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Medicare Appeals 101

Wednesday, April 2, 2025

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About the Center for Medicare Advocacy

The Center for Medicare Advocacy is a non-profit, non-partisan law organization founded in 1986 that works to advance health equity, access to comprehensive Medicare, and quality health care. Based in Connecticut and Washington DC with additional attorneys in California, Maryland, Massachusetts, and Wisconsin.

- Attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic Change - Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

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Agenda

- Overview
- Traditional Medicare Appeals
- Medicare Advantage Appeals
- Part D Appeals
- Appeal Tips, including ALJ Hearings
- New Observation Status Appeals
- Q&A

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Overview

Overview

- Informal or other resolution of problems v. appeals
  - See, e.g., "The Medicare Complaints Process" Urban Institute (Sept. 2024)
- Medicare Advantage and Part D – difference between appeals and grievances
- "**Standard**" appeals vs. "**Expedited**" appeals in certain situations
- Appeal rights often triggered by an **Initial Decision**
  - Traditional Medicare: Initial Determination as shown on your Medicare Summary Notice (MSN)
  - MA – Organization Determination
  - Part D – Coverage Determination

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5 Step Administrative Appeals Process

- 1st level – Redetermination
  - MA – Reconsideration by plan; Part D – Redetermination by plan
- 2nd level – Reconsideration
  - MA and Part D – Independent Review Entity (IRE)
- 3rd level - Administrative Law Judge Hearing ($190 AIC, 2025)
- 4th level (last administrative appeal) – Departmental Appeals Board (aka Medicare Appeals Council)
- 5th level - Federal Court ($1,900 AIC, 2025)

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IRMAA Appeals

- **Income-related monthly adjustment amount (IRMAA)** applies to Part B (since 2007) and D (since 2011) premiums for higher income individuals
- SSA determines IRMAA amounts using individual federal income tax data from the IRS, applicable to individuals with federal modified adjusted gross taxable income (MAGI) over the threshold amounts
- Can request a **new initial determination** due to **life changing events** (that cause a significant reduction in MAGI) to use a more recent tax year:
- Medicare Rights Center resources:
  - Guide: “How to Appeal a Higher Part B or Part D Premium”: https://www.medicareinteractive.org/get-answers/medicare-denials-and-appeals/premium-appeals/appealing-a-higher-part-b-or-part-d-premium-irmaa
  - Also see: https://go.medicareinteractive.org/how-to-appeal-higher-part-b-or-d-premiums/

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HHS Cuts and Reorganization

- HHS Fact Sheet (3/27): agency reorganization includes: “HHS will have a new Assistant Secretary for Enforcement to provide oversight of the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeal (OMHA), and the Office for Civil Rights (OCR) to combat waste, fraud, and abuse.”
- *Politico* (3/28) – CMS staff cuts include 200 from the Office of Program Operations and Local Engagement which “ensures Medicare health plans and providers are in compliance with CMS requirements and helps manage case work for Medicare Advantage and Affordable Care Act marketplace patients.”

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Appeals Resources

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- Self-help materials: https://medicareadvocacy.org/take-action/self-help-packets-for-medicare-appeals/
- Also see National Center on Law and Elder Rights (NCLER): https://ncler.acl.gov/medicare#gsc.tab=0

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Traditional Medicare Appeals (Parts A and B)

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What Can Be Appealed?

- A provider's decision to terminate Medicare covered hospital, home health, skilled nursing facility, hospice, or comprehensive outpatient rehab facility care
  - Referred to as an expedited appeal
- Medicare's decision not to pay for an item or service (e.g., durable medical equipment, outpatient rehabilitation therapy, skilled nursing facility care, ambulance service, etc.)
  - Referred to as a standard appeal

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Standard vs. Expedited Appeals

- Two distinct processes with distinct remedies:
- Expedited Appeals
  - As implied, expedited appeals are processed more quickly.
  - A favorable decision overturns the provider's decision to terminate coverage.
- Standard appeals
  - Can take months (or longer) to get a favorable decision
  - A favorable decision results in coverage and payment.

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Expedited Appeals

- Two expedited processes based on setting:
  - **Hospital**
    - 42 C.F.R. §§ 405.1205 – 405.1208
  - **SNF, Home Health, Hospice, and Comprehensive Outpatient Rehab Facility**
    - 42 C.F.R. §§ 405.1200 - 405.1204

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Expedited Hospital Appeals

- How to know the hospital is terminating coverage?
  - An “Important Message from Medicare”
    - See The Medicare Claims Processing Manual, Chapter 30 §§ 200 – 220.5
- How to initiate the appeal?
  - Call the appeals contractor – the BFCC-QIO (Beneficiary and Family Centered Care – Quality Improvement Organization).
  - Their phone number is on the IM.

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Expedited Hospital Appeals Timeline

- The beneficiary must receive the IM within 2 days of admission the hospital and again within 2 days of discharge.
- The beneficiary must contact the BFCC-QIO by midnight of the day of discharge.
  - Requesting BFCC-QIO review obligates the hospital to provide the beneficiary with a more detailed explanation for coverage termination.
- The BBFCC-QIO must issue a decision within 1 calendar day of the request.
- If the BFCC-QIO decision is unfavorable, financial liability begins to accrue.

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Expedited Hospital Appeals Timeline (Cont'd)

- A beneficiary can appeal an unfavorable BFCC-QIO decision to another appeal contractor – the QIC (Qualified Independent Contractor).
- The beneficiary must call the QIC no later than noon of the calendar day following notification of the unfavorable decision.
- The QIC must issue a decision within 72 hours of a reconsideration request.
- If the QIC decision is unfavorable, the beneficiary can request a hearing before an Administrative Law Judge (which will likely be scheduled weeks out).

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Other Expedited Appeals

- SNF, Home Health, Hospice, and CORF appeals
- How to know a provider is terminating coverage?
  - A “Notice of Medicare Non-Coverage”
    - See The Medicare Claims Processing Manual, Chapter 30 §§ 260 – 300.5
- How to initiate the appeal?
  - Call the appeals contractor – the QIO (Quality Improvement Organization).
  - Their phone number is on the NOMNC.

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Other Expedited Appeals Timeline

- The beneficiary must receive the NOMNC at least 2 calendar days before termination of Medicare covered services
- The beneficiary must contact the QIO by noon of the day before the effective date on the NOMNC.
  - Requesting QIO review obligates the provider to provide the beneficiary with a more detailed explanation for coverage termination.
- The QIO must issue a decision within 72 hours.
- If the QIO decision is unfavorable, financial liability begins to accrue.

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Other Expedited Appeals Timeline (Cont'd)

- A beneficiary can appeal an unfavorable QIO decision to another appeal contractor – the IRE (Independent Review Entity).
- The beneficiary must call the IRE no later than noon of the calendar day following notification of the unfavorable decision.
- The IRE must issue a decision within 72 hours of a reconsideration request.
  - A beneficiary who requests IRE review may request an extension of the 72-hour timeframe (not to exceed 14 days) so that additional evidence can be submitted.
- If the IRE decision is unfavorable, the beneficiary can request a hearing before an Administrative Law Judge (which will likely be scheduled weeks out).

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Expedited Appeals Considerations

- Is it worth requesting an ALJ hearing?
  - Relevant regulations and policy manual provisions do not give ALJs the authority to order coverage and payment on appeals of an IM or NOMNC.
- What if a provider fails to issue an IM or NOMNC on time?
  - The beneficiary should appeal as soon as they receive an untimely notice and request a waiver of liability.
- What if a provider gives the IM or NOMNC to a beneficiary who is incapacitated?
  - A representative should immediately advocate directly with the provider, requesting that a new notice be issued, and alert the BFCC-QIO or QIO.

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Standard Appeals

- Appealing to obtain coverage and payment
- If a beneficiary receives any item or service coverable under Part A or B—from durable medical equipment to a hospital stay to outpatient rehabilitation therapy—and Medicare refuses to pay, the beneficiary can appeal.
- A provider submitting a bill to Medicare for the item or service is the first step.
- 42 C.F.R. §§ 405.800 – 405.1140.
- In rare circumstances, prior authorization may have been required (certain DME, certain ambulance transport, certain physician services).

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ABNs and Demand Billing

- In certain situations, providers are obligated to notify beneficiaries in advance of furnishing an item or service when they believe that the item or service will likely be denied by Medicare. An Advance Beneficiary Notice is the Medicare-approved form.
  - See Medicare Claims Processing Manual, Chapter 30 §§ 50 – 80.
  - SNFs and home health agencies commonly issue ABNs.
- When the beneficiary receives the ABN, they may elect to: (1) receive the item or service and have the provider bill Medicare; (2) receive the item or service, agreeing the provider won't bill Medicare; (3) decline the item or service.

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Medicare Summary Notices

- Quarterly statement of benefits.
- A provider submitting a bill to Medicare is the first step towards a standard appeal. Receipt of an MSN with denied claims is the second step.
- Non-covered items or services will be listed on MSNs with a denial reason.
  - Denial codes can be searched using the CMS coverage database.
- MSNs provide directions on how to appeal denied claims.

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Standard Appeals Timeline

- 120 days from the date of an unfavorable MSN to request redetermination from the Medicare Administrative Contractor (MAC)
- 180 days from the date of an unfavorable MAC decision to request reconsideration from the Qualified Independent Contractor (QIC)
- 60 days from the date of an unfavorable QIC decision to request an Administrative Law Judge (ALJ) hearing
- 60 days from the date of an unfavorable ALJ decision to request review by the Medicare Appeals Council
- 60 days from the date of an unfavorable Council decision to request judicial review

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Standard Appeals Considerations

- What if a provider refuses to bill Medicare?
  - In general, unless it's an opt-out provider, they have an obligation.
  - Call 1-800-MEDICARE. They can assist you in filing a claim yourself.
- What if a provider fails to provide an ABN?
  - An ABN is not always required. To determine if one was required, search through the Medicare Claims Processing Manual, Chapter 30.
  - If an ABN was required, and the provider failed to provide it, misled the beneficiary, or failed to provide it on time, they may be found liable on appeal.

Decisions Types

- Dismissal
  - There was some sort of procedural issue identified by the adjudicator.
  - Generally, parties have the right to request reopening.
- Favorable or Unfavorable
- Partially Favorable (or Partially Unfavorable)
  - Appellant can continue to seek a fully favorable decision.
- Waiver of Liability
  - See Medicare Claims Processing Manual, Chapter 30.

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The MAC and Federal Court

- The Medicare Appeals Council
  - Like a state or federal appellate adjudicator in that cases are primarily decided based on briefs submitted by the parties
  - Unlike a state or federal appellate adjudicator in that the review is de novo
- 42 C.F.R. §§ 405.1100 – 405.1140

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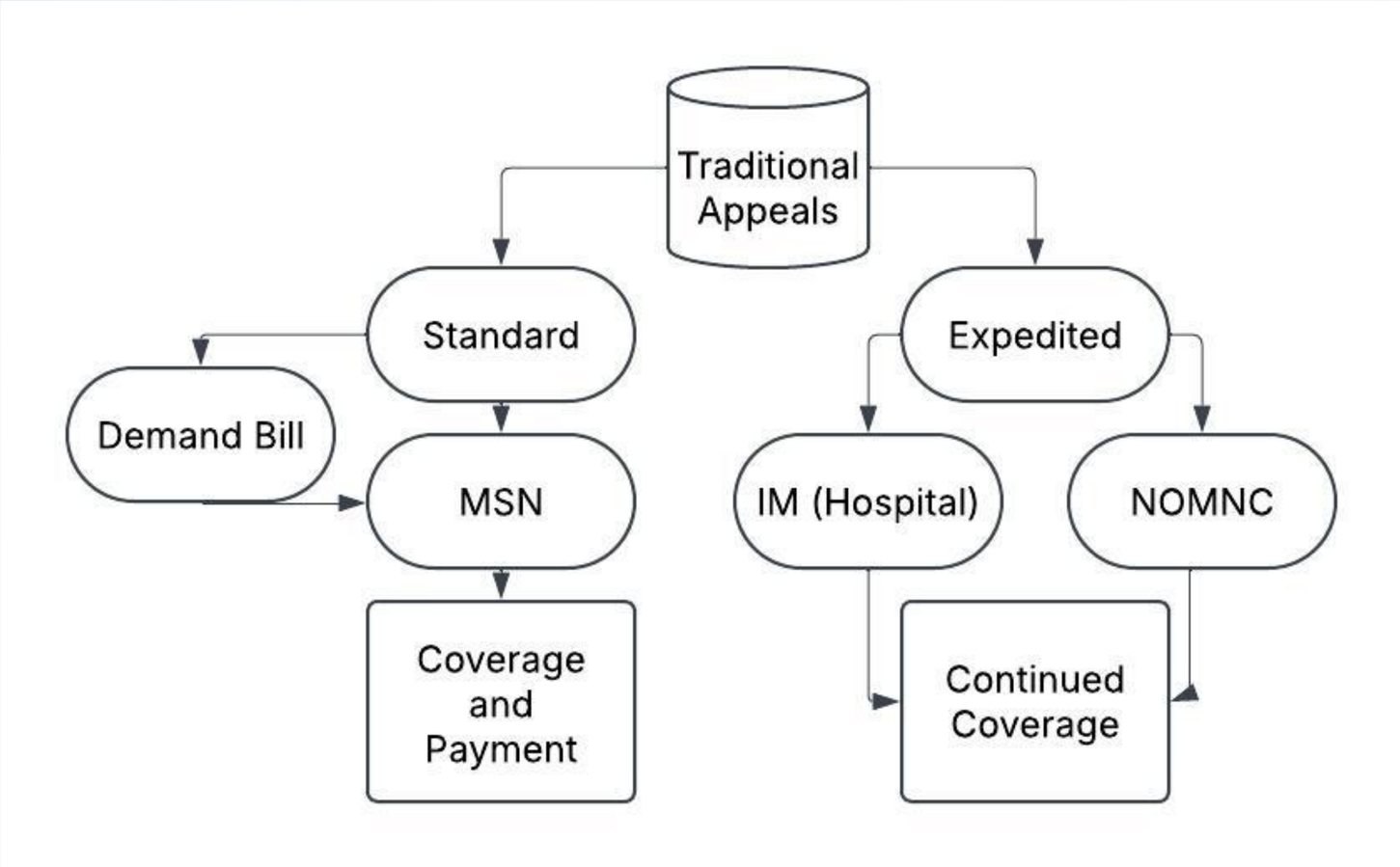
Traditional Medicare Appeals Review



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Medicare Advantage Appeals

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Appeals v. Grievances

- **Appeal**
  - Benefits to which enrollee is entitled under the MA plan, including such things as basic benefits, mandatory and optional supplemental benefits, and the amount, if any, a beneficiary is to pay – 42 C.F.R. §422.566
- **Grievance**
  - Any complaint/dispute expressing dissatisfaction with any aspect of an MA organization or provider's operations, activities, or behavior, regardless of whether remedial action is requested, 42 C.F.R. § 422.561
    - **May be filed either orally or in writing**; Must be filed no later than 60 days after the event or incident giving rise to the grievance; generally, MA plan must respond no later than 30 days after date grievance is received

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Prior Authorization

- Nearly all MA enrollees (99%) are in plans that use PA for some services - most often required for relatively expensive services, such as Part B drugs, skilled nursing facility stays, and inpatient hospital stays (KFF, Jan. 2025)
  - Only 11.7% of denials appealed in 2023, of those 81.7% were partially or fully overturned
- HHS OIG (2022): among sample of 2019 denials, found 13% of prior auth denials met Medicare coverage rules
- Plans' increased use of AI or algorithmic decision-making tools have seemingly led to more frequent and repeated denials in certain settings, such as SNF, HH (see, e.g., *STAT News* articles)

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Medicare Advantage Rules

- MA plans must provide benefits currently available under Parts A and B (except for hospice) and Part D (if they offer such coverage)
- Recent CMS efforts to rein in prior authorization – see CMA Special Report (May2023) includes:
  - Coverage criteria clearly established – plans cannot use external criteria (including inpatient admissions, SNF, HH, Inpatient Rehab Facilities (IRFs)
  - Coverage criteria not clearly established – plans can use "widely used treatment guidelines or clinical literature" which must be made publicly available
    - §422.101(b)(6)(i)(A) states: "The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services."

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Medicare Advantage – Expedited Appeals – Part A Settings

- Part A Care Settings: Hospital, Skilled Nursing Facility (SNF), Home Health (HH), Hospice and Comprehensive Outpatient Rehabilitation Facility (CORF)
- MA Plan members have the right to file an expedited appeal with the Beneficiary and Family Centered Care – Quality Improvement Organizations (BFCC-QIOs = Kepro, Livanta) 42 C.F.R. §§ 422.620 – 422.626
- Remember: This is an appeal of the decision to terminate coverage, not an appeal for payment of subsequent services!
- See https://medicareadvocacy.org/expedited-v-standard-medicare-appeals-not-knowing-the-difference-could-cost-you-your-appeal-rights/

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Medicare Advantage – Pre-Service and Standard Appeals

- An enrollee has the right to ask their MA plan to provide or pay for items or services they think should be covered, provided, or continued. This is called an **Organization Determination** and can be requested in advance to make sure that the services are covered or after payment of the service is denied. Unless it involves a request for payment, request may be made orally or in writing, 42 C.F.R. § 422.566
- Plan must issue an Organization Determination as follows:
    - 72 hours for expedited request
    - 14 days for standard service request (7 days in 2026)
    - 60 days for payment request

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Medicare Advantage – Pre-Service and Standard Appeals

- **Expedited Organization Determination** may be requested by the enrollee or physician and will be granted if applying standard decision procedures could "seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function."
- Appeal tip: If expedited request is made by a doctor plan must treat as expedited. Have doctor submit something orally or in writing to support request for expedited decision.

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Resources

- **Grievances, Organization Determinations and Appeals**
  - 42 C.F.R. § § 422.560 – 422.626 (See also, 42 C.F.R. § 405 – Administrative Review and Hearings)
- **Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance** (also see Appeal Flowchart)
  - https://www.cms.gov/medicare/appeals-grievances/managed-care

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Part D Appeals

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Part D Appeals Vs. Grievances

Both Are Types Of Complaints

Plan Decides Whether A Complaint Is An Appeal Or A Grievance

Plans Must Have Processes For Both

Appeal

- When drug is denied for any reason
- Multi-step legal process
- Strict adherence timelines
- May take years at higher levels of appeal
- Only process for a formal, legally binding determination on coverage

Grievance

- Other types of complaints, not denial of a drug
- Poor customer service, wrong cost-sharing, mail order delays & other issues
- Formal customer service compliant process, but does not normally result in binding coverage determination
- Call 1-800-Medicare, or your state's SHIP program

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Exception Requests

For Medically Necessary Prescriptions

- Appeal process is used to challenge plan's decision to deny a drug, e.g., thru Prior Authorization, Quantity Limits or Step Therapy requirements, or to lower the co-payment costs for a drug.
- Prior to appeal, must first ask the plan for an "exception" to the denial
- Must get the plan's decision in writing. (Pharmacy's "say-so" is no good)
- The plan's written denial decision is called a "coverage determination" or "organization determination."

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Formulary versus Tier Exceptions

“My drug isn’t covered by my plan!”

Formulary Exceptions:

- Cover non-formulary drug, *or*
- To waive the plan’s utilization management tools: prior authorization, quantity limit, or step-therapy
- Must have prescriber supporting statement
- If non-formulary drug is approved:
  - Must be covered at least through the end of the plan year

“My drug co-pay is too expensive!”

Tier Exceptions:

- Lower cost sharing
- A tier exception should be requested to obtain a non-preferred drug at the lower cost-sharing terms applicable to drugs in a preferred tier.
- Must have a prescriber supporting statement
- Read the EOC sections on tier exceptions. No tier exceptions allowed for high cost or unique drugs if the plan has exempted a formulary tier (e.g., Tier 4 or 5)

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Advice for Advocates: “Request and Research”

- Request: prescribing physician’s relevant medical records, including visit notes, Prior Authorization requests, any relevant medical history or health issues, and any previous Rx “failures”
- Research:
  - The drug(s) at issue for the beneficiary.
  - The drug plan’s EOC and Drug Formulary. Rules for formulary, tiers, how exceptions are granted, and any utilization management requirements for the drug(s) at issue.
  - The prescribing physician’s related medical records—then obtain the required written Physician Statement.
  - The Plan’s forms for requesting an exception and CMS guidelines on Rx drug coverage appeals.
- Draft and Submit with Exception Request: concise written statement about why the exception should be approved per the physician’s opinion, the rules in the EOC, and any other relevant law.

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Physician Statement- Formulary Exceptions

- Prescriber's supporting statement must indicate that the non-formulary drug is necessary for treating the patient's condition because:
  - All covered Part D drugs on any tier would not be as effective or would have adverse effects;
  - The number of doses under a dose restriction has been or is likely to be less effective; or
  - The alternative(s) listed on the formulary or required to be used in accordance with step therapy has been or is likely to be less effective or have adverse effects.
- In summary: "Not as effective or will have adverse effects"

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Physician Statement - Tiering Exceptions

- The prescriber's supporting statement must indicate that the preferred drug(s) would
  - Not be as effective as the requested drug for treating the enrollee's condition, and/or
  - The preferred drug(s) would have adverse effects for the enrollee.
- In summary: “Not as effective or will have adverse effects.”

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Transitional Supply During an Appeal

- Normally, Plan is not required to provide supply of drugs while exception or appeal is being pursued.
- When drug coverage begins, beneficiary may get a transition fill: a one-time, 30-day supply of a drug being taking the Plan either doesn't cover or requires prior authorization/step therapy.
- "Practical solution" while legal solution is pending—beneficiary should investigate: Cost Plus Drugs, GoodRx, drug manufacturer patient access programs, other coupon cards or programs.

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If the Exception is Granted…

- If granted, the formulary or tier exception will stay in effect until the end of the calendar year. Plan should retroactively apply tier exception.
- Plan may, but is not required to, renew the exception if remaining in the plan the following year
- The drug will be treated as a high tier formulary drug for purposes of cost sharing. Read EOC for details.

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If the Exception is Denied, Start the Part D Appeals Process

STEP 1 Redetermination = Drug Plan's review of their own coverage decision

– Appeals must be requested within 60 days of coverage determination

STEP 2 Reconsideration = Independent Review Entity (IRE) review of the Plan's decision

– Appeals must be requested within 60 days of Plan's drug coverage redetermination

STEP 3 Hearing by Administrative Law Judge (ALJ)

– Appeals must be requested within 60 days of IRE reconsideration.

– Telephone hearing

STEP 4 Council Review - Case review by Medicare Appeals Council

– Appeals must be requested within 60 days of adverse ALJ decision

STEP 5 Federal Court Review - Case reviewed by a Federal judge. May be multiple levels of Federal Court Review.

*Appeals must be requested within 60 days of coverage determination

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Enforcement of Favorable Decisions

- OMHA (and other levels of appeal) do not enforce their own decisions.
- OMHA manual's advice for beneficiaries experiencing issues with decision enforcement: "Beneficiaries should contact 1-800-MEDICARE (1-800-633-4227) for the status of, or questions about, effectuation."
- In my practice: calls to customer service, demand letters, contact CMS Regional Office, and filing grievances with the Plan.
- Part D is the only area where I've run into issues around enforcement. Not clear why.

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Part D Appeals Resources:

– **CMS Guidelines for Part D Appeals**: Not binding on ALJs but must be given "substantial deference" per 42 C.F.R. § 423.2062.

  • Part D Guidelines: "Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance." Link here.

– **Part D Regulations**: 42 C.F.R. § 423 ("Voluntary Medicare Prescription Drug Benefit"). Binding on ALJs per 42 C.F.R. § 423.2063(a). Link to eCFR here.

– **Beneficiary's Drug Plan Formulary, EOC, and Exception Request Forms**. Available online or call the plan's customer service line.

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Appeal Tips

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General Appeal Guidelines

- Keep an eye on deadlines
  - At each level of appeal, you should receive instructions on how to move to the next level of appeal. Follow directions and keep copies. Failure to do this could cause delays in your appeal.
  - Appeal forms should accompany all appeal decisions.
  - There are good cause exceptions for a late appeal request but no guarantee a good cause request for late appeal will be granted

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Build Your Case

- Read decisions carefully to understand why claim was denied
- Gather all medical records relevant to your care
- Construct a narrative including a medical argument as to why services were medically reasonable and necessary and send with appeal requests
- Enlist assistance from community physician
- Collect and submit supporting medical research
- Familiarize yourself with the applicable rules – regulations, policy (including National Coverage Determinations and Local Coverage Determinations)
  - See Medicare coverage database. https://www.cms.gov/medicare-coverage-database/

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Preparing for an ALJ Hearing

- Review Notice of Hearing closely regarding issues to be addressed, time and place of hearing, how hearing will be conducted, name of ALJ assigned to your appeal, name and contact information for the ALJ's legal assistant
  - If beneficiary appeal request VTC hearing
  - Correct errors in Notice of Hearing
  - Can object to time and place of hearing
- Request a copy of the exhibit list and OMHA case file (administrative record). Cite law if necessary, 42 C.F.R. § 405.1042(a)(3)
- Supplement case file prior to the hearing – statement of support from attending physician, additional medical records, and written argument in support of coverage

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Arguing a Case in Front of an ALJ

- The hearing while formal, is not the same as court
  - Procedures more relaxed, rules of evidence do not apply
- Make sure any additional evidence or documentation you sent is included in the administrative record and the exhibit list
- Cite regulation and policy. For any appeal, you need to know the law for the kind of appeal and kind of coverage sought – regulations, policy, NCDs, LCDs, etc. Should also know the rules regarding Financial Liability Protections (Notices). Don't be afraid to object if another party misstates the law or facts or doesn't send you written materials.
- With only very few exceptions, MA plans must cover or make payment for all services that are covered by Part A and Part B of Medicare. Don't accept anything less! 42 C.F.R. § 422.101.

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Arguing a Case in Front of an ALJ (Cont'd)

- Each party will be given the opportunity to make their case:
  - Oral argument
  - Have client or family member testify
  - Medical experts
- Assume nothing. Present argument in a way that's most helpful for the ALJ to understand the person's condition, diagnosis and need for the item or services you are arguing for
- Use medical experts, medical texts and other medical research
- Be prepared to address MA plan's medical director
- Cross-examine any other parties arguing against you
- Be prepared to combat false information

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Getting a Timely Decision

- If you don’t get decisions in a timely manner call 1-800 Medicare or your Medicare Advantage plan
- OMHA instructs that if you are a beneficiary filing an appeal, you should include the following as part of the address:
  - “Attn: Beneficiary Mail Stop”
- Toll Free OMHA Beneficiary Help Line (844) 419-3358

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Most Important Appeal Tip

- Don’t give up! Very little coverage is granted prior to the ALJ hearing level of review.
- See CMA ALJ Hearing Tips: https://medicareadvocacy.org/advocacy-tips-how-to-prepare-for-medicare-administrative-law-judge-alj-hearing/

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Resources

- Office of Medicare Hearings and Appeals:
  - https://www.hhs.gov/about/agencies/omha/index.html
- Office of Medicare Hearings and Appeals Case Processing Manual setting forth day-to-day procedures for carrying out adjudicative functions:
  - https://www.hhs.gov/about/agencies/omha/the-appeals-process/case-processing-manual/index.html

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Observation Status Appeals

42 C.F.R. §§ 405.1210 through 405.1212

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The Problem

- Medicare requires 3-day **inpatient** (Part A) hospitalization for a covered nursing home stay. Note: the 3 days does not include day of discharge.
- Time in "outpatient observation status" (Part B) is not counted toward the 3 days.
  - 1 day (inpatient) + 2 days (observation) ≠ 3 days. **No nursing home coverage**.
  - 2 days (inpatient) + 3 days (observation) ≠ 3 days. **No nursing home coverage**.
- Also, someone not enrolled in Part B may owe full "sticker price" for **hospital** stay.
- Medicare did not allow appeals of patient status.
  - Pay thousands or go without care.

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The Lawsuit

- CMA filed class action in November 2011. Co-counsel Justice in Aging and Wilson Sonsini Goodrich & Rosati. Challenged Medicare's failure to allow patients to appeal observation status classification.
- **Decision**: Class members who are **reclassified** from inpatient to observation while in hospital (among other criteria) are constitutionally entitled to due process.
- **Order:** Create appeals process for class members who were harmed in the past (retrospective), and expedited appeals for class members going forward (prospective).

Alexander v. Azar, 613 F. Supp. 3d 559 (D. Conn. 2020), *aff'd sub nom. Barrows v. Becerra*, 24 F. 4th 116 (2d Cir. 2022)

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Prospective Appeals

- Appeals process became operational on **February 14, 2025**
- For **eligible** Medicare beneficiaries who wish to appeal reclassification from inpatient to observation
- Can be requested before leaving the hospital so that, if they win, they may be able to qualify for post-hospital nursing home coverage
- Expedited **and** standard appeals available

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Who is Eligible For Prospective Appeal Rights?

A person enrolled in **Traditional Medicare** (not Medicare Advantage) who is admitted as an inpatient, but later reclassified as an “outpatient receiving observation services”

And Either

Spent at least 3 consecutive days in the hospital (not counting day of discharge) but fewer than 3 days as an inpatient.

* since they would be disqualified from covered stay in nursing home*

Or

Is not enrolled in Part B during the hospitalization

since they could be financially liable for entire hospital bill

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Hospitals Must Issue Notice of Appeal Rights to Eligible Patients

- New: **Medicare Change of Status Notice (MCSN)**

  Standardized notice informs of status change to “outpatient on observation” **and**

  - Hospital stay will be billed to Medicare Part B instead of Part A
  - Could impact their hospital bill – Part B 20% copay for items and services could be higher or lower than Part A inpatient deductible **TIP:** check with the billing department
  - Patient without Part B will be charged full cost of hospital stay
  - Medicare will not pay for skilled nursing home stay
  - **Appeal Rights**, how to appeal to the QIO (Appeal Contractor)

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How Do Eligible Patients Appeal?

- **Expedited determination request:** made in writing or by phone to QIO *before leaving hospital*

QIO (appeal contractor) must:

a) examine medical & other records

b) ask for views of beneficiary (or representative), and hospital's explanation

c) issue decision **within 1 calendar day** of receiving all requested pertinent information from hospital

d) notify patient, hospital & nursing home (if applicable) of decision by phone, followed by a written notice with rationale, payment consequences, & beneficiary's right to expedited reconsideration.

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How Do Eligible Patients Appeal? (Cont'd)

- **Expedited <u>Reconsideration</u> Request:** made in writing or by phone before noon of day following initial notification of QIO's decision.

QIO (appeal contractor) must

a) offer eligible beneficiary & hospital an opportunity to provide further information

b) issue reconsideration decision **within 2 calendar days** of receiving information

c) notify patient, hospital & nursing home (if applicable) by phone, followed by a written notice explaining rationale, payment consequences, & beneficiary's right to ALJ hearing

<u>Note</u>: No financial liability protection during expedited appeals.

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How Do Eligible Patients Appeal? (Cont'd)

- **Standard or "untimely" appeal request to QIO:** can be made at ***any time***

  Note: After the reconsideration level, observation status appeals follow the time frames for standard Medicare appeals at the next three levels of review: ALJ, MAC (Appeals Council), and Judicial Review.

- **If successful,** Medicare Part A will cover the inpatient hospital stay and patient may qualify for covered nursing facility stay.

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Who Can Help With Prospective Appeals?

- You can appoint trusted family/friend, caregiver, advocate, lawyer, or someone else, as a representative: FORM or online. (tip: submit form with each request and level of appeal)
- Some people are already authorized: rep payee, guardian, power of att'y (include docs.)
- The hospital/nursing home **cannot *represent*** the patient in the appeal, but **can *help*** patients navigate the process, provide info, records.
- Upon request, hospital must furnish copy of, or access to, any documentation it has sent to the QIO, including written records of information provided by phone. Due by close of business of next calendar day. May charge a reasonable amount.

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Medicare Criteria for Inpatient Hospital Coverage

- **Doctor's order:** Hospital must formally admit patient after a doctor orders inpatient care to treat their illness or injury
- **Two Midnight Rule:**
  - Was there a *reasonable expectation at time of doctor's inpatient admission order* that you needed medically necessary hospital care crossing at least 2 midnights?
  - Factors considered can include medical history, medical needs, severity of signs and symptoms, medical predictability of adverse event.

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Retrospective Appeals Process

- **Who May Appeal?**
  - Traditional Medicare beneficiary who was **reclassified** from inpatient to observation status during **January 1, 2009 – February 13, 2025**; **And**
  - Received a **notice** showing hospital not covered by Part A (either a "Medicare Summary Notice" [MSN] or a "Medicare Outpatient Observation Notice" [MOON]); **And**
  - **Either**:
    - Stayed in hospital **at least 3 days, but inpatient fewer than three days**, **and was admitted to a nursing home within 30 days** after leaving hospital.
  - **Or**:
    - **Was not enrolled in Part B** at time of hospitalization.

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Retrospective Appeals

- **How?** Submit a request to the "Eligibility Contractor" – Q2 Administrators
  - **FORM**: "Request Form for Retrospective Appeal of Medicare Part A Coverage"

    Or:

  - Follow instructions listed on Medicare website (CMS.gov). Lists information to include.
  - Can be mailed or faxed, instructions on form and on website.
- **By When? January 2, 2026** (but possible exceptions for "good cause" late filing)

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Additional Resources

- Observation Status Appeal Resource Page.
  - Recorded webinar
  - CMS instructions and forms
- Expedited Appeals Flowchart
- Retrospective Appeals Flowchart

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Questions and Discussion

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