MEDICARE ADVANTAGE APPEALS - PRE-SERVICE

If you have a Medicare Advantage plan and were denied coverage for a health service or item **prior to** receiving the service or item, you can appeal the plan to reconsider if you disagree. First, call your plan to learn why the service or item was denied. Also check with your doctor to be sure there was no billing error.

Next you should receive a "Notice of Denial of Medical Coverage" from your insurance company within 14 days.

You can expedite your appeal if you and your doctor feel your health could be seriously harmed by waiting. If plan approves the request to expedite the appeal, they should issue a decision within 72 hours.

1st Appeal – to the plan

Follow instructions on "Notice of Denial of Medical Coverage" and file within 60 days of date on notice. If you have not received the "Notice of Denial of Medical Coverage" by 14 days, you can start the appeal by including a letter stating it's been 14 days and you haven't received the denial notice.

Send a letter with your appeal explaining why you need the service or item. To strengthen your appeal, include your doctor' letter of support. Include your claim # and relevant attachments.

Decision by the plan should be within 30 days, or 72 hours if you were granted an expedited appeal. In some cases, the plan can extend decision the deadline by 14 days. If your plan misses the 30 day deadline, your appeal is considered denied and forwarded to IRE (below).

2nd Appeal - IRE

If 1st appeal is denied, you should receive a written denial notice and your plan will forward your appeal to the next level: the Independent Review Entity (IRE). IRE will make a decision within 30 days or if you were granted an expedited appeal within 72 hours.

3rd Appeal - OMHA

If the IRE appeal is denied and your service or item is worth at least $180, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA). You must file this appeal within 60 days of the IRE denial. At this point, you may want to contact a lawyer or legal services.

Subsequent Appeals

If OMHA appeal is denied, you can appeal to the Medicare Appeals Council within 60 days. The value of the service or item must be more than $180. There is no timeline for a decision.

If the Council appeal is denied, you can appeal to the Federal District Court within 60 days. The value of the service or item must be more than $1,840. There is no timeline for a decision.