

What a Beneficiary can do if Medicare Refuses to Pay for a Medical Service

This Medicare topic sheet was prepared by Leslie Fried, Director of the Alzheimer's Association Medicare Advocacy Project.

If Medicare refuses to pay for a service under original fee-for-service Part A or Part B, the beneficiary should receive a denial notice. The medical provider is responsible for submitting a claim to Medicare for the medical service or procedure. If Medicare denies payment of the claim, it MUST be in writing and state the reason for the denial. This notice is called the Medicare Summary Notice (MSN) and is usually issued quarterly.

Look for the reasons for denial

The notice must state the reason for the denial. Sometimes payment is denied because of a problem with the claim form (i.e. missing information, included errors, or incorrect codes.) Other times, the notice states that the service or procedure was "not medically necessary" or that the case "does not support the need for this many visits or treatments." If the claim was denied due to a local coverage rule (called local coverage determination), it must be stated on the notice. In addition, the notice must identify the applicable local coverage determination and how to obtain a copy of it.

What the beneficiary/caregiver can do

If the claim is denied because there is a problem with the claim form, contact the provider or the provider's billing office and ask them to correct the mistake and resubmit the claim. The beneficiary/caregiver can also file an appeal as provided in the notice.

If the claim is denied because the medical service/procedure was "not medically necessary," there were "too many or too frequent" services or treatments or due to a local coverage determination, the beneficiary/caregiver may want to file an appeal of the denial decision.

Appeal the denial of payment

The standard appeal procedures for Part A and Part B of the Original (fee-for-service) Medicare program has five levels and are similar. There is also an expedited appeals process for individuals who are being discharged or whose services are being terminated in a skilled nursing facility, home health, hospice or comprehensive outpatient rehabilitation facilities (CORF).

The appeal procedure must be included on the denial notice. Read the instructions carefully. Be sure to file the appeal within the stated time requirements. If the claim was denied because it was "not medically necessary" or the services "too many or too frequent," it is helpful to submit supporting information from the treating doctor and other medical providers.

Where to find help

Beneficiaries/caregivers can get free assistance from the local legal services for senior citizens program (Title IIIB provider), the Area Aging Agency and the State Health Insurance Counseling and Assistance Program (SHIP).

The Alzheimer's Association is the leading voluntary health organization in Alzheimer care, support and research.
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1.800.272.3900