

assets (not counting retirement accounts & personal belongings). Your spouse's income and assets are not counted.

**New!** [www.db101.org](http://www.db101.org): You can go to [www.db101.org](http://www.db101.org) to find more information about work incentives, see how your benefits and income might change with a job, set work goals and plan next steps. DB101.org is a free service and does not affect your benefits.

### Medicare enrollment periods, health screening and turning age 65

- When you turn age 65, you will be entitled to another initial enrollment period for Medicare Part B
  - ▶ If you enrolled in Medicare Part B due to a disability and had to pay a premium penalty because you did not enroll when initially eligible, once you turn age 65, you will no longer have to pay the premium penalty.
- When you turn age 65, you will be entitled to another initial enrollment period for Medicare Part D
- When you turn age 65, you will be entitled to another Medicare Supplement (Medigap) open enrollment period with no health screening. This applies if you voluntarily dis-enrolled from Medicare Part B because you had employer group health plan coverage due to employment.

### Questions?

If you are under age 65 and have a disability please visit [www.db101.org](http://www.db101.org) or call the Disability Linkage Line® at **1-866-333-2466** for personalized assistance with understanding your options. The Disability Linkage Line® is open from 8:30 a.m.-5:00 p.m. Monday – Friday.

The Disability Linkage Line® is a free statewide comprehensive information, referral and assistance service for people with disabilities, chronic illnesses, and their representatives. Disability Linkage Line® specialists provide objective one-to-one assistance to help people learn about and manage their health care and other benefit options, as well as access community supports and services.

Disability Linkage Line® is a service of the Minnesota Department of Human Services and provided locally in all 87 counties by the Metropolitan Center for Independent Living and Southeastern Minnesota Center for Independent Living.

The Disability Linkage Line® is an integral part of the MinnesotaHelp Network™ which includes:

- Disability Linkage Line® 1-866-333-2466
- Senior LinkAge Line® 1-800-333-2433

- Veterans Linkage Line™ 1-888-546-5838 (1-888-LinkVet)
- [www.MinnesotaHelp.info](http://www.MinnesotaHelp.info)

## Your Rights: Medicare Part A, B, C and D Appeals

You have the right to appeal any decision about your Medicare services. This is true whether you are in Original Medicare, a Medicare Advantage plan, Other Medicare Plan or Medicare Part D stand alone prescription drug plan. If Medicare does not pay for an item or service you have been given, or if you are not given an item or service you think you should get, you can appeal.

### Fast Track Appeals under Original Medicare

If you are receiving Medicare services from a hospital, a skilled nursing facility, a home health agency, an outpatient rehabilitation facility, or a hospice, you have the right to ask for a fast or expedited appeal if you think that your covered services are ending too soon.

At least two days before your health care services will end, these types of Medicare providers must give you a written notice, usually called "Important Message from Medicare" or "Notice of Medicare Provider Non-coverage." The notice will explain how you can appeal to Medicare's Quality Improvement Organization (QIO), a private contractor hired by Medicare to decide this type of appeal. You can ask your doctor for medical information to help your appeal.

In Minnesota, the QIO is Stratis Health. If you believe you are being discharged from the hospital too soon, did not receive the proper quality of care or will lose any services you had been receiving from a provider, you should call Stratis Health right away to appeal these decisions. Stratis Health has phone numbers for each type of complaint in order to assist you as quickly as possible.

- Appeal your date of discharge: 1-866-894-1327
- Appeal discontinuing services (outside a hospital setting): 1-877-624-1414
- Quality of Care Complaint: 1-800-443-4323

**You must contact Stratis Health (QIO) to ask for a fast appeal no later than noon of the day before your Medicare services will end.** If you meet this deadline for a fast appeal and the QIO decides your services should end, Medicare will continue to pay only until the next day at noon. You will be responsible for any charges after that

time. If Stratis Health decides your care should continue, Medicare will continue the coverage for as long as it decides the care is medically necessary. If you did not meet the time deadline for a fast appeal, you still have standard appeal rights and should contact Stratis Health immediately.

### **Original Medicare Part A and B Appeal Rights :**

If you are enrolled in Original Medicare, you can file an appeal if you think Medicare should have paid for, or did not pay enough for, an item or service you received. If you file an appeal, ask your doctor or provider for any information related to the bill that might help your case. Your appeal rights are on the back of the Explanation of Medicare Benefits or Medicare Summary Notice that is mailed to you from the company that handles bills for Medicare. The notice will also tell you why your bill was not paid and what appeal steps you can take.

### **Original Medicare Part A and B Appeals Process**

Medicare Summary Notice (MSN) is issued to you quarterly if you have received any Medicare services or supplies. The MSN lists all of the services or supplies that were billed to Medicare for a 90 day period of time. If you disagree with a claims decision on your MSN, you have the right to file an appeal.

### **Medicare Advantage (Part C) and Medicare Part D Grievances**

A grievance is any complaint or dispute (other than one that involves an organization determination) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a Medicare health plan, or its providers, regardless of whether remedial action is requested.

You must file the grievance either orally or in writing no later than 60 days after the triggering event or incident precipitating the grievance.

Listed below are some examples of problems that are typically dealt with through the plan grievance process:

- Problems getting an appointment, or having to wait a long time for an appointment .
- Disrespectful or rude behavior by doctors, nurses or other plan clinic or hospital staff.
- Difficulties getting through to the plan.

### **Medicare Advantage (Part C) Appeals**

Medicare Advantage Plans are private companies that include inpatient, outpatient, and drug coverage through

enrollment in a managed care plan (HMO, PPO, PFFS, etc.). Medicare Advantage beneficiaries have appeal rights that are similar to Original Medicare beneficiaries' appeal rights.

If you are in a Medicare Advantage Plan, you can file an appeal if your plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service, ask the plan for a fast decision. The plan must answer you within 72 hours.

The Medicare Advantage Plan must tell you in writing how to appeal. After you file an appeal, the plan will review its decision. Then, if your plan does not decide in your favor, the appeal is reviewed by an independent organization that works for Medicare, not for the plan. See your plan's membership materials or contact your plan for details about your Medicare appeal rights.

### **Medicare Prescription Drug (Part D) Appeals**

If you are in a Medicare Prescription Drug Plan, you can appeal a plans' decision not to provide or pay for a Part D prescription drug that you believe the plan should provide or pay for. The word "provide" includes such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting. The Medicare Prescription Drug Plan must tell you in writing how to request an appeal.

If you request a standard appeal, the plan must answer you within 7 calendar days after receiving your request. If you (or your physician) think your health could be seriously harmed by waiting up to 7 calendar days for a decision, you or your physician can ask the plan for a fast appeal. If the request is approved, the plan must answer you within 72 hours.

After you file an appeal, the plan will review its decision. If the plan does not decide in your favor, you can appeal the plan's decision to an Independent Review Organization (IRE) that works for Medicare, not for the plan. See your plan membership materials or contact your plan for details about your appeal rights.

## Original Medicare Part A and Part B Appeals Process

Level/Type of Appeal	Time Limit	Amount at Issue	Who Handles Appeal?
<b>Redetermination</b>	You must request within <b>120 days</b> of receipt of the notice of initial determination (Medicare Summary Notice).	No minimum required	Medicare Administrative Contractor – different staff than those that made the Initial Determination.
<b>Qualified Independent Contractor (QIC) Reconsideration</b>	You must request within <b>180 days</b> from the date of receipt of the notice of the redetermination.	No minimum required	<p><b>Medicare Part A:</b>                      QIC Part A West Project                      MAXIMUS Federal Services, Inc.                      QIC Part A West Project                      P.O. Box 62410                      King of Prussia, PA 19406                      Phone: (484) 688-8900 or 1-800-MEDICARE</p> <p><b>Medicare Part B:</b>                      First Coast Service Options (FCSO)                      FCSO – QIC Part B North                      P.O. Box 45208J                      Jacksonville, Florida 32232-5029                      Phone: 904-791-6330 or 1-800-MEDICARE</p> <p><b>Part B Durable Medical Equipment:</b>                      River Trust Solutions                      DME QIC                      RiverTrust Solutions, Inc.                      1 Cameron Hill Circle                      Ste 0011                      Chattanooga, TN 37402-0011                      Phone: 423-535-4386 or 1-800-MEDICARE</p>
<b>Administrative Law Judge Hearing (ALJ)</b>	You must request within <b>60 days</b> after the receipt of the reconsideration decision.	2012 minimum amount = \$130	Office of Medicare Hearings and Appeals Cleveland, Ohio (Mid-West Field Office – including Minnesota) BP Tower, Suite 1300, 200 Public Square, Cleveland, OH 44114-2316 Phone: 866-236-5089
<b>Medicare Appeals Council</b>	You must request within <b>60 days</b> from the date of receipt of the ALJ decision.	No minimum required	Department of Health and Human Services Departmental Appeals Board Medicare Appeals Council, MS 6127 Cohen Building Room G-644 330 Independence Ave., S.W. Washington, D.C. 20201 Phone: 202-565-0100
<b>Federal District Court</b>	You must request within <b>60 days</b> of the date of the MAC's decision.	2012 minimum amount = \$1,300	U. S. District Court: District of Minnesota

## Medicare Advantage and Other Medicare Plan (Part C) Appeals

Level/Type of Appeal	Time Limit	Amount at Issue	Who Handles Appeal?
<b>Organizational Determination</b>	The Medicare Advantage Plan must give you its decision within <b>14 calendar days</b> after the date your plan received your request and <b>72 hours</b> for an <i>Expedited Organization Determination request</i> .	No minimum required	Medicare Advantage Plan
<b>First Level of Appeal is Reconsideration by Plan:</b> If you disagree with your Medicare Advantage Plan's decision, you, your representative, or your doctor may ask for a reconsideration as the first level of appeal. If your plan decides or your doctor tells the plan that your life or health is at risk, the plan must give an expedited decision.	You have <b>60 days</b> to file your Reconsideration request.  The Medicare Advantage Plan must give you its decision within <b>30 calendar days</b> for a standard request, <b>60 calendar days</b> for a payment request, and <b>72 hours</b> for a <i>fast (expedited) appeal</i> .	No minimum	Medicare Advantage Plan  If plan denies coverage, your case must be forwarded to the Independent Review Entity (MAXIMUS).
<b>Reconsideration by Independent Review Entity (IRE)</b>	You have <b>60 days</b> to request IRE reconsideration, however, the Medicare Advantage Plan is <u>required</u> to forward your case to the IRE for review if they deny your reconsideration request. The IRE's decision will come within <b>30 calendar days</b> for a standard request, <b>60 calendar days</b> for a payment request, and <b>72 hours</b> for a fast (expedited) appeal.	No minimum	Independent Review Entity for MN MAXIMUS Federal Services, Inc. Medicare Managed Care Reconsideration Project 50 Square Drive, Suite 210 Victor, New York 14564 Phone: 585-425-5210 or 1-800-MEDICARE
<b>Administrative Law Judge (ALJ)</b>	You must request the hearing within <b>60 days</b> of your unfavorable reconsideration decision.	2012 minimum amount = \$130	Office of Medicare Hearings and Appeals Cleveland, Ohio (Mid-West Field Office – including Minnesota) BP Tower, Suite 1300, 200 Public Square, Cleveland, OH 44114-2316 Phone: 866-236-5089
<b>Medicare Appeals Council</b>	You have <b>60 days</b> to request an appeal to the Medicare Appeals Council if you disagree with the ALJ's decision.	No minimum required	Department of Health and Human Services Departmental Appeals Board Medicare Appeals Council, MS 6127 Cohen Building Room G-644 330 Independence Ave., S.W. Washington, D.C. 20201 Phone: 202- 565-0100
<b>Federal District Court</b>	You have <b>60 days</b> to file an action in Federal District Court.	2012 minimum amount = \$1,300	U. S. District Court: District of Minnesota

## Medicare Part D Appeals

Level/Type of Appeal	Time Limit	Amount at Issue	Who Handles Appeal?
<p><b>Exception/Coverage Determination:</b> You or your prescriber may ask for an exception or a coverage determination from your Part D drug plan if it denies payment for your prescription.</p> <p>This request must usually be in writing, unless your plan will accept it by phone. In most cases, your prescriber must fax the information to your drug plan, stating the medical reasons why no similar drugs covered by your plan can be substituted for the prescribed drug.</p> <p><i>The time limits for the drug plan's decision are much shorter than the limits for Part A and Part B decisions. In addition, if the drug plan decides on its own or your doctor or prescriber tells the drug plan that your life or health is at risk, the drug plan must make a fast or expedited decision.</i></p>	<p>The drug plan has <b>72 hours</b> (for a standard request) or <b>24 hours</b> (for an expedited request) to notify you of its decision. If you disagree with your drug plan's decision, you then proceed to the next appeal level.</p>	<p>No minimum required</p>	<p>Your Medicare Prescription Drug Plan</p>
<p><b>First Level of Appeal: Redetermination</b></p>	<p>You, your representative, doctor, or prescriber must request a redetermination within <b>60 days</b> of the drug plan's decision. The drug plan must decide within <b>7 calendar days</b> for a standard request and <b>72 hours</b> for an expedited request.</p>	<p>No minimum required</p>	<p>Your Medicare Prescription Drug Plan</p>
<p><b>Reconsideration</b></p>	<p>If you disagree with your drug plan's decision, you have <b>60 days</b> to request reconsideration from Medicare's Independent Review Entity (IRE). The IRE must give you a decision within <b>7 days</b> for a standard appeal and <b>72 hours</b> for an expedited request.</p>	<p>No minimum required</p>	<p>Independent Review Entity for Minnesota: MAXIMUS Federal Services Part D QIC 1040 First Ave. Suite 200 King of Prussia, PA 19406 Phone: 484-688-5600 or 877-240-6965</p>
<p><b>Administrative Law Judge (ALJ)</b></p>	<p>You must request the hearing within <b>60 days</b> of your unfavorable reconsideration decision.</p>	<p>2012 minimum amount = \$130</p>	<p>Office of Medicare Hearings and Appeals Cleveland, Ohio (Mid-West Field Office – including Minnesota) BP Tower, Suite 1300, 200 Public Square, Cleveland, OH 44114-2316 Phone: 866-236-5089</p>
<p><b>Medicare Appeals Council</b></p>	<p>You have <b>60 days</b> to request an appeal to the Medicare Appeals Council if you disagree with the ALJ's decision.</p>	<p>No minimum required</p>	<p>Department of Health and Human Services Departmental Appeals Board Medicare Appeals Council, MS 6127 Cohen Building Room G-644 330 Independence Ave., S.W. Washington, D.C. 20201 Phone: 202-565-0100</p>
<p><b>Federal District Court</b></p>	<p>You have <b>60 days</b> to file an action in Federal District Court.</p>	<p>2012 minimum amount = \$1,300</p>	<p>U. S. District Court: District of Minnesota</p>

## Medicare Part D and Home and Community Based Waivers

Since Medicare Part D began on January 1, 2006, Medicare beneficiaries on Medical Assistance residing in a nursing home have not paid any co-payments for their prescription drugs.

Beginning January 1, 2012, Medicare beneficiaries on Medical Assistance Home and Community Based Waivers will no longer have to pay co-payments for prescription drugs covered by Medicare Part D.

This includes Medicare beneficiaries enrolled in the following waivers in Minnesota:

- Elderly Waiver
- Brain Injury Waiver
- Community Alternative Care Waiver
- Community Alternatives for Disabled Individuals Waiver
- Developmental Disabilities Waiver

This change does not apply to Alternative Care enrollees.

## Observation Stay in the Hospital: Medicare May Not Cover Your Nursing Home Stay

If you are in the hospital and you have Medicare, are you an inpatient or an outpatient? It may sound simple, but it isn't. It may be hard to imagine when you are in a hospital gown in a hospital bed on an upper floor of the hospital, wearing a hospital band on your wrist and filling out a meal form, that you may not actually be an inpatient, but are instead in the hospital for an "observation stay".

Observation is a word used by Medicare when a patient's care does not meet required guidelines for hospital inpatient status — a hospital stay with full services. Although you are in a hospital room and bed and receive services that are similar to a hospital inpatient stay, observation is not the same as being an inpatient at the hospital. Patients may have both observation days and inpatient hospital days during the same hospital stay.

Observation days in the hospital are covered under Part B Medicare services rather than Part A, which covers inpatient services. As a patient in observation, you may have to pay a co-payment for each service you receive.

Generally, prescription drugs and over-the-counter drugs are not covered under Part B while in observation.

### **Ask the critical question**

When in the hospital, you or a family member should ask, "Am I being placed in observation status?"

### **The impact on Nursing Home Medicare coverage**

The Senior LinkAge Line® has received appeal requests from an increasing number of Medicare beneficiaries who had a hospital stay classified as "Observation" and were admitted to a nursing home for skilled care and/or skilled rehab services. They were unable to get any Medicare coverage for their stay because they did not have a three day hospital inpatient stay, which is a requirement to qualify for Medicare Part A coverage in the nursing home. Days spent in a hospital for observation services do not count toward meeting the three day hospital requirement.

To find out more about observation status or to get help with an appeal, call the Senior LinkAge Line® at 1-800-333-2433.

## Keeping Yourself Healthy: Use Your Medicare Preventive Benefits

Medicare covers many preventive services. As long as you meet basic eligibility standards, you have the right to receive these services no matter if you have Original Medicare or a Medicare Advantage Plan.

**Disability Linkage Line®**

**1.866.333.2466**

**Minnesota's connection to disability-related information and assistance**

Housing

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Transportation

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***and much more!***