

Medicare Appeals and Grievances (Complaints)

In the Original Medicare Plan:

If you are dissatisfied, you have a right to appeal any decision concerning your Medicare covered services in the Original Medicare Plan. You can file an appeal if you believe Medicare did not pay enough for services or should have paid for health care services you received. Your appeal rights will be detailed on the back of the Medicare Summary Notice (MSN) or Explanation of Medicare Benefits (EOMB) that is mailed to you.

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization. Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals paid by the federal government to monitor the care given to Medicare patients. They are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; Medicare Managed Care Plans and ambulatory surgical centers. You can stay in the hospital at no charge and cannot be discharged before the PRO makes a decision.

In Other Medicare Health Plans:

You have a right to appeal decisions concerning your Medicare benefits in the other Medicare health plans. If you have any concerns or problems with your plan, you also have a right to file a grievance (complaint). You have these rights

regardless of the type of plan in which you are enrolled. To participate in Medicare, each health plan must have an appeal and grievance process for its members. See the health plan's membership materials or contact your health plan for details about your rights and how to file a Medicare appeal and complaint.

You may file an appeal if your health plan denies a service, or terminates or refuses to pay for services that you believe should be covered. You may be eligible for a fast decision (within 72 hours) if you believe that your health or ability to function could be seriously harmed by waiting the amount of time needed for a standard decision. Your health plan must provide you with written instructions on how to appeal. The first step is to contact your plan.

After you file an appeal, the health plan reviews its original decision to deny you coverage. Then, if your health plan does not decide in your favor, the appeal automatically goes to an independent reviewer that contracts with Medicare.

If you believe you are being discharged too soon from a hospital, you have a right to immediate review by the Peer Review Organization (PRO) in your State. During the immediate PRO review, you **may** be able to stay in the hospital at no charge and the hospital cannot discharge you before the PRO reaches a decision.

