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INSURANCE SOLUTIONS

Medicare Newsletter

November 2017

Medicare Appeals for Care that is Ending

If you are receiving care in a hospital or non-hospital setting and learn that your care is going to end, you have the right to a fast appeal to request that Medicare cover continued care. This is known as an expedited review.

Non-hospital settings include skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), hospice settings, and home health settings.

Step 1: Read your appeal notices.

Important Message from Medicare notice. You get this notice when you are a **hospital inpatient.**

Your provider should give you this notice within two days of entering the hospital. This notice should be given to you again no later than four hours before you are discharged. This notice includes instructions for how to appeal.

Notice of Medicare Non-Coverage. You get this notice when you are **receiving non-hospital care.**

You can use the entire Fall Open Enrollment Period to make your decisions. You will not receive extra benefits for signing up early for a plan.

If you disagree with your facility's decision to end your care, start an appeal (see step 2 on next page) by contacting your Quality Improvement Organization (QIO) at the number listed on your Important Message or Notice of Medicare Non-Coverage.

Step 2: Start your appeal.

If your hospital care is ending: File an appeal with QIO by **midnight** of the day of your discharge. The QIO should call you with its decision within **24 hours** of receiving all the information it needs. If the QIO decides your care should end, you will be responsible for paying for any care you receive after noon of the day after the QIO makes its decision.

Additional Resources

To schedule an appointment with a Medicare Specialist:

Call 866-448-0160 or email medicare@connexioninsurance.com

If your non-hospital care is ending: File an appeal with QIO by **noon** of the day **before** your care is set to end. If you have **Original Medicare**, the QIO should make a decision no later than two days after your care was set to end.

If you have a **Medicare Advantage Plan**, the QIO should make a decision no later than the day your care is set to end.

If the QIO decides your care should end, you will be responsible for paying for any care you receive after the end date on the Notice of Medicare Non-Coverage.

Step 3: If you are denied, continue your appeal.

If the QIO appeal is successful, your care will continue to be covered, including for the time you were appealing. If the QIO decides that your care should end, you can file a second appeal within the timeframe on your QIO denial notice.

The timing and agency involved depend on which type of care is ending and whether you have Original Medicare or a Medicare Advantage Plan.

Additional Resources

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