

Original Medicare and Medicare Advantage Appeals

1. What are Medicare appeals?

An appeal is a formal request for review of a decision made by Original Medicare or your Medicare Advantage or Part D plan. If you were denied coverage or authorization for a health service or item, you may appeal the decision.

Before you start your appeal, make sure you fully read all the letters and notices sent by Medicare and/or your plan. Call 1-800-MEDICARE (1-800-633-4227) or your private health or drug plan to learn why your coverage is being denied, if the information was not provided. Your appeal letter should address the reason(s) for denial stated by Medicare or your plan. You can strengthen your appeal by including a letter from your doctor in support of your appeal.

There is more than one level of appeal, and you have the right to continue appealing if you are not successful at the first level. Be aware that at each level there is a separate timeframe for when you must file the appeal and when you will receive a decision. Make sure to file each appeal in a timely manner. If there is a reason you cannot submit your appeal within the timeframe, see whether you are eligible for a good cause extension (see question 6). Otherwise, your appeal may not be considered.

Keep in mind that an appeal is different from a grievance. A grievance is a formal complaint that you file with your plan (see question 8) about a plan's action.

Keep in mind that you will follow a different appeals process than the ones listed below if you are appealing the denial of a Part D-covered prescription drug or if you disagree with a hospital's or skilled nursing facility's decision to discharge you or with a home health agency's or hospice's decision to end your care.

2. How can I file a standard appeal with Original Medicare/?

If you have Original Medicare and your health service or item was denied, you have the right to appeal. An appeal is a formal request you make if you disagree with a coverage or payment decision. Check your Medicare Summary Notice (MSN) to see if Medicare has paid for your services and how much you may owe your provider. If your MSN says that Medicare did not pay for a service, and you think it should, call your doctor to make sure there was not a billing error before appealing.

Note: You can also appeal if you signed an Advance Beneficiary Notice (ABN). An ABN is given to you when a provider or supplier thinks that Medicare might not cover a service or item. Before appealing, make sure that Medicare was billed and that you received a denial.

Follow the steps below if your health service or item was denied. Note that these steps are for a standard appeal, which you file if you have already received the service but Medicare is denying payment. You should file an expedited appeal if you disagree with a hospital's or skilled nursing facility's plans to discharge you, or if you disagree with a home health agency's or hospice's plans to end your care. For all kinds of appeal, you should keep a copy of all documents sent and received during the process.

1. Start your appeal by following the appeal instructions listed on your MSN or Redetermination Request form. This includes circling the denied service listed and filling out the shaded section at the end of the MSN. Then, send your appeal to the Medicare Administrative Contractor (MAC) within 120 days of the date on your MSN. (The MAC's name and address are listed in the shaded section of your MSN.) This will start your appeal. The MAC should make a decision within 60 days.
 - If your provider sends you a bill for this service, let your provider's billing office know that you are in the process of appealing Medicare's coverage decision.
 - If you have a good reason for missing your appeal deadline, you may be eligible for a good cause extension (see question 6).
2. If your appeal is successful, your service or item will be covered. If your appeal is denied, you can move on to the next level by appealing to the Qualified Independent Contractor (QIC) within 180 days of the date listed on the MAC denial letter. The QIC may go by a different name in your area. Follow the instructions on the MAC denial notice to file your appeal. The QIC should make a decision within 60 days.
3. If your QIC appeal is successful, your service or item will be covered. If your appeal is denied and your health service or item is worth at least \$200 in 2026, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level. You must file your OMHA level appeal within 60 days of the date on your QIC denial letter. If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required. OMHA should make a decision within 90 days.
4. If your appeal to the OMHA level is successful, your service or item will be covered. If your appeal is denied and your health service or item is worth at least \$200 in 2026, you can choose to appeal to the Council within 60 days of the date on your OMHA level denial letter.
 - You may not receive an OMHA level decision within 90 days. If your appeal has spent more than 90 days at the OMHA level, you can ask OMHA to move the appeal to the next level (the Council). Speak to an attorney to see if proceeding directly to the Council may be appropriate for you.
5. If your appeal to the Council is successful, your service or item will be covered. If your appeal is denied and your health service or item is worth at least \$1,960 in 2026, you can choose to appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision.

3. How can I file a pre-service standard appeal with my Medicare Advantage plan?

If you have a Medicare Advantage plan and you were denied coverage or authorization for a health service or item before you received the service or item, you can appeal to ask your plan to reconsider its decision. Follow the steps below if you feel that the health service or item should be covered by your plan.

Note: You will follow different appeal processes and timeline if your plan has denied coverage for care you have already received (see question 4) or a prescription drug.

1. Before you can start your appeal, you will need to get an official written decision from your plan, called a Notice of Denial of Medical Coverage. You are typically first told verbally that your plan will not cover a service or item when you or your doctor call to confirm coverage before the service is provided.

If the plan tells you that the service or item will not be covered, they should also send you the Notice of Denial of Medical Coverage. You should receive this written denial within 14 days.

- You can request a fast (expedited) appeal if you or your doctor feel that your health could be seriously harmed by waiting the standard timeline for appeal decisions. If your plan approves your request to expedite, it should issue a decision within 72 hours. For this and the following levels of appeal, your doctor can ask that the plan follow the expedited timeline.
2. Start your appeal by following the instructions on the Notice of Denial of Medical Coverage. Make sure to file your appeal within 60 days of the date on this notice. You will need to send a letter to your plan explaining why you need the service or item. You may also want to ask your doctor to write a letter of support, explaining why you need care and addressing the plan's concerns. Your plan should make a decision within 30 days. If you file an Expedited Appeal, your plan should make a decision within 72 hours.
 - In some cases, your plan can extend its decision deadline up to 14 days. You should be notified if this happens.
 - If you don't receive a Notice of Denial of Medical Coverage within two weeks (or 28 days if your plan extended its decision deadline), you can file an appeal without it. Start your appeal by sending a letter to your plan explaining that it has been two weeks since you initially requested an item or service, and you have not received a denial notice. If possible, include a doctor's letter of support. You may also want to file a grievance.
 - If you have a good reason for missing your appeal deadline, you may be eligible for a good cause extension (see question 6).
 3. If the appeal is successful, your service or item will be covered. If your appeal is denied, you should receive a written denial notice. Your plan should also automatically forward your appeal to the next level, the Independent Review Entity (IRE). The IRE should make a decision within 30 days of the date on your plan denial notice. If you file an expedited appeal, the IRE should make a decision within 72 hours.
 - If your plan misses the 30-day decision deadline, your appeal will be considered denied, and your plan should automatically forward your appeal to the IRE.
 4. If your appeal to the IRE is successful, your service or item will be covered. If your IRE appeal is denied and your service or item is worth at least \$200 in 2026, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level. You must file your OMHA level appeal within 60 days of the date on your IRE denial letter. If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required.
 5. If your appeal to the OMHA level is successful, your service or item will be covered. If your appeal is denied and your service or item is worth at least \$200 in 2026, you can appeal to the Council within 60 days of the date on your OMHA level denial letter. There is no decision timeframe for the Council to make a decision about your appeal.
 6. If your appeal to the Council is successful, your service or item will be covered. If your appeal is denied and your service or item is worth at least \$1,960 in 2026, you can appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision about your appeal.

4. How can I file a post-service appeal with my Medicare Advantage plan?

If you have a Medicare Advantage plan and were denied coverage for a health service or item that you have already received, you may choose to appeal to ask your plan to reconsider its decision. Follow the steps below if you think the denied health service or item should be covered by your plan.

1. You should receive a written notice from your plan stating that it is not covering your health service or item. This can either be an Explanation of Benefits (EOB) or a notice titled Notice of Denial of Payment. The notice should explain what you need to do to appeal and the reason your care is not being covered.
 - Remember, an EOB is not a bill. If your EOB states that a service was not paid for by your plan, call your plan to ask why. It may be a billing or coding error. If it is a denial, you should begin your appeal.
2. Start your appeal by following the instructions on the notice you received from your plan. Make sure to file your appeal within 60 days of the date on the notice. You will most likely need to send a letter to the plan explaining why you needed the service you received. You may also want to ask your doctor to write a letter of support, explaining why you need care and addressing the plan's concerns. Your plan should make a decision within 60 days.
 - If you have a good reason for missing your appeal deadline, you may be eligible for a good cause extension (see question 6).
3. If your appeal is successful, your service or item will be covered. If your appeal is denied, you should receive a written denial notice. Your plan should automatically forward your appeal to the next level, the Independent Review Entity (IRE). The IRE should make a decision within 60 days of the date on your plan denial notice.
 - If your plan misses the 60-day decision deadline, your appeal will be considered denied, and your plan should automatically forward your appeal to the IRE.
4. If your appeal to the IRE is successful, your service or item will be covered. If your IRE appeal is denied and your care is worth at least \$200 in 2026, you can choose to appeal to the Office of Medicare Hearings and Appeals (OMHA) level. You must file your OMHA level appeal within 60 days of the date on your IRE denial letter. If you decide to appeal to the OMHA level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal—but this is not required.
5. If your appeal to the OMHA level is successful, your service or item will be covered. If your appeal is denied and your health service or item is worth at least \$200 in 2026, you can appeal to the Council within 60 days of the date on your OMHA level denial letter. There is no decision timeframe for the Council to make a decision.
6. If your appeal to the Council is successful, your care will be covered. If your appeal is denied and your health service or item is worth at least \$1,960 in 2026, you can appeal to the Federal District Court within 60 days of the date on your Council denial letter. There is no timeframe for the Federal District Court to make a decision.

5. What are tips for making a strong appeal?

Here are some general tips that may help you through the appeal process:

- Make sure you fully read and understand all notices sent by Medicare or by your Medicare Advantage plan.

- Call 1-800-MEDICARE (if you have Original Medicare) or your Medicare Advantage plan to learn why your health service or item is being denied, if the information was not provided. Your appeal letter should address the reason(s) for denial stated by Medicare or your plan.
- If you need help understanding coverage rules surrounding your appeal, you can call 1-800-MEDICARE or your State Health Insurance Assistance Program (SHIP). Contact information for your local SHIP is on the last page of this document.
- Include a letter from your doctor in support of your appeal.
- Make sure to meet appeal deadlines. If there is a reason you cannot submit your appeal within the timeframe, request a good cause extension (see question 6).
- Keep a copy of all documents sent and received during the process.
 - If possible, send your appeal certified mail or delivery confirmation.
 - Do not send the original copies of important documents.
- Keep any notices you receive from Medicare and write down the names of any representatives you speak to, the date and time you spoke, and what you spoke about.

6. How should I request a good cause extension?

When initially filing an appeal and for each subsequent level, you have a limited amount of time to file. That said, after the deadline has passed, if you can show good cause for not filing on time, your late appeal may be considered. You can request a good cause extension at any level of appeal, and it is available for Original Medicare, Medicare Advantage, and Part D appeals. Extension requests are considered on a case-by-case basis, so there is no complete list of acceptable reasons for filing a late appeal, but some examples include:

- The notice you are appealing was mailed to the wrong address.
- A Medicare representative gave you incorrect information about the claim you are appealing.
- Illness—either yours or a close family member’s—prevented you from handling business matters.
- The person you are helping appeal a claim is illiterate, does not speak English, or could not otherwise read or understand the coverage notice.

If you think you have a good reason for not appealing on time, send in your appeal as you normally would and include a clear explanation of why your appeal is late. If the reason has to do with illness or other medical conditions, a letter or supporting documentation from your health care provider can be helpful.

7. Can I still appeal if I signed an Advance Beneficiary Notice?

You can still appeal if you signed an Advance Beneficiary Notice (ABN). An ABN is a notice a provider should give you before you receive a service if, based on Medicare coverage rules, your provider has reason to believe Medicare will not pay for the service. You may receive an ABN if you have Original Medicare, but not if you have a Medicare Advantage plan. The ABN may look different, depending on the type of provider who gives it to you.

While the ABN serves as a warning that Medicare may not pay for the care your provider recommends, it is possible that Medicare will pay for the service. To get an official decision from Medicare, you must first sign the ABN, agreeing to pay if Medicare does not, and receive the care. Make sure you request that your provider bills Medicare for the service before billing you (the ABN may have a place on the form where you can elect

this option). Otherwise, your provider is not required to submit the claim, and Medicare will not provide coverage.

Medicare has rules about when you should receive an ABN and how it should look. If these rules are not followed, you may not be responsible for the cost of the care. However, you may have to file an appeal to prove this.

If your MSN you later receive shows that Medicare has denied payment for a service or item, you can choose to file an appeal. Remember, receiving an ABN does not prevent you from filing an appeal, as long as Medicare was billed. You may not be responsible for denied charges if the ABN:

- Is difficult to read or hard to understand
- Is given by the provider (except a lab) to every patient with no specific reason as to why a claim may be denied
- Does not list the actual service provided, or is signed after the date the service was provided
- Is given to you during an emergency or is given to you just prior to receiving a service (for instance, immediately before an MRI)

You also may not be responsible for denied charges if an ABN was not provided when it should have been. You may not need to pay for care if you meet all of the following requirements:

1. You did not receive an ABN from your provider before you were given the service or item
2. Your provider had reason to believe your service or item would not be covered by Medicare
3. Your item or service is not specifically excluded from Medicare coverage
4. Medicare has denied coverage for your item or service

8. When and how should I file a grievance?

If you are dissatisfied with your Medicare Advantage or Part D prescription drug plan for any reason, you can choose to file a grievance. A grievance is a formal complaint that you file with your plan. It is not an appeal, which is a request for your plan to cover a service or item it has denied. Times when you may wish to file a grievance include if your plan has poor customer service or you face administrative problems (such as the plan taking too long to file your appeal or failing to deliver a promised refund). In some cases, you may want to file both an appeal and a grievance.

To file a grievance, send a letter to your plan's Grievance and Appeals department. Check your plan's website or contact them by phone for the address. You can also file a grievance with your plan over the phone, but it is best to send your complaints in writing. Be sure to send your grievance to your plan within 60 days of the event that led to the grievance. You may also want to send a copy of the grievance to your regional Medicare office and to your representatives in Congress, if you feel they should know about the problem. Go to www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) to find out the address of your regional Medicare office. Keep a copy of any correspondence for your records.

Your plan must investigate your grievance and get back to you within 30 days. If your request is urgent, your plan must get back to you within 24 hours. If you have not heard back from your plan within this time, you can check the status of your grievance by calling your plan.

9. What are skin substitutes and how can I recognize skin substitute fraud?

Skin substitutes are specialized treatment for wounds that are not healing. These wounds could be from infections, burns, injuries, bites, cysts, or diabetes, just to name a few causes. When these wounds persist long-term and are not healing, they may need more advanced treatment. Skin substitutes act as a protective cover and support new tissue growth. They can be made from biological materials (like donated human or animal tissue) or synthetic materials. For more complicated wounds, there are surgical treatments like skin grafts—when healthy skin from one part of the body is used to cover or repair damaged skin on another part of the body. Medicare costs for skin substitutes have skyrocketed, surpassing \$10 billion annually by the end of 2024. Data show that they are vulnerable to fraud schemes.

Here are red flags signaling potential wound care fraud that you can look out for:

- Someone other than your health care provider (like a sales representative) offers to order you wound care.
- Someone comes to your home and applies wound care in ways that seem odd—like a skin substitute over healthy skin where there isn't a wound, several on a single wound, or very large substitutes on small wounds. This could signal an over-ordering and over-use of skin substitutes.
- Your loved one in hospice care is offered complicated wound care from a sales representative. Patients nearing the end of their lives can be vulnerable to wound care fraud.
- You see claims on your Medicare statements for wound care that you did not receive, or for a different type or amount of wound care than you received.

Skin substitutes may appear on your Medicare statements using the following billing codes:

- Skin substitute products: Q4100-Q4397
- Application of skin substitutes: 15271-15278

If you suspect you may have experienced potential Medicare fraud, errors, or abuse contact your local Senior Medicare Patrol (SMP). Contact information for your local SMP is on the last page of this document.

10. Who should I contact for more help?

State Health Insurance Assistance Program (SHIP): Contact your SHIP for counseling around appeals. Contact information for your local SHIP is on the last page of this document.

Medicare / your Medicare Advantage plan: Contact 1-800-MEDICARE (633-4227) or your Medicare Advantage plan for more information regarding their denial.

Your health care provider: Request a letter from your doctor in support of your appeal.

Senior Medicare Patrol (SMP): Contact your SMP if you believe you have experienced potential Medicare fraud, errors, or abuse. Contact information for your local SMP is on the last page of this document.

SHIP case example

Lucille is 67 years old and has a Medicare Advantage plan. She received a screening for abdominal aortic aneurysm (AAA) a couple months ago because her doctor recommended it. She just received a letter in the mail from her plan. The letter listed the AAA screening and several other services, and it said that the AAA screening would not be covered by the plan.

What should Lucille do?

- Lucille can contact her State Health Insurance Assistance Program (SHIP) for help.
 - The SHIP counselor can tell Lucille about the Explanation of Benefits (EOB) notice that she received and let Lucille know that she has the right to appeal her plan's coverage decision.
 - If Lucille doesn't know how to contact her SHIP, she can call 877-839-2675 or visit www.shiphelp.org.
- Lucille can contact her doctor's billing department and her Medicare Advantage plan to ensure a billing or coding error was not made.
 - She can also ask her Medicare Advantage plan for more information about the reason the AAA screening would not be covered by the plan. If she is going to appeal her plan's decision, it is important for her appeal letter to address the reason(s) for denial stated by her plan.
- Lucille can call 1-800-MEDICARE to learn more about Medicare's coverage rules surrounding AAA screenings. This information would likely help her write an appeal letter.
- If Lucille decides to appeal her plan's decision, she can start by following the instructions on the notice she received from her plan.
 - She should make sure to file the appeal within 60 days of the date on the notice.
 - If Lucille has a good reason for missing her appeal deadline, she may file a good cause extension, by filing her appeal along with a clear explanation of why the appeal is late.
- Lucille may also want to ask her doctor to write a letter of support, explaining why she needed this screening and addressing the plan's denial reason.
- Throughout the appeal processes, Lucille should keep a copy of all documents sent and received. She should also write down the names of any representatives she speaks to, the date and time they spoke, and what they spoke about.
- If her appeal is successful, Lucille's AAA screening will be covered.
 - If the decision is unfavorable, Lucille's plan will automatically forward the case file to the second level, the Independent Review Entity (IRE).

SMP case example

Victor is 81 years old and has Original Medicare. He receives home health care visits from a nurse twice a week. One day the nurse arrives and notices some cuts on his arm from gardening. She offers to treat the shallow cuts with advanced wound care, to which he agrees. She proceeds to place multiple layers of large skin substitutes on his arms. The next time Victor saw his daughter, he recounted the story and showed her the skin substitutes. His daughter seemed concerned that his usual prescribing doctor was not involved as he usually is with Victor's plan of care. Now Victor is worried, too.

What should Victor do?

- Victor should contact her Senior Medicare Patrol (SMP) to report the situation.

- If Victor does not know how to contact his local SMP, he can visit www.smpresource.org or call 877-808-2468.
- The SMP team member will encourage Victor to check his Medicare statements to look for any suspicious charges,
- The SMP team member will report the suspected fraud to Medicare and the proper authorities.
- Victor should speak with his doctor if he received medical treatment from a provider and company that he now realizes he may not trust. He can work with his doctor to discuss any effects of this potentially unnecessary treatment, or to perhaps discuss appropriate or needed treatment.

Local SHIP Contact Information	Local SMP Contact Information
<p>SHIP toll-free: 800-247-4422 SHIP email: idahoshiba@doi.idaho.gov SHIP website: shiba.idaho.gov</p> <p>To find a SHIP in another state: Call 877-839-2675 and say “Medicare” when prompted or visit www.shiphelp.org.</p>	<p>SMP toll-free: 800-247-4422 SMP email: idahoshiba@doi.idaho.gov SMP website: Medicare Fraud Prevention - Idaho Commission on Aging</p> <p>To find an SMP in another state: Call 877-808-2468 or visit www.smpresource.org.</p>
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