What a beneficiary can do if Medicare refuses to pay for a medical service

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 reason for denial.
The notice must state the reason for the denial. Sometimes payment is denied because of a problem with the claim form (e.g., missing information, 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 "local coverage determination" (a local coverage rule), it must be stated on the notice. In addition, the notice must identify the applicable local coverage determination and how to obtain a copy.

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 Original fee-for-service Medicare have five similar levels. There is also an expedited appeals process for individuals who are being discharged or whose services are being terminated in a hospital, 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 were "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 older Americans program (Title IIIB provider), the local Area Agency on Aging and the State Health Insurance Assistance Program (SHIP).

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