You have the right to appeal any decision about your Medicare services. This is true whether you are in the Original Medicare Plan, a Medicare managed care plan, or a Medicare prescription drug plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal. You should review the Medicare Appeals Information before downloading the forms below.

"It's important to point out that a denied claim means that the patient received the medically necessary services, but the doctor or hospital was not paid for that care," said Lynne Randolph, spokeswoman for the Department of Managed Health Care. "The department has been very active in ensuring that providers of care should be paid fairly and on time."

Randolph said the department's provider complaint unit has obtained almost $20 million in disputed claims payments for physicians since 2005.

PacifiCare, the Cypress-based subsidiary of UnitedHealthcare Group, ranked highest in the state for claims denied in the first half of 2009. It has been the subject of considerable scrutiny for its claims-handling practices.

The HMO paid $3.5 million in fines last year for claims payment problems, and the department is conducting a follow-up examination.

"We still do get frequent complaints about PacifiCare, and obviously the numbers in the California Nurses Assn. report backed that up," Randolph said. "We do expect we will be taking some further action."

PacifiCare also faces a hearing this year over state Department of Insurance allegations of 133,000 violations of claims-handling laws that could result in as much as $1.33 billion in fines.

PacifiCare said it has been cooperating with both inquiries and had already corrected most of the identified problems, which it described as technical. The insurer said its claims-denial rate was higher than average because of its unique business model.

"It doesn't truly reflect an impact on the consumer," said PacifiCare spokesman Tyler Mason.

PacifiCare said it delegates the financial responsibility for many of its members' care to physician groups. As a result, many of the denials involve confusion over whether the HMO or the physician groups are responsible for paying certain types of claims. But, the HMO said, consumer bills usually get paid.

Similarly, Woodland Hills-based Health Net said many of its denials were ultimately covered by physician groups that care for patients in exchange for set monthly fees from the insurer.

Cigna spokesman Chris Curran said that, nationwide, the Philadelphia-based insurer approves "more than 99% of eligible claims for care that the doctor recommends."

A spokesman for Oakland-based Kaiser Permanente said the reported denials were not a reflection of the vast majority of care provided within the HMO's network.

Blue Shield defended its failure to break out claims denials in its annual report.

"We've reported the data this way for years, and the [Department of Managed Health Care] has never asked for any additional information," said spokesman Aron Ezra. "We're more than happy to break out the information differently if the [department] requests it from us."

A spokeswoman said the department has requested the information, which it expects the Chicago insurer to provide.etermine the reason your claim was rejected. There is typically a reason code provided on your explanation of benefits, although they're not always clear. Call the insurance company for details about why the claim was rejected.

If a Medicare health plan decides to deny services or payments, in whole or in part, the plan is required to provide the enrollee with a written notice of its determination. Additionally, Medicare health plan enrollees receiving services from an inpatient hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility have the right to a fast, or expedited, appeal if they think their Medicare-covered services are ending too soon. Plans and providers have certain responsibilities related to notifying beneficiaries of Medicare appeal rights. **For additional information concerning Medicare managed care appeals notice requirements, including Spanish versions of the notices, click on the links in the "Related Links Inside CMS" below.**

A grievance is any complaint or dispute, (other than one that involves an organization determination), expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested.

The enrollee must file the grievance either orally or in writing no later than 60 days after the triggering event or incident precipitating the grievance.

Listed below are some examples of problems that are typically dealt with through the plan grievance process:

- Problems getting an appointment, or having to wait a long time for an appointment
- Disrespectful or rude behavior by doctors, nurses or other plan clinic or hospital staff

Each plan must provide meaningful procedures for timely hearing and resolving both standard and expedited grievances between enrollees and the Medicare health plan or any other entity or individual through which the Medicare health plan provides health care services.

The Medicare health plan must include in its grievance procedures:

- The ability to accept any information or evidence concerning the grievance orally or in writing not later than 60 days after the event; and
- The requirement to respond within 24 hours to an enrollee's expedited grievance whenever:
    1. A Medicare health plan extends the time frame to make an organization determination or reconsideration; or
    2. A Medicare health plan refuses to grant a request for an expedited organization determination or reconsideration.

Plans must notify all concerned parties about the results of the investigation as expeditiously as the enrollee's case requires based on the enrollee's health status, but not later than 30 days after the grievance is received.

If a Medicare health plan denies an enrollee's request for an item or service in whole or in part (issues an adverse organization determination), the enrollee may appeal the decision to the plan by requesting a reconsideration. An enrollee or an enrollee's representative may request a standard or expedited reconsideration.

An enrollee or an enrollee's representative may request a standard or expedited reconsideration.

An enrollee's physician may request an expedited reconsideration on the enrollee's behalf. If a physician requests the expedited reconsideration, plans are required to expedite the request.

If the enrollee's physician is also the enrollee's representative, he, or she may also request a standard reconsideration.

For more information about reconsiderations, including appointing a representative, see section 60.1.1 in Chapter 13 of the Medicare Managed Care Manual in the "Downloads" section below.

How to Request a Reconsideration
Reconsideration requests must by filed with the health plan within 60 calendar days from the date of the notice of the organization determination.

Expedited requests can be made either orally or in writing.

Standard requests must be made in writing, unless the enrollee's plan accepts oral requests. An enrollee should call the plan or check his or her Evidence of Coverage to determine if the plan accepts oral standard requests.

1. Step 2

   Decide whether the rejection was legitimate. If the insurance company denied payment for a prescription that is clearly not covered on your formulary, that is a legitimate rejection. If you feel that your claim should have been covered, proceed with trying to fight the denial. The most common reasons claims are inaccurately rejected are that the insurance company determined the treatment was not medically necessary, or there was a billing error between the provider and the insurance company.

2. Step 3

   File an appeal with your insurance company. Request an appeal form from the insurance company, or ask for instructions on submitting an appeal. Write a letter to accompany your appeal, explaining why you feel the claim should have been covered.

3. Step 4

   Contact the medical provider to explain that the claim has been denied but you have filed an appeal. Ask for an extension to avoid being sent to collections for not paying the bill. Confirm that the provider has your correct insurance information and the correct billing address of the insurance company.

4. Step 5

   Obtain records from your physician or other provider that will help document the medical necessity of the treatment you received. Often, insurance companies deny claims based on very little information. When provided with the appropriate documentation, they often reverse their rejection. For example, if you were instructed by another medical provider to go to the emergency room, providing proof that you were directed there can help reverse a denial for emergency room payment.

5. Step 6

   Have the medical provider resubmit the bill to the insurance company. Even if you were not able to determine a billing error through phone conversations with representatives, sometimes resubmitting the bill can cause it to go through without a problem.

6. Step 7

   File a complaint with your state's Insurance Commission and the Attorney General's health care department. Obtain forms for filing a complaint by contacting each organization through its website. The Office of Attorney General Health Care helps mediate medical claim disputes, and the Insurance Commission investigates insurance companies for wrongdoing.

Tips & Warnings

- If you're certain your claim is being denied inappropriately, yet your efforts have failed, enlist the help of an attorney, particularly if your medical expenses are extremely high. Often, insurance companies don't want to deal with the hassle of working with an attorney, so you may be able to get your claim paid easily.

References

- Bad Faith Insurance
- Tips to Effectively Battle an Insurance Company

Who Can Help: