Know your Medicare Plan

There are many different Medicare plans, with different prosthesis coverages. Knowledge of your particular plan coverage is important. Standard Medicare plans cover 80% of the cost of prosthetic care, and the beneficiary is responsible for 20% of the cost. There are Medicare advantage and supplement plans available that may cover additional health services, including prosthetic care. It is important to understand which plan you have, as most plans do not provide prosthetic coverage. When you receive a denial from Medicare, it will note at which Medicare level your claim was denied. Here is what you can do at each of these levels.

Advocate for change!

Visit www.amputee-coalition.org/advocacy-awareness/and tell your story of your insurance denial and get involved with the Amputee Coalition's advocacy team. With many stories, like yours, our leaders will be able to understand that the denial of appropriate prosthetic devices is a universal problem across the country, keeping individuals from living their lives to their fullest potential. Help make a change in current policies, by sharing your story and getting involved with the advocacy team.

Available tools and resources to elevate further:

Amputee-Coalition.org
Insurance commissioner
Contact your state legislators
Contact your federal legislators
State assistance programs
Centers for Independent Living

Medicare Denials and Appeals
No Is Not an Answer!

Work with your medical team

Communicate your needs, lifestyle, activity level, goals, work and hobbies with your prosthetist, surgeon, primary care physician, physical/occupational therapist, and/or physiatrist. Their assessments and thorough documentation of the above details are crucial in the claims process.

How to write an appeal letter

Include your name, group and ID numbers, and reason for denial. Be polite and courteous; using please and thank you. Explain your activities of daily living (using stairs in the home, walking up ramps in driveway, taking care of small children, etc.). Also explain your work environment and the necessity of certain functions you need the prosthesis to perform. Explain hardships that occur every day when a prosthetic device is not provided, and ask for a timely approval of your device. Make it personal, giving as much detail of your daily life and activities as possible. Include photos, and/or videos of the above to help personalize your story. You can also include research outlining the benefits of the prosthetic device you are requesting.

Stages of a Medicare Appeal

<u>Stage One: Redetermination</u>

At this level you have 120 days from the date of denial to file your appeal. Be prepared to submit all documentation in support of your claim (see the documentation mentioned above in the insurance section). The review is generally conducted by the same Durable Medical Equipment Medicare Administrative Contractors (DME MAC) that processed your denial. This process averages 45 days, but can take longer. Be prepared for another denial at this level, and plan to take your appeal to the next level.

<u>Stage Two: Reconsideration</u>

In this stage you will appeal to a Qualified Independent Contractor (QIC), within 180 days of your redetermination denial. You may submit even more documentation at this level, but it is also important to place a call to the individual listed on the prior denial letter and ask why the claim has been denied. In most cases you will receive more information than what was written in the denial letter. You should ask for a copy of any notes that were taken, in making this decision. If another denial is received, then proceed to the next level.

<u>Stage Three: Administrative Law Judge Hearing (ALJ) from the Department of Health and Human Services.</u>

You must respond within 60 days of the date of the letter of denial at the reconsideration level. At this level you are asking the judge, in person, via video/phone conference for an independent review of all of your previous documentation. Note that this judge is not bound by the same DME MAC rules and regulations as before, but looks at all Medicare rules in totality of the circumstances surrounding your claim. As these judges are often more reasonable, most of these appeals are often successful.

<u>Stage Four: HHS Department of Appeals Board (DAB).</u>

If your ALJ appeal is unsuccessful, you have 60 days from the date of your letter of denial to appeal to the DAB. The court will now only review: 1) whether the ALJ improperly applied the laws governing Medicare; 2) whether there is ALJ abuse of discretion; 3) whether policy and procedure were incorrectly followed. The DAB will either uphold, reverse, or return it to the ALJ level, and must do so within 90 days of review.

<u>Stage Five: The Judicial Review</u>

This is the final level of appeal. This is a filing of a civil law suit against Medicare in federal court and must be made in writing within 60 days of receipt of the DAB's date on their letter of ruling. The monetary threshold must be over $1150. This level is the most complex and necessitates the use of an attorney.