Fact Sheet

Improving the Medicare Appeals Process

The Medicare appeals process—designed to protect beneficiaries' access to treatment and quality of care—can be streamlined and made more balanced and transparent.

How the Current Appeals Process Works

Appeal of Claim Denials

If traditional fee-for-service Medicare (Parts A and B) denies payment of a claim for care, for example because the service is not deemed to be medically necessary, beneficiaries can appeal. Medicare's Summary Notice of Benefits, which accompanies a claim denial, includes instructions for how to appeal. More information and appeals forms are available on Medicare's Web site: www.medicare.gov/Basics/appealsoverview.asp. Medicare's toll-free telephone number (800-Medicare) can provide additional information but cannot accept complaints or appeals. A beneficiary may pursue an appeal through several levels.

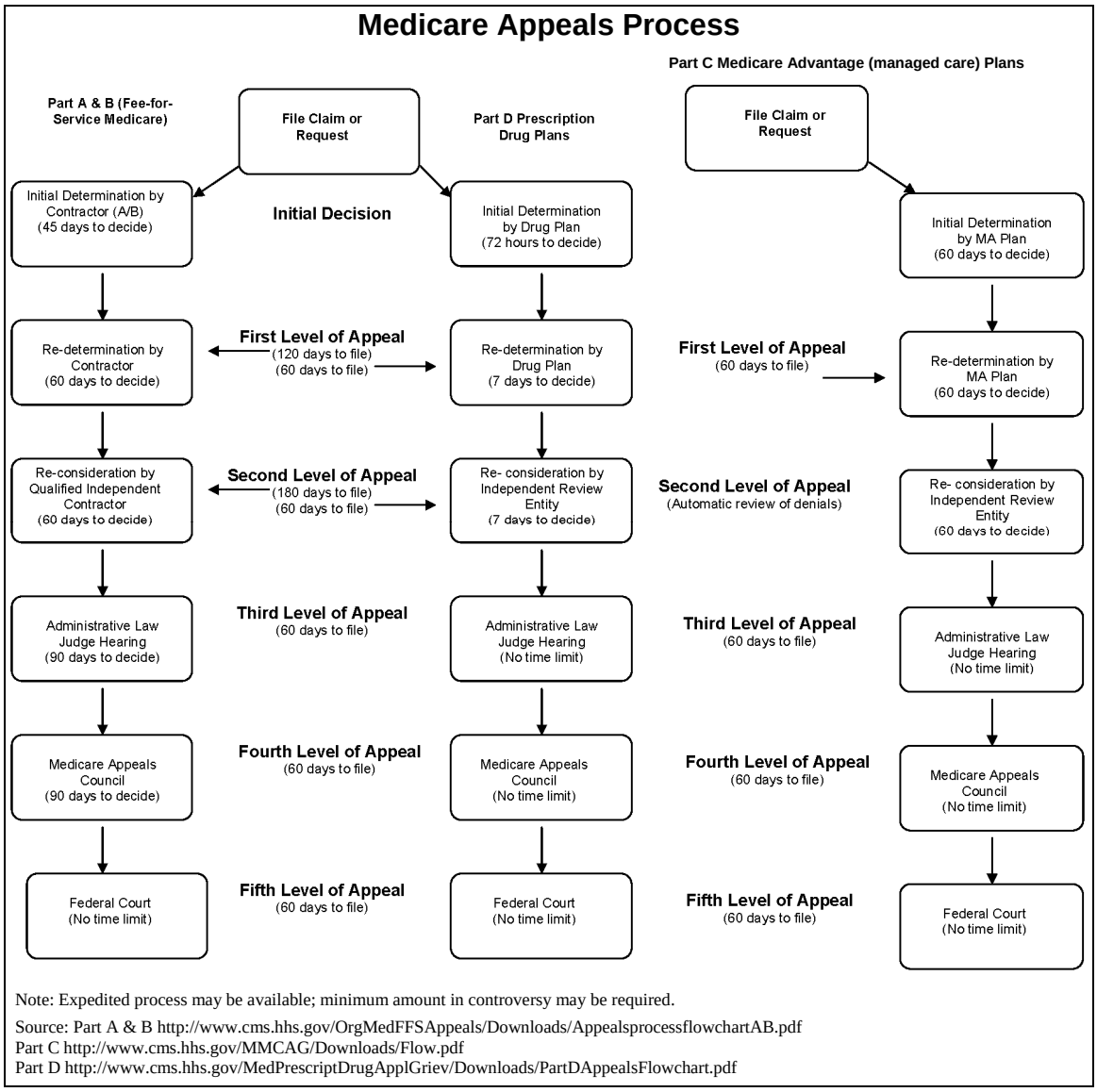
1. A beneficiary may request a second look, called a redetermination, by the Medicare contractor that initially denied a claim or request.
2. The beneficiary may appeal for reconsideration by an independent review organization known as a Qualified Independent Contractor.
3. The beneficiary may appeal for a hearing by an Administrative Law Judge (ALJ).
4. The beneficiary may appeal to the Medicare Appeals Council, an office within the U.S. Department of Health and Human Services (HHS).
5. The beneficiary may appeal to federal court.

Requests for contractor redetermination and appeals to a Qualified Independent Contractor do not have to meet minimum dollar thresholds regarding the amount in controversy. Appeals to higher levels must meet minimum thresholds. These thresholds ($130 for ALJ hearings, $130 for Medicare Appeals Council hearings, and $1,260 for federal district court in 2010) are indexed for inflation. The results of an appeal regarding a specific claim denial apply only to the individual beneficiary's claim, not to a larger group of beneficiaries who may want a service covered. In most ALJ cases, HHS has adopted the use of videoconferencing instead of in-person hearings.

The appeals process for Medicare Parts A, B, C, and D varies slightly, as shown in the diagram on page 2.

Appeal of Coverage Denials

When a Medicare contractor or the Center for Medicare and Medicaid Services (CMS) has determined that a specific item or service is categorically not covered by Medicare (as opposed to not being medically necessary for a particular patient), a beneficiary may appeal this determination through a separate coverage appeal process. The right to challenge a local or national coverage decision is distinct from appeal rights for individually denied claims.



Note: Expedited process may be available; minimum amount in controversy may be required.

Source: Part A & B http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf
Part C http://www.cms.hhs.gov/MMCAG/Downloads/Flow.pdf
Part D http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PartDAppealsFlowchart.pdf

This process requires examination of the entire coverage policy and may lead to changes that affect other beneficiaries. An adverse decision (one that goes against the beneficiary) may be appealed to the Medicare Appeals Board and, ultimately, to federal court.

Appeal of Quality Issues

For issues regarding the quality of services (i.e., poor quality or inappropriate service), a beneficiary may file a complaint with one of Medicare's Quality Improvement Organizations. If the result is adverse, the beneficiary may request reconsideration. An adverse redetermination may be appealed to the Secretary of HHS. A beneficiary who has been harmed by the care may file a civil lawsuit for malpractice against the provider or physician directly in state or federal court.

Appeal of Medicare Advantage Plan Denials

Medicare Advantage (managed care) plans (Part C) are required by regulation to have a standard internal grievance and appeal process. A plan must respond to grievances, such as complaints about timeliness or quality of services. Grievances related to quality of care may be appealed to the Medicare Quality

Improvement Organization. Adverse redeterminations related to denial of services are automatically forwarded to a Qualified Independent Contractor for external review. Adverse decisions at this level may be appealed to an ALJ and above under the same process applied to traditional Medicare appeals.

Appeal of Medicare Part D Drug Plan Denials

The appeal process under the Medicare prescription drug benefit (Part D), which started in 2006, is similar to the appeals process for Part C, with certain exceptions.

Appeal of Medicare Eligibility Denials

A person who is denied enrollment as a Medicare beneficiary may appeal this decision to the Social Security Administration. More information is available on the Social Security Administration Web site: www.SocialSecurity.gov.

How Can the Medicare Appeals Process Be Improved?

An effective appeals process is essential for correcting payment and coverage errors. The HHS Office of Inspector General has indicated that the appeals process must meet certain minimum requirements.

> "[T]he appeals process must provide independent, neutral, and competent adjudicators. It must be trusted by all parties who use it and by the public at large who funds it. Sufficient time must be allowed and effective procedures must be established to ensure that beneficiaries and health care providers have easy access to it and have the opportunity to have their concerns, arguments, and evidence fairly considered."[1]

The Medicare appeals process is complicated and lengthy, particularly in the later stages, according to consumer groups. Many beneficiaries find the process confusing and sometimes fail to receive or understand information about the reason for coverage or claim denials or their appeal rights.[2] A recent report by the Office of Inspector General found that the content of beneficiary appeal notices issued by Medicare Advantage plans was commonly deficient.[3]

Consumer groups also report that Medicare contractors and Qualified Independent Contractors are often inaccessible and unresponsive to beneficiary inquiries about their appeals. Contractor Web sites contain only generic information about appeals. Beneficiaries are unable to get information about how to file or obtain personal assistance filing appeals or learn the status or disposition of their appeals. When beneficiaries call customer service, they have no option to speak to a live person.[4]

Notice of beneficiary appeal rights under Part D has also been found to be inadequate. When a beneficiary is told at the pharmacy counter that his or her drug plan will not cover or pay for a prescribed drug, the pharmacy is required only to provide a generic notice directing beneficiaries with complaints to call their drug plan. The pharmacy is not required to provide the plan's phone number, and often, a posted notice is hard to find and difficult to read.[5]

Decisions by Medicare contractors and the Medicare Appeals Council tend to favor the government. CMS data reveal that less than 2 percent of denied claims were appealed for redetermination in 2007. For Part A, about 45 percent of 240,000 appeals for redetermination were denied by Medicare contractors, and 80 percent of 35,000 appeals for reconsideration were denied by independent review organizations.[6] For Part B, about 37 percent of 2.5 million appeals for redetermination were denied

by Medicare contractors, and 64 percent of 333,000 appeals for reconsideration were denied by independent review organizations.[7]

Decisions by ALJs and federal courts tend to be more balanced. However, CMS has constrained ALJs to follow certain Medicare rules that do not apply to federal courts. While CMS does not release data on ALJ appeals rates or disposition of cases, a report by the HHS Office of Inspector General found that in 1996, 81 percent of home health appeals were reversed in favor of beneficiaries at the ALJ level. In 1997, 78 percent of appeals for durable medical equipment used in the home were reversed at the ALJ level.[8]

Simplify and Clarify the Process

Congress and CMS could simplify the process and make it clearer to beneficiaries and their physicians. The process could move more quickly, through fewer levels. It could be more balanced and easier to understand.

- Appeals procedures should be as simple and streamlined as possible without sacrificing beneficiary protections. They should ensure basic fairness for the beneficiary, including an opportunity for an informal in-person hearing with the Medicare contractor that made the initial denial.
- Notice to beneficiaries of their appeal rights should be clear and understandable to a layperson. For instance, beneficiaries should receive an easily readable notice of appeal rights and how to reach their plan at the pharmacy counter when their drug plan will not cover or pay for a prescribed drug.
- All decisions that could result in a beneficiary's not receiving the care in question should be made and communicated as rapidly as the beneficiary's medical situation warrants.
- Medicare beneficiaries affected by coverage or claim denials should receive a timely written explanation of the basis for the decision and of their appeal rights. This information should be understandable to a layperson and sufficiently detailed, including citations to the legal authority upon which the denial is based, to permit a meaningful appeal.

Streamline the Process

- Medicare contractors should have incentives to reach the correct decision on a claim at the first level of review. Medicare payment rules should encourage contractors to promptly request missing information for incomplete claims and provide adequate explanation of denied claims to beneficiaries and providers, rather than simply deny claims which may encourage appeals.
- To streamline the process, one or more levels of administrative review might be dropped from the appeals process.[9]
- The grievance and appeals process for Medicare Part D prescription drug plans should be streamlined to permit faster resolution and access to temporary drug supplies sufficient to last throughout a pending appeal.
- To avoid further unnecessary delay, appeals of decisions adverse to beneficiaries under Parts A, B, and D should be forwarded automatically to the first level of independent review without further action by the beneficiary, as is required under Part C.

Maintain Impartiality of the Process

- Medicare contractors and plans should be held accountable, perhaps through random independent audits, to ensure that their internal appeals procedures comply with applicable rules and that beneficiaries are afforded due process in their appeals.
- Beneficiaries who appeal their cases to an ALJ should have an unrestricted opportunity for an in-person hearing, upon request.
- ALJs should remain free from undue influence from HHS and be allowed to make impartial decisions in Medicare hearings.

Improve Transparency of the Process

- Beneficiaries and their representatives should have easy access to all information and documents related to coverage, payment, the quality of their care, and the status of their appeal.
- HHS should publish data regarding the number and disposition of appeals by service sector (i.e., hospitals, physicians, etc.) for payment claims, beneficiary complaints, and coverage denials from initial hearing to final disposition at each level, including appeals to ALJs, the Medicare Appeals Council, and federal court.

Resources

Official Web site on Medicare appeals: www.medicare.gov/Basics/appealsoverview.asp.

Official CMS description of Medicare appeals process: http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf.

HHS web site on Medicare ALJ hearings: www.hhs.gov/omha/needtoknow.html.

HHS Web site on Medicare Appeals Council hearings: http://www.hhs.gov/dab/MOD2005.html.

CMS Web site on Medicare coverage and appeals: http://www.medicareadvocacy.org/FAQ_CoverageAndAppeals.htm.

Official Social Security Web site: www.SocialSecurity.gov.

Medicare Rights Center Web site: Medicare Interactive, "What if Medicare denies my appeal?" http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&slide_id=859.

Source for Medicare appeals diagrams, Part A and B: http://www.cms.hhs.gov/OrgMedFFSAppeals/Downloads/AppealsprocessflowchartAB.pdf.

Part C: http://www.cms.hhs.gov/MMCAG/Downloads/Flow.pdf.

Part D: http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PartDAppealsFlowchart.pdf.

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[1] Office of Inspector General, *Medicare Administrative Appeals: The Potential Impact of BIPA*, OEI-04-01-02960 (Washington, DC: U.S. Department of Health and Human Services, 2002).

[2] Vicki Gottlich, "The Perspective of Medicare Beneficiaries," in *Guide to Medicare Coverage Decision-Making and Appeals*, ed. Eleanor Kinney (Washington, DC: American Bar Association, Sec. of Administrative Law and Regulatory Practice, 2002).

[3] Deputy Inspector General, Memorandum Report: *Beneficiary Appeals in Medicare Advantage*, OEI-01-08-00280 (Washington, DC: U.S. Department of Health and Human Services, Oct. 22, 2009).

[4] Ilene Stein, Medicare Rights Center, Personal Communication (Nov. 4, 2009).

[5] Op cit., Gottlich.

[6] CMS. "Fact Sheet – Original Medicare (Fee-For-Service) Appeals Data – 2007" (2008). http://www.cms.hhs.gov/OrgMedFFS Appeals/Downloads/appealsfactsheet 2008.pdf.

[7] Ibid.

[8] Office of Inspector General, *Medicare Administrative Appeals: ALJ Hearing Process*, OEI-04-97-00160 (Washington, DC: U.S. Department of Health and Human Services, 1999).

[9] Ibid.

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