SHIBA

Senior Health Insurance Benefits Assistance

Section 6

Medicare Appeals

SHIBA Volunteer Training Program, April 2008

Section 6, Medicare Appeals Procedures

Part A & B Appeal Processes

All beneficiaries have the right to appeal any decision concerning covered services in the Medicare program. All *Medicare Summary Notices* have current appeal procedures on the reverse side. Please refer to the *Medicare Summary Notice's* **"Important Deadlines and Procedures."**

This section (Section 6) will cover Medicare Part A, Part B, and Part D appeals, as well as Medicare Advantage (MA) plan appeals.

First, Medicare *eligibility* denials

The Social Security Administration determines Medicare eligibility and notifies people of their Initial Determination if they are ineligible.

For a successful appeal, they must submit evidence:

- that they are 65,

or

- that they had enough payroll quarters of coverage.

The appeals timetable is strict. All appeals must be signed and in writing. Proper forms are available from the Social Security office.

Medicare *service* denials – "Initial Determination"

The beneficiary will receive a notice of "Initial Determination" (*Medicare Summary Notice* or a Notice of Non-Coverage) denying payment for an item or service. If the notice is not in writing, a written denial needs to be requested.

At each step of the appeals process, further appeal rights will be clearly stated on Determinations. Beneficiaries must keep all Determinations received from the Medicare contractor (including envelopes – postmarks). Beneficiaries or representatives should refer to the most current documents when proceeding with the appeal.

The Five Standard Levels of Appeal

First level of appeal: Redetermination

"Initial Determination" notice and any QIO decisions to Medicare:

1. Must be sent to the fiscal intermediary or carrier
2. with a "Please review" note.
3. Circle the item that is in dispute
4. and explain why the beneficiary disagrees with the decision or payment amount.
5. Beneficiaries (or their representatives) must sign and provide their telephone number.
6. Include any additional medical records that support the case.
7. Send a copy of the notice to the address in the "Customer Service Information" box.

Part B review requests can also be made by telephoning the Customer Service number on the *Medicare Summary Notice*.

- **An appeal must be filed with the intermediary or carrier within 120 days of receiving the Initial Claim Determination.**
- The Medicare contractor must make its decision within 60 days of request.

Second level of appeal: Reconsideration hearing

Request a reconsideration if the beneficiary disagrees with the Level I Redetermination decision. A Medicare-appointed Quality Improvement Contractor (QIC) will determine if the carrier's decision followed guidelines.

- At least $110 must be in dispute.
- The appeal must be filed within six months from the date of the redetermination.
- The QIC has 60 days to make a decision.

Third level of appeal: Administrative Law Judge

Beneficiaries may appeal to an Administrative Law Judge (ALJ) if they disagree with the *Second* Level of Appeal's QIC's Hearing Officer's (HO) decision. The ALJ hearing request must be sent to the intermediary or carrier involved, who will forward it to the Office of Hearing and Appeals of the Social Security Administration, who will respond back to the intermediary or carrier within 45 days.

- At least $110 must be in dispute (Part A or Part B).
- Appeal must be filed within 60 days from date of the HO decision.

Fourth level of appeal: Departmental Appeals Board Review (DAB)

If the beneficiary disagrees with the decision of the ALJ, an appeal to the DAB can be requested. The DAB, at its discretion, may review the case. There are no requirements regarding the amount of money in controversy. The request for a DAB review must be submitted within 60 days of receipt of the ALJ's decision. If appeals reach this point, it is suggested that the beneficiary retain legal assistance.

Fifth level of appeal: Judicial Review in US District Court

To appeal to Federal Court, at least $1,090 must be in dispute following the DAB's decision. Request must be made within 60 days of receipt of the DAB's decision.

For more information about the appeal process:

1. visit www.cms.hhs.gov,
2. click on **Medicare,**
3. then click on CMS Forms,
4. then click on Departmental Appeals Board,
5. then click on whatever seems appropriate to give the help being sought.

Hospital Appeals

Pre-admission appeals

- To receive a prompt review of a hospital Pre-Admission Notice of Denial, **the Quality Improvement Organization (QIO) should be *phoned* as quickly as possible**. The QIO will then have three working days to respond to the request.
- If the request is not phoned in promptly, the beneficiary may still write to ask for QIO review up to 30 days after receiving the hospital Admission Denial Notice. In that case, the QIO will have 30 days after receipt of the written request to issue its response.

In either case, the QIO review decision will advise of further rights to a reconsideration and the time periods involved.

The Oregon QIO may be contacted at:

Acumentra
2020 SW 4th Avenue, Suite 520
Portland, OR 97201
Beneficiary Hotline: 1-800-633-4227 (1-800-MEDICARE)
SHIBA Helpline – 1-800-344-4354

Hospital discharge appeals – initial appeal

A hospital may notify a beneficiary that he or she no longer needs inpatient care. A hospital Medicare patient has special protections that allow for hospital stay coverage while a denial is being determined:

- The hospital must issue a written notice of non-coverage.
- If the beneficiary has not received a written notice of non-coverage, one needs to be requested from the hospital.

- If the beneficiary disagrees with the written notice of non-coverage, and wishes to appeal the decision, the beneficiary or appointed representative must contact the QIO by noon the day after receiving the written notice of non-coverage.
- The QIO will review the case and inform the beneficiary of its decision by phone or in writing.
- If the doctor agreed with the hospital's notice of non-coverage, the beneficiary, a family member, or a representative must request a review by noon of the next working day after receiving the notice.
- The QIO, after contacting the beneficiary to ask about the condition, must review the case and give a decision no later than the next full workday after getting the request.

Note: The hospital must send the QIO all necessary medical records by the end of the day the request was made.

- If the QIO agrees with the beneficiary, Medicare will cover the additional costs.
- If the QIO does ***not*** agree with the beneficiary and approves the hospital notice of non-coverage, the beneficiary cannot be charged for continued services until noon of the next calendar day after receipt of the QIO's decision.
- If the beneficiary stays in the hospital after receiving a notice of non-coverage, *but misses the one-day deadline to request an immediate QIO review*, the beneficiary can still call the QIO at any time during the hospital stay and ask that it review the case. The beneficiary's liability for the hospital stay would begin to be counted from the third calendar day after receipt of the original hospital notice.
- If the doctor agrees with the beneficiary, the hospital must get permission from the QIO before it issues a notice of non-coverage.
- The QIO has three (3) days to review the case.
- If the QIO agrees with the hospital, the beneficiary will receive a notice of non-coverage. In this situation, the beneficiary should request a reconsideration immediately.

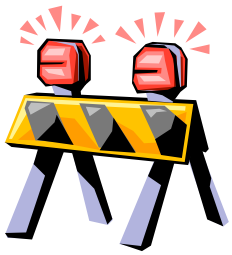
- If the QIO decides against the beneficiary's reconsideration request as well, the beneficiary has 60 days to request a hearing before an Administrative Law Judge.

Special situations in Home Health Care or Skilled Nursing Facilities

Home Health Care agencies and Skilled Nursing Facilities (SNFs) may mistakenly tell patients that Medicare will not cover their cost of care. They must provide a written "Notice of Medicare Non-Coverage" to the beneficiary or their representative. The notice must state:

- The date coverage will end and why the stay is no longer covered.
- The beneficiary's right to request that the SNF send Medicare its opinion and request for Medicare to decide if the stay still qualifies for SNF coverage (This request is often called a Demand Bill.)
- Where the beneficiary or representative must sign as proof of having received the notice.
- If a Demand Bill is requested, the beneficiary is not required to pay for the Medicare portion of the SNF stay until informed of Medicare's decision.

To request a Demand Bill, the beneficiary or representative must check the appropriate box on the Notice of Non-Coverage that indicates the beneficiary's wishes and the Notice must be signed by the beneficiary or representative. The beneficiary is still responsible for any costs that would normally be charged while the demand bill is being processed. Medicare will notify the SNF of its decision. If the beneficiary still does not agree with the decision of non-coverage, they can file an appeal through the normal appeal processes.



Note: If Medicare decides your care is no longer covered, you are responsible for the cost of the care you received while awaiting the decision!

Part A & Part B Waiver of liability

When a Medicare claim is disallowed, beneficiaries may be responsible for paying providers for services rendered. However, in many cases, beneficiaries may have received services without knowing Medicare would not pay for them. A *waiver of liability* applies in situations in which beneficiaries did not know or could not have been expected to know that services they received were not covered by Medicare.

Example: A beneficiary was admitted to a SNF and was assured by her doctor that she would be receiving skilled care and that Medicare would cover the stay. If it turns out that she didn't receive skilled care and Medicare denied coverage, the beneficiary could appeal the decision, seeking a waiver of liability.

The following conditions must exist for the beneficiary to receive a *waiver of liability*:

1. A claim must have been disallowed on grounds that service was not reasonable or necessary for diagnosis or treatment of an illness or injury, or that expenses were for custodial care.
2. The institution (hospital, nursing home, or home health agency) must be Medicare-certified.
3. The beneficiary must be without fault and must show that they neither knew, nor reasonably could have been expected to know, that Medicare would not cover the services. (This condition is met when a provider did not give written notice to the beneficiary that Medicare probably would not cover the service.)

Note: Waivers are not granted when services clearly are excluded from Medicare coverage (e.g., hearing aids, dental care, etc.)

Seeking a Waiver of Liability

The *Medicare Summary Notice* may alert beneficiaries with a message indicating that they may request a review of the denial if they were unaware that Medicare would not pay for the services or supplies.

Beneficiaries may initiate the appeal process by requesting a review and may submit evidence supporting the request for a *waiver of liability*.

When beneficiaries have already paid bills, Medicare can reimburse them for the expenditure. Medicare will try to get a refund from the provider or pay the beneficiaries directly.

Beneficiaries should make written requests for reimbursement to the intermediary within six months from the date of paying the provider. The reimbursed amount is reduced by the deductible and coinsurance amounts for which beneficiaries would otherwise be liable.

The amount paid to beneficiaries is an overpayment to the provider. When beneficiaries have not paid the bills, providers absorb the loss.

PART D – Coverage Determinations, *Exceptions*, Grievances, and *Appeals*

The process for resolving coverage determinations, grievances and appeals under the Medicare Part D program is modeled after the Medicare Advantage program (next segment of Section 6). "Exceptions" are unique to Medicare Part D.

Coverage Determinations

A Coverage Determination is the initial decision made by, or on behalf of, a Part D plan regarding payment or benefits to which enrollees believe they are entitled.

An enrollee, the enrollee's appointed representative, or the enrollee's prescribing physician may request a coverage determination by the plan. A plan must notify an enrollee of its coverage determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving an expedited request, or 72 hours after receiving a standard request. If a plan does not make a coverage determination within the applicable timeframe, the request must be forwarded to the independent review entity for review.

An **exception** is a type of coverage determination unique to Medicare Part D. An enrollee may request a tiering exception or a formulary exception.

- **Tiering exception**: Permits enrollees to obtain a non-preferred drug at the cost-sharing amount applicable to drugs on the preferred tier (i.e., allowed to pay preferred price for non-preferred drug). Generally, a plan must grant a tiering exception when the plan's preferred drug for treatment of the condition would not be as effective as the non-preferred, prescribed drug of the beneficiary, and/or would have adverse effects for the enrollee. A supporting statement from the enrollee's physician is required.

- **Formulary exception**: Ensures that enrollees have access to medically necessary Part D drugs that are not included on a plan's formulary (i.e., allowed to get drug the plan said it did not cover). The Formulary Exception also permits enrollees to request an exception to a quantity or dose limit, and/or to request an exception to a plan's requirement that the enrollee try another drug before the plan will pay for the requested drug.

Generally, a plan must grant a formulary exception when its formulary drug for treatment of the same condition would not be as effective as the enrollee's prescribed drug, and/or would have adverse effects for the enrollee. As with the tiering exception, a supporting statement from the enrollee's physician is required.

Plans are prohibited from requiring enrollees to seek additional exception requests for refills.

Appeals

If a Part D plan makes an adverse coverage determination, the enrollee may request an appeal. There are **five levels** of appeal available in the following sequence:

1. **Redetermination by the Part D Plan**
   - Enrollees can make expedited requests orally or in writing. They must make standard requests in writing.
   - The enrollee must be notified of the decision no later than 72 hours after receiving an expedited request, or 7 days after receiving a standard request.
   - If a plan does not make a redetermination within the applicable timeframe, the request must be forwarded to the independent review entity for review.

Unfavorable decisions are appealable to the IRE.

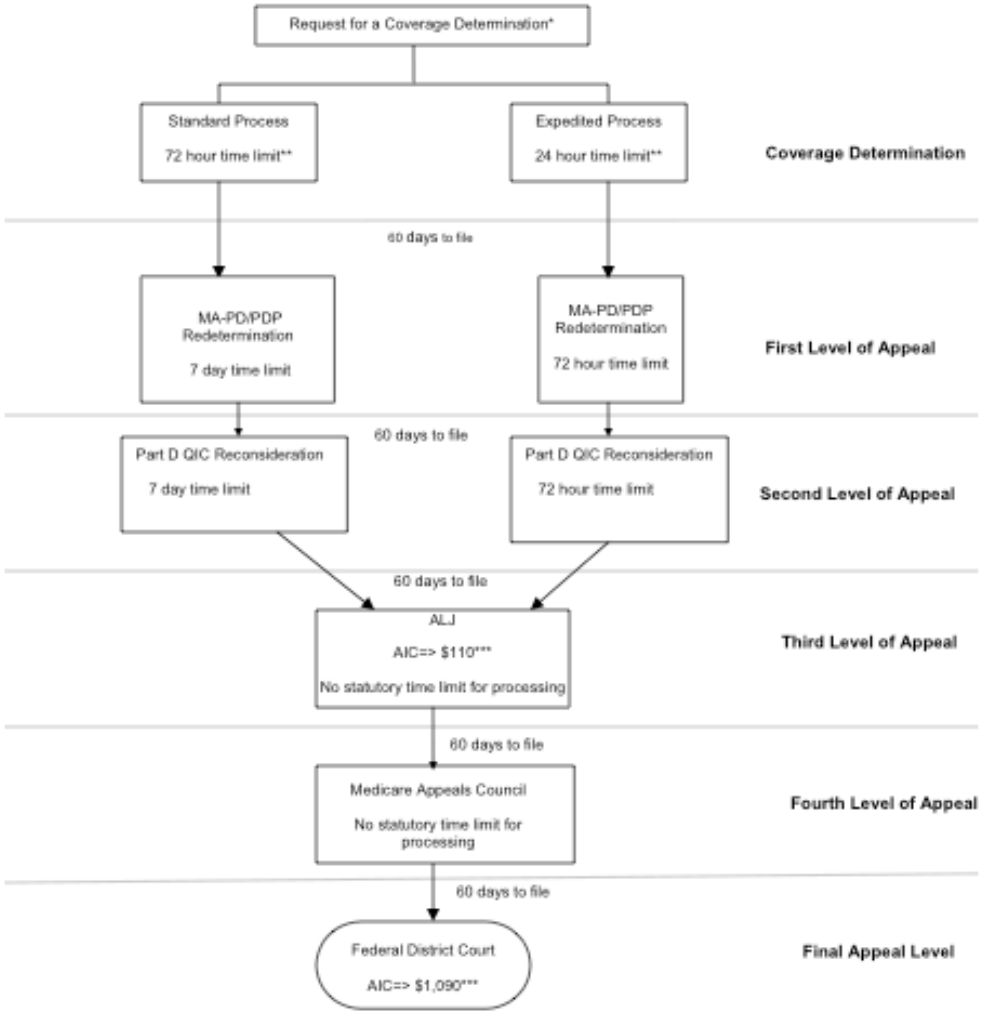
2. **Reconsideration by the Independent Review Entity (IRE)**
    - Expedited and standard requests must be made in writing.
    - The enrollee must be notified of the decision no later than 72 hours after receiving an expedited request, or 7 days after receiving a standard request.
    - Unfavorable decisions are appealable to a DHHS Administrative Law Judge (ALJ).
3. **Hearing with a DHHS ALJ**
    - Hearing requests must be in writing; unfavorable ALJ decisions are appealable to the Medicare Appeals Council (MAC).
4. **Review by the MAC**
    - Review requests must be in writing; unfavorable decisions are appealable to federal district court.
5. **Review by a federal district court**
    - Enrollee must file a civil action in federal district court.

Grievances

A grievance is any complaint or dispute, other than one involving a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a plan.

- ♦ Enrollee may file a grievance with the plan orally or in writing.
- ♦ Enrollee must file a grievance within 60 days of the event that gives rise to the grievance.
- ♦ Enrollee must be notified of the decision no later than 30 days after the plan receives the grievance.
- ♦ If the grievance relates to a plan's refusal to expedite a coverage determination, the enrollee must be notified of the decision no later than 24 hours after the plan receives the grievance.

Medicare Part D Appeals Process



AIC = Amount in controversy
ALJ = Administrative Law Judge
IRE = Independent Review Entity
MA-PD = Medicare Advantage plan that offers Part D benefits
PDP = Prescription Drug Plan

*A request for a coverage determination includes a request for a tiering exception or a formulary exception. A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, or the enrollee's physician.

**The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

***Starting in 2005, the AIC requirement for an ALJ hearing and Federal District Court will be adjusted in accordance with the medical care component of the consumer price index.

Medicare Advantage Appeals

Medicare Advantage plans must state in writing how to appeal. If beneficiaries are in Medicare Managed Care plans or Private Fee-for-Service plans, they can file appeals if their plans will not pay for, do not allow, or stop a service that beneficiaries think should be covered or provided. If they think their health could be seriously harmed by waiting for a decision about a service, they should ask their plans for an expedited appeal decision.

Medicare Advantage appeals process

The redetermination process, as with Original Medicare, is subject to deadlines. The process is outlined below. Contact the plan for how to file an appeal or grievance.

Plan Reconsideration: must be filed within 60 days of the initial 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 hearing: must be filed within 60 days of the date of Independent Review Entity decision; minimum amount $100, to be adjusted annually beginning January 2005.

Departmental Appeals Board review: must be filed within 60 days of receipt of ALJ hearing decision/dismissal; no minimum amount; Department of Health and Human Services has jurisdiction.

Judicial Review: must be filed within 60 days of receipt of DAB decision/declination; minimum amount $1,000; jurisdiction of U.S. District Court.

These appeal rights also apply to a Medicare Advantage plan's decision to deny a claim for emergency care or for out-of-service-area urgently needed care.

Expedited Appeals

Because the appeals process can be lengthy, a faster system of review is now available for people who require urgent care. If the Medicare Advantage plan denies health services or they fail to provide urgent services quickly it may:

- jeopardize the patient's life or health, or
- jeopardize the patient's ability to regain maximum function.

Beneficiaries should request expedited appeals from their Medicare Advantage plan. The plans must issue a decision within 72 hours.

Beneficiaries, or their plans, may extend the timeframe up to 14 days to get more medical information.

If appeals are requested without a doctor's support, Medicare Advantage plans will determine whether or not the appeal should be processed under the expedited system.

Grievances

The Medicare Advantage plan grievance procedure applies to complaints that are not appeals. Examples of grievances:

- coverage for optional benefits (such as prescriptions and eyeglasses)
- waiting time for services
- physician behavior (rudeness, inattentiveness)
- involuntary disenrollment
- inadequate number of specialists to meet beneficiary's needs

Medicare Advantage Plans must do the following:

- respond in a timely fashion to grievances
- make appropriate action on grievances, including full investigations
- notify all involved of the investigation's outcome
- provide all enrollees with information about how to file a grievance, the difference between an appeal and a grievance, and of grievance time limits

Medicare Advantage (MA) plan appeals flow chart

For Managed Care and Private-Fee-For-Service Organizations

<table>
<tr><th>NON-URGENT
(Standard)</th><th colspan="2">URGENT
(Expedited)</th></tr>
<tr><td>You need a service or your claim is denied.</td><td colspan="2">You need a service URGENTLY.</td></tr>
<tr><td>The MA has 14 calendar days to approve or deny the service.</td><td colspan="2">Ask your MA for an EXPEDITED (fast) decision or appeal.</td></tr>
<tr><td>If the MA denies service or the plan denies payment of a claim, you can file a STANDARD appeal.</td><td colspan="2">If you request an EXPEDITED decision, the plan may refuse to expedite a decision. If any doctor supports your request with a letter or phone call, the MA must expedite its decision within 72 hours.</td></tr>
<tr><td>The MA has 30 calendar days to review and respond to your STANDARD appeal for service and 60 days for claims payment.</td><td>If the MA expedites, it must give a decision within 72 hours of receiving a request.</td><td>If the MA does not expedite, it will make its decision using the standard appeal process at left.</td></tr>
<tr><td>If the MA still says no, it must send your appeal to the Center for Health Dispute Resolution (CHDR). CMS contracts with CHDR to make decisions on appealed managed care organizations denials.</td><td colspan="2">If the MA still says no, it must send your appeal to CHDR.
You can also file a grievance with your plan for not providing an expedited response.</td></tr>
<tr><td colspan="3">CHDR has 30 days to review your appeal.</td></tr>
<tr><td colspan="3">If CHDR agrees with the MA to deny service or payment of a claim, you can appeal the decision to an Administrative Law Judge (ALJ) provided the amount in dispute exceeds $110. (Contact CHDR for details.)</td></tr>
</table>

Further levels of appeal:

- Departmental Appeals Board
- Federal Court (must be at least $1,090 in dispute)

NOTE: Beneficiaries also have the right to file a "grievance" for complaints not involving money or services. For example, they can file a grievance if it takes too long to get a doctor's appointment. They should review their *Member Handbook* or *Explanation of Coverage* for details.

Counseling activities related to appeals

- Explain basic coverages as applicable.
- Explain deductibles and coinsurance.
- Explain and assist the beneficiary with appeals process.
- Have beneficiaries sign authorization forms giving you (SHIBA volunteer) permission to secure necessary information and documentation to represent them.
- Contact the intermediary and request a copy of the section of the intermediary manual used as basis for an adverse decision.
- Analyze the intermediary manual section and compare it with the facts. (Does the client need more facts? Was the provider's submission of information complete and adequate and sufficient to meet the manual definition? Does the situation clearly not satisfy the definition?)
- Suggest that the beneficiary secure additional medical documentation. The beneficiary should contact the provider and request additional documentation consistent with the manual section's criteria. (The beneficiary/SHIBA volunteer may draft a letter for the provider.)

Useful appeal information and documentation

- **Doctors' statements.** Depending on circumstances, a statement may include detailed information about a patient's medical condition including an explanation of the diagnosis and distinctions between the care given to the patient and care given in other circumstances.
- **Written orders and prescriptions.** These are helpful in appealing equipment claim denials.
- **Medical records.** Copies of records regarding a patient's care in a hospital or nursing home may be helpful in establishing the existence of special circumstances and need.
- **Medicare records.** Federal law provides for beneficiary access to the Part B carrier's records on his or her case. The carrier should be contacted well before the hearing to arrange a time to examine the records. A beneficiary may also obtain a free copy of the records in his or her hearing file.
- **Other medical records.** Beneficiaries may have access to providers' records on the basis of a state open record law. This right will vary from state to state. Generally, the provider is under no obligation to provide copies for free.

Types of Medicare decisions commonly appealed

- **Incorrect codes.** If the approved charge is more than 30% below the doctor's actual charge, Medicare may have used an incorrect procedure code.
- **Concurrent care.** If more than one doctor visits a beneficiary who is in the hospital, Medicare sometimes denies the claim for services from one of them on the grounds that the service is duplicative. Medicare will pay both doctors, however, if the care from each was necessary.
- **Services are beyond the normal level.** Medicare will deny coverage when a beneficiary makes too many visits to a provider for a covered service.

- **Service is not considered reasonable and necessary.** CMS provides manuals for doctors and other providers that describe what to consider in applying the reasonable and necessary rule. Providers must consider the nature and length of treatment, the diagnosis, and the needs of the individual patient. A medical necessity determination is therefore subject to different opinions. What may be reasonable and necessary for one patient may not be so for another.

Other appealable decisions

- Ambulance service denials for lack of necessity
- Oxygen and equipment denials for lack of necessity
- Physical therapy denials for maintenance therapy
- Durable medical equipment denials for lack of necessity

Reopening the case

If a beneficiary's appeal is unsuccessful at the review and hearing stages, Medicare law does not provide for further appeal. The only alternative is to ask the carrier to reopen the case. Beneficiaries may write a letter or call the Part B carrier to request reopening. The carrier may also reopen a case on its own initiative.

- The carrier may reopen if an error was made in the initial processing or if additional information becomes available that could alter an earlier decision.
- A case may be reopened for any reason within 12 months of a processing date (on the MSN form) review date, or hearing date.
- After 12 months, but within four years, a carrier will reopen the case for good cause.
- *Anytime* if a processing error was made or fraud and/or abuse is suspected.

Appendix – More Appeal Help

How to Help on a Medicare Appeal as a SHIBA Volunteer

1. Understand What's Happening.

- **a.** Find out what service is being denied Medicare coverage and why.
  - **i.** Ask if the beneficiary has received any Medicare non-coverage notices.
  - **ii.** Look at the notices and, if possible, the envelopes in which the notices were delivered in order to determine whether the notice was delivered in a timely fashion as well as to calculate deadlines for submitting appeals.
- **b.** Decide if there are grounds to appeal the denial
  - **i.** You can start to do this by answering the question of whether you believe that the beneficiary met the Medicare coverage criteria for the service being denied Medicare coverage.
  - **ii.** Find out what the applicable laws and regulations say about the coverage criteria for the service.

The Health Assistance Partnership's (HAP) guide to free online legal and medical research can help you find relevant legal and medical material. You can access HAP's guide by going to the Resources page on HAP's Web site, www.healthassistancepartnership.org.

2. Know What Steps To Take and When To Take Them.

- **a.** Determine which appeals process is applicable to the beneficiary's Medicare denial. Is it
  - **i.** Traditional Medicare. Or
  - **ii.** Medicare Advantage. or
  - **iii.** National Coverage Determination or Local Medical Review Policy/Local Coverage Determination?

b. Be familiar with the stages of a Medicare appeal and know how, when, and where to submit an appeal.

i. Be sure you know what stage in the appeal process the beneficiary's case has reached when s/he contacts you.

c. Pay close attention to the timelines of a Medicare appeal. Don't let the beneficiary miss deadlines!

d. Keep a supply of appeal forms and Appointment of Representative forms so that you can easily help beneficiaries submit the appropriate paperwork. Forms are available on the www.medicare.gov Web site at http://www.medicare.gov/Basics/forms/default.asp.

e. Make sure the beneficiary keeps copies of all appeals-related documents, and mails all appeals forms by "return receipt requested" so that there is a way for you and the beneficiary to know that the appeal was received.

f. Be prepared to help the beneficiary deal with liability and debt collection issues, or know where to refer the beneficiary for assistance with these matters, e.g., legal aid or similar resources in your community.

3. Build the Case.

a. Understand the medical factors involved in the beneficiary's Medicare denial in order to help craft an argument that the service Medicare has denied is reasonable and necessary.

i. Ask the treating physician and other involved health care providers to explain the beneficiary's medical situation to you. Ask for help understanding why the service Medicare has denied is important to the beneficiary. If you don't understand, keep asking questions until the medical factors involved in the appeal are clear to you.

You will need to adhere to the HIPAA Privacy Rule when asking health care providers to talk to you and share the beneficiary's records with you. For more information about the HIPAA Privacy Rule, go to the Resources page on HAP's Web site, www.healthassistancepartnership.org.

ii. Research the medical factors related to the beneficiary's Medicare denial.

b. Work collaboratively with treating physicians and other involved health care providers to strengthen the beneficiary's case.

i. Ask the beneficiary's health care providers to prepare and submit supportive letters on behalf of the beneficiary. Letters of support from health care providers should describe the beneficiary's medical condition and explain why the provider believes that the service Medicare has denied meets all relevant Medicare coverage criteria. Help health care providers to understand that the more fact-based their letters are, the more persuasive weight they will carry in helping to reverse a Medicare denial.

ii. Obtain the beneficiary's medical records relevant to the Medicare denial and review them to see if the records support the claim for Medicare coverage. Medical records may be submitted into evidence so that they are included in the record of the appeal.

c. Consider attending the appeal with the beneficiary, either as the beneficiary's representative, or to be a supportive presence for the beneficiary.

4. Support the Beneficiary.

a. You can engage in informal advocacy with health care providers and Medicare contractors that might resolve the problem without the need to pursue a formal appeal. For example, you can talk to the provider and the carrier about Medicare coverage criteria and how the beneficiary's case satisfies the coverage criteria and the beneficiary's claim should result in an award of Medicare coverage.

i. Medicare contractors are also subject to the HIPAA Privacy Rule.

b. Remain aware of beneficiary liability issues and offer ongoing assistance to the beneficiary throughout the lengthy appeals process.

c. Your support and advocacy can help the beneficiary to deal with the stress and anxiety that the beneficiary may experience while pursuing the appeal.