



CALIFORNIA HEALTH ADVOCATES

Appeals: When Your Part A or B Medicare Claim is Denied

Note: This fact sheet discusses appeals regarding services under Medicare Parts A and B for individuals who are enrolled in the original, fee-for-service Medicare program; other fact sheets discuss appeals for members of Medicare Advantage plans and Part D prescription drug plans.

About Appeals

An appeal is a procedure to help resolve disagreements regarding the Medicare program's decision about your health care. It is a way to deal with a payment problem, complaint about a treatment decision, or a service that was not provided. You have the right to appeal any decision about your Medicare services. Ask your doctor or provider for a letter to support your appeal, or for medical records related to the bill that might help your case. Your appeal rights are described on the back of the Medicare Summary Notice (MSN) form that you get after receiving Medicare-covered services.

If a Medicare Part A or a Medicare Part B claim is denied, or not handled in the way you think it should be, you can challenge the decision. Few people do this, but more than half of the appeals to Medicare result in favorable decisions for the individual.

Initial Determination

After a claim for Medicare coverage or payment has been processed by the Medicare carrier or intermediary, you are sent a Medicare Summary Notice (MSN). This notice tells you whether or not Medicare will pay for the services and how much you must pay. If Medicare will not pay for the services, the MSN should provide the reason why coverage is denied. It also explains your appeal rights. If you are not satisfied with Medicare's determination, you may file an appeal. There are potentially five levels of appeal:

Step 1. Redetermination

If you want to appeal an initial decision, you must submit a written, signed request for redetermination within 120 days from the date of the initial determination. The MSN will direct you where and how to file the request. The contractor to which you appeal must issue a decision within 60 days.

Step 2. Reconsideration by the Qualified Independent Contractor (QIC)

If the redetermination is not in your favor you can file a request for reconsideration with the QIC, who will conduct an external review. In California, the QIC contractor is Maximus CHDR (Center for Health Dispute Resolution). You have 180 days to request a redetermination. The QIC must issue its decision within 60 days of receiving your request. You can request an extension of 14 days. Also, a 14-day extension is added each time additional evidence is submitted to the QIC.

If the QIC does not issue a timely decision, you can request that the appeal be "escalated" to the next level. Once a request for escalation is made, the QIC has five days to either issue a decision or send the request to the Administrative Law Judge (ALJ) level. The ALJ normally has 90 days to issue a decision; yet, if an appeal is escalated without a QIC decision, the ALJ time period is extended to 180 days.

Step 3. Administrative Law Judge (ALJ) Review

If your claim is denied by the QIC review, you have the right to a fair hearing before an Administrative Law Judge (ALJ). The amount in dispute must be at least \$120 (in 2008). You have 60 days from the date of the QIC decision to file a request for an ALJ hearing. The ALJ has 90 days to issue a decision, but the timeframe can be extended for various reasons, such as submission of new evidence or if you request an in-person hearing.

ALJ hearings take place within the federal Department of Health and Human Services (DHHS). These hearings are usually held by video teleconference or over the telephone. An in-person hearing is at the ALJ's discretion. You must show "good cause" and there are only four offices nationwide where in-person hearings take place.

Step 4. Medicare Appeals Council (MAC)

If the ALJ decides against you and you want to continue the appeals process, you have 60 days to request a MAC review. Most MAC reviews will not be in person. Instead, the MAC will review the relevant documents and issue a decision. The MAC has 90 days to issue a decision, but this time period can be delayed for several reasons.

Step 5. Federal Court

If the MAC rules against you and the amount in dispute is at least \$1,180 (in 2008), you can file a lawsuit in federal district court within 60 days.

Note: You should consider seeking legal advice before appealing to an administrative law judge, the Medicare Appeals Council, or federal court.

Expedited Appeals

If you face a termination of services from a hospital, skilled nursing facility (SNF), home health agency (HHA), hospice, or comprehensive outpatient rehabilitation facility (CORF), you may request an expedited, independent determination. The four steps in an expedited appeals process are as follows:

- 1. You receive notice of termination or discharge.** The provider must give you notice no later than two visits or two days before the proposed end of services. You may appeal if you disagree with the termination and, if the services are from an HHA or CORF, a doctor certifies that failure to continue the service may place your health at significant risk.
- 2. You appeal the decision to the Quality Improvement Organization (QIO),** which in California is Lumetra. You must request the appeal by noon of the day before your services end. You can make

this request by phone (1-800-841-1602) or in writing. The provider must send you a detailed notice explaining why the services will no longer be covered. The provider must continue services for two days after you receive the first notice or until the service termination date, whichever is later.

- 3. Lumetra has 72 hours from receipt of your request for an expedited appeal** to issue a decision. They will first notify you by phone of their decision, followed by a written notice. The written decision must include:
 - A detailed explanation of the decision;
 - A statement explaining when you are liable for payment; and
 - Information about your appeal rights, including how to request a reconsideration.
- 4. You have the right to request a reconsideration** by the Qualified Independent Contractor (QIC), which is Maximus CHDR. Your request must be in writing or by telephone, and must be submitted no later than noon of the calendar day following the initial notification from Lumetra about their decision (whether by telephone or in writing). The QIC must issue a decision within 72 hours after your request for expedited reconsideration is received. (You can extend this period up to 14 days if you require more time to collect medical records.) The QIC decision may be by telephone, followed by a written notice that includes the same information as required above by Lumetra. If you would like to appeal further, your next request would be for an Administrative Law Judge (ALJ) hearing.