The Medicare Advantage Roadmap

1. The test order — Before the visit

Does it need approval?

What it says

Your doctor's order

The tests or scan, and the diagnosis codes the office chose. Your plan decides whether to pay, and some services need its approval first.

What it means

Check the network and the list

Is the lab or imaging center in your plan's network? Is the service on the plan's posted prior-authorization list? Ask member services; note the date and name.

Medterpret shows Medicare's rate for each test, and what labs charge.[1]

[1] Rate lookup and Find a lab on medterpret.com work whatever your coverage.

What to do next

In network, and no approval needed:

Go. Keep a copy of the order for your file.

Out of network, or approval needed:

Move the order to an in-network lab, or wait for the plan's answer.

No in-network option: Doc 8.

At every step: keep every notice, letter and envelope, log every call, and send anything that matters so you can prove the date it arrived.

Rule on your side, or nothing more to do — Act now

Medterpret can help with this step — You are done

Next: 2. Prior authorization, page 2

Snap a picture of your order, denial notice or bill and see what it says in plain English: medterpret.com

The forms (Doc) and chapters (Ch.) named here are in The Medicare Advantage Appeal Playbook: medterpret.com/playbooks

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2. Prior authorization — Before the visit

Did the plan approve it?

What it says

The plan's answer before the service

The doctor's office, or you, can ask. A yes is an approval. A no arrives as the Integrated Denial Notice (Form CMS-10003), and it can be appealed.

What it means

When the plan's answer is due

Standard request: the plan must answer within 7 calendar days (from 2026, for services under the prior-authorization rules). Expedited request: within 72 hours. The rules are in Ch. 4.

No approval on file? Ask the office to request it (Ch. 4).

What to do next

Approved: go.

Keep the approval.

The plan may not deny it later as not medically necessary (Ch. 4; 42 CFR §422.138(c)).

Denied:

Your 60-day clock starts. File Track A, Doc 3, and ask the doctor's office to appeal too (Doc 5). Turn to page 2.

Health at risk? Ask for a fast decision. Doc 7.

A resubmitted request is not an appeal and does not stop your clock (42 CFR §§422.582, 422.566).

☐ Rule on your side, or nothing more to do ☐ Act now ☑ You are done

Next: 3. The denial, page 3

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3. The denial — After the visit

Why, and by when?

What it says

The plan's denial notice

Prior authorization: the Integrated Denial Notice (CMS-10003). A claim: your EOB or a denial letter. It must "State the specific reasons" (§422.568(e)(2)).

What it means

Read the notice

Track A: prior authorization, service not yet done. Track B: a claim, service already done.[1]

The deadline: 60 days from receipt, presumed 5 days after the date printed on it (42 CFR §422.582(b)).

[1] Medterpret reads a photo of your denial notice or EOB, tells you which track it is on and your deadline, and drafts the reconsideration for members.

What to do next

Day one, all four

1. File the reconsideration. Doc 3 or Doc 4.
2. Ask your doctor for notes and a letter. Doc 5.
3. Start the tracker. Doc 19.
4. No specific reason given? Ask for it. Doc 29.

Members: Medterpret drafts the reconsideration and sends a deadline reminder.

☐ Act now Medterpret can help with this step

The denial continues on page 4

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3. The denial (continued) After the visit

What to do next (continued)

The plan reverses at Level 1: you are done.

Keep the decision. Send a copy to anyone still billing you.

Plan says no, or misses its deadline:

It must send your file to the IRE. You file nothing. Evidence: Doc 10.

42 CFR §422.590(a)(2), (d).

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The IRE reverses: you are done.

The IRE says no:

ALJ hearing within 60 days, $200 minimum.

Figures for each level: Ch. 6.

At every step: keep everything, log every call, prove the date.

Care ending at a nursing facility, home health agency or rehab facility (CORF) is a faster, separate appeal. Doc 30, Ch. 8.

Rule on your side, or nothing more to do Act now You are done

Next: 4. The bill, page 5

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4. The bill — After the visit

Do I owe this?

Compare every bill with your EOB first.

What it says

The provider's bill

What the lab or provider wants you to pay, at its own price. Your EOB shows the patient balance. "Your bill should not be higher than the Patient Balance." (CMS)

What it means

Check the bill

Each charge next to Medicare's rate for that test.[1] Then: was the provider in your plan's network? If not, it must accept as payment in full what it could collect under Original Medicare (42 CFR §422.214(a)(1)): for a hospital, facility or lab, the Medicare rate; for a doctor, the Medicare rate or at most 9.25% above it (Ch. 7).

Bill check: GougeStop, a Medterpret tool.

[1] GougeStop, a Medterpret tool, shows Medicare's rate for each test on a lab bill. Doctor and hospital bills: compare with your EOB.

What to do next

Out of network, billed above Medicare's amount:

Send Doc 25 asking the provider to bill no more than it could collect under Original Medicare.

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The provider accepts the Medicare amount: you are done.

☐ Rule on your side, or nothing more to do Medterpret can help with this step

✓ You are done

The bill continues on page 6

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4. The bill (continued) After the visit

What to do next (continued)

The charge is yours:

Negotiate from Medicare's rate. Doc 26 and the phone script.

Not covered, or the appeal did not reverse the denial.

Sent to collections:

Dispute it in writing as soon as the notice comes. Doc 24.

Still billing? Complain. Doc 27.

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☐ Act now

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