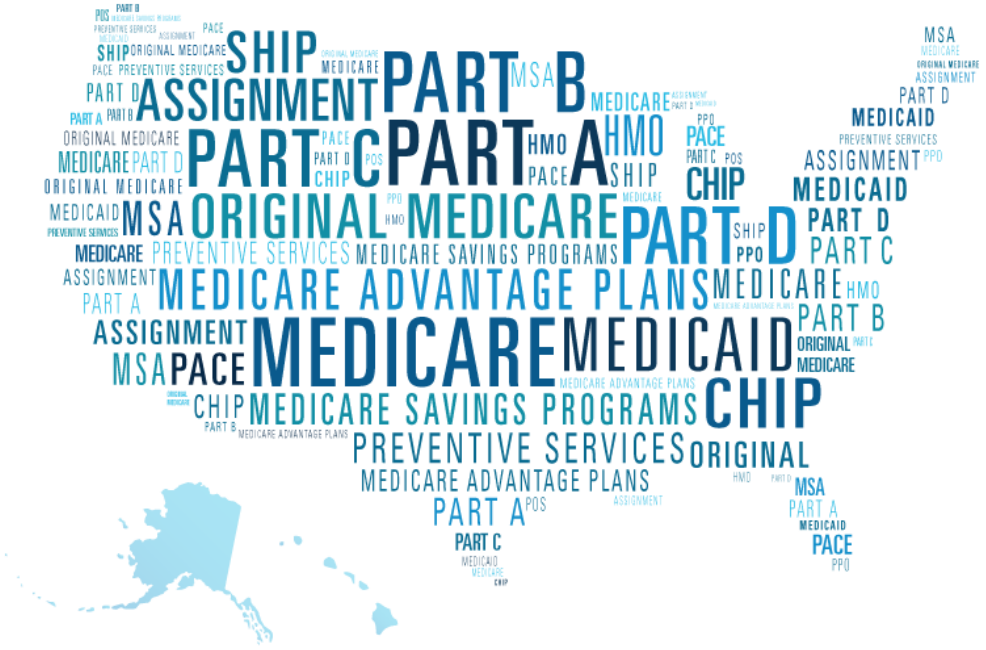
# 2015 National Training Program

Workbook

## Module: 2

## Medicare Rights and Protections

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**Centers for Medicare & Medicaid Services (CMS)**
**National Training Program (NTP)**
**Instructor Information Sheet**

# Module 2—Medicare Rights and Protections

## Module Description

The lessons in this module, "Medicare Rights and Protections", explain the rights, protections, and appeals processes afforded to you in the various parts of Medicare.

The materials—up to date and ready to use—are designed for information givers/trainers who are familiar with the Medicare program, and would like to have prepared information for their presentations.

## Objectives

- Explain Medicare rights and protections
- Recognize rights in certain health care settings
- Summarize Medicare privacy practices
- Discuss appeals processes
- Locate additional information and resources

## Target Audience

This module is designed for presentation to trainers and other information givers. It can be easily adapted for presentations to groups of beneficiaries.

## Time Considerations

The module consists of 74 PowerPoint slides with corresponding speaker's notes, Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) map, web links, appendices, and 8 quiz questions. It can be presented in about 75 minutes. Allow approximately 15 more minutes for discussion, questions, and answers. Additional time may be allocated for add-on activities.

## Course Materials

Materials are self-contained within the module. Additional materials available:

- Job Aids—2015 Comparison of the Parts A, B, C, and D Appeals Process
- Publications—Medicare Rights & Protections, Medicare Appeals
- Appendices—full size—Original Medicare Appeal Process 2015, Part C Appeal Chart Process 2015, Appeal Chart Process Part D 2015, Appeals Flow Charts Foot Note, Advanced Beneficiary Notice, Appointment of Representative Form and Instructions

## References

U.S. Department of Health and Human Services Office for Civil Rights

"Medicare & You" handbook

**Module 2: Medicare Rights and Protections**

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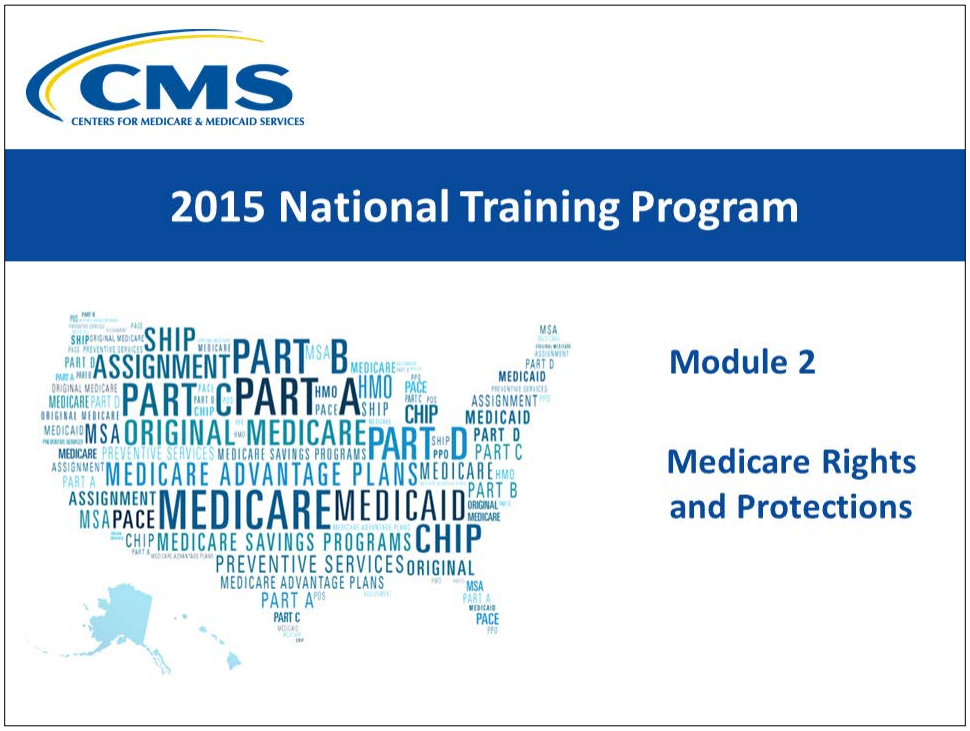


Module 2, "Medicare Rights and Protections," explains the rights and protections afforded to you whether you enrolled in Original Medicare, a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization), other Medicare health plan (like a Medicare Cost Plan or Program of All-Inclusive Care for the Elderly), or a Medicare Prescription Drug Plan.

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Federally-facilitated Health Insurance Marketplace.

The information in this module was correct as of May 2015. To check for an updated version of this training module, visit CMS.gov/outreach-and-education/training/cmsnationaltrainingprogram/index.html.

The CMS National Training Program provides this as an informational resource for our partners. It's not a legal document or intended for press purposes. The press can contact the CMS Press Office at press@cms.hhs.gov. Official Medicare program legal guidance is contained in the relevant statutes, regulations, and rulings.

## Session Objectives

- This session should help you
  - Explain Medicare rights and protections
  - Recognize rights in certain health care settings
  - Summarize Medicare privacy practices
  - Locate additional information and resources

05/01/2015 Medicare Rights and Protections 2

This session should help you

- Explain specific Medicare rights and protections for people with Medicare
- Recognize rights in certain health care settings
- Summarize Medicare privacy practices
- Locate additional information and resources

## Lesson 1—Medicare Rights

- Guaranteed rights for everyone with Medicare
  - Specific rights in
    A. Original Medicare
    B. Medicare Advantage and other Medicare health plans
    C. Medicare Prescription Drug Plans
- In general, these rights
  - Protect you when you get health care
  - Protect you against unethical practices
  - Make sure you get medically necessary services
  - Protect your privacy

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Lesson 1, "Medicare Rights," explains that no matter how you get your Medicare, you have certain guaranteed rights and protections. We'll provide information on additional rights that are specific to how you choose to get your Medicare coverage.

- Original Medicare
- Medicare Advantage and other Medicare health plans
- Medicare Prescription Drug Coverage

Your Medicare rights and protections are designed to

- Protect you when you get health care
- Protect you against unethical practices
- Make sure you get the medically necessary health care services that the law says you can get
- Protect your privacy

## Your Medicare Rights

You have the right to

- Be treated with dignity and respect
- Be protected from discrimination
  - Race, color, or national origin
  - Sex
  - Age
  - Disability
- If you think you haven't been treated fairly, visit HHS.gov/ocr
  - Call the Office for Civil Rights at 1-800-368-1019
    - TTY users should call 1-800-537-7697

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If you have Medicare, you have the right to be

- Treated with dignity and respect at all times
- Protected from discrimination
  - Discrimination is against the law. Every company or agency that works with Medicare must obey the law, and can't treat you differently because of your
    - Race, color, or national origin
    - Sex
    - Age
    - Disability

These protections are generally limited to complaints of discrimination filed against providers of health care and social services who get federal financial assistance.

If you think you haven't been treated fairly for any of these reasons, call the U.S. Department of Health and Human Services, Office for Civil Rights, at 1-800-368-1019. TTY users should call 1-800-537-7697. For more information, visit HHS.gov/ocr.

## Medicare and Your Information Rights

You have the right to

- Have personal and health information kept private
- Get information in a way you understand from
  - Medicare
  - Health care providers
  - Medicare contractors

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If you have Medicare, you have the following information rights:

- To have your personal and health information kept private
  - To learn more about this right
    - If you have Original Medicare, see the "Notice of Privacy Practices for Original Medicare" in your "Medicare & You" handbook. To view or download, visit Medicare.gov/pubs/pdf/10050.pdf (you may also order a copy).
    - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.
- To get information in a way you understand from
  - Medicare
  - Health care providers
  - Medicare contractors

## Medicare Rights—Available Help

You have the right to

- Get information to help you make decisions
  - What is covered
  - What Medicare pays
  - How much you have to pay
  - What to do to file a complaint or an appeal
- Have questions about Medicare answered
  - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - Call your State Health Insurance Assistance Program.

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If you have Medicare, you have the right to the following:

- Get understandable information about Medicare to help you make health care decisions, including what is covered; what Medicare pays; how much you have to pay; and what to do if you want to file a complaint or an appeal.
- Have your Medicare questions answered.
  - Visit Medicare.gov.
  - Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - Call your State Health Insurance Assistance Program (SHIP). To get the most up-to-date SHIP phone numbers, visit Medicare.gov/contacts, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Call your plan if you're in a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan and you have questions about how they cover items, services, or medications.

## Medicare Rights and Access to Care

You have the right to

- Have access to doctors, specialists, hospitals
- Learn about your treatment choices
  - In clear language
  - Participate in treatment decisions
- Get health care services
  - In a language you understand
  - In a culturally sensitive way
- Get emergency care when and where you need it
  - If your health is in danger and emergency help is needed, call 911

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If you have Medicare, you have the right to the following:

- Have access to doctors, specialists, and hospitals.
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions. If you can't fully participate in your treatment decisions, ask a family member, friend, or anyone you trust to help you make a decision about what treatment is right for you.
- Get health care services in a language you understand and in a culturally sensitive way.
  - For more information about getting health care services in languages other than English, visit HHS.gov/ocr, or call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.
- Get emergency care when and where you need it.
  - If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets worse, call 911. You can get emergency care anywhere in the United States.

To learn about Medicare coverage of emergency care in Original Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

In a Medicare Advantage Plan or other Medicare health plan, review your plan materials.

## Medicare Rights—Claims and Appeals

You have the right to

- Have a claim for payment filed with Medicare
- Get decisions about
  - Health care payment
  - Coverage of services
  - Prescription drug coverage
- Get an appeal (review) of the decisions above

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If you have Medicare, you have the right to the following:

- Have a claim for payment filed with Medicare and get a decision about health care payment, coverage of services, or prescription drugs, even when your doctor says that Medicare won't pay for a certain item or service.
  - When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered. This might be different from what your doctor says. If you disagree with Medicare's decision on your claim, you have the right to appeal.
- Appeal if you disagree with a decision about your health care payment, coverage of services, or prescription drug coverage.
  - For more information about appeals, visit Medicare.gov/appeals.
  - For help with filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. To get the most up-to-date SHIP phone numbers, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

## Medicare Grievance Rights

You have the right to

- File complaints (also called grievances) about
  - Services you got
  - Other concerns or problems getting health care and quality of care
    - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
    - In Medicare Advantage or other Medicare health plan, call your plan, the BFCC-QIO, or both
    - If you have End-Stage Renal Disease (ESRD), call the ESRD network in your state

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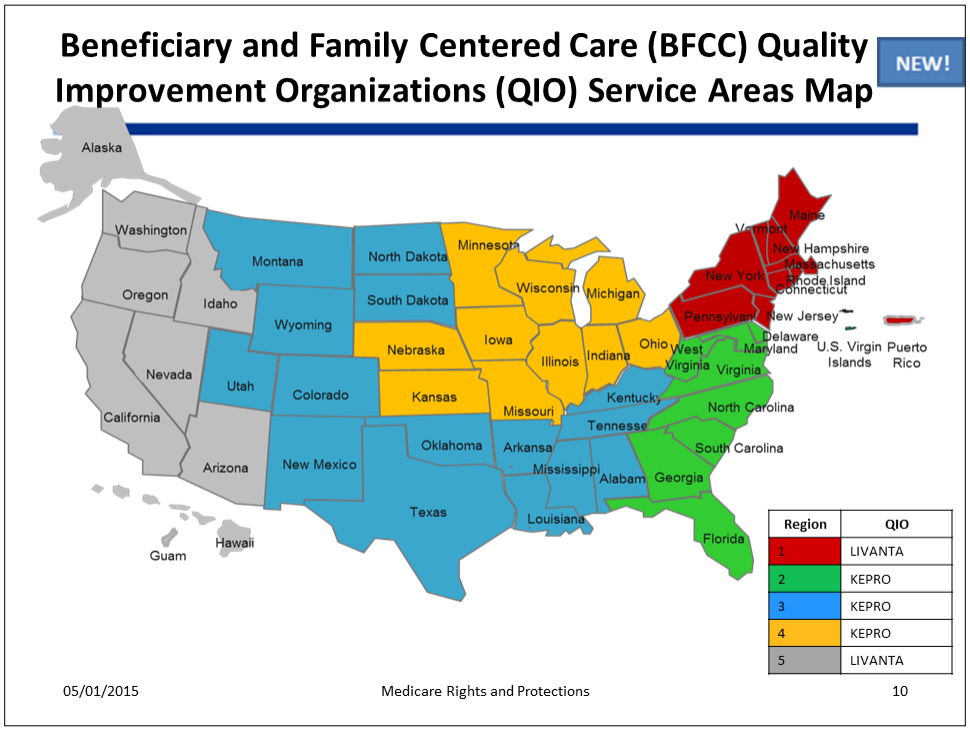
If you have Medicare, you have the right to the following:

- To file complaints (also called grievances) about services you got, other concerns or problems you have in getting health care, and the quality of the health care you received.
- If you're concerned about the quality of care you're getting
  - In Original Medicare, call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) in your region to file a complaint. Visit Medicare.gov/contacts to get your BFCC-QIO's phone number, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
  - In a Medicare Advantage or other Medicare health plan, call the BFCC-QIO, your plan, or both.
  - If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD network in your state. To get the phone number, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

**NOTE:** The next slide displays a map of the BFCC-QIOs by region.




There are 2 Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) that review quality of care concerns and discharge appeals: KEPRO and Livanta. This slide shows a map of the service areas of the BFCC-QIOs.

There are 5 regions handled by KEPRO or Livanta:

**KEPRO Area 2**—Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. Call 1-844-455-8708.

**KEPRO Area 3**—Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and Wyoming. Call 1-844-430-9504.

**KEPRO Area 4**—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin. Call 1-855-408-8557.

TTY for *all* KEPRO areas is 1-855-843-4776.

For more information, visit keprogio.com/bene/helpline.aspx.

**Livanta Area 1—**Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, and the Virgin Islands. Call 1-866-815-5440. TTY number is 1-866-868-2289. For more information, visit bfccqioarea1.com/faq.html.

**Livanta Area 5—**Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, and Washington State. Call 1-877-588-1123. TTY number is 1-855-887-6668. For more information, visit bfccqioarea5.com/faq.html.

## Check Your Knowledge—Question 1

If you have Medicare, you have which of the following rights?

a. To learn about treatment choices in clear, understandable language

b. To have personal and health information kept private

c. To get emergency care services when and where you need it

d. All of the above

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Check Your Knowledge—Question 1

If you have Medicare, you have which of the following rights?

a. To learn about treatment choices in clear, understandable language
b. To have personal and health information kept private
c. To get emergency care services when and where you need it
d. All of the above

**ANSWER: d.** All of the above

Some of your Medicare rights include the right to

- Be treated with dignity and respect
- Be protected from discrimination
- Have personal and health information kept private
- Get information in a way you understand
- Get information to help you make decisions
- Learn about your treatment choices
- Get emergency care when and where you need it

## Check Your Knowledge—Question 2

The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) handles complaints (sometimes called a "grievance"), including complaints about the quality of your care.

a. True

b. False

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Check Your Knowledge—Question 2

The Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) handles complaints (sometimes called a "grievance"), including complaints about the quality of your care.

a. True
b. False

**ANSWER: a.** True

A grievance is a formal complaint about the services you got, other concerns or problems you have in getting health care, and the quality of the health care you received. The BFCC-QIO will be the QIO that will manage all beneficiary complaints and quality of care reviews to ensure consistency in the case review process.

## A. Your Rights in Original Medicare

- See any Medicare-participating doctor or specialist
- Go to any Medicare-certified hospital
- Get information when Medicare isn't expected to pay or doesn't pay
  - Notices
  - Appeal rights

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Your rights when you're enrolled in Original Medicare include the following:

- See any Medicare-participating doctor or specialist (including women's health specialists)
- Go to any Medicare-certified hospital
- Get certain information, like notices and appeal rights, that helps you resolve issues when Medicare isn't expected to pay or doesn't pay for health care

## Appeal Rights in Original Medicare

- File an appeal if
  - A service or item isn't covered
    - And you think it should've been
  - Payment for a service or item is denied
    - And you think Medicare should've paid for it
  - You question the amount Medicare paid for a service

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In Original Medicare, you have the right to a fair, timely, and efficient appeals process.

You can file an appeal if

- A service or item you got isn't covered and you think it should've been
- Payment for a service or item is denied, and you think Medicare should've paid for it
- You question the amount that Medicare paid for a service

## How to Appeal in Original Medicare

- "Medicare Summary Notice" will tell you
  - Why Medicare didn't pay
  - How to appeal
  - Where to file your appeal
  - How long you have to appeal
- Collect information that may help your case
- Keep a copy of everything you send to Medicare

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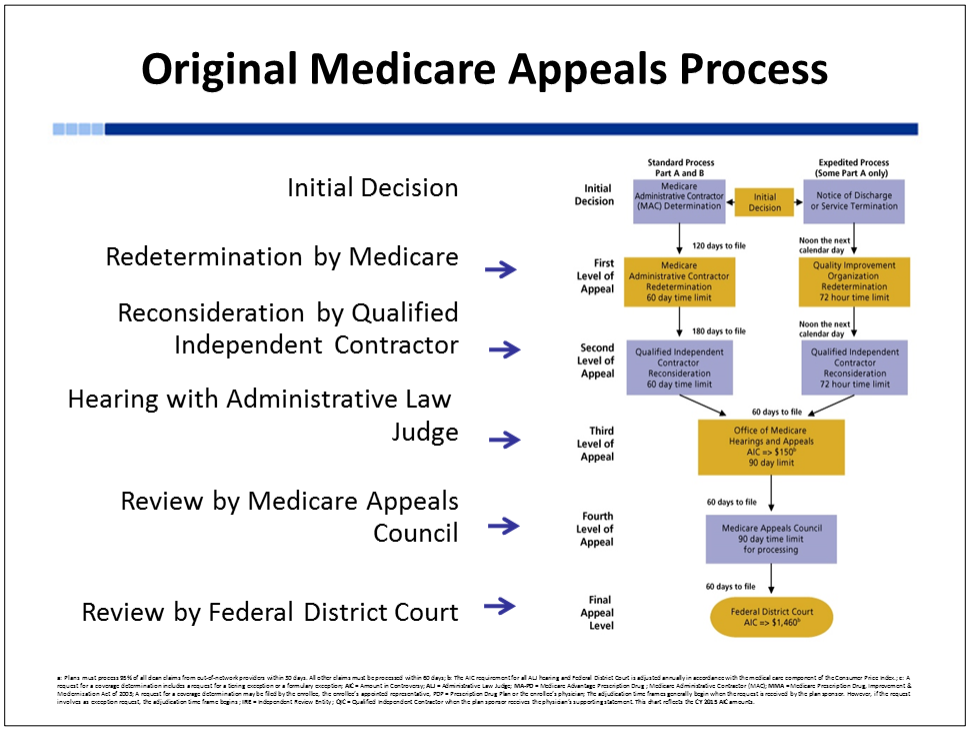
In Original Medicare, when providers and suppliers bill Medicare, you'll get a "Medicare Summary Notice." This notice will tell you

- Why Medicare didn't pay
- How to appeal
- Where to file your appeal
- How much time you have to file an appeal

If you decide to appeal, ask your doctor, health care provider, or durable medical equipment supplier for any information that may help your case. Keep a copy of everything you send to Medicare as part of your appeal.




There are 5 levels in the appeals process in Original Medicare Parts A and B (fee for service). Look at the job aid section at CMS.gov/Outreach-and-Education/Training/ CMSNationalTrainingProgram/index.html for a chart of the Parts A, B, C, and D appeals processes.

There is a standard process and an expedited (fast) process. It's important to note that for an expedited appeal, a provider must decide to terminate services or discharge you.

- **Redetermination by the company that handles claims for Medicare within 120 days** from the date you get the "Medicare Summary Notice" (MSN). Details are on the MSN.
- **Reconsideration by a Qualified Independent Contractor (QIC)** (a contractor who didn't take part in the first decision)**.** Details are included in the redetermination notice.
  - **Contact your Beneficiary and Family Centered Care Quality Improvement Organization (QIO)** no later than noon the day before Medicare-covered services end to request a fast appeal.
- **Hearing before an Administrative Law Judge (ALJ)**. The amount of your claim must meet a minimum dollar amount ($150 in 2015), which is updated yearly. Send the request to the ALJ office listed in the reconsideration notice.
- **Review by the Medicare Appeals Council (MAC).** Details on how to file are included in the ALJ's hearing decision. There's no minimum dollar amount to get your appeal reviewed by the MAC.
- **Review by a federal district court.** To get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount ($1,460 in 2015), which is updated yearly.

**NOTE:** See Appendix A and D for a full-size copy of the Original Medicare (Parts A and B) appeals process and footnote charts.

## Fast Appeals in Original Medicare

- Ask your provider for information related to your case
- Call the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
  - To request a fast (expedited) appeal
  - No later than listed on the notice
- If you miss the deadline
  - You still have appeal rights
    - Contact your BFCC-QIO for late appeals

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You may ask your doctor or health care provider for any information that may help your case if you decide to file a fast (expedited) appeal*.

You must call your regional Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) to request a fast appeal no later than noon on the day before your notice says your coverage will end.

- The number for the BFCC-QIO in your region should be on your discharge notice. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you miss the deadline, you still have appeal rights:

- If you have Original Medicare, call your local BFCC-QIO
- If you're in a Medicare Advantage Plan or other Medicare health plans, call your plan. Look in your plan materials to get the phone number

Contact your local State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. You can find SHIP contact information on the "Medicare Helpful Contacts" page at Medicare.gov/contacts/. Select your state or U.S. territory from the drop-down list.

For more information, see the CMS publication "Medicare Appeals" at Medicare.gov/Pubs/pdf/11525.pdf.

***NOTE:** Your request will be a fast request if your plan or your doctor determines with sufficient supporting documentation that waiting for a standard service decision may seriously jeopardize your life, health, or ability to regain maximum function.

## Types of Liability Notices for People With Original Medicare

- "Advance Beneficiary Notice of Non-coverage"
- "Skilled Nursing Facility Advance Beneficiary Notice"
- "Hospital Issued Notice of Non-coverage"

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There are 3 primary types of liability notices for people with Original Medicare. These notices explain that you may be liable for the cost of certain services under certain conditions. The notices include

- **"Advance Beneficiary Notice of Non-coverage" (ABN)**—Used by providers and suppliers of Medicare Part B (Medical Insurance) items and services. It's also used by hospices and religious nonmedical health care institutions providing Medicare Part A (Hospital Insurance) items and services.

There are other types of liability notices for people with Original Medicare that are used in specific health care settings. Like the ABN, these notices explain that you may be liable for the cost of certain services under certain conditions. These notices include

- **"Skilled Nursing Facility Advance Beneficiary Notice"**—Only used for skilled nursing facility care
- **"Hospital Issued Notice of Non-coverage"**—Used for inpatient hospital care when the hospital thinks Medicare may not pay for some or all of your care

You can view or print these notices at CMS.gov/bni/.

## Original Medicare
## Protection From Unexpected Bills

- "Advance Beneficiary Notice of Non-coverage"
  - Given by health care provider or supplier
    - Says Medicare probably won't pay for an item or service
    - Not required for items or services excluded under law
    - Will ask you to choose whether to get services
    - Will ask you to confirm you read/understood notice

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You're protected from unexpected bills. If your health care provider or supplier believes that Medicare won't pay for certain items or services, in many situations they'll give you a notice that says Medicare probably won't pay for an item or service under Original Medicare and explains why. This is called an "Advance Beneficiary Notice of Non-coverage (ABN)." The ABN is used by providers and suppliers of Medicare Part B (Medical Insurance) items and services. It's also used by home health agencies, hospice, and religious nonmedical health care institutions providing Medicare Part A (Hospital Insurance) items and services.

You'll be asked to choose an option on the ABN form and sign it to say that you've read and understand the notice. If you choose to get the items or services listed on the ABN, you'll have to pay if Medicare doesn't. In some cases, the provider may ask for payment at the time the service is received.

Providers (including independent laboratories), physicians, practitioners, and suppliers will use an ABN (Form CMS-R-131) for situations where Medicare payment is expected to be denied because the item or service may not be reasonable and necessary.

Doctors and suppliers aren't required to give you an ABN for services Medicare never covers (i.e., excluded under Medicare law), like routine eye exams, dental services, hearing aids, and routine foot care. However, they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.

**NOTE:** See Appendix E for a copy of the ABN. It's also available at CMS.gov/Medicare/Medicare-General-information/BNI/index.html.

## Medigap Rights in Original Medicare

- Buy a private Medicare Supplement Insurance (Medigap) policy
  - Guaranteed issue rights in your Medigap Open Enrollment Period ensure insurance companies
    - Can't deny you Medigap coverage
    - Can't place conditions on coverage
    - Must cover pre-existing conditions
    - Can't charge more because of past or present health problems
  - Some states give additional rights

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A Medigap (Medicare Supplement Insurance) policy is a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage, like coinsurance amounts.

Your rights when you're enrolled in Original Medicare include the following:

- In some situations, you have the right to buy a Medigap policy.
  - Medigap policies must follow federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance."
  - Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a "standardized" Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
- You have the right to buy a Medigap policy during your Medigap Open Enrollment Period, a 6-month period that automatically starts the month you're 65 and enrolled in Medicare Part B, and once it's over, you can't get it again.
- When you have guaranteed issue rights, the Medigap policy
  - Can't deny you Medigap coverage or place conditions on your policy
  - Must cover you for pre-existing conditions
  - Can't charge you more for a policy because of past or present health problems
- Some states offer additional rights to purchase Medigap policies.

**NOTE**: Module 3, "Medigap (Medicare Supplement Insurance)" describes these situations at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

## The Windsor Ruling

- June 26, 2013: *United States v. Windsor*
  - The Supreme Court ruled that Section 3 of the Defense of Marriage Act (DOMA), as outlined in 1 U.S.C. § 7, is unconstitutional
- The federal government is no longer prevented from recognizing same-sex marriages
- For more information about how your marital status affects Social Security or Medicare
  - Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
  - Visit your local Social Security office.

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On June 26, 2013, the Supreme Court ruled in United States v. Windsor that Section 3 of the Defense of Marriage Act (also known as DOMA) was unconstitutional. Section 3 of DOMA defined "marriage" and "spouse" as excluding same-sex marriages and same-sex spouses, and effectively precluded the federal government from recognizing same-sex marriages and spouses.

After the Supreme Court's opinion in Windsor, Section 3 of DOMA no longer prohibits the federal government from recognizing same-sex marriages when administering federal statutes and programs, and no longer controls the definition and recognition of a marital relationship in that context.

Marital status is relevant to certain Medicare entitlements, premiums, benefits, and enrollment provisions. For information about how your marital status affects Social Security or Medicare, contact Social Security.

- Call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
- Visit your local Social Security office.

## Windsor Ruling Resources

- CMS Website:
  - Medicare.gov/sign-up-change-plans/same-sex-marriage.html
- SSA Website:
  - ssa.gov/same-sexcouples/
  - Public listing of all policies
    - secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=02002
      - See Section GN 00210 – Windsor Same-Sex Marriage Claims

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For more information about the Windsor ruling and frequently asked questions related to enrollment in Medicare and same-sex couples, see the links listed on this slide. Some of the information outlined in these links include the policies for premium-free Part A based on the earnings of a same-sex spouse and for the special enrollment period when someone has employer coverage based on current employment of a same-sex spouse.

The CMS website has information available at Medicare.gov/sign-up-change-plans/same-sex-marriage.html.

The SSA website has information available at ssa.gov/same-sexcouples/.

For a listing of all policies, visit secure.ssa.gov/apps10/poms.nsf/subchapterlist!openview&restricttocategory=02002.

See Section GN 00210—Windsor Same-Sex Marriage Claims.

## Check Your Knowledge—Question 3

Which document identifies why an Original Medicare claim wasn't paid and how to file an appeal?

a. "Skilled Nursing Facility Advance Beneficiary Notice"

b. "Advance Beneficiary Notice of Non-coverage" (ABN)

c. "Medicare Summary Notice" (MSN)

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Check Your Knowledge—Question 3

Which document identifies why an Original Medicare claim wasn't paid and how to file an appeal?

a. "Skilled Nursing Facility Advance Beneficiary Notice"
b. "Advance Beneficiary Notice" (ABN)
c. "Medicare Summary Notice" (MSN)

**ANSWER: c**. **"**Medicare Summary Notice" (MSN)"

The "Medicare Summary Notice" will tell you

- Why Medicare didn't pay
- How to file an appeal
- Where to file your appeal
- How much time you have to file an appeal

## B. Your Rights in Medicare Part C Health Plans

You have the right to

- Choose health care providers within the plan
- Get a treatment plan from your doctor
  - For complex or serious conditions
  - Allows you to directly see specialists as often as necessary

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If you're in a Medicare health plan, in addition to the rights and protections previously listed in the first section, you have the right to

- Choose health care providers within the plan, so you can get the health care you need.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.

**NOTE:** Medicare Advantage Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) Plans are both coordinated care plans. In most cases you have to get a referral to see a specialist in HMO plans. However, Medicare Part C, that is the Medicare Advantage program, also includes Private Fee-for-Service (PFFS) and Medicare Savings Account (MSA) Plans. PFFS and MSA plans aren't coordinated care plans to enrollees in these plan types won't necessarily have a network of providers or be required to have a provider coordinate their care.

## Coverage and Appeal Rights in Medicare Health Plans

You have the right to

- Know how your doctors are paid
- Get a coverage decision or coverage information
- A fair, efficient, and timely appeals process
  - Five levels of appeal
  - Decision letter sent explaining further appeal rights
  - Automatic review of Part C plan reconsideration
    - By Independent Review Entity (IRE)
- File a grievance about concerns or problems

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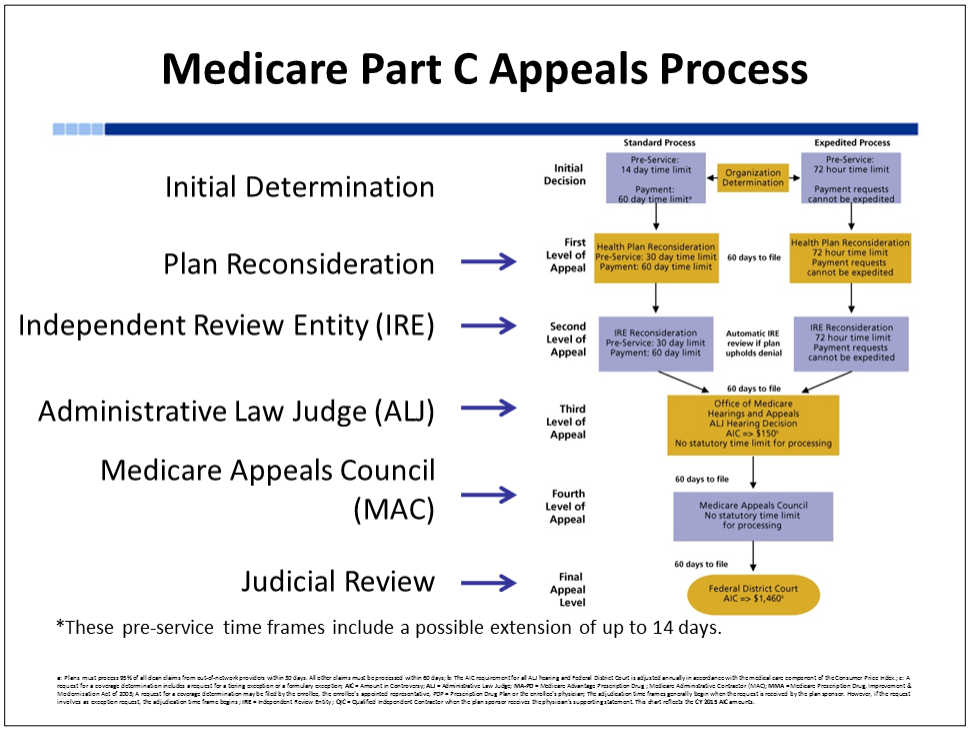
If you're in a Medicare health plan, you have the right to

- Know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Find out from your plan, before you get a service or supply, if it'll be covered. You can call your plan to get information about the plan's coverage rules.
- A fair, efficient, and timely appeals process to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered, provided, or continued.
  - The appeals process consists of 5 levels.
  - If coverage is denied at any appeal level, you'll get a letter explaining the decision and instructions on how to proceed to the next appeal level.
  - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C (Medicare Advantage) Independent Review Entity.
- File a grievance about other concerns or problems with your plan, check your plan's membership materials, or call your plan to find out how to file a grievance.

See "Medicare Rights & Protections" (CMS Product No. 11534) for more details at Medicare.gov/publications/pubs/pdf/11534.pdf.




This chart shows the appeals process for Medicare Advantage Plan or other Medicare health plan enrollees. The time frames differ depending on whether you're requesting a standard appeal, or if you qualify for an expedited (fast) appeal.

If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You'll get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are 5 levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

First, your plan will make an Initial Determination. These pre-service time frames include a possible extension of up to 14 days. After each level, you'll get instructions on how to proceed to the next level of appeal. The 5 levels of appeal are

- Reconsideration by the plan
- Reconsideration by the Independent Review Entity
- Hearing with the Administrative Law Judge—the amount of your claim must meet a minimum dollar amount ($150 in 2015), which is updated yearly
- Review by the Medicare Appeals Council
- Review by a federal district court (to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount "[$1,460 in 2015]" which is updated yearly)

**For further information, visit** [CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html](CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html).

**NOTE:** See Appendix B and D for a full-size copy of the Part C (Medicare Advantage) appeals process and footnote charts.

## Rights When Filing Medicare Health Plan Appeals

You have the right to

- Access your case file
  - Call or write your plan
  - Plan may charge you a reasonable fee for
    - Copying
    - Mailing
- Present evidence to support your case
- Ask for an expedited appeal
  - When supported by a doctor

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If you're in a Medicare Advantage or other Medicare health plan and you're filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your case file. To get the phone number or address of your plan, look at your "Evidence of Coverage," or the notice you get that explained why you couldn't get the services you requested.

The plan may charge you a fee for copying this information and sending it to you. Your plan should be able to give you an estimate of how much it'll cost based on the number of pages in the file, plus normal mail delivery.

The timeframe for a plan to complete standard service coverage decisions is 14 days and **may be extended by up to 14 days**. The timeframe may be extended if, for example, your plan needs more information from a non-contract provider to make a decision about the case, and the extension is in your best interest.

If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask your plan for a fast decision. You have the right to an expedited appeal when your request is supported by a doctor, or when applying the standard appeal time frame could seriously jeopardize your life or health, or your ability to regain maximum function. The plan must notify you of its decision within 72 hours. The 72 hours might be extended based on supporting documentation.

## Check Your Knowledge—Question 4

After an unfavorable decision by the Administrative Law Judge, Medicare Advantage enrollees have no more options for appeals. They must abide by the decision.

a. True

b. False

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Check Your Knowledge—Question 4

After an unfavorable decision by the Administrative Law Judge (ALJ), Medicare Advantage enrollees have no more options for appeals. They must abide by the decision.

a. True
b. False

**ANSWER: b.** False

After the decision at each level, you'll get instructions on how to proceed to the next level of appeal. There are 2 remaining levels of appeal after the ALJ.

## C. Medicare Prescription Drug Coverage (Part D) Rights—Access to Covered Drugs

- Must ensure enrollees can get the medically necessary drugs they need
- Must include more than one drug in each classification
- Must pay for brand-name as well as generic drugs
- Will have rules for managing access

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Medicare Prescription Drug Plans work to provide people with Medicare high-quality, cost-effective prescription drug coverage. Medicare drug plans must ensure that their enrollees can get medically necessary drugs to treat their conditions.

Each plan has a list of covered drugs called a formulary. A plan's formulary may not include every drug you take. However, in most cases, a similar drug that is safe and effective will be available.

Plans must pay for both brand-name and generic drugs. Covered drugs include prescription drugs, biological products, and insulin. Medical supplies associated with the injection of insulin—like syringes, needles, alcohol swabs, and gauze—are also covered.

Some of the methods that plans use to manage access to certain drugs include prior authorization, step therapy, and quantity limits, which we'll discuss in this section.

## Required Coverage—Part D

- Medicare drug plans must cover all drugs in 6 protected categories
  1. Cancer medications
  2. Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) treatments
  3. Antidepressants
  4. Antipsychotic medications
  5. Anticonvulsive treatments
  6. Immunosuppressants
- All commercially available vaccines
  - Except those covered under Part B (e.g., flu shot)

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Medicare drug plans must cover all drugs in 6 categories to treat certain conditions:

- Cancer medications
- Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions
- Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine, but not vaccines covered under Part B (Medical Insurance), like the flu and pneumococcal pneumonia shots. You or your provider can contact your Medicare drug plan for more information about vaccine coverage.

## Formulary

- A list of prescription drugs covered by the plan
- May have tiers that cost different amounts

### Tier Structure Example

| Tier | You Pay | Prescription Drugs Covered |
|---|---|---|
| 1 | Lowest copayment | Most generics |
| 2 | Medium copayment | Preferred, brand name |
| 3 | High copayment | Non-preferred, brand name |
| 4 or Specialty | Highest copayment or coinsurance | Unique, very high cost |

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Each Medicare drug plan has a formulary, a list of prescription drugs that it covers. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Here's an example of how a plan might form its tiers:

- **Tier 1–Generic drugs** (the least expensive copayment)—A generic drug is the same as its brand-name counterpart in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. Generic drugs are less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration (FDA). Today, almost half of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- **Tier 2–Preferred brand-name drugs** (medium copayment)—Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drug** (higher copayment)—Tier 3 drugs cost more than Tier 2 drugs.
- **Tier 4–(or Specialty Tier)** (highest copayment)—These drugs are unique and have a high cost.

**NOTE:** In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and ask your plan for a lower copayment.

## Transition Supply—Part D

- Plans must fill prescriptions for Part D drugs not on plan's formulary for
  - New enrollees
  - Residents of long-term care facilities
- Immediate supply provided to new enrollee
  - Fill one-time, 30-day supply of current prescription
- While using transition supply
  - Work with doctor to switch to drug on plan's formulary
  - If medically necessary, request an exception
  - Don't wait until supply runs out to take action

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Some new and existing plan members may already be taking a drug not on their plan's drug list, or that's on the list but subject to a restriction like step therapy. Medicare generally requires the plans to provide a standard 30-day transition supply of all Medicare-covered drugs, if the prescription is for a drug that's not on the plan's drug list, or has a restriction (step therapy, prior authorization, quantity limits). This gives you and your prescriber time to find another drug on the plan's drug list that would work as well. However, if you have already tried similar drugs and they didn't work, or if the prescriber believes that because of your medical condition you must take a certain drug, you or your prescriber can contact the plan to request an exception to the formulary rules. If your request is approved, the plan will cover the drug. If the exception isn't granted, you or your prescriber can file an appeal.

It's important to understand how to work with your plan's formulary and to plan ahead. If you get a transition supply, you'll get written notice from your plan, and you shouldn't wait until that supply is gone to take action. You should talk to your doctor about

- Prior authorization, if necessary
- Safe and effective alternative drugs that are on your plan's list and may also save you money
- Requesting an exception, if necessary for your condition

You should contact your drug plan with any questions about what's covered by the plan.

**NOTE:** In most cases with step-therapy drugs, you must try certain alternative drugs first.

## Request a Part D Coverage Determination

- A coverage determination is the initial decision made by a plan
  - Which benefits you're entitled to get
  - How much you have to pay for a benefit
- You, your prescriber, or your appointed representative can request it
- Time frames for coverage determination request
  - Standard (decision within 72 hours)
  - Expedited (decision within 24 hours)
    - If life or health may be seriously jeopardized

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A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits. This includes whether a certain drug is covered, whether you've met all the requirements for getting a requested drug, and how much you must pay for a drug.

You, your prescriber, or your appointed representative (see Appendix F) can ask for a coverage determination by calling your plan or writing them a letter. If you write to the plan, you can write a letter or use the "Model Coverage Determination Request" form available at CMS.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/forms.html.

There are 2 types of coverage determinations: standard or expedited. Your request will be fast (expedited) if the plan determines, or if your doctor tells the plan that your life or health may be seriously jeopardized by waiting for a standard request.

A plan must give you its coverage determination decision as quickly as your health condition requires. After getting your request, the plan must give you its decision no later than 72 hours for a standard determination, or 24 hours for an expedited (fast) determination. If your coverage determination request involves an exception, the time clock starts when the plan gets your doctor's supporting statement.

If a plan fails to meet these time frames, it must automatically forward the request and case file to the Independent Review Entity (IRE) (MAXIMUS) for review, and the request will skip over the first level of appeal (redetermination by the plan). MAXIMUS contact information is available at Medicarepartdappeals.com/.

## Request an Exception

- Two types of exceptions
  1. Tier exceptions
  2. Formulary exceptions
- Need supporting statement from prescriber
- You, your appointed representative, or prescriber can make requests

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An exception is a type of coverage determination. There are 2 types of exceptions: tier exceptions (like getting a Tier 4 drug at the Tier 3 cost), and formulary exceptions (either coverage for a drug not on the plan's formulary, or relaxed access requirements).

If you want to make an exception request, you'll need a supporting statement from the prescriber. In general, the statement must point out the medical reason for the exception. The prescriber may give the statement verbally or in writing.

**NOTE:** If you choose to have a representative help you with a coverage determination or appeal, you and the person you want to help you must fill out the "**Appointment of Representative**" Form CMS-1696 (see Appendix F). You can get a copy of the form at CMS.gov/cmsforms/downloads/cms1696.pdf. You can also appoint a representative with a letter signed and dated by you and the person helping you, but the letter must have the same information that's requested on the "Appointment of Representative" form. You must send the form or letter with your coverage determination or appeal request.

## Formulary Exceptions—Part D

- Access to Part D drugs
  - Not included on the plan's list, or
  - On the list but with special coverage rules
    - Prior authorization
    - Quantity limits
    - Step therapy
- Plan can determine the level of cost sharing

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Formulary exceptions make sure enrollees have access to Medicare-covered drugs that aren't included on the plan's formulary or for which the plan has special coverage rules. These special rules include prior authorization, quantity limits, and step therapy.

When a plan approves coverage of an off-formulary drug (a formulary exception), the plan decides the amount of cost sharing the enrollee is required to pay for the off-formulary drug. For example, the plan may decide that the enrollee must pay the cost sharing that applies to "non-preferred" drugs on the plan's formulary, which is typically a higher level of cost sharing.

## Rules Plans Use to Manage Access to Drugs

| Rule Name | Coverage Rule Description |
|---|---|
| **Prior Authorization** | ▪ Enrollee or prescriber must contact plan and show prior authorization (PA) criteria is met before the drug will be covered.<br>▪ Enrollee or prescriber may request an exception to PA criteria, which plan must allow if medically necessary. |
| **Step Therapy** | ▪ Type of prior authorization<br>▪ Must use alternative drug(s) on plan's list<br>▪ Enrollee or prescriber may request an exception if alternative drug(s):<br>• Wouldn't work as well as requested drug, or would have adverse effect<br>• Plan must allow exception if medically necessary |
| **Quantity Limits** | ▪ Plan may limit drug quantities over a period of time for safety and/or cost<br>▪ Enrollee or prescriber may request an exception if quantity/dose restriction would be ineffective in treating the enrollee's condition or would have adverse effects<br>▪ Plan must allow exception if additional amount is medically necessary |

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Medicare drug plans manage access to covered drugs in several ways, including prior authorization, step therapy, and quantity limits.

You may need drugs that require prior authorization. This means before the plan will cover a particular drug, you or your doctor or other prescriber must first show the plan you meet the plan's CMS-approved criteria for that particular drug. Plans may do this to be sure you're using these drugs correctly. Contact your plan about its prior authorization requirements, and talk with your prescriber.

Step therapy is a type of prior authorization. In most cases, you must first try a certain alternative drug(s) on the plan's drug list that has been U.S. Food and Drug Administration approved for treating your condition before you can move up a step to a more expensive drug. For instance, some plans may require that you first try a generic drug on their drug list before you can get coverage for a similar, more expensive brand-name drug.

Plans may **limit the quantity of drugs** they cover, for safety and cost reasons, over a certain time period. If you or your prescriber believes that a quantity limit isn't appropriate for your condition, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.

If you or your prescriber believe that a prior authorization, step therapy, or quantity limit requirement shouldn't apply to you because of your medical condition, you (with your prescriber's help) can contact the plan to request an exception to the rule.

## When Plans Must Grant Formulary Exceptions

- Plan must grant a formulary exception if
  - All formulary alternatives aren't as effective and/or
  - Drug would have adverse effects
- Plan must grant an exception to a coverage rule
  - If coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or
  - It has caused, or is likely to cause, harm to enrollee

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A plan must grant a formulary exception when it determines that none of the formulary alternatives for treatment of the same condition would be as effective for the enrollee as the non-formulary drug and/or the drug would have an adverse effect. A plan must grant an exception to a coverage rule when it determines the coverage rule has been, or is likely to be, ineffective in treating the enrollee's condition, or has caused, or is likely to cause, harm to the enrollee.

## Part D—Approved Exceptions

- Exception valid for remainder of the plan year if
  - You're still enrolled
  - Prescriber continues to prescribe drug
  - Drug stays safe to treat your condition
- Plan may extend coverage into new plan year
- Plan must notify you in writing
  - If coverage not extended
  - The date coverage will end
  - The right to request a new exception

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If an exception request is approved, the exception is valid for refills for the remainder of the plan year, as long as

- You remain enrolled in the plan
- The prescriber continues to prescribe the drug
- The drug remains safe for treating your condition

A plan may choose to extend coverage into a new plan year. If it doesn't, it must provide written notice to you either at the time the exception is approved, or at least 60 days before the plan year ends. The written notice must tell you about the date coverage will end, the right to request a new exception, and the process for making a new exception request. If coverage isn't extended, you should consider switching to a drug on the plan's formulary, requesting another exception, or changing plans during the Medicare Open Enrollment Period, also known as Open Enrollment (October 15–December 7 each year).

## Requesting Part D Appeals

- If your coverage determination or exception is denied, you can appeal the plan's decision
- In general, you must make your appeal requests in writing
  - Plans must accept verbal expedited (fast) requests
  - Limited timeframe to file an appeal request (within 60 days or later with good cause)
- An appeal can be requested by
  - You or your appointed representative
  - Your doctor or other prescriber
- There are 5 levels of appeals

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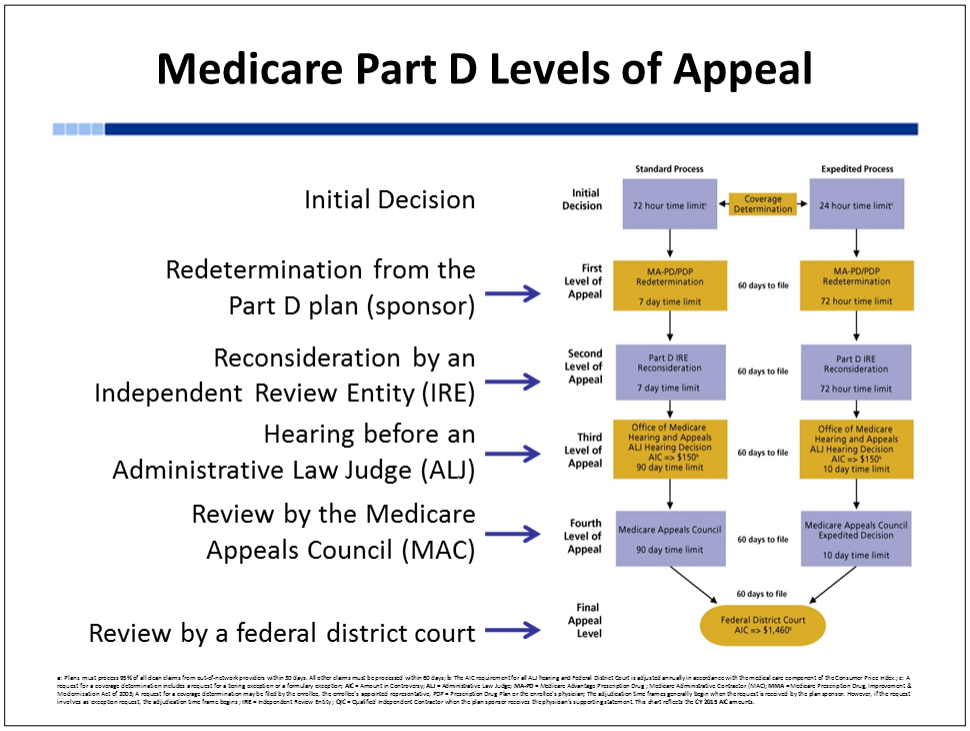
If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully and call your plan if you have questions. Most appeals must be requested within 60 days of the coverage determination or denial of an exception. However, this timeframe may be extended for good cause (a circumstance that kept the party from making the request on time or whether any actions by the plan may have misled the party). For more information on good cause, see Chapter 18 of the Prescription Drug Benefit Manual "Part D Enrollee Grievances, Coverage Determinations, and Appeals," Section 70.3—"Good Cause Extension" at CMS.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/index.html.

In general, you must make your appeal requests in writing. However, plans must accept verbal expedited (fast) redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials, or contact your plan to see if you can make verbal standard redetermination requests.

You or your appointed representative (see Appendix F) may ask for any level of appeal. Your doctor or other prescriber can only ask for a redetermination or Independent Review Entity reconsideration (level 1 or 2 appeal) on your behalf without being your appointed representative.




If you get an unfavorable initial decision, you have the right to appeal the decision.

There are 5 levels of appeal:

1. Redetermination from the Part D plan (sponsor)
2. Reconsideration by an Independent Review Entity
3. Hearing before an Administrative Law Judge—the amount of your claim must meet a minimum dollar amount ($150 in 2015), which may change yearly
4. Review by the Medicare Appeals Council
5. Review by a federal district court—to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount ($1,460 in 2015), which may change yearly

**NOTE:** The Part D Late Enrollment Penalty (LEP) reconsideration process is unrelated to the appeals process flowchart—the appeals flowchart relates to *benefit appeals*. There is only one level of independent review for LEP disputes. See Appendix C and Appendix D for a full-size copy of the Part D (Drug) appeals process and footnote charts.

Please visit the CMS National Training Program's Training Library (job aid section) at CMS.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/index.html or a chart comparing the Parts A, B, C, and D appeals processes.

## Required Part D Notices

- At the pharmacy counter
  - Whenever a prescription isn't filled as written
  - This isn't a coverage decision
- For every coverage determination
- For every appeal decision
- Adverse (unfavorable) coverage decisions must
  - Include information on the next appeal level
  - Include specific filing instructions
  - Provide specific reason(s) for denial

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Plan sponsors must ensure that their network pharmacies provide a written copy of the standardized CMS "Pharmacy Notice" to you whenever a prescription can't be filled by Part D and the issue isn't resolved at the pharmacy counter. This notice explains your right to contact your plan to ask for a coverage determination, including an exception.

Plans' sponsors are required to provide written notices for every coverage determination or appeal decision.

In addition, all other appeal entities are required to send written notice of decisions. If a decision is adverse (unfavorable), the notice will explain the reason for the decision, include information on the next appeal level, and provide specific instructions about how to file an appeal.

**NOTE:** An initial coverage decision about your Part D drugs is called a "coverage determination," or simply put, a "coverage decision." A coverage decision is a decision the plan makes about your benefits and coverage or about the amount they'll pay for your prescription drugs. The plan is making a coverage decision for you whenever they decide what is covered for you and how much they'll pay.

## Provider/Plan Disclosure of Personal Health Information (PHI)

- Plan may disclose relevant PHI to people you identify
  - Family member or other relatives
  - Close personal friends
  - Others (see examples on next slide)
- May disclose relevant PHI only if
  - You're present and agree or plan infers you don't object
  - You're not present or are incapacitated, the plan can exercise professional judgment

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A health care provider or plan, like a Medicare drug plan, may disclose relevant protected Personal Health Information (PHI) to someone who assists you, specifically regarding your drug coverage. However, the guidance applies to all providers and plans, not just drug plans. It's important to note that health plans are permitted, but not required, to make these disclosures.

Your plan may disclose relevant PHI to those identified by you as being involved in your care or payment, including the following:

- Family members or other relatives
- Close personal friends
- Others (see examples on the next slide)

Your plan may disclose relevant PHI to those identified by you only under the following conditions:

- When you're present and agree or the plan reasonably infers from the circumstances that you don't object
- When you're not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest

## To Whom Plans May Disclose Personal Health Information

- A plan may disclose Personal Health Information (PHI) to
  - A person's adult child to resolve a claim or payment issue for a hospitalized parent
  - A human resources representative if the person is on the call or gives permission by phone
  - A Congressional office that faxed your request for Congressional assistance
  - The Centers for Medicare & Medicaid Services (CMS) staff if information satisfies the plan that you requested CMS's assistance

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A plan may disclose Personal Health Information (PHI) to

- A person's adult child who is resolving a claim or payment issue for a hospitalized parent
- A human resources representative if the person with Medicare is on the line or gives permission by phone
- A Congressional office or staff person who has faxed the person's request for Congressional assistance
- The Centers for Medicare & Medicaid Services' (CMS's) staff if the available information satisfies the plan that the individual requested CMS's assistance

**NOTE:** PHI guidelines were published by the Office for Civil Rights, U.S. Department of Health and Human Services.

## Check Your Knowledge—Question 5

If the plan verbally notifies you of its coverage decision, the plan sponsor isn't required to provide a written notice to you.

a. True

b. False

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Check Your Knowledge—Question 5

If the plan verbally notifies you of its coverage decision, the plan sponsor isn't required to provide a written notice to you.

- True
- False

**ANSWER: b.** False

The plan must notify you (and the prescriber involved, if applicable) of all coverage determinations within the required timeframe. If the plan first provides verbal notice of the decision, the plan must send a standardized, written denial notice to you within 3 calendar days of the initial verbal notice.

If you disagree with your plan's initial denial (coverage determination), you can request a redetermination. You must request the redetermination within 60 days from the date of the coverage determination, or later with good cause.

## Lesson 2—Your Rights in Certain Settings

- A brief explanation of your rights
  - In the hospital
  - In a skilled nursing facility
  - When getting home health care
  - When getting hospice care
  - In a Comprehensive Outpatient Rehabilitation Facility

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Lesson 2, "Your Rights in Certain Settings," explains your guaranteed rights when you're admitted to a hospital or skilled nursing facility, or you're receiving care from a non-institutional provider, like home health, hospice, or a Comprehensive Outpatient Rehabilitation Facility.

Many of these rights and protections are the same whether you're in Original Medicare, a Medicare Advantage Plan (like a Health Maintenance Organization or Preferred Provider Organization), or another Medicare health plan.

## Right to Hospital Care

- Right to medically necessary Medicare-covered hospital care
  - To diagnose an illness
  - To treat an illness or injury
  - To get follow-up care
- You'll get a notice when admitted to an inpatient hospital setting
  - An "Important Message From Medicare About Your Rights"

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All people with Medicare, including those in Medicare Advantage or other Medicare health plans, have the right to get all of the medically necessary Medicare-covered hospital care they need to diagnose and treat their illness or injury, including any follow-up care they need after leaving the hospital.

When admitted to the hospital as an inpatient, you'll get a notice called an "Important Message From Medicare About Your Rights," and the hospital must provide you with a written copy of the notice so that you know your rights as a hospital inpatient.

## "Important Message From Medicare"

- Notice signed by you and copy provided
  - Explains your rights to
    - Get all medically necessary hospital services
    - Be involved in any decision(s)
    - Get services you need after you leave the hospital
    - Appeal discharge decision and steps for appealing decision
    - Circumstances in which your hospital services may be paid for during the appeal

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The "Important Message From Medicare" is a notice you get after being admitted to the hospital. This notice is signed by you, and a copy is provided to you explaining your rights to

- Get all medically necessary hospital services
- Be involved in any decision(s)
- Get services you need after you leave the hospital
- Appeal discharge decision and steps for appealing decision
- Circumstances in which your hospital services may be paid for during the appeal

## Rights in a Skilled Nursing Facility (SNF)

Some of your rights in a SNF include

- Freedom from discrimination
- Freedom from abuse and neglect
- Freedom from restraints
- Receive information on services and fees
- Receive privacy, personal property, and spousal living arrangements
- Get Medical care
- Have visitors who can also participate in family councils
- Be protected against unfair transfer or discharge
- Manage your own money
- Make a complaint
- Get medically-related social services

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As a resident of a skilled nursing facility (SNF), you have certain rights and protections under federal and state law that help ensure you get the care and services you need. They can vary by state. The SNF must provide you with a written description of your legal rights. You have the right to

- Freedom from discrimination
- Freedom from abuse and neglect
- Freedom from restraints
- Information on services and fees
- Privacy, personal property, and spousal living arrangements
- Get medical care
- Have visitors who may participate in family councils and can help with your care plan with your permission
- Protection against unfair transfer or discharge
- Manage your own money
- Be able to make a complaint
- Receive medically-related social services

More information is available at Medicare.gov/what-medicare-covers/part-a/rights-in-snf.html.

## Rights in Home Health and Hospice

All persons with Medicare, have certain guaranteed rights and protections regardless of setting. With Home Health and Hospice, you also have the following rights:

- Discharge appeal rights
- Home Health and Hospice providers must give you a written copy of your rights and obligations before care begins, to include your right to
  - Choose your agency
  - Have your property treated with respect
  - Participate in and receive a copy of your plan of care
  - Have your family or guardian act for you if you're unable
  - Receive a copy of the "Home Health Agency Outcome and Assessment Information Set (OASIS) Statement of Patients Privacy Rights" when getting in-home health care

Medicare Rights and Protections 49

All persons with Medicare, have certain guaranteed rights and protections regardless of setting. In home health and hospice settings, you also have the following rights:

- Discharge appeal rights
- Home Health and Hospice providers must give you a written copy of your rights and obligations before care begins, to include your right to
  - Choose your agency. (For members of managed care plans, choices will depend upon which agencies your plan works with.)
  - Have your property treated with respect.
  - Be given a copy of your plan of care, and participate in decisions about your care.
  - Have your family or guardian act for you if you're unable.

For information on your privacy rights as a home health patient, read the Home Health Agency Outcome and Assessment Information Set (OASIS) Statement of Patients Privacy Rights.

## Rights in Other Settings— Comprehensive Outpatient Rehab Facility (CORF)

All persons with Medicare have certain guaranteed rights and protections regardless of setting

- In CORF setting, you have the following rights:
  - Provider must explain your treatment program
  - Discuss if your therapy services will go above the therapy cap limits

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A Comprehensive Outpatient Rehab Facility (CORF) is a facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation.

In a CORF setting, you have the following rights:

- To have the CORF explain your treatment program
- To have the CORF discuss if your therapy services will go above the therapy cap limits. For more information on therapy caps, visit Medicare.gov/Pubs/pdf/10988.pdf.

## Fast Appeals Process

- "Notice of Medicare Non-coverage" (NOMNC)
  - Provider must deliver in most cases at least 2 days before care will end
    - Skilled nursing facility, Comprehensive Outpatient Rehabilitation Facility, hospice or home health care
- Contact Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO) if services are ending too soon
  - See your NOMNC for how to contact your BFCC-QIO
- BFCC-QIO must notify you of its decision
  - Provider or plan gives the "Detailed Explanation of Non-Coverage" (DENC) no later than close of business of the day of the BFCC-QIO's notification

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You have certain rights if you think services are ending too soon. With the Medicare fast appeals process, your provider or plan must deliver (in most cases) a "Notice of Medicare Non-coverage" (NOMNC) at least 2 days before Medicare-covered hospice, skilled nursing facility, Comprehensive Outpatient Rehabilitation Facility (CORF), or home health care will end, for the expedited (fast) determination process.

- You have the right to ask the Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIO) to require your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, hospice, or in a CORF.
  - Contact your BFCC-QIO no later than noon the day before Medicare-covered services end to request a fast appeal. See your notice for how to contact your BFCC-QIO and for other important information.
- The BFCC-QIO must notify you of its decision by close of business of the day after it gets all necessary information. If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal**,** you won't be responsible for paying the charges (except for applicable coinsurance or deductibles) until noon of the day after the BFCC-QIO gives you its decision.

A Medicare provider or health plan (Medicare Advantage Plans and Cost Plans) must deliver a completed copy of the "Detailed Explanation of Non-coverage (DENC)" to beneficiaries/enrollees receiving covered skilled nursing, home health, CORF, and hospice services upon notice from the BFCC-QIO that the beneficiary/enrollee has appealed the termination of services in these settings. The DENC must be provided no later than close of business of the day of the BFCC-QIO's notification.

You have the right to ask for a reconsideration by the Qualified Independent Contractor (QIC) if you're dissatisfied with the results of the fast appeal. The QIC is an independent contractor who didn't take part in the first fast appeal decision. The decision notice that you get from your first fast appeal will have directions on how to file a request for reconsideration.

## Check Your Knowledge—Question 6

A Medicare health provider or plan must give you an advance, completed copy of the "Notice of Medicare Non-coverage" no later than 2 days before the termination of services if they are receiving

a. Skilled nursing facility care

b. Home health or hospice care

c. Comprehensive Outpatient Rehabilitation Facility services

d. All of the above

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Check Your Knowledge—Question 6

A Medicare health provider must give you an advance, completed copy of the "Notice of Medicare Non-coverage (NOMNC)" no later than 2 days before the termination of services if they are receiving

a. Skilled nursing facility care
b. Home health or hospice care
c. Comprehensive Outpatient Rehabilitation Facility (CORF) services
d. All of the above

**ANSWER: d.** All of the above

A Medicare health provider or plan must give an advance, completed copy of the NOMNC to enrollees receiving skilled nursing, home health or hospice, or Comprehensive Outpatient Rehabilitation Facility services no later than 2 days before the termination of services. This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2).

The NOMNC informs individuals of their right to an immediate, independent review of the proposed discontinuation of covered services. Plans are required to provide a Detailed Explanation of Non-coverage (DENC) when an independent review is requested. The DENC provides additional explanation concerning the reasons Medicare coverage is ending.

## Lesson 3—Medicare Privacy Practices

- A brief explanation of Medicare privacy
  - Practices
  - Notices
  - Required and permitted disclosures
  - Rights

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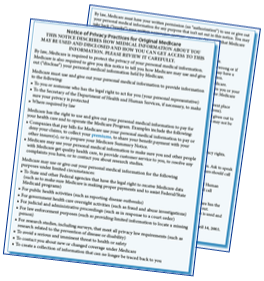
Lesson 3, “Medicare Privacy Practices,” explains Medicare’s privacy practices, notices, required and permitted disclosures, and rights.

## “Notice of Privacy Practices”

- Tells you how Medicare
  - Must protect the privacy of your personal health information
  - Uses and discloses your personal medical information
- Describes your rights and how you can exercise them
- Published annually in the “Medicare & You” handbook
- For more information
  - Visit Medicare.gov
  - Call 1-800-MEDICARE (1-800-633-4227)
  - TTY users should call 1-877-486-2048



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Medicare is required to protect your personal medical information. The “Notice of Privacy Practices for Original Medicare” describes how Medicare uses and gives out your personal health information and tells you your individual rights. If you’re enrolled in a Medicare Advantage Plan or other Medicare health plan, or in a Medicare Prescription Drug Plan, your plan materials describe your privacy rights.

The “Notice of Privacy Practices” is published annually in the “Medicare & You” handbook at Medicare.gov/medicare-and-you.

To learn more about the “Notice of Privacy Practices” for Original Medicare, visit Medicare.gov/forms-help-and-resources/privacy-practices/privacy.html.

For more information, go to Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## Required Disclosures

- Medicare **must** disclose your medical information
  - To you
  - To someone with the legal right to act for you
  - To the Secretary of U.S. Department of Health & Human Services
  - When required by law

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Medicare must disclose your personal medical information

- To you or someone who has the legal right to act for you (your personal representative)
- To the Secretary of U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When required by law (federal, state, or local), for example: public health activities when required or authorized by law or in response to a lawsuit, court order, subpoena, warrant, summons, or similar process

## Permitted Disclosures

- Medicare **may** disclose medical information to
  - Pay for your health care
  - Operate the program
  - Examples
    - To Medicare contractors, to process your claims
    - To make sure you get quality health care
    - To give you customer service
    - To resolve your complaints
    - To contact you about research studies
    - To Accountable Care Organizations (ACO) Update

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Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare program. Medicare contractors use your personal medical information to pay or deny your claims, to collect your premiums, to share your benefit payment with your other insurer(s), and to prepare your "Medicare Summary Notice."

Medicare may use your personal medical information to make sure that you and other people with Medicare get quality health care, to give you customer service, to resolve any complaints you have, or to contact you about research studies.

**NOTE:** An Accountable Care Organization (ACO) is a way for local health care providers and hospitals to volunteer to work together to provide you with coordinated care. If your doctor or health care provider chooses to participate in an ACO, you'll be notified. This notification might be a letter, written information provided to you when you see your doctor, a sign posted in a hospital, or it might be a conversation with your doctor the next time you go to see him or her.

Medicare will share certain information about your medical care with your doctor's ACO, including medical conditions, prescriptions, and visits to the doctor. This is important to help the ACO keep up with your medical needs and track how well the ACO is doing to keep you healthy and helping you get the right care. Your privacy is very important to us. You can remove the type of information Medicare shares with your doctor for care coordination by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or, sign a form available in your doctor or other health care provider's office, which you may also get in the mail from your doctor.

If you get a letter from your doctor, unless you take one of the steps above, your medical information will be shared automatically for purposes of care coordination starting 30 days from the date you're notified. Medicare won't share information with an ACO about any treatment for alcohol or substance abuse without written permission. For more information, visit Medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.html or Medicare.gov/Pubs/pdf/11588.pdf.

## Permitted Disclosures Continued

- Medicare **may** disclose your medical information
  - To state and federal agencies
  - For public health activities
  - For government oversight
  - For judicial proceedings
  - For law enforcement purposes
  - To avoid a serious threat to health and safety
  - To contact you regarding a Medicare benefit
  - To create a non-traceable collection of information

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Medicare also may use or give out your personal medical information for the purposes shown here, under limited circumstances:

- To state and other federal agencies that have the legal right to get Medicare data (like to make sure Medicare is making proper payments and to assist federal/state Medicaid programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like fraud and abuse investigations)
- For judicial and administrative proceedings (like in response to a court order)
- For law enforcement purposes (like giving limited information to locate a missing person)
- To avoid a serious threat to health or safety
- To contact you regarding a new or changed Medicare benefit
- To create a collection of information that can no longer be traced back to you

## Personal Medical Information Authorization

- Written permission (authorization) is required
  - For Medicare to use or give out your personal medical information
  - For any purpose not set out in the "Privacy Notice"
- You may revoke your permission at any time

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By law, Medicare must have your written permission (an authorization) to use or give out your personal medical information for any purpose that isn't set out in the "Privacy Notice." You may take back (revoke) your written permission at any time. However, this won't affect information Medicare has already given out based on your earlier permission.

Visit Medicare.gov/MedicareOnlineForms/AuthorizationForm/OnlineFormStep.asp for an online version of the required "Authorization to Disclose Personal Health Information Form."

## Personal Medical Information Privacy Rights

You have the right to

- See and copy your personal medical information
- Correct medical information you believe is wrong or incomplete
- Know who your medical information was sent to
- Communicate in a different manner
- Ask Medicare to limit use of your medical information
  - To pay your claims and run the program
- Get a written privacy notice

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You have the following privacy rights. You may

- See and copy your medical information held by Medicare.
- Correct any incorrect or incomplete medical information.
- Find out who received your medical information for purposes other than paying your claims, running the Medicare program, or for law enforcement.
- Ask Medicare to communicate with you in a different manner (for example, by mail versus by phone) or at a different place (for example, by sending materials to a post office box instead of your home address).
- Ask Medicare to limit how your personal medical information is used and given out to pay your claims and run the Medicare program. Please note that Medicare may not be able to agree to your request.
- Ask for a separate paper copy of these privacy practices.
- If you want information about the privacy rules, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

## If Privacy Rights Are Violated

- You may file a complaint in writing
  - Electronically via the Office for Civil Rights complaint portal, or on paper by mail, fax, or email
  - Contact the U.S. Department of Health and Human Services Office for Civil Rights
    - Visit HHS.gov/ocr/office/file/.
    - Call 1-800-368-1019. TTY users should call 1-800-537-7697.
- Won't affect your Medicare benefits

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Government programs that pay for health care, like Medicare, Medicaid, and the military and veterans' health care programs, are covered by Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules.

If you believe Original Medicare has violated your privacy rights, you may file a complaint.

You can file a complaint by mail, fax, email, or electronically via the complaint portal. Contact the U.S. Department of Health and Human Services, Office for Civil Rights at HHS.gov/ocr/privacy/hipaa/complaints/, or by calling 1-800-368-1019. TTY users should call 1-800-537-7697.

Your complaint won't affect your benefits under Medicare.

## Check Your Knowledge—Question 7

Medicare MUST disclose your personal medical information

a. To your spouse

b. When requested by your pharmacy

c. To you or someone who has the legal right to act for you (your personal representative)

d. All the above

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Check Your Knowledge—Question 7

Medicare MUST disclose your personal medical information

a. To your spouse
b. When requested by your pharmacy
c. To you or someone who has the legal right to act for you (your personal representative)
d. All the above

**ANSWER: c.** To you or someone who has the legal right to act for you (your personal representative)

Medicare **must** disclose your medical information

- To you
- To someone with the legal right to act for you
- To the Secretary of U.S. Department of Health & Human Services
- When required by law

## Lesson 4—Medicare Rights and Protections Resources

- Advance Directives
- Medicare Ombudsman
- Other sources for information about Medicare rights and protections

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Lesson 4, “Medicare Rights and Protections Resources,” explains

- Advance Directives
- The Medicare Ombudsman
- Other sources for information about Medicare rights and protections

## Advance Directives

- Protect yourself
- Let people know your wishes now
  - Should a time come when you can't speak for yourself
- Complete a "health care advance directive"
  - Identifies who you want to speak for you
  - What kind of health care you want
  - What kind of health care you don't want

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As people live longer, there's a greater chance that they won't be able to make their own health care decisions at some point in time. Alzheimer's and other diseases affect your ability to make health care decisions.

Making future health care decisions is another health care protection available to anyone, not just people with Medicare. Check for your state's requirements.

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to speak for yourself. Advance directives most often include a health care proxy (durable power of attorney), a living will, and after-death wishes.

Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure that your wishes are followed. It's better to think about these important decisions before you're ill or a crisis occurs.

A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A living will is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened. For example, dialysis for kidney failure, a breathing machine if you can't breathe on your own, cardiopulmonary resuscitation if your heart and breathing stop, or tube feeding if you can no longer eat.

## Who's the Medicare Beneficiary Ombudsman?

- An ombudsman is a person who reviews complaints and help resolve them
- The Medicare Beneficiary Ombudsman help make sure information is available about
  - Medicare coverage
  - Making good health care decisions
  - Medicare rights and protections
  - Getting issues resolved
- The Ombudsman reviews the concerns raised by people with Medicare
- The Ombudsman reports yearly to Congress

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An ombudsman is a person who reviews complaints and helps resolve them.

The Medicare Beneficiary Ombudsman helps make sure information is available about

- Medicare coverage
- Making good health care decisions
- Medicare rights and protections
- Getting issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE and through your State Health Insurance Assistance Program (SHIP).

Visit Medicare.gov for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know.

The Ombudsman reports yearly to Congress.

## Check Your Knowledge—Question 8

The Medicare Beneficiary Ombudsman makes sure information is available about all of the following EXCEPT which option?

a. Medigap coverage
b. Making good health care decisions
c. Medicare rights and protections
d. Getting issues resolved

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Check Your Knowledge—Question 8

The Medicare Beneficiary Ombudsman makes sure information is available about all of the following EXCEPT?

a. Medigap coverage
b. Making good health care decisions
c. Medicare rights and protections
d. Getting issues resolved

**ANSWER: a.** Your Medigap coverage

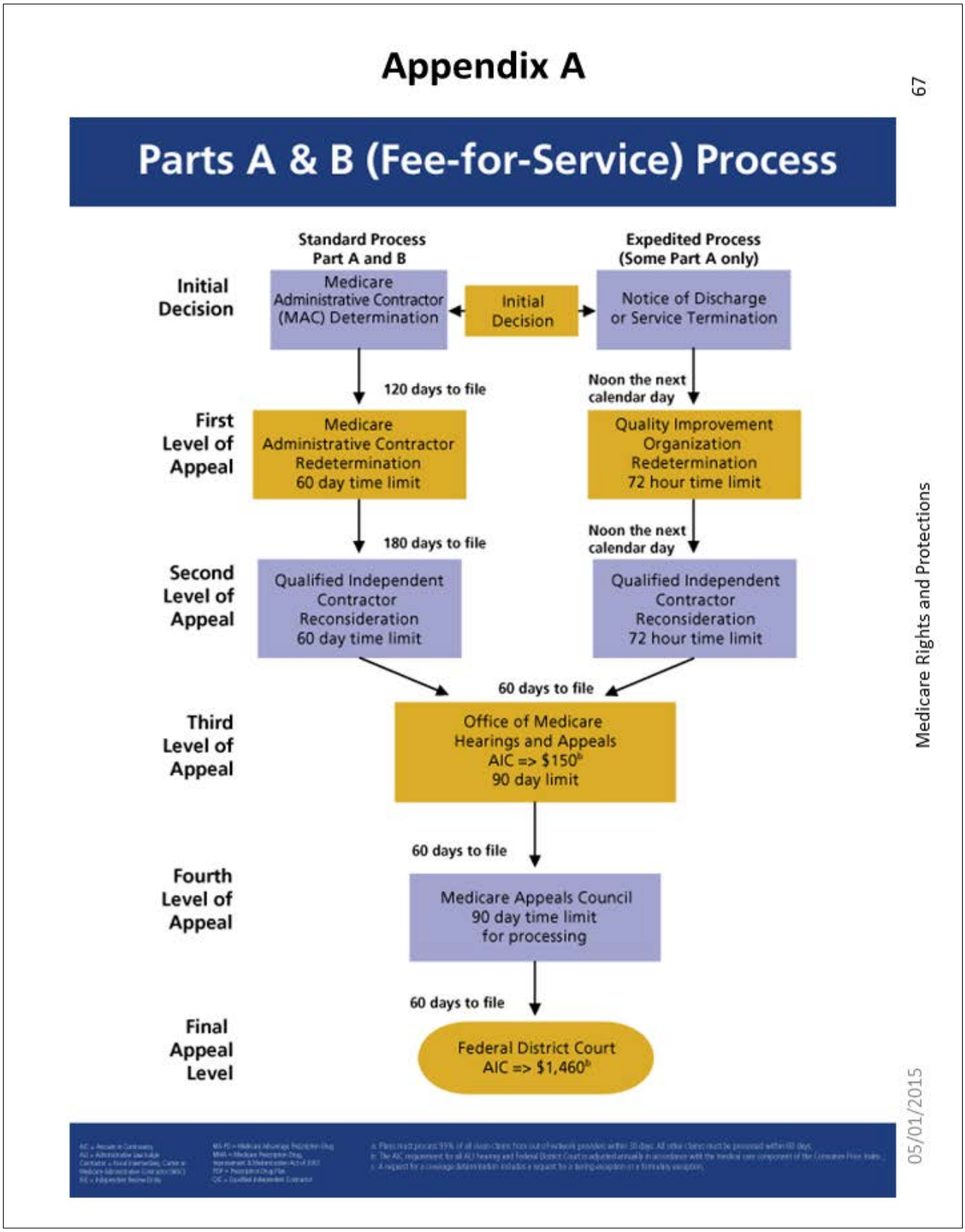
The Medicare Beneficiary Ombudsman helps make sure information is available about

- Medicare coverage
- Making good health care decisions
- Medicare rights and protections
- Getting issues resolved

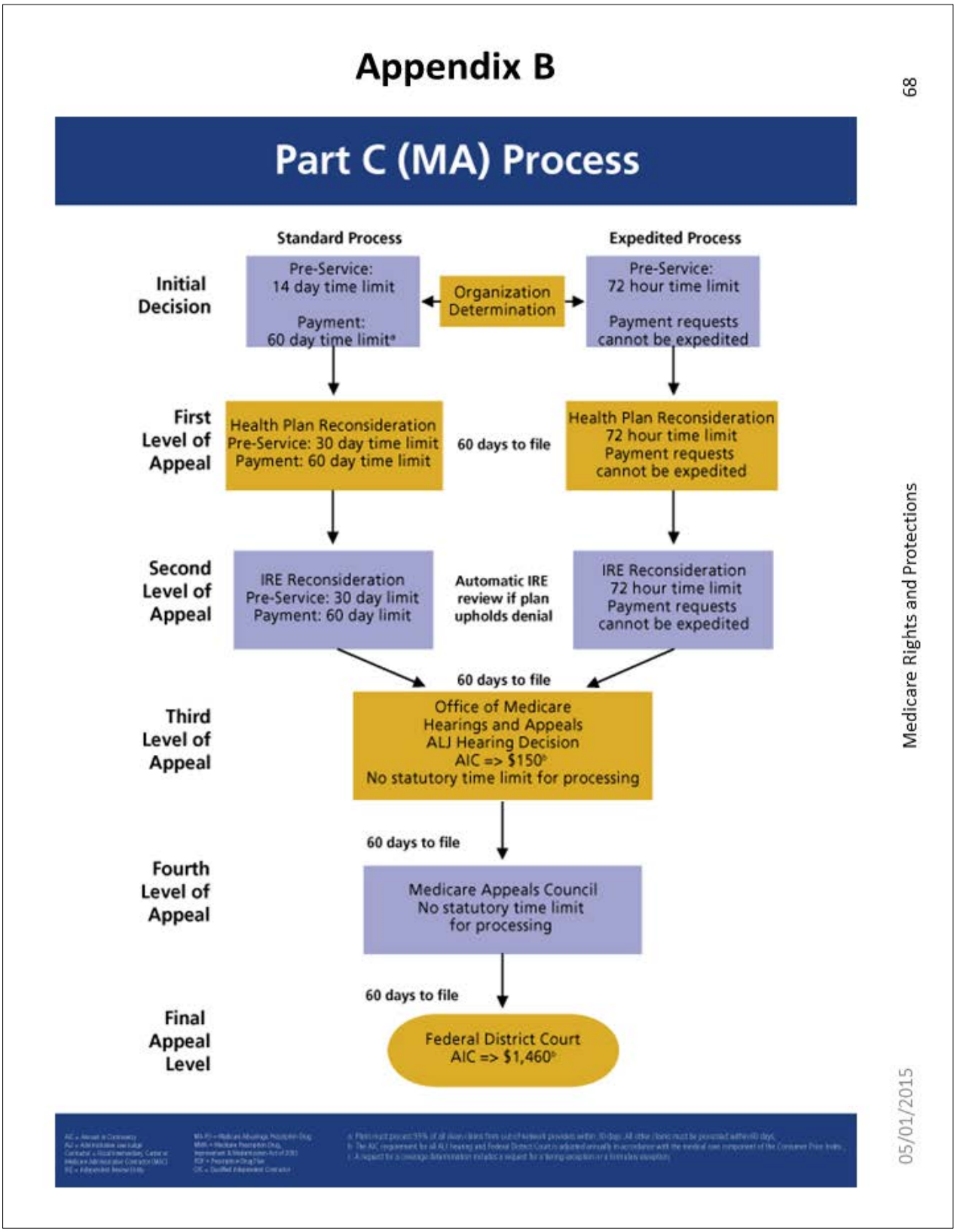
# Medicare Rights and Protections Resource Chart

| CMS Resources | Additional Resources | Medicare Products |
|---|---|---|
| Centers for Medicare & Medicaid Services (CMS)<br>1-800-MEDICARE<br>(1-800-633-4227)<br>(TTY 1-877-486-2048)<br>Medicare.gov<br><br>Medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html<br><br>Medicare.gov/claims-and-appeals<br><br>CMS.gov/bni<br>(Beneficiary Notice Initiative)<br><br>Medicare Managed Care Manual, Chapter 13, Beneficiary Grievances, Organization Determinations, and Appeals:<br>CMS.gov/regulations-and-guidance/guidance/manuals/downloads/mc86c13.pdf | Beneficiary and Family-Centered Care Quality Improvement Organizations*<br><br>Independent Review Entity (Medicare Advantage & Part D claims only)*<br><br>State Health Insurance Assistance Programs*<br><br>U.S. Railroad Retirement Board<br>RRB.gov<br><br>HHS.gov<br><br>*For phone numbers, call CMS<br>1-800-MEDICARE (1-800-633-4227)<br>1-877-486-2048 for TTY users<br><br>U.S. Department of Health and Human Services, Office for Civil Rights<br>HHS.gov/ocr/office/index.html<br>1-800-368-1019<br>1-800-537-7697 for TTY users | **"Medicare & You Handbook"**<br>CMS Product No. 10050<br><br>**"Medicare Rights & Protections"**<br>CMS Product No. 11534<br><br>**"Medicare Appeals"**<br>CMS Product No. 11525<br><br>**To access these products:**<br><br>View and order single copies at Medicare.gov/publications.<br><br>Order multiple copies (partners only) at productordering.cms.hhs.gov. You must register your organization. |

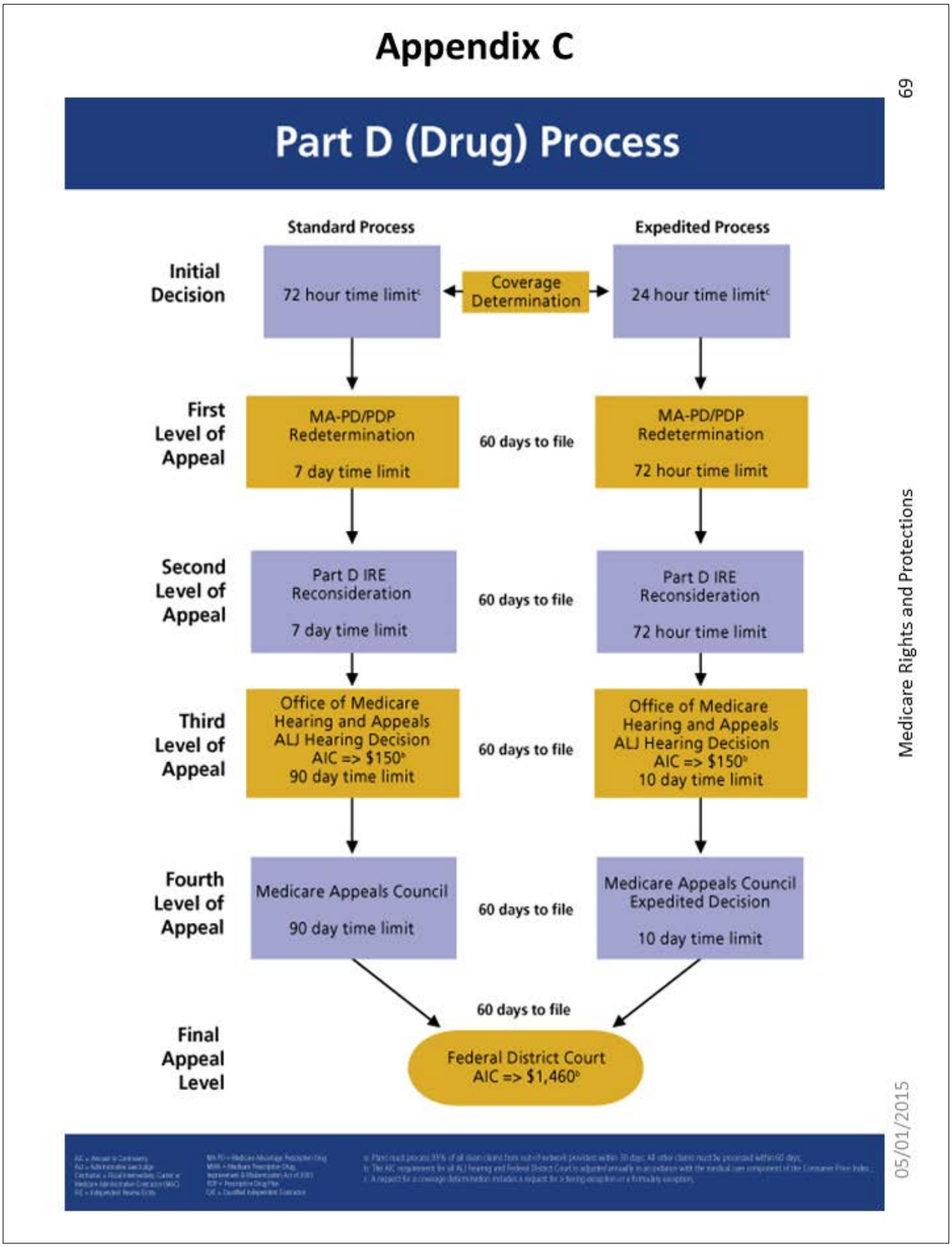
**Appendix A: Original Medicare Appeals Process 2015 (see Appendix D for footnotes)**



**Appendix B: Part C Appeals Chart Process 2015 (see Appendix D for footnotes)**



**Appendix C: Appeals Chart Process Part D 2015 (see Appendix D for footnotes)**



# Appendix D: Appeals Flowcharts Footnote

**a**: 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.

**b**: The AIC requirement for all ALJ hearings and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.

**c**: A request for a coverage determination includes a request for a tiering exception or a formulary exception.

**AIC** = Amount in Controversy

**ALJ** = Administrative Law Judge

**MA-PD** = Medicare Advantage Prescription Drug

**MAC** = Medicare Administrative Contractor

**MMA** = Medicare Prescription Drug, Improvement & Modernization Act of 2003

A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, Prescription Drug Plan (**PDP**), or the enrollee's physician.

The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins when the plan sponsor gets the physician's supporting statement.

**IRE** = Independent Review Entity

**QIC** = Qualified Independent Contractor

This chart reflects the **CY 2015 AIC** amounts.

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**a**: 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.

**b**: The AIC requirement for all ALJ hearings and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index.

**c**: A request for a coverage determination includes a request for a tiering exception or a formulary exception.

**AIC** = Amount in Controversy

**ALJ** = Administrative Law Judge

**MA-PD** = Medicare Advantage Prescription Drug

**MAC** = Medicare Administrative Contractor or Medicare Appeals Council

**MMA** = Medicare Prescription Drug, Improvement & Modernization Act of 2003

A request for a coverage determination may be filed by the enrollee, the enrollee's appointed representative, the Prescription Drug Plan (**PDP**), or the enrollee's physician.

The adjudication time frames generally begin when the request is received by the plan sponsor. However, if the request involves as exception request, the adjudication time frame begins when the plan sponsor gets the physician's supporting statement.

**IRE** = Independent Review Entity

**QIC** = Qualified Independent Contractor

This chart reflects the **CY 2015 AIC** amounts.

## Appendix E: Advanced Beneficiary Notice As Discussed on Slide 20

Appendix E

A. Notifier:

B. Patient Name: C. Identification Number:

### Advance Beneficiary Notice of Noncoverage (ABN)

**NOTE:** If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

| D. | E. Reason Medicare May Not Pay: | F. Estimated Cost |
|---|---|---|
| | | |

**WHAT YOU NEED TO DO NOW:**

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  **Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

**G. OPTIONS: Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

**H. Additional Information:**

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

| I. Signature: | J. Date: |
|---|---|
| | |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

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Medicare Rights and Protections

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Visit CMS.gov/Medicare/Medicare-General-information/BNI/index.html.

# Appendix F: Appointment of Representative Form Instructions

Individuals who represent enrollees may either be appointed or authorized , they are both referred to as "representatives" to act on behalf of the enrollee in filing a grievance, requesting an organization determination, or in dealing with any of the levels of the appeals process. An enrollee may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative.

Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with state law to act on behalf of an enrollee. A surrogate could include, but isn't limited to, a court-appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute. Due in part to the incapacitated or legally incompetent status of an enrollee, a surrogate isn't required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee's authorized representative. Medicare health plans with service areas comprising more than one state should develop internal policies to ensure that they are aware of the different state representation requirements in their service areas.

Send this form to the same location where you're sending your appeal if you're (1) filing an appeal, (2) filing a grievance, or (3) requesting an initial determination or decision.

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Send this form to the same location where you are sending your

- Appeal if you are filing an appeal
- Grievance if you are filing a grievance
- Initial determination or decision if you are requesting an initial determination or decision.

## Appendix F: Appointment of Representative Form

Appendix F: Appointment of Representative Form

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB
No. 0938-0950

### Appointment of Representative

| Name of Party | Medicare or National Provider Identifier Number |
|---|---|
| | |

**Section 1: Appointment of Representative**

**To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):**

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

| Signature of Party Seeking Representation | | Date |
|---|---|---|
| Street Address | | Phone Number (with Area Code) |
| City | State | Zip Code |

**Section 2: Acceptance of Appointment**

**To be completed by the representative:**

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

| Signature of Representative | | Date |
|---|---|---|
| Street Address | | Phone Number (with Area Code) |
| City | State | Zip Code |

**Section 3: Waiver of Fee for Representation**

**Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation.** (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

| Signature | Date |
|---|---|
| | |

**Section 4: Waiver of Payment for Items or Services at Issue**

**Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act.** (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

| Signature | Date |
|---|---|
| | |

Form CMS-1696 (Rev 06/12)

## Acronyms

| | |
|---|---|
| ABN | Advance Beneficiary Notice of Non-coverage |
| ACO | Accountable Care Organization |
| AIDS | Acquired Immune Deficiency Syndrome |
| ALJ | Administrative Law Judge |
| BFCC | Beneficiary and Family Centered Care |
| CHIP | Children's Health Insurance Program |
| CORF | Comprehensive Outpatient Rehab Facility |
| DENC | Detailed Explanation of Non-coverage |
| DOMA | Defense of Marriage Act |
| ESRD | End-Stage Renal Disease |
| HIV | Human Immunodeficiency Virus |
| HMO | Health Maintenance Organization |
| IRE | Independent Review Entity |
| LEP | Late Enrollment Penalty |
| MA | Medicare Advantage |
| MAC | Medicare Appeals Council |
| MSA | Medicare Savings Account |
| MSN | Medicare Summary Notice |
| NOMNC | Notice of Medicare Non-coverage |
| NTP | National Training Program |
| OASIS | Outcome and Assessment Information Set |
| OCR | Office for Civil Rights |
| PFFS | Private Fee-for-Service |
| PHI | Personal Health Information |
| PPO | Preferred Provider Organization |
| QIC | Qualified Independent Contractor |
| QIO | Quality Improvement Organization |
| SHIP | State Health Insurance Assistance Program |
| SNF | Skilled Nursing Facility |
| SSA | Social Security Administration |
| TTY | Teletypewriter |

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For questions about these training products, email training@cms.hhs.gov.