



CHANGES TO MEDICARE APPEALS COUNCIL REVIEW: ANOTHER OBSTACLE TO SUCCESS ON APPEAL?

This is the third in a series of Alerts to address changes to the Medicare appeals process contained in interim final regulations issued by the Centers for Medicare & Medicaid Services (CMS) on March 8, 2005. 70 Fed. Reg. 11420 (March 8, 2006). The information below, while sometimes complex, is crucial to any individual undertaking Medicare appeals. Advocates in particular will need to quickly become familiar with the many changes to the appeals process. The changes discussed in this Alert pertain to Medicare Appeals Council (MAC) and judicial review of administrative law judge (ALJ) hearings for all Medicare claims, including managed care claims and future prescription drug claims.

Medicare Appeals Council Review

The Medicare Appeals Council is part of the Departmental Appeals Board (DAB) of the United States Department of Health and Human Services. The MAC is the final administrative appeal review for all Medicare cases under Part A, Part B, Part C and Part D. There is one Medicare Appeals Council for all Medicare cases. The next level of review is into federal court.

A dissatisfied party, including CMS, has 60 days to request review of an ALJ decision. No review is available when the ALJ remands a case to the Qualified Independent Contractor (QIC) or affirms dismissal of a claim by the QIC. A written request for review must be filed with the MAC or the hearing office that issued the decision. Copies must be sent to other parties in the case or the 90-day time period for the MAC to decide the case is tolled.

CMS may request MAC review, and a contractor can refer a case to the MAC if in their view 1) it contains an error of law material to the outcome; 2) it contains broad policy or procedural issues that may affect the public interest; or 3) CMS thinks the ALJ decision is not supported by a preponderance of the evidence or involves abuse of discretion.

If CMS or a contractor participated in the hearing, the MAC may exercise its own review if it believes there is an error of law, abuse of discretion, or the decision is not consistent with the preponderance of evidence. If CMS did not participate and refers a case to the MAC, MAC will accept the case if it believes there may be an error of law or the outcome of the case presents a policy or procedural issue. The MAC has 90 days to accept or reject the case after CMS referral.

The MAC is supposed to conduct a de novo review. Only evidence already in the record will be considered unless a new issue is raised on appeal. A party may request a copy of the record, but may be asked to pay the costs. Again, if a party requests the record and an opportunity to comment on the evidence from the MAC, the time beginning with the MAC's receipt of the request for evidence through the expiration of time granted to submit comments does not count towards the 90 days. Unless a party files a brief with the request for review, the time beginning with the receipt of a request to file a brief until date brief is received is not counted towards the 90 days. The MAC may request CMS or a contractor to file a brief

The parties have no right to a hearing at the MAC level. A party, including CMS if it was a party at the ALJ level, may request oral argument. The MAC may grant the request if the claim raises an important question of law, policy, or fact that cannot be decided on written submissions.

A party may request escalation of the case to federal district court. After receiving the request, the MAC has the later of 5 days after it gets the request or the end of the 90 day time period to issue a decision, dismissal, remand, or notice of receipt of the request. The party requesting escalation then had 60 days to file in federal court.

Federal Court Review

Generally, a MAC decision is a prerequisite for proceeding with an individual Medicare appeal in federal court. The required amount in controversy for federal court appeals is \$1,050 in 2005. The jurisdictional amount will increase yearly by the percentage increase in the medical component of the consumer price index for all urban areas. The amount increased by \$50 in 2005.

The complaint appealing a Medicare denial must be filed in federal district court within 60 days of receipt of the MAC decision. It must be filed in the district in which the beneficiary resides. The complaint must name the Secretary of the Department of Health and Human Services, in his or her official capacity, as defendant. If the defendant is not properly named, the plaintiff will be given 60 days to amend the complaint.

Expedited Access to Judicial Review

Starting in May 2005, a beneficiary may request expedited access to judicial review (EAJR) in place of an ALJ hearing or MAC review. The beneficiary must show that there are no material facts in dispute. In addition, the beneficiary must challenge the constitutionality of a statutory provision or the constitutionality or validity of a regulation or of a national coverage determination.

After the party files a request for an ALJ hearing, the party may file a request for EAJR with the ALJ office. A determination on the request is made by a review entity consisting of up to three ALJs or members of the DAB. If the review entity certifies the

request, the party may file an appeal with federal district court within 60 days. If the request is denied, the case is returned to the ALJ hearing or MAC if a hearing has already been held.

Advocates with questions on appeals issues should contact Vicki Gottlich (vgottlich@medicareadvocacy.org) in the Center's D.C. office, 202-216-0028, or Brad Plebani (bplebani@medicareadvocacy.org) in the Center's Connecticut office (860-7790).