Medicare Coverage Appeals

Florida Poverty Health Law Conference

Medicare Advocacy Project
Protecting your medicare rights.

Community Legal Aid
CENTRAL AND WESTERN MA

November 17, 2025

OVERVIEW

WHO WE ARE

Community Legal Aid, Inc. (CLA) is the free civil legal aid provider for residents of the five counties of Central and Western Massachusetts (Berkshire, Franklin, Hampden, Hampshire, and Worcester).

CLA provides free legal help with civil (non-criminal) legal problems such as evictions, foreclosures, domestic violence, unfair consumer practices, accessing public benefits, and more. Through CLA's subsidiary, Central West Justice Center (CWJC), we are also able to provide humanitarian-based immigration services.

*CWJC receives no funding from the Legal Services Corporation.

Medicare Advocacy Project

Protecting your medicare rights.

MAP helps Massachusetts residents statewide secure Medicare coverage.

- Provides free legal services to older adults and people with disabilities in traditional Medicare and Medicare Advantage.
- Helps with wrongful denials of coverage, enrollment problems, and other Medicare-related issued, such as programs to help low-income beneficiaries (Medicare Savings Programs)
- Offers comprehensive and up-to-date education on Medicare. MAP advocates speak to community groups and organizations and offer training to social service agencies and others.

OVERVIEW

MEDICARE COVERAGE DENIED – WHAT NEXT?

- **Medicare Appeals**
  - Traditional Medicare vs. Medicare Advantage
  - Standard vs. Expedited Appeals
- **Examples:**
  - Home Health (incl. “improvement standard”)
  - Prescription Drugs

- NOT addressing:
  - Enrollment issues. Part B or Part D premium penalties (Social Security/Ind Review Entity)
  - Unique issues, e.g. observation status – see Observation Status Appeal Resources

MEDICARE

- Currently approx. 69 million beneficiaries total

- 49% Traditional/Original Medicare
- 51% Medicare Advantage

- 90% age 65 and over
- 10% under 65 with disability

- 18% dually eligible overall
  - 13% full benefit
  - 5% partial benefit

Source CMS, KFF

Florida:

- 2024: 5.1 million total
- TM 44%; MA 56%
- 22% of state population (8th)
- 46% male/54% female (same as nat'l)
- Approx 91% age 65 and over
- 13% < 100% FPL, 19% 100-199% FPL, 31% 200-399% FPL, 37% 400+% FPL (comparable to national)
- 19% dually eligible overall
  - 10% full benefit
  - 9% partial benefit

Source KFF

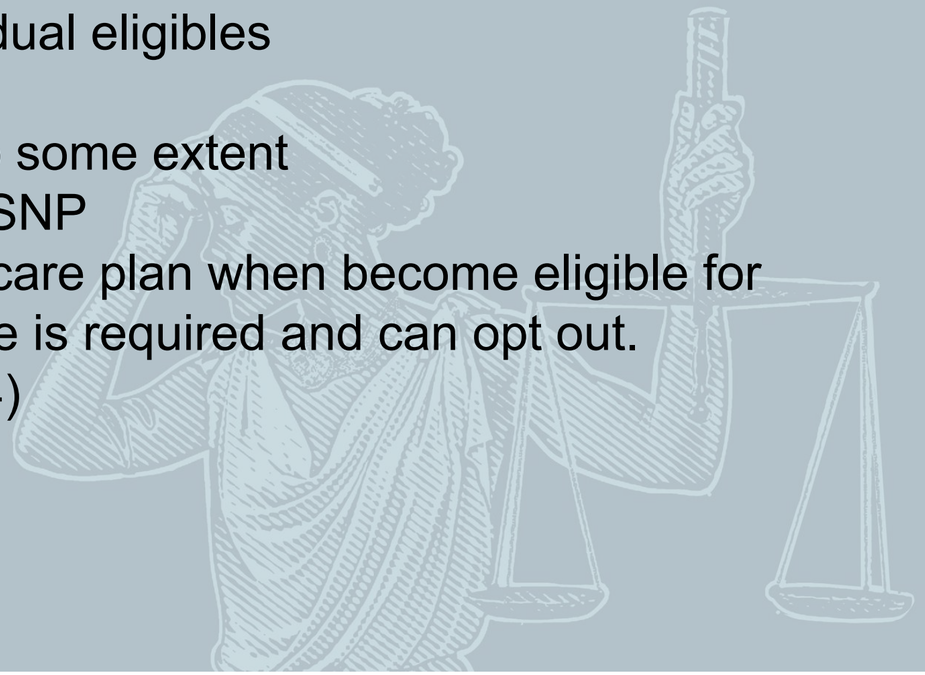
- **Traditional Medicare**
  - Part A (Hospital Ins): inpatient hospital, skilled nursing facility, home health, hospice
  - Part B (Medical Ins): outpatient doctors' visits, ambulance, labs, durable medical equip/supplies
    - For cost-sharing: "Medigap"(private supplemental plan) **OR** Medicaid

- **Part D**: outpatient Rx drugs through private plans; paired with **TM** (**stand alone** plan) **or** thru **MA plan**
    - Low-Income Subsidy (LIS)/Extra Help covers some costs

- **Medicare Advantage (Part C) – all-in-one plans administered by private insurance companies**
  - Required by law to cover all medically necessary services/supplies that TM Parts A and B cover, with limited exceptions (hospice care – always covered by TM, certain costs of clinical trials).
    - Out-of-pocket costs can differ from TM; must be "actuarially equivalent"; Medicaid can help
  - Also may cover some "extras" (e.g. *limited* dental, hearing, vision; gym memberships)
  - **BUT**: MA plans have **networks**; **prior authorization**; **aggressive "utilization management"**

MEDICARE

- **Within Part C/Medicare Advantage: focus on dually eligible individuals**
  - Dual Eligible Special Needs Plans (D-SNPs)
    - Type of Medicare Advantage health plan that serves dual eligibles
    - Run by private insurance companies
    - Required to coordinate Medicare/Medicaid benefits to some extent
  - Not required that dually eligible individuals enroll in a D-SNP
    - Some enrolled by "default" if in a Medicaid managed care plan when become eligible for Medicare; put in D-SNP affiliated with that plan. Notice is required and can opt out.
  - See Florida D-SNPs At-A-Glance, Justice in Aging (2024)



APPEALS

- **Coverage denied – what next?**
  - Step 1 in <u>standard</u> appeals: What type of coverage does the beneficiary have?
    - Traditional Medicare? Part A/B?
      - Initial decisions made by government contractors
    - Some form of Part C Medicare Advantage plan?
      - Initial decisions made by the plan
        - (Same for a stand-alone Part D drug plan)

APPEALS

- **Coverage denied – what next?**
  - Medicare **standard appeals** – after the fact
    - Medicare does not pay for an item or service beneficiary **has received**
  - **Traditional Medicare**:
    - Receive **Medicare Summary Notice (MSN)** in the mail (or online) listing item/service as non-covered. Check "You May Billed" column for patient liability. Often worth checking with provider to see if billing error first. Remember MSN in not a bill, just an explanation.
    - Follow instructions on MSN to appeal to send appeal to a Medicare Administrative Contractor (MAC) within 120 days of date of MSN. Decision should issue in 60 days.
      - Decision addresses:
        1. Is the service covered? 2. If not, who is liable, the beneficiary or the provider?

APPEALS

- **Coverage denied – what next?**

  - Medicare **<u>standard appeals</u>** – **Traditional Medicare**, cont'd

  - MAC (redetermination), appeal w/in 180 days
  - QIC (reconsideration), appeal w/in 60 days if over $190 (in '25)
  - ALJ (**live hearing**, testimony, generally by phone), appeal w/in 60 days
  - Medicare Appeals Council, appeal w/in 60 days if over $1900 (in'25) days
  - Federal District Court

APPEALS

- **Coverage denied – what next?**
  - **Medicare Advantage** – standard, **post-service** appeals
    - Receive **Explanation of Benefits** (**EOB**) or Notice of Denial of Payment from plan
    - Follow instructions on notice - first level is appeal is w/in 60 days to **plan**
    - Then, appeal w/in 60 days to Independent Review Entity (IRE)
    - Then same as TM, if over $190 can appeal w/in 60 days to **ALJ**, have telephone hearing
    - Appeal w/in 60 days to Medicare Appeals Council
    - Appeal w/in 60 days Federal District Court (if over $1900)

APPEALS

- **Coverage denied – what next?**
  - **Medicare Advantage** – standard, **PRE-SERVICE** appeals
    - If plan denies coverage BEFORE you receive item/service
    - First told verbally, then receive Notice of Denial of Payment from plan
      - Standard 14 days; expedited (72 hrs) if bene/dr feel health seriously harmed by waiting
    - Follow instructions on Notice of Denial – first level is reconsideration by **plan,** 65 days to file
    - Automatic forwarding to Independent Review Entity (IRE) if plan upholds denial
    - Then same as TM, if over $190, 60 days to appeal to **ALJ**, have hearing
    - 60 days to file with Medicare Appeals Council
    - 60 days to file with Federal District Court (if over $1900)

APPEALS

- **Coverage denied – what next?**

- **Medicare Advantage Appeals: Special Consideration for D-SNPs**

  - CMS requires certain D-SNPs to have integrated appeals for services potentially covered by both Medicare and Medicaid
  - Plan reviews the request and **applies Medicare & Medicaid criteria**, issuing a **single decision for both programs**; does the same for appeals of any denial.
  - CMS encourages other D-SNPs to integrate their appeals processes and at least assist members in filing Medicaid appeals. 42 C.F.R. § 422.562(5).
  - See D-SNPs: What Advocates Need To Know, Justice in Aging (2024)

APPEALS

Expedited/“Fast Track” Appeals in Certain Care Settings- **liability protection through first decision.**
Important for low-income beneficiaries – can succeed before financial liability

- Same procedure TM/MA
  - Medicare will no longer pay for your care in/by a:
    - Hospital – **Important Message from Medicare**
      - **appeal by midnight of day of discharge**
      - **receive Detailed Notice of Discharge; can continue appeal**

APPEALS

Expedited/“Fast Track” Appeals in Certain Care Settings- **liability protection through first decision.**
Important for low-income beneficiaries – can succeed before financial liability

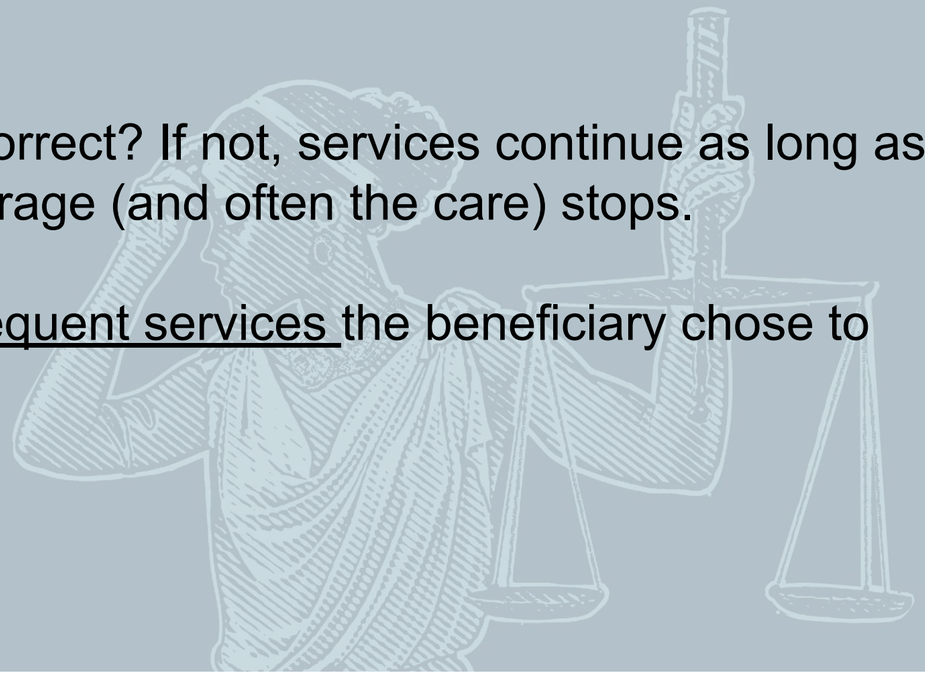
- Same procedure TM/MA
  - Medicare will no longer pay for your care in/by a:

    - Skilled Nursing Facility
    - Home Health Agency } **Notice of Medicare Non-Coverage – appeal by noon of day before**
    - Hospice **termination; receive Detailed Expl Non-Cov; can continue**
    - Comprehensive Outpatient Rehab. Facil. (CORF)

Note: for MA, bene is arguing against MA plan decision.
Provider may be ally! Higher rate of success

APPEALS

- Can go through all 5 levels, but pursuing fast appeal generally only makes sense through second level (reconsideration by QIC).
- ONLY covers decision to terminate coverage/care – was it correct? If not, services continue as long as continue to meet coverage criteria. If correct, Medicare coverage (and often the care) stops.
- Expedited appeal does NOT address coverage of any subsequent services the beneficiary chose to receive.



APPEALS

- EXAMPLE: Mrs. S receiving Part A coverage in SNF for 20 days skilled PT; received NOMNC 8/29 stating Medicare coverage will end 9/1. Requests fast appeal. QIO affirms. QIC affirms on recon. Mrs. S requests ALJ hearing & continues to receive SNF services through 10/31. At ALJ hearing she argues why services of 9/1-10/31 should be covered. ALJ issues decision two months later in which only issue considered is whether the termination of Medicare coverage on 9/1 was appropriate. ALJ notes he did not have jdn over services provided over 9/1 – no MSN, redetermination, reconsideration, etc. Mrs. S remains liable for the services from 9/1 – 10/31.

- INSTEAD: Bene who continues to receive services after coverage termination notice should ask provider to submit claim to Medicare for those services, begin standard appeal process in addition to expedited appeal.

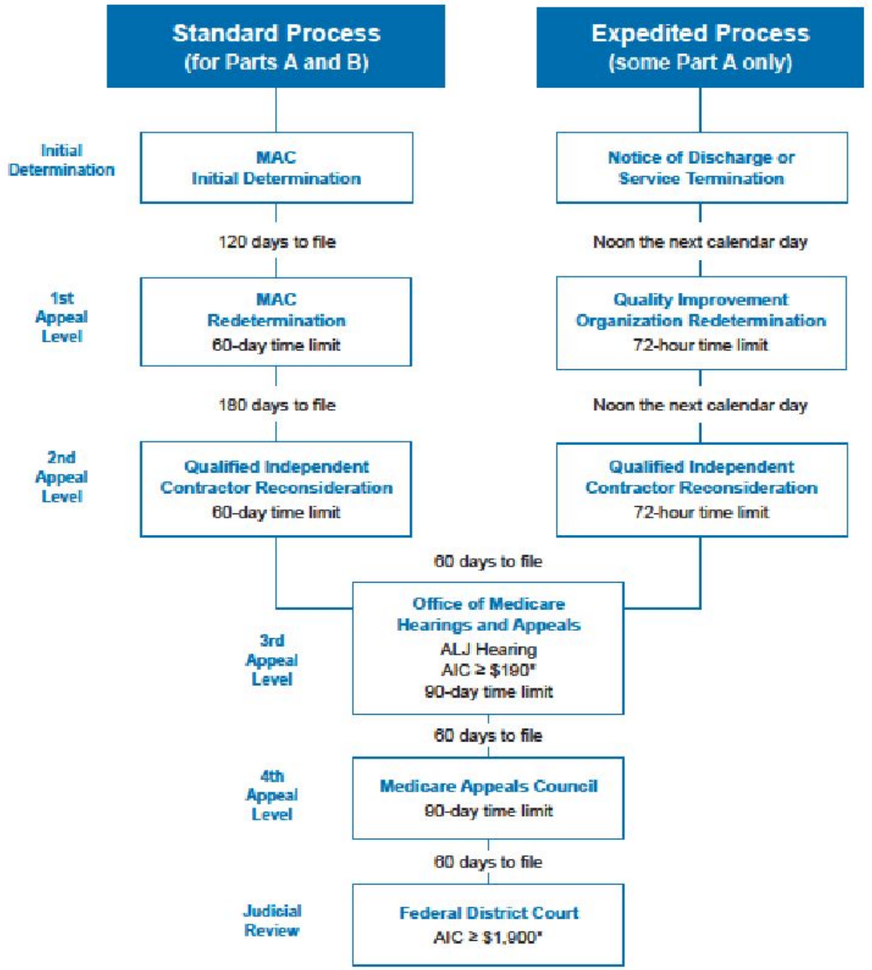
- Covered in link in background materials: Expedited v. Standard Medicare Appeals

APPEALS

- **Part D prescription drug appeals**
  - If plan will not cover, pharmacist should provide “Medicare Prescription Drug Coverage & Your Rights” flyer.
    - This is not a denial! Contact Part D (or MA) plan – what is the issue?
      - Not on formulary? Coverage restriction? (Step therapy?) Is there an equivalent drug that would work?
    - If cannot be resolved easily with doctor, request a “coverage determination” (to find out if drug is covered, seek prior approval, or seek reimbursement); or an “exception” (if not on formulary or if need to waive a restriction or other requirement) from plan. If not approved, **this will generate an appealable denial**.
  - Then appeal up through levels. There is an expedited track if “health could be seriously harmed” by waiting for standard timeframe.

Original Medicare (Parts A and B Fee-for-Service)

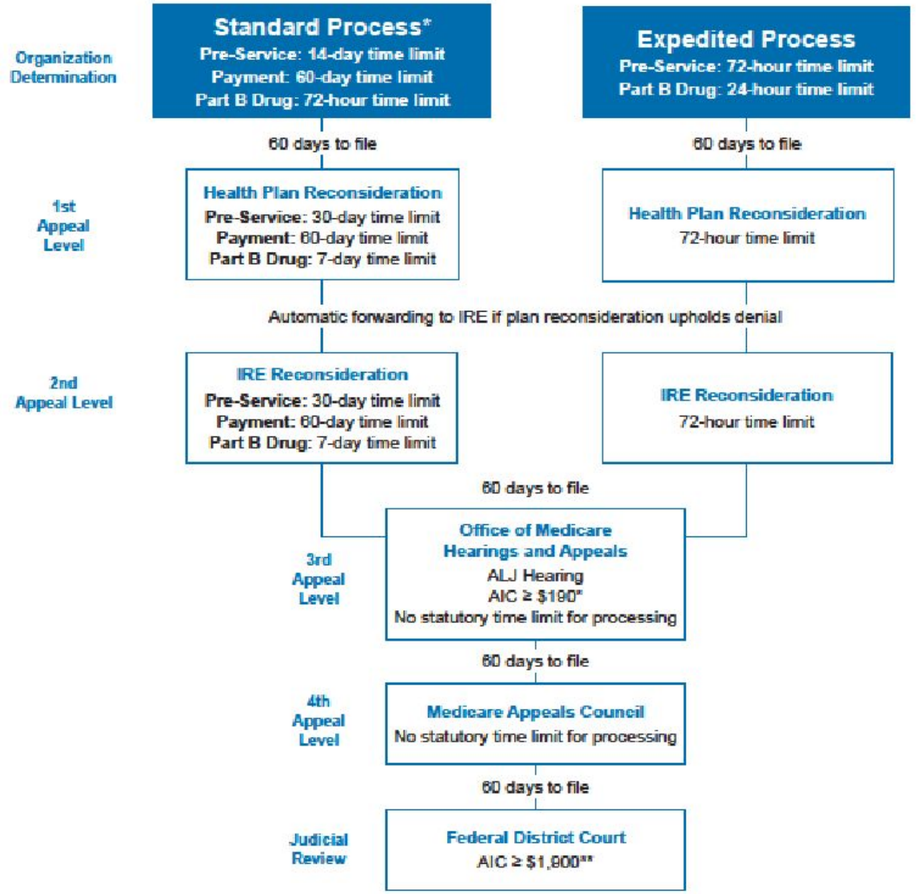
Initial Determination/Appeals Process



AIC: Amount in Controversy
ALJ: Administrative Law Judge
MAC: Medicare Administrative Contractor
*The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2025.

Medicare Managed Care (Part C – Medicare Advantage)

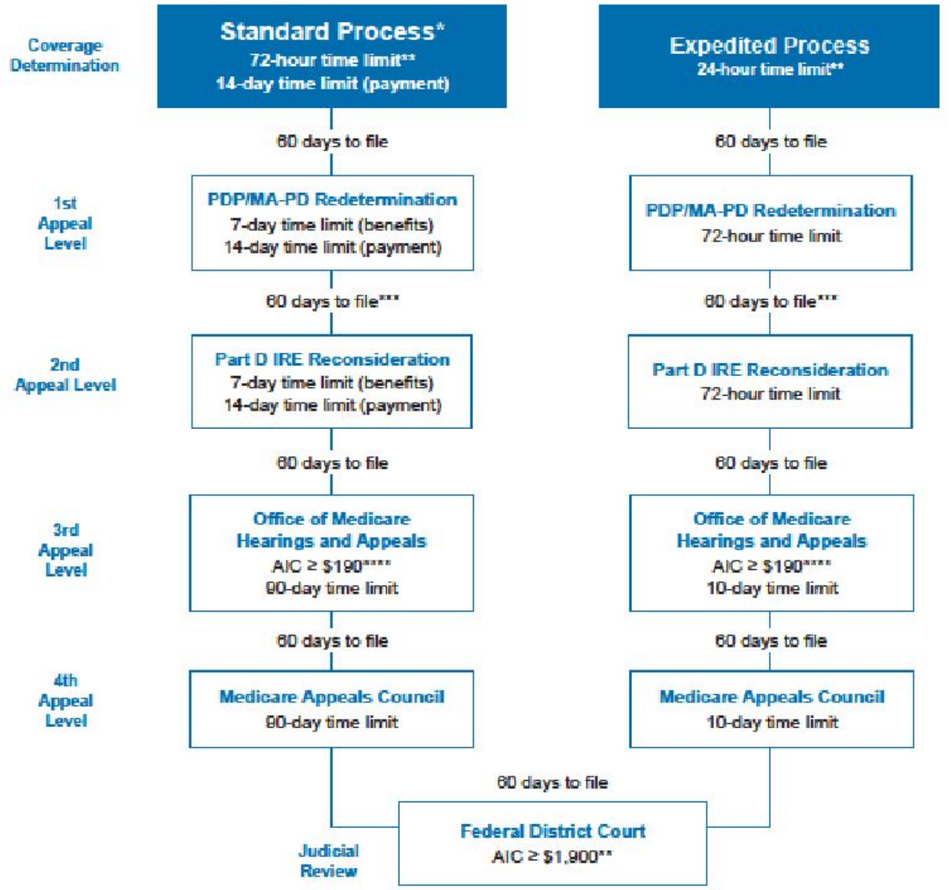
Organization Determination/Appeals Process



AIC: Amount in Controversy
ALJ: Administrative Law Judge
IRE: Independent Review Entity
*Plans must process 95% of all clean claims from out of network providers within 30 days. All other claims must be processed within 60 days.
**The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2025.

Medicare Prescription Drug (Part D)

Coverage Determination*/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, by the enrollee's appointed representative or by the enrollee's physician or other prescriber.

**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.

*** If, on redetermination, a plan sponsor upholds an at-risk determination made per 42 CFR § 423.153(f), the plan sponsor must auto-forward the case to the Part D IRE.

****The AIC requirement for an ALJ hearing and Federal District Court is adjusted annually in accordance with the medical care component of the consumer price index. The chart reflects the amounts for calendar year 2025.

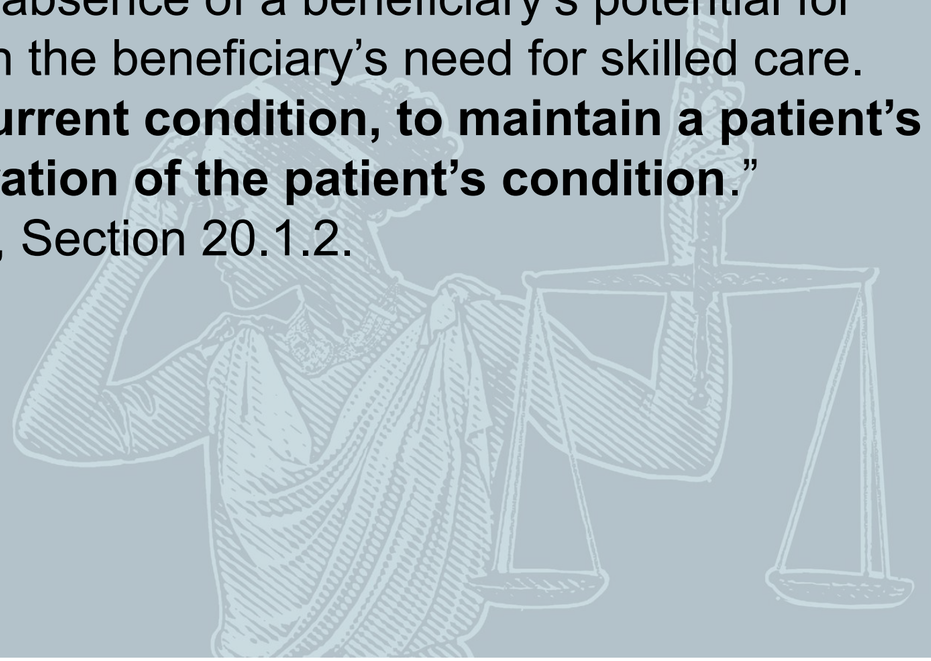
HYPOTHETICAL #1

Ms. A is 80 years old and a traditional Medicare beneficiary. She has Parkinson's disease and is receiving care from a Medicare-certified home health provider. Medicare is paying for these services because some of her care is provided by a skilled physical therapist for mobility, balance, and strength. She is told that the care will be discontinued because she has "plateaued," or returned to "baseline." She believes she continues to need and will continue to benefit from the provided skilled care. In fact she worries she her capabilities will decline without it and she will lose some of her independence.

The home health provider gives Mrs. A (or her representative) a Notice of Medicare Non-Coverage. This standardized notice that coverage for her care is ending must be given at least two days prior to the last day of covered care. The notice must include the date that coverage of care ends, the date she will become financially responsible for continued care from the home health care provider, and a description of her right to an expedited determination. **What steps should Mrs. A take? What information should she gather?**

HYPOTHETICAL #1

- *Jimmo v. Sebelius* Settlement
  - Restoration potential is not necessary.
  - E.g., Medicare coverage "does not turn on the presence or absence of a beneficiary's potential for improvement from the nursing care or therapy, but rather on the beneficiary's need for skilled care. **Skilled care may be necessary to improve a patient's current condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition**." Medicare Benefit Policy Manual, Chapter 7 (Home Health), Section 20.1.2.
  - CMS dedicated Jimmo web page
  - Sample letters of support – start at page 226: CMA Toolkit



HYPOTHETICAL #2

Ms. B is a dually eligible individual in a D-SNP (Dual Eligible Special Needs Plan – a Medicare Advantage plan that integrates her Medicare and Medicaid benefits). She manages multiple chronic conditions, including rheumatoid arthritis. Her rheumatologist prescribes a new medication for her severe RA. The medication is not on the formulary of her D-SNP, and the pharmacy informs her that the plan will not cover her medication. **What steps should Ms. B take?**

HYPOTHETICAL #3

Mr. C is a 56-year-old with quadriplegia in traditional Medicare only. He receives Medicare-covered home health services from a Medicare-certified home health agency. He receives ongoing skilled nursing for a supra-pubic catheter change once per month and for checks of the catheter in between changes. Nurses also do skin integrity checks weekly. The agency also sends home health aides on Sunday, Monday, Tuesday, Wednesday, and Thursday for a little over an hour each visit to assist with hands-on, personal care, and they are covered by the Medicare home health benefit as well. However, three to four days per week Mr. C also pays the same home health agency privately to send aides for a second visit on the same day for repositioning to avoid skin breakdown and to help him with water and food. He pays $75 out of pocket per visit for the aides he pays for privately. **The home health agency says that Medicare will not cover a second home health aide visit in one day. What do you advise? What information might you provide to Mr. C and/or his home health agency?**

Community Legal Aid, Inc.

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APPEALS – Additional Resources

CMS

- Traditional Medicare Appeals Flowchart
- Medicare Advantage Flowchart
- Part D Flowchart

- www.medicareadvocacy.org
- www.justiceinaging.org
- www.medicarerights.org

- www.Medicare.gov
- Medicare & You handbook (2026 is out)