



## It's FINAL! Reviewing the Current Medicare Appeals Process

During the last decade, the Centers for Medicare and Medicaid Services (CMS) underwent significant changes in an attempt to improve output, reduce waste, and streamline processes. As part of this overhaul, the Medicare Appeals Process was revised.

Both the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required significant changes to the then current Medicare Appeals Process. After over five years of delays "due to the need to allow an opportunity for full consideration of issues of law and policy raised in the regulation," on December 9, 2009, the final rule addressing the changes to the Medicare Appeals Process was issued, to be effective on January 8, 2010. Now that the final rule has been issued, all participants should again acquaint themselves with the revised Medicare Appeals Process, which unites Part A and Part B under one appeals system.

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### First Level of Appeal - The Redetermination

The first step in the Medicare process is the provision of Medicare covered services to a Medicare beneficiary. Following the provision of this covered service, the provider would file the appropriate claim forms with the Medicare claims processor for the region. After reviewing the claim, Medicare would issue an initial determination letter (the Medicare Summary Notice or the Remittance Advice) to the parties involved. Upon receipt of that initial determination letter, if a party disagrees with the determination, the party has the right to request a "redetermination" from the applicable claims processor (fiscal intermediary, carrier, or Medicare Administrative Contractor). The request for redetermination must be filed in writing within one hundred twenty (120) days of the receipt of the Medicare demand letter and may (and should) include any supporting documentation. The claims processor must then have the determination reviewed by new personnel and issue a decision regarding the redetermination generally within sixty (60) days of receipt of the request for redetermination. Notably, if additional supporting documentation is submitted after filing the request for redetermination, the claims processor is granted an additional fourteen (14) days to review the request. In the event of a repeated denial, the Medicare Redetermination Notice (MRN) will explain the basis for such denial as well as the recipient's right to appeal further.

### Second Level of Appeal - The Reconsideration

The second level in the appeals process is a "reconsideration" by the Qualified Independent Contractor (QIC). The reconsideration is a record review of all documentation submitted. If a party is unhappy with the result of the redetermination, the party would file in writing for a reconsideration within one hundred eighty (180) days of the receipt of the MRN. Upon filing for reconsideration, the party is again offered the opportunity to submit additional supporting documentation. Further, the party is expected to submit a copy of the MRN and clearly explain why the party disagrees with the MRN. Importantly, evidence and documentation not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless good cause is shown. Therefore, it is important for the party to submit any and all documentation and supporting evidence that may be necessary at the very latest during the appeal at this level.

In addition to reviewing the documentation presented, the QIC must also consider any applicable local coverage determinations (LCD), local medical review policy (LMRP), and CMS program guidance. To the extent applicable, the QIC should defer to those policies, as "the use of

consistent review criteria will serve several important purposes, including the identification of recurrent problems with CMS policies, fostering consistency in appeal decisions, and potentially reducing both ALJ appeals volume and the ALJ reversal rate." However, to the extent the QIC finds such policies do not apply to the facts of the case, the QIC may use its discretion to not apply such policies. Furthermore, if necessary, the QIC is permitted to contact the appellant to obtain any additional necessary information by phone or other means.

The QIC will issue a decision regarding the reconsideration generally within sixty (60) days of receipt of the request. Again, to the extent evidence or documentation is submitted after the initial submission of the reconsideration, the QIC is granted an additional fourteen (14) days to review the reconsideration. If the reconsideration does not fully favor the appellant, the appellant would be informed of its right to appeal further. Should the QIC fail to issue a decision within the specified time frames, the QIC will inform the appellant of its inability to make a determination using an escalation option letter and advise the appellant of its right to submit the appeal to the Administrative Law Judge, the next step in the appeals process, without having received a determination.

### **Third Level of Appeal - The ALJ Hearing**

The third level of appeal is the first opportunity for the appellant to have the appeal considered in a hearing. Within sixty (60) days of the appellant's receipt of the reconsideration notice or escalation option letter, the appellant has the opportunity to file a request for a hearing by an Administrative Law Judge (ALJ). In addition to being within the specified time frame, only those claims with amounts in controversy above the requisite threshold may be submitted for an ALJ hearing. The requisite threshold is adjusted each year. Beginning in 2010, to request an ALJ hearing, the amount in controversy must be at least \$130.

The ALJ performs the role of an independent evaluator of the facts presented. The ALJ hearing may be heard via telephone, video-teleconference or in person. However, an in-person hearing will only be granted upon a showing of good cause as to why an in person hearing is necessary. In certain cases, the appellant may request that the ALJ hearing be "on-the-record" and based upon submitted documents only. At the ALJ level, upon notifying all parties to the hearing, CMS or its contractors may elect to become a party to or participate in the hearing. Contractor means "an entity that contracts with the Federal government to review and/or adjudicate claims, determinations, and/or decisions, including fiscal intermediaries, carriers, and Medicare administrative contractors." As this is the first time CMS or its contractors may enter the appeals process, CMS or its contractors are permitted to submit evidence into the administrative record for consideration.

The decision of the ALJ is expected within ninety (90) days of the receipt of the hearing request. During such review, the ALJ, like the QIC, must also give deference to CMS rules, regulations, LMRPs, and LCDs if such policies are applicable to the facts of the case. This time frame may be extended in instances of additional submission of evidence, the request for an in-person hearing, CMS's intervention into the proceeding, or the escalation to an ALJ hearing without a QIC reconsideration finding. As with the QIC, in the event the ALJ is unable to issue a decision within the requisite time period, ALJ will notify the appellant of the right to escalate the case to the next appellate level, the Medicare Appeals Council.

### **Fourth Level of Appeal - Medicare Appeals Council**

The fourth level of appeal is a review by the Medicare Appeals Council (MAC). The MAC is a part of the U.S. Department of Health and Human Services. The request for a de novo review by the MAC must be submitted within sixty (60) days of receipt of the determination or notice of escalation from the ALJ. Any party may submit a MAC request, if applicable, including CMS or a contractor. CMS or a contractor may request a MAC review if it believes the determination contains an error of law that is material to the outcome, contains broad policy or procedural issues that may affect the public interest, or is not supported by a preponderance of the evidence or includes an abuse of discretion by the ALJ.

Upon submitting the request for review, the appellant must specifically state the issues and findings that are being challenged. The MAC review is not a hearing process, but in certain cases, the MAC may grant a request for oral argument if the issues raised involve an important question of law, policy or fact that cannot be determined based upon written submissions. The parties may submit briefs in support of their positions, but only evidence already on the record or approved for submission by the MAC due to good cause will be considered by the MAC.

The MAC decision is typically issued within ninety (90) days of the receipt of the request for review. Similar to the ALJ, that time period may be extended in certain circumstances, including the escalation of the appeal from the ALJ without a decision. Should the MAC fail to issue a decision in the provided timeframe, the parties may request the appeal be escalated to the final appeal stage, Federal District Court. Following such request, the MAC must issue either a decision, dismissal, remand, or notice of receipt of the request.

### **Fifth Level of Appeal - Federal District Court**

Typically, to escalate a Medicare appeals claim to the Federal District Court, each administrative level of the Medicare appeals process must be exhausted. The request for review by the Federal District Court may only be filed if the amount in controversy exceeds a certain threshold amount. The threshold amount for 2010 is \$1,220. If the amount in controversy is met, the complaint must be filed within sixty (60) days of the receipt of the MAC decision or determination. The defendant for the complaint shall be the Secretary of the Department of Health and Human Services and the complaint must be filed in the federal district court where the beneficiary resides.

### **Dismissals of Actions**

CMS has also included special provisions when dealing with a dismissal of a claim. A dismissal at any level of the appeals process may be appealed to the next level. However, upon the approval of the dismissal of the claim at that subsequent level, the dismissal is binding and not subject to further review. For example, an appeal that is dismissed at the redetermination level by the claims processor may be reviewed by the QIC at the reconsideration level. Should the QIC affirm the dismissal, the dismissal would be final and binding and not subject to further review. Notably, despite the affirmation of a dismissal, a party may still request that the dismissal be vacated in accordance with the regulations.

With the final rule issued, the BIPA and MMA sections addressing the revised Medicare appeals process have become fully realized. While additional changes may arise in the future, as health care reform continues to loom on the horizon, it is important for all parties to be aware of the basic changes in the Medicare appeals process so as to protect their rights now.

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