

MEDICARE APPEALS RIGHTS AND PROCEDURES

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MEDICARE APPEALS GENERALLY

Due Process Rights

All Medicare beneficiaries have “due process” or procedural rights when Medicare or its payment contractors deny payment for covered services, and when providers decide to discharge a patient or discontinue covered services. These due process rights include:

- Written notice
- The right to reconsideration by someone who was not involved in the first decision
- The right to a hearing when a certain amount of money is at stake
- The right to judicial review when a certain amount of money is at stake

The Context for Appeals in Original Medicare

Some SHIP counselors and clients may wonder if it is worth the trouble to appeal a Medicare coverage or payment denial. Some national statistics from 2007 may help address the issue.

At the first stage in Original Medicare Appeals, Medicare’s payment contractors – Fiscal Intermediaries (FI), Carriers, and Medicare Administrative Contractors (MAC) – decided more than 240,000 redetermination requests for Part A denials, and more than 2.5 million redetermination requests for Part B denials. They returned fully favorable decisions in 50 percent of their Part A redeterminations; in 53 percent of Durable Medical Equipment redeterminations; and in 60 percent of the redeterminations for physician, ambulance, and other Part B services.

At the second stage in the appeals process, the Qualified Independent Contractors processed about 400,000 reconsideration requests following adverse decisions at the redetermination level. The QICs made favorable or partly favorable decisions in 20 percent of their Part A reconsiderations and in more than a quarter of their DME reconsiderations. For physician, ambulance, and other Part B service denials, the QICs issued favorable or partly favorable decisions in more than one-third of the cases. (See *CMS Fact Sheet: Original Medicare (Fee-For-Service) Appeals Data - 2007*, available online at <http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/ffsappealsfactsheet2008.pdf>.)

Differences in Original Medicare and Medicare Advantage Appeal Procedures

While the appeal procedures for the Original Medicare, Medicare Advantage, and Part D Prescription Drug programs are similar in many ways, there are some important differences that counselors should keep in mind. These main differences are in the coverage and payment notices, the filing deadlines, and the decision-makers in the early stages of the appeals process.

In Original Medicare, the *Medicare Summary Notices* that Medicare's payment contractors send to beneficiaries are different than the "Explanation of Benefit" statements (EOBs) that Medicare Advantage plans and Part D drug plans may send to their plan members. The MSNs in Original Medicare and the EOBs in the Medicare Advantage and Part D programs are official Medicare coverage notices called "initial determinations" and "organization determinations," respectively.

The deadlines for filing an appeal in the first stage of the appeal process differ for Original Medicare, Medicare Advantage, and Part D plans. The deadline is 120 days for Original Medicare and 60 days for Medicare Advantage and Part D plans. The organization that decides on appeal at the second step of the Original Medicare appeal process is a Qualified Independent Contractor (QIC). In Medicare Advantage and Part D, an Independent Review Entity (IRE) handles appeals that reach the second stage in the process.

ORIGINAL MEDICARE COVERAGE DECISIONS AND APPEAL PROCEDURES

Coverage Decision Notices in Original Medicare

As you work with clients, be aware of these four kinds of coverage and payment notices in Original Medicare. All notices contain information about the next step that a beneficiary can take to request a coverage decision or appeal. The next steps may vary, depending on the notice.

- **Medicare Summary Notices (MSN)**

After a provider, like a home health agency, physician, or ambulance company, submits a claim for payment to Medicare, the FI, Carrier, or MAC makes a coverage and payment decision detailed in an MSN (see Appendices C and E). The MSN is Medicare’s official “initial determination” on a claim for coverage and payment. Medicare sends MSNs to beneficiaries every three months. If the MSN shows that Medicare denied coverage and payment, the beneficiary, her representative, or the provider can look to the instructions on the MSN to request a redetermination.

- **Inpatient Hospital Notices**

Acute care hospitals issue *An Important Message from Medicare about Your Rights (IM)* to all Medicare patients at the time of admission (see Appendix A), and may reissue the *IM* before the patient’s discharge. If a beneficiary disagrees with the proposed discharge, she can ask the Quality Improvement Organization (QIO) to make an expedited determination of the need for a longer hospital stay. Soon after a beneficiary makes this request, the hospital must deliver a *Detailed Notice of Discharge (DND)* (see Appendix B).

- **Service Termination Notices**

Skilled nursing facilities (SNFs), home health agencies, comprehensive outpatient rehabilitation facilities (CORFs), and hospices must give written notice to beneficiaries before they end Medicare-covered services or discharge a beneficiary from their care. This standard notice of a decision to terminate services is called a *Notice of Medicare Provider Non-Coverage* (see Appendix D). This notice is not an official initial determination or Medicare coverage decision. It merely states the provider’s opinion that the beneficiary no longer meets Medicare’s coverage rules for the service.

This notice must give the:

- Patient at least two days notice of the proposed end of services.
- Date that coverage of services ends.
- Date that the beneficiary’s financial liability for continued services starts.
- Notice of the right to an expedited determination by the Quality Improvement Organization (QIO).



CMS does not require providers to issue service termination notices when beneficiaries use up their 150 covered inpatient hospital days or 100 covered Skilled Nursing Facility days in a benefit period. Similarly, providers need not issue Advance Beneficiary Notices for excluded services that, by law, Medicare cannot cover. CMS guidance allows providers to issue ABNs on a voluntary basis in such cases, including those where a National Coverage Determination is the basis for a likely coverage denial.

- **Advance Beneficiary Notices (ABN)**

Medicare Part A and Part B health care providers may issue ABNs. CMS has a general ABN (see Appendix F) for use by physicians, DME suppliers, laboratories, and hospices. Home health agencies and skilled nursing facilities use other ABNs. Because ABNs are not official Medicare coverage determinations, there is nothing to appeal unless the provider submits a claim. After receiving an ABN, a patient has the right to ask a provider to submit a claim to Medicare. If the Medicare payment contractor then issues an MSN showing that it denied payment on the claim for lack of medical necessity, a beneficiary can start the appeal process by requesting a redetermination.

The Appeals Process

- **Step 1: Redetermination**

The beneficiary, a representative, or a physician must send a written request for a redetermination to the Fiscal Intermediary, Carrier, or MAC within 120 days of receiving the MSN with its denial notice. Those with good cause can request an extension. The written request can take the form of a letter, a copy of the MSN with the words “Please Review” written on it, or a CMS *Redetermination Request* form (see Appendix I).

In the redetermination process, a person who was not involved in the initial decision reviews the claim for improper coding, missing documentation, and additional information from the provider or patient. Redetermination notices explain the facts, policies, and law that underlie the Medicare payment contractor’s redetermination decision. The FI, Carrier, or MAC has 60 days to make its redetermination decision.

- **Step 2: Reconsideration**

The deadline for filing a request for reconsideration is 180 days after receipt of the FI’s, Carrier’s, or MAC’s adverse redetermination decision. Those with good cause can ask for an extension.

You can send a *Reconsideration Request* (see Appendix J) to the Qualified Independent Contractor (QIC) named on the redetermination notice. CMS contracts with four regional QICs for Part A and Part B, and a national QIC for Durable Medical Equipment, Prosthetic, and Supply (DMEPOS) appeals. The QICs are:

- Part A west region:
First Coast Service Options, Inc., <http://www.fcso.com>
- Part A east region:
Maximus Federal Services, Inc., <http://www.medicarepartaappeals.com/>
- Part B north region: First Coast Service Options, Inc., <http://www.fcso.com>

- Part B south region:
Q2A Administrators, LLC., <http://www.q2a.com/q2a/q2a.nsf/mainp?openform>
- DMEPOS-National: River Trust Solutions, Inc., <http://www.rivertrustsolutions.com>

In its reconsideration, the QIC conducts a review of the medical record in light of CMS manual guidelines and coverage determinations. There is no face-to-face meeting with a decision maker at this stage. The QIC must issue a written reconsideration decision, explaining its rationale, within 60 days.

- **Step 3: ALJ Hearings**

A beneficiary, a beneficiary's representative, or a physician who receives an unfavorable reconsidered determination from the QIC has a right to a hearing with an Administrative Law Judge (ALJ) if a minimum amount of money is at stake. This "amount in controversy" is \$130 for 2010. The amount in controversy is the amount of money involved with the denied services. In other words, the amount in controversy is the total projected value of the denied services or benefits. Enrollees having more than one denied claim may combine their claims to meet the threshold amount in controversy, if needed, as long as all of the claims have followed the proper procedures.

Beneficiaries (or the representative or physician) may request an ALJ hearing only in writing and according to the instructions found in the QIC's reconsideration notice. The request for an ALJ hearing must be made within 60 days of notice of the QIC's unfavorable reconsidered determination. As with requests for reconsideration, those with good cause may be granted an extension past this 60-day time frame.

Most ALJ hearings take place using video-teleconferencing (VTC) facilities. The ALJ hearing is a beneficiary's first chance to meet face-to-face (to the extent that VTC technology allows) with a decision-maker. It provides a chance to ask and answer questions, and to bring in witnesses, such as a physician.

Administrative Law Judges work for the Office of Medicare Hearings and Appeals (OMHA). Like CMS, OMHA is an agency within the federal department of Health and Human Services. For more information about ALJ hearings, including relevant forms, internal procedures, and FAQs, visit OMHA's website at <http://www.hhs.gov/omha/index.html>.

- **Step 4: Medicare Appeals Council (MAC) Review**

Any of the relevant parties who disagree with an adverse ALJ hearing decision (including case dismissal) may ask the Medicare Appeals Council (MAC) to review the case. The MAC has the option to grant or decline each request for review. In response to each case, the MAC may issue a final decision or a dismissal, or return the case to the

ALJ with instructions. The MAC may initiate its own review of any ALJ hearing decision or dismissal. When it does so, the MAC must notify all relevant parties.

Beneficiaries, their representatives, physicians, or CMS may request MAC review only in writing. If CMS requests the MAC review, it must provide notice to the beneficiary. The request for a MAC review must be made within 60 days of receipt of the ALJ hearing decision or dismissal. As with other steps in the appeals process, those with good cause may be granted an extension past this 60-day time frame.

The MAC uses the following criteria to either grant or decline cases submitted for review:

- Does there appear to be an abuse of discretion by the ALJ?
 - Is there an error of law?
 - Are the actions, findings, or conclusions of the ALJ not supported by substantial evidence?
 - Is there a broad policy or procedural issue that may affect the general public interest?
- **Step 5: Judicial Review**

Any of the relevant parties who disagree with a hearing decision (including case dismissal) may request a federal district court to review the ALJ decision if the MAC declined to review the case or affirmed an adverse ALJ decision, and if the amount in controversy is at least \$1,260 (in 2010).

To start the judicial review process, the relevant party must file a civil action in a district court in the judicial district where the beneficiary lives. See Appendix K for *Original Medicare: Appeals Process* flowchart.

Other Medicare Appeal Rules

Medicare adjusts the amounts in controversy for ALJ hearings and judicial review to reflect inflation in medical costs. The amount in controversy for judicial review increased from \$1,000 in 2004 to \$1,260 in 2010. The amount in controversy for ALJ hearings is \$130 for 2010.

Starting in 2005, Medicare regulations allow physicians, equipment suppliers, and other service providers to appeal a denial of an initial determination. This creates the potential for both the beneficiary and the provider to request a redetermination for the same denial. Regulations also enable providers and suppliers to use an informal “reopening” procedure to correct minor mistakes or omissions, coding errors for example, with the FI, Carrier, or MAC rather than go through the formal appeals process.

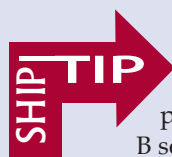
National and Local Coverage Determinations

CMS has National Coverage Determinations (NCDs) that describe the circumstances and conditions of Medicare coverage for specific medical services, procedures, or devices. It is important to know that the terms of these NCDs control Medicare coverage decisions nationwide. NCDs generally outline the conditions under which CMS considers a service, procedure, or device to be covered – or not covered – under the “reasonable and necessary” language of the Medicare law. For example, chelation therapy for atherosclerosis is the subject an NCD that instructs Medicare’s payment contractors not to cover the procedure because its safety and effectiveness are in question. (See *Medicare Program Integrity Manual*, CMS Pub. No. 100-08, Chapter 13, NCD 20.21.)

Once published, an NCD is binding on all Medicare payment contractors including A/B MACs, DME-MACs, Regional Home Health/Hospice Intermediaries, Quality Improvement Organizations (QIOs), Program Safeguard Contractors (PSCs), and Medicare Advantage Organizations. NCDs are also binding on Administrative Law Judges (ALJ) during the claim appeal process.

Coverage denials based on NCDs differ from denials that simply involve a decision that a procedure, such as a diagnostic test, is not reasonable and necessary in an individual case. When NCDs state that Medicare does not cover the use of a procedure for a specific medical indication, CMS effectively excludes that use from program coverage. As a result, NCD coverage denials have two very important consequences. One is that Medicare’s financial liability (waiver of liability) protections for beneficiaries do not apply in these cases. The other is that a beneficiary can bypass the general appeals process described above and use a special procedure to challenge the NCD by appealing directly to the DHHS Departmental Appeals Board (DAB).

A Local Coverage Determination (LCD) is a decision by a Medicare administrative contractor (MAC), fiscal intermediary, or carrier whether to cover a particular service on a MAC-wide, intermediary-wide or carrier-wide basis in accord with the reasonable and necessary language in the Medicare law. An LCD is binding on the Medicare payment contractor and the QIC at the first and second levels of the appeals process described above. An LCD, however, does not bind the decision of an ALJ. For more information on CMS’s NCD and LCD operational policy, refer to



Clients often bring issues that may be resolved fairly quickly through the appeal process, especially for Part B service denials. You can help in many ways, even if you don’t want to get into the nitty-gritty of dealing with medical records. First, know something about the coverage “red flags” like denials for medical equipment and ambulance services. Second, be prepared to help clients assess the notices they receive from Medicare and care providers. Medicare Summary Notices (MSNs) should note that a coverage denial is based on an NCD or LCD. Third, know the deadlines for filing appeals and how to get the process started. Fourth, refer your clients to other information resources and to those who can guide or represent them as they move on to higher levels in the appeals process

the *Medicare Program Integrity Manual* (CMS Pub. No. 100-08, Chapter 13). For instructions on how to find and appeal NCDs and LCDs, see two HAP tools, *Medicare Coverage: How to Find Specific Coverage Under Medicare* and *National and Local Coverage Determination Appeals* at <http://www.hapnetwork.org/original-medicare/coverage.html>.

EXPEDITED DETERMINATIONS AND RECONSIDERATION IN ORIGINAL MEDICARE

Right to an Expedited Determination

If a beneficiary receives a *Notice of Medicare Provider Non-Coverage* (see Appendix D) service termination notice from a home health agency, hospice, skilled nursing facility, or Comprehensive Outpatient Rehabilitation Facility (CORF), she has a right to an expedited determination by the Medicare Quality Improvement Organization (QIO). Use the QIO Locator at <http://www.ahqa.org> to find contact information for each QIO.

Expedited Determination Procedures

A beneficiary must ask the QIO for an expedited determination, by telephone or in writing, by noon of the day following receipt of the provider's service termination notice. The *Notice of Medicare Provider Non-Coverage* has instructions on how to reach the QIO. The beneficiary or her representative must be available to answer questions for, or provide information to, the QIO staff. The beneficiary may submit evidence to the QIO.

When it makes an expedited determination about a provider's decision to terminate services, the QIO:

- Must immediately notify the provider about the request.
- Determines if the termination notice is valid.
- Examines the medical record and determines if a physician certified that a significant health risk exists for the patient.
- Must seek the beneficiary's views.
- Gives the provider a chance to explain why the termination or discharge is appropriate.
- Notifies the beneficiary, her physician, and the provider of its decision generally within two days of receiving the expedited determination request.
- May initially notify the parties by telephone but must follow up with a written notice. The notice must give the date on which the beneficiary becomes liable for the cost of continued services, and describe her right to an expedited reconsideration.

When a beneficiary requests an expedited determination, Medicare coverage continues until the QIO completes the determination process. A provider may not bill the beneficiary for the disputed services until then. If the patient decides to pay for ongoing care after coverage termination, she can ask the provider to submit a claim to Medicare. This is called a “demand bill.” If Medicare denies payment, the patient can request a redetermination.

Inpatient Hospital Notices and Expedited Procedures

An acute care hospital must give *An Important Message from Medicare about Your Rights (IM)* to all Medicare patients at the time of admission (see Appendix A) and again no later than two days before a proposed discharge. The *IM* describes a beneficiary’s right to an independent review when she disagrees with a proposed discharge. If a beneficiary disagrees with a hospital’s discharge decision, he or someone on his behalf should call the Quality Improvement Organization (QIO) no later than the planned discharge date to request a quick review.

Instructions for this process and the QIO’s toll-free phone number should appear on the Important Message from Medicare. After a person requests the QIO review, the hospital must give the patient a *Detailed Notice of Discharge* that contains specific information about the Medicare coverage policies upon which the hospital has based its decision.

To receive an official expedited coverage determination, the patient must call the QIO no later than noon of the proposed day of discharge. Medicare requires the QIO to issue a written decision within one day of receiving all the information it needs to make a decision. If the QIO decides that the patient is ready to be discharged, Medicare covers the hospital stay until noon of the day after the QIO gives notice of its decision.

Note: Because many people cannot afford to stay in a hospital at their own expense for even a day or two, the real choice after a hospital re-issues the IM two days before discharge is to leave the hospital or to ask the QIO to review the decision through an Expedited Determination request.

If the patient disagrees with the QIO’s decision, he may request expedited reconsideration of the QIO’s decision by noon of the next calendar (not working) day. The Qualified Independent Contractor (QIC) reviews the case and issues a decision within 72 hours.

WHERE TO LEARN MORE

For background on the Medicare appeals process and beneficiary rights, see:

- The Health Assistance Partnership (HAP) website's Medicare Resource Page, <http://www.hapnetwork.org>. Go to the "Medicare Appeals" Resource Center. This site contains some very helpful tips for counselors in its *How to Help on a Medicare Appeal* fact sheet.
- HAP also has more information on the *Important Message from Medicare* and expedited appeal procedures in its *Hospital Discharge Appeals Notice* fact sheet at <http://www.hapnetwork.org/assets/pdfs/im-fact-sheet.pdf>. HAP also has two tools on finding and appealing National and Local Coverage Determinations on its Medicare Coverage webpage at <http://www.hapnetwork.org/original-medicare/coverage.html>.
- For guides to advocacy in the Medicare appeals process, see the Center for Medicare Advocacy at <http://www.medicareadvocacy.org>.