

Legal Basics: Medicare Appeals

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since the organization's founding in 1972, we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency. Justice in Aging authored this issue brief under a contract with the National Center on Law and Elder Rights.

Key Lessons

1. **There are different appeals processes based on Medicare enrollment.** The appeals processes for Medicare Parts A and B differ if a beneficiary is enrolled in original fee-for-service Medicare versus enrollment in a Medicare Advantage managed care plan.
2. **Beneficiaries can request expedited appeals in certain circumstances.** If a beneficiary is facing a hospital discharge or termination of services for skilled nursing facility, hospice, or home health care, they can use an expedited appeal process to prevent a disruption in services. Expedited appeals are also available in Medicare Advantage.
3. **Advocates should be aggressive in requesting and pursuing Medicare appeals.** Appeals frequently are successful—persistence pays.
4. **Close coordination with the provider is a critical element in a successful appeal.** Helping the provider understand Medicare coverage criteria can significantly strengthen a case.
5. **Advocates need to pay careful attention to deadlines.** Many deadlines for expedited appeals are very short. Failure to meet deadlines can cause a beneficiary to lose important rights.

There Are Different Appeals Processes Based on Medicare Enrollment

Steps in the appeals process differ based on whether a beneficiary is enrolled in traditional fee-for-service Medicare or, instead, enrolled in a Medicare Advantage managed care plan. Note that this chapter does not discuss appeals for prescription drug coverage under Part D.¹

Original Fee-For-Service Medicare

For a denial of a Part A or Part B service in original Medicare, there are five standard steps in the appeal process. First, the beneficiary will receive an initial determination. The initial determination is processed by Medicare contracting carriers and intermediaries. The beneficiary is informed of the denial on a Medicare Summary Notice (MSN), which provides information on why the claim was denied or partially paid and informs the beneficiary of their appeal rights.²

Redetermination

A beneficiary who wants to appeal an initial determination must file a written, signed request for redetermination to the Medicare Administrative Contractor (MAC) within 120 days of the initial

determination. Medicare providers and suppliers can also file a request for redetermination. The MAC must issue a redetermination decision in 60 days.³

Reconsideration

If the denial is upheld, the beneficiary can file a reconsideration. Beneficiaries have 180 days to request a reconsideration of a redetermination. Providers and suppliers also can file reconsideration requests. Reconsiderations are conducted by Medicare Qualified Independent Contractors (QICs), which conduct an external, independent review of the redetermination. The QIC has to render a decision within 60 days of receiving the request for reconsideration.⁴

Administrative Law Judge (ALJ) Hearing

Beneficiaries who want to appeal a reconsideration decision have the right to request an administrative law judge (ALJ) hearing if the amount of money at issue is at least \$160. The request for an ALJ hearing must be filed within 60 days of receiving an unfavorable reconsideration decision. An ALJ has 90 days to issue a decision, but the timeframe can be extended to review additional evidence or to permit an in-person hearing. ALJ hearings are conducted by the Department of Health and Human Services (HHS). In most cases, the hearings are conducted by telephone or video teleconference. In-person ALJ hearings are rare and only available if the beneficiary can show “good cause.”⁵

Medicare Appeals Council

If an ALJ issues an unfavorable decision, the beneficiary can request a review of the decision by the Medicare Appeals Council (MAC). The beneficiary has 60 days to request the MAC review and the review is generally a paper review where a decision is made without a hearing. The time frame for a MAC decision is 90 days, but can be extended.⁶

Federal District Court

A beneficiary can appeal a MAC decision by filing a lawsuit in federal district court. The suit must be filed within 60 days of receiving an unfavorable MAC decision. To appeal at this level, a beneficiary must show that at least \$1,600 is at issue.⁷

Medicare Advantage managed care

Medicare provides an appeals process for Medicare Advantage (MA) managed care plan members who have disputes with their plans. There are five steps in the appeals process.⁸ First, an MA plan will make an organization determination to either provide or deny a service or claim. There are different time frames for service and claim payment requests. Claim payment requests must be reviewed in 60 days. Service requests must be reviewed in 14 calendar days. If the organization determination is a denial, it must be in writing and must provide the reason for the denial and information on how to appeal the denial.

Reconsideration

To appeal the denial, the beneficiary must request a reconsideration, which will be performed by the MA plan. The member must file the request within 60 days of the date of the organization determination. The beneficiary or his representative is entitled to present evidence, either in person or in writing. The MA plan has 60 days to reconsider a claim payment denial. On service request denials, however, the MA plan has 30 days. It may add 14 days more upon a member’s request, or if the MA plan can show that additional information is needed and that the extension will benefit the member’s reconsideration request.

Independent Review Entity

If the MA plan decides to uphold the organization determination, in whole or in part, it must forward the case to the Independent Review Entity (IRE) that is contracted to review reconsideration cases for the federal government. This step happens without the need for the beneficiary to ask for the review. The MA plan must inform the member, in writing. Depending on the case, the IRE has up to 60 days to make a decision.

ALJ Hearing, MAC Review, District Court

If the IRE upholds the denial, the beneficiary has the same appeals rights as discussed above for fee-for-service including an ALJ hearing, MAC review, and filing a lawsuit with the Federal District Court.

Beneficiaries Can Request Expedited Appeals in Certain Circumstances

Hospital discharges

A Medicare beneficiary must be provided with notice of discharge rights twice during the course of the hospital stay, once within two days after admission and again two days to four hours before discharge; if the stay is three days or less, once is sufficient. If the beneficiary believes that she is not medically ready to be discharged from the hospital, the beneficiary has the right to appeal the discharge in an expedited appeal process. The appeal is made to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO).⁹

The patient may remain in the hospital at least until noon of the day after the BFCC-QIO decision. If the beneficiary's physician agreed with the discharge decision, the beneficiary has the right to appeal the decision by requesting an expedited review. The beneficiary should contact the BFCC-QIO no later than midnight of the day on which discharge is scheduled and ask for review.

If the BFCC-QIO issues a favorable decision, Medicare will continue to pay for the care. If the BFCC-QIO is contacted within the above time limit and decides against the beneficiary, the hospital may charge the beneficiary for any costs incurred starting at noon of the day after the day the BFCC-QIO decision is received.

If the BFCC-QIO decision is unfavorable, the beneficiary has the right to request a reconsideration by the Quality Independent Contractor (QIC). The request for reconsideration must be made by no later than noon of the calendar day following the receipt of the BFCC-QIO decision and the QIC has 72 hours to decide. The hospital may not bill the beneficiary until the QIC makes a decision. However, if the QIC decision is unfavorable, the beneficiary will be responsible for all costs including costs incurred during the 72 hours.

Skilled nursing facility, home health, hospice

An expedited appeal also is available when services are terminated by a skilled nursing facility, home health agency, hospice, or comprehensive outpatient rehabilitation facility. Some details and timeframes are different from hospital expedited appeals.

The provider must provide written notice to the beneficiary at least two days or two visits before the services are to be terminated. The beneficiary must request an expedited determination by the BFCC-QIO by noon of the day prior to the termination of services. The provider must provide a second notice that includes detailed information regarding why the services were terminated. The provider must also continue to provide services until two days after the first notice was given or until the service termination date (whichever is later).

Once the request for an expedited appeal is made, the BFCC-QIO has 72 hours to make a determination along with an explanation of the decision, the beneficiary's liability for services, and information on the beneficiary's appeal rights. If the decision is unfavorable, the beneficiary has the right to appeal by requesting an expedited reconsideration by the QIC. The QIC must make a decision within 72 hours.

Medicare Advantage enrollees have the same expedited discharge review and appeal rights for hospital, skilled nursing facility, home health, hospice, and comprehensive outpatient rehabilitation facility services as beneficiaries who use fee-for-service Medicare.

Medicare Advantage expedited appeals

In addition to the above circumstances, beneficiaries enrolled in a Medicare Advantage (MA) plan can request an expedited review if the timeframe for a standard appeal could seriously jeopardize the member's health or ability to gain maximum function. This faster appeal process can be used to request medical care from the MA plan, and to appeal an MA plan denial of service or termination of care.

An expedited appeal must be completed within 72 hours. The request can be made in person, by phone, or in writing. If the member requests the expedited review, the plan has the option to deny expedited processing. If, however, a physician requests expedited treatment, the MA plan must review the case within the 72-hour timeframe. An MA plan member who wants an expedited review should contact the MA plan's member services department.

Advocates Should Be Aggressive in Requesting and Pursuing Medicare Appeals

The success rates for Medicare appeals are high at the Independent Review Entity level and Administrative Law Judge hearing levels. It is therefore important to persevere through lower levels of appeals. Advocates and beneficiaries should work closely with the provider, who can supply important evidence including letters in support of services and medical records in support of the beneficiary's claim.

Close Coordination with the Provider Is a Critical Element in a Successful Appeal

Doctors and other providers are busy and often unfamiliar with Medicare appeals. Advocates can limit the burden on providers and get more cooperation if they lay out what is needed as clearly as possible. For example, National Coverage Determination (NCDs) and Local Coverage Determinations (LCDs) set out the Medicare coverage criteria for many, but not all, procedures. Advocates can review the coverage databases¹⁰ and, if an NCD or LCD is available, share it with the provider as a guide to the information that would be most relevant to the appeal.

Advocates Need to Pay Careful Attention to Deadlines

All appeal deadlines are important. The deadlines for hospital and skilled nursing discharges are very short. Marshalling both the beneficiary and provider input is a challenge. If a beneficiary does not act within required timeframes, rights to coverage during an appeal can be lost. Both timely filing and timely collection of needed information are essential.

Conclusion

Medicare appeals processes are vital to beneficiaries and their advocates. Medicare appeals are often successful at later stages of the appeal, so it is important to continue forward despite losses early on. Federal regulations and policies provide significant due process protections, and advocates should utilize those to ensure access to Medicare services.

Additional Resources

- 42 U.S.C. § 1395ff (Section 1869 of the Social Security Act)
- 42 C.F.R. § 405.920 et seq.
- 42 C.F.R. § 422.560 et seq.

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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Endnotes

- 1 NCLER's Legal Basic training on Medicare Part D and the accompanying Chapter Summary provide information on the Part D benefit, including information on the appeals process.
- 2 See 42 C.F.R. §§ 405.920-405.928 for regulations governing initial determinations. Sample Part A and Part B Summary Notices are available at [cms.gov/Medicare/Medicare-General-Information/MSN/index.html](https://www.cms.gov/Medicare/Medicare-General-Information/MSN/index.html).
- 3 See 42 C.F.R. §§ 405.940-405.958. The websites of each Medicare Administrative Contractor have additional information on filing an appeal with that MAC. Contact information for each MAC can be found using the link: [cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html).
- 4 See 42 C.F.R. §§ 405.960-405.978.
- 5 See 42 C.F.R. §§ 405.1000-405.1058.
- 6 See 42 C.F.R. §§ 405.1100-405.1130.
- 7 See 42 C.F.R. §§ 405.1132-405.1136.
- 8 Detailed guidance for Medicare Managed Care appeals is found at Ch. 13 of the Medicare Managed Care Manual, *available at* [cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf).
- 9 A self-help packet on hospital discharge appeals and self-help packets for other Medicare appeals in other specific situations are available from the Center for Medicare Advocacy at [medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals/](https://www.medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals/).
- 10 A searchable database is available at [cms.gov/medicare-coverage-database/overview-and-quick-search.aspx](https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).