



VERMONT

MEDICARE APPEAL RESOURCE GUIDE

FOR ADVOCATES

SERVING MEDICARE BENEFICIARIES

May 2007

Produced by:

**SMP of Vermont, a special project of the Community of Vermont Elders; and
Medicare Advocacy Project, a Project of Vermont Legal Aid, Inc.**

About this Guide

Advocates who work with elders on Medicare billing and coverage problems identified one of their major problems as the lack of a resource guide. Practical information was needed to assist people with the appeals process for Medicare denials of coverage for health care services in Vermont. Vermont SMP (Senior Medicare Patrol) located at the Community of Vermont Elders collaborated with the Medicare Advocacy Project at Vermont Legal Aid to produce this guide.

Vermont SMP is a federally funded project of the Administration On Aging and is housed at the Community of Vermont Elders. SMP educates and assists Medicare beneficiaries and advocates about issues with health care billing errors, fraud and abuse. The goal is to empower seniors to prevent healthcare fraud.

The Community of Vermont Elders' (COVE) mission is to promote and protect a higher quality of life for the state's seniors. COVE works with and for elder Vermonters and the organizations that serve them to identify, interpret and respond to issues that impact the dignity, security and wellbeing of seniors.

The Appeals Guide was originally developed as a joint effort in June 2004 in collaboration with COVE's SMP, the Medicare Advocacy Project (MAP), the Northeast Health Insurance Company (NHIC- a Medicare contractor for claims processing), the State Health Insurance Assistance Program (SHIP), elders, and Vermont Medicare officials. SMP wishes to acknowledge and thank the Medicare Advocacy Project for researching and revising this guide as well as the support of Jerri Holmes who served as an SMP intern. This guide was last updated in May 2007.

For additional information or questions, please contact either Vermont SMP at the Community of Vermont Elders (COVE) by calling (802) 229-4731 or the Medicare Advocacy Project at the Vermont Legal Aid at (888) 909-0935.

Vermont

Medicare Appeal Resource Guide

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I. Introduction

A beneficiary has the right
to appeal any decision
about their Medicare services

There is a right to appeal Medicare coverage determinations. This is true whether you are in the original Medicare Plan, a Medicare Managed care plan, or a Medicare prescription drug plan.

A Medicare beneficiary who is unsatisfied with a Medicare coverage determination that did not cover or did not pay enough for an item or health care service has a legal right to appeal the decision. A beneficiary who wants help filing an appeal can have his or her health care provider appeal directly, or may receive help from a friend or lawyer to file a beneficiary appeal.

If a service at issue will not be covered or will be discontinued, the Medicare beneficiary must be given notice. In general, the rights and means for a Medicare beneficiary to appeal as well as the reasons for the Medicare denial are contained in the document that informs a beneficiary of the coverage determination. This document is typically titled either **Medicare Summary Notice** or **Explanation of Medicare Benefits**. This information will include instructions on how to appeal the Medicare determination. A Medicare beneficiary wishing to appeal a Medicare determination should follow the directions on the forms he or she receives. **If the information in this Guide differs from the instructions on a beneficiary's forms, a beneficiary should usually follow the directions given on the forms.**

If you think Medicare should pay, **be persistent**. Beneficiaries should not give up or be discouraged if Medicare denies their claims at the first few levels of the appeals process. The fourth level of review – the Administrative Law Judge – is the first opportunity to actually talk to the person who makes the coverage decision. Many people who are entitled to Medicare coverage have their claims denied several times before they finally win the coverage they deserve.

II. Types of Medicare appeals

This guide covers four categories of Medicare Appeals:

- **Medicare Part A** – includes inpatient hospital, skilled nursing facility, hospice, and home health care services.
- **Medicare Part B** – includes outpatient services such as physician services, and medically related items such as durable medical equipment (DME), e.g., wheelchairs, walkers, canes or crutches, prosthetics and orthotics.
- **Medicare Advantage (Part C)** – (formerly called Medicare+Choice) are the Medicare Advantage Plans offered by private companies that have entered into contracts with the Center for Medicare and Medicaid Services (CMS).
- **Medicare Part D** – consists of the new Medicare prescription drug benefit.

III. Procedures for each type of Medicare appeal

All Medicare payments are made on the condition that the beneficiary will pay Medicare back if benefits can or could be paid by their insurance company. Types of insurance that should pay before Medicare include employer group health plans, no-fault insurance, automobile medical insurance, liability insurance and worker's compensation.

1) Medicare Part A appeals and Medicare Part B appeals

The first few levels of appeal are actually decided by various **independent contractors** hired by Medicare, not by the government. The contractor is different at each level of appeal, and the contractors used vary from place to place and may change over time. It is, therefore, very important to check the contact information on each form the beneficiary receives.

Before an appeal

A beneficiary's first "denial" for Medicare often comes in a form of a **notice** that their health care provider believes that Medicare will not pay for their medical services. Technically, this notice is not a Medicare denial; it is just the provider's opinion. After receiving this notice – and before a beneficiary can appeal – the beneficiary must officially ask Medicare to pay and get an official denial. The following are notices do not constitute official Medicare denials:

- Notice for discontinuation of coverage of hospital services is called an **Important Message to Medicare Beneficiaries**. This notice will tell the beneficiary how to formally disagree with the hospital's decision to discontinue services.

- Notice for the discontinuation of skilled nursing facility services comes with a disagreement form that must be completed and returned before starting an appeal.
- Notice for discontinuation of coverage of home health services is called a **Home Health Advance Beneficiary Notice**, which says that the Home Health Agency thinks that Medicare will not pay for home health services.

First Step: Initial Determination

After receiving one of the notices listed above, ask for an official Medicare decision on whether the care is covered. Again, the notice from a provider is not an official Medicare decision and cannot itself be appealed. The first official decision of coverage is called an **initial determination**. To ask for this initial determination, the beneficiary must continue to receive care and must ask their provider (such as a Home Health Agency) to send a **demand bill** to Medicare.

Appeals begin as soon as the beneficiary receives an initial determination that is a Medicare benefit denial letter, usually titled **Medicare Summary Notice** or **MSN**.

Second Step: Redetermination

The first level of a Part A or Part B appeal is called a **request for redetermination** of the initial determination.

- A beneficiary has **120 days** from when they receive the initial determination (the MSN) to request an appeal.
- The paperwork that comes with the “initial determination” will include information on the right to request a “redetermination” and on how to appeal.
- The beneficiary must be sure to have all information relevant to the appeal ready when writing to request a “redetermination.” This includes the following information:
 1. Beneficiary name
 2. Name and address of provider/supplier of item/service
 3. Medicare health insurance claim (HIC) number
 4. Date of initial determination (1st notice or MSN)
 5. Date(s) of service for which the initial determination was issued
 6. Which item(s), if any, and/or service(s) are at issue in the appeal
- The “initial determination” is actually decided by a contractor hired by Medicare, not by the government. The “initial determination” paperwork will have contact information for the contractor. A beneficiary can call or write the contractor to ask the customer service representative why the claim was denied and what rule, policy or regulation led to the denial. The beneficiary should ask the customer service person whether their information corresponds to the claim file, as many Medicare denials are due to simple clerical errors.
- It helps if a beneficiary submits a signed statement of why they feel the service or item

should be covered, describing how the item or service addressed a particular medical need. Also, a similar signed statement from the provider or treating health care professional (such as a doctor) will greatly improve the odds of a positive result.

- The independent contractor reviewing the claim has **60 days** to make a decision. If additional evidence is sent after filing the request for “redetermination,” the decision deadline is automatically extended up to **14 days** for each submission.

Third Step: Reconsideration

If the beneficiary is dissatisfied with the “redetermination” decision, the beneficiary may request a **reconsideration** by a Qualified Independent Contractor (QIC). The paperwork from the lower-level “redetermination” decision is usually titled **Medicare Appeal Decision**.

- A beneficiary has **180 days** from the “redetermination” to request “reconsideration.”
- The “redetermination” decision will state the beneficiary’s rights and process of requesting a “reconsideration” decision. Be sure to send the request for “reconsideration” to the address noted on the “redetermination” decision.
- The beneficiary for this appeal can use a form located at www.cms.hhs.gov/cmsforms/downloads/cms20033.pdf
- Use of the form is not required as long as the appeal includes the following information:
 1. Beneficiary name and address
 2. Name and address of provider/supplier of item/service
 3. Medicare health insurance claim (HIC) number
 4. Name and address of person appealing
 5. Date(s) of service for which the reconsideration decision was made
 6. Which item(s), if any, and/or service(s) are at issue in the appeal
 7. A statement you have sent a copy of the request to the other parties to the appeal
- The qualified independent contractor reviewing the claim has **60 days** to make a decision in “reconsideration.”

Fourth Step: Administrative Law Judge

If the beneficiary is dissatisfied with the “reconsideration” decision by QIC and the **amount in dispute** is greater than **\$110**, the beneficiary is entitled to a hearing before an **Administrative Law Judge (ALJ)**. A “reconsideration” decision will usually say the words “Reconsideration decision” in the top left corner. The “amount in dispute” is the amount that the beneficiary wants Medicare to pay and that Medicare still has not agreed to pay.

- The ALJ hearing can be by video teleconferencing, by telephone, in person, or “on the record” (that is, based solely on the paperwork submitted by the beneficiary). It is possible to get an in person hearing if the beneficiary shows “good cause,” but such hearings are rare because the Administrative Law Judges closest to Vermont are in Cleveland, Ohio.
- The “reconsideration” decision will state the rights and process of requesting an ALJ hearing, including contact information.
- The beneficiary for this appeal can use a form located at <http://www.medicare.gov/Basics/forms/default.asp>
- Use of the form is not required as long as the appeal includes the following information:
 1. Beneficiary name and address
 2. Name and address of provider/supplier of item/service
 3. Medicare health insurance claim (HIC) number
 4. Name and address of person appealing
 5. Date(s) of service for which the reconsideration decision was made
 6. Which item(s), if any, and/or service(s) are at issue in the appeal
 7. A statement you have sent a copy of the request to the other parties to the appeal
- An ALJ hearing must be requested within **60 days** from the date of the “reconsideration” decision.
- The beneficiary has a right to submit **new evidence** (such as letters from a doctor) at this level, just like at the lower levels of appeal. The deadline for submitting new written evidence is **10 days** after receiving the “notice of hearing” from the ALJ’s office.
- After a hearing is requested, the ALJ’s office will contact the beneficiary to set up a hearing. The beneficiary will usually be referred to a video teleconferencing site. If the teleconferencing site is far away, ask whether there are any closer locations. Hearings by telephone can be used if necessary.

Fifth Step: Medicare Appeals Council

If the beneficiary is dissatisfied with the decision of the ALJ, the beneficiary may request that the **Medicare Appeals Council** of the Centers for Medicare and Medicaid Services (CMS) review the ALJ decision. The appeal must be made within **60 days** of receipt of the ALJ decision.

A form for making this appeal is available at <http://www.hhs.gov/dab/DAB101.pdf> but use of that form is not required.

Send the appeal to the following address (or if the address noted on the ALJ decision differs, to the address on the decision):

Department of Health and Human Services
 Departmental Appeals Board, MS 6127
 Medicare Appeals Council
 330 Independence Avenue, SW, Room G-644
 Washington DC 20201

Sixth Step: Federal Court

If the beneficiary is dissatisfied with the conclusion of the Appeals Council, the beneficiary may file a civil action in U.S. District Court within **60 days** if the amount in controversy is **\$1130** or more. Appeals at this level are complicated, and the help of a lawyer is usually necessary.

Levels of appeal for Medicare Parts A and B

Level	Appeals deadline - counting from receipt of lower decision	Name on the decision	Minimum amount in controversy
0. Notice	Not actually a medicare denial. Ask for an initial determination.	Various names, depending on service	none
1. Initial determination	n/a	Medicare Summary Notice	none
2. Redetermination	120 days from initial determination	Medicare Appeal Decision	none
3. Reconsideration	180 days from redetermination decision	Reconsideration Decision	none
4. Administrative Law Judge (ALJ)	60 days from reconsideration decision	ALJ Decision	\$110**
5. Medicare Appeals Council	60 days from ALJ decision	MAC Decision	none
6. Federal Court	60 days from MAC decision		\$1130**

**For appeals in 2007. These amounts are increased each year.

2) Medicare Part C Advantage Plans

There are three different types of appeals for Medicare Advantage Plan (MA plan) coverage:

1. **Fast-track appeal (Quality Improvement Organization appeal)**
2. **The regular appeals process**
3. **Expedited appeal**

A fast-track appeal is a special appeals process available only for a beneficiary who is about to be discharged from a hospital, skilled nursing facility, home health care agency or a comprehensive rehabilitation facility. If a beneficiary misses the deadline for filing a fast-track appeal, he or she can still request a regular or expedited appeal.

The **regular appeals** and **expedited appeals** have the same process. The only difference is that in an expedited appeal the reviewers must make their decisions more quickly.

An **expedited** appeal is allowed if waiting for a regular decision would “seriously jeopardize” the beneficiary’s life, health, or ability to regain maximum function.

A. Fast Track Appeals for beneficiaries about to be discharged from care:

If a beneficiary has been receiving care in a hospital, skilled nursing facility, home health care agency or a comprehensive rehabilitation facility, and is about to be discharged from care before he or she is ready, the beneficiary can make a **fast track appeal** to challenge discharge. A “fast track appeal” differs from regular appeals and from expedited appeals and is reviewed by a **Quality Improvement Organization (QIO)**.

- At least two days before care is about to end, the MA plan must provide a beneficiary with a **Notice of Medicare Non-Coverage**. The Notice of Medicare Non-Coverage will have instructions on how to make a fast-track appeal.
- **A beneficiary has only one day to appeal:** he or she must request a fast-track appeal by noon the day after receiving the Notice of Medicare Non-Coverage.
- If a beneficiary misses the deadline for filing with a Quality Improvement Organization (QIO), he or she can still request a regular or expedited appeal.

B. Regular and Expedited Appeals

First Step: Organization Determination

- Before making an appeal, a beneficiary must ask the MA plan to pay.
- An **expedited determination** is available where waiting 14-days for a decision would “seriously jeopardize” the beneficiary’s life, health, or ability to regain maximum function.
- Requesting an **expedited determination**:
 - The beneficiary or a physician can make an oral or written request for an expedited determination.
 - If an expedited determination is appropriate, a beneficiary should usually make an oral or faxed request and should have his or her physician support the request orally or in writing.
 - The appeal is automatically expedited if a physician asserts orally or in writing that delay will seriously jeopardize the patient’s life, health, or ability to regain maximum function. Otherwise the MA decides whether to expedite the appeal.
- For services that have not been provided yet, the MA plan has **14 days** to make a decision for a regular appeal, or **72 hours** for an expedited appeal.
- For services that have already been provided, the MA plan has 30 days to process a claim.
- The MA plan must respond in writing and explain how to appeal a denial.

Second Step: Reconsideration by MA plan

The first level of a MA plan appeal is **reconsideration** by the plan itself.

- A beneficiary has **60 days** to request a reconsideration of the initial denial.
- A beneficiary can request reconsideration by filing a signed, written request with the MA plan. The paperwork that comes with the organization determination will include information on how to request a reconsideration.
- Requesting an **expedited reconsideration**:
 - The beneficiary or a physician can make an oral or written request that the reconsideration be expedited.
 - Usually, a beneficiary should make an oral request for an expedited determination and should have his or her physician support the request orally or in writing.
 - The appeal is automatically expedited if a physician asserts orally or in writing that delay will seriously jeopardize the patient’s life, health, or ability to regain maximum function. Otherwise the MA decides whether to expedite the appeal.
- For services that have not been provided yet, the MA plan has **30 days** to make a decision for a regular appeal, or **72 hours** for an expedited appeal.

- For services that have already been provided, the MA plan has **60 days** to process a claim.
- If the plan rejects the appeal (refuses to change its mind), it must **automatically forward the appeal** to an Independent Review Entity (the third step).

Third Step: Reconsideration by Independent Review Entity (IRE)

If the MA plan rejects an appeal at the second step (reconsideration by the plan), it must **automatically forward** the appeal to a contractor called an Independent Review Entity (IRE).

- The IRE must ask for the beneficiary's input, and the beneficiary can submit new evidence.
- Federal regulations do not set a deadline for the reconsideration decision, but the IRE must follow any deadline set by its contract. Expedited decisions are usually made within 10 days.

Fourth Step: Administrative Law Judge

If the beneficiary is dissatisfied with the IRE's decision and the **amount in dispute** is greater than **\$110**, the beneficiary is entitled to a hearing before an **Administrative Law Judge (ALJ)**. The "amount in dispute" is the amount that the beneficiary wants Medicare to pay and that Medicare still has not agreed to pay.

- The beneficiary has **60 days** from receipt of the IRE decision to file an ALJ appeal.
- The beneficiary has a right to submit **new evidence** (such as letters from a doctor) at this level, just like at the lower levels of appeal. The deadline for submitting new written evidence is **10 days** after receiving the "notice of hearing" from the ALJ's office.
- After a hearing is requested, the ALJ's office will contact the beneficiary to set up a hearing. The beneficiary will usually be referred to a video teleconferencing site. If the teleconferencing site is far away, ask whether there are any closer locations. Hearings by telephone can be used if necessary.

Fifth Step: Medicare Appeals Council

If the beneficiary is dissatisfied with the decision of the ALJ, the beneficiary may request that the **Medicare Appeals Council** of the Centers for Medicare and Medicaid Services (CMS) review the ALJ decision. The appeal must be made within **60 days** of receipt of the ALJ decision. The ALJ decision will include information on the process for appealing.

Sixth Step: Federal Court

If the beneficiary is dissatisfied with the conclusion of the Appeals Council, the beneficiary may file a civil action in U.S. District Court within **60 days** if the amount in controversy is **\$1130** or more. Appeals at this level are complicated, and the help of a lawyer is usually necessary.

Levels of Appeal for Medicare Part C – Medicare Advantage*

Level	Appeals deadline	Time for decision		Minimum amount in controversy
		Regular	Expedited	
1. Organizational Determination		72 hours	24 hours	none
2. Reconsideration by plan	60 days from organizational determination	30 days	72 hours	none
3. Reconsideration by Independent Review Entity	None (automatic appeal)	no limit	n/a	none
4. Administrative Law Judge (ALJ)	60 days from IRE decision	90 days	n/a	\$110**
5. Medicare Appeals Council	60 days from ALJ decision	90 days	n/a	none
6. Federal Court	60 days from MAC decision	no limit	n/a	\$1130**

* Does not include the fast-track appeals process

**For appeals in 2007. These amounts are increased each year.

3) Medicare Part D appeals (Prescription drug benefit):

Technically, there are two kinds of Medicare Part D Appeals for disputes concerning benefit coverage: **exceptions** and **appeals**.

- An **exception** is a request for the drug plan to cover a drug that it normally does not cover, or to cover a non-preferred drug as if it were preferred.
- An **appeal** is an effort to reverse some other type of plan decision, such as a decision that a drug that should be covered is not “medically necessary.”

Both the “exceptions” and the “appeals” processes are the same, and they are both referred to as “appeals” in this guide (thus, this is also the process used to ask for advance permission to prescribe a drug that is normally not covered).

First Step: Coverage Determination

Before making a Medicare appeal, a beneficiary must get an official **coverage determination** stating whether the Part D Prescription Drug Plan will pay for a prescription.

To get the official “coverage determination,” call the beneficiary’s drug plan; the phone number should be on the beneficiary’s drug insurance card. Alternatively, a beneficiary can write the drug plan or call **1-800-Medicare** to request a “coverage determination.” No specific format is required to request the coverage determination.

- The beneficiary has **60 days** to ask for a “coverage determination.”
- The drug plan must normally issue a “coverage determination” within **72 hours** of a request. If the beneficiary needs the drugs immediately, it is possible to request an **“expedited” review**, which means that the plan only has **24 hours** to make its decision. To make a request for an “expedited review,” a beneficiary should get a letter from his or her doctor explaining that a delay will harm the beneficiary’s health.

Second Step: Redetermination

A **“redetermination”** by the plan sponsor is the second level of review.

- The beneficiary’s coverage determination will have information on how to request a “redetermination” by the Part D plan. The request must be in writing, and new evidence can be submitted.
- The beneficiary has **60 days** to ask for a “redetermination.”
- The drug plan must normally issue a “redetermination” decision within **7 days** of a

request. If the beneficiary requests “expedited review,” the decision must be made within **72 hours**. The decision can be made orally and confirmed in writing.

Third Step: Reconsideration

Appeal for reconsideration by an Independent Review Entity (IRE) is the third review level.

- The beneficiary’s lower-level “redetermination” decision will have information on how to request a “reconsideration” by the IRE. The reconsideration request must be in writing. The IRE must request the views of the prescribing physician, and new evidence can be submitted.
- The beneficiary has **60 days** after receiving the “redetermination” decision to ask for “reconsideration.”

The IRE must normally issue a “reconsideration” decision within **7 days** of a request. If the beneficiary requests “expedited” review, the decision must be made within **72 hours**. In an “expedited” review, the IRE must contact the beneficiary’s doctor to check the status of the beneficiary’s health.

Fourth Step: Administrative Law Judge

At the fourth level of review, an **Administrative Law Judge (ALJ)** will review the decision. This hearing can be held by video teleconferencing, by telephone, in person, or “on the record” (that is, based solely on the paperwork submitted by the beneficiary).

- The beneficiary’s “reconsideration” decision will have information on how to request an ALJ hearing.
- The beneficiary has **60 days** after receiving the “reconsideration” decision to ask for an ALJ hearing.
- The beneficiary’s claim must be worth at least **\$110** or else it is not possible to appeal to an ALJ. To calculate the value of the claim, include the cost of all refills that have been denied, not just the original fill.

Fifth Step: Medicare Appeals Council

If the ALJ denies the appeal, an appeal can be made to the **Medicare Appeals Council** (MAC) of the Centers for Medicare and Medicaid Services (CMS). The appeal must be made within **60 days** of receipt of the ALJ decision. A form for making this appeal is available at <http://www.hhs.gov/dab/DAB101.pdf> but the use of that form is not required.

Sixth Step: Federal Court

If the beneficiary is dissatisfied with the conclusion of the Appeals Council, he or she may file a civil action in **U.S. District Court** if the amount in controversy is **\$1130** or more. It is possible to combine appeals to meet this amount, and refills are included in the total cost. The action must be filed within **60 days** of the MAC decision. See *42 U.S.C. § 405(g)* for a description of the review available.

Levels of Appeal for Medicare Part D

Level	Appeals deadline	Time for decision		Minimum amount in controversy
		Regular	Expedited	
1. Coverage Determination	At any time	72 hours	24 hours	none
2. Redetermination	60 days from coverage determination	7 days	72 hours	none
3. Reconsideration by Independent Review Entity	60 days from redetermination decision	7 days	72 hours	none
4. Administrative Law Judge (ALJ)	60 days from reconsideration decision	no limit	n/a	\$110**
5. Medicare Appeals Council	60 days from ALJ decision	no limit	n/a	none
6. Federal Court	60 days from MAC decision	no limit	n/a	\$1130**

**For appeals in 2007. These amounts are increased each year.

IV. Resources for more information about Medicare appeals

The following resources provide more information about Medicare appeal procedures:

For General Medicare Information:

The Medicare Hotline of the Centers for Medicare & Medicaid Services
Website: www.cms.gov or www.medicare.gov
1-800-MEDICARE (1-800-633-4227)

For more information on Medicare Part D Appeals:

The Medicare Rights Center has produced a detailed “Advocate’s manual to navigating the Medicare private drug plan appeals process,” which includes various case examples. It is available online at <http://www.medicarerights.org/appealsmanual.html> or by calling 888-466-9050.

V. Vermont organizations that help with Medicare appeals

State Health Insurance Assistance Programs

The State Health Insurance Assistance Programs (SHIPs) provide information, counseling, and assistance to Vermont Medicare beneficiaries who have questions about Medicare. If a Medicare beneficiary wishes to call SHIP with Medicare questions they may be referred to their local Area Agency on Aging (AAA) for help. Call the SHIP Senior Help Line at **1-800-642-5119** with any Medicare questions or concerns or to be linked to a nearby AAA.

Area Agencies on Aging

A Medicare beneficiary may contact their local Area Agency on Aging (AAA) directly for help with Medicare Questions. Local AAA contact information is listed below.

Northeastern Vermont Area Agency on Aging
1161 Portland Street
St. Johnsbury, Vermont 05819
1-802-748-5182 or 1-800-642-5119 (Senior Help Line)
www.nevsaaa.org

Champlain Valley Agency on Aging
Chase Mill, Room 3-51 Mill Street
1-802-865-0360 or 1-800-642-5119 (Senior HelpLine)

www.cvaa.org

Southwestern Vermont Council on Aging

1085 U.S. Route 4 East, Unit 2B

Rutland, Vermont 05701

802-786-5990 or 1-800-642-5119 (Senior Help Line)

www.svcoa.org

Central Vermont Council on Aging

30 Washington Street

Barre, Vermont 05641

802-479-0531 or 1-800-642-5119 (Senior Help Line)

Council on Aging for Southeastern Vermont

56 Main Street

Springfield, Vermont 05156

802-885-6636, 1-802-885-2656 or 1-800-642-5119 (Senior Help Line)

www.coasevt.org

Vermont Legal Aid

For legal questions or concerns regarding Medicare or Vermont state insurance programs, call **1-800-889-2047** to be referred to a Vermont Legal Aid office near you. If you prefer, you can call a specific Legal Aid project using the contact information that follows. The following projects at Vermont Legal Aid help Medicare beneficiaries with appeals over denied coverage and will not charge for this service. Each project serves a different category of Vermonters; see below for a description of each project and the people they help.

The Office of Health Care Ombudsman (HCO) is a project of Vermont Legal Aid mandated to assist all Vermonters with issues related to health care and health insurance.

It assists Vermonters regardless of income or type of insurance. Some examples of the types of cases it assists Vermonters with include coverage of medically necessary care, access to care, billing issues, eligibility for federal and state health care programs. It is available to assist any Medicare beneficiaries with issues related to coverage or eligibility and may also refer individuals to other projects of VLA that handle Medicare coverage and appeals.

The HCO's toll free number is **1-800-917-7787** (TTY/TDD 1-888-884-1955). It is located in the Burlington office of Vermont Legal Aid at:

The Office of Health Care Ombudsman

264 North Winooski Avenue
P.O. Box 1367
Burlington VT 05402.

The Senior Citizen Law Project (SCLP) of Vermont Legal Aid represents seniors in a wide variety of legal matters, including Medicare.

SHIP Coordinators can contact SCLP attorneys with questions regarding Medicare, and should refer clients with legal problems related to Medicare like denials, terminations, or problems with coverage for services, to the SCLP. SCLP attorneys are located in 4 offices around the state, and cover all counties except Caledonia, Essex and Orleans.

Clients should be referred to the local VLA office, or they can use the statewide number: 800-747-5022

Director:	Michael Benvenuto	
	Burlington office:	802 863-7155
Staff Attorneys:	Burlington office:	800 747-5022
	Rutland office:	800 769-7459
	Montpelier office:	800 789-4195
	Springfield office:	800 769-9164

The Medicare Advocacy Project (MAP) of Vermont Legal Aid assists Vermonters who have both Medicare and Medicaid coverage (dual eligibles) under a special contract with Vermont Medicaid.

MAP's purpose is to bring Medicare appeals on behalf of any Vermont dual eligible for any service covered by Medicare. SHIP Coordinators can contact MAP for Medicare appeal assistance on behalf of dual eligible clients. MAP also assists advocates, lawyers and health providers with technical information on Medicare law and service coverage questions.

MAP's toll free number is 1-888-909-0935. MAP is located at:

The Medicare Advocacy Project
56 Main St., Suite 301
Springfield, VT 05156

The Disability Law Project (DLP) of Vermont Legal Aid provides free legal representation to Vermonters with physical and developmental disabilities in legal

problems arising from their disability.

The DLP regularly represents individuals with disabilities in appeals of denials of Medicaid or Medicare coverage for needed health care and long term care. The DLP receives special funding to provide legal representation to individuals with disabilities to help them obtain access to Medicare or Medicaid funding for assistive technology devices and services. The DLP also provides technical assistance and training to lay advocates and professional organizations.

SHIP Coordinators can contact DLP for assistance on behalf of individuals with physical and developmental disabilities by contacting any Vermont Legal Aid office.

The DLP can be reached through the project's statewide number: **800-889-2047**.

VI. List of Appendices

Sample Medicare Decisions for Part A and B

1. Sample Part A **initial determination**, titled “**Medicare Summary Notice**”
2. Sample Part B **initial determination**, titled “**Medicare Summary Notice**”
3. Sample **redetermination notice**, titled “**Medicare Appeal Decision**”
4. Sample **reconsideration decision**, titled “**Medicare Reconsideration Decision**”

Medicare Part A and B appeals Forms (use is optional)

5. Reconsideration Request Form (CMS 20033)
6. Request for Hearing by an Administrative Law Judge (CMS-20034 A/B)

Other Medicare Forms

7. Transfer of Appeal Rights Form (CMS 20031)

More specialized forms can be found at the following websites:

<http://www.medicare.gov/Basics/forms/default.asp>

<http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp>