

## **Medicare Advantage Plans: The Appeals Process**

There are two types of appeals processes that a Medicare Advantage plan enrollee may need to use to assure Medicare health insurance coverage. The first type of appeal, a coverage and payment appeal, may be used by an enrollee in two circumstances. First, it can be used to appeal the MA plan's decision to deny coverage and payment for health care services that the enrollee has already received. Second, it may be used to appeal the MA plan's decision to deny coverage and payment for services that the enrollee has not yet received, but that he or his physician are seeking pre-approval of.

The second type of appeals process, fast-track appeals, may be used by enrollees who are receiving hospital care, skilled nursing facility care, outpatient rehabilitation facility care, hospice, or home health care, and who are notified by their MA plan that these services are coming to an end. The enrollee may appeal this denial of coverage and termination of services through the fast-track appeals process.

In both instances the appeals process may progress through a number of stages. Below are the stages of a Medicare appeal with Coverage and Payment Appeals discussed first and a review of the Fast-Track Appeals process to follow.

### **Coverage and Payment Appeals**

#### **I. The Organization Determination**

The ability to appeal an adverse Medicare coverage decision begins when the enrollee receives notice of the MA plan's initial coverage decision, called the organizational determination.

There are two ways that a MA plan enrollee may receive notice of the organizational determination. First, the enrollee may have received medical treatment or services that the plan refused to cover. For example, this may happen if the enrollee receives medical care without prior authorization from an outside provider. The MA plan, usually upon receiving a bill for the care provided to the enrollee, issues a [Notice of Denial of Payment](#) informing the enrollee that Medicare will not cover the medical services or treatment received.

The second way in which a MA plan enrollee may receive notice of the organization determination is as a result of the enrollee's (or the health care provider's) request for prior authorization of a proposed treatment or health care service. Upon receiving a standard request for an organizational determination, the MA plan must issue a

coverage determination as quickly as the enrollee's health requires, but no later than 14 days from the date of request.

In some cases, however, 14 days of non-treatment may jeopardize the enrollee's health. In that case, an enrollee or his doctor may request that the organizational determination be expedited. If the plan expedites its determination process, it must complete its determination and notify the enrollee of its coverage decision within 72 hours. In either the standard or expedited determination of coverage processes, the MA plan must issue a [Notice of Denial of Medical Coverage](#) if it decides to deny coverage.

Upon receiving the organizational determination or denial, the enrollee may begin the appeals process.

See [42 CFR §§ 422.566 – 422.576](#)

## II. Stages of a Medicare Appeal

### Step One: Reconsideration by the MA Plan

- **Who:** Any party to the organization determination may request a standard reconsideration. If the reconsideration is sought to be expedited based on the enrollee's medical need for a quicker determination, only the enrollee or a physician may make the request for an expedited reconsideration.
- **When:** The request must be made within 60 days of the date of the organization determination, although this time frame may be extended based on a showing of good cause. A request for an extension must be in writing, explain why the request for reconsideration was delayed, and be accompanied by the request for reconsideration.
- **How:** A request for a standard reconsideration must be made in writing to the MA plan. Requests for expedited reconsideration may be either oral or in writing.
- **What:** For both standard and expedited requests for reconsideration, the request should explain why the initial determination was wrong and include any evidence that the enrollee wants the MA plan to consider in making its reconsideration. See "[How to Help on a Medicare Appeal](#)" for suggestions on deciding what to include.

**NOTE:** When making a request for an expedited reconsideration, the enrollee and/or his physician must explain how applying the standard reconsideration time frame would jeopardize the health of the enrollee.

- **What Happens Next:** What happens after a request for reconsideration is made will depend on two factors: 1) whether the request was for a standard review or an expedited review, and 2) whether the request for reconsideration was for pre-approval of services or a request for payment for services already received.

**Standard Reconsiderations:**

a. Request for pre-approval: The MA plan must notify the enrollee as quickly as his or her health condition requires, but no later than 30 days from the date it receives the reconsideration request, whether coverage is granted or denied. If the MA plan again denies coverage, or fails to issue a reconsidered determination within 30 days, it must forward the case file on for review by an independent review entity (IRE).

b. Request for payment for services already received: The MA plan must notify the enrollee within 60 days from the date it receives the reconsideration request whether coverage is granted or denied. If the MA plan again denies coverage, or fails to issue a reconsidered determination within the 60 day period, it must also forward the case file on to the independent review entity.

**Expedited Reconsiderations:**

An enrollee and/or his physician may only request expedited reconsideration when seeking coverage for services not yet provided. Under an expedited reconsideration request, the MA plan must notify the enrollee of its determination within 72 hours of receiving the request. If the MA plan denies coverage, or fails to issue a reconsidered determination within the 72 hour period, the MA plan must forward the case file on to the independent review entity.

See [42 CFR §§ 422.578 - 422.590](#); Ch. 13 Medicare

[Managed Care Manual](#) Pub. 100-16, Ch. 13

## Step Two: Reconsideration by Independent Review Entity (IRE)

- **Who:** The MA plan automatically forwards the case file of an enrollee to the IRE whenever the MA plan makes a determination upon reconsideration to again deny Medicare coverage.
- **When:** The MA plan must forward the case file to the IRE within the time frames set forth above.
- **What Happens Next:** The IRE reviews the initial determination of the MA plan and the determination that the MA plan made upon the filing of the request for reconsideration. Reviewing the applicable law and facts, and following the same time frame requirements for making a reconsidered determination that the MA plan is required to follow, the IRE must determine whether or not the MA plan was correct in again denying coverage.

The IRE must then issue its reconsidered determination to the parties and send a copy of its determination to CMS. The notice must describe the basis for the IRE's determination and, if the IRE finds that the MA plan was in any way correct in denying Medicare coverage, it must inform the enrollee of his right to an Administrative Law Judge (ALJ) hearing when the amount in controversy is \$120 or more (2008).

See [42 CFR §§ 422.592 - 422.594](#)

## Step Three: Administrative Law Judge Hearing

- **Who:** Any party to the reconsideration who is dissatisfied with the reconsidered determination, except for the MA plan, may request an ALJ hearing if the [amount in controversy](#) exceeds a threshold amount of \$120 (2008). A request for an ALJ Hearing may also be filed where the IRE fails to issue its notice of determination in a timely manner.
- **When:** A party must file a request for a hearing within 60 days of the date of the notice of a reconsidered determination. An extension of this deadline may be granted where good cause is shown.
- **How:** A party must file a written request for a hearing with the entity specified in the IRE's reconsideration notice and mail copies of this request to all parties subject to the matter.

- **What:** The request must be made either by submission of the standardized [Form CMS-20034A/B](#), or in a separate written document. It must contain each of the following elements:
  - The name, address, and Medicare number of the enrollee whose claim is being appealed;
  - The name and address of the appellant, when the appellant is not the enrollee;
  - The name and address of designated representatives if any;
  - The reasons for disagreeing with the IRE's reconsidered determination; and
  - A statement of any additional evidence to be submitted and the date it will be submitted.
  
- **What Happens Next:** The ALJ will conduct a hearing. The hearing is likely to be conducted by video-teleconferencing, but may also be by telephone or in person. The ALJ considers all the information in the record as well as new information submitted in preparation for the hearing or elicited during the course of the hearing. The ALJ will issue a notice of decision within 90 days of receipt of the request for an ALJ hearing. The notice will advise the parties of their appeal rights.

See [42 CFR §§ 422.600 - 422.602](#); [42 CFR § 405.1020](#)

#### **Step Four: Medicare Appeals Council (MAC) Review**

- **Who:** Any party to the ALJ hearing, including the MA organization, may request MAC review of an ALJ determination.
  
- **When:** The request for a MAC review must be filed within 60 days of receiving the notice of decision from the Administrative Law Judge. If a written request for extension of this deadline is filed with the MAC and the MAC determines that good cause for granting the extension exists, the deadline may be extended.
  
- **How:** A request for a MAC review may be made using a standardized CMS form, if available, or in a writing that contains each of the following elements:
  - The enrollee's name;
  - The enrollee's Medicare number;
  - The specific service(s) or item(s) for which the review is requested;
  - The specific date(s) of service;
  - The date of the ALJ's final action, if any;
  - If the party is requesting escalation from the ALJ to the MAC, the hearing office in which the appellant's request for hearing is pending;
  - The name and signature of the party or the representative of the party

- **What:** The request for review must identify the parts of the ALJ's decision that are believed to be incorrect. It must explain why the ALJ's decision is wrong by referring to the specific law and/or facts at issue.
- **What Happens Next:** Parties to the MAC review may submit written statements to the MAC that outline their position in relation to the facts in the case and the law at issue. Parties may also request to present oral argument on the matter. The MAC is not required to allow oral argument, but may permit it if the case raises an important question of law, policy, or fact and it determines that written statements by the parties are not sufficient. The MAC will issue a decision within 90 days of the initial request for MAC review.

See [42 CFR §§ 422.608](#); [42 CFR §§ 405.1100 - 405.1132](#)

### Step Five: Judicial Review

- **Who:** Any party to a MAC review may request judicial review. An action for judicial review may be filed upon receipt of an unfavorable MAC determination. Judicial review may also be sought upon the failure of a MAC to issue a decision within 90 days. Only claims with an amount in controversy that exceeds the threshold amount, \$1,180 in 2008, are eligible for judicial review.
- **When:** An action in federal court must be filed within 60 days of receiving the MAC's decision or within 60 days of receiving notice that the MAC will be unable to complete a timely determination of the matter. Where a request for a time extension is filed with the MAC and the MAC determines that good cause for the delay exists, this time limit on filing in federal court may be extended.
- **How:** A complaint, naming the Secretary of Health and Human Services, in his or her official capacity, as defendant, must be filed with the appropriate U.S. District Court.
- **What:** The complaint is a statement of facts and demand for judicial relief, filed by the person appealing the MAC decision. A complaint begins the judicial process; all prior stages of the Medicare appeal having been purely administrative. In administrative proceedings the decision maker is an official of, or has been appointed by, the Department of Health and Human Services. The filing of a complaint is the first stage of a Medicare appeal that will be decided by a judge who is independent of any party.
- **What Happens Next:** As in any civil legal proceeding, both parties will be able to file statements as to their position in the case, file motions to dispose of the

case before trial, engage in discovery, and choose to settle or proceed to trial. If the case proceeds to trial, the judge will issue a decision. The decision entered by the judge may be appealed to the same extent that other legal actions may be appealed.

See [42 CFR §§ 422.612](#); [42 CFR §§ 405.1130 - 405.1136](#)

## Fast Track Appeals for Termination of Services

### I. Introduction

All Medicare beneficiaries are entitled to request an expedited process for having their Medicare claims examined or reviewed when existing health care services, including hospitalization, hospice, home health, outpatient rehabilitation, and skilled nursing facility care, are to be imminently terminated. Below is a summary of the appeal rights and procedures that apply to each.

### II. Hospital Discharge Appeal Rights

See [Hospital Discharge Appeal Notices](#)

See also [42 CFR § 422.620 - 422.622](#); [Medicare Managed Care Manual](#), Ch. 4

### III. Termination of Skilled Nursing Facility, Comprehensive Outpatient Rehabilitation Facility, Home Health, Hospice, or Skilled Nursing Facility Appeal Rights

#### Step One: The Notice of Medicare Non-Coverage

- **Who:** The provider of medical care through a Comprehensive Outpatient Rehabilitation Facility, Home Health Agency, or a Skilled Nursing Facility must issue a [Notice of Medicare Noncoverage](#) to the enrollee. If the enrollee is unable to understand the nature and meaning of the notice, the notice must be delivered to the enrollee's representative to be valid.
- **When:** The Notice of Medicare Non-Coverage must be issued to the Medicare enrollee or his representative no later than two days before the proposed end of care. The provider of care remains liable for costs associated with the enrollee's care until two days after the enrollee receives valid notice.
- **What:** The Notice of Medicare Non-Coverage must inform the enrollee or his representative of the date that coverage of services ends, the date that the enrollee's financial liability for continued services begins, a description of the enrollee's right to a fast-track appeal, how to request one, and the enrollee's rights during the appeals process.
- **What Happens Next:** The enrollee decides whether or not they disagree with the decision to discontinue services. If the enrollee disagrees with the decision to terminate, he may request a review of this decision, called a fast-track appeal.

See [42 CFR § 422.624](#)

## Step Two: Requesting Fast-Track QIO Review

- **Who:** The enrollee or his representative may request fast-track QIO review.
- **When:** The request must be submitted, in writing or by telephone, to the [Quality Improvement Organization](#) (QIO) for the state in which the enrollee resides. It must be received by noon of the day following the day in which the enrollee received the Notice of Medicare Provider Non-Coverage. If the QIO is not available (i.e., closed for the weekend), the request must be submitted by noon of the next day that the QIO is available.

If the enrollee fails to submit his request on time, he may still file a request for expedited reconsideration with the MA plan. See “Step One: Reconsideration by the MA plan” under Part I, Coverage and Payment Appeals, above.

- **What:** The request should indicate that the enrollee disagrees with the MA plan’s determination that HHA, SNF, or CORF services must end due to Medicare non-coverage.

The enrollee is permitted to submit evidence to the QIO to aid in its decision-making. See “[How to Help on a Medicare Appeal](#)” for suggestions on deciding what evidence to include in the request for Fast-Track QIO review.

- **What Happens Next:** If a timely request for QIO review was made, the following three things happen next:
  - a. [Detailed Explanation of Non-Coverage](#): The QIO informs the provider of services and the MA plan of the enrollee’s request for fast track review. By the end of the same day in which the MA plan is notified, the MA plan must give the enrollee a Detailed Explanation of Non-Coverage. This notice must state:
    - Why, specifically, the services are either no longer reasonable and necessary or are no longer covered;
    - Any applicable Medicare coverage rule or policy;
    - Facts specific to the enrollee and relevant to the coverage determination that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee’s case; and
    - The right of the enrollee to obtain copies of records that the provider sends to the QIO in completing its review.

b. Financial Protection: Medicare, through the MA plan, continues to cover services provided until the date indicated on the Notice of Medicare Non-

Coverage. If the QIO disagrees with the MA plan's proposed termination of services and determines that services should continue, Medicare coverage continues as well.

c. QIO Determination: The QIO must issue a determination of coverage by close of business of the day after it receives the information necessary to make the decision. In reaching its decision, the QIO reviews the medical records and evidence submitted by the provider and by the enrollee. It must solicit the views of the enrollee. Although the enrollee is encouraged to present evidence and argument as to why services should continue, the burden of proving that termination of services is correct rests on the MA plan.

See [42 CFR § 422.626](#)

### Step Three: Requesting Reconsideration of the QIO Decision

- **Who:** The enrollee or the enrollee's representative may request reconsideration of the QIO's decision.
- **When:** The enrollee or the enrollee's representative must request reconsideration within 60 days of receiving notice of the QIO's determination.
- **What:** The request for reconsideration should explain why the prior decision is wrong by referring to the specific law and/or facts at issue. See "How to Help on a Medicare Appeal"[ <http://www.hapnetwork.org/original-medicare/medicarehowtohelpmcappeal.html>] for suggestions on deciding what information to include in the request for reconsideration.
- **What Happens Next:** The QIO must issue its reconsidered determination as quickly as the enrollee's health condition requires but no later than 14 days from the date of the enrollee's request for reconsideration.

Should the QIO determine that continued services are not covered by Medicare, it must also explain how the enrollee can further appeal this denial of coverage. The beneficiary will be liable for any costs that arise for continued provider services unless the QIO's decision is reversed on further appeal.

If the QIO determines that Medicare coverage should continue, provider services will continue and Medicare will pay for the cost.

See [42 CFR § 422.626](#)

**Step Four: Requesting ALJ Hearing**

[See Step Three](#): Administrative Law Judge Hearing under Coverage and Payment Appeals, above.

**Step Five: Requesting MAC Review**

[See Step Four](#): Medicare Appeals Council (MAC) Review under Coverage and Payment Appeals, above.

**Step Six: Requesting Judicial Review**

[See Step Five](#): Judicial Review under Coverage and Payment Appeals, above.