



Date: _____

Helpline caller:

The Medicare Rights Center is a national, nonprofit organization. We help older adults and people with disabilities through education, advocacy, and counseling. We are not a government agency, nor are we connected to any insurance plan or company.

You recently called our helpline for assistance with a Medicare Advantage denial of service. You have the right to appeal, which is a formal request that your plan review its initial decision. In most cases, you can appeal any time you believe that your plan's decision to deny, reduce, or terminate medically necessary care was incorrect.

This packet contains additional information we discussed in our phone call regarding your Medicare Advantage appeal, including:

Overview of appeals process
Appeals chart

If you have more questions or concerns, please call us again at 800-333-4114.

Sincerely,

Helpline Counselor

If you are receiving care from a hospital, skilled nursing facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), hospice, or home health agency and are told that your Medicare Advantage Plan will no longer pay for your care (meaning that you will be discharged), you have the right to a fast (expedited) appeal if you do not believe your care should end. There are separate processes for hospital and non-hospital appeals. You can file an appeal to extend your care as long as you feel that continued care is medically necessary.

Inpatient hospital appeal

If you are an inpatient at a hospital, you should receive a notice titled Important Message from Medicare within two days of being admitted. This notice explains your patient rights, and you will be asked to sign it. If your inpatient hospital stay lasts three days or longer, you should receive another copy of the same notice before you leave the hospital. This notice should arrive up to two days, and no later than four hours, before you are discharged.

If the hospital says you must leave and you disagree, follow the instructions on the Important Message from Medicare to file an expedited appeal to the Quality Improvement Organization (QIO). You must appeal by midnight of the day of your discharge. The QIO should call you with its decision within 24 hours of receiving all the information it needs.

1. If you are appealing to the QIO, the hospital must send you a Detailed Notice of Discharge. This notice explains in writing why your hospital care is ending and lists any Medicare coverage rules related to your case.
2. The QIO will request copies of your medical records from the hospital. It can be helpful to ask the hospital for your own copy (a copying charge may apply). The QIO will usually call you to get your opinion on the discharge, but you can also send a written statement.
3. If your appeal to the QIO is unsuccessful, you will not be held responsible for the cost of the 24-hour period while you waited for the QIO to make a decision. If you remain in the hospital after that period, you may be responsible for the cost of your care if you do not win at a higher level of appeal.

SNF, HHA, CORF, and hospice appeals

If your care is ending at a SNF, CORF, hospice, or home health agency because your provider believes Medicare will not pay for it, you should receive a Notice of Medicare Non-Coverage. You should get this notice no later than two days before your care is set to end. If you receive home health care, you should receive the notice on your second to last care visit.

If you feel that your care should continue, follow the instructions on the Notice of Medicare Non-Coverage to file an expedited appeal with the Quality Improvement Organization (QIO) by noon of the day before your care is set to end. The QIO should make a decision no later than the day your care is set to end. Your provider cannot bill you before the QIO makes its decision.

1. Once you file the appeal, your provider should give you a Detailed Explanation of Non-Coverage. This notice explains in writing why your care is ending and lists any Medicare coverage rules related to your case.
2. The QIO will usually call you to get your opinion. You can also send a written statement. If you receive home health or CORF care, you must get a written statement from a physician who confirms that your care should continue.

Further appeals

Subsequent levels of appeal are the same for hospital and non-hospital care that is ending.

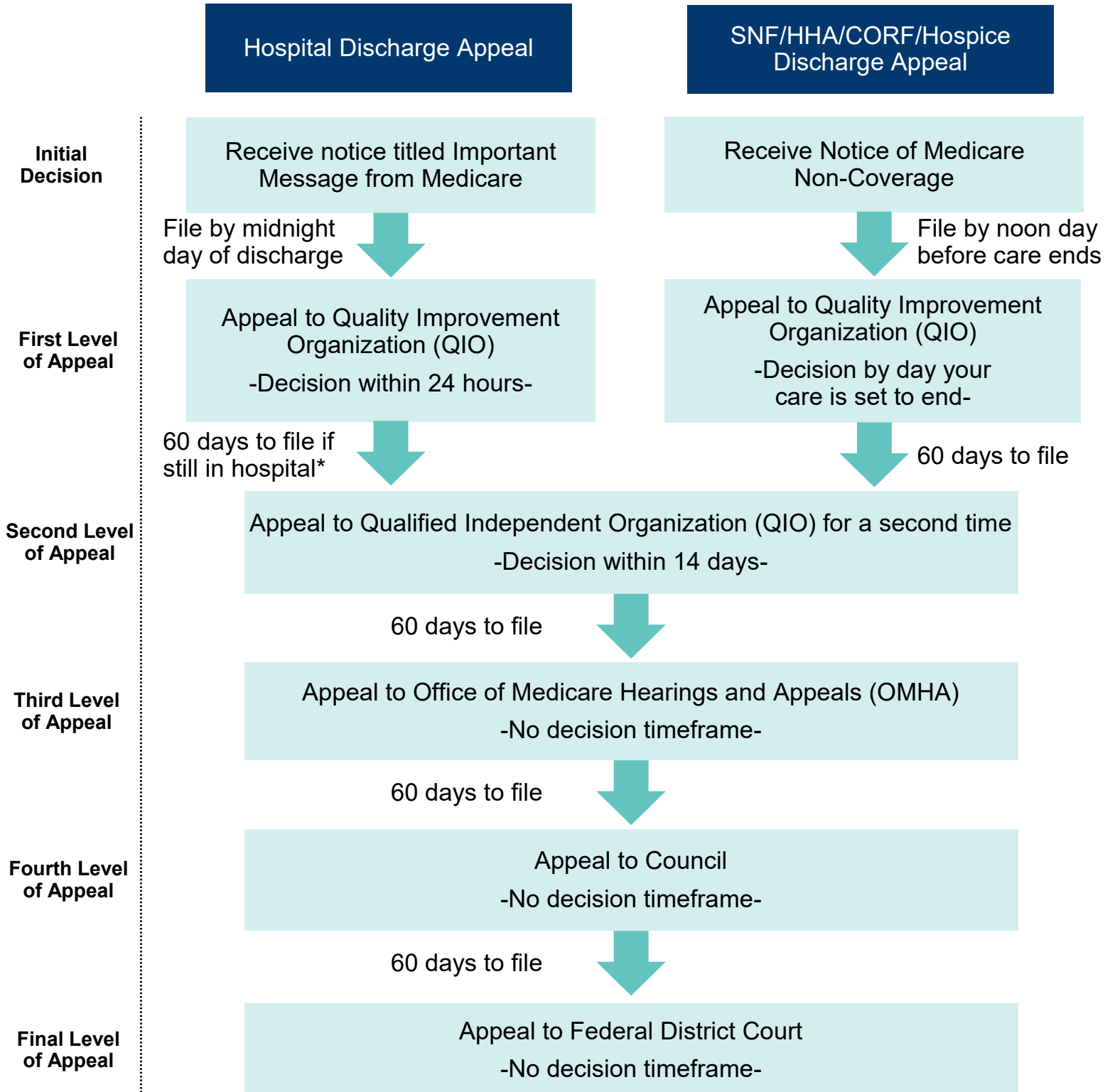
If the appeal to the QIO is successful, your care will continue to be covered. If your appeal is denied, you can file an appeal with the QIO a second time. A different set of staff will review your appeal and reconsider whether care should be continued. You have 60 days following the QIO's initial denial. The QIO should issue a second decision within 14 days of getting the appeal. If you continue to stay in the hospital, you cannot be charged until the QIO makes its decision. However, if you lose your appeal, you will be responsible for all costs, including costs incurred during the time the QIO deliberated.

If the second appeal to the QIO is successful, your hospital care will continue to be covered. If the appeal is denied and your care is worth a certain amount, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level within 60 days of the date on your QIO denial letter. If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required. There is no timeframe for OMHA to make a decision.

If your appeal to the OMHA level is successful, your care will be covered. If your appeal is denied, you can choose to appeal to the Council within 60 days of the date on your OMHA level denial letter. There is no timeframe for the Council to make a decision.

If your appeal to the Council is successful, your care will be covered. If your appeal is denied, you can choose to appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision.

Medicare Advantage Appeals: Ending Care



*If already discharged, proceed directly to OMHA, if eligible.

Note: This process is for when your care is ending and you have a Medicare Advantage Plan. [Click here](#) to learn more about this process. Keep in mind there are different appeals processes for Original Medicare and a Part D prescription drug plans.