Can You Appeal If Medicare Refuses to Cover Care You Received?

Absolutely. Sometimes Medicare will decide that a particular treatment or service is not covered and will deny a beneficiary's claim. Many of these decisions are highly subjective and involve determining, for example, what is "medically and reasonably necessary" or what constitutes "custodial care." If a beneficiary disagrees with a decision, there are reconsideration and appeals procedures within the Medicare program.

While the federal government makes the rules about Medicare, the day-to-day administration and operation of the Medicare program are handled by private insurance companies that have contracted with the government. In the case of Medicare Part A, these insurers are called "intermediaries," and in the case of Medicare Part B they are referred to as "carriers." In addition, the government contracts with committees of physicians -- quality improvement organizations (QIOs) -- to decide the appropriateness of care received by most Medicare beneficiaries who are inpatients in hospitals.

If an intermediary, carrier or QIO decides Medicare shouldn't pay for care you received, you will learn this when you receive your Medicare Summary Notice (MSN). The Medicare Rights Center recommends first making sure that the coverage denial isn't simply the result of a coding mistake. You can ask your doctor to confirm that the correct medical code as used. If the denial is not the result of a coding error, you can appeal the denial using Medicare's review process.

Once Medicare's review process has been exhausted, the matter can be taken to court if the amount of money in dispute exceeds either $1,000 or $2,000, depending on the type of claim. Medicare beneficiaries can represent themselves during these appeal proceedings, or they can be represented by a personal representative or an attorney. The Medicare Rights Center estimates that only about 2 percent of Medicare beneficiaries appeal denials of care, but 80 percent of those who appeal Part A denials and 92 percent who appeal Part B denials win more care.

Even if Medicare ultimately rejects a disputed claim, a beneficiary may not necessarily have to pay for the care he or she received. If a recipient did not know or could not have been expected to know that Medicare coverage would be denied for certain services, the recipient is granted a "waiver of liability" and the health care provider is the one who suffers the economic loss. In cases where this limited waiver of liability does not apply, however, the beneficiary is liable for any costs of care that Medicare does not cover. For example, a patient is financially responsible for any services normally provided under Medicare Part B if provided by a nonparticipating provider who did not "accept assignment" of the claim.