THE MEDICARE APPEALS PROCESS

This section will address appeals under Medicare Parts A, B, and C.

A. Traditional Medicare

1. Notice of Medicare Payment

Generally, official notice from Medicare must be obtained before a beneficiary has a right to appeal. The MSN constitutes the “initial determination” or written notice that briefly explains what Medicare will pay on a claim. The MSN is prepared by the Medicare contractor that reviews the claim.² CMS now issues MSNs quarterly, rather than monthly, unless a reimbursement check is due the beneficiary.³ Many claims are denied in whole or in part on the MSN due to insufficient information and mistakes. Determinations that find that the medical service was not medically necessary and is, therefore, not covered under Medicare should be closely examined. If the claimant does not think Medicare is allowing a sufficient reimbursement amount, the claimant should also question the MSN.

It may be useful to telephone the contractor to question why Medicare benefits were denied. Often the claimant will discover that inadequate information or documentation was mailed to the contractor and that the coverage denial can be resolved by providing better documentation.

It is important to note that, for all Part A claims, the first notice Medicare beneficiaries should receive informing them that care will not be covered by Medicare is from the health care provider. This is also the case for most Part B services. Before they can charge a beneficiary, providers who participate in the Medicare program must first issue a written notice to the patient informing him or her that Medicare coverage will not be available. Providers have a financial incentive to issue denial notices because they may have to absorb the cost of the care they provide if they erroneously inform the beneficiary that the care will be covered but not if they erroneously deny coverage.

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¹ This material is based on Chapter 1 of the Medicare Handbook, Stein, Chiplin editors, (Aspen Pub., 2010), written by attorneys at the Center for Medicare Advocacy. Reprinted with permission of the publisher. Copyright © Center for Medicare Advocacy, Inc.

² Fiscal intermediaries review claims that arise under Part A and carriers review claims that arise under Part B. CMS is in the process of combining these functions under “Medicare Administrative Contractors.”

Notices from providers, however, do not form the basis for an appeal. The beneficiary must obtain a formal Medicare coverage determination or “initial determination” from the appropriate Medicare contractor. Patients who receive denial notices from a provider must, therefore, request that a claim for payment be submitted to Medicare if they want to obtain an initial determination that can then be appealed. In addition, the initial determination does sometimes grant coverage that was denied by the provider. If the beneficiary or representative requests a provider to submit a claim to Medicare, the provider is required to do so.

2. Redeterminations

If the claimant remains dissatisfied with the initial determination as described in the MSN, a redetermination may be requested. The redetermination is the first formal appeal stage for Medicare Part A and Part B claims. The request for redetermination must be filed within 120 days of receipt of the MSN. The redetermination is performed by the entity that issued the initial determination denying benefits: the intermediary for Part A SNF, home health, and hospice claims, the Quality Improvement Organization (QIO) for hospital claims, and the carrier for Part B claims. Generally, these appeals simply entail submitting a written request (forms are available on the CMS Web site at www.medicare.gov, but requests may also be made in writing without the form). If at all possible, the claimant should attach a copy of the denial notice issued by the health care provider and a supporting letter and/or documentation from the treating physician to the redetermination request. Assistance from the attending physician is always key to a successful appeal. Be certain to keep copies of all appeal requests and all supporting data.

3. Reconsideration

SCHIP Benefits Improvement & Protection Act of 2000 (BIPA) created a new intermediate level of appeal, the “reconsideration,” that beneficiaries must complete before receiving a hearing. The reconsideration is a new level of review for Part A claims and replaces the carrier hearing for Part B claims. Reconsiderations are a paper review conducted by a new review entity that contracts with CMS, the Qualified Independent Contractor (QIC). A beneficiary has 180 days after receipt of an unfavorable redetermination to request QIC review. The QIC must issue a decision within 60 days, with certain exceptions. Beneficiaries may appeal an unfavorable reconsideration decision to an Administrative Law Judge (ALJ).

4. Summary of Expedited Appeals Process

Beneficiaries may seek expedited review of a skilled nursing facility (SNF), home health, or hospice discharge or termination. The provider must give the beneficiary a general, standardized notice at least two days in advance of the proposed end of the service. If the service is fewer than

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5 MCP Manual, Ch. 1, §50.1.5. (CMS implementation of this provision has been spotty.)
6 This level of appeal was known as “reconsideration” prior to implementation of the BIPA appeal changes.
8 BIPA, §521.
two days, or if the time between services is more than two days, then notice must be given by the
next to last service. 10 The notice describes the service, the date coverage ends, the beneficiary’s
financial liability for continued services, and how to file an appeal. 11

A beneficiary must request expedited review, orally or in writing, by noon of the next
calendar day after receiving notice. At that time, the beneficiary is given a more specific notice
that includes a detailed explanation of why services are being terminated, a description of any
applicable Medicare coverage rules and information on how to obtain them, and other facts
specific to the beneficiary’s case. The beneficiary is not financially liable for continued services
until the later of two days after receiving the notice or the termination date specified on the
notice. 12

Expedited review is available in cases involving a discharge from the provider of services, or
a termination of services where “a physician certifies that failure to continue the provision of
such services is likely to place the individual’s health at risk.” 13 Services furnished by a
residential provider, such as a hospital or a SNF, or a hospice, are discharges for which a
doctor’s certificate is not required. Services furnished by a “non-residential provider,” such as
home health services, are treated as a termination of services for which a doctor’s certificate of
significant health risk must be provided. 14 A reduction in service is not considered a termination
or discharge for purposes of triggering expedited review. 15

A beneficiary who wishes to exercise the right to an expedited determination must submit a
request for a determination with the QIO in the state in which the beneficiary is receiving the
services at issue. The request may be made in writing or by telephone, but it must be made no
later than noon of the calendar day following receipt of the provider’s notice of termination. If
the QIO is unavailable to accept the beneficiary’s request, the beneficiary must submit the
request by noon of the next day the QIO is available. 16

Coverage of the services at issue continues until the date and time designated on the
termination notice, unless the QIO reverses the provider’s service termination decision. If the
QIO’s decision is delayed because the provider did not timely supply necessary information or
records, the provider may be liable for the costs of any additional coverage, as determined by the
QIO. 17 If the QIO finds that the beneficiary did not receive valid notice, coverage of the provider
services continues until at least 2 days after valid notice has been received. Continuation of
coverage is not required if the QIO determines that coverage could pose a threat to the
beneficiary’s health or safety. 18

10 42 C.F.R. §405.1200(b)(1).
11 42 C.F.R. §405.1200(b)(2).
12 42 C.F.R. §405.1202(b).
14 42 C.F.R. §405.1202(a).
15 42 C.F.R. §405.1200(a)(2).
16 42 C.F.R. §405.1202(b).
17 42 C.F.R. §405.1202(c).
18 42 C.F.R. §405.1202(c).
If the QIO sustains the decision to terminate services or discharge the beneficiary, the beneficiary may request expedited reconsideration, orally or in writing, by noon of the calendar day following initial notification. The reconsideration will be conducted by the QIC, which must issue a decision within 72 hours of the request. If the QIC does not comply with the time frame, the beneficiary may escalate the case to the ALJ level.\(^{19}\)

5. **Special Rules for Hospital Claims**

Hospitals must deliver a revised version of the *Important Message from Medicare* (IM) (CMS-R-193) and the *Detailed Notice of Discharge* (CMS 10066).\(^{20}\) Under 42 C.F.R. §405.1205 (for Traditional Medicare) and 42 C.F.R. §422.620 (for MA), Medicare participating hospitals must deliver the written IM notice with information about an individual’s rights as a hospital patient. The information must include discharge and appeal rights and must be delivered within 2 calendar days of admission. A follow-up copy of the signed IM is to be given again as far as possible in advance of discharge but, in any case, no more than 2 calendar days prior to discharge.\(^{21}\) The follow-up notice is not required if the admission IM was issued to the individual within 2 calendar days of discharge.\(^{22}\)

For a hospital stay, a beneficiary must make a timely request for expedited review, orally or in writing, no later than the day of discharge. CMS, in its manual system, interprets a “timely” request as no later than midnight of the day of discharge.\(^{23}\) The beneficiary (or his or her authorized representative), upon request by the QIO, must be prepared to discuss the case with the QIO.\(^{24}\) On the date that the QIO receives the beneficiary’s request, the QIO must notify the hospital that the beneficiary has filed a request for intermediate review.\(^{25}\) The hospital must supply any information, including medical records, that the QIO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day after the day the beneficiary receives notice of the planned discharge.\(^{26}\) When the beneficiary requests an expedited determination in accordance with §405.1206(d)(1), the QIO must make a determination and notify the beneficiary, the hospital, and physician of its determination by close of business of the first working day after it receives all requested pertinent information.\(^{27}\)

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\(^{19}\) See 42 C.F.R. §405.1204.


\(^{21}\) 42 C.F.R. §405.1205 (Traditional Medicare); 42 C.F.R. §422.620(Medicare Advantage)

\(^{22}\) 42 C.F.R. §405.1205(c)(2) (Traditional Medicare); 42 C.F.R. §422.620(c)(2)(Medicare Advantage).


\(^{24}\) See revised 42 C.F.R. §405.1206(b)(1). See also MCP Manual, Ch. 30, §200.4.1.

\(^{25}\) See revised 42 C.F.R. §405.1206(b)(2).

\(^{26}\) See revised 42 C.F.R. §405.1206(e)(1).

\(^{27}\) See revised 42 C.F.R. §405.1206(e)(5).
B. Appeal Procedures in Medicare Part C Plans

1. Medicare Advantage Claims

Medicare Part C establishes a different appeals process for Medicare Advantage (MA) cases. In MA cases, initial determinations are known as “organization determinations.” Organization and reconsideration determinations are made by the MA plan. If a reconsidered decision is denied in whole or in part, it is sent automatically to MAXIMUS Federal Services (MAXIMUS), an external review organization hired by CMS to review Medicare HMO reconsidered decisions.28

In addition, MA plans are required to have internal grievance procedures.29 They must provide information to members regarding this grievance process in the plan’s written membership rules, along with timetables and information about the steps necessary to utilize the grievance process.30 The grievance procedures are to be used in all cases that do not involve an “organization determination.” For example, controversies about hours of service, location of facilities, or courtesy of personnel would go through the grievance process.31

MA plans must also inform enrollees of the appeals process in writing.32 They are required to provide access to QIO review on issues of hospital non-coverage;33 to provide pre-termination review of home health, and SNF services;34 to make expedited determinations with respect to emergency or urgently needed services;35 to provide reconsideration review;36 and to provide access to independent review outside the plan by an entity under contract with CMS for such review.37

If an unfavorable reconsideration determination is issued, whether through the expedited review process or within ordinary time frames, and the amount in controversy is $130 or more (in 2010), the enrollee has a right to a hearing before an ALJ.38 The written request for a hearing must be filed within 60 days of the date of the notice of the reconsideration determination. In MA cases, the plan must be made a party to the hearing and subsequent levels of review.39

28 42 U.S.C. §1395w-22(f)-(g); 42 C.F.R. §§422.560–422.626. Note that the MMA requires private insurance companies that offer a prescription drug plan under Part D to have grievance and appeals mechanisms that accord with the grievance and appeals mechanisms under Part C.
29 42 C.F.R. §§422.560, 422.564.
30 42 C.F.R. §422.111(b)(8).
31 42 C.F.R. §422.564(b).
32 42 C.F.R. §§422.111(b)(8), 422.562(a)(2). (Issues for appeal include coverage of emergency or urgently needed services, and denial or termination of other medical service, including specialist care and/or referrals.).
33 42 C.F.R. §422.620.
34 42 C.F.R. §422.624.
35 42 C.F.R. §422.570.
36 42 C.F.R. §§422.578, 422.580.
37 42 C.F.R. §422.592 (currently provided by MAXIMUS Federal Services).
38 42 U.S.C. §1395w-22(g)(5). Note that the new provisions concerning amount in controversy for ALJ hearings and judicial review also apply to Part C claims. 70 Fed. Reg. 11,423 (Mar. 8, 2005).
39 See 42 C.F.R. §422.602(b), (c).
2. QIO Review: An Alternative Means of Appealing Hospital Denials

An enrollee who wishes to appeal a determination by an MA plan or hospital that inpatient hospital care is no longer necessary may request immediate QIO review and may remain in the hospital without additional financial liability according to the following procedures:

The enrollee must submit the request for immediate review to the QIO, in writing or by telephone, by noon of the first working day after receipt of written notice that the MA plan or hospital has determined that the hospital stay is no longer necessary;

On the date of receipt of the request, the QIO must notify the MA plan that the enrollee has filed a request for immediate review; the organization must supply any information that the QIO requires to conduct its review, including medical records and other pertinent information; information is to be provided by telephone or in writing by the close of business of the first full working day immediately following the day the organization makes its request; the QIO must solicit the views of the enrollee with respect to the denial at issue;

Where the MA plan has authorized inpatient coverage of admission directly or by delegation, the organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed until noon of the calendar day following the day the QIO notifies the enrollee of its review determination. If coverage of the hospital admission was never approved by the MA plan, the MA plan is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the MA plan.

C. Administrative Law Judge Hearings

As described above, a beneficiary who has received an unfavorable reconsideration decision for a claim under any part of Medicare may request an ALJ hearing. For all claims except hospital claims, in 2010 there must be at least $130 in controversy to proceed to an ALJ hearing; this amount may increase yearly. Hospital claims may be appealed to an ALJ if $200 or more remains at issue. The request for hearing must be filed within 60 days of receipt of the reconsideration determination. For claims under Parts A and B, the ALJ must issue a decision within 90 days of receipt of the appeal request, with certain exceptions.

The ALJ hearing has traditionally been the beneficiary’s best chance to win Medicare coverage previously denied. ALJs have considered the beneficiary’s right to Medicare coverage in accordance with the Medicare statute and regulations (in contrast to the less formal and more restrictive guidelines and directives used by fiscal intermediaries, QIOs, and carriers at their decision levels). The different nature of the hearing evaluation has been reflected by the nationwide win rates in most cases. Appeals taken to ALJ hearings had been successful nationwide in about 70 percent of all cases. As described below, the ALJ process and standards changed in 2005 in ways contrary to the interests of beneficiaries. Nonetheless, ALJ hearings are

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40 42 C.F.R. §422.622.
41 Section 940 of the MMA requires that the amount in controversy for ALJ hearings and for judicial review be adjusted annually by the percentage increase in the medical care component of the consumer price index for urban consumers and be rounded to the nearest multiple of $10. For ALJ hearing requests filed in 2009, the amount in controversy was $120.
still more likely to be successful than earlier appeals levels. Thus, it makes sense for an advocate to expend the greatest time and energy at the hearing stage where vigorous representation will often lead to satisfying results.

Previously, Medicare claims were heard by the same ALJs who reviewed Social Security claims. The Office of Medicare Hearings and Appeals (OMHA) in the Department of HHS was created in 2005, so that by January 1, 2006, all Medicare ALJ hearings are conducted by Medicare ALJs from OMHA. Instead of being located throughout the country, Medicare ALJs are housed in four offices, in Arlington, Virginia; Cleveland, Ohio; Irvine, California; and Miami, Florida.

Medicare rules now create a presumption that all hearings will be conducted by video teleconference (VTC) where the technology is available. In Part A and Part B appeals, CMS may participate in an ALJ hearing as a party, with the right to submit evidence and cross-examine witnesses; CMS cannot examine and cross-examine witnesses if the beneficiary is unrepresented.

Further, and perhaps most significantly, although ALJs are still not bound by CMS policy and directives, they are required under the new rules to give them deference. If an ALJ decides not to follow a policy, the ALJ must explain in the decision why the policy is not being followed.

D. Beyond ALJ: Medicare Appeals Council and United States District Court

If the ALJ decision is unsatisfactory and at least $130 in 2010 ($120 in 2009) ($200 in hospital cases) remains in controversy, the case may be further appealed to the MAC. 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 MAC for all Medicare cases. Cases are almost always decided on the record. A request for MAC review must be filed within 60 days of receipt of the ALJ decision. Cases are sometimes won or remanded for new hearings. MAC decisions in Part A and Part B appeals must be issued within 90 days of receipt of the appeal, with some exceptions.

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 $1,260 in 2010 (1,220 in 2009) ($2,000 for hospital cases). Again, other than for hospital cases, these jurisdictional amounts will increase yearly. The complaint appealing a Medicare denial must be filed in federal court within 60 days of receipt of the MAC decision and must name the Secretary of HHS, in his or her official capacity, as defendant.

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42 42 C.F.R. §478.46 (amount in controversy for review of unfavorable ALJ decisions in hospital cases).