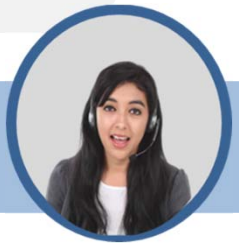
Medicare Appeal Guidance

Here's a simple way to determine when to inform the member to their right to file an appeal.

A member calls asking for an explanation regarding an HFHP ***decision*** or ***outcome*** i.e. copays, claim or pre-auth denials.

You explain the basis of the decision.



The member does not agree with the decision.

You must ***inform*** the member of their right to an ***appeal***.

Below is the CMS definition

Appeal*: Any of the procedures that deal with the review of* ***adverse organization determinations*** *on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.*