

Hepatic Haven

A publication for the liver transplant community

Insurance and Liver Transplantation

Understand your coverage. Protect access to care.



Michael Irwin Baruch, MD, FACS | Editor

[LiverTransplantGuide.com](https://www.LiverTransplantGuide.com)

Disclaimer and editor's note

Education, informed decisions, and support for appropriate care

A physician's and a patient's perspective

As a physician and liver transplant patient, I have experienced the insurance difficulties discussed here. I share this experience to help families feel prepared and less alone.

Education that supports appropriate treatment

This newsletter helps patients and caregivers make informed insurance decisions. It is general education, not individual medical, insurance, legal, financial, or tax advice or a guarantee of coverage. Rules vary by plan, state, and year. It is not intended to obstruct, discourage, or delay appropriate treatment. Do not postpone needed care or change prescribed treatment because of this newsletter; discuss concerns promptly with your team.

Cost control and oversight

Insurers manage costs and decide what a plan covers under its terms, applicable law, and clinical criteria. Your team recommends treatment; a coverage decision is not necessarily a medical treatment recommendation. [27] State insurance departments oversee state-regulated plans. Many self-funded private-employer plans fall under Department of Labor oversight; Medicare products use Medicare/CMS oversight and appeals. Eligible disputes may receive independent review; initial decisions can still be wrong. [29] [41]

New Jersey's [Independent Health Care Appeals Program \(IHCAP\)](#) reviews eligible medical-necessity and related denials: 1-888-393-1062. Self-funded plans and Medicare products generally follow other routes. Ask your coordinator about the correct review route and deadline.

Ask your team, family, and support group

Ask your physicians, transplant and financial coordinators, social worker, and pharmacist to help compare choices and find appropriate assistance. Confirm coverage answers with your plan in writing. Use the take-along questions on page 41 and cost worksheet on page 42; add your own questions and concerns. Discuss decisions with family or a trusted caregiver, keeping your preferences central. Bring questions to our support group meetings; shared experiences complement individual professional guidance. Share only information you are comfortable discussing.

Free public guides and counseling

[American Liver Foundation — financial guide](#) — Insurance, prescriptions, transplant and other financial support.

[Patient Advocate Foundation — patient information](#) — Financial assistance information and one-on-one case-management support.

[CMS — Coverage to Care](#) — Benefit guides and worksheets in multiple languages.

[SHIP — local Medicare counseling](#) — Free, unbiased Medicare counseling.

Resource links checked September 30, 2026. Assistance eligibility and funding vary.

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Physician and liver transplant recipient

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Print pages 34, 41 and 42 for counseling; page 45 is your calendar. Underlined abbreviations jump to definitions; highlighted reference numbers open sources.

Editorial

A second chance deserves dependable access to care

By Michael Irwin Baruch, [MD](#), [FACS](#) | Editor, Hepatic Haven

As a retired surgeon and a liver transplant recipient, I approach this subject from two sides of the hospital bed. I know what careful treatment can accomplish. I also know that receiving a new liver does not end a patient's need for support. The life made possible by transplantation must be protected after the operating room lights go out.

Insurance belongs in that conversation. A family should be able to understand where care is covered, how medicines will be obtained, and whom to call when a bill or denial arrives. The language of benefits should not become another burden for someone already coping with illness.

This issue asks readers to begin those conversations early. Ask the question that feels basic. Request the explanation a second time. Invite a trusted person to take notes. A confusing letter is a reason to seek help, not a measure of your ability to manage your health.

My editorial position is straightforward: a transplant program's financial guidance should be treated as an essential part of patient support. Clear communication, timely decisions, and an accessible path to review are reasonable expectations. Patients deserve to be heard when a coverage barrier threatens continuity of care.

We cannot promise that every request will be approved or every expense paid. We can insist on asking better questions and keeping better records. We can thank the coordinators, social workers, pharmacists, nurses, physicians, and caregivers who make complicated systems more navigable.

To anyone facing this process today: you do not have to master the entire insurance system in one sitting. Begin with the next appointment, the next prescription, and the next unanswered question. Let someone stand beside you.



Your coverage options

Start with eligibility and the care you need to keep

There is no single insurance choice that fits every transplant household. Begin by identifying the coverage you have today, what may change, and the people and services you must be able to reach. Ask the transplant financial coordinator to help you compare realistic options before you enroll or cancel a policy. The coordinator works with the team and insurers on financial aspects of care. [\[18\]](#)

Employment and individual coverage

An employer plan, a spouse's plan, or an individual Marketplace plan may be a starting point. A familiar insurer's name is not enough: record the exact plan, product, network, and effective date. Marketplace plans protect people with pre-existing conditions; that protection does not eliminate their coverage rules. [\[3\]](#)

Medicare

People who qualify can consider Original Medicare, usually with separate drug coverage and possibly supplemental insurance, or Medicare Advantage. The difference affects provider access, cost sharing, and how services are arranged. Evaluate the complete combination of coverage, not one premium. See pages 7 and 8. [\[14\]](#)

Medicaid and CHIP

Eligibility and benefits depend on state rules and individual circumstances. These programs can be especially relevant after an income change or for children. A state application is more reliable than a guess based on a neighbor's experience. See page 9. [\[12\]](#)

Veterans and other established benefits

Eligible veterans should ask their [VA](#) care team how needed specialty care will be arranged and authorized. [VA](#) benefits depend on eligibility and clinical needs; possession of other insurance does not by itself explain how a particular transplant will be handled. Military families should similarly consult their own benefit administrator. [\[20\]](#)

Make a short list

For each realistic option, write down the transplant center, physicians, pharmacy, premium, cost-sharing limits, approval requirements, and coverage start date. Put any unanswered item in writing. A plan that cannot yet be verified should remain an unresolved option, not an assumed solution.

Employer and Marketplace plans

Read the transplant details before choosing the premium

Marketplace plans cover essential health benefit categories, including hospital care and prescription medicines. Details still differ among plans. A transplant candidate should examine the actual benefit documents and obtain plan-specific answers about evaluation, surgery, donor services, and ongoing care. [22]

Pre-existing does not mean uninsurable

A Marketplace plan cannot reject you, charge more because of your medical condition, or refuse essential health benefits for a condition that existed before enrollment. This is a major protection for people with liver disease. It is not a promise that every hospital or requested service is covered. [3]

Ask for the documents

Request the Summary of Benefits and Coverage and the full plan document or Evidence of Coverage. Ask where transplant services, exclusions, prior authorization, specialty medicines, out-of-area care, and appeals are described. For an employer plan, identify the benefits administrator as well as the company processing claims.

Compare a complete year

A lower premium may leave more costs at the point of care. Conversely, a higher premium does not prove that a center or medication is covered. Build the comparison around the care your team expects, then add a separate contingency for complications and uncovered expenses. Keep all quotes dated.

Be precise about financial assistance

Ask the Marketplace or a certified enrollment helper to calculate any assistance using your current household information and the applicable coverage year. Do not assume that a previous year's subsidy, income estimate, or enrollment deadline still applies. Update an application when required circumstances change.

Questions to take to enrollment

Which exact liver transplant program participates? Are the treating specialists included? Is a referral required? Which pharmacy must dispense my medicines? What happens if I am hospitalized across the plan-year boundary? Does a travel benefit exist, and must it be authorized first?

If a product is advertised mainly as inexpensive cash benefits or a discount arrangement, ask directly whether it is comprehensive major medical insurance and obtain all exclusions. Do not cancel established coverage on the strength of an advertisement or a verbal assurance.

Medicare choices

Separate provider access from financial protection

Medicare covers liver transplant services at Medicare-approved facilities. Part A and Part B cover different portions of care; doctors' services and certain immunosuppressive therapy fall under Part B. For covered Part B transplant services, the usual patient share is 20 percent of the approved amount after the deductible, before other coverage pays. [\[1\]](#)

Original Medicare

Original Medicare generally allows access to providers who take Medicare across the United States. It has no annual out-of-pocket ceiling for Part A and Part B on its own. Supplemental coverage can therefore matter greatly. A separate Part D plan may be needed for outpatient medicines not covered by Part B. [\[14\]](#)

Medicare Advantage

These plans provide Medicare benefits through private insurers and have an annual limit on out-of-pocket costs for covered Part A and Part B services. Networks and prior authorization can affect care. Check the transplant program and all relevant providers before joining. Drug benefits and costs require a separate review. [\[1\]](#) [\[14\]](#)

Medigap requires advance planning

The federal Medigap open enrollment period generally lasts six months beginning when a person is at least 65 and enrolled in Part B. Outside protected periods, underwriting can affect access and price. State protections may be broader. People under 65 have different access depending on state rules. Medicare's annual enrollment season does not automatically create a new Medigap right. [\[11\]](#)

Before changing arrangements

Ask a State Health Insurance Assistance Program counselor to examine your specific situation. Confirm any supplement's acceptance and effective date before relying on it. Ask the transplant center to review the proposed Medicare Advantage network or Original Medicare combination.

Keep a written explanation of how the proposed coverage handles the hospital, professional services, laboratory work, outpatient prescriptions, and supplemental payments. If the answer is "Medicare covers it," ask which part pays and what remains your responsibility. These are separate questions, and both deserve clear answers.

Paying for transplant medicines

The Part B and Part D distinction matters

For Medicare-covered transplant drug therapy under Part B, Medicare specifies that Part A must have been in place at the covered transplant and Part B must be in place when the immunosuppressive drugs are received. Part D covers many outpatient medicines that Part B does not. Ask the dispensing pharmacy to verify the correct billing route for each prescription.

[2]

Avoid the kidney benefit misunderstanding

Medicare's immunosuppressive-only extension beyond the 36-month post-kidney-transplant period applies to qualifying people whose [ESRD](#)-based Medicare ends and who meet other requirements. It does not create a general lifetime liver-transplant drug benefit, and it does not replace comprehensive health coverage. [2]

Understand the drug spending limit

In 2026, the Part D out-of-pocket threshold is \$2,100 for covered Part D drugs, including qualifying payments made on the beneficiary's behalf. After that threshold, covered Part D drugs have no further out-of-pocket cost for the year. This is not a cap on premiums, Part B medicines, or all health expenses. Verify the figure for the year of coverage. [9]

Cash flow is a separate problem

The Medicare Prescription Payment Plan spreads eligible Part D out-of-pocket costs across the calendar year; it does not reduce the total price. Extra Help may reduce Part D costs for eligible people with limited income and resources. A counselor can help assess eligibility and applications. [8] [9]

Make a prescription inventory

Record each medicine's exact name, formulation, strength, quantity, prescriber, pharmacy, benefit category, approval expiration, and refill date. Include medicines prescribed by other specialists. Ask the pharmacy for a test claim or plan-specific estimate when available.

If the pharmacy reports a rejection, ask for the exact message. An incorrect benefit route, missing authorization, or network problem requires a different response from an unaffordable copayment. Tell the team how many doses remain. Do not skip or reduce anti-rejection medicine to stretch the supply; contact the transplant team promptly for a safe plan. [15]

2027 planning update: Medicare lists a \$2,400 Part D out-of-pocket threshold for 2027. Use figures for the correct coverage year. [9]

Medicaid and financial assistance

Eligibility deserves an individual review

Medicaid and [CHIP](#) provide free or low-cost coverage to eligible people. States differ in eligibility, benefits, and delivery systems; some use managed care plans. Applications can be made throughout the year. Ask the state agency to evaluate your circumstances, including disability-related pathways when relevant. [\[12\]](#)

Access across state lines

Living near a major transplant center does not answer whether your coverage can be used there. Ask your Medicaid agency or managed care plan and the center to confirm participation and any out-of-state authorization. Request the answer for evaluation, transplantation, and follow-up rather than for one office visit.

Keep renewal notices visible

Create a single place for agency mail and electronic notices. Record requested documents and due dates. If you receive a termination notice, contact the agency and transplant financial coordinator immediately. Ask what review rights, correction options, or other coverage pathways apply.

Help beyond the insurance card

Ask the hospital about financial assistance for eligible patients, the scope of that assistance, and whether separately billing clinicians participate. Ask for written applications and document requirements. Assistance for one hospital bill should not be assumed to cover prescriptions, a different hospital, or future visits.

For Medicare beneficiaries

Extra Help assists with Part D costs, while Medicare Savings Programs may help with other Medicare expenses. Eligibility is program-specific. An application review can be worthwhile even if a household was previously ineligible. A change in income or resources may change the answer. [\[8\]](#)

Make requests concrete

Instead of saying only “I need financial help,” identify the immediate problem: a premium due next week, a medication refill, transportation to a laboratory, or lodging near the center. Ask who owns the next step, when a decision is expected, and what documents are missing.

Keep charity, government benefits, and insurance approvals in separate sections of your records. Each may have different conditions and expiration dates. Before starting a fundraiser or moving money, obtain individualized advice about possible effects on benefits and taxes. This issue does not determine those effects for any household.

When work or coverage changes

Build the bridge before the old plan ends

A job change, reduced hours, retirement, or a spouse's coverage change can arrive at a difficult point in treatment. Start by obtaining the exact final day of existing coverage. Then ask each possible replacement for its effective date, enrollment requirements, and provider access.

COBRA as a temporary option

Where applicable, COBRA can preserve an employer plan temporarily after a qualifying event. The election period is generally 60 days from the later of coverage loss or the election notice, and coverage commonly lasts up to 18 months. The household generally pays the full premium. Confirm the notice, deadlines, payment rules, and duration for your event. [\[5\]](#)

Marketplace enrollment after a loss

Loss of qualifying coverage can open a Special Enrollment Period, commonly within 60 days before or after the loss; some circumstances differ. Voluntarily dropping COBRA early generally does not create that opportunity. Confirm eligibility and timing before canceling anything. [\[10\]](#)

Disability is a separate determination

Social Security's adult liver transplant listing considers a person disabled for one year from transplant, then evaluates remaining impairments. Financial and other program requirements still apply. That listing is not an automatic award of benefits or immediate health insurance. [\[17\]](#)

Medicare eligibility based on disability generally follows 24 months of disability benefit entitlement, with exceptions for certain conditions. Liver disease or liver transplantation alone does not waive that waiting period. Ask Social Security to explain your actual entitlement dates rather than estimating from the surgery date. [\[19\]](#)

A transition conference

Arrange a call with the benefits administrator, financial coordinator, and a trusted helper. Put the current plan's ending date and the proposed plan's starting date on the same page. Review pending authorizations, scheduled visits, and refills before the handoff.

Ask an employer about available leave, disability income benefits, and how employee premium contributions will be collected during an absence. Do not confuse wage replacement with medical coverage. Record separate contacts for the leave request, benefit payment, and health plan enrollment.

Protecting access to your center

A network check needs names and dates

The phrase “we accept your insurance” can mean different things in different offices. Your goal is a specific answer: does this exact plan cover this liver transplant program and the clinicians needed for your care, at the expected level of patient cost?

Build a care map

List the hospital, transplant surgeon, hepatologist, anesthesiology group, laboratory, imaging provider, rehabilitation facility, home-care agency, and pharmacy as applicable. Ask the center which services are billed together and which may arrive separately. Use this list during the insurer call.

Keep evidence of the answer

Save a dated provider-directory result and any written confirmation. Record the representative’s name, call reference, plan identification, and the provider identifiers supplied by the center. Ask the office to confirm its answer with the insurance contracting or financial team if needed.

When a provider leaves the network

Some patients receiving ongoing care may qualify for up to 90 days of continued in-network treatment after a provider’s network contract ends. Conditions apply. Ask promptly whether you qualify as a continuing-care patient and request the required notice and instructions. [\[13\]](#)

When your preferred center is not covered

Ask whether a network exception or individual agreement can be considered and who must submit it. Ask your clinician to explain the medical reasons for the requested center. At the same time, obtain information about covered alternatives so there is a practical next step if the request is denied.

A realistic example

Hypothetical: a patient sees that the hospital is listed in a directory and assumes every service is covered. A later pharmacy claim fails. The useful response is to verify the prescription network and benefit rules separately. Hospital participation alone did not answer the pharmacy question.

Repeat the check when changing plans, relocating, or receiving a network notice. Keep the transplant team informed before making an enrollment decision. If care is urgent, tell the clinical team immediately; do not postpone emergency care while trying to complete an administrative checklist.

Approval before and after surgery

Turn a general assurance into a usable record

A transplant journey includes multiple stages: evaluation, waiting, admission, surgery, discharge, and long-term follow-up. Ask which stages require separate review under your plan. [NIDDK](#) advises discussing transplant costs and available financial help with the transplant team. [\[16\]](#)

Ask exactly what was approved

Record the approved service, facility, clinician if specified, authorization number, beginning and ending dates, and any visit or quantity limits. Ask whether further review is required if surgery occurs later than expected or the proposed service changes.

Know the difference between decisions

A clinical decision that transplant is appropriate, a center's financial clearance, an insurer's authorization, and payment of a claim are different steps. Ask the team which step is complete and what remains pending. Do not interpret one approval as a guarantee that every subsequent charge will be paid.

Prepare for a changing course

Discuss how the plan handles an extended admission, readmission, rehabilitation, home services, and new medications. These questions are planning prompts, not predictions that complications will occur. Ask the center who will handle insurer communications during hospitalization.

Before discharge

Ask for the medication list, pharmacy arrangements, follow-up appointments, and any necessary home-care approvals to be reviewed together. A discharge plan is easier to use when the family knows who to call if a prescription cannot be dispensed that evening.

A short call script

"I am preparing for liver transplantation at [center]. Please tell me what this approval covers, when it expires, and what additional approvals will be needed. Where can I receive that information in writing? If my condition changes, which team should contact you?"

Keep a pending-items list with an owner and expected response date for each item. If the deadline passes, follow up using the same reference number. If delay may harm your health, ask the treating clinician to evaluate urgency and seek the plan's expedited process where applicable. An ordinary administrative follow-up and an urgent clinical escalation are different tasks.

The household cost picture

A covered transplant can still strain a family budget

The out-of-pocket maximum usually concerns specified covered care, not every dollar a household spends. Premiums, noncovered services, and out-of-network expenses are generally outside a Marketplace plan's limit. Check the exact plan rules. Deductibles and qualifying copayments or coinsurance count toward the applicable limit; do not add them twice. [\[4\]](#)

Use four budget categories

First, record premiums. Second, estimate covered medical and drug cost sharing. Third, list uncovered or uncertain medical expenses. Fourth, list practical costs such as lodging, transportation, meals away from home, dependent care, and lost income. Ask which of these may qualify for assistance.

A hypothetical comparison

Plan A costs \$450 per month with a \$9,000 in-network out-of-pocket maximum. Plan B costs \$700 per month with a \$5,000 maximum. If covered in-network claims reach those limits, premium plus that cost sharing equals \$14,400 for A and \$13,400 for B. These are invented figures, not offers or predictions.

The calculation assumes a full year of premiums and that the stated limits apply to the relevant services. It excludes uncovered expenses and any separate benefit limits. A cheaper total in this example is meaningful only if the necessary center, clinicians, and medicines are accessible under that plan.

Watch the calendar

Ask when deductibles and limits reset. A course of care spanning two benefit years may expose a household to costs in both years. Request separate estimates for each year rather than assuming one annual limit applies to the whole episode.

Review unexpected bills

For most private coverage, federal surprise-billing protections apply to many emergency services, certain out-of-network services at in-network facilities, and air ambulances. They do not make all out-of-network care free; ground ambulances are generally outside those federal protections. Ask for a review of a questionable bill. [\[13\]](#)

Compare the provider bill with the insurer's Explanation of Benefits and ask about mismatches before arranging payment. Request an itemized explanation and written terms for any payment plan. Preserve appeal deadlines while a billing office investigates.

When denial practices cross the line

What federal reviewers have actually documented

Patients sometimes call these experiences “insurance tricks”: repeated requests, unexplained delays, or a refusal that seems unrelated to the medical record. Some are errors; some reflect restrictive rules. Intent cannot be inferred from a denial alone. The strongest response begins with evidence.

A federal review found inappropriate denials

In a 2022 report, [HHS OIG](#) reviewed samples of denials from 15 large Medicare Advantage organizations during one week in June 2019. It estimated that 13 percent of denied prior authorization requests met Medicare coverage rules. Among denied payment requests, 18 percent met Medicare coverage and the organizations’ billing rules. These percentages concern denied requests, not all claims or all patients. [\[23\]](#)

Reviewers identified additional clinical criteria, claims of insufficient documentation despite adequate records, and manual or system-processing errors. Some decisions were later reversed. These findings establish real administrative failures; they do not prove misconduct in every denial. [\[23\]](#)

What this means for transplantation

The study was not a liver-transplant denial-rate study. Its findings identify problems worth checking when a transplant service is delayed or unpaid. Ask what was requested, what evidence was reviewed, and exactly why the decision was made. The following pages pair warning signs with practical responses.



Watercolor illustration • Patient and advocate reviewing a coverage decision

Repeated requests and stalled reviews

Turn “we need more information” into a specific answer

A request can stall when documents move among a hospital, insurer, review contractor, and pharmacy. Repeated requests for the same material deserve scrutiny, particularly when no one can identify the missing item. Preserve a record of the exchange rather than assuming a new submission erases the earlier one.

Ask for one complete missing-items list

Request the exact document, date range, required signature, or clinical question. Have the submitting office confirm the destination, page count, transmission receipt, and case number. Ask whether the reviewer can see the upload and whether the request is pending or formally denied.

Keep the original clock visible

Write down when the plan first received the request and every later document submission. Ask which decision deadline applies and whether an extension has been taken. Request its basis and the new decision date. Do not assume that every document request lawfully restarts the clock.

Identify the accountable organization

If the plan refers you to a contractor, ask the plan to identify who owns the decision and appeal. Ask for a joint call if the two offices give conflicting instructions. Keep one chronology across both organizations.

These are suggested responses, not findings about your insurer. If a delay threatens treatment, the clinician should explain the urgency and seek the appropriate expedited process. For affected non-drug prior authorizations, current [CMS](#) rules require a specific reason for denial. [\[25\]](#)



Watercolor illustration • Organized records and an authorization timeline

Changing criteria and vague reasons

Ask for the rule and the patient-specific explanation

A denial that says only “not medically necessary” leaves the patient unable to tell what is disputed. Ask whether the plan questions the service itself, its timing, the treatment setting, or the submitted evidence. Each requires a different response.

Request the policy that was used

Ask for the policy title, version, effective date, and precise unmet criterion. Have the transplant clinician respond to the criterion using the relevant findings. If the explanation changes, request a written account of what changed and preserve both decisions.

Know the Medicare Advantage safeguard

[CMS](#) requires Medicare Advantage plans to follow applicable Traditional Medicare coverage criteria for basic benefits. Internal criteria are permitted only in specified circumstances and must meet evidence and public-access requirements. A plan cannot simply substitute any unpublished standard it prefers. [\[27\]](#)

Challenge an unsuitable comparison

Ask the clinician to explain why an offered alternative is unsafe, ineffective, or clinically unsuitable for this patient, if that is the case. Relevant details may include earlier treatment response, contraindications, or the level of monitoring required. Submit accurate records, not generalized accusations.

For an “experimental” or benefit-exclusion denial, request the exact definition and provision and ask how they were applied. An approval request needs to address the actual reason given. Clinical urgency and coverage eligibility are related concerns, but one does not automatically establish the other.



Watercolor illustration • Clinician explaining a patient-specific treatment plan

Algorithms and automated review

The individual medical record must still matter

Software can organize a claim or flag a request for review. Its presence alone does not establish an improper denial. The concern arises when a prediction or broad population rule replaces consideration of the individual patient.

What CMS has said

CMS guidance allows algorithms to assist Medicare Advantage coverage decisions, but the plan remains responsible for compliance. Decisions must consider individual circumstances. A predicted rehabilitation length of stay alone cannot justify ending coverage; the patient must be reassessed against the applicable level-of-care requirements. [26]

Questions that make the review concrete

Which clinical records were reviewed? What findings support the decision? Did the reviewer consider the treating team's current recommendations? If software influenced the result, how did the final review account for this patient's condition? Ask for the applicable criteria and an explanation you can address.

Correct the record before arguing about the tool

Check whether the decision used the correct diagnosis, admission dates, functional status, and treatment setting. Ask the clinician to identify omitted or outdated facts. A focused correction can be more useful than speculating about an algorithm you have not seen.

Use the formal appeal process when necessary. Ask who performed the clinical review and what further review is available. Do not treat an online allegation about an insurer as evidence that your own request was decided the same way. Keep the argument tied to your record and the coverage rule.



Watercolor illustration • Human clinical review alongside digital records

Step therapy and pharmacy barriers

Recognize the restriction and request the right exception

Drug plans may use prior authorization, quantity limits, and step therapy. Step therapy generally requires trying a preferred, less expensive treatment before another medicine is covered. These tools are not inherently improper, but an unsuitable requirement can delay an appropriate prescription. [28]

Ask what rule blocked the fill

Obtain the exact rejection message. Is the drug excluded from the formulary, subject to a quantity limit, billed to the wrong benefit, or restricted to a particular pharmacy? Confirm the prescribed formulation and dose. A pharmacy rejection is a signal to investigate, not a complete clinical explanation.

Build the exception around the patient

[CMS](#) describes Part D exceptions supported by a prescriber's statement explaining why alternatives would be less effective or cause adverse effects, or why a dose restriction is inappropriate. The statement should address the actual restriction and the patient's history. [31]

Protect an existing regimen

Ask whether transition-supply rules apply when new coverage starts. Medicare describes a possible temporary fill for certain previously used drugs that the new plan does not cover or restricts; it is not a permanent approval. Confirm eligibility and the next step with the pharmacy. [28]

If anti-rejection medicine is at risk of running out, contact the transplant team promptly with the remaining dose count. Do not independently switch drugs, formulations, or doses. Rules differ by benefit and drug; do not assume every transplant medicine is subject to the same restriction or exception pathway.



Watercolor illustration • Transplant pharmacist discussing a prescription

Payment denials after care

Separate a claim defect from a coverage dispute

A bill can remain unpaid even when care has already occurred. The first task is to locate the reason: a processing rejection, a coverage denial, a coordination problem, or a dispute about the billed amount. Do not assume the unpaid balance is automatically the patient's legal responsibility.

Check the claim against the approval

Ask the billing office to compare the service date, provider, codes, units, and authorization number. Request a corrected claim for genuine errors. Never ask anyone to change a diagnosis or service description merely to obtain payment. If the plan alleges missing approval, attach the approval and explain the match.

Resolve who pays first

When more than one plan is involved, coordination rules determine the payment order. Medicare's guidance shows that the answer varies with the coverage and circumstances. Ask each payer to confirm its role and update inaccurate other-insurance information. [\[30\]](#)

Keep filing deadlines separate

A corrected claim, provider reconsideration, patient appeal, and payment complaint may have different deadlines. Ask which route is being used and who will submit it. Preserve proof of the original submission if timeliness is disputed.

Request an itemized bill and the insurer's explanation. Ask the provider to pause collection activity while the dispute is reviewed and obtain written confirmation if it agrees. A pause is not automatic. Payment standards depend on the program, contract, and applicable law; ask which standard governs rather than assuming one national deadline.



Watercolor illustration • Reviewing an itemized bill and explanation of benefits

The clock on an insurance decision

Identify the coverage type before counting the days

“It is still under review” is a status, not an explanation of the deadline. Ask when the request was received, how it was classified, what information is outstanding, and when a decision is due. Record the answer and the source of the timing rule.

Certain non-drug prior authorizations

Beginning in 2026, [CMS-0057-F](#) requires affected payers, other than federally facilitated Marketplace [QHP](#) issuers, to issue expedited decisions within 72 hours and standard decisions within seven calendar days. The affected groups include Medicare Advantage and specified Medicaid and [CHIP](#) payers. These provisions do not cover drug prior authorization. Applicable exceptions and extensions require case-specific review. [\[25\]](#)

Workplace plans have a different framework

For [ERISA](#)-covered workplace health plans, Department of Labor guidance generally describes initial decision limits of 72 hours for urgent claims, 15 days for pre-service claims, and 30 days for post-service claims. Permitted extensions and missing-information rules can affect timing. These are decision periods, not a universal deadline for a provider to receive payment. [\[29\]](#)

Ask for urgency to be evaluated

Explain a worsening condition or impending medication gap to the treating team. Let the clinician document why the ordinary timeframe would be harmful. Ask how an expedited request is filed and how a denial of expedited handling can be challenged.

Do not import these numbers into a different plan or appeal stage. Use the notice, benefit documents, and appropriate regulator to verify the clock. Emergency symptoms require medical attention, not completion of an insurance timetable.



Watercolor illustration • A calendar with the decision deadline clearly marked

Recovery care can face denials too

New federal findings reinforce the value of review

Insurance disputes can continue after the transplant admission. Rehabilitation or skilled nursing requests deserve the same attention to clinical evidence, deadlines, and appeal rights as the operation itself.

A 2026 oversight update

[HHS OIG](#)'s June 2026 findings on 19 Medicare Advantage organizations reported that 12 percent of skilled nursing facility admission requests in June 2024 were denied. Eighteen percent of those denials were appealed; 95 percent of appealed denials were overturned. That last figure applies only to appealed denials in the reviewed group, not all denials or all rehabilitation decisions. [\[24\]](#)

[OIG](#) also reported substantial reversals for appealed long-term acute care hospital and inpatient rehabilitation denials. These studies raise concerns about initial review and contractor oversight. They do not establish a liver-transplant-specific denial rate or guarantee a successful appeal. [\[24\]](#)

Document why this level of care is needed

Ask the treating team to describe the patient's current function, skilled needs, monitoring, and why the proposed alternative is inadequate, if applicable. Ask which setting and duration were requested and what was actually approved.

If ongoing services are being terminated, promptly obtain the written notice and the instructions for the applicable fast appeal. Deadlines can be short. The hospital or facility should help identify the correct review organization. Do not assume that an ordinary complaint about service quality also files a coverage appeal.



Watercolor illustration • A supportive rehabilitation consultation

A practical response guide

Match the obstacle to the evidence needed

Use this guide to organize the next conversation. It is an editorial checklist, not a finding that every listed problem is intentional or unlawful. Keep the formal appeal deadline visible while seeking a correction.

Repeated “missing records” requests

Ask for an itemized list, verify receipt, and attach the transmission record. Record the original submission date and ask for the decision deadline.

An unexplained medical-necessity denial

Request the criterion and policy version. Ask the clinician to address the stated reason with patient-specific evidence.

A denial that changes its explanation

Keep every notice. Ask for the current complete rationale and how the new basis affects the review and response period.

An approval followed by nonpayment

Have billing compare the authorization with the actual claim. Ask for a written explanation of any mismatch and who is responsible for correcting it.

A contractor and plan passing the case back

Ask the plan to identify the accountable decision-maker and appeal address. Seek a joint call and a single case chronology.

A refill or discharge deadline approaching

Tell the clinical team immediately. Ask for urgent review or a safe temporary arrangement as appropriate. Follow the specific notice instructions.

Close each call with a concrete question: “Who will do what next, and by which date?” The objective is an accurate decision and uninterrupted appropriate care, supported by a record that another reviewer can understand.



Watercolor illustration • Patient and caregiver making a follow-up call

When the answer is no

Identify the reason before choosing the response

A denial is a decision to examine carefully. It may concern coverage, medical necessity, authorization, network participation, or how a claim was submitted. The next step depends on the stated reason. Ask for the written decision and the specific plan provision or clinical criterion used.

Start with the notice

Mark the appeal deadline and submission address immediately. Save the envelope or electronic timestamp. Share the notice with the transplant team and identify the service or prescription involved. If you are appointing someone to act for you, ask what authorization form is required.

Match the response to the problem

A clerical issue may need a corrected claim or missing document. A medical-necessity decision may need the treating clinician's explanation and records. A network dispute may require participation evidence or a request for an exception. Ask whether the planned correction preserves your appeal rights; do not assume that it does.

Internal and external review

HealthCare.gov describes internal review by the plan and external review by an independent party. Urgent circumstances may require faster handling. The applicable route depends on the plan and type of decision; Medicare and Medicaid have their own procedures. Use the instructions on your actual notice. [\[7\]](#)

Make the record easy to follow

Prepare a brief chronology: request date, decision date, service needed, supporting evidence, and the action requested. Include the denial and relevant records, not an unsorted collection of every document you own. Number attachments and keep an exact copy of the submission.

Escalate with a purpose

Ask the team whether a clinician-to-clinician discussion is useful and whether it is separate from the formal appeal. Ask the plan what further review is available. If a regulator or benefits-assistance office is needed, ask which agency has jurisdiction over your particular coverage.

For internal appeals described by HealthCare.gov, the site provides filing steps and timeframes, including a generally applicable 180-day filing window. Other programs and decisions can differ. Follow your notice and seek help promptly rather than assuming that a generic deadline applies.

[\[21\]](#)

An appeal letter you can adapt

An original template for the patient and treating team

Use the required plan form if one is specified. This template is a starting point; it does not replace program-specific instructions. The clinician should supply and verify medical statements. Remove any sentence that does not fit your situation.

Date: [date]

To: [plan appeals unit and address]

Re: [member name, member [ID](#), claim or authorization number]

Decision dated: [date]

Service or medication: [exact request]

Dear Appeals Reviewer,

I request review of the decision denying [service or medication] for my liver transplant care. The notice states that the reason is [quote or accurately summarize the reason]. I am requesting [specific coverage decision or claim correction].

My treating clinician, [name], recommends this care because [clinician-verified explanation]. The enclosed statement addresses the plan's stated criterion and explains why [the proposed alternative, delay, or exclusion] is not appropriate in my circumstances, if applicable.

The relevant timeline is [brief dates and events]. Supporting documents include [denial notice, clinician letter, relevant results, treatment history, authorization records, or network confirmation]. Please review these materials together with the applicable benefit provisions.

If my clinician determines that the ordinary review period would jeopardize my health, I request expedited handling under the applicable process. The clinician's explanation and contact details are attached. [Delete this paragraph if it does not apply.]

Please confirm receipt, identify any missing information, and provide a written decision with the basis for that decision and instructions for any further review available to me. You may contact me at [telephone] and my authorized representative at [contact, if applicable].

Sincerely,
[name and signature]

Before sending

Confirm the deadline, secure submission method, and recipient. Include copies rather than irreplaceable originals. Retain delivery confirmation and an exact copy. A clinician discussion should not be assumed to substitute for a filed appeal. General internal-appeal instructions are available in reference [\[21\]](#).

Keeping medicines within reach

A refill problem needs attention before the bottle is empty

Anti-rejection treatment and follow-up are continuing parts of life after liver transplantation. [NIDDK](#) emphasizes taking medicines as directed and maintaining ongoing care. Coverage planning should therefore continue long after the first hospital bill has been settled. [\[15\]](#)

Start before the last doses

Ask the pharmacy how early to request refills and when approvals expire. Arrange a reminder that allows time for delivery or a correction. If a dose changes, ask the prescriber and pharmacy to reconcile the prescription and quantity so the next fill reflects the current regimen.

Describe the barrier accurately

When calling, give the exact drug, remaining number of doses, next scheduled dose, rejection message, and a reliable callback number. Ask whether the problem is a missing prescription, prior authorization, pharmacy network, benefit category, quantity rule, or cost.

Ask about a safe bridge

If the issue cannot be resolved in time, ask the transplant team and pharmacist whether an authorized temporary supply or another safe arrangement is available. Availability and payment vary. Do not independently change formulations, substitute medicines, or alter the dose to solve an insurance problem.

Review assistance without assumptions

For people with Medicare, Extra Help and other drug assistance may be relevant. Program eligibility, covered medicines, and application rules differ. Ask the pharmacist or financial coordinator to verify the terms of a manufacturer or charitable program before relying on it. [\[8\]](#)

Check every new plan year

Use the current medication list to compare coverage and participating pharmacies. Request an explanation of any formulary or cost change. Ask whether a pending exception or approval must be renewed. Keep the answer with the next refill date rather than filing it away from the prescription record.

Make a backup contact plan

Choose a trusted person who can help with calls when you feel unwell, and complete the permissions the plan and care team require. Keep the transplant team's after-hours number accessible. The objective is simple: make it clear who will act, what information they need, and how urgently the problem must be resolved.

Living donors need a financial plan

Generosity should be met with clear information

Living liver donation brings a second person's needs into the discussion. [HRSA](#) explains that the recipient's insurance generally pays donor evaluation, testing, and surgery related to donation. Coverage for unrelated disease, long-term care, and some other expenses may differ. Each donor should receive a specific explanation before proceeding. [\[6\]](#)

Ask for the donor billing pathway

Who receives the evaluation bills? Which account should the donor give to outside providers? If an incorrect bill arrives, which office will correct it? Ask these questions before testing so the donor is not left trying to resolve the recipient's coverage independently.

Discuss complications and follow-up

Request written information about donation-related complications, follow-up appointments, and any limits on the period of coverage. Ask how an unrelated condition discovered during evaluation would be handled. Separate what the recipient's plan covers from what may depend on the donor's own insurance.

Plan for time away from work

Travel, lodging, dependent care, and lost wages require their own review. [HRSA](#) identifies the National Living Donor Assistance Center as a potential source of help with qualifying nonmedical expenses. Eligibility and advance application requirements should be confirmed with the donor team. [\[6\]](#)

Respect the donor's independence

The donor should have room to ask private questions and make a voluntary decision. Ask the donor coordinator or independent living donor advocate for help with concerns. Financial planning should support an informed choice and should never pressure someone to proceed.

Do not promise insurance outcomes

Ask about implications for the donor's existing or future insurance, including products beyond health coverage. Legal protections and underwriting rules are not identical across health, life, disability, and long-term-care insurance. Seek advice specific to the donor's situation.

Reimbursement of permitted expenses is different from buying an organ; payment in exchange for an organ is prohibited. Ask the donor social worker to explain allowable support. [\[6\]](#) Keep the budget transparent, document arrangements, and avoid assurances that another person or organization has not actually agreed to provide.

The caregiver and the paperwork

Share the work without losing the patient's voice

Insurance work can consume the same hours a family needs for rest, transportation, meals, and recovery. A workable system should be simple enough to use on a difficult day. The suggestions on this page are practical organizational tools, not coverage requirements.

Divide tasks clearly

One person can track appointments, another can organize bills, and a third can help with calls if the patient agrees. Designate a primary contact for each unresolved issue. When several people call independently, information can become fragmented and follow-up can be missed.

Create one shared record

Keep insurance cards, benefit summaries, authorizations, notices, contact numbers, and a medication list together. Use a secure folder with access limited to trusted people. Keep a paper copy of essential phone numbers in case a device is unavailable.

Write useful call notes

Record the date, representative, department, reference number, question, answer, promised action, and expected response date. End the call by repeating the next step aloud. "You will send the written decision by Friday, and I should call this number if it does not arrive. Is that correct?"

Get permission the right way

Ask each organization how a caregiver becomes an authorized contact or representative. Do not assume that a spouse's relationship alone gives access to every account or authority for every decision. Let the patient choose the level of assistance whenever possible.

Name the strain

A caregiver who says "I cannot keep up" is describing a problem that deserves attention. Ask the transplant social worker what practical support is available and whether meetings can be combined. For the patient, ask how counseling or other recommended support is covered if needed.

A manageable weekly routine

Set aside a short scheduled time to review new mail, upcoming refill dates, and unresolved items. Put only the next few actions on the working list. Move completed matters to an archive. Leave room in the week for activities that have nothing to do with illness or insurance.

Your coverage readiness checklist

Bring this page to the financial coordinator

Use these prompts before evaluation, before admission, after discharge, and whenever coverage changes. Write the answer, date, and person confirming it. An unanswered question is an item to resolve, not a reason to feel discouraged.

Coverage and access

1. What is my exact plan name and coverage period?
2. Is the liver transplant center participating under this product?
3. Which clinicians, laboratories, and pharmacies are covered?
4. Do I need referrals, a network exception, or a designated center?

Authorization and treatment

5. Which stages of care require separate approval?
6. What are the approval numbers and expiration dates?
7. Who communicates with the insurer during admission?
8. How will rehabilitation, home services, and follow-up be arranged?

Medicines and money

9. Which benefit pays for each prescription?
10. What will I pay at the first fill and during the year?
11. What counts toward my applicable out-of-pocket limits?
12. What assistance can I apply for, and when?
13. Are travel, lodging, and caregiver expenses included anywhere?

Continuity and appeals

14. What happens if employment or eligibility changes?
15. When does the new plan start and the old plan end?
16. Where do I send an appeal, and what is my deadline?
17. Who is my authorized helper if I cannot make the calls?

Three actions for this week

My most urgent unanswered question: _____

The person or office I will contact: _____

The date I will follow up: _____

Start with your center's financial coordinator and social worker. For Medicare counseling, ask for your State Health Insurance Assistance Program. The official references in the source pages at the end provide direct entry points to coverage and appeal information. Avoid sending insurance identifiers or medical records through public social media.

Abbreviations 1: ADL-EOC

Select a highlighted abbreviation in an article to jump to its meaning

Underlined abbreviations throughout the issue link to these descriptions. Use your PDF viewer's Previous View command to return to the passage, or use Contents below.

ADL	Activities of daily living Basic tasks such as bathing, dressing, eating, and using the toilet.
AI	Artificial intelligence Computer methods that can assist review; they do not establish coverage by themselves.
ANOC	Annual Notice of Change A Medicare plan's notice of changes for the coming year.
CDC	Centers for Disease Control and Prevention Federal public-health agency; source for the disability overview.
CFPB	Consumer Financial Protection Bureau Federal agency with consumer-finance, credit-reporting, and debt-collection resources.
CHIP	Children's Health Insurance Program Coverage for eligible children under state and federal rules.
CMS	Centers for Medicare & Medicaid Services Federal agency administering Medicare and overseeing other health programs.
CMS-0057-F	CMS interoperability and prior authorization final rule Rule addressing specified payers' non-drug authorization processes.
COBRA	Consolidated Omnibus Budget Reconciliation Act Federal law providing temporary continuation of eligible employer coverage.
CPT	Current Procedural Terminology Code set for medical services and procedures; HCPCS Level I.
EBSA	Employee Benefits Security Administration Department of Labor office assisting with many private-employer benefit plans.
EOB	Explanation of benefits Insurer's account of claim processing and patient responsibility; not a bill.
EOC	Evidence of Coverage Detailed document explaining a plan's benefits and conditions.

Abbreviations 2: ERISA-IRS

Select a highlighted abbreviation in an article to jump to its meaning

Underlined abbreviations throughout the issue link to these descriptions. Use your PDF viewer's Previous View command to return to the passage, or use Contents below.

ERISA	Employee Retirement Income Security Act Federal law governing many private-employer benefit plans.
ESRD	End-stage renal disease Kidney failure that may confer Medicare eligibility under specific rules.
FACS	Fellow of the American College of Surgeons Professional fellowship designation used in the editor's credentials.
FAP	Financial assistance policy Hospital's written rules for free or reduced-price eligible care.
FAQ	Frequently asked questions A document format that answers recurring questions.
HCPCS	Healthcare Common Procedure Coding System Service and supply codes; Level II includes many drugs, supplies, and equipment.
HHS	Department of Health and Human Services U.S. federal department responsible for major health programs.
HRSA	Health Resources and Services Administration Federal agency associated with transplant oversight and access resources.
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification U.S. diagnosis codes describing documented medical conditions and reasons for care.
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System Codes used for procedures on hospital inpatient facility claims.
ID	Identification A member, claim, or authorization identifier; protect it as personal information.
IHCAP	Independent Health Care Appeals Program New Jersey's external review program for eligible coverage disputes.
IRS	Internal Revenue Service Federal tax agency; publishes tax-exempt-hospital charity-care requirements.

Abbreviations 3: MD-VA

Select a highlighted abbreviation in an article to jump to its meaning

Underlined abbreviations throughout the issue link to these descriptions. Use your PDF viewer's Previous View command to return to the passage, or use Contents below.

MD	Doctor of Medicine Medical degree used in the editor's credentials.
NAIC	National Association of Insurance Commissioners Association providing a directory of state insurance regulators.
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases NIH institute publishing liver-disease and transplant education.
NIH	National Institutes of Health Federal medical research agency that includes NIDDK.
OIG	Office of Inspector General In this issue, HHS's oversight office reviewing federal health programs.
OPTN	Organ Procurement and Transplantation Network National network for organ allocation and transplantation.
PDF	Portable Document Format The electronic document format used for this newsletter.
QHP	Qualified health plan A plan certified to meet applicable Marketplace requirements.
QR	Quick response A scannable code; the cover's code contains Dr. Baruch's contact information.
SBC	Summary of Benefits and Coverage Standardized benefit summary used to compare individual and job-based plans.
SHIP	State Health Insurance Assistance Program Free, unbiased individual Medicare counseling.
SSA	Social Security Administration Agency that administers Social Security disability and other benefits.
VA	Department of Veterans Affairs Federal agency providing benefits and health services to eligible veterans.

Your insurance coordinator

A partner in decisions before, during, and after transplantation

Ask the transplant center for its financial or insurance coordinator early in evaluation. This role helps connect the expected care with benefit requirements and financial arrangements. Ask how the coordinator works with the social worker, clinical team, pharmacy, and hospital billing office.

[18]

Ask whose role it is

The transplant center's coordinator, the insurer's case manager, a hospital financial counselor, and an enrollment broker have different responsibilities. Ask whom each person represents and what decisions they can make. A coordinator can investigate and explain options, but cannot guarantee an insurer's approval or eliminate every bill.

Compare choices using your actual care

Bring the exact plan names and plan-year documents. Ask the coordinator to check the transplant program, surgeons, hepatologist, laboratories, rehabilitation providers, and specialty pharmacy. Ask which services need separate authorization and whether an authorization survives a plan change. Request confirmation from the plan as well as the center.

Questions that lead to useful answers

Which realistic coverage options keep my team accessible? What is the largest unresolved expense? Which drugs might be billed under the medical benefit? What must be approved before evaluation, listing, surgery, and discharge? Who will contact the insurer if the answer is unclear?

Leave with a written next step

Ask for a short comparison, the documents supporting it, an owner for each unresolved item, and a follow-up date. For Medicare choices, an independent [SHIP](#) counselor can add a second perspective. Ask any broker which insurers they represent and whether they receive commissions. The final choice should reflect your treatment needs, budget, and verified eligibility. [39]

Read the policy in plain English

Find the rule, the exception, and the cost before deciding

Begin with the Summary of Benefits and Coverage ([SBC](#)), a standardized summary for individual and job-based plans. Ask for its glossary. Then obtain the full policy, Evidence of Coverage, or employer plan document and amendments. The summary is a starting point; it does not contain every exclusion or authorization rule. [\[32\]](#)

Start with identity and dates

Confirm the exact product, network, member category, coverage year, effective date, and renewal date. A familiar insurer's logo can appear on plans with very different benefits. Check whether an employer plan is self-funded; this affects where some complaints should go.

Translate the money words

Premium: the recurring price of coverage. Deductible: the amount you may pay before specified benefits begin. Copayment: a fixed charge. Coinsurance: a percentage of the plan's allowed amount. Allowed amount: the price recognized by the plan, which can differ from the provider's charge.

Read the ceiling carefully

For a plan with an out-of-pocket maximum, ask which expenses count toward it. Premiums, noncovered services, and many out-of-network expenses generally do not. Check individual versus family limits and whether medical and pharmacy spending share a limit. Original Medicare alone has no overall annual Part A/B out-of-pocket maximum. [\[4\]](#) [\[14\]](#)

Find the transplant conditions

Search for "transplant," "network," "medical necessity," "authorization," "exclusions," "specialty drugs," "rehabilitation," and "appeal." Ask whether evaluation, donor services, surgery, complications, and follow-up have separate rules. A covered benefit may still require approval at a designated center.

Turn a difficult sentence into three questions

What care does this allow? What must happen first? What could I owe? Write the section and page beside the answer. If two documents conflict, ask the administrator which provision controls and request a written explanation. Do not rely on an advertisement as the policy.

Insurance plan checklist

Mark confirmed, unresolved, or not applicable for each item

Use this checklist with the counselor. A checked box means you have dated evidence, not simply an assumption. Put a question mark beside anything still unresolved.

Coverage and access

- ☐ Exact plan, network, effective date, and plan year recorded.
- ☐ Transplant center and key clinicians confirmed by plan and center.
- ☐ Laboratory, imaging, rehabilitation, and home-care access checked.
- ☐ Referral, out-of-state, and designated-center rules understood.

Approvals and continuity

- ☐ Evaluation, surgery, donor services, and follow-up rules reviewed.
- ☐ Authorization numbers, service dates, and expiration dates saved.
- ☐ Plan-change and temporary transition arrangements verified.
- ☐ Appeal route and urgent-review contact recorded.

Medicines

- ☐ Every drug's name, strength, formulation, and quantity checked.
- ☐ Formulary tier, benefit route, restrictions, and pharmacy confirmed.
- ☐ Refill cost estimated; approval renewal date recorded.
- ☐ A safe response is arranged if a needed refill is blocked.

Household costs

- ☐ Premium, remaining deductible, and cost-sharing limits recorded.
- ☐ Costs excluded from the limit listed separately.
- ☐ Travel, lodging, caregiver costs, and lost income considered.
- ☐ Assistance applications and renewal dates tracked.

People and evidence

- ☐ Caregiver authorization or representative forms completed if needed.
- ☐ Written answers and source document pages saved.
- ☐ Each unresolved question has an owner and due date.
- ☐ Next review appointment is scheduled.

This is an editorial planning tool, not an insurer's coverage certification. Use the out-of-pocket worksheet for figures and the counseling handout for questions. Verify the final choice before ending existing coverage.

Review the material you receive

Build a small, usable record rather than a pile of paperwork

Keep six sections

1. Current policy and benefit summary.
2. Provider network and pharmacy/formulary information.
3. Authorizations and clinical submissions.
4. Bills, explanations of benefits, and payment receipts.
5. Denials, appeals, and deadline notices.
6. Assistance approvals, contacts, and call notes.

Match documents before paying

An explanation of benefits ([EOB](#)) describes claim processing; it is not itself a bill. Compare patient name, date, provider, service, allowed amount, insurer payment, and patient responsibility with the itemized bill. Ask about duplicate charges, missing secondary payments, or a bill larger than the [EOB](#) responsibility. [\[37\]](#)

Use a one-page reading routine

Date each document when received. Circle what changed, underline the action required, and enter the deadline on a calendar. Save the envelope or electronic timestamp when a deadline depends on receipt. Put unclear wording in a questions list with the page number.

Check understanding together

Ask the counselor to explain one actual claim or authorization in ordinary language. Then say it back: “My understanding is that I must do ___ by ___ and my estimated share is ___.” Ask for correction and written confirmation. Request an interpreter, accessible format, or a slower explanation if needed.

Separate a complaint from an appeal

A billing inquiry, customer-service complaint, or peer-to-peer discussion may not file the formal appeal. Confirm the correct submission route, required representative form, and receipt. Track the appeal deadline even while a staff member is trying to fix the problem. [\[7\]](#) [\[29\]](#)

Keep originals and send copies. Use the plan’s secure portal or an approved delivery method for sensitive records. A caregiver should have the appropriate permission to speak and obtain information; being present at an appointment may not be enough for later calls.

Where to go for help

Match the problem with the office that can address it

Care and immediate medication access

Contact the transplant team and transplant pharmacist for clinical urgency or a threatened interruption. Ask the center's financial coordinator and social worker to coordinate coverage and assistance questions. An emergency should not wait for routine insurance counseling.

Medicare choices and costs

[SHIP](#) offers free, unbiased individual Medicare counseling. Use its state directory. Medicare can also answer benefit questions at 1-800-MEDICARE (1-800-633-4227). Bring your plan and medicine list. [\[39\]](#) [\[8\]](#)

Marketplace or Medicaid enrollment

Use HealthCare.gov's local-help directory for enrollment assistance, or the appropriate state Marketplace. For Medicaid, contact the state agency about eligibility, renewals, and appeal notices. Confirm whether the helper is an assister or a broker and whose plans a broker represents. [\[40\]](#) [\[12\]](#)

A disputed insurance decision

Start with the appeal instructions in the notice. State insurance departments assist with state-regulated insurance issues; [NAIC](#) lists their contacts. For many private employer plans, Department of Labor [EBSA](#) is the appropriate federal resource, particularly for [ERISA](#) questions. Government and church plans can follow different rules. [\[41\]](#) [\[29\]](#)

A hospital bill or debt problem

Ask the billing office for financial assistance and a collections hold while it reviews your application; obtain confirmation. For credit-report or debt-collection errors, follow the dispute process. For a lawsuit, threatened lien, or serious debt burden, seek local legal aid promptly. [\[33\]](#) [\[38\]](#) [\[42\]](#)

The linked source numbers take you to the relevant directories or instructions. A regulator's complaint does not automatically pause an appeal deadline or collection action. Ask exactly which process has been opened and what you must do next.

Lowering prescription costs

Ask the transplant pharmacist to help build a safe plan

First identify the exact barrier

Ask whether the problem is an incorrect Part B/Part D billing route, a nonparticipating pharmacy, a restriction, or a high patient share. Correcting a claim is different from applying for assistance. Tell the team how many doses remain. [\[2\]](#) [\[28\]](#)

Government and state assistance

For Medicare Part D, Extra Help can reduce costs for eligible people. Medicare Savings Programs may help with other Medicare expenses. Ask about Medicaid eligibility and state pharmaceutical assistance where available. A counselor can help with applications and renewal requirements. [\[8\]](#)

Manufacturers and charitable funds

Ask the pharmacist about a manufacturer's patient assistance program for your exact drug and about independent charitable funds. Availability, income rules, insurance eligibility, and funding change. Get approval before budgeting on an award. Manufacturer copay coupons generally cannot be used for drugs paid by Medicare or other federal health programs; free-drug assistance has separate eligibility rules. [\[8\]](#) [\[43\]](#)

Compare the whole transaction

Ask about a clinically appropriate generic or lower-cost formulation, preferred network pharmacy, and permitted days' supply. Only the prescriber should approve treatment changes. Compare cash or discount prices with insurance costs, and ask whether cash payments count toward your deductible or spending limit; do not assume they do. [\[8\]](#) [\[15\]](#)

Help with timing is not a price reduction

The Medicare Prescription Payment Plan spreads eligible Part D expenses over the calendar year. It does not lower the total drug cost. Ask how a late-year enrollment affects monthly amounts. [\[9\]](#)

Do not ration, borrow, or substitute anti-rejection medication on your own. If a fill is at risk, ask the transplant team and pharmacist the same day about urgent review, an eligible transition supply, or another safe bridge while assistance is arranged. [\[15\]](#) [\[28\]](#)

Charity care and unpaid bills

Start with accuracy, then assistance, then an affordable agreement

Check what is actually owed

Request an itemized bill and compare it with the [EOB](#) and payments already made. Ask billing to correct errors and submit missing insurance claims. Request a temporary collection hold and written confirmation of its duration; an inquiry alone does not guarantee a hold. [\[37\]](#)

Apply for financial assistance

Charity care is free or discounted eligible care under a hospital's financial assistance policy ([FAP](#)). Ask for the policy, application, and plain-language summary. Tax-exempt hospital facilities have federal obligations in this area. Ask whether you qualify despite having insurance and which separately billing clinicians participate. Include the requested household and income records and keep proof of submission. [\[33\]](#)

Know the collection safeguards

For covered tax-exempt hospitals, federal rules require reasonable efforts to assess assistance eligibility before extraordinary collection actions. The rules generally include at least 120 days before such actions after the first post-discharge bill, and a 240-day application period, subject to detailed conditions. These are not universal grace periods for every creditor or bill. Apply promptly. [\[34\]](#)

Negotiate the remaining valid balance

Ask about a hardship discount, an interest-free plan, and a monthly payment that leaves room for housing, food, and medicines. Get the balance, interest, fees, missed-payment consequences, and any settlement terms in writing before paying. A discount or installment plan is a request, not an automatic entitlement. [\[37\]](#)

Be cautious about moving the debt

A credit card or medical financing product can create interest charges and reduce flexibility. Ask about deferred interest and the full repayment schedule. Seek advice before using home equity or retirement funds. If repayment remains impossible, legal aid can discuss debt remedies, including whether bankruptcy advice is appropriate. [\[37\]](#) [\[42\]](#)

Keep the clinical team informed if bills are affecting access. Ask billing and the counselor to agree on the next action and response date. Financial difficulty is a reason to seek assistance early, not a reason to stop essential treatment.

Collections, liens, and credit reports

Know the difference between a debt, a report, and a court action

Credit-report protection is not debt forgiveness

The [CFPB](#)'s broad 2025 medical-debt credit-reporting rule was vacated on July 11, 2025. Do not assume all medical debt is barred from credit reports. As currently described by TransUnion, the three major bureaus exclude paid medical collections and those with an initial reported balance under \$500, and delay reporting unpaid medical collections for one year. These policies do not cancel the debt. [\[35\]](#) [\[36\]](#)

A medical charge on a credit card is different

Paying a provider with a credit card generally leaves ordinary card debt; medical-collection reporting policies should not be assumed to protect it. Review all three credit reports and dispute inaccurate entries with the bureau and the company furnishing the information. State protections and their enforceability can differ; ask local legal aid about your situation. [\[36\]](#) [\[42\]](#)

Respond to a collector in writing

Confirm that the collector and debt are legitimate. Keep the validation notice. A written dispute within its 30-day validation window generally requires the collector to stop collection until verification is provided. Keep proof of sending. The dispute process is separate from defending a court case. [\[38\]](#)

A lien is not automatic

A property lien may arise through a judgment or under a specific statute; available remedies, exemptions, and procedures vary by state. Certain hospital liens concern personal-injury settlement proceeds rather than a home. Federal tax-exempt-hospital rules identify property liens and lawsuits among extraordinary collection actions, with exceptions. They do not themselves authorize every collection method. [\[34\]](#)

Do not ignore legal papers

If a summons, judgment notice, garnishment, or lien notice arrives, contact legal aid or a qualified attorney immediately and meet the court deadline. Ask about exempt income or property and assistance that may still apply. Do not transfer assets or sign a secured agreement simply to stop collection calls. [\[42\]](#)

Reviewed September 30, 2026. Reporting policies and state law can change; confirm the current rule before relying on it. An insurance appeal does not automatically stop a lawsuit or remove a credit entry.

How often should you review coverage?

A yearly comparison, plus a check whenever circumstances change

At least once each year

Set a review appointment before your plan's enrollment deadline. Compare the coming year's premium, benefits, provider network, formulary, pharmacy, and authorization requirements. Reuse your cost worksheet, but replace every figure and date. Staying in the same plan still requires a review.

For Medicare plans

Read the Annual Notice of Change, generally received in September, and the Evidence of Coverage. Medicare Open Enrollment runs October 15 through December 7 for the following year's coverage. Review the transplant program and every prescription. This enrollment season does not create a general guaranteed right to buy Medigap. [\[44\]](#) [\[45\]](#) [\[11\]](#)

Review again after a major change

Contact the counselor after a job or income change, loss of dependent coverage, relocation, Medicare eligibility, a new prescription, transplant listing, hospitalization, or a provider leaving the network. Review can happen at any time; switching plans may require an enrollment period or qualifying event. [\[10\]](#)

Use a short ongoing check

As an editorial routine, review upcoming refills, pending authorizations, unresolved bills, and deadlines each month. Recheck coverage before a planned major service and when an authorization is about to expire. A written approval should identify the relevant service, provider, dates, and conditions.

Before making a change

Verify eligibility, effective dates, drug access, and the new plan's participation with your transplant team. Confirm what happens to existing authorizations and deductibles. Avoid ending current coverage before you understand the replacement and any gap.

My next full review: _____

My enrollment deadline: _____

My coordinator / counselor: _____

Changes I must report: _____

Take-along counseling handout

Patient and caregiver appointment sheet • Print and bring this page

Patient: _____ Caregiver: _____

Plan / year: _____ Counselor / date: _____

1. Which options cover my transplant center, clinicians, and pharmacy?

2. What approvals are needed, who submits them, and when are they due?

3. What will each medicine cost, and what assistance can I apply for?

4. What is my likely yearly cost and what falls outside the spending limit?

5. If a service is denied, who helps me appeal and what is the deadline?

6. Which bill-assistance or payment-plan options fit my situation?

7. What is unresolved, who will handle it, and when will we speak again?

Bring: insurance cards; full policy and benefit summary; medicine list; provider list; authorizations; denial notices; bills and [EOBs](#); requested income documents. Ask what caregiver permission forms are needed. Keep this completed sheet private.

Estimated out-of-pocket costs

Complete with the counselor • One sheet per plan and coverage year

Patient: _____ Plan / year: _____

Estimate date: _____ Counselor / contact: _____

Plan-year dates: _____ Coverage months: ____ Monthly premium: \$ _____

Remaining medical deductible: \$ _____ Drug deductible: \$ _____

Remaining medical spending limit: \$ _____ Separate drug limit: \$ _____

Limits reset on: _____ Individual or family: _____

Expected expense	Your share \$	Count in limit?	Basis / confirmed?
Evaluation / tests / imaging			
Hospital / transplant admission			
Surgeon / anesthesia / other clinicians			
Follow-up / labs / procedures			
Prescription medicines for the year			
Rehabilitation / home care / equipment			
Travel / lodging / parking / caregiver			
Other / uncovered care			

Planning total = premiums for covered months + estimated patient shares above + other expenses – confirmed assistance: \$ _____

Assistance approved: \$ _____ Due dates / largest first-month need: _____

Unresolved costs / next review: _____

Avoid double counting: deductibles are part of patient shares, not an extra charge to add again. A spending limit is a ceiling for qualifying costs, not an additional bill. Apply shared limits only once. Original Medicare alone has no annual Part A/B ceiling. Ask for a higher-cost scenario and a second estimate if care crosses a plan year. Estimates do not guarantee coverage or final charges.

Common disabilities and daily limitations

Recognize the support needed; a diagnosis alone does not settle benefit eligibility

[CDC](#) describes six common disability categories among U.S. adults: cognition, mobility, independent living, hearing, vision, and self-care. These are population categories, not a ranking of liver-transplant complications. A person may experience more than one. [\[46\]](#)

Thinking, memory, and independent living

Cognitive limitations can affect concentration, recall, and decisions. Independent-living limitations can make errands or attending appointments alone difficult. Consider what help is needed to understand instructions, organize records, or carry out a daily plan. [\[46\]](#)

Movement and self-care

Mobility limitations involve walking or climbing stairs. Self-care limitations affect dressing or bathing and other activities of daily living ([ADL](#)). Describe the distance a person can walk, help needed for transfers, and whether tasks can be performed safely and reliably. Ask the team what rehabilitation or assistance is appropriate. [\[46\]](#)

Hearing and vision

Difficulty hearing or seeing can make instructions and paperwork harder to use. Tell the office what communication format helps: larger print, accessible electronic information, captioning, or another arrangement. Ask staff to confirm understanding without assuming that a sensory limitation affects decision-making ability. [\[46\]](#)

In liver disease and transplant recovery

Fatigue, altered mental status, treatment effects, rejection episodes, and complications can affect function. Ask the clinician to document what is present in your case and how it limits daily activities or work. Do not assume every recipient has these problems or that recovery follows one timetable. [\[17\]](#)

Disability benefits are a separate determination

[SSA](#)'s adult liver-transplant listing considers disability for one year from transplantation; afterward, residual impairments are evaluated. Financial, work-history, and other program conditions still matter. This is not automatic payment, permanent disability, or immediate Medicare eligibility. Employer disability policies have their own definitions. [\[17\]](#) [\[19\]](#)

Bring a short activity log: task, difficulty, frequency, help needed, and effect on work. Ask the social worker or benefits counselor which application and supporting records fit your situation.

Accurate diagnosis and procedure coding

Help the clinical record, authorization, and claim describe the same care

Coding translates documented diagnoses and services into standardized claim information. Clinicians establish diagnoses and describe the care; trained coding and billing staff assign and review codes. Patients can help identify factual errors, but should not have to choose their own billing codes. [47]

Different codes answer different questions

[ICD-10-CM](#) describes the diagnosis or reason for care. [CPT](#) and [HCPCS](#) identify medical services, procedures, and many supplies or drugs. [ICD-10-PCS](#) applies to procedures on hospital inpatient facility claims. A surgeon's professional claim and the hospital's claim may therefore use different code systems. [48] [50]

Transplant status is not the same as a complication

A history of liver transplantation, routine aftercare, and an active transplant complication are distinct circumstances. A condition occurring after surgery is not automatically a surgical or transplant complication. Ask the clinician and coder to clarify the documented relationship, current diagnosis, and reason for the encounter before changing a claim. [47]

Ask for an accuracy check

Request the itemized bill, relevant diagnosis and procedure codes, dates, units, and plain-language descriptions. Compare them with the service received and the [EOB](#). Ask: Is the diagnosis current and supported? Does the procedure match the operative or visit note? Are modifiers, service setting, and any authorization details correct? Who will submit a correction? [49]

When an error or denial occurs

Send the discrepancy to the provider's billing or coding office. Request clinician clarification if the record is unclear, a corrected claim when appropriate, and written confirmation of resubmission. Keep the appeal deadline visible. Accurate coding may correct an error; it does not guarantee coverage or replace a medical-necessity appeal.

Codes and rules change. Staff must use the code set applicable to the encounter or discharge date. The linked FY 2027 diagnosis guidelines apply beginning October 1, 2026. Codes must reflect the documented facts; do not request an unsupported diagnosis simply to obtain payment. [47]

My treatment and insurance calendar

Reusable monthly planner • Fill in the month, date numbers, and your own schedule

Patient / initials: _____ Month / year: _____
Fill in date numbers. Use this page again each month; follow your team’s actual schedule.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Appointment and deadline details

Date / time	Visit, test, refill or deadline	Office / contact	Prep, approval or transport

Record: clinic visits, laboratory tests, medication refills, authorization expiry, appeal deadlines, insurance renewal, and assistance applications. Confirm arrival time, location, preparation, and any transport help with the office.

Team’s daytime contact: _____ After-hours contact: _____
Who will confirm results / follow up? _____

Keep this completed page private. Do not change medication or fasting instructions based on this blank planner; obtain instructions from your treatment team.

Sources and citations

References | Original review September 30; additions October 1, 2026

01 Medicare

[Organ transplants](#)

02 Medicare

[Prescription drugs and Part B transplant therapy](#)

03 HealthCare.gov

[Pre-existing conditions](#)

04 HealthCare.gov

[Out-of-pocket maximum](#)

05 HealthCare.gov

[COBRA and Marketplace alternatives](#)

06 HRSA OPTN

[Living donation FAQs](#)

07 HealthCare.gov

[Appealing a health plan decision](#)

08 Medicare

[Help with drug costs](#)

09 Medicare

[Part D costs and payment options](#)

10 HealthCare.gov

[Special Enrollment Periods](#)

11 Medicare

[Medigap enrollment protections](#)

12 HealthCare.gov

[Medicaid and CHIP coverage](#)

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15 NIDDK NIH

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16 NIDDK NIH

[The liver transplant process](#)

17 Social Security

[Digestive disorders and liver transplantation](#)

18 HRSA OPTN

[The transplant team](#)

19 Social Security

[Medicare and disability](#)

20 Veterans Affairs

[About VA health benefits](#)

21 HealthCare.gov

[Internal appeals](#)

22 HealthCare.gov

[What Marketplace plans cover](#)

23 HHS OIG

[Improper prior authorization and payment denials, 2022](#)

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28 Medicare

[Drug plan rules and step therapy](#)

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[Filing a claim for your health benefits \(web edition\)](#)

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[Coordination of benefits and who pays first](#)

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[Part D exceptions and prescriber support](#)

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[Summary of Benefits and Coverage](#)

33 IRS

[Hospital financial assistance policies](#)

34 IRS

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35 CFPB

[Medical-debt rule vacated July 11, 2025](#)

36 TransUnion

[Collections and medical-debt reporting](#)

37 CFPB

[If you cannot pay a medical bill](#)

38 CFPB

[Disputing a debt collector's demand](#)

39 SHIP

[Find free local Medicare counseling](#)

40 HealthCare.gov

[Find local enrollment help](#)

41 NAIC

[Find your state insurance department](#)

42 Legal Services Corporation

[Find civil legal aid](#)

43 HHS OIG

[Manufacturer copayment coupon restrictions](#)

44 Medicare

[Annual Notice of Change](#)

45 CMS

[Medicare Open Enrollment](#)

Sources and citations

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46 [CDC](#)

[Common disability types in U.S. adults](#)

47 [CMS / NCHS](#)

[FY 2027 official diagnosis coding guidelines](#)

48 [CMS](#)

[Diagnosis and inpatient procedure code sets](#)

49 [CMS](#)

[Check your medical bill for errors](#)

50 [CMS](#)

[Healthcare Common Procedure Coding System](#)

Publication notes. U.S. educational edition, adapted from the supplied Issue 12. New AI-generated cover; original articles, worksheets, portrait, and interior illustrations retained.

Link review: October 18, 2026. All 50 references were checked. Department of Labor material was verified through indexed official content because direct retrieval was blocked. The local-help directory is interactive. Rules and benefits may change; confirm the plan and year.