U.S. Department of Health & Human Services
Office of Medicare Hearings and Appeals

National Medicare
Education Program Meeting

Benefit Entitlement and Claim Appeal Process

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DISCLAIMERS

- This is a general overview of the appeals process and is not:
  1) Authoritative; or
  2) Exhaustive of a party's rights and responsibilities in pursuing appeals.
- Terminology varies among Parts A and B, Part C, and Part D. I default to Part A and B terms unless something is specific to Part C or Part D.
- To the extent that I present an opinion, it is my own—it does not present the position of HHS, CMS, OMHA, or the DAB.
- To the extent that I have over-simplified anything, I apologize.

Terms to know

- CMS = Centers for Medicare & Medicaid Services
- SSA = Social Security Administration
- MAC = Medicare Administrative Contractor
- QIO = Quality Improvement Organization
- QIC = Qualified Independent Contractor
- IRE = Independent Review Entity
- OMHA = Office of Medicare Hearings and Appeals
- ALJ = Administrative Law Judge
- DAB = Departmental Appeals Board
- Council = Medicare Appeals Council (part of the DAB)

Additional Information

- https://www.medicare.gov/claims-and-appeals/
- https://www.hhs.gov/about/agencies/omha/index.html
- https://www.hhs.gov/about/agencies/dab/index.html

- An appealable *determination* is made
  - Quality of care complaints and grievances cannot be appealed through this process
- *Administrative appeals* may be sought
  - Whether there are three or four levels depends on the determination
    - If a QIO or SSA made the determination, three levels
    - If others made the determination, four levels
  - An amount in controversy is required for an ALJ hearing
    - $160 for 2017, except $200 for appeals of standard QIO reconsidered determinations
- *Judicial review* can be sought after appeals
  - Higher amount in controversy is required
    - $1560 for 2017, except $2000 for appeals of standard QIO reconsidered determinations
  - Regular court filing fees apply

Determination (Contractor/Plan/SSA)
Redetermination/ Reconsideration (Contractor/Plan/SSA)
Independent Reconsideration (Contractor)
ALJ Hearing (OMHA)
Council Review (DAB)
Judicial Review (U.S. District Court)

Appealable determinations

- Part A and Part B—"Initial Determination"
  - SSA: Eligibility or entitlement to Medicare program
  - SSA: Part B late enrollment penalty
    - Impacts Part B monthly premium for life
  - SSA: Income-related premium adjustment—a.k.a. IRMAA
    - Impacts Part B monthly premium (and Part D, if enrolled)
  - MAC: Claim for items or services
    - Beneficiaries *usually* not liable
      - The provider or supplier *usually* appeals
    - Recovery Audit Contractors (RACs) and Zone Program Integrity Contractors (ZPICs) also review claims but generally deal with providers and suppliers
  - Medicare Secondary Payer recoveries

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Appealable determinations

Part A and Part B—"Initial Determination"

- QIO: Review of furnished or proposed services
  - Furnished or proposed services are not reasonable or necessary, or not in the appropriate inpatient setting
- QIO: Home Health Agency, Skilled Nursing Facility, Comprehensive Outpatient Rehabilitation Facility or Hospice termination of covered services
  - Can obtain an *expedited determination* if requested within 72 hours following notice of discharge
- QIO: Inpatient hospital discharge
  - Can obtain an *expedited determination* if requested on day of discharge
  - Can file non-expedited request: (1) at any time if still in the hospital and without coverage; or (2) within 30 days after leaving the hospital

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Appealable determinations

Part C—"Organization Determination"

- Furnished health services that the enrollee believes:
  - Are covered under Medicare Part A or B; or
  - If not covered, should have been furnished, arranged for, or reimbursed by Medicare Advantage (MA) organization
- Temporary out-of-area dialysis, emergency services, post-stabilization care, or urgently needed services
- Refusal to provide or pay for services that the enrollee believes should be furnished or arranged for
- Failure to approve, furnish, arrange for, or pay for services in a timely manner, or provide an adverse determination when a delay would adversely affect the enrollee's health

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Appealable determinations

- Part C—"Organization Determination"
  - Reduction or premature discontinuation of a previously authorized ongoing course of treatment, including:
    - Inpatient hospital discharge (subject to QIO expedited review)
    - Home Health, Skilled Nursing Facility, or Comprehensive Outpatient Rehabilitation Facility termination of covered services (subject to IRE Fast Track review)

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Appealable determinations

Part D—"Coverage Determination"

- Refusal to provide or pay for a Part D drug that the enrollee believes may be covered by the plan
- Denial of a request for an exception to the plan's tiered cost-sharing structure
- Denial of a request for an exception to the plan formulary
- Determination on the cost-sharing amount for a drug
- Failure to provide a coverage determination in a timely manner when a delay would adversely affect the enrollee's health

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Administrative Appeals—Overview

- **Redetermination** or **Reconsideration**
  - Conducted by the same entity that made determination, but by staff not involved in the determination, except:
    - Not conducted for Part A expedited QIO determinations
    - QIO conducts expedited review of Part C inpatient hospital discharges
    - IRE conducts Fast Track review of Part C provider terminations
- **Independent Reconsideration**
  - Independent CMS contractors
  - Not conducted for SSA and standard QIO reconsiderations
- **ALJ hearing** (or attorney adjudicator review, if no hearing)
  - HHS Office of the Secretary: OMHA
- **Medicare Appeals Council review**
  - HHS Office of the Secretary: DAB

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Administrative Appeals—Time Frames

- Time to request an appeal
  - Varies with the level of appeal
  - Questions after a determination or decision do not extend time to appeal
  - Must establish good cause for late requests
- Time to get a decision
  - Varies with the level of appeal
  - Time may be extended for certain actions or events
  - Some processes allow for expedited reviews and decisions
- Escalating appeals
  - Can escalate appeals of Part A and Part B QIC reconsiderations
  - Moves case to next level of appeal

Administrative Appeals—Tips

- Be realistic about what you are appealing
  - Medicare is a defined benefit—adjudicators have to follow the law
- Explain why you think the item or service should be covered
  - Address the reasons the item or service was denied
  - Focus on facts that relate to Medicare coverage and documentation requirements
- Include copies of documentation to support the appeal
  - Adjudicators can only consider what is sent to them
  - Always keep the original for your own records
- Follow the appeal instructions

Administrative Appeals—Redetermination/Reconsideration

Time to request

- 120 days following receipt of Part A or B MAC initial determination
- 60 days following date of Part C organization determination
  - Day of discharge for Part C QIO expedited review of hospital discharge
  - Noon, next day for Part C Fast Track review of termination of services
- 60 days following date of Part D coverage determination
- 60 days following an SSA initial determination
- 60 days following a standard QIO initial determination

Who can request

- Party
  - Part A or B: Beneficiary, provider/supplier, Medicaid agency
  - Part C: Enrollee or treating physician (on behalf of enrollee), or an assignee of enrollee who waives collection
  - Part D: Enrollee or prescriber (on behalf of enrollee)
- Party's authorized or appointed representative

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Administrative Appeals—Redetermination/Reconsideration

Expedited reviews available

- Note: Expedited review of Part A QIO expedited determination of termination of covered services in a skilled setting or hospital when the beneficiary is still in the institution are available by an independent entity
- Part C when the plan will not provide or pay for a service, or reduces or discontinues a service
- Part D when drug has not been obtained and serious jeopardy to life or health, or regain maximum function

Expect a decision

- 60 days for Part A or B MAC redetermination
- 30 days for Part C request for services / 72 hours for expedited
  - Day after all information received for Part C QIO expedited review
  - Day after all information received for Part C IRE Fast Track review
- 60 days for Part C request for payment
- 7 days for standard Part D determination/ 72 hours for expedited

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Administrative Appeals—Independent Reconsideration

Time to request

- 180 days following receipt of Part A or B MAC redetermination
- Noon on day following Part A QIO expedited determination
  - Note: If no longer a hospital inpatient, a Part A QIO expedited determination of an inpatient hospital discharge follows the standard claim appeals process
  - Requests that do not meet this deadline follow the standard claim appeals process
- 60 days following Part C QIO expedited or IRE Fast Track review
  - Note: If no longer a hospital inpatient, a Part C QIO expedited review is appealed to an ALJ
  - No request needed for Part C organization reconsiderations
- 60 days following date of Part D redetermination

Who can request

- Party
  - Part A or B: Beneficiary, provider/supplier, Medicaid agency
  - Part C: Enrollee or an assignee of enrollee who waives collection
  - Part D: Enrollee or prescriber (on behalf of enrollee)
- Party's authorized or appointed representative

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Administrative Appeals—Independent Reconsideration

Expedited reviews available

- Part A QIO expedited determination (unless no longer a hospital inpatient)
- Part C QIO expedited (if still a hospital inpatient) or IRE Fast Track review
- Part D when drug has not been obtained and serious jeopardy to life or health, or regain maximum function

Expect a decision

- 60 days for Part A or B QIC reconsideration
- 72 hours for timely requested Part A expedited reconsideration of provider discharge if patient still in facility
  - General appeals process and time frames apply if 72 hour time frame does not
- 14 days for Part C reconsideration of expedited review or Fast Track
- 60 days for Part D IRE reconsideration / 72 hours for expedited
- Note: Not all time frames are address in regulations

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Administrative Appeals—ALJ Hearing

Time to request

- 60 days following Part A or Part B QIC reconsideration, Part D IRE reconsidered determination, or SSA or QIO reconsidered determination
- A partially favorable or unfavorable Part C organization reconsideration does not require a request for hearing

Who can file a request

- Part A or B: Beneficiary, provider or supplier, Medicaid agency
- Part C: Enrollee or an assignee of enrollee who waives collection
  - Treating physician cannot file "on behalf of" the enrollee at ALJ hearing level—must be appointed as a representative
- Part D: Enrollee
  - Prescriber cannot file "on behalf of" the enrollee at ALJ hearing level—must be appointed as a representative

Expedited reviews available

- Part D when drug has not been obtained and serious jeopardy to life or health, or regain maximum function

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Administrative Appeals—ALJ Hearing

Beneficiary and enrollee appellants

- Send request for ALJ hearing to location identified in appeal instructions
- If instructions say to send directly to OMHA, send to:

  OMHA Central Operations
  Attn: Beneficiary Mail-Stop
  200 Public Square, Suite 1260
  Cleveland, OH 44114-2316

- Requests must be in writing (except Part D expedited requests)

Part D expedited hearing requests

- May be filed orally at 1-866-941-7012 or by fax at 1-216-615-4116
- Cannot be solely a request for payment for drugs already furnished
- Applying standard time frame (90 days) will seriously jeopardize life or health, or ability to regain maximum function
  - Prescribing physician statement can be filed or ALJ makes determination

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Administrative Appeals—ALJ Hearing

Beneficiary and enrollee appeal prioritization

- Beneficiary or enrollee files a request for hearing
- If represented by a provider or supplier, or common representative:
  - Discharged from a facility, or has not received the item/service in question
  - Financially responsible for the item or service in question, beyond standard deductibles and co-payments or co-insurance
  - Financially responsible for related items or services that have been denied and are being appealed
  - Denied item or service is preventing receipt of additional related items or services
- Appeals are assigned and processed before non-priority appeals

Beneficiary and enrollee assistance

- OMHA Beneficiary (and enrollee) Help Line: 1-844-419-3358
- Other callers use OMHA National Toll Free Line: 1-855-556-8475

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Administrative Appeals—ALJ Hearing

When the beneficiary is not the appellant

- Will *usually* receive a copy of the request for hearing from the appellant
  - They likely received a copy of the reconsideration—they can check that to see whether they were held financially responsible for the denied item or service
- Will be sent a notice of hearing if they may be held financially responsible for the denied item or service
  - They may also receive a notice if the ALJ believes their testimony would be helpful or they requested the reconsideration that is being appealed
- Will *usually* be sent a copy of the decision
  - Decision is not sent to a beneficiary when they are: (1) not financially responsible; and (2) the appeal involved multiple beneficiaries and an overpayment assessed against the provider or supplier

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Administrative Appeals—ALJ Hearing

Procedural screening

- Procedural issues can result in a dismissal

Case record is reviewed

- Record from lower level and additional evidence sent with request
- Decision can be issued if record alone supports coverage
- Remands to CMS contractors sometimes result

Hearing is scheduled

- Most prefer telephone hearing
- Unrepresented beneficiaries have right to video-teleconference hearing
- Represented beneficiaries and other appellants can request video-teleconference or in-person hearing

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Administrative Appeals—ALJ Hearing

Hearing is conducted

- Issues to be determined are generally the reasons an item or service was denied
- Parties can explain their positions
- Parties can present witnesses and question the witnesses of others
- CMS contractors and Part C and Part D plans may be at the hearing
- ALJ may ask questions of anyone at the hearing
- ALJ may call an expert witness
- ALJ is in charge and directs the hearing

Decision is made

- After the hearing and with any additional evidence allowed by the ALJ, the ALJ will make a decision

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Administrative Appeals—ALJ Hearing

Expect a decision

- 10 days for Part D enrollee expedited appeals
- 90 days for standard beneficiary or enrollee appeals
- 180 days for beneficiary escalated requests for QIC reconsideration

The OMHA appeals backlog

- Impacts providers, suppliers, and Medicaid agencies
- Delays beyond 90 days in obtaining decisions
- OMHA measures to address:
  - OMHA beneficiary/enrollee appeal prioritization
  - Settlement Conference Facilitation with CMS
  - Statistical sampling option
  - Adding adjudication capacity as resources are made available
  - Moving to a standardized, electronic adjudication model

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Administrative Appeals—Council Review

Time to request

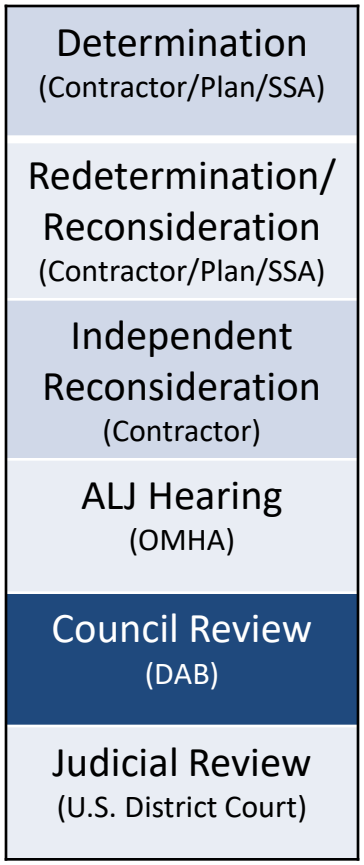
- 60 days after receipt of ALJ or Attorney Adjudicator decision

Who can file a request

- Part A or B: Beneficiary, provider or supplier, Medicaid agency, or CMS or a CMS contractor that elected party status
- Part C: Enrollee or an assignee of enrollee who waives collection, or the MA organization
- Part D: Enrollee

Expedited reviews available

- Part D when drug has not been obtained and serious jeopardy to life or health, or regain maximum function



Administrative Appeals—Council Review

Requests

- Must be in writing (except for Part D expedited requests)
- Provide required information
- Identify what parts of the ALJ or attorney adjudicator decision you do not agree with
- Can file electronically at: https://dab.efile.hhs.gov/mod/

Part D expedited review requests

- May be filed orally at 1-866-365-8204 or by fax at 1-202-565-0227
- Cannot be solely a request for payment for drugs already furnished
- Applying standard time frame (90 days) will seriously jeopardize life or health, or ability to regain maximum function
  - Prescribing physician statement can be filed or Council makes determination

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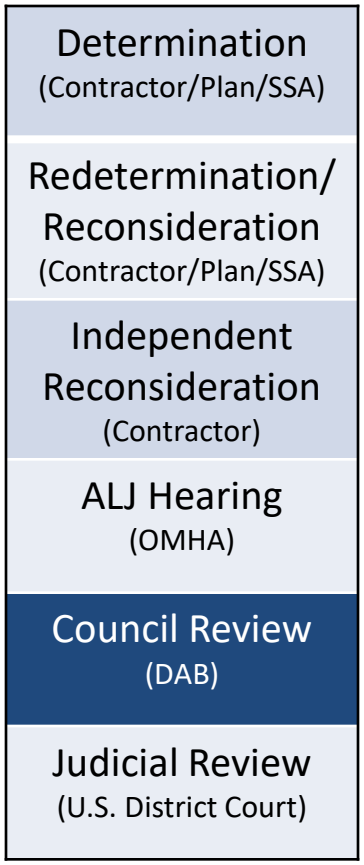
Administrative Appeals—Council Review

- Beneficiary and enrollee appeal prioritization
  - Beneficiary or enrollee files a request for review
  - Appeals are processed before non-priority appeals
- Beneficiary and enrollee assistance
  - Assistance line: 1-866-365-8204



Administrative Appeals—Council Review

"Own Motion Review"

- Council can review an ALJ or Attorney Adjudicator decision without a request from the parties

Referrals for own motion review

- CMS and its contractors, and SSA can refer an ALJ or Attorney Adjudicator decision to the Council
- Council may use its own motion review authority to review a referred decision

Party notice and response period

- Copies of referrals are sent to the parties
- Parties have 20 calendar days to file exceptions by submitting written comments to the Council, referring entity, and other parties

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Administrative Appeals—Council Review

- Review is based on the record and filings unless leave is granted for oral argument. As a matter of practice, the Council does not typically permit oral arguments.

Council may:

- Adopt, modify, or reverse a decision
- Vacate a decision and remand to the ALJ or Attorney Adjudicator
- Deny a request for review
- Dismiss a request for review
- Dismiss a request for hearing
- Decline own motion review

Expect an action

- 10 days for Part D enrollee expedited appeal
- 90 days for standard beneficiary or enrollee, or referred appeal
- 180 days for beneficiary escalated request for an ALJ hearing

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Administrative Appeals—Judicial Review

Time to file

- 60 days following receipt of Council decision
- Can request an extension of time to file for judicial review from the Council

Who can file

- Part A or B: Any party to the Council decision
- Part C: Any party to the Council decision
- Part D: Enrollee

What is filed

- Civil complaint against the HHS Secretary in the United States district court for the judicial district in which the party resides or where the individual, institution, or agency has its principle place of business

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QUESTIONS?

Jason Green
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http://www.hhs.gov/omha
Medicare.Appeals@hhs.gov

Supplemental Information

ALJ Appeal Status Information

OMHA Contact Information Summary

Process Summary

ALJ Appeal Status Information System (AASIS)

- Online appeal status lookup tool available on OMHA website
  - www.hhs.gov/omha/Appeal_Status_Lookup/index.html
- Updated weekly (active cases and 180 days after close)
- Can use QIC reconsideration or ALJ appeal numbers
  - Search up to 10 at a time
  - Answer a simple arithmetic problem (to prevent automated programs)
- Information returned by system includes:
  - Appeal status
  - ALJ team assigned to hear the appeal, including team contact information
  - Date of any scheduled hearing
  - Date decision letter was mailed

AASIS

Field marked with an asterisk (*) is required.

Enter Appeal Number(s) *

Enter up to 10 ALJ Appeal Numbers and/or Medicare Appeal Numbers (Reconsideration).

Please enter one per line pressing the e

1-1000638791R1

Please validate the following expr

Question: What is seven - four ?

3

Submit Inquiry

ALJ Appeal Status Information System Results Page

SEARCH RESULTS

Medicare Appeal Number (Reconsideration)	1-895134209
ALJ Appeal Status	Assigned
ALJ Appeal Number	1-1000638791R1
Request for ALJ Hearing Received Date	05/18/2013
ALJ Hearing Date	
ALJ Decision Mailed Date	
ALJ Hearing Office	Miami
Administrative Law Judge	Lauren Heard
ALJ Team Phone Number/Extension	305-415-7449
New ALJ Appeal Number	
Notes	This appeal has been assigned, and will be reviewed by the Administrative Law Judge indicated above.

HEARING OFFICE(S)

Miami
OMHA Miami Field Office
100 SE 2nd St., Suite 1660
Miami, FL 33131-2100
Phone: 866-622-0382

Contacting OMHA

- Cases assigned to an ALJ, can contact the ALJ team
  - OMHA Field Office phone numbers available at: http://www.hhs.gov/about/agencies/omha/contact/index.html
- Cases not assigned to an ALJ / or other issues
  - Beneficiaries: (844) 419-3358 (toll free)
  - Other appellants: (855) 556-8475 (toll free)
  - Medicare.Appeals@hhs.gov (ALJ-level appeals only)
- Helping beneficiaries file appeals:
  - Send requests for hearing to: OMHA Central Operations
    Attn: Beneficiary Mail Stop
    200 Public Sq., Suite 1260
    Cleveland, OH 44114-2316
  - Part D expedited appeals (ONLY): (866) 941-7012

	Parts A and B					Part C			Part D
Action	General Initial Determinations	Inpatient Hospital Discharge	HHA, SNF, CORF, Hospice Termination of Covered Services	Furnished or proposed services are not reasonable or necessary, or in the appropriate inpatient setting	Eligibility/ Entitlement/ Part B LEPs/ IRMAAs	General Organization Determinations	Inpatient Hospital Discharge	HHA, SNF, CORF Termination of Covered Services	General Coverage Determinations
Made by	MAC initial determination	QIO expedited determination	QIO expedited determination	QIO initial determination	SSA initial determination	MAO organization determination	MAO organization determination	MAO organization determination	D Plan coverage determination
Entity Review	MAC redetermination	Skip	Skip	QIO reconsidered determination	SSA reconsideration	MAO reconsidered determination	expedited QIO determination	IRE fast track decision	D Plan redetermination
Independent Review	QIC reconsideration	(if inpatient) QIC expedited reconsideration (if not inpatient or late request) *GO TO* QIO reconsidered determination	QIC expedited reconsideration (if late request) *GO TO* QIO reconsidered determination	Skip	Skip	IRE reconsideration	(if inpatient) QIO Fast Track reconsideration (if not inpatient) Skip	IRE Fast Track reconsideration	IRE reconsideration
Hearing	ALJ hearing	ALJ hearing	ALJ hearing	ALJ hearing	ALJ hearing	ALJ hearing	ALJ hearing	ALJ hearing	ALJ hearing
DAB Review	Council review	Council review	Council review	Council review	Council review	Council review	Council review	Council review	Council review
Judicial Review	U.S. District Court	U.S. District Court	U.S. District Court	U.S. District Court	U.S. District Court	U.S. District Court	U.S. District Court	U.S. District Court	U.S. District Court