



CALIFORNIA HEALTH ADVOCATES

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

As a Medicare beneficiary, you have the right to appeal any coverage or payment decision made by Medicare, your Medicare Advantage plan, or your Medicare prescription drug plan. This fact sheet discusses the appeals process for claims under Medicare Parts A and B for beneficiaries enrolled in Original fee-for-service Medicare. The appeals processes for beneficiaries in Medicare Advantage plans and Part D prescription drug plans are addressed in other fact sheets. See cahealthadvocates.org/fact-sheets/index.html.

Initial Determination

When you receive a service or item, your doctor, supplier or other provider submits a claim to Medicare through a Medicare Administrative Contractor (MAC). In California, the MAC is Palmetto GBA. The MAC processes your claim and determines whether the item or service received is covered under Medicare Part A or B. This is called an initial determination. You receive your initial determination through your Medicare Summary Notice (MSN).

Your MSN is sent to you each quarter listing the services and/or supplies billed to Medicare in the past 90 days. It summarizes:

- Treatment(s) you received during the quarter;
- Amounts your providers charged;
- Amounts Medicare paid; and
- Amounts you owe (if any).

Note: The MSN is not a bill. If Medicare did not pay for a service or item, the MSN should provide the reason why coverage was denied. Some examples include: Medicare does not cover such a service or item; the service or item was not medically necessary or reasonable; or you had not yet met your deductible.

If you disagree with the MAC's initial determination, you may appeal by asking for a redetermination. This is the first level in the appeals process (see below). Instructions for filing an appeal are on the back of your MSN.

You may also ask your doctor or provider for a letter of support or related medical records that might help strengthen your appeal. In addition, you may appoint someone else — a family member, friend, caregiver or doctor — to be your representative in filing an appeal. To do this, fill out an "Appointment of Representative" form (Form CMS-1696, available on [medicare.gov](https://www.medicare.gov)), or write a letter naming your representative, signed and dated by you and the representative.

The 5 potential levels of an appeal are explained below along with information on appealing a discharge from a hospital or other facility. Knowing and using these appeal rights are important. Few people do this, but more than half of the appeals to Medicare result in favorable decisions for the individual.

Five Levels of Appeal

1st Level - Redetermination

If you want to appeal the MAC's initial determination, you must submit a written, signed request, or complete Form CMS-20027 (available on [medicare.gov](https://www.medicare.gov)), for a redetermination within 120 days from the date of the initial determination. Additional information, such as where to send the request, is on the back of your MSN. The MAC must issue a decision within 60 days of receiving your request.

2nd Level - Reconsideration by the Qualified Independent Contractor (QIC)

If the redetermination is not in your favor, you may file a request for reconsideration with the Qualified Independent Contractor (QIC). In California, the QIC contactor is First Coast Service Options (FCSO; see fcsso.com). Information about how to request a reconsideration is on the redetermination notice you receive, along with a form to complete, Form CMS-20033 (available on medicare.gov).

You have 180 days from the date you receive the redetermination to request a reconsideration. The QIC will conduct an external review of your appeal and 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—an Administrative Law Judge (ALJ) review. Once a request for escalation is made, the QIC has 5 days to either issue a decision or send the request to the ALJ level.

3rd Level - Administrative Law Judge (ALJ) Review

If you disagree with the QIC's reconsideration, you may request a hearing before an ALJ if the amount in controversy is at least \$120 (in 2009). You can make this request by submitting a completed Form CMS-20034A/B (available on medicare.gov).

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 can extend the timeframe for various reasons, such as submission of new evidence or if you request an in-person hearing. In addition, if the appeal is escalated without a QIC decision, the ALJ timeframe is extended to 180 days.

ALJ hearings take place within the federal Department of Health and Human Services (DHHS), which has only 4 offices nationwide with ALJs. As a result, these hearings are usually held by video teleconference or over the

telephone. An in-person hearing can be requested at the ALJ's discretion, if you can show good cause. More information on how to request an ALJ hearing is in your reconsideration notice.

4th Level - Medicare Appeals Council

If the ALJ decides against you and you want to continue the appeals process, you have 60 days to request a review by the Medicare Appeals Council. The ALJ's decision letter has information about how to file this request. Council reviews are not in person; the Council reviews the relevant documents and issues a decision. The Council has 90 days from the date of receiving your request for a review to issue a decision.

5th Level - Federal Court

If the Medicare Appeals Council rules against you and you want to continue the appeals process, you may request a review by a federal court if the amount in controversy is at least \$1,220 (in 2009). You must file the request within 60 days of receiving the Council's decision, which has information about how to appeal at this final level.

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

Appealing a Discharge from a Hospital

You have the right to appeal a hospital discharge decision if you believe you are being discharged too soon. When you are admitted in a hospital for a Medicare-covered stay, the hospital is required to give you a notice called "An Important Message from Medicare About Your Rights" within 2 days of your admission.

The notice includes information on: 1) your right to appeal a discharge decision; and 2) the name and phone number of the Quality Improvement Organization (QIO), which, in California, is Health Services Advisory Group (HSAG). You will be asked to sign the "Important Message" notice as evidence that you received it. The

hospital must give you a copy of the signed notice no more than 2 days before your scheduled discharge date. You may also designate someone as an “authorized representative” to receive and sign the “Important Message” notice and appeal on your behalf.

If the hospital determines, and your physician agrees, that you no longer need inpatient care, but you disagree, you may request a review by calling the HSAG Appeals Helpline, 1-800-841-1602. You must call by midnight (12am) of the day you are to be discharged. During the QIO’s review, you will not be financially responsible for your medical care, except for applicable deductibles and coinsurance.

If you do not request a review by midnight of the day of discharge, you may still request a review, but you will be financially responsible for services provided after the scheduled day of discharge.

When you request a review, the QIO must notify the hospital of the request, and the hospital must give you a Detailed Notice of Discharge that explains reasons for the discharge. The hospital must give you the Detailed Notice as soon as possible but no later than noon of the day after the QIO notifies the hospital of your request.

The QIO must notify you, the hospital and the doctor of its determination within 1 calendar day after it receives all pertinent information. Some of this information may include asking you and your hospital about your condition and your discharge plan, and for your medical records. If the QIO decides in your favor that you should remain in the hospital, you will not be financially responsible for continued care. If the QIO agrees with the hospital’s discharge decision, you will be financially responsible for care provided as of noon of the day after the QIO notifies you of its determination.

Appealing a Discharge from Other Health Care Settings

If you are receiving Medicare-covered services from a skilled nursing facility (SNF), home health agency (HHA), hospice agency, or comprehensive outpatient rehabilitation facility (CORF), and you are notified that Medicare coverage for those services will end, you have the right to request an immediate, independent review. **Note:** In some cases, your services will end the date you’re notified that your Medicare coverage ends. In other cases, your services will continue but you may be responsible for payment.

The 4 steps in an expedited determination process are as follows:

- 1. You receive a Notice of Medicare Provider Non-Coverage.** The provider must give you this Notice (Form CMS-10123) no later than 2 visits or 2 days before the proposed end of coverage. If you are receiving services from an HHA or CORF, and you disagree with the decision to end coverage, you must ask a licensed doctor to certify that failure to continue services may place your health at significant risk.
- 2. You appeal to the Quality Improvement Organization (QIO).** In California, the QIO that reviews end of coverage decisions is Health Services Advisory Group (HSAG). You must request a review by noon of the day before your coverage ends (as indicated on the Notice) by calling HSAG at 1-800-841-1602 (7 days a week). When the QIO receives your request, it must notify your provider. Your provider must then send you and the QIO a detailed notice explaining why the services will no longer be covered.
- 3. You receive the QIO Determination.** The QIO has 72 hours from receipt of your request to notify you, your physician and the provider of its determination. The QIO may notify you by phone followed by a

written notice. The written decision must include:

- A detailed explanation for the decision;
- A statement explaining when you are liable for payment, if you are liable; and
- Information about your right to a reconsideration and how to request one.

If the QIO makes a decision in your favor, you will not be financially liable for any services provided. However, if the QIO agrees with the provider, your financial liability starts the day after the last day of coverage (as indicated in your Notice of Medicare Provider Non-Coverage).

Note: If you fail to request a review by noon of the day before your coverage ends, you may still request a review. The QIO honors “untimely” requests, but is not required to issue a determination within 72 hours, and you may be financially liable for your health care costs during the QIO’s review.

- 4. You receive the QIC Reconsideration.** If you disagree with the QIO’s determination, you have the right to a reconsideration by the Qualified Independent Contractor (QIC). In California, the QIC is Maximus Federal Services. Your request for a reconsideration must be submitted, in writing or by telephone, no later than noon of the calendar day following receipt of the QIO determination notice. The QIC must issue a reconsideration within 72 hours after receiving your request. (You may extend this period up to 14 days if you require more time to collect medical records.) The QIC may notify you, your doctor and the provider by telephone, followed by a written notice, that includes:

- A detailed explanation for the decision;
- A statement explaining when you are liable for payment, if you are liable; and
- Information about your right to appeal to an Administrative Law Judge (ALJ) and how to request an ALJ hearing.

At the ALJ level of appeal, the amount in controversy must be at least \$120. You have a

right to additional levels of appeal, as described above.

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This fact sheet contains general information and should not be relied upon to make individual decisions. If you would like to discuss your specific situation, call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides free and objective information and counseling on Medicare and can help you understand your specific rights and health care options. You can call **1-800-434-0222** to make an appointment at the HICAP office nearest you.