

## What Can a Beneficiary Do if Medicare Refuses to Pay for a Medical Service?

### **The Beneficiary Should Receive a Denial**

**Notice:** The medical provider is responsible for submitting a claim to Medicare for the medical service or procedure. If Medicare denies payment of the claim, it **MUST** be in writing and state the reason for the denial. This notice is usually called the Medicare Summary Notice.

**Look for the Reasons for Denial:** The notice must state the reason for the denial. Sometimes payment is denied because of a problem with the claim form (e.g. missing information, included errors, incorrect codes.) Other times, the notice states that the service or procedure was “not medically necessary” or that the case “does not support the need for this many visits or treatments.” If the claim was denied due to a local coverage rule (called local coverage determination), it must be stated on the notice. In addition, the notice must identify the applicable local coverage determination and how to obtain a copy of it.

**What the Beneficiary/Caregiver can do:** If the claim is denied because there is a problem with the claim form, contact the provider or the provider’s billing office and ask them to correct the mistake and refile the claim. The beneficiary/caregiver can also file an appeal as provided in the notice.

If the claim is denied because the medical service/procedure was “not medically necessary,” there were “too many or too frequent” services or treatments or due to a local coverage determination, the beneficiary/caregiver may want to file an appeal of the denial decision.

**Appeal the Denial of Payment:** There are different appeal procedures for Part A and Part B of the Original (fee-for service) Medicare program. The appeal procedure must be included on the denial notice. Read the instructions carefully and be sure to file the appeal within the stated time requirements. If the claim was denied because it was “not medically necessary,” or the services “too many or too frequent,” it is helpful to submit supporting information from the treating doctor and other medical providers.

**Where to Find Help:** Beneficiaries/caregivers can get free assistance from the local legal services for senior citizens program (Title IIIB provider), the Area Aging Agency, and the State Health Insurance Counseling and Assistance Program (SHIP).

### **Resources for Alzheimer’s Association**

**Chapters:** The Medicare Advocacy Project is available for technical assistance if you have questions about Medicare denials of services in the Original Medicare program. The Project is especially interested in claims that are denied because the service was “not medically necessary” or “too many or too frequent.” In those cases, the denial is often because of a Local Coverage Determination, which limits payment of certain services, which has been adopted by the local carrier or intermediary. Please contact the Medicare Advocacy Project if you have any questions about Medicare coverage at (202) 662-8684 or [leslie.fried@alz.org](mailto:leslie.fried@alz.org).