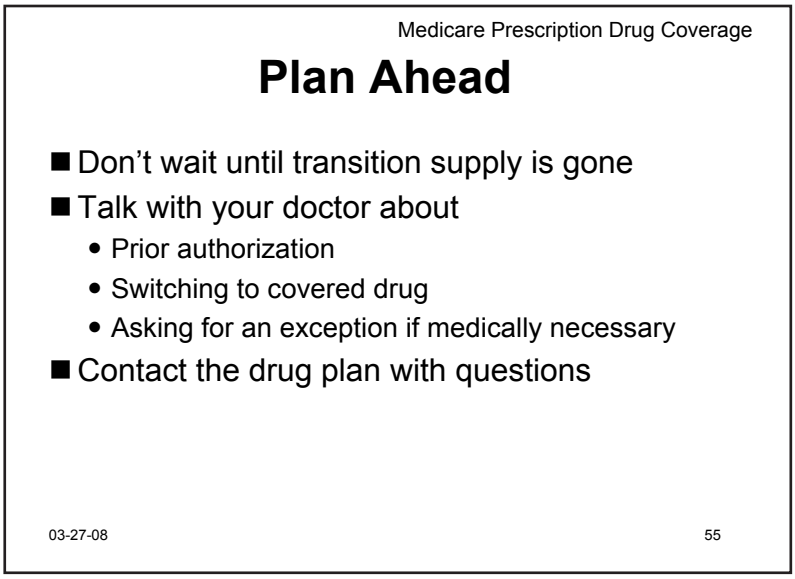
- Cancer medications
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions; and
- Immunosuppressants

My Health. My Medicare.

Some new members may already be taking a drug that's not on their plan's drug list or that is a step therapy drug*. Medicare requires the plans to provide a standard 30-day transition supply of all Medicare-covered drugs. Medicare requires drug plans to fill these prescriptions even if the prescription is for a drug that's not on the plan's drug list or is on the plan's drug list but is a step-therapy drug* or requires the doctor to contact the plan (prior authorization). This gives you and your doctor time to find another drug on the plan's drug list that would work as well. However, if you have already tried similar drugs and they didn't work, or if the doctor believes that because of your medical condition you must take a certain drug, the doctor can contact the plan to request an exception to the formulary rules. If the doctor's request is approved, the plan will cover the drug.

*With step therapy drugs, in most cases the plan member must first try certain less-expensive drugs that have been proven effective for most people with that condition.

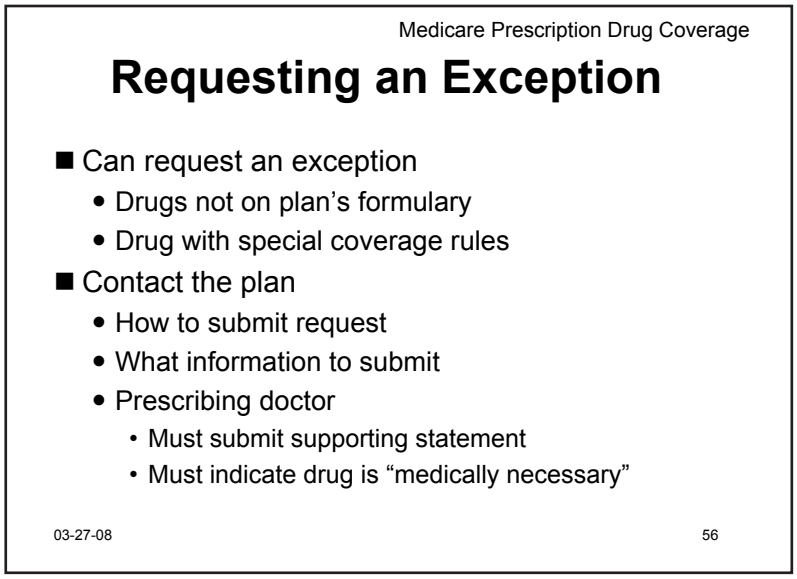
My Health.
My Medicare.



It is important to understand how to work with your plan's formulary and to plan ahead. If you receive a transition supply, you shouldn't wait until that supply is gone to take action. You should talk to your doctor about prior authorization if necessary, about safe and effective alternative drugs that may also save you money, or to request an exception if necessary for your condition.

You should contact your drug plan with any questions about what is covered by the plan.

My Health. My Medicare.

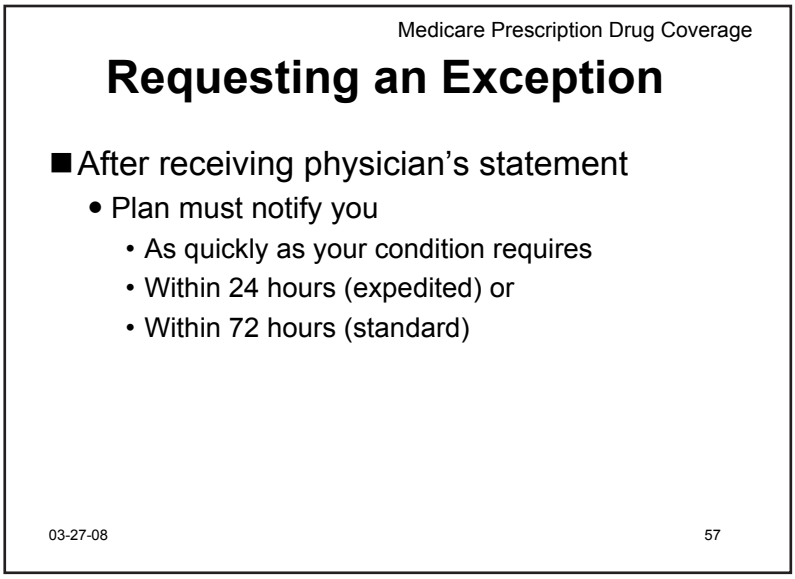


If your doctor needs to prescribe a drug that isn't on the Medicare drug plan's drug list, you or that doctor can request an exception from the plan.

An exception request is a kind of coverage determination. A coverage determination is the first decision a plan makes about the benefits you are entitled to receive.

The first step in requesting an exception is to contact the drug plan. The plan will advise how to submit the request and the information needed to make a decision. Your doctor must submit a statement supporting the request. The doctor's statement must indicate that the requested drug is "medically necessary"for treating your condition.

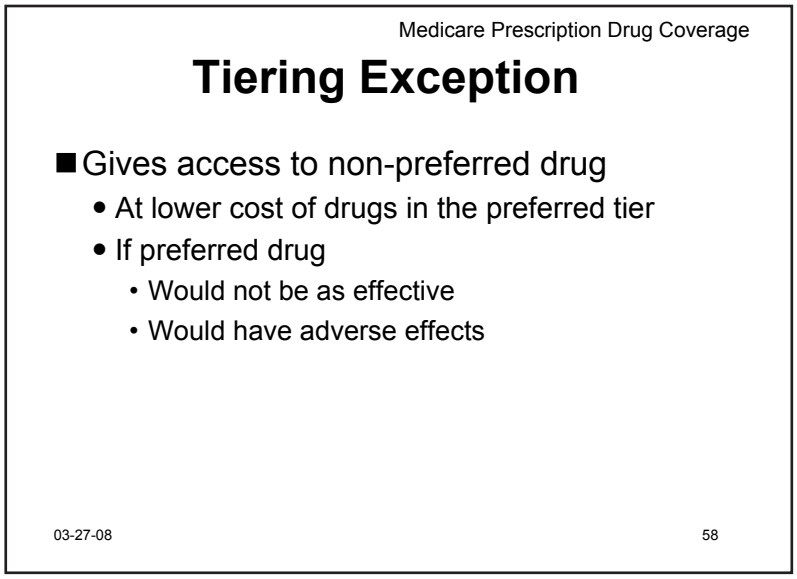
My Health. My Medicare.



Once this information is submitted, a plan must inform you and your prescribing physician, if appropriate, of its decision on the exceptions request as quickly as your health condition requires, but no later than 24 hours after receipt of an expedited request and no later than 72 hours after receipt of a standard request.

The next slides discuss two types of exceptions: tiering exceptions, and formulary exceptions.

My Health. My Medicare.



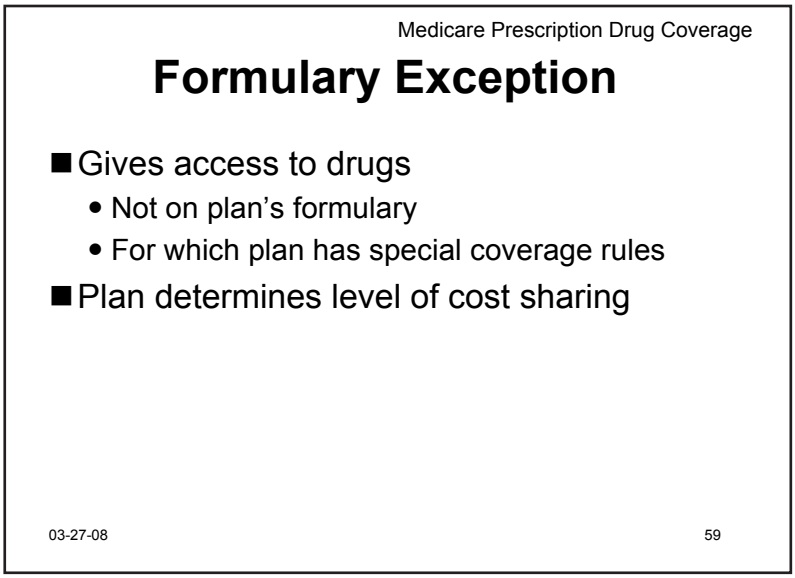
Let's look at one type of exception—a tiering exception.

If a plan uses a tiered cost-sharing structure to manage its Medicare drug benefit, it must provide exceptions procedures that permit enrollees to obtain a non-preferred drug at the more favorable cost-sharing level for drugs in the preferred tier.

A plan must grant a tiering exception when it determines that the preferred drug for treatment of your condition would not be as effective for you as the requested drug and/or it would have adverse effects.

When a tiering exception is approved, the plan must provide coverage at the cost-sharing level that applies for preferred drugs, but not at the generic cost-sharing level. Also, if a plan maintains a formulary tier in which it places very high-cost and unique items, it may design its exception process so that drugs placed in that tier are not eligible for a tiering exception.

My Health.
My Medicare.



Another type of exception is a formulary exception.

Formulary exceptions ensure enrollees have access to Medicare-covered drugs that are not included on the plan's formulary or for which the plan has special coverage rules. These special rules include: prior authorization, quantity limits, and step therapy.

When a formulary exception is approved, the plan has the flexibility to determine what level of cost sharing will apply for the non-formulary drug(s). For example, a plan sponsor may apply the non-preferred level of cost sharing for all non-formulary drugs approved under the exception process.

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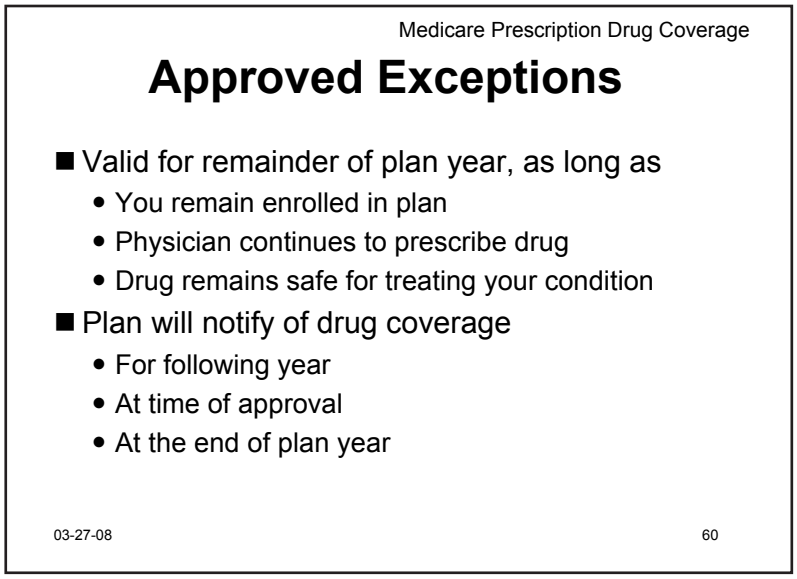

Approved exceptions are valid for refills for the remainder of the plan year, as long as

- You remain enrolled in the plan
- Your doctor continues to prescribe the drug
- The drug remains safe for treating your condition

The plan will notify members of coverage for the following year, either at the time of approval or at the end of the plan year. You may need to consider switching to a drug on your plan's formulary, requesting another exception, or changing plans during the Annual Coordinated Election Period, November 15 –December 31 of each year.

NOTE: Unlike an approved exception, which is valid for the remainder of the plan year, satisfying a prior authorization requirement may not be valid for the rest of the year. If you satisfy a plan's prior authorization requirement, it is generally only valid for the number of refills written in the prescription.

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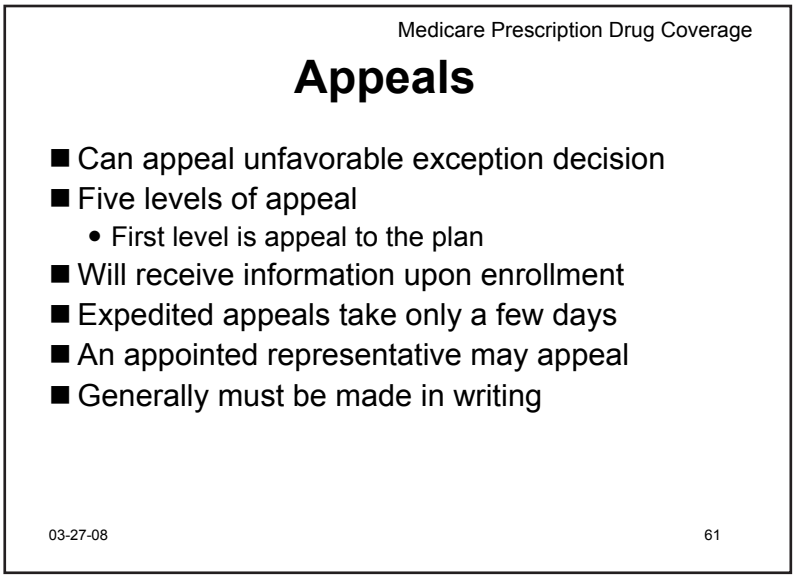

If the plan still won't cover a specific drug, you may appeal the decision. There are five levels of appeal, beginning with an appeal to the plan. You will receive information about the plan's appeal procedures when you enroll. Expedited appeals take only a few days.

Either you or a representative appointed by you, such as a doctor or family member, may request a coverage determination or an appeal. An appointment of representation form or letter must be filed with the plan sponsor. More information about these appeals is available in your Evidence of Coverage notice or on **www.medicare.gov** on the web, or you can contact the drug plan for information on its exception and appeals process.

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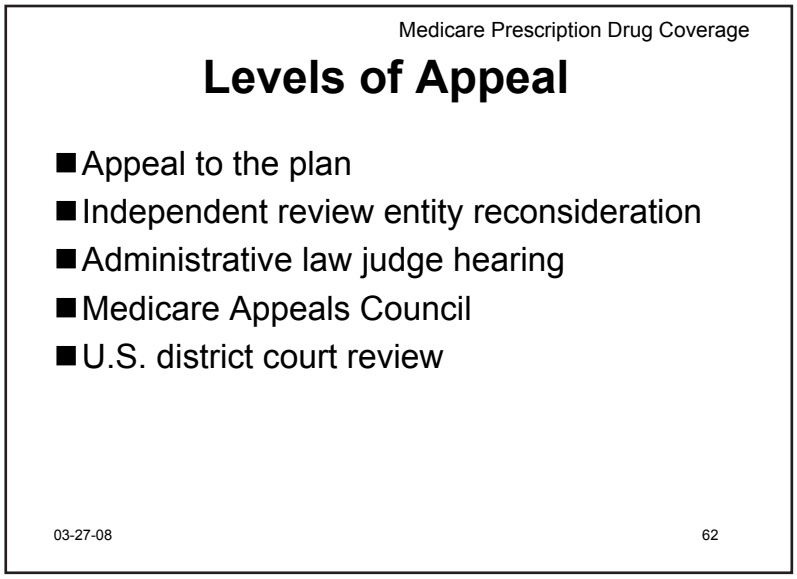

You can appeal your Medicare drug plan's unfavorable decision. Any representative you appoint, such as a doctor or family member, may help request a coverage determination or an appeal. You will receive information about the plan's appeal procedures when you enroll. There are five levels of appeal:

- **Appeal to the plan**—Must request within 60 calendar days from the date of receiving the unfavorable decision, in writing unless the plan accepts requests by phone. A person can call or write for an **expedited request** for coverage. The plan has 7 days from when it receives a standard request, or 72 hours for an expedited request, to notify you of its decision.
- **Reconsideration by an independent review entity**—Must request in writing within 60 days from the date of receiving the plan's unfavorable appeal decision. The IRE has 7 days for a standard request, or 72 hours for an expedited request, to notify you of its decision.
- **Hearing with an administrative law judge**—Must request in writing within 60 days from the date of receiving the unfavorable IRE decision. The projected value of the denied coverage must be $120 or more. The ALJ generally has 90 days to make a decision.
- **Review by the Medicare Appeals Council**—Must request in writing within 60 days from the date of receiving the unfavorable ALJ decision. The MAC generally has 90 days to make a decision after receiving the request for review.
- **Judicial review by a U.S. district court**—If the MAC agrees with the plan's decision, the person with Medicare can request (in writing) a review by a U.S. district court. To receive a judicial review, the amount must be $1,180 or greater.

The minimum amounts are determined annually, and appeals may be combined to meet them.

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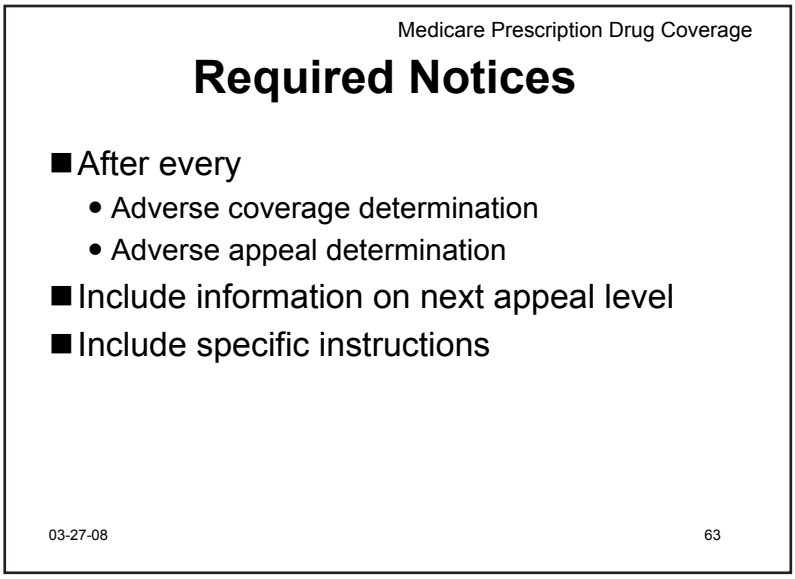

Plans sponsors are required to provide notices after every adverse coverage determination or appeal.

In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain the decision, include information on the next appeal level, and provide specific instructions about how to file the appeal.

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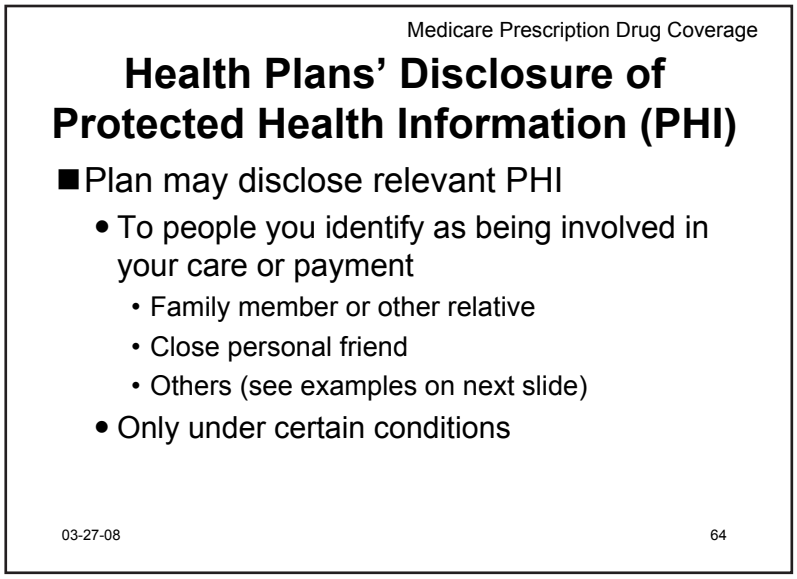

The guidelines shown on the next two slides were published by the Office for Civil Rights in the U.S. Department of Health and Human Services. They explain that a health care provider or health plan, such as a Medicare drug plan, may disclose relevant protected health information (PHI) to someone who is assisting you, specifically regarding the drug benefit. However, the guidance applies to all providers and plans, not just drug plans. It's important to note that health plans are permitted, but not required, to make these disclosures.

Your plan may disclose relevant PHI to those identified by you as being involved in your care or payment

- Family member or other relative
- Close personal friend
- Others (see examples on next slide)

Your plan may disclose relevant PHI to those identified by you only under the following conditions

- When you are present and agree/do not object or the plan reasonably infers from the circumstances that you do not object
- When you are not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest

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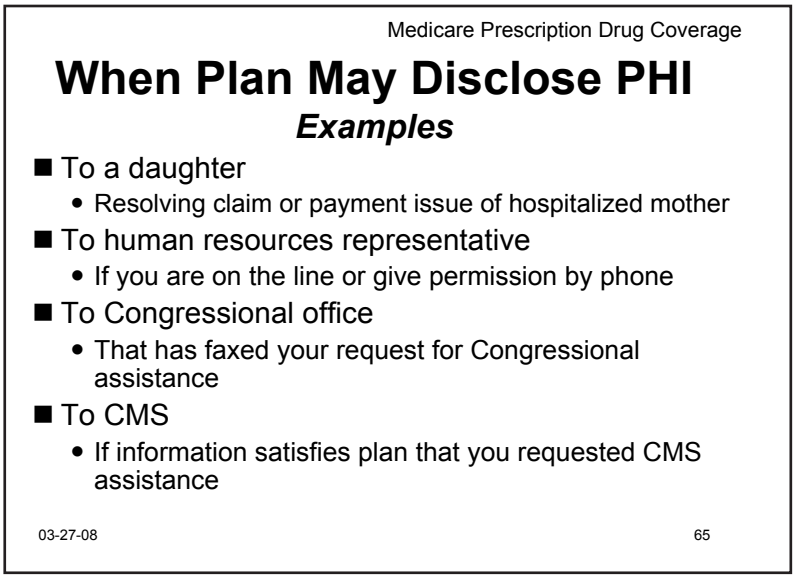

Examples of when a plan may disclose PHI:

- To the daughter of a person with Medicare who is resolving a claim or payment issue for her hospitalized mother
- To a human resources representative if the person with Medicare is on the line or gives permission by phone
- To a Congressional office or staff person that has faxed the person's request for Congressional assistance
- To CMS staff if the available information satisfies the plan that the individual requested CMS assistance

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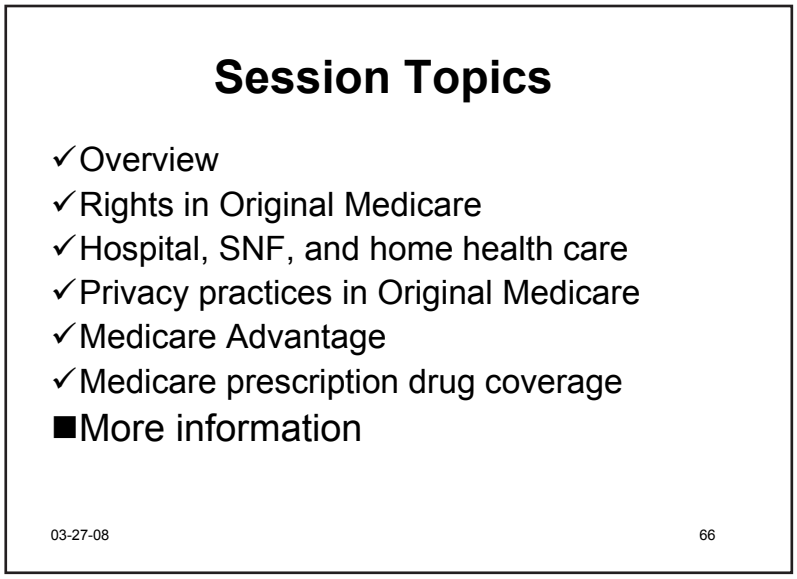

Let's take the last few minutes to discuss where you can get more information.

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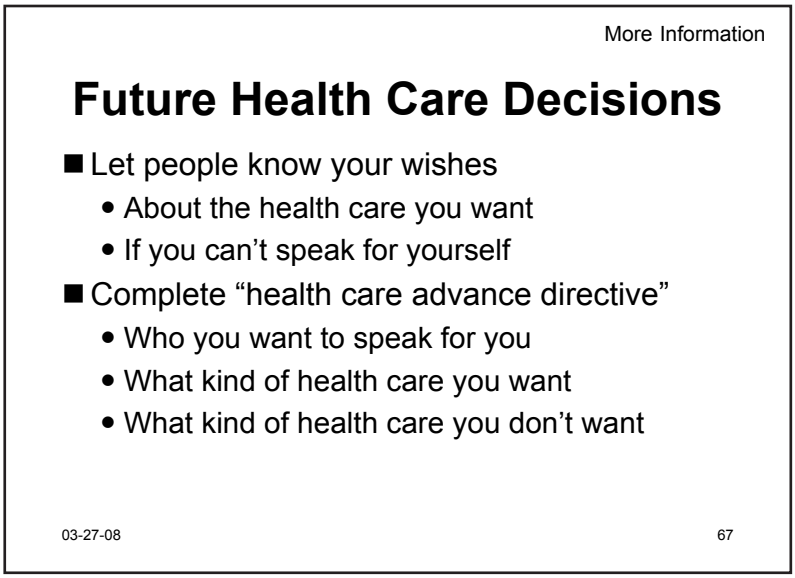

Another health care protection available to anyone, not just people with Medicare.

As people live longer, there is a greater chance that they may not be able to make their own health care decisions at some point in time. Alzheimer's and other diseases affect a person's ability to make health care decisions.

To let people know what kind of treatment you want if you lose the ability to make your own health care decisions in the future, you need to fill out a "health care advance directive." An advance directive is a written document in which you give directions about who you want to speak for you and what kind of health care you want or don't want in the event you cannot speak for yourself.

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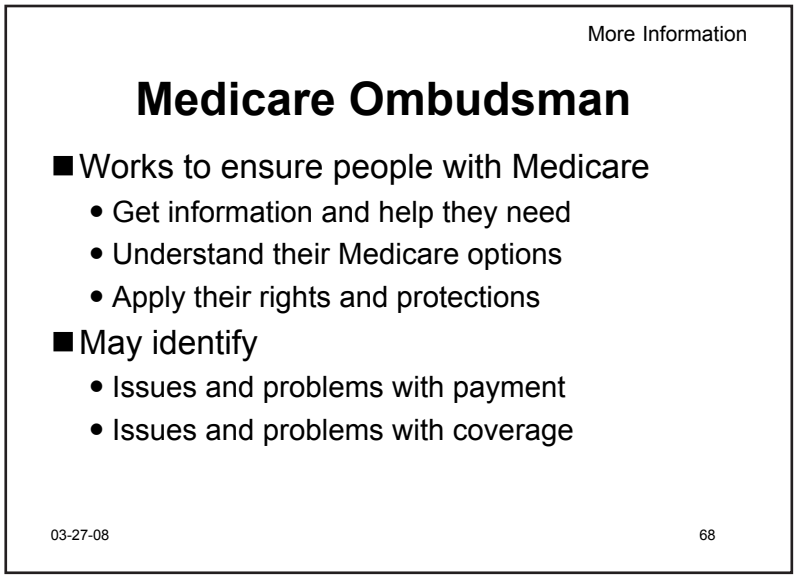

Another protection for people with Medicare is the Medicare Beneficiary Ombudsman's office. The Medicare Beneficiary Ombudsman works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections.

The Ombudsman may identify issues and problems in payment and coverage policies, but doesn't advocate for any increases in program payments or new coverage of services.

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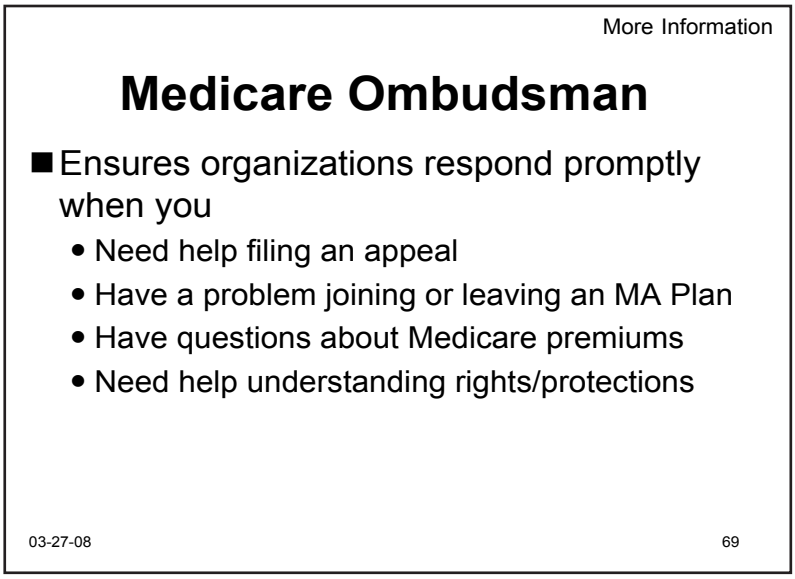

The Medicare Ombudsman works to make sure the organizations that should help you with your complaints, appeals, grievances, or questions about Medicare work the way they should and respond to you promptly.

For example, the Medicare Beneficiary Ombudsman can help you getthe assistance you need include when you:

- Need help to file an appeal
- Have a problem joining or leaving a Medicare Advantage Plan (like an HMO or PPO) or other Medicare plan, or a Medicare Prescription Drug Plan
- Have questions about Medicare premiums
- Need help understanding your Medicare rights and protections

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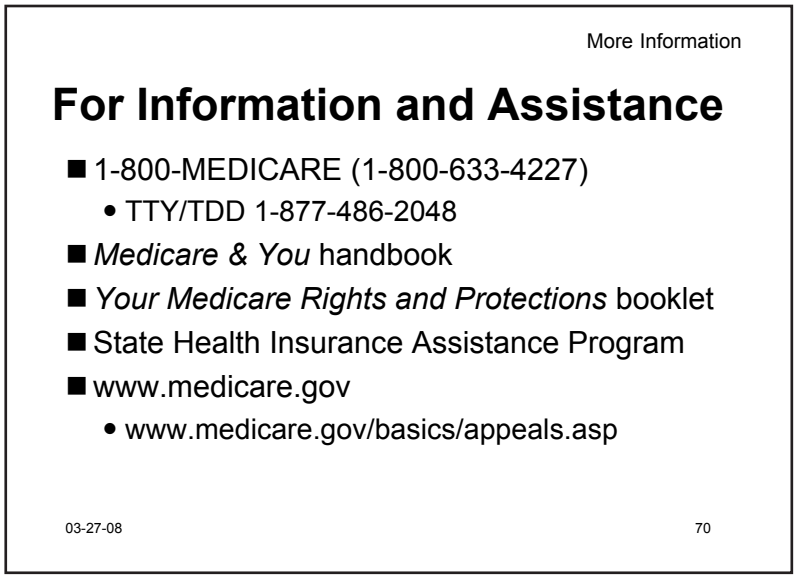

There are a number of resources you can use to get more information or assistance regarding your Medicare rights and protections:

- 1-800-MEDICARE (1-800-633-4227)
- *Medicare & You* handbook
- *Your Medicare Rights and Protections* booklet, CMS Pub. No. 10112
- Your local State Health Insurance Assistance Program (SHIP)
- **www.medicare.gov** on the web. You can get information specifically about Medicare appeals and grievances at **www.medicare.gov/basics/appeals.asp**

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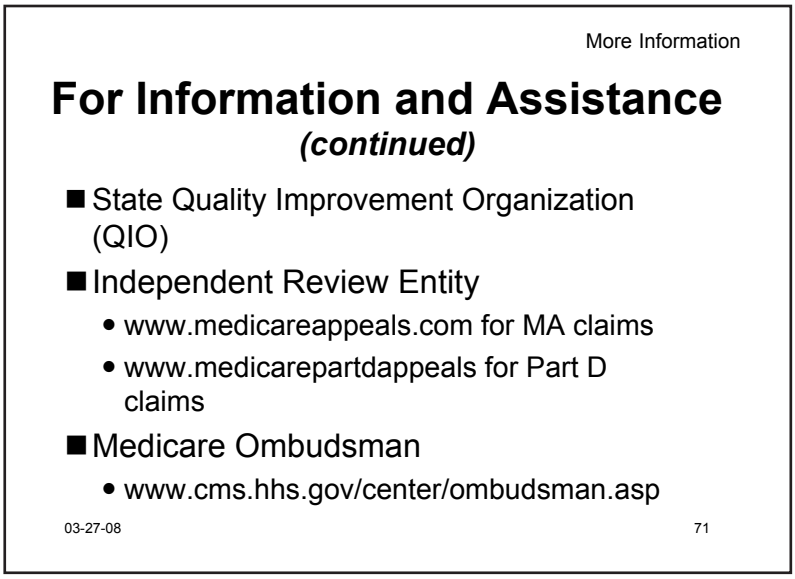

Some other resources for help regarding your Medicare rights and protections include:

- Your state Quality Improvement Organization (QIO)
- You can find the number for your QIO at **www.medicare.gov/Contacts** on the web
- Independent Review Entity
  - **www.medicareappeals.com** for Medicare Advantage claims
  - **www.medicarepartdappeals** for Part D claims
- Medicare Ombudsman
  - **www.cms.hhs.gov/center/ombudsman.asp**

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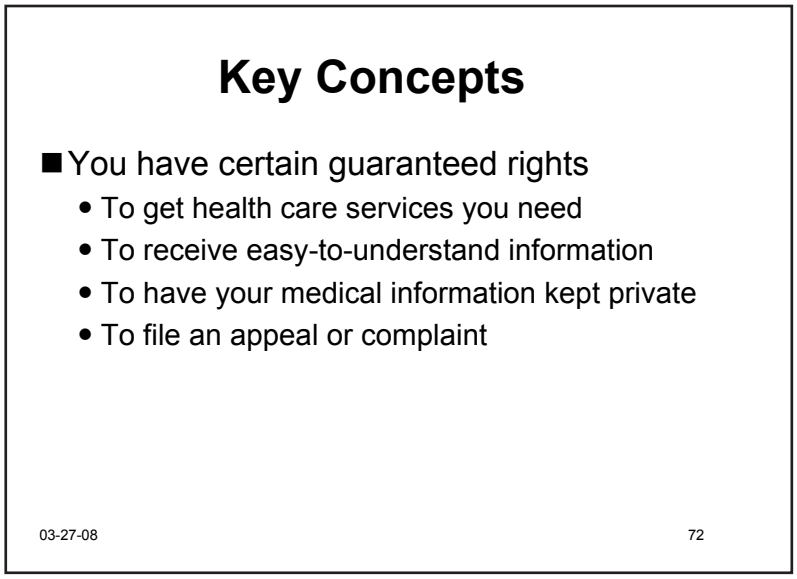

In summary, it's important to remember that, as a person with Medicare, you have certain guaranteed rights. You have the right to get the health care services you need and to get easy-to-understand information about Medicare, what costs it pays, and how much you have to pay. And you have a right to know what to do if you want to file an appeal or complaint. You also have the right to have your medical information kept private.

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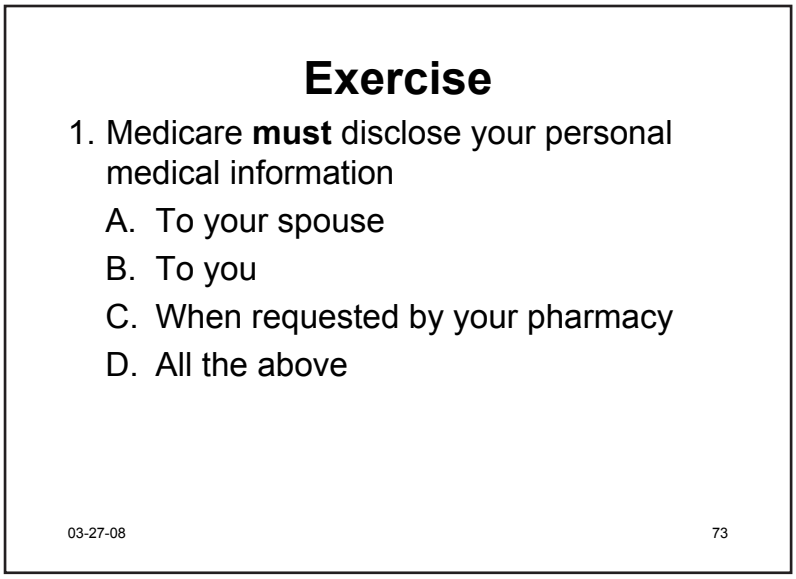
Exercise



1. Medicare **must** disclose your personal medical information
   A. To your spouse
   B. To you
   C. When requested by your pharmacy
   D. All the above

NOTES:

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Answer: B. To you

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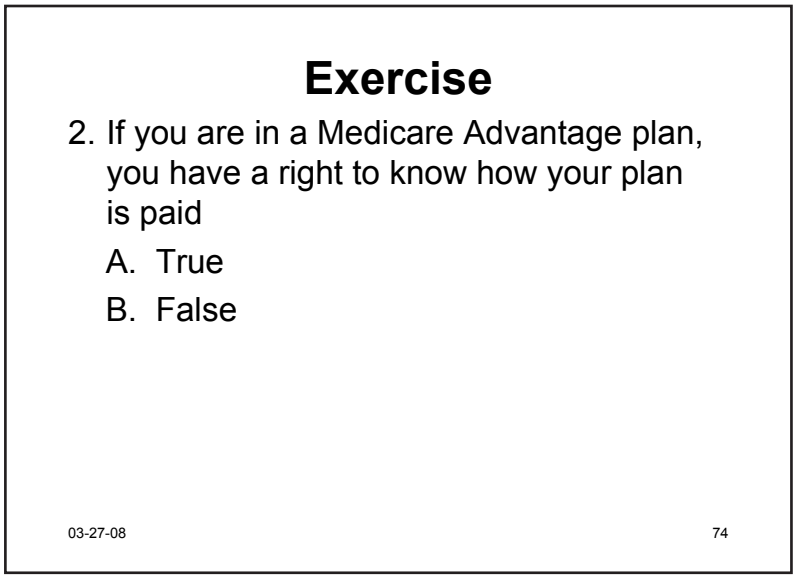
Exercise



2. If you are in a Medicare Advantage plan, you have a right to know how your plan is paid
   A. True
   B. False

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Answer: A. True

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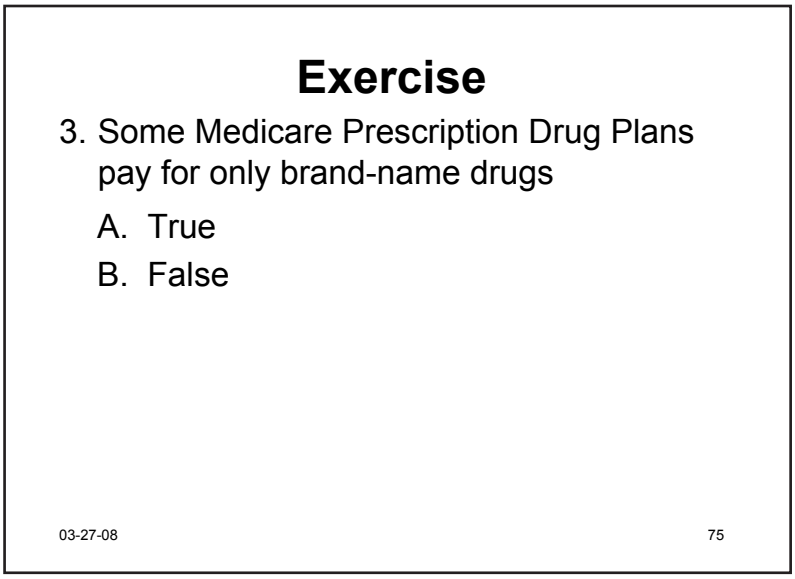
Exercise



3. Some Medicare Prescription Drug Plans pay for only brand-name drugs
   A. True
   B. False

NOTES:

Answer: B. False

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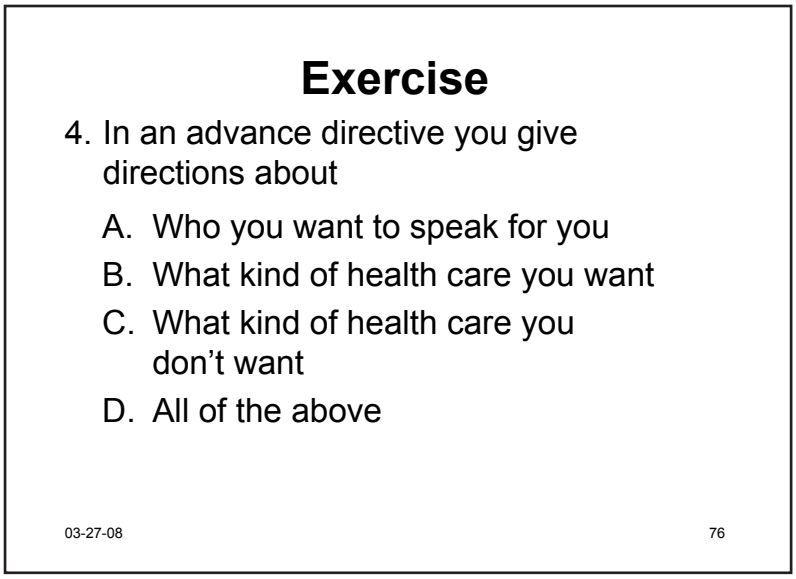
Exercise



4. In an advance directive you give directions about
   A. Who you want to speak for you
   B. What kind of health care you want
   C. What kind of health care you don't want
   D. All of the above

NOTES:

Answer: D. All of the above

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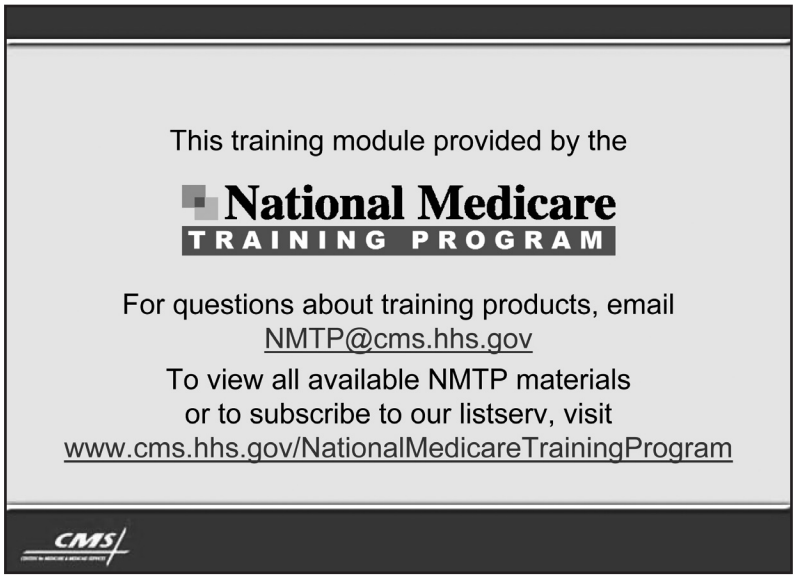
Module 2: Your Medicare Rights and Protections



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