WHAT TO DO WHEN MEDICARE DENIES YOUR CARE: MEDICARE APPEALS

When facing a denial from Medicare, you may have the option to appeal the decision through a multi-level process. There are five levels of appeals with each level based on a specific dollar amount of the claim. The five levels include Redetermination, Reconsideration, Administrative Law Judge (ALJ) Hearing, Appeal to Medicare Appeal Council, and Appeal to the Federal District Court.

The appeals process works differently for each part of Medicare and depends on whether you are denied healthcare services, supplies, or prescription drugs. The State Health Insurance Assistance Program (SHIP) offers free services to help people with Medicare questions or concerns. We will discuss SHIP more in this guide on page 40.

What Can You Appeal Under Medicare?

- You can request a healthcare service, supply, item, or prescription drug that you think you should be able to get
- You can request payment for a health care service, supply, item, or prescription drug that you have already received
- You can request a change in the amount you have to pay for a healthcare service, supply, item, or prescription drug

You can ask for an expedited (faster) appeal decision for services received from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation, or hospice. The Beneficiary and Family-Centered Care Quality Improvement Organization (BF CC-QIO) conducts the review. You can find the contact information for the QIO on Medicare.gov.

What Cannot be Appealed?

You cannot appeal a service or item that is not considered a covered benefit under Medicare.

Medicare beneficiaries usually learn about denials on their Medicare Summary Notice (MSN). The MSN is an explanation of benefits over three months, so you will not receive a separate MSN for every service, test, or procedure. The MSN shows all the services or supplies that providers and suppliers billed to Medicare during the 3-month period, what Medicare paid, and the maximum amount you may owe the provider. There are very few services requiring Prior Authorization in Original Medicare, so most appeals for Medicare Parts A and B take place after the service is provided.

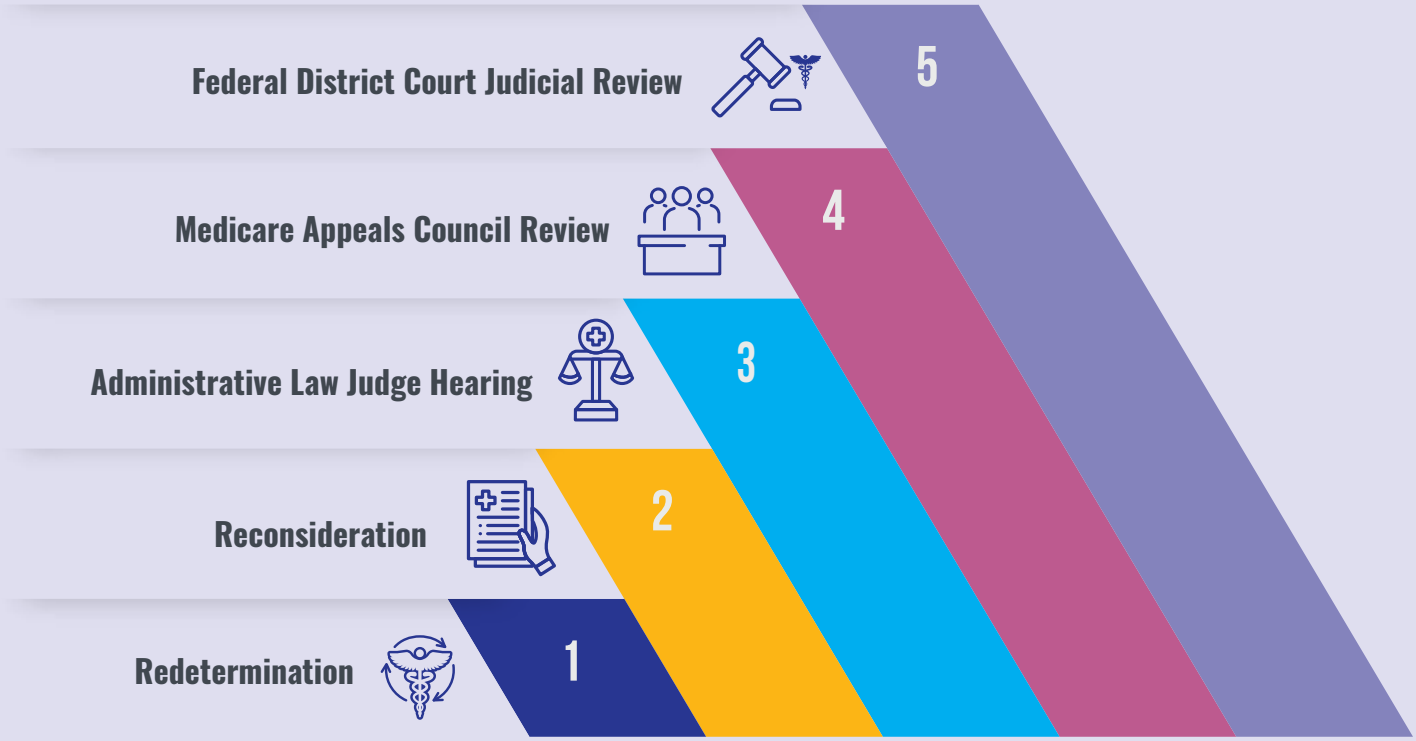
The last page of the MSN gives you step-by-step directions on when, where, and how to file an appeal. To appeal, you need to explain the reason you are appealing the coverage, sign the form, and send it back with supporting documentation. This documentation usually includes health records provided by your doctor, a letter from their office detailing your medical history and why you need this treatment, and any peer-reviewed journal articles

supporting the need for this care (your doctor can help with this too).

There are **5 Levels** of Medicare Appeals: Redetermination, Reconsideration, Administrative Law Judge Hearing, Medicare Appeals Council Review, and Federal District Court Judicial Review.

Each level is based on a specific dollar amount of the claim.

5 LEVELS OF MEDICARE APPEALS



1. Redetermination

The first level of appeal is called **Redetermination**. At this level, the Medicare Administrative Contractor (MAC) reviews the claim. You can formally request a redetermination of the coverage or payment decision by submitting a request verbally or in writing. The denial is based on information provided with the claim. Claims at this level can be any dollar amount. The appeal must be filed within 120 days (Original Medicare) and 60 days (Medicare Advantage or Part D plan) of receipt of the MSN.

If you want to appeal, contact the provider who submitted the claim to find out what information was included and if there is any additional information they can provide for the appeal (such as new test results or updated treatment results). All documentation submitted should support the reasoning that Medicare should cover the claim. A representative (for example, a friend, family member, social worker, or patient advocate) can complete the appeal on your behalf, but they need to submit an Appointment of Representative form.

2. Reconsideration

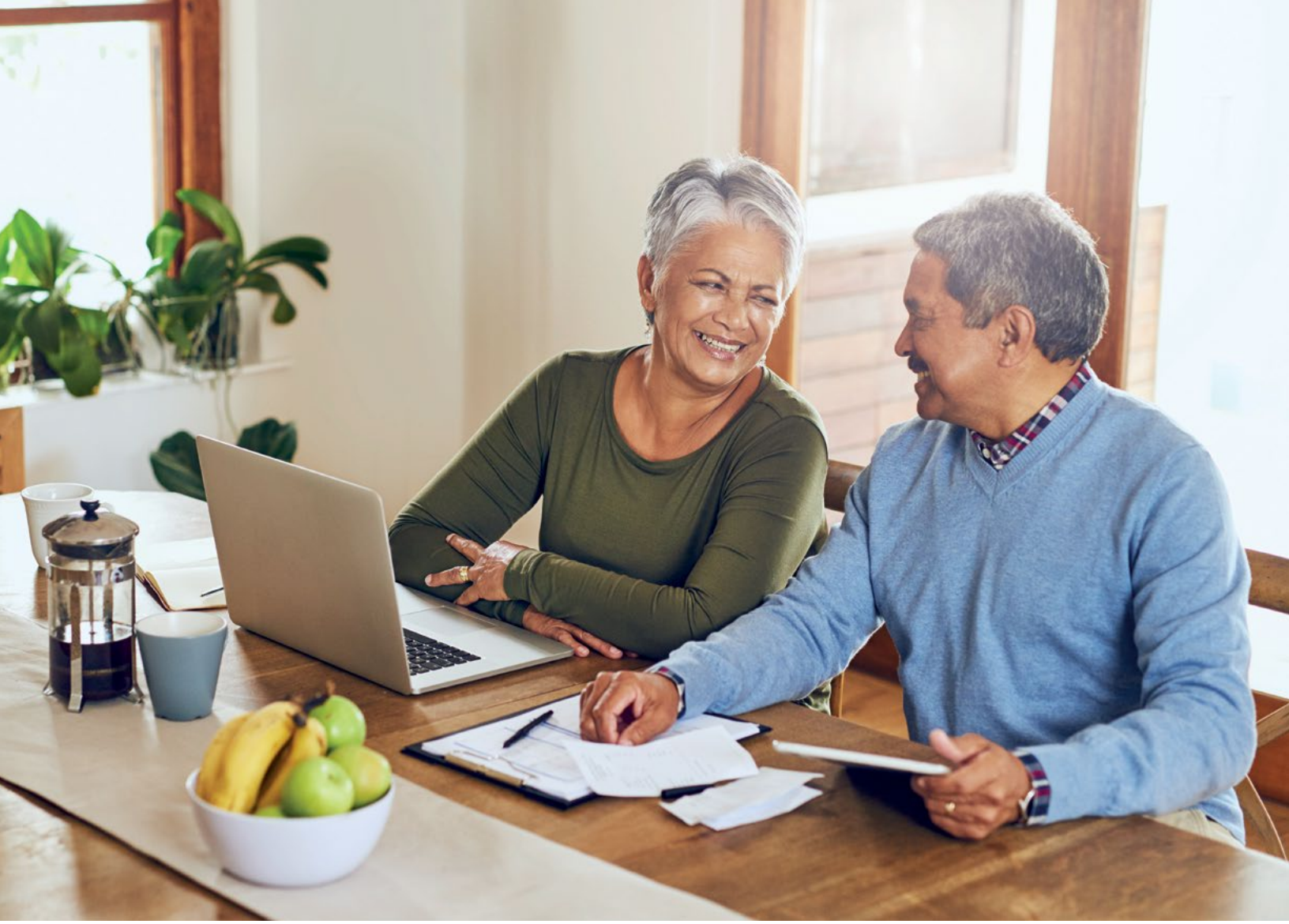
The second level of appeal is called **Reconsideration**. You can file a reconsideration if you don't agree with the decision made during the first-level appeal. If you have Original Medicare, your case will be reviewed by a Qualified Independent Contractor (QIC), and the QIC should send a written response within 60 days of receiving your request.

If the case involves a Medicare Advantage plan and the denial was upheld after the level one review, the plan will automatically send the case for a level two review. This review will be completed by an Independent Review Entity (IRE) or Part C QIC if it applies to a Medicare Advantage or Part D drug plan denial. You can submit new information, but it must be done within ten days of being sent to level two.

Claims at this level can be of any dollar amount, and second-level appeals must be filed within 120 days (Original Medicare) and 60 days (Medicare Advantage or Part D plan) of receiving the MSN or IRE's decision. Instructions for filing will be provided in the Redetermination Notice.

3. Administrative Law Judge (ALJ) Hearing

The third level appeal is the **Administrative Law Judge (ALJ) Hearing** or attorney adjudicator. A request for an ALJ hearing can be filed with the Office of Medicare Hearings and Appeals (OMHA). If you decide to appeal at this level, you may want to contact a lawyer or legal services organization to help you with this or later steps in your appeal, but this is not required. At this level, the case is reviewed by an independent judge who reviews the facts of the appeal and listens to testimony before making an impartial decision. The hearings are done via phone



or video conference. You can be present at the hearing, but this is not required.

To request an ALJ hearing, you need to send the paperwork within 60 days of receiving the second-level appeal decision. Your claim must meet a certain minimum dollar amount as stated on the Medicare Reconsideration Notice. If you have more than one denial, you can combine the claims to meet the minimum dollar amount. However, be prepared for a long wait, as it can take a year or more to get a date for the ALJ Hearing.

4. Medicare Appeals Council Review

If you disagree with the decision made during the ALJ hearing, you can file an appeal (the fourth level) called a review by the **Medicare Appeals Council (The Council)**. To request this review, you need to submit the request within 60 days of receiving the third-level appeal decision. Your claim must meet a minimum dollar amount as stated on the ALJ Hearing notice. You can complete the "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal"

form OR write a request to the Appeals Council. If the Appeals Council does not make a decision in time, you can ask the Appeals Council to move your case to the fifth-level appeal. If you disagree with the Appeals Council's decision at the fourth level, you have 60 days after receiving the decision to request a hearing at the Federal District Court Judicial Review.

5. Federal District Court Judicial Review

A fifth-level appeal is called a **Federal District Court Judicial Review**. To be able to request a federal review, your case must meet a minimum dollar amount. To proceed, you must follow the instructions in the Medicare Appeals Council decision letter on how to file a complaint.

LEVEL OF APPEAL	DEADLINE TO FILE	DEADLINE FOR DECISION	DEADLINE FOR URGENT DECISION
Redetermination	60 days	7 days	72 hours
Reconsideration	60 days	7 days	72 hours
Administrative Law Judge (ALJ) Hearing	60 days	90 days	10 days
Appeal to Medicare Appeal Council	60 days	90 day	10 days
Appeal to Federal District Court	60 days	No decision deadline	N/A