

**National Medicare Training Program Workbook**



**Module 2:  
Your Medicare  
Rights and Protections**



*...helping people with Medicare  
make informed health care decisions*

**National Medicare  
TRAINING PROGRAM**

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# Module 2: Your Medicare Rights and Protections



In this module, **Your Medicare Rights and Protections**, we'll be talking about your right to get the health care services you need; your right to file a complaint; and where you can get help with your questions. (Reference: *Your Medicare Rights and Protections*, CMS Publication 10112)

This training module was developed and approved by the Centers for Medicare & Medicaid Services (CMS), the Federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The information in this module was correct as of April 2009. To check for an updated version of this training module, visit [www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp](http://www.cms.hhs.gov/NationalMedicareTrainingProgram/TL/list.asp) on the web.

Slides with this symbol in your workbook are not included in the presentation, but are provided as a resource for more detail.

This set of National Medicare Training Program materials is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations, and rulings.

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## Module 2: Your Medicare Rights and Protections

# SLIDE 2

## *Speaker's Notes*

The topics in this module we will cover include:

- An overview of Medicare rights and protections
- Your rights and appeals in Original Medicare
- Hospital, skilled nursing facility, and home health care rights
- Privacy practices in Original Medicare
- Your rights and appeals in a Medicare Advantage Plan or Medicare Cost Plan
- Your rights and appeals in a Medicare Drug Plan
- Where to get more information

### Session Topics

- Overview
- Rights in Original Medicare
- Hospital, SNF, and home health care
- Privacy practices in Original Medicare
- Medicare Advantage/Medicare Cost Plan
- Medicare drug coverage
- More information

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## Module 2: Your Medicare Rights and Protections

# SLIDE 3

## *Speaker's Notes*

Let's begin with an overview of your Medicare rights and appeals.

### Session Topics

- Overview
- Rights in Original Medicare
- Hospital, Skilled Nursing Facility (SNF), and home health care
- Privacy practices in Original Medicare
- Medicare Advantage/Medicare Cost Plan
- Medicare drug coverage
- More information

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## Module 2: Your Medicare Rights and Protections

# SLIDE 4

## *Speaker's Notes*

If you have Original Medicare (with or without a Medigap policy), a Medicare Advantage or other Medicare plan, and/or have a Medicare Drug Plan, you have certain guaranteed rights. These rights protect you when you get health care, make sure you get the health care services the law says you can get, protect you against unethical practices, and protect your privacy.

**NOTE:** Original Medicare is a "fee-for-service" plan. You are in Original Medicare unless you join a Medicare Advantage or other Medicare health plan. Some people in Original Medicare buy a Medigap policy to help cover the costs Medicare doesn't pay.

Medicare Advantage includes Medicare Health Maintenance Organization (HMO) Plans, Preferred Provider Organization (PPO) Plans, Special Needs Plans, Private Fee-for-Service Plans, and Medicare Medical Savings Account Plans. Other Medicare plans include Medicare Cost Plans, demonstrations, and Programs of All-Inclusive Care for the Elderly (PACE).

### Medicare Patients' Rights

- You have guaranteed rights in
  - Original Medicare
  - Medicare Advantage/Medicare Cost Plans
  - Medicare Drug Plans
- These rights
  - Protect you when you get health care
  - Ensure you get covered health care services
  - Protect you against unethical practices
  - Protect your privacy

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## Module 2: Your Medicare Rights and Protections

# SLIDE 5

## Speaker's Notes

You have the right to:

- Be treated with dignity and respect at all times
- Be protected from discrimination
- Get information about Medicare you can understand to make health care decisions
  - This includes information on what is covered, what costs are paid, how much you have to pay, and what to do to file a complaint
- Get your questions about Medicare answered
  - You can call 1-800-MEDICARE or contact your State Health Insurance Assistance Program. Their numbers are on **medicare.gov** or listed in the *Medicare & You* handbook.
- Get culturally-competent services in a language you can understand and in a culturally sensitive way
- Get emergency care when and where you need it

### You Have the Right to ...

- Be treated with dignity and respect
- Be protected from discrimination
- Get information you can understand
- Get answers to your Medicare questions
- Get culturally-competent services
- Get emergency care

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## Module 2: Your Medicare Rights and Protections

# SLIDE 6

## *Speaker's Notes*

You also have the right to:

- Learn about treatment choices in clear, understandable language
  - Medicare health plans cannot prevent your doctor from telling you what you need to know about your treatment choices.
- File a complaint about payment, services, or other problems, and the quality of your health care
- Appeal decisions relating to your treatment or benefits
- Have the personal information that Medicare collects about you kept private
- Know your privacy rights

### You Have the Right to ...

- Learn about your treatment choices
  - In clear understandable language
- File a complaint
- Appeal a denial of a treatment or payment
- Have personal information kept private
- Know your privacy rights

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### Notes:

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# SLIDE 7

## *Speaker's Notes*

Emergency care is care given for a medical emergency when you think your health is in serious danger—when every second counts.

You don't need an OK from your health plan. If you think your health is in serious danger because you have severe pain, a bad injury, sudden illness, or an illness quickly getting much worse, you can get emergency care anywhere in the United States.

### Right to Emergency Care

- Medicare Emergency
- Without an OK from your health plan
- Anywhere in the United States
- When and where you need it

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# SLIDE 8

## *Speaker's Notes*

Urgently needed care is care that you get for a sudden illness or injury that needs medical care right away, but is not a serious threat to your health.

If you are in a Medicare Advantage Plan or a Medicare health plan other than Original Medicare, health care providers in the plan's network generally provide care if you are in the plan's service area. If you are out of your plan's service area for a short time (less than 6 months) and cannot wait until you return home, the health plan must pay for urgently needed care.

Medicare drug plans are required to provide convenient access to pharmacies including out-of-network pharmacies in case of emergency.

### Urgently Needed Care

- For a sudden illness or injury
  - Medical care needed right away
  - Not a serious threat to health
- In a Medicare Advantage Plan
  - In service area
    - Network providers generally provide care
  - Out of service area
    - Plan must pay

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# SLIDE 9

## *Speaker's Notes*

You cannot be treated differently because of your race, color, national origin, disability, age, religion, or gender (generally limited to complaints of discrimination filed against providers of health and social services who receive Federal financial assistance). If you think you have been discriminated against for any of these reasons, call the Office for Civil Rights at 1-800-368-1019.

### Right to Non-Discrimination

- Cannot be treated differently because of
  - Race, color, national origin
  - Disability
  - Age
  - Religion
  - Gender
    - Generally limited to complaints against providers
- Call Office for Civil Rights in your state

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# SLIDE 10

## *Speaker's Notes*

A beneficiary has the right to express concern about payment, services received, and/or other concerns or problems he or she may have had in getting health care, or the quality of the health care received under any Medicare plan. There are two kinds of complaints: appeals and grievances.

An appeal is the action a beneficiary should take if he or she disagrees with a coverage or payment decision, i.e., Medicare should have paid but didn't, or didn't pay enough; a Medicare Advantage Plan denied a needed service; or a Part D plan didn't cover a prescription drug.

A grievance is a complaint about anything else including the quality of services or care that is received.

For more information on filing an appeal, call your Plan, the State Health Insurance Assistance Program (SHIP) in your state, or 1-800-MEDICARE (1-800-633-4227).

### Beneficiary Complaints

- Appeals
  - Coverage
  - Payment
- Grievance
  - Quality
  - Anything else
- Call Plan or SHIP

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## Module 2: Your Medicare Rights and Protections

# SLIDE 11

## *Speaker's Notes*

So far in this module, we've talked about your rights as a person with Medicare. These include the right to:

- Information
- Emergency care and urgent care
- Non-discrimination
- File a complaint, whether it is regarding payment or coverage or quality of care

### Session Topics

- ✓ Overview
  - Rights in Original Medicare
  - Hospital, SNF, and home health care
  - Privacy practices in Original Medicare
  - Medicare Advantage
  - Medicare prescription drug coverage
  - More information

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# SLIDE 12

## *Speaker's Notes*

You have additional rights when you are enrolled in Original Medicare. They include the following.

- Access to doctors, specialists (including women's health specialists), and hospitals. You can see any doctor or specialist, or go to Medicare-certified hospitals that participate in Medicare.
- Certain information, notices, and appeal rights that help you resolve issues when Medicare doesn't pay for health care, including timely information on Medicare payment and a fair, efficient, and timely appeals process.
- Rights to buy a Medigap policy.
- The Notice of Privacy Practices for Original Medicare.

### Additional Rights Under Original Medicare

- Access to doctors, specialists, hospitals
- Timely information on Medicare payment
- Fair and efficient appeals processes
- General appeal rights
- Rights to buy a Medigap policy
- Privacy practices notices for Original Medicare

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# SLIDE 13

## *Speaker's Notes*

In Original Medicare, you can file an appeal if you think Medicare should have paid for an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case.

Your appeal rights are on the back of the Medicare Summary Notice (MSN) that is mailed to you by the company that handles your Medicare bills. The notice will also tell you why Medicare didn't pay your bill and how you can appeal. It will also tell you where to file the appeal and the time limit for filing your appeal.

You should keep a copy of everything you send to Medicare as part of your appeal.

### Appeal in Original Medicare

- Ask doctor or provider
  - For information that might help your case
- Appeal rights
  - On back of Medicare Summary Notice tells
    - Why Medicare didn't pay
    - How to appeal
    - Where to file your appeal
    - How long you have to appeal

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# SLIDE 14

## *Speaker's Notes*

There are five levels in the appeals process in Original Medicare. See the laminated Appeals Processes job aid with your materials, or look at the job aid section of your CD suite for a chart of the Part A, B, C, and D Appeal Processes.

1. **Written request for redetermination** to the company that handles your claims for Medicare **within 120 days** from the date you get the MSN. Details are on the MSN.
2. **Reconsideration by a Qualified Independent Contractor (QIC)** (a contractor that didn't take part in the first decision). Details are included in the redetermination notice.
3. **Hearing by an Administrative Law Judge (ALJ)** (if you meet a **minimum dollar amount, \$120 in 2009**). Send the request to the ALJ office listed in the reconsideration notice.
4. **Review by the Medicare Appeals Council (MAC)**. Details on how to file are included in the ALJ's hearing decision. There is no minimum dollar amount in order to get your appeal reviewed by the Medicare Appeals Council.
5. **Review by a Federal Court**. To get a review by a Federal court, the amount of your case must meet a **minimum dollar amount, \$1,220 in 2009**.

### Appeal Levels in Original Medicare

- Redetermination by Medicare
- Reconsideration by a Qualified Independent Contractor
- Hearing with Administrative Law Judge
- Review by Medicare Appeals Council
- Review by a Federal Court

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# SLIDE 15

## *Speaker's Notes*

You are protected from unexpected bills. If a doctor or supplier of health care services believes that Medicare won't pay for certain items or services, in many situations he or she will give you a notice that says Medicare probably (or certainly) won't pay. This is called an Advance Beneficiary Notice (ABN). The Advance Beneficiary Notice is used only in Original Medicare.

Doctors and suppliers are not required to give you an Advance Beneficiary Notice for services Medicare never covers (i.e., excluded under Medicare law), such as routine physical exams, routine eye exams, dental services, hearing aids, and routine foot care.

If you still want to get the service, you will be asked to choose an option and sign an agreement to pay for the service yourself if Medicare does not pay for it. You will be asked to sign a Waiver of Liability for these services and products. You will be responsible for paying for the services you received.

### Protection from Unexpected Bills

- When Medicare might not pay for a service
  - Provider gives you Advance Beneficiary Notice
    - Used in Original Medicare
    - Not required for non-covered services
      - Excluded under Medicare law
    - Will ask you to sign agreement to pay

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## Module 2: Your Medicare Rights and Protections

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## *Speaker's Notes*

There are four types of Advance Beneficiary Notices:

- **Advance Beneficiary Notice of Non-coverage** — Effective March 1, 2009, this notice will replace the Advance Beneficiary Notice-General, the Advance Beneficiary Notice-Laboratory, and the Notice of Exclusion from Medicare Benefits (NEMB).
- **Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) or denial letters** — The SNFABNs or denial letters are used only for skilled nursing facility care.
- **Home Health Advance Beneficiary Notice (HHABN)** — This notice is used only by home health agencies.
- **Hospital Issued Notice of Non-coverage (HINN)** — This notice is used for inpatient hospital care when the hospital thinks Medicare may not pay for your care.

### Beneficiary Liability Notices

- 1) Advance Beneficiary Notice of Noncoverage  
– Effective March 1, 2009
- 2) Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)  
– Or denial letter
- 3) Home Health Advance Beneficiary Notice (HHABN)
- 4) Hospital-Issued Notice of Non-coverage (HINN)

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# SLIDE 17

## *Speaker's Notes*

In some situations, you have the right to buy a Medigap policy. A Medigap policy is a health insurance policy sold by private insurance companies to fill the “gaps” in Original Medicare Plan coverage, such as coinsurance amounts.

Medigap policies must follow Federal and state laws that protect you. There are 12 standardized Medigap policies called “Plan A” through “Plan L.” The front of the Medigap policy must clearly identify it as “Medicare Supplement Insurance.” Each Medigap Plan A through L has a different set of benefits.

You have the right to buy a Medigap policy during your Medigap open enrollment period and when you have guaranteed issue rights. In these situations, the company:

- Can't deny you Medigap coverage or place conditions on your policy
- Must cover you for all pre-existing conditions
- Can't charge you more for a policy because of past or present health problems

(Module 3, Medigap, describes these situations.)

### Medigap Rights and Protections

- Right to buy a Medigap policy
  - Medigap open enrollment period
  - Guaranteed issue rights
    - 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

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## Module 2: Your Medicare Rights and Protections

# SLIDE 18

## *Speaker's Notes*

If you are admitted to a hospital or skilled nursing facility, or you are receiving home health care, you are guaranteed certain rights and protections. Many of these rights and protections are the same whether you are in Original Medicare or a Medicare Advantage Plan.

### Session Topics

- ✓ Overview
- ✓ Rights in Original Medicare
- Hospital, SNF, home health care
- Privacy practices in Original Medicare
- Medicare Advantage
- Medicare prescription drug coverage
- More information

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# SLIDE 19

## Speaker's Notes

All people with Medicare, including those in a Medicare Advantage Plan or other Medicare health plan, have the right to get all of the 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, you must sign the *Important Message From Medicare* and the hospital must provide you with a copy of the signed notice so that you know your following rights.

- The right to get medically necessary hospital care you need, and any follow-up care that is covered by your Medicare plan after you leave the hospital
- The right to be involved in any and all decisions about your hospital services and who will pay for them.
- What your appeal rights are
- What you may have to pay

### Right to Hospital Care

- You have the right to get the medically-necessary hospital care you need to
  - Diagnose
  - Treat illness/injury
  - Follow-up care
- *Important Message From Medicare (IM)*
  - Signed by beneficiary
  - Copy to beneficiary

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## Module 2: Your Medicare Rights and Protections

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## Speaker's Notes

When the hospital or your plan thinks you no longer need inpatient care, it will give you a follow-up copy of the Important Message from Medicare (IM) you received at or near admission if more than two days have passed since receiving the original IM.

If you have questions about this notice or think the hospital is making you leave too soon, call your Quality Improvement Organization (QIO), or call your Medicare Advantage Plan if you miss the deadline to appeal to a QIO. Each state has a QIO. QIOs are groups of practicing doctors and other health care experts who are paid by the Federal government to check on and improve the care given to Medicare patients, including those enrolled in Medicare Advantage Plans.

The QIO's telephone number should be on the IM the hospital gave you. Or, call 1-800-MEDICARE (1-800-633-4227) or visit [www.medicare.gov/Contacts](http://www.medicare.gov/Contacts) on the web to get the number for your QIO. The phone numbers can also be found in the booklet *Your Medicare Rights and Protections*. You may be able to stay in the hospital at no charge while the QIO reviews your case if you file an appeal by the day of discharge. The hospital cannot force you to leave before the QIO makes its decision.

### Hospital Discharge Rights

- Important Message from Medicare (IM)
- Follow-up copy of IM delivered
- If hospital is making you leave too soon
  - Call state's Quality Improvement Organization (QIO)
  - QIO reviews for all people with Medicare
  - Hospital can't force discharge before QIO's decision

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## SLIDE 21 *Speaker's Notes*

If you are in Original Medicare or a Medicare Advantage Plan and don't have any remaining days of coverage, or if you no longer qualify for, a Skilled Nursing Facility (SNF) Part A covered days, you should receive a written notice informing you that you will be liable for the remainder of your stay in the facility. Depending on the notice you receive, you'll have different rights. The purpose of this notice is to let you know that the facility believes you no longer qualify to have Medicare pay for the facility's services. If someone is acting on your behalf, the facility must notify that person in writing.

Your Medicare coverage ends the day after you get the notice.

### Rights in a Skilled Nursing Facility

- Should receive a written notice
  - Facility believes Medicare won't pay
  - You will be liable for remainder of stay
  - Notice will inform you of rights
  - Coverage ends day after you get notice

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## SLIDE 22 *Speaker's Notes*

If you are in Original Medicare or a Medicare Advantage Plan, you have rights to get home health care. Only your doctor can change your plan of home health care. Your home health agency cannot change your plan of care without getting your doctor's approval. You must be told in writing of any changes in your plan of care. If you have a question about your care, you should call your doctor. If your agency changes your plan of care without your doctor's approval, you should contact the local Quality Improvement Organization (QIO). Visit [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE to get the telephone number.

If a home health agency denies or reduces care or it believes that Medicare will not pay for the home health care services that the doctor has ordered, then the home health agency must provide a *Home Health Advance Beneficiary Notice*. (This applies only to Original Medicare).

When all home care ends, you may also have the right to a fast appeals process.

### Home Health Rights

- Your plan of care
  - Can only be changed by your doctor
  - You must be told of changes in writing
- Agency must provide Home Health Advance Beneficiary Notice
  - When it denies or reduces care
- You may receive a fast appeal notice
  - In some cases when all home care ends

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# SLIDE 23

## *Speaker's Notes*

The Medicare expedited determination or fast appeal process allows people with Medicare in specific care settings—home health, hospice, Comprehensive Outpatient Rehabilitation Facility (CORF), skilled nursing facility (SNF) and swing bed hospital care—the right to file an appeal. A Quality Improvement Organization (QIO) will review your provider's decision to end your covered care. Your provider must give you notice of your right to an expedited review.

In short, the expedited review process gives you the right to appeal your provider's decision to discharge you.

(If you disagree with a decision to deny payment for a claim, rather than a decision to discharge you, you can use the standard appeal process.)

### Original Medicare Expedited Appeal

- People in certain care settings have right to request expedited appeals
- Provider must give notice of your rights
  - Explains your right to independent reviewer (QIO)

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## Module 2: Your Medicare Rights and Protections

# SLIDE 24

## Speaker's Notes

In Original Medicare, the following time-frames apply for expedited determinations and reviews:

- **Advance notice of Medicare non-coverage.** The provider must give you this notice usually no later than 2 days before the proposed end of covered services. If services are for fewer than 2 days, you must be given notification at the time of admission, or for nonresidential providers, the next-to-last time services are furnished.
- **Request to state QIO.** You must make your request to the QIO no later than noon of the calendar day before Medicare covered services end. Once you request the fast appeal process, the provider cannot bill you until the QIO determines if coverage can continue. Note: If the notice is given early, you still have until noon of the day before coverage ends to request QIO review.

*(continued)*

### Original Medicare Expedited Appeal

- You must get advance notice
  - Usually NLT 2 days before end of covered services
- If you disagree
  - File request with state QIO
    - NLT noon the day before Medicare-covered services end

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# SLIDE 25

## *Speaker's Notes*

It is important to make a timely contact with the appropriate QIO as directed on the notice. The QIO must immediately notify the provider of your timely request for expedited review (on the same day if your request is timely).

The provider must give you a detailed explanation of non-coverage, usually by close of business the same day the QIO notifies the provider you have requested an expedited redetermination.

The QIO must make its decision no later than 72 hours after receiving the request for the expedited redetermination. Notification may initially be by telephone but must be followed by a written notice, which includes information on reconsideration options. The QIO may make a decision even if not all the requested information has been received. The QIO will try to contact you to discuss your concerns with the termination or discharge.

You have the right to file for an expedited reconsideration with the Qualified Independent Contractor (QIC), a company that didn't take part in the first request, if you are dissatisfied with the results of the expedited redetermination by the QIO. The request must be filed by noon of the calendar day following notification of the QIO expedited redetermination decision.

### Original Medicare Expedited Appeal

- QIO must notify provider immediately
- Provider must give you detailed explanation of non-coverage
  - Usually by COB same day QIO notifies the provider
- Determination by QIO
  - No later than 72 hours after receipt of request

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## SLIDE 26 *Speaker's Notes*

You also have the right to a fast-track appeals process if you are in a Medicare Advantage Plan. This process is available when you believe your services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. The provider or plan must give you a Notice of Medicare Non-coverage (NOMNC) at least 2 days before your services are expected to end. If you appeal, the plan must give you a *Detailed Explanation of Non-coverage*.

In general, you will get a decision within approximately 2 days from the QIO that will decide if your services need to continue.

### MA Fast-Track Appeals Process

- Your right when services are ending too soon
  - Skilled nursing facility
  - Home health agency
  - Comprehensive outpatient rehabilitation facility
- Provider or plan must give Notice of Medicare Non-coverage (NOMNC)
  - At least 2 days before services end
- Plan must give *Detailed Explanation of Non-coverage*
- Decision from QIO within 2 days

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# SLIDE 27

## *Exercise*

A. No matter how you have chosen to get your Medicare benefits you can get emergency care anywhere in the United States.

1. True
2. False

### Exercise

A. No matter how you have chosen to get your Medicare benefits you can get emergency care anywhere in the United States

1. True
2. False

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## Module 2: Your Medicare Rights and Protections

# SLIDE 28

## *Exercise*

- B. Your appeal rights listed on the back of the Medicare Summary Notice (MSN) include:
1. Information about why Medicare didn't pay your bill
  2. How you can appeal
  3. The time limit for filing your appeal
  4. All of the above

### Exercise

- B. Your appeal rights listed on the back of the Medicare Summary Notice (MSN) include:
1. Information about why Medicare didn't pay your bill
  2. How you can appeal
  3. The time limit for filing your appeal
  4. All of the above

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# SLIDE 29

## *Exercise*

- C. An insurance company can refuse to issue you a Medigap policy when you are in your Open Enrollment Period.
1. True
  2. False

### Exercise

- C. An insurance company can refuse to issue you a Medigap policy when you are in your Open Enrollment Period
1. True
  2. False

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## Module 2: Your Medicare Rights and Protections

# SLIDE 30

## *Exercise*

D. If you think you are being made to leave the hospital too soon, you should call the Quality Improvement Organization for your state.

1. True
2. False

### Exercise

D. If you think you are being made to leave the hospital too soon, you should call the Quality Improvement Organization for your state

1. True
2. False

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Your Medicare Rights and Protections

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### Notes:

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# SLIDE 31

## *Speaker's Notes*

Medicare has special rules that protect your privacy. You are probably aware of some of these rules when you visit the doctor or pick up a prescription.

### Session Topics

- ✓ Overview
- ✓ Original Medicare
- ✓ Hospital, SNF, and home health care
- Privacy practices in Original Medicare
- Medicare Advantage
- Medicare prescription drug coverage
- More information

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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 32

## Speaker's Notes

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 are enrolled in a Medicare Advantage Plan or other Medicare 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. For more information, go to [www.medicare.gov](http://www.medicare.gov) or call 1-800-MEDICARE (1-800-633-4227).

### Notice of Privacy Practices

- Tells you
  - That Medicare is required to protect the privacy of your personal medical information
  - How Medicare uses and discloses your personal medical information
  - Your rights and how to exercise them
- Published annually in *Medicare & You* handbook
- For more information
  - [www.medicare.gov](http://www.medicare.gov)
  - 1-800-MEDICARE (1-800-633-4227)
    - TTY users call 1-877-486-2048

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Your Medicare Rights and Protections

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### Notes:

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# SLIDE 33

## *Speaker's Notes*

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 Health and Human Services, if necessary, to make sure your privacy is protected
- Where required by law

### Required Disclosures

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

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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 34

## *Speaker's Notes*

Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare program.

For example:

- 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 you and other people with Medicare get quality health care, to provide customer services to you, or to resolve any complaints you have or to contact you about research studies.

### Permitted Disclosures

- Medicare may disclose personal medical information
  - To pay for your health care and
  - To operate the program
  - Examples
    - To Medicare contractors to process your claims
    - To ensure you get quality health care
    - To provide you with customer service
    - To resolve your complaints
    - To contact you about research studies

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Your Medicare Rights and Protections

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### Notes:

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# SLIDE 35

## *Speaker's Notes*

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 receive Medicare data (such as to make sure Medicare is making proper payments and to assist Federal/State Medicaid programs)
- For public health activities (such as reporting disease outbreaks)
- For government health care oversight activities (such as fraud and abuse investigations)
- For judicial and administrative proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing 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

### Other Permitted Disclosures

- Medicare may disclose your personal 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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Your Medicare Rights and Protections

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### Notes:

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## SLIDE 36 *Speaker's Notes*

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 this notice. You may take back ("revoke") your written permission at any time, except if Medicare has already acted based on your permission.

### Additional Privacy Rights and Protections

- Medicare needs written permission (authorization)
  - For any disclosures not required or permitted
- You may revoke your permission at any time

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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 37

## *Speaker's Notes*

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 or at a different place (for example, by sending materials to a P.O. 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.

### 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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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 38

## *Speaker's Notes*

If you believe Original Medicare has violated your privacy rights, you may file a complaint. Your complaint will not affect your benefits under Medicare.

You can file a complaint by:

- Calling 1-800-MEDICARE (1-800-633-4227) and ask to speak with a customer service representative. TTY users should call 1-877-486-2048.
- Contacting the HHS Office for Civil Rights at [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) or by calling 1-866-627-7748. TTY users should call 1-800-537-7697.

### If You Believe Your Privacy Rights Were Violated

- You may file a complaint
  - Call 1-800-MEDICARE (1-800-633-4227)  
TTY users should call 1-877-486-2048 or
  - Contact HHS Office for Civil Rights
    - Visit [www.hhs.gov/ocr/hipaa](http://www.hhs.gov/ocr/hipaa) or
    - Call 1-866-627-7748. TTY users should call 1-800-537-7697.
  - Will not affect your Medicare benefits

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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 39

## *Speaker's Notes*

So far, we've primarily discussed your rights and protections under Original Medicare and the *Notice of Privacy Practices for Original Medicare*. Now, let's discuss your rights and protections if you are in a Medicare Advantage Plan.

### Session Topics

- ✓ Overview
- ✓ Rights in Original Medicare
- ✓ Hospital, SNF, and home health care
- ✓ Privacy practices in Original Medicare
- Medicare Advantage
- Medicare prescription drug coverage
- More information

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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 40

## Speaker's Notes

You these additional rights when you are enrolled in a MA Plan.

- Choose providers in the plan to get the health care you need.
- Get a treatment plan to see a specialist in the plan as often as you and your doctor think you need for a complex or serious medical condition. Women can go directly to a women's health care specialist in the plan (no referral needed) for routine and preventive health care services.
- Find out how the plan pays its doctors if you ask.
- A fair, efficient, and timely process to resolve differences with the plan including the initial decision made by the plan, an internal review, and an independent external review. The right to ask the plan to provide or pay for a service you think should be covered, provided, or continued. A fast appeal process for services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility.
- A fast-track appeals process if you are in a Medicare Advantage Plan if you believe your services from a skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility are ending too soon. The provider or plan must give you a Notice of Medicare Non-coverage (NOMNC) at least 2 days before your services are expected to end. If you appeal, the plan must give you a Detailed Explanation of Non-coverage. In general, you will get a decision within 2 days from the QIO that will decide if your services need to continue.

*(continued)*

### Rights in MA or Other Medicare Plan

- Additional rights and protections
  - Choice of health care providers
  - Access to health care providers
  - Know how your doctors are paid
  - Fair, efficient, and timely appeals process
  - Fast appeals in certain health care settings

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Your Medicare Rights and Protections

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# Module 2: Your Medicare Rights and Protections

## SLIDE 41 *Speaker's Notes*

- You also have the right to file a grievance about other concerns or problems. For example, if you believe there are not enough specialists in the plan to meet your needs, you can file a grievance. Check your plan's membership materials or call your plan to find out how to file a grievance.
- You can call your Medicare Advantage Plan or Medicare Cost Plan to find out if a medical service or supply will be covered, or to get information regarding Skilled Nursing Facility Coverage if you have questions regarding your home health rights and protections.
- You have the right to have your health information kept private.

**NOTE:** You can get a list of your PACE rights and protections by visiting [www.cms.hhs.gov/pace/downloads/prtemp.pdf](http://www.cms.hhs.gov/pace/downloads/prtemp.pdf) on the web. Or, you can call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have a Medicare cost plan, you will need to follow Original Medicare appeal process for any services you receive outside the plan's network.

### Rights in MA or Other Medicare Plan

- Additional rights and protections
  - File a grievance for other concerns and problems
  - Call your plan for information
  - Privacy of your personal health information
  - For PACE rights and protections visit [cms.hhs.gov/pace/downloads/prtemp.pdf](http://cms.hhs.gov/pace/downloads/prtemp.pdf)

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Your Medicare Rights and Protections

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### Notes:

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# SLIDE 42

## *Speaker's Notes*

The plan must tell you in writing how to appeal. If you are in a Medicare Advantage Plan or other Medicare plan, you can appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for an expedited appeal decision.

If your request for an expedited decision is requested or supported by a doctor, the plan must make a decision within 72 hours. You or the plan may extend the time-frame up to 14 days to get more medical information. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, an independent organization that works for Medicare—not for the plan—reviews the decision. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

### Appeals in Medicare Advantage

- Plan
    - Will not pay for a service
    - Does not allow a service
    - Stops a service
  - Can ask for fast (expedited) decision
    - Plan must decide within 72 hours
  - See plan's membership materials
- } Must tell you in writing how to appeal

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# SLIDE 43

## *Speaker's Notes*

This slide outlines the appeals process in a Medicare Advantage Plan. See the laminated Appeals Processes job aid with your materials, or look at the job aid section of your CD suite for a chart of the Part A, B, C, and D Appeal Processes.

- Plan Reconsideration
- Independent Review
- Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Judicial Review

### MA Appeal Process

- Plan Reconsideration
- Independent Review Entity
- Administrative Law Judge
- Medicare Appeals Council
- Federal Court Review

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Your Medicare Rights and Protections

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## SLIDE 44 *Speaker's Notes*

If you are in a Medicare Advantage Plan or Other Medicare Plan and you are filing an appeal, you have special rights. You have the right to ask your plan for a copy of the file that contains your medical and other information regarding your appeal.

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 will cost based on the number of pages contained in the file, plus normal mail delivery.

### Special Rights

- If you file an appeal
  - You have right to plan's files about you
    - Your case file
  - Plan may charge you a reasonable fee
    - For copying and mailing

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Your Medicare Rights and Protections

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## Module 2: Your Medicare Rights and Protections

# SLIDE 45

## *Speaker's Notes*

You may want to call or write your plan and ask for a copy of your file. Look at your *Evidence of Coverage*, or the notice you received that explained why you could not get the services you requested, to get the phone number or address of your plan.

You may also ask to receive a copy of the case file the plan sent to the Independent Review Entity (IRE), currently MAXIMUS Federal Services, Inc. You may call MAXIMUS at 585-425-5210, or you may send a letter to:

MAXIMUS Federal Services, Inc.  
Medicare Managed Care & PACE Reconsideration Project  
Victor, NY 14564-1099

### To Get Your Case File

- Call or write your plan
- For a copy of case file sent to Independent Review Entity (IRE)
  - Contact MAXIMUS Federal Services, Inc.
    - Call 585-425-5210
    - Write  
MAXIMUS Federal Services, Inc.  
Medicare Managed Care & PACE  
Reconsideration Project  
Victor, NY 14564-1099

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## Module 2: Your Medicare Rights and Protections

# SLIDE 46

## *Speaker's Notes*

Medicare works with private drug plans to provide people with Medicare with the high-quality, cost-effective drug coverage they need. All Medicare drug plans must make sure that the people in their plan, their enrollees, have access to medically necessary drugs to treat their conditions.

If you are enrolled in a Medicare Prescription Drug Plan, you are guaranteed certain rights and protections. These rights and protections are the same whether you are in Original Medicare with stand-alone prescription drug plan or a Medicare Advantage Plan with prescription drug coverage.

### Session Topics

- ✓ Overview
- ✓ Rights in Original Medicare
- ✓ Hospital, SNF, and home health care
- ✓ Privacy practices in Original Medicare
- ✓ Medicare Advantage
- Medicare prescription drug coverage
- More information

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# SLIDE 47

## *Speaker's Notes*

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

**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, such as syringes, needles, alcohol swabs, and gauze, are also covered.

Some of the methods plans use to manage access to certain drugs include:

- Formularies
- Prior authorization
- Step therapy
- Quantity limits

CMS requires Medicare drug plans to cover "all or substantially all" medications in six categories:

- Cancer medications
- HIV/AIDS treatments
- Antidepressants
- Antipsychotic medications
- Anticonvulsive treatments for epilepsy and other conditions; and
- Immunosuppressants

### Access to Covered Drugs

- Plans
  - May not cover all Medicare-covered drugs
  - Must ensure enrollees can get drugs they need for their conditions
  - Must include more than one drug in each classification
  - Must pay for brand-name as well as generic drugs
  - May have rules for managing access
  - Must cover all or substantially all drugs to treat certain conditions

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Your Medicare Rights and Protections

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# SLIDE 48

## *Speaker's Notes*

Some new members may already be taking a drug that's not on their plan's drug list or that is a step therapy drug\*. Medicare requires the plans to provide a standard 30-day transition supply of all Medicare-covered drugs, even if the prescription is for a drug that's not on the plan's drug list, is a step-therapy drug\*, or requires prior authorization. This gives you and your doctor 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 doctor believes that because of your medical condition you must take a certain drug, the doctor can contact the plan to request an exception to the formulary rules. If the doctor's request is approved, the plan will cover the drug.

It is important to understand how to work with your plan's formulary and to plan ahead. If you receive a transition supply, you shouldn't wait until that supply is gone to take action. You should talk to your doctor about prior authorization if necessary, about safe and effective alternative drugs that may also save you money, or to request an exception if necessary for your condition. You should contact your drug plan with any questions about what is covered by the plan.

\* With step therapy drugs, in most cases the plan member must first try certain less-expensive drugs that have been proven effective for most people with that condition.

### Transition Supply

- Plans must fill prescriptions not on plan's list
  - For new enrollees
  - For 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 list
  - If medically necessary, request an exception

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Your Medicare Rights and Protections

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# SLIDE 49

## *Speaker's Notes*

If your doctor needs to prescribe a drug that isn't on the Medicare drug plan's drug list, you or that doctor can request an exception from the plan. An exception request is a kind of coverage determination. A coverage determination is the first decision a plan makes about the benefits you are entitled to receive.

The first step in requesting an exception is to contact the drug plan. The plan will advise how to submit the request and the information needed to make a decision. Your doctor must submit a statement supporting the request. The doctor's statement must indicate that the requested drug is "medically necessary" for treating the enrollee's condition, and must explain why none of the formulary alternatives will work or why a coverage rule cannot be satisfied.

### Requesting an Exception

- Can request an exception
  - Drugs not on plan's formulary
  - Drug with special coverage rules
- Contact the plan
  - How to submit request
  - What information to submit
  - Prescribing doctor
    - Must submit supporting statement
    - Must indicate drug is "medically necessary"

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### Notes:

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# SLIDE 50

## *Speaker's Notes*

Once the exceptions request is submitted, a plan must inform you and your prescribing physician, if appropriate, of its decision on the exceptions request as quickly as your health condition requires, but no later than 24 hours after receipt of an expedited request and no later than 72 hours after receipt of a standard request.

### Requesting an Exception

- After receiving physician's statement
  - Plan must notify you
    - As quickly as your condition requires
    - Within 24 hours (expedited) or
    - Within 72 hours (standard)

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## SLIDE 51 *Speaker's Notes*

If a plan uses a tiered cost-sharing structure to manage its Medicare drug benefit, it must provide exceptions procedures that permit enrollees to obtain a non-preferred drug at the more favorable cost-sharing level for drugs in the preferred tier.

A plan must grant a tiering exception when it determines that the preferred drug for treatment of your condition would not be as effective for you as the requested drug and/or it would have adverse effects.

When a tiering exception is approved, the plan must provide coverage at the cost-sharing level that applies for preferred drugs, but not at the generic cost-sharing level. Also, if a plan maintains a formulary tier in which it places very high cost and unique items, it may design its exception process so that drugs placed in that tier are not eligible for a tiering exception.

### Tiering Exception

- Gives access to non-preferred drug
  - At lower cost of drugs in the preferred tier
  - If preferred drug
    - Would not be as effective
    - Would have adverse effects

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### Notes:

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# SLIDE 52

## *Speaker's Notes*

Formulary exceptions ensure enrollees have access to Medicare-covered drugs that are not 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 formulary exception is approved, the plan has the flexibility to determine what level of cost sharing will apply for the non-formulary drug(s). For example, a plan sponsor may apply the non-preferred level of cost sharing for all non-formulary drugs approved under the exception process.

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 would have adverse effects. A plan must grant an exception to a coverage rule when it determines that coverage rule has been or is likely to be ineffective in treating the enrollee's condition, or is likely to cause harm to the enrollee.

### Formulary Exception

- Gives access to drugs
  - Not on plan's formulary
  - For which plan has special coverage rules
- Plan determines level of cost sharing

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## SLIDE 53 *Speaker's Notes*

Approved exceptions are valid for refills for the remainder of the plan year, as long as the following are true.

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

If the plan chooses to extend coverage of an exception into a following plan year, the plan will notify members of coverage for the following year either at the time of approval or at the end of the plan year. If a plan does not extend coverage of an exception into a following plan year, you may need to consider switching to a drug on your plan's formulary, requesting another exception, or changing plans during the Annual Coordinated Election Period, November 15-December 31 of each year.

**Note:** Unlike an approved exception, which is valid for the remainder of the plan year, satisfying a prior authorization requirement may not be valid for the rest of the year. If you satisfy a plan's prior authorization requirement, it is generally only valid for the number of refills written in the prescription.

### Approved Exceptions

- Valid for remainder of plan year, if
  - You remain enrolled in plan
  - Physician continues to prescribe drug
  - Drug remains safe for treating your condition

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Your Medicare Rights and Protections

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### Notes:

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# SLIDE 54

## Speaker's Notes

If the plan still won't cover a specific drug, you may appeal the decision. There are five levels of appeal, beginning with an appeal to the plan. You will receive information about the plan's appeal procedures when you enroll. Expedited appeals take only a few days.

Either you or a representative appointed by you, such as a doctor or family member, may request a coverage determination or an appeal. An appointment of representation form or letter must be filed with the plan sponsor if you want your representative to file an appeal for you. More information about these appeals is available in your *Evidence of Coverage* notice or on [www.medicare.gov](http://www.medicare.gov) on the web, or you can contact the drug plan for information on its exception and appeals process.

### Appeals

- Can appeal a determination decision
- Five levels of appeal
  - First level is appeal to the plan
- Will receive information upon enrollment
- Expedited appeals take only a few days
- An appointed representative may appeal
- Appeals must generally be submitted in writing

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# SLIDE 55

## *Speaker's Notes*

You can appeal your Medicare drug plan's unfavorable decision. Any representative you appoint (like a doctor or family member) may help request an appeal. You'll get the plan's appeal procedures when you enroll. There are five levels of appeal. See the laminated Appeals Processes job aid with your materials, or look at the job aid section of your CD suite for a chart of the Part A, B, C, and D Appeal Processes.

1. Appeal to the plan
2. Reconsideration by an independent review entity (IREO)
3. Hearing with an administrative law judge
4. Review by the Medicare Appeals Council
5. Judicial review by a U.S. district court

### Levels of Appeal

- Appeal to the plan
- Independent review entity reconsideration
- Administrative law judge hearing
- Medicare Appeals Council
- U.S. Federal Court review

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Your Medicare Rights and Protections

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### Notes:

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# SLIDE 56

## *Speaker's Notes*

Plans sponsors are required to provide written notices after every adverse coverage determination or appeal.

In addition, all appeal entities are required to send written notice when they make adverse decisions. These notices will explain the decision, include information on the next appeal level, and provide specific instructions about how to file the appeal.

### Required Notices

- After every
  - Adverse coverage determination
  - Adverse appeal determination
- Include information on next appeal level
- Include specific instructions

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## SLIDE 57 *Speaker's Notes*

relevant protected health information (PHI) to someone who assists you, specifically regarding the drug benefit. 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 next slide)

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

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

### Health Plans' Disclosure of Protected Health Information (PHI)

- Plan may disclose relevant PHI to
  - People you identify
  - Who are involved in your care or payment, like
    - Family member or other relative
    - Close personal friend
    - Others (see examples on next slide)
  - Only under certain conditions

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## Module 2: Your Medicare Rights and Protections

# SLIDE 58

## *Speaker's Notes*

Examples of when a plan may disclose PHI:

- To the daughter of a person with Medicare who is resolving a claim or payment issue for her hospitalized mother
- To a human resources representative if the person with Medicare is on the line or gives permission by phone
- To a Congressional office or staff person that has faxed the person's request for Congressional assistance
- To CMS staff if the available information satisfies the plan that the individual requested CMS assistance

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

### When Plan May Disclose PHI

Examples

- To a daughter
  - To resolve claim or payment issue for mother in hospital
- To human resources representative
  - If you are on the line or give permission by phone
- To Congressional office
  - That faxed your request for Congressional assistance
- To CMS
  - If information satisfies plan that you requested CMS assistance

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### Notes:

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# SLIDE 59

## *Exercise*

- A. Medicare **must** disclose your personal medical information
1. To your spouse
  2. To you
  3. When requested by your pharmacy
  4. All the above

### Exercise

- A. Medicare **must** disclose your personal medical information
1. To your spouse
  2. To you
  3. When requested by your pharmacy
  4. All the above

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Your Medicare Rights and Protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

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## *Exercise*

B. If you are in a Medicare Advantage plan, you have a right to know how your plan is paid.

1. True
2. False

### Exercise

B. If you are in a Medicare Advantage plan, you have a right to know how your plan is paid.

1. True
2. False

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Your Medicare Rights and Protections

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### Notes:

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## SLIDE 61

### *Exercise*

C. Some Medicare Prescription Drug Plans pay for only brand-name drugs.

1. True
2. False

### Exercise

C. Some Medicare Prescription Drug Plans pay for only brand-name drugs.

1. True
2. False

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### Notes:

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## Module 2: Your Medicare Rights and Protections

# SLIDE 62

## *Speaker's Notes*

Let's take the last few minutes to discuss where you can get more information.

### Session Topics

- ✓ Overview
- ✓ Rights in Original Medicare
- ✓ Hospital, SNF, and home health care
- ✓ Privacy practices in Original Medicare
- ✓ Medicare Advantage
- ✓ Medicare prescription drug coverage
- More information

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### Notes:

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# SLIDE 63

## *Speaker's Notes*

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

Making future health care decisions is another health care protection available to anyone, not just people with Medicare.

Let people know what kind of treatment you want if you lose the ability to make your own health care decisions in the future. You need to fill out a "health care advance directive." An advance directive is a written document in which you give directions about who you want to speak for you and what kind of health care you want or don't want in the event you cannot speak for yourself.

### Future Health Care Decisions

- Let people know your wishes
  - About the health care you want
  - If you can't speak for yourself
- Complete "health care advance directive"
  - 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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### Notes:

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# SLIDE 64

## *Speaker's Notes*

Another protection for people with Medicare is the Medicare Beneficiary Ombudsman's office. The Medicare Beneficiary Ombudsman works to ensure that people with Medicare get the information and help they need to understand their Medicare options and to apply their rights and protections.

The Ombudsman may identify issues and problems in payment and coverage policies, but doesn't advocate for any increases in program payments or new coverage of services.

### Medicare Ombudsman

- Works to ensure people with Medicare
  - Get information and help they need
  - Understand their Medicare options
  - Apply their rights and protections
- May identify issues and problems with
  - Payment policies
  - Coverage policies

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### Notes:

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## SLIDE 65 *Speaker's Notes*

The Medicare Ombudsman works to make sure the organizations that should help you with your complaints, appeals, grievances, or questions about Medicare work the way they should and respond to you promptly.

For example, the Medicare Beneficiary Ombudsman can help in the following situations.

- You need help to file an appeal.
- You have a problem joining or leaving a Medicare Advantage Plan (like an HMO or PPO) or other Medicare plan, or a Medicare Prescription Drug Plan.
- You have questions about Medicare premiums.
- You need help understanding your Medicare rights and protections.

### Medicare Ombudsman

- Ensures prompt organization response if you
  - Need help filing an appeal
  - Have a problem joining or leaving an MA Plan
  - Have questions about Medicare premiums
  - Need help understanding rights/protections

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### Notes:

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## Module 2: Your Medicare Rights and Protections

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## *Speaker's Notes*

There are a number of resources you can use to get more information or assistance regarding your Medicare rights and protections:

- 1-800-MEDICARE (1-800-633-4227)
- *Medicare & You* handbook
- *Your Medicare Rights and Protections* booklet, CMS Pub. No. 10112
- Your local State Health Insurance Assistance Program (SHIP)
- **www.medicare.gov** on the web. You can get information specifically about Medicare appeals and grievances at **www.medicare.gov/basics/appeals.asp**

### For Information and Assistance

- 1-800-MEDICARE (1-800-633-4227)
  - TTY/TDD 1-877-486-2048
- *Medicare & You* handbook
- *Your Medicare Rights and Protections* booklet
- State Health Insurance Assistance Program
- **www.medicare.gov**
  - [www.medicare.gov/basics/appeals.asp](http://www.medicare.gov/basics/appeals.asp)

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### Notes:

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## Module 2: Your Medicare Rights and Protections

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## *Speaker's Notes*

Some other resources for help regarding your Medicare rights and protections include:

- Your state Quality Improvement Organization (QIO)
  - You can find the number for your QIO at [www.medicare.gov/Contacts](http://www.medicare.gov/Contacts) on the web
- Independent Review Entity
- [www.medicareappeals.com](http://www.medicareappeals.com) for Medicare Advantage claims
- [www.medicarepartdappeals.com](http://www.medicarepartdappeals.com) for Part D claims
- Medicare Ombudsman
  - [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)

### For Information and Assistance (continued)

- State Quality Improvement Organization (QIO)
- Independent Review Entity
  - [www.medicareappeals.com](http://www.medicareappeals.com) for MA claims
  - [www.medicarepartdappeals.com](http://www.medicarepartdappeals.com) for Part D claims
- Medicare Ombudsman
  - [www.cms.hhs.gov/center/ombudsman.asp](http://www.cms.hhs.gov/center/ombudsman.asp)

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## Module 2: Your Medicare Rights and Protections

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## *Speaker's Notes*

In summary, it's important to remember that, as a person with Medicare, you have certain guaranteed rights. You have the right to get the health care services you need and to get easy-to-understand information about Medicare, what costs it pays, and how much you have to pay. And you have a right to know what to do if you want to file an appeal or complaint. You also have the right to have your medical information kept private.

### Key Concepts

- You have certain guaranteed rights
  - To get health care services you need
  - To receive easy-to-understand information
  - To have your medical information kept private
  - To file an appeal or complaint

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Your Medicare Rights and Protections

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