Module 2 – Medicare Rights and Protections

Section Objectives

- Explain Medicare rights and protections
- Recognize rights in certain health care settings
- Summarize Medicare privacy practices
- Locate additional information and resources

Lesson 1: Medicare Rights

Your Medicare Rights?

If you have Medicare, you have the right to be

- Treated with dignity and respect at all times
- Protected from discrimination
    - Discrimination is against the law. Every company or agency that works with Medicare must the law. The Centers for Medicare & Medicaid Services (CMS) doesn't exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, national origin, disability, sex, or age.

These protections are generally limited to complaints of discrimination filed against providers of health care and social services who get federal financial assistance.

If you think you haven't been treated fairly for any of these reasons, call the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), at 1-800-368-1019. TTY: 1-800-537-7697. For more information, visit HHS.gov/ocr.

Medicare and Your Information Rights

If you have Medicare, you have the following information rights:

- To have your personal and health information kept private
    - To learn more about this right if you have
        - Original Medicare, see the "Notice of Privacy Practices for Original Medicare." To view, visit Medicare.gov/forms-help-and-resources/privacy-practices/privacy.html.
        - A Medicare Advantage (MA) Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.
- To get information in a language and format that you understand from
    - Medicare
    - Health care providers
    - Medicare contractors

For more information about getting health care services in languages other than English, visit HHS.gov/ocr, or call the Office for Civil Rights at 1-800-368-1019. TTY: 1-800-537-7697.

Medicare Rights and Access to Care

If you have Medicare, you have the right to:

- Have access to doctors, specialists, and hospitals.
- Learn about your treatment choices in clear language that you can understand, and participate in treatment decisions. If you can't fully participate in your treatment decisions, ask a family member, friend, or anyone you trust to help you make a decision about what treatment is right for you.
- Get Medicare-covered health care services in an emergency when and where you need it.
    - If your health is in danger because you have a bad injury, sudden illness, or an illness quickly gets worse, call 911. You can get emergency care anywhere in the United States.

To learn about Medicare coverage of emergency care in Original Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. In a Medicare Advantage Plan or other Medicare health plan, review your plan materials.

Medicare Rights – Claims and Appeals

If you have Medicare, you have the right to the following:

- Have a claim for payment filed with Medicare (with limited exceptions). While there's a mandatory claim submission law, not all Medicare "enrolled" providers have to submit claims to Medicare.
- Get a decision about health care payment, and coverage of services, supplies or prescription drugs, even when your doctor says that Medicare won't pay for a certain item or service.
- Request an appeal, if you disagree with Medicare's decision on your claim. When a claim is filed, you get a notice from Medicare letting you know what will and won't be covered. This might be different from what your doctor says.
- Appeal if you disagree with a decision about your health care payment, coverage of services, or prescription drug coverage.

For more information about appeals, visit Medicare.gov/appeals. For help with filing an appeal, call the State Health Insurance Assistance Program (SHIP) in your state. To get the most up-to-date SHIP phone numbers, visit shiptacenter.org.

If you have a Medicare Advantage Plan, other Medicare health plan, or a Medicare Prescription Drug Plan, read your plan materials.

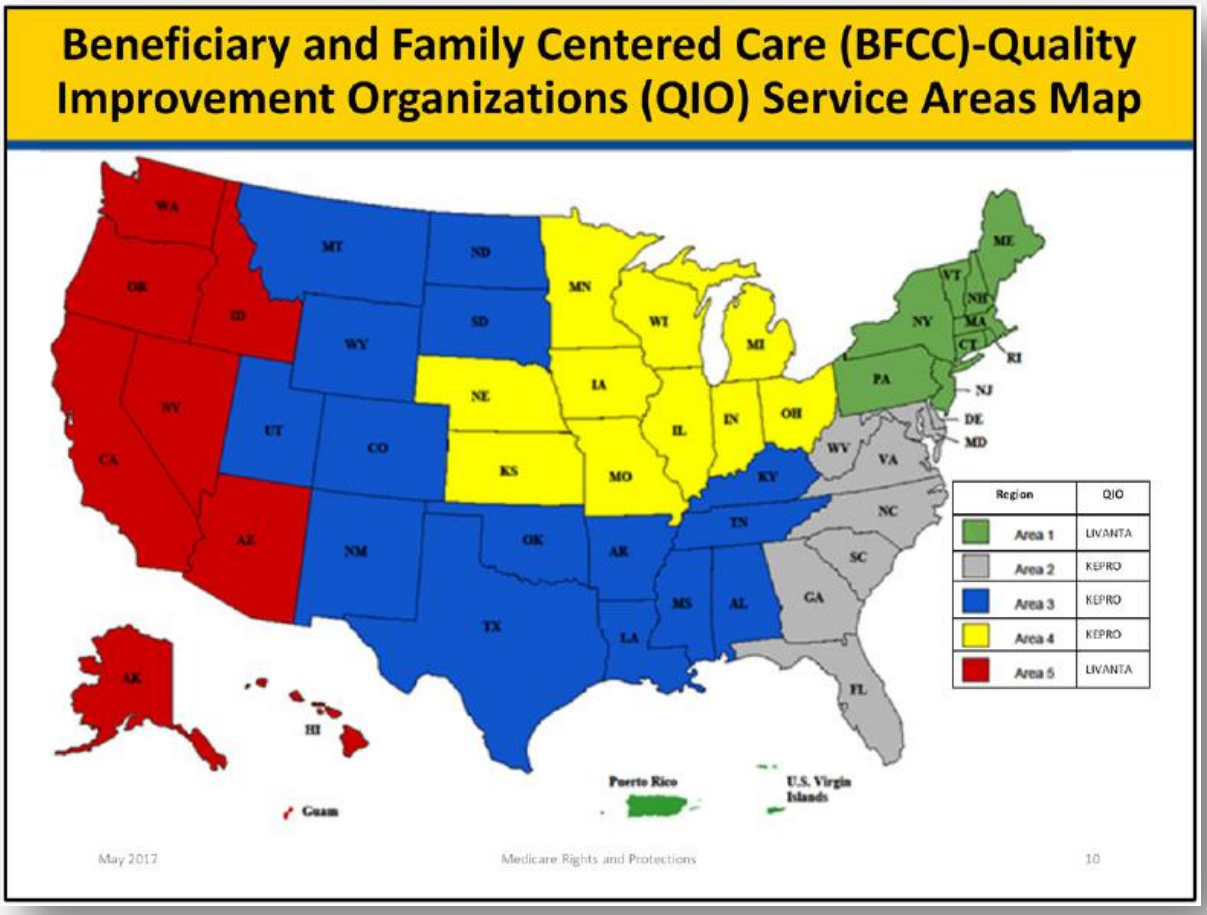
Medicare Grievance Rights

If you have Medicare, you have the right to the following:

- File complaints (also called grievances) about services you got, other concerns, or problems you have in getting health care and the quality of the health care you received.

If you're concerned about the quality of care you're getting

- In Original Medicare, call the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) in your region to file a complaint. Visit Medicare.gov/contacts to get your BFCC-QIO's phone number, or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.
- In a Medicare Advantage or other Medicare health plan, call your plan before contacting the BFCC-QIO.
- If you have End-Stage Renal Disease (ESRD) and have a complaint about your care, call the ESRD network in your state. To get the phone number, visit Medicare.gov/contacts or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.



There are 2 Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIOs) that review quality of care concerns and discharge appeals: KEPRO and Livanta. This map shows of the service areas of the BFCC-QIOs.

- There are 5 regions handled by KEPRO or Livanta:
  - **KEPRO Area 2**—Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia. Call 1-844-455-8708.
  - **KEPRO Area 3**—Alabama, Arkansas, Colorado, Kentucky, Louisiana, Mississippi, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and Wyoming. Call 1-844-430-9504.
  - **KEPRO Area 4**—Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, Ohio, and Wisconsin. Call 1-844-430-9504.

  Note: TTY (for all KEPRO areas): 1-855-843-4776. For more information, visit keprogio.com/bene/helpline.aspx.

  - **Livanta Area 1**—Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, Rhode Island, Vermont, and the Virgin Islands. Call 1-866-815-5440. TTY: 1-866-868-2289. For more information, visit bfccqioarea1.com .
  - **Livanta Area 5**—Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, and Washington State. Call 1-877-588-1123. TTY: 1-855-887-6668. For more information, visit bfccqioarea5.coml. **NOTE:** The American Samoa and the Commonwealth of the Mariana Islands (not pictured on the map) are part of the Livanta Area 5 service area.

Your Rights in Original Medicare

Your rights when you're enrolled in Original Medicare include the following:

- See any Medicare-participating doctor or specialist (including women's health specialists)
- Go to any Medicare-certified hospital
- Get certain information, like notices and appeal rights, that helps you resolve issues when Medicare isn't expected to pay or doesn't pay for health care

Appeal Rights in Original Medicare

In Original Medicare, you have the right to a fair, timely, and efficient appeals process.

You can file an appeal if

- A service or item you got isn't covered and you think it should've been
- Payment for a service or item is denied, and you think Medicare should've paid for it
- You question the amount that Medicare paid for a service or item

How to Appeal in Original Medicare

In Original Medicare, when providers and suppliers bill Medicare, you'll get a "Medicare Summary Notice." This notice will tell you

- Why Medicare didn't pay
- Who to contact if you need help filing an appeal
- How and where to appeal
- How much time you have to file an appeal

If you decide to appeal, ask your doctor, health care provider, or durable medical equipment supplier for any information that may help your case. Be sure to keep a copy of everything you send to Medicare as part of your appeal.

- You may have the right to a fast (expedited) appeal in certain settings

Fast Appeals in Original Medicare

You have the right to a fast appeal if you think your Medicare-covered services are ending too soon. This includes services you get from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice. Your provider will give you a written notice before your services end that tells you how to ask for a fast appeal.

You may ask your doctor or health care provider for any information that may help your case if you decide to file a fast (expedited) appeal. Your request will be a fast request if your plan or your doctor determines, with sufficient supporting documentation, that waiting for a standard service decision may seriously jeopardize your life, health, or ability to regain maximum function.

You must call your regional Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) to request a fast appeal no later than noon on the day before your notice says your coverage will end.

The number for the BFCC-QIO in your region should be on your discharge notice. You can also call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048

If you miss the deadline, you still have appeal rights:

- If you have Original Medicare, call your local BFCC-QIO
- If you're in a Medicare Advantage Plan or other Medicare health plans, call your plan. Look in your plan materials to get the phone number

Contact your local State Health Insurance Assistance Program (SHIP) if you need help filing an appeal. To get the most up-to-date SHIP phone numbers, visit shiptacenter.org.

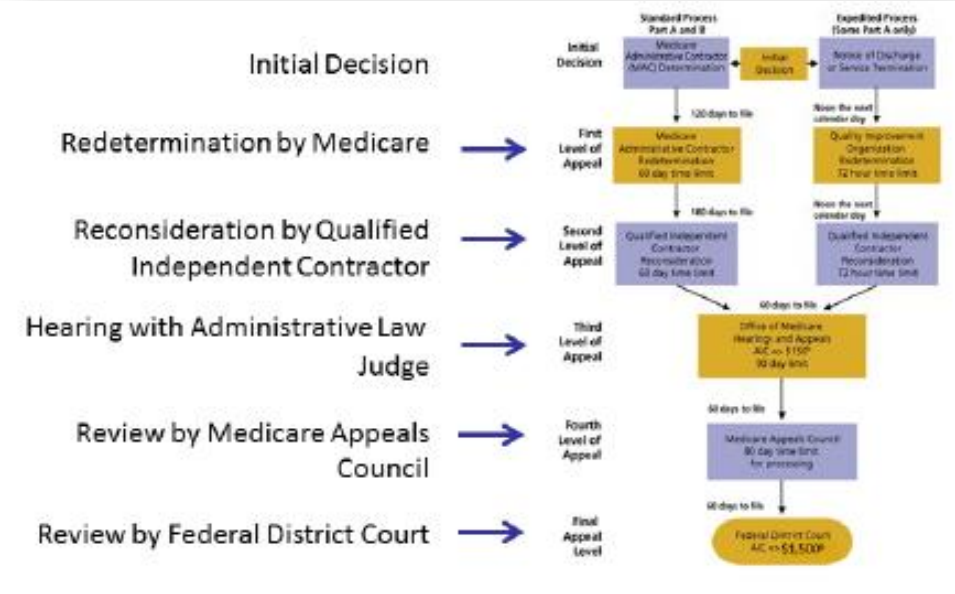
See "Medicare Appeals" (CMS Product No. 11525) for more details at Medicare.gov/Pubs/pdf/11525.pdf.

Original Medicare Appeals Process

There are 5 levels in the appeals process in Original Medicare Parts A and Part B (fee for service).

Redetermination by the company that handles claims for Medicare within 120 days from the date you get the "Medicare Summary Notice" (MSN). Details are on the MSN.

1. **Reconsideration by a Qualified Independent Contractor (QIC)** (a contractor who didn't take part in the first decision). Details are included in the redetermination notice.
2. **Contact your Beneficiary and Family Centered Care Quality Improvement Organization (BFCC QIO)** no later than noon the day before Medicare-covered services end to request a fast appeal.
3. **Hearing before an Administrative Law Judge (ALJ)**. The amount of your claim must meet a minimum dollar amount which is updated yearly. In 2017, that amount is $160. 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's no minimum dollar amount to get your appeal reviewed by the MAC.
5. **Review by a federal district court**. To get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount, which is updated yearly. In 2017, that amount is $1,560.



NOTE: For a full-size copy of the Original Medicare (Part A and Part B) appeals process flowchart, visit CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Flowchart-FFS-Appeals-Process.pdf.

Types of Liability Notices for People With Original Medicare

Original Medicare liability notices explain that there may be a shift in liability for you, and you may be liable for the cost of a certain service or item under certain conditions. The notices include:

- **"Advance Beneficiary Notice of Non-coverage"** (ABN)—Used by providers and suppliers of Medicare Part B (Medical Insurance) items and services. It's also used by hospices and religious nonmedical health care institutions providing Medicare Part A (Hospital Insurance) items and services.

There are other types of liability notices for people with Original Medicare that are used in specific health care settings. Like the ABN, these notices explain that you may be liable for the cost of certain services or items under certain conditions. These notices include

- **"Skilled Nursing Facility Advance Beneficiary Notice/Skilled Nursing Facility Denial Letter"—**Only used for skilled nursing facility care (does not include instances where the patient does not meet the 3-day qualifying stay).
- **"Hospital Issued Notice of Non-coverage"**—Used for inpatient hospital care when the hospital thinks Medicare may not pay for some or all of your your care.
- **"Home Health Change of Care Notice"**—Used when home health agencies reduce or discontinue care listed in the person with Medicare's plan of care.
- **"Hospital Discharge Appeal Notices"**—Used for people with Medicare discharged from hospitals.
- **"Notice of Exclusion from Medicare Benefits–Skilled Nursing Facility"**—Used by skilled nursing facilities to alert people with Medicare that Medicare doesn't cover certain extended care items or services.
- **"Expedited Determination Notices"**—Used by home health agencies, skilled nursing facilities, hospices, and comprehensive outpatient rehabilitation facilities to provide notice to beneficiaries when their Medicare covered services are ending.

You can view or print all of these notices at CMS.gov/bni/.

Original Medicare Protection From Unexpected Bills

You're protected from unexpected bills. If your health care provider or supplier believes that Medicare won't pay for certain items or services, in many situations they'll give you a notice that says Medicare probably won't pay for an item or service under Original Medicare and explains why. This is called an "Advance Beneficiary Notice of Non-coverage (ABN)." The ABN, Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to people with Original Medicare (fee for service) in situations where Medicare payment is expected to be denied.

Doctors and suppliers aren't required to give you an ABN for services Medicare never covers (i.e., excluded under Medicare law), like routine eye exams, dental services, hearing aids, and routine foot care. However, they may voluntarily give you an ABN for items and services excluded by Medicare as a courtesy.

You'll be asked to choose an option on the ABN form and sign it to say that you've read and understand the notice. If you choose to get the items or services listed on the ABN, you'll have to pay if Medicare doesn't. In some cases, the provider may ask for payment at the time the item or service is received.

NOTE: See Appendix A for a copy of the ABN. It's also available at CMS.gov/Medicare/Medicare-General-Information/BNI/ABN.

Medigap Rights in Original Medicare

A Medicare Supplement Insurance (Mediga) policy is a health insurance policy sold by private insurance companies to fill the gaps in Original Medicare coverage, like coinsurance amounts.

Your rights when you're enrolled in Original Medicare include the following:

- In some situations, you have the right to buy a Medigap policy. Medigap policies must follow federal and state laws that protect you. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." Medigap insurance companies in most states (except Massachusetts, Minnesota, and Wisconsin) can only sell you a standardized Medigap policy. These policies are identified by the letters A, B, C, D, F, G, K, L, M, and N. The benefits in any Medigap plan identified with the same letter are the same regardless of which insurance company you purchase your policy from.
- You have the right to buy a Medigap policy during your Medigap Open Enrollment Period, a 6-month period that automatically starts the month you're 65 and enrolled in Medicare Part B, and once it's over, you can't get it again.
- When you have guaranteed issue rights, the Medigap insurance company
    - Can't deny you Medigap coverage or place conditions on your policy
    - Must cover you for pre-existing conditions
    - Can't charge you more for a policy because of past or present health problems
- Some states offer additional rights to purchase Medigap policies.

NOTE: Module 3, "Medicare Supplement Insurance (Medigap policies)" describes these situations at cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Training-Library.html.

Your Rights in Medicare Advantage and Other Medicare Health Plans

If you're in a Medicare health plan (such as a Medicare Advantage (MA) Plan), in addition to the rights and protections previously listed in the first section, you have the right to

- Choose health care providers within the plan, so you can get the health care you need.
- Get a treatment plan from your doctor if you have a complex or serious medical condition. A treatment plan lets you directly see a specialist within the plan as many times as you and your doctor think you need. Women have the right to go directly to a women's health care specialist within the plan without a referral for routine and preventive health care services.

NOTE: Medicare Advantage Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) Plans are both coordinated care plans. In most cases you have to get a referral to see a specialist in HMO plans. However, Medicare Part C (MA Plans), also includes Private Fee-for-Service (PFFS) and Medicare Savings Account (MSA) Plans. PFFS and MSA plans aren't coordinated care plans. If you enroll in these plan types, you won't necessarily have a network of providers or be required to have a provider coordinate your care.

Coverage and Appeal Rights in Medicare Health Plans

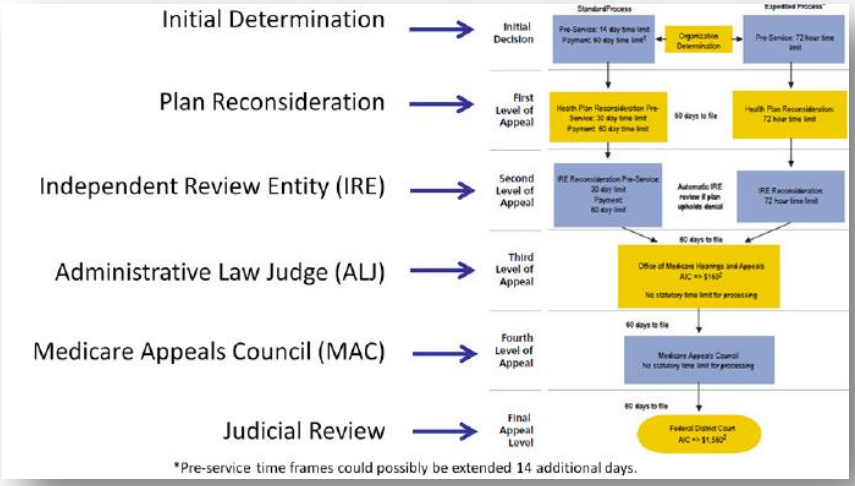
If you're in a Medicare health plan, you have the right to

- Know how your doctors are paid. Medicare doesn't allow a plan to pay doctors in a way that interferes with you getting needed care.
- Find out from your plan, before you get a service or supply, if it'll be covered. You can call your plan to get information about the plan's coverage rules.
- Resolve your appeal in a fair, efficient, and timely process to resolve differences with your plan. You have the right to ask your plan to provide or pay for an item or service you think should be covered, provided, or continued.
    - The appeals process consists of 5 levels
    - If coverage is denied at any appeal level, you'll get a letter explaining the decision and instructions on how to proceed to the next appeal level
    - If the plan continues to deny coverage at the reconsideration level, the appeal is automatically sent to the Part C (Medicare Advantage) Independent Review Entity
- File a grievance about other concerns or problems with your plan, check your plan's membership materials or call your plan to find out how to file a grievance.

See "Medicare Rights & Protections" (CMS Product No. 11534) for more details at Medicare.gov/Pubs/pdf/11534.pdf.

Medicare Part C Appeals Process

This chart shows the appeals process for Medicare Advantage (MA) or other Medicare health plan enrollees. The time frames differ depending on whether you're requesting a standard appeal, or if you qualify for an expedited (fast) appeal.



If you ask your plan to provide or pay for an item or service and your request is denied, you can appeal the plan's initial decision (the "organization determination"). You'll get a notice explaining why your plan denied your request and instructions on how to appeal your plan's decision.

There are 5 levels of appeal. If you disagree with the decision made at any level of the process, you can go to the next level if you meet the requirements for doing so.

First, your plan will make an Initial Determination. Pre-service time frames could possibly be extended 14 additional days. After each level, you'll get instructions on how to proceed to the next level of appeal. The 5 levels of appeal are

1. Reconsideration by the plan
2. Reconsideration by the Independent Review Entity (IRE)
3. Hearing with the Administrative Law Judge (ALJ) —the amount of your claim must meet a minimum dollar amount which is updated yearly. The amount for 2017 is $160
4. Review by the Medicare Appeals Council (MAC)
5. Review by a federal district court (to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount which is updated yearly. The amount in 2017 is $1,560

NOTE: For a full-size copy of the Part C (Medicare Advantage (MA)) appeals process flowchart, visit CMS.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf.

Rights When Filing Medicare Health Plan Appeals

If you're in a Medicare Advantage (MA) or other Medicare health plan and you're filing an appeal, you have certain rights. You may want to call or write your plan and ask for a copy of your case file. To get the phone number or address of your plan, look at your "Evidence of Coverage," or the notice you get that explained why you couldn't get the services you requested.

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'll cost based on the number of pages in the file, plus normal mail delivery.

The time frame for a plan to complete standard service coverage decisions is 14 days and may be **extended by up to 14 days**. The time frame may be extended if, for example, your plan needs more information from a non-contract provider to make a decision about the case, and the extension is in your best interest.

If you think your health could be seriously harmed by waiting the standard 14 days for a decision, ask your plan for a fast decision. You have the right to an expedited appeal when your request is supported by a doctor, or when applying the standard appeal time frame could seriously jeopardize your life or health; or your ability to regain maximum function. The plan must notify you of its decision within 72 hours. The 72 hours might be extended based on supporting documentation.

Medicare Prescription Drug Coverage (Part D) Rights – Access to Covered Drugs

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

Each plan has a list of covered drugs called a formulary. 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—like syringes, needles, alcohol swabs, and gauze—are also covered.

Some of the methods that plans use to manage access to certain drugs include prior authorization, step therapy, and quantity limits, which we'll discuss in this section.

Required Coverage – Part D

Medicare drug plans must cover substantially all drugs in 6 categories to treat certain conditions:

1. Cancer medications
2. Human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) treatments
3. Antidepressants
4. Antipsychotic medications
5. Anticonvulsive treatments for epilepsy and other conditions
6. Immunosuppressants

Also, Medicare drug plans must cover all commercially available vaccines, including the shingles vaccine, but not vaccines covered under Part B (Medical Insurance), like the flu and pneumococcal pneumonia shots. You or your provider can contact your Medicare drug plan for more information about vaccine coverage.

Formulary

Each Medicare drug plan has a formulary, a list of prescription drugs that it covers. Each formulary must include a range of drugs in the prescribed categories and classes. To offer lower costs, many plans place drugs into different tiers, which cost different amounts. Each plan can form its tiers in different ways.

Here's an example of how a plan might form its tiers:

- **Tier 1–Generic drugs** (the least expensive copayment)—A generic drug is the same as its brand-name counterpart in safety, strength, quality, the way it works, how it's taken, and the way it should be used. Generic drugs use the same active ingredients as brand-name drugs. Generic drug makers must prove that their product performs the same way as the corresponding brand-name drug. Generic drugs are less expensive because of market competition. Generic drugs are thoroughly tested and must be approved by the U.S. Food and Drug Administration (FDA). Today, over 70% of all prescriptions in the United States are filled with generic drugs. In some cases, there may not be a generic drug available for the brand-name drug you take. Talk to your prescriber.
- **Tier 2–Preferred brand-name drugs** (medium copayment)—Tier 2 drugs cost more than Tier 1 drugs.
- **Tier 3–Non-preferred brand-name drug** (higher copayment)—Tier 3 drugs cost more than Tier 2 drugs.
- **Tier 4–(or Specialty Tier)** (highest copayment)—These drugs are unique and have a high cost.

NOTE: In some cases, if your drug is in a higher (more expensive) tier and your prescriber thinks you need that drug instead of a similar drug on a lower tier, you can request an exception and ask your plan for a lower copayment.

Request a Part D Coverage Determination

A coverage determination is the first decision made by your Medicare drug plan (not the pharmacy) about your prescription drug benefits. This includes whether a certain drug is covered; whether you've met all the requirements for getting a requested drug; and how much you must pay for a drug.

You, your prescriber, or your appointed representative (see Appendix B) can ask for a coverage determination by calling your plan or writing them a letter. If you write to the plan, you can write a letter or use the "Model Coverage Determination Request" form available at cms.gov/Medicare/Prescription-DrugCoverage/PrescriptionDrugCovGenIn/downloads/ModelCoverageDeterminationRequestForm.pdf.

There are 2 types of coverage determinations: standard or expedited. Your request will be fast (expedited) if the plan determines, or if your doctor tells the plan that your life or health may be seriously jeopardized by waiting for a standard request.

A plan must give you its coverage determination decision as quickly as your health condition requires. After getting your request, the plan must give you its decision no later than 72 hours for a standard determination, or 24 hours for an expedited (fast) determination. If your coverage determination request involves an exception, the time clock starts when the plan gets your doctor's supporting statement.

If a plan fails to meet these time frames, it must automatically forward the request and case file to the Independent Review Entity (IRE) (MAXIMUS) for review, and the request will skip over the first level of appeal (redetermination by the plan). MAXIMUS contact information is available at Medicarepartdappeals.com/.

Rules Plans Use to Manage Access to Drugs

Medicare drug plans manage access to covered drugs in several ways, including prior authorization (PA), step therapy, and quantity limits.

Rule Name	Coverage Rule Description
Prior Authorization	▪ Enrollee or prescriber must contact plan and show prior authorization (PA) criteria are met before the drug will be covered ▪ Enrollee or prescriber may request an exception to PA criteria, which the plan must allow if medically necessary
Step Therapy	▪ Type of PA ▪ Must use alternative drug(s) on plan's list ▪ Enrollee or prescriber may request an exception if alternative drug(s): • Wouldn't work as well as requested drug, or would have adverse effect • Plan must allow exception if medically necessary
Quantity Limits	▪ Plan may limit drug quantities over a period of time for safety and/or cost ▪ Enrollee or prescriber may request an exception if quantity/dose restriction would be ineffective in treating the enrollee's condition or would have adverse effects ▪ Plan must allow exception if additional amount is medically necessary

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You may need drugs that require prior authorization. This means before the plan will cover a particular drug, you or your doctor, or other prescriber must first show the plan you meet the plan's CMS-approved criteria for that particular drug. Plans may do this to ensure you're using these drugs correctly. Contact your plan about its prior authorization requirements and talk with your prescriber.

Step therapy is a type of prior authorization. In most cases, you must first try a certain alternative drug(s) on the plan's drug list that has been U.S. Food and Drug Administration approved for treating your condition before you can move up a step to a more expensive drug. For instance, some plans may require that you first try a generic drug on their drug list before you can get coverage for a similar, more expensive brand-name drug.

Plans may **limit the quantity of drugs** they cover for safety and cost reasons over a certain time period. If you or your prescriber believes that a quantity limit isn't appropriate for your condition, you or your prescriber can contact the plan to ask for an exception. If the plan approves your request, the quantity limit won't apply to your prescription.

If you or your prescriber believe that a prior authorization, step therapy, or quantity limit requirement shouldn't apply to you because of your medical condition, you (with your prescriber's help) can contact the plan to request an exception to the rule.

When Plans Must Grant Formulary Exceptions

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

Requesting Part D Appeals

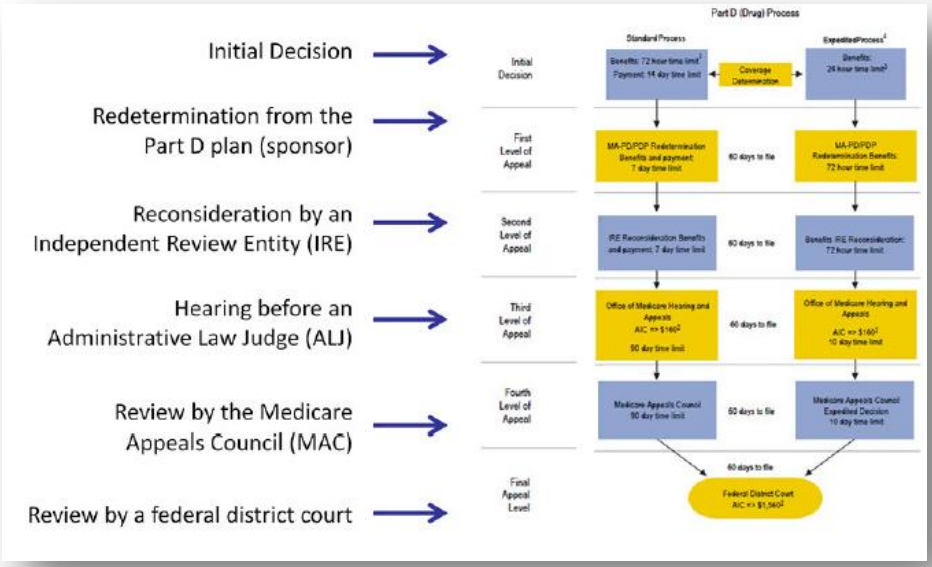
If you disagree with your Medicare drug plan's coverage determination or exception decision, you have the right to appeal the decision. Your plan's written decision will explain how you may file an appeal. Read this decision carefully and call your plan if you have questions. Most appeals must be requested within 60 days of the coverage determination or denial of an exception. However, this time frame may be extended for good cause (a circumstance that kept you from making the request on time or whether any actions by the plan may have misled you). For more information on good cause, see Chapter 18 of the Prescription Drug Benefit Manual "Part D Enrollee Grievances, Coverage Determinations, and Appeals," Section 70.3—"Good Cause Extension" at CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html.

In general, you must make your appeal requests in writing. However, plans must accept verbal expedited (fast) redetermination requests. In addition, plans may choose to accept verbal standard redetermination requests. Check your plan materials, or contact your plan to see if you can make verbal standard redetermination requests.

You or your appointed representative (see Appendix B) may ask for any level of appeal. Your doctor or other prescriber can only ask for redetermination or Independent Review Entity reconsideration (level 1 or 2 appeal) on your behalf without being your appointed representative.

Medicare Part D Levels of Appeal

If you get an unfavorable initial decision, you have the right to appeal the decision.



There are 5 levels of appeal:

1. Redetermination from the Part D plan (sponsor)
2. Reconsideration by an Independent Review Entity
3. Hearing before an Administrative Law Judge—the amount of your claim must meet a minimum dollar amount which may change yearly. The amount for 2017 is $160.
4. Review by the Medicare Appeals Council
5. Review by a federal district court—to get a review by a federal court, the remaining amount in controversy of your case must meet a minimum dollar amount which may change yearly. The amount for 2017 is $1,560.

Important: The Part D Late Enrollment Penalty (LEP) reconsideration process is unrelated to the appeals process flowchart—the appeals flowchart relates to benefit appeals. There's only one level of independent review for LEP disputes.

NOTE: For a full-size copy of the Part D (Drug) appeals process flowchart, visit CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/Downloads/Flowchart-Medicare-Part-D.pdf.

Required Part D Notices

Plan sponsors must ensure that their network pharmacies provide a written copy of the standardized CMS “Pharmacy Notice” to you whenever a prescription can’t be filled by Part D and the issue isn’t resolved at the pharmacy counter. This notice explains your right to contact your plan to ask for a coverage determination, including an exception.

Plans’ sponsors are required to provide written notices for every coverage determination or appeal decision.
In addition, all other appeal entities are required to send written notice of decisions. If a decision is adverse (unfavorable), the notice will explain the reason for the decision, include information on the next appeal level, and provide specific instructions about how to file an appeal.

NOTE: An initial coverage decision about your Part D drugs is called a "coverage determination," or simply put, a "coverage decision." *A coverage decision is a decision the plan makes about your benefits and coverage*, or about the amount it will pay for your prescription drugs. The plan is making a coverage decision for you whenever it decides what’s covered for you and how much it will pay.

Provider/Plan Disclosure of Personal Health Information (PHI)

A health care provider or plan, like a Medicare drug plan, may disclose relevant protected Personal Health Information (PHI) to someone who assists you, specifically regarding your drug coverage. 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 the next page)

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

- When you’re present and agree or the plan reasonably infers from the circumstances that you don’t object. (For example, your representative is speaking to CMS on the phone and you’ve been included in the conversation. Although the CMS representative may not have explicitly asked for your permission to speak to the person who’s assisting you, your direct involvement in the conversation may reasonably imply your consent.)
- When you’re not present or are incapacitated, the plan may exercise its professional judgment to determine whether disclosure is in your best interest.

To Whom Plans May Disclose Personal Health Information

A plan may disclose Personal Health Information (PHI) to

- A person's adult child who is resolving a claim or payment issue for a hospitalized parent when the parent gives permission
- A human resources representative if the person with Medicare is on the line or gives permission by phone
- A congressional office or staff person who has faxed the person's request for congressional assistance
- CMS staff if the available information satisfies the plan that the individual requested CMS' help

NOTE: PHI guidelines were published by the Office for Civil Rights, U.S. Department of Health and Human Services (HHS.gov/ocr/index.html).

Lesson 2: Your Rights in Certain Settings

Right to Hospital Care

All people with Medicare, including those in Medicare Advantage (MA) or other Medicare health plans, have the right to get all of the medically necessary Medicare-covered 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 as an inpatient, you'll get a notice within 2 days of hospital admission and not more than 2 days before the day of discharge. The notice is called an "Important Message From Medicare About Your Rights," and the hospital must provide you with a written copy of the notice so that you know your rights as a hospital inpatient.

You'll get a "Medicare Outpatient Observation Notice" (MOON) notice if you receive observation services as an outpatient for more than 24 hours.

Right to Hospital Care – Medicare Outpatient Observation Notice (MOON)

A Medicare Outpatient Observation Notice (MOON) lets you know if you're an inpatient or outpatient in a hospital or critical access hospital. You must get this notice if you're getting outpatient observation services for at least 24 hours.

The MOON will tell you why you're an outpatient getting observation services, instead of an inpatient. It will also let you know how this may affect what you pay while in the hospital, and for care you get after leaving the hospital.

- Hospitals and Critical Access Hospitals (CAHs) must provide you the MOON notice no later than 36 hours after observation services begin
- Will inform you of the reason(s) why you're an outpatient receiving observation services and what this means for you
- An oral explanation will be given
- Notice signed by you or someone representing you

"Important Message From Medicare"

The "Important Message From Medicare" is a notice you get after being admitted to the hospital. This notice is signed by you and a copy is provided to you explaining your rights to

- Get all medically necessary hospital services
- Be involved in any decision(s)
- Get services you need after you leave the hospital
- Appeal discharge decision and steps for appealing decision
- Circumstances in which your hospital services may be paid for during the appeal

Rights in a Skilled Nursing Facility (SNF)

As a resident of a skilled nursing facility (SNF), you have certain rights and protections under federal and state law that help ensure you get the care and services you need. They can vary by state. The SNF must provide you with a written description of your legal rights. You have the right to

- Freedom from discrimination
- Freedom from abuse and neglect
- Freedom from restraints
- Information on services and fees
- Privacy, personal property, and spousal living arrangements
- Get medical care
- Have visitors who may participate in family councils and can help with your care plan with your permission
- Protection against unfair transfer or discharge
- Manage your own money
- Be able to make a complaint
- Receive medically-related social services

Residents of SNFs who need assistance in resolving complaints or information about their rights may contact the Office of the State Long-Term Care Ombudsman. For contact information, visit aoa.acl.gov/AoA_Programs/Elder_Rights/Ombudsman. More information is available at Medicare.gov/what-medicare-covers/part-a/rights-in-snf.html.

Rights in Home Health and Hospice

All persons with Medicare have certain guaranteed rights and protections regardless of setting. In home health care and hospice care settings, you also have the following rights:

- Discharge appeal rights
- Home health care and hospice care providers must give you a written copy of your rights and obligations before care begins, to include your right to
    - Choose your agency (For members of managed care plans, choices will depend on which agencies your plan works with.)
    - Have your property treated with respect

- Be given a copy of your plan of care, and participate in decisions about your care
- Have your family or guardian act for you if you're unable

Reference – Home Health Agency Outcome and Assessment Information Set (OASIS) Statement of Patient Privacy Rights.

Rights in Other Settings – Comprehensive Outpatient Rehab Facility (CORF)

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a facility that provides a variety of services on an outpatient basis, including physicians' services, physical therapy, social or psychological services, and rehabilitation.

In a CORF setting, your provider must

- Explain your treatment program
- Discuss if your therapy services will go above the therapy cap limits – $3,700 for 2017

NOTE: For more information on therapy caps, visit Medicare.gov/Pubs/pdf/10988-Medicare-Limits-Therapy-Services.pdf.

Fast Appeals Process

You have certain rights if you think services are ending too soon. With the Medicare expedited (fast) appeals process, your provider or plan must deliver (in most cases) a "Notice of Medicare Non-coverage" (NOMNC) at least 2 days before Medicare-covered hospice, skilled nursing facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), or home health care will end.

- You have the right to ask the Beneficiary and Family Centered Care-Quality Improvement Organizations (BFCC-QIO) to require your plan to provide or pay for a Medicare-covered service you think should be continued in a skilled nursing facility, from a home health agency, hospice, or in a CORF.
  - Contact your BFCC-QIO no later than noon the day before Medicare-covered services end to request a fast appeal. See your notice for how to contact your BFCC-QIO and for other important information.

The BFCC-QIO must notify you of its decision by close of business on the day after it gets all necessary information. If the BFCC-QIO decides that you're ready to be discharged and you met the deadline for requesting a fast appeal, you won't be responsible for paying the charges (except for applicable coinsurance or deductibles) until noon of the day after the BFCC-QIO gives you its decision.

- A Medicare provider or health plan (Medicare Advantage (MA) Plans and Cost Plans) must deliver a completed copy of the "Detailed Explanation of Non-coverage (DENC)" to you if you're receiving covered skilled nursing, home health, CORF, and hospice services upon notice from the BFCC-QIO that the you appealed the termination of services in these settings. The DENC must be provided no later than close on business of the day of the BFCC-QIO's notification.

You have the right to ask for reconsideration by the Qualified Independent Contractor (QIC) if you're dissatisfied with the results of the fast appeal. The QIC is an independent contractor who didn't take part in the first fast appeal decision. The decision notice that you get from your first fast appeal will have directions on how to file a request for reconsideration.

Lesson 3: Medicare Privacy Practices

"Notice of Privacy Practices"

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're enrolled in a Medicare Advantage (MA) Plan or other Medicare health 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 at Medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf. This publication is mailed to all Medicare households every fall.

To learn more about the "Notice of Privacy Practices" for Original Medicare, visit Medicare.gov/forms-help-and-resources/privacy-practices/privacy.html.

For more information, go to Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

Required Disclosures

Medicare must disclose your personal medical information

- To you
- To someone who has the legal right to act for you (your personal representative)
- To the Secretary of U.S. Department of Health and Human Services, if necessary, to make sure your privacy is protected
- When required by law (federal, state, or local). For example: public health activities when required or authorized by law or in response to a lawsuit, court order, subpoena, warrant, summons, or similar process.

Permitted Disclosures

Medicare may use and give out your personal medical information to pay for your health care and to operate the Medicare Program. 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 that you and other people with Medicare get quality health care, to give you customer service, to resolve any complaints you have, or to contact you about research studies.

NOTE: An Accountable Care Organization (ACO) is a way for local health care providers and hospitals to volunteer to work together to provide you with coordinated care. If your doctor or health care provider chooses to participate in an ACO, you'll be notified. This notification might be a letter, written information provided to you when you see your doctor, a sign posted in a hospital, or it might be a conversation with your doctor the next time you go to see him or her.

Medicare will share certain information about your medical care with your doctor's ACO, including medical conditions, prescriptions, and visits to the doctor. This is important to help the ACO keep up with your medical needs and track how well the ACO's doing to keep you healthy and helping you get the right care. Your privacy is very important to us. You can remove the type of information Medicare shares with your doctor for care coordination by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. Or, sign a form available in your doctor or other health care provider's office, which you may also get in the mail from your doctor.

If you get a letter from your doctor, unless you take one of the steps above, your medical information will be shared automatically for purposes of care coordination starting 30 days from the date you're notified. Medicare won't share information with an ACO about any treatment for alcohol or substance abuse without written permission. For more information, visit Medicare.gov/manage-your-health/coordinating-your-care/accountable-care-organizations.html or Medicare.gov/Pubs/pdf/11588.pdf.

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 get Medicare data (like to make sure Medicare's making proper payments and to assist federal/state Medicaid Programs)
- For public health activities (like reporting disease outbreaks)
- For government health care oversight activities (like fraud and abuse investigations)
- For judicial and administrative proceedings (like in response to a court order)
- For law enforcement purposes (like giving 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

Personal Medical Information Authorization

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 the "Privacy Notice." You may take back (revoke) your written permission at any time. However, this won't affect information Medicare has already given out based on your earlier permission.

Visit Medicare.gov/MedicareOnlineForms/AuthorizationForm/OnlineFormStep.asp for an online version of the required "Authorization to Disclose Personal Health Information Form."

Personal Medical Information Privacy Rights

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 (for example, by mail versus by phone) or at a different place (for example, by sending materials to a post office 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: 1-877-486-2048.

If Privacy Rights Are Violated

Government programs that pay for health care – like Medicare, Medicaid, and the military and veterans' health care programs – are covered by Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules.

If you believe Original Medicare has violated your privacy rights, you may file a complaint. You can file a complaint by mail, fax, email, or electronically via the complaint portal.

- Contact the U.S. Department of Health and Human Services, Office for Civil Rights at HHS.gov/ocr/privacy/hipaa/complaints/, or
- Call 1-800-368-1019. TTY: 1-800-537-7697.

Your complaint won't affect your benefits under Medicare.

Lesson 4: Medicare Rights and Protections Resources

Advance Directives

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

Making future health care decisions is another health care protection available to anyone, not just people with Medicare. Check for your state's requirements.

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you are too ill to speak for yourself. Advance directives most often include a health care proxy (durable power of attorney), a living will, and after-death wishes.
Talking with your family, friends, and health care providers about your wishes is important, but these legal documents ensure that your wishes are followed. It's better to think about these important decisions before you're ill or a crisis occurs.

A health care proxy (sometimes called a durable power of attorney for health care) is used to name the person you wish to make health care decisions for you if you aren't able to make them yourself. Having a health care proxy is important because if you suddenly aren't able to make your own health care decisions, someone you trust will be able to make these decisions for you.

A living will is another way to make sure your voice is heard. It states which medical treatment you would accept or refuse if your life is threatened. For example, dialysis for kidney failure, a breathing machine if you can't breathe on your own, cardiopulmonary resuscitation if your heart and breathing stop, or tube feeding if you can no longer eat.

Who's the Medicare Beneficiary Ombudsman

An ombudsman is a person who reviews complaints and helps resolve them.
The Medicare Beneficiary Ombudsman helps make sure information is available about

- Medicare coverage
- Making good health care decisions
- Medicare rights and protections
- Getting issues resolved

The Ombudsman reviews the concerns raised by people with Medicare through 1-800-MEDICARE (1-800-633-4227), TTY: 1-877-486-2048, and through your State Health Insurance Assistance Program (SHIP).
Visit Medicare.gov for information on inquiries and complaints, activities of the Ombudsman, and what people with Medicare need to know. The Ombudsman reports yearly to Congress.

Resources

Resources

Centers for Medicare & Medicaid Services (CMS)

- 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048
- Medicare.gov
- CMS.gov

Social Security

- 1-800-772-1213. TTY: 1-800-325-0778
- socialsecurity.gov

Railroad Retirement Board

- 1-877-772-5772. TTY: 1-312-751-4701
- RRB.gov

U.S. Department of Health and Human Services, Office for Civil Rights

- 1-800-368-1019. TTY: 1-800-537-7697
- HHS.gov/ocr

Beneficiary Notice Initiative

- CMS.gov/Medicare/Medicare-General-Information/BNI
- Medicare.gov/claims-and-appeals

Medicare Beneficiary Ombudsman

- Medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman
- Medicare.gov/what-medicare-covers/part-a/rights-in-snf

State Health Insurance Assistance Programs and State Insurance Departments

SHIP

- shiptacenter.org/

Contact CMS (CMS.gov/) for the phone numbers to

- **Beneficiary and Family Centered Care-Quality Improvement Organizations** (bfccqioarea5.com/index.html)
- **Independent Review Entity** (Medicare Advantage & Part D claims only)

Medicare Products

1. **"Medicare & You Handbook"** (CMS Product No. 10050)
2. **"Medicare Rights & Protections"** (CMS Product No. 11534)
3. **"Medicare Appeals"** (CMS Product No. 11525)

To access these products:

- View and order single copies at Medicare.gov/publications.
- Order multiple copies (partners only) at Productordering.cms.hhs.gov. *You must register your organization.*

Appendix A – Advanced Beneficiary Notice as discussed on page 17
Visit CMS.gov/Medicare/Medicare-General-Information/BNI/ABN.html.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Appendix B – Model Coverage Determination Request as discussed on page 28.
CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/downloads/ModelCoverageDeterminationRequestForm.pdf

REQUEST FOR MEDICARE PRESCRIPTION DRUG COVERAGE DETERMINATION

This form cannot be used to request barbiturates, benzodiazepines, fertility drugs, drugs for weight loss or weight gain, drugs for hair growth, over-the-counter drugs, or prescription vitamins (except prenatal vitamins and fluoride preparations)

Enrollee's/Requestor's Information

Enrollee's Name

Enrollee's Date of Birth

Enrollee's Medicare Number

Enrollee's Part D Plan ID Number

Requestor's Name (if not enrollee)

Requestor's relationship to Enrollee (attach documentation that shows authority to represent enrollee, if other than prescribing physician)

Enrollee/Requestor's Address City State Zip Code

( )
Phone

Name of prescription drug you are requesting (if known, include strength, quantity and quantity requested per month):

Prescribing Physician's Information

Name

Medical Specialty

Address City State Zip Code

( ) Work Phone

( ) Fax

Office Contact Person

Type of Coverage Determination Request

☐ I need a drug that is not on the plan's list of covered drugs (formulary exception).*

☐ I have been using a drug that was previously included on the plan's list of covered drugs, but is being removed or was removed from this list during the plan year (formulary exception).*

Appendix B – Model Coverage Determination (continued).

CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/downloads/ModelCoverageDeterminationRequestForm.pdf

☐ I request an exception to the requirement that I try another drug before I get the drug my doctor prescribed (formulary exception).*

☐ I request prior authorization for the drug my doctor has prescribed.

☐ I request an exception to the plan's limit on the number of pills (quantity limit) I can receive so that I can get the number of pills my doctor prescribed (formulary exception).*

☐ My drug plan charges a higher copayment for the drug my doctor prescribed than it charges for another drug that treats my condition, and I want to pay the lower copayment (tiering exception).*

☐ I have been using a drug that was previously included on a lower copayment tier, but is being moved to or was moved to a higher copayment tier (tiering exception).*

☐ I want to be reimbursed for a covered prescription drug that I paid for out of pocket.

***NOTE: If you are asking for a formulary or tiering exception, your PRESCRIBING PHYSICIAN must provide a statement to support your request. You cannot ask for a tiering exception for a drug in the plan's Specialty Tier. In addition, you cannot obtain a brand name drug at the copayment that applies to generic drugs.**

Additional information we should consider *(attach any supporting documents)*:

_____

_____

_____

_____

If you, or your prescribing physician, believe that waiting for a standard decision (which will be provided within 72 hours) could seriously harm your life or health or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescribing physician asks for a faster decision for you, or supports you in asking for one by stating (in writing or in a telephone call to us) that he or she agrees that waiting 72 hours could seriously harm your life or health or ability to regain maximum function, we will give you a decision within 24 hours. If you do not obtain your physician's support, we will decide if your health condition requires a fast decision.

☐ I need an expedited coverage determination (attach physician's supporting statement, if applicable)

_____ _____

Beneficiary/Requestor's Signature Date

Send this request to your Medicare drug plan. Note that your Medicare drug plan may require additional information. See your plan benefit materials for more information.

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

Appendix C – Appointment of Representative Form as discussed on slide 28.

Visit CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the "Act") and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		**Phone Number (with Area Code)**
City	**State**	**Zip Code**

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (DHHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		**Phone Number (with Area Code)**
City	**State**	**Zip Code**

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of DHHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Form CMS-1696 (11/15) 1

Appendix C – "Appointment of Representative" Instructions

Visit CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads /cms1696.pdf

Charging of Fees for Representing Beneficiaries before the Secretary of DHHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of DHHS (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance if you are filing a grievance, initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227). TTY users please call 1-877-486-2048.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-1696 (11/15) 2

Acronyms

- **ABN** Advance Beneficiary Notice of Non-coverage
- **ACO** Accountable Care Organization
- **AIDS** Acquired Immune Deficiency Syndrome
- **ALJ** Administrative Law Judge
- **BFCC** Beneficiary and Family Centered Care
- **CAH** Critical Access Hospital
- **CHIP** Children' Health Insurance Program
- **CORF** Comprehensive Outpatient Rehab Facility
- **DENC** Detailed Explanation of Non-coverage
- **ESRD** End-Stage Renal Disease
- **FDA** Food and Drug Administration
- **HIV** Human Immunodeficiency Virus
- **HMO** Health Maintenance Organization
- **IRE** Independent Review Entity
- **LEP** Late Enrollment Penalty
- **MA** Medicare Advantage
- **MAC** Medicare Appeals Council
- **MOON** Medicare Outpatient Observation Notice
- **MSA** Medicare Savings Account
- **MSN** Medicare Summary Notice
- **NOMNC** Notice of Medicare Non-coverage
- **NTP** National Training Program
- **OASIS** Outcome and Assessment Information Set
- **OCR** Office for Civil Rights
- **PA** Prior Authorization
- **PFFS** Private Fee-for-Service
- **PHI** Personal Health Information
- **PPO** Preferred Provider Organization
- **QIC** Qualified Independent Contractor
- **QIO** Quality Improvement Organization
- **SHIP** State Health Insurance Assistance Program
- **SNF** Skilled Nursing Facility
- **SSA** Social Security Administration
- **TTY** Teletypewriter