MEDICARE ADVANTAGE APPEALS - PRE-SERVICE

If your Medicare Advantage plan denied coverage for a health service **prior to** receiving the service, you can appeal your plan to reconsider its denial. Contact your plan to get an organization determination, sometimes referred to as coverage decision.

You can request an expedited appeal if you and your doctor feel your health could be harmed by waiting. If the plan approves the request to expedite the appeal, they should issue a decision within 72 hours. Otherwise, a standard decision will be made within 14 days. If this step fails, continue to the 1st level of appeals.

1st Appeal – Reconsideration

Follow instructions from your plan on "Notice of Denial of Medical Coverage" and file within 60 days of date on notice.

Send a letter with your appeal explaining why you need the service. To strengthen your appeal, include your doctor's letter indicating why the service is medically necessary. Include your claim # and relevant attachments. Keep copies of all paperwork submitted.

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.