

# SHIBA



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Senior

Health

Insurance

Benefits

Assistance

## Section 6

# Medicare Appeals

# Section 6, Medicare Appeals Procedures

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# Appeal Information 2009

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Appeal Minimum Monetary Amounts in Dispute	
Level	Amount
One	None
Two	None
Three	\$120
Four	None
Five	\$1,220

## **Level Two Appeal Quality Improvement Contractors for Oregon**

Part A & Part B: First Coast Service Operations, Inc.  
Durable Medical Equipment: RiverTrust Solutions, Inc.

## **Part A Quality Improvement Organization (QIO)**

**Acumentra Health**  
2020 SW Fourth Ave., Suite 520  
Portland, OR 97201

**Beneficiary hotline:**  
1-800-633-4227 (1-800-MEDICARE)  
1-800-344-4354 (Toll Free)  
503-279-0100 (Local)  
503-279-0190 (Fax)

**Online information:**  
[Acumentra.org](http://Acumentra.org)  
[communications@acumentra.org](mailto:communications@acumentra.org)

# Part A and Part B Appeal Processes

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All beneficiaries have the right to appeal any decision concerning covered services in the Medicare program. All Medicare Summary Notices (MSNs) have current appeal procedures on the reverse side. Please refer to the MSN's **“Important Deadlines and Procedures.”**

## Medicare Eligibility Denials

The Social Security Administration determines Medicare eligibility and notifies applicants of their Initial Determination if they are ineligible.

For a successful appeal, they must submit evidence of one of the following:

- ◆ That they turned 65 years old
- ◆ That they or their spouse earned enough payroll quarters of coverage

The appeals timetable is strict. All appeals must be signed and in writing. Proper forms are available from the Social Security office.

## Medicare Service Denials – Initial Determination

A beneficiary may get a medical item or service and afterwards receive information in a Medicare Summary Notice (MSN) that Medicare is refusing to pay for it. This first denial of payment is an Initial Determination or a Notice of Non-Coverage. The beneficiary may contest, or appeal, this rejection of the payment. If the notice is not in writing, a written denial needs to be requested. See appendix for MSN examples.

At each step of the appeals process, further appeal rights will be clearly stated on Determinations. Beneficiaries need to keep all Determinations received from the Medicare contractor (including envelopes for their postmarks). Beneficiaries or their representatives should refer to the most current documents when proceeding with the appeal.

# The Five Standard Levels of Appeal

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## **First Level of Appeal: Redetermination**

Steps for sending the Initial Determination notice and any Qualified Improvement Organization (QIO) decisions to Medicare:

1. Send the notice to the Fiscal Intermediary, carrier, or Medicare Administrative Contractor (MAC).
2. Write “Please review” on the notice.
3. Circle the item that is in dispute.
4. Explain why the beneficiary disagrees with the decision or payment amount.
5. Sign and provide the beneficiary’s (or the representative’s) telephone number(s).
6. Include any additional medical records that support the case.
7. Send a copy of the notice to the address in the “Customer Service Information” box.

**Part B review requests can be made by telephoning the Customer Service number on the Medicare Summary Notice (MSN).**

Further information on redeterminations:

- ◆ An appeal must be filed with the intermediary or carrier within 120 days of receiving the Initial Claim Determination.
- ◆ The Fiscal Intermediary, carrier, or MACs must make their decision within 60 days of the request.
- ◆ An expedited appeal process can occur after a Notice of Discharge or Service Termination. In this case:
  - The request must be filed by noon the next calendar day.
  - The QIO has 72 hours to make a decision.

## **Second Level of Appeal: Reconsideration Hearing**

Reconsideration can be requested if the beneficiary disagrees with the Redetermination decision. A Medicare-appointed Quality Improvement Contractor (QIC) will determine whether the decision followed guidelines. Specifics on the second level of appeal are as follows:

- ◆ The appeal must be filed within 180 days from the date of the redetermination.
- ◆ The beneficiary must follow the instructions on his or her Medicare Redetermination Notice (MRN).
- ◆ The QIC has 60 days to make a decision.
- ◆ If it is an expedited appeal:
  - It must be filed by noon the next calendar day after the redetermination denial.
  - The QIC has 72 hours to make a decision.

## **Third Level of Appeal: Administrative Law Judge**

Beneficiaries may appeal to an Administrative Law Judge (ALJ) if they disagree with the QIC's redetermination decision. The ALJ hearing request must be sent to the QIC, who will forward it to the Office of Medicare Hearings and Appeals of the Department of Health and Human Services (HHS). Specifics on this level of appeal are as follows:

- ◆ The appeal must be filed within 60 days from date of the QIC's decision.
- ◆ A minimum amount must remain in dispute, see table on page 3 for this year's amount.
- ◆ The ALJ has 90 days to make a decision.

## **Fourth Level of Appeal: Medicare Appeals Council (MAC)**

If the beneficiary disagrees with the decision of the ALJ, an appeal to the MAC can be requested. There are no requirements regarding the amount of money in controversy. Specifics are as follows:

- ◆ The request for a MAC review must be submitted within 60 days of the ALJ's decision.
- ◆ The MAC has 90 days to make a decision.
- ◆ If appeals reach this point, it is suggested that the beneficiary retain legal assistance.

## **Fifth Level of Appeal: Judicial Review in US District Court**

To appeal to Federal Court, a minimum amount must remain in dispute following the MAC's decision, see table on page 3 for this year's amount.

The request must be made within 60 days of receipt of the MAC's decision.

***For more information about the appeals process go to:  
[www.cms.hhs.gov/OrgMedFFSAppeals/](http://www.cms.hhs.gov/OrgMedFFSAppeals/)***

# Hospital And Other Part A and Part B Appeals

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## Pre-Admission Appeals

To receive a prompt review of a hospital Pre-Admission Notice of Denial, **the Quality Improvement Organization (QIO) should be *phoned* as quickly as possible.** The QIO will then have three working days to respond to the request.

If the request is not phoned in promptly, the beneficiary may still write to ask for QIO review up to 30 days after receiving the hospital Admission Denial Notice. In that case, the QIO will have 30 days after receipt of the written request to issue its response.

The QIO review decision will advise of further reconsideration rights and the time periods involved.



**Example:** Margaret wants to be admitted to the hospital the night before her surgery. Since Medicare will only pay for the hospital stay the day of the surgery, she would have to appeal the pre-admission denial.

## Advance Beneficiary Notices

If health care providers or suppliers think Medicare won't pay for an item or service, they will supply a written notice called an Advance Beneficiary Notice (ABN). The ABN explains what items or services Medicare *probably* won't pay for, the reasons why Medicare won't pay, and gives an estimate of costs. The ABN informs beneficiaries that they or their insurance may be responsible for payment.

In most cases, options will be explained on the ABN. The beneficiaries must choose an option. They will have to sign and date the ABN to show they understand their options. If they get the item or service and Medicare later pays for it, they will be

refunded any money they paid (except for applicable coinsurance or deductibles). By signing an ABN the beneficiary has waived any appeal rights. If the beneficiary refuses to sign the ABN the provider may refuse to perform the service or the supplier may refuse to supply the item. There are four types of ABNs:

- ◆ Advance Beneficiary Notice – General (ABN-G)
  - Used by physicians, durable medical equipment suppliers, and certain health care providers (for example, independent physical and occupational therapists, and outpatient hospitals)
- ◆ Skilled Nursing Facility Advance Beneficiary Notice (SNFABN)
  - Used only for Skilled Nursing Facility care
- ◆ Home Health Advance Beneficiary Notice (HHABN)
  - Used by home health care agencies
- ◆ Hospital-Issued Notice of Non-coverage (HINN)
  - Used for inpatient hospital care; may be received at any time before or during the hospital stay
  - This notice doesn't have options to check off like other ABNs, but still requires that the beneficiaries sign and date to show they understand their options.

## **Hospital Discharge Appeals – Initial Appeal**

A hospital may notify a beneficiary that he or she no longer needs inpatient care. A hospital Medicare patient has special protections that allow for hospital stay coverage while a denial is being determined:

- ◆ The hospital must issue a HINN.
- ◆ If the beneficiary has not received a HINN, one needs to be requested from the hospital.

If the beneficiary disagrees with the HINN and wishes to appeal the decision, the beneficiary or appointed representative must contact the QIO by noon the day after receiving the written notice of non-coverage.

The QIO will review the case and inform the beneficiary of its decision by phone or in writing. Further QIO information:

- ◆ If the doctor agreed with the HINN, the beneficiary, a family member, or a representative must request a review by noon of the next working day after receiving the notice.
- ◆ The QIO, after contacting the beneficiary to ask about his or her condition, must review the case and give a decision no later than the next full workday after getting the request.



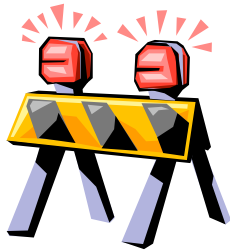
**Note:** The hospital must send the QIO all necessary medical records by the end of the day the request was made.

- ◆ *If the QIO agrees with the beneficiary*, Medicare will cover the additional costs.
- ◆ *If the QIO does **not** agree with the beneficiary* and approves the hospital notice of non-coverage, the beneficiary cannot be charged for continued services until noon of the next calendar day after receipt of the QIO's decision.
- ◆ If the beneficiary stays in the hospital after receiving a notice of non-coverage, *but misses the one-day deadline to request an immediate QIO review*, the beneficiary can still call the QIO at any time during the hospital stay and ask that it review the case.
  - The beneficiary's liability for the hospital stay would begin to be counted from the third calendar day after receipt of the original hospital notice.
- ◆ If the doctor agrees with the beneficiary, the hospital must get permission from the QIO before it issues a notice of non-coverage.
- ◆ The QIO has three (3) days to review the case.
- ◆ If the QIO agrees with the hospital, the beneficiary will receive a notice of non-coverage.
  - In this situation, the beneficiary should request reconsideration immediately.
- ◆ If the QIO decides against the beneficiary's reconsideration request as well, the beneficiary has 60 days to request a hearing before an Administrative Law Judge.

## The “Important Message From Medicare”

Hospitals must deliver a revised version of the Important Message from Medicare to inform Medicare beneficiaries who are hospital inpatients about their hospital discharge appeal rights. Notice is required both for Original Medicare beneficiaries and for those enrolled in Medicare Advantage plans. Beneficiaries who choose to appeal a discharge decision will receive a more detailed notice. To see an example of the Important Message from Medicare go to:

[www.cms.hhs.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp). It is under the Downloads section.



**Note:** If Medicare decides your care is no longer covered, you are responsible for the cost of the care you received while awaiting the decision!

## Special Situations in Home Health Care or Skilled Nursing Facilities

Home Health Care agencies and Skilled Nursing Facilities (SNFs) may mistakenly tell patients that Medicare will not cover their cost of care. They must provide a written HHABN or SFNABN to the beneficiary or their representative. The notice must state:

- ◆ The date coverage will end and why the stay is no longer covered
- ◆ The beneficiary’s right to request that the SNF send Medicare its opinion and request for Medicare to decide if the stay still qualifies for SNF coverage (this request is often called a Demand Bill)
- ◆ Where the beneficiary or representative must sign as proof of having received the notice
- ◆ If a Demand Bill is requested, the beneficiary is not required to pay for the Medicare portion of the SNF stay until informed of Medicare’s decision.

To request a Demand Bill, the beneficiary or representative must check the appropriate box on the SNFABN form that indicates the beneficiary's wishes. The beneficiary is still responsible for any costs that would normally be charged while the demand bill is being processed. Medicare will notify the SNF of its decision. If the beneficiary or representative still does not agree with the decision of non-coverage, they can file an appeal through the normal appeal processes.

## **Part A and Part B Waiver of Liability**

When a Medicare claim is disallowed, beneficiaries may be responsible for paying providers for services rendered. However, in some cases, beneficiaries may have received services without knowing Medicare would not pay for them. A waiver of liability applies in situations in which beneficiaries did not know or could not have been expected to know that Medicare did not cover services they received.

The following conditions must exist for the beneficiary to receive a waiver of liability:

- ◆ A claim must have been disallowed on grounds that service was not reasonable or necessary for diagnosis or treatment of an illness or injury, or that expenses were for custodial care.
- ◆ The institution (hospital, nursing home, or home health agency) must be Medicare-certified.
- ◆ The beneficiary must be without fault and must show that she or he neither knew, nor reasonably could have been expected to know, that Medicare would not cover the services.
  - This condition is met when a provider did not give an Advance Beneficiary Notice (ABN) to the beneficiary to inform him or her that Medicare probably would not cover the service.



**Example:** Harold has been admitted to a SNF and was assured by his doctor that he would be receiving skilled care and that Medicare would cover the stay. If it turns out that he doesn't receive skilled care and Medicare denies coverage, he could appeal the decision, seeking a waiver of liability.

### ***Seeking a Waiver of Liability***

The Medicare Summary Notice (MSN) may alert beneficiaries with a message indicating that they may request a review of the denial if they were *unaware* that Medicare would not pay for the services or supplies.

Beneficiaries may initiate the appeal process by requesting a review and may submit evidence supporting the request for a waiver of liability.

When beneficiaries have already paid bills, Medicare can reimburse them for the expenditure. Medicare will try to get a refund from the provider or pay the beneficiaries directly.

Beneficiaries should make written requests for reimbursement to the intermediary within six months from the date of paying the provider. The reimbursed amount is reduced by the deductible and coinsurance amounts for which beneficiaries would otherwise be liable.

The amount paid to beneficiaries is an overpayment to the provider. When beneficiaries have not paid the bills, providers absorb the loss.



**Note:** Waivers are not granted when services clearly are excluded from Medicare coverage (e.g., hearing aids, dental care, etc.)

# Medicare Advantage Appeals

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Medicare Advantage plans must state how to appeal in their Member Handbook or Explanation of Coverage. If beneficiaries are in coordinated care plans or Private Fee-for-Service plans, they can file appeals if their plans will not pay for, do not allow, or stop a service that beneficiaries think should be covered or provided. If the beneficiaries think waiting for a decision about a service could seriously harm their health, they should ask their plans for an expedited appeal decision.

## Medicare Advantage Appeals Process

The redetermination process, as with Original Medicare, is subject to *deadlines*. The process is outlined below. Contact the plan for how to file an appeal or grievance.

**Plan Reconsideration:** must be filed within 60 days of the initial determination notice; no minimum amount in controversy needed; health plan has jurisdiction.

**Independent Review Entity review:** automatic if Plan Reconsideration does not change initial determination; minimum amount in controversy is not required; Independent Review Entity has jurisdiction.

**Office of Medicare Hearings and Appeals (OMHA) Administrative Law Judge hearing:** must be filed within 60 days of the date of Independent Review Entity decision; minimum amount adjusted annually. See page 3 for this year's amount.

**Medicare Appeals Council (MAC) review:** must be filed within 60 days of receipt of ALJ hearing decision/dismissal; no minimum amount required; Department of Health and Human Services has jurisdiction.

**Judicial Review:** must be filed within 60 days of receipt of MAC decision/declination; minimum amount remaining in dispute required, see page 3 for details; jurisdiction of U.S. District Court.

These appeal rights also apply to a Medicare Advantage plan's decision to deny a claim for emergency care or for out-of-service-area urgently needed care.

## ***Expedited appeals***

Because the appeals process can be lengthy, a faster system of review is now available for people who require urgent care. If the Medicare Advantage plan denies health services or it fails to provide urgent services quickly it may jeopardize the patient's life, health, or ability to regain maximum function.

- ◆ Expedited appeals should be requested from the Medicare Advantage plan.
- ◆ The plan must issue a decision within 72 hours
  - The beneficiary or plan may extend the timeframe up to 14 days in order to get more medical information.

If appeals are requested without a doctor's support, Medicare Advantage plans will determine whether or not the appeal should be processed under the expedited system.

## ***Grievances***

The Medicare Advantage plan grievance procedure applies to complaints that are not appeals. Examples of grievances:

- ◆ Coverage for optional benefits (such as eyeglasses)
- ◆ Waiting time for services
- ◆ Physician behavior (rudeness, inattentiveness)
- ◆ Involuntary disenrollment
- ◆ Inadequate number of specialists to meet the beneficiary's needs



**NOTE:** Beneficiaries have the right to file a grievance for complaints not involving money or services. For example, they can file a grievance if it takes too long to get a doctor's appointment. They should review their *Member Handbook* or *Explanation of Coverage* for details.

**Medicare Advantage Plans must:**

- ◆ Accept any information, written or oral, no later than 60 days after the event
- ◆ Respond within 24 hours of an expedited grievance
- ◆ Notify enrollees of their right to an expedited grievance
- ◆ Make appropriate action, including full investigations
- ◆ Notify all involved of the investigation's outcome within 30 days after the date the oral or written request is received

# Part D Appeals

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The process for resolving coverage determinations, grievances and appeals under the Medicare Part D program is modeled after the Medicare Advantage program.

## *Coverage Determinations*

A Coverage Determination is the initial decision made by, or on behalf of, a Part D plan regarding payment or benefits to which enrollees believe they are entitled.

An enrollee, the enrollee's appointed representative, or the enrollee's prescribing physician may request a coverage determination by the plan. A plan must notify an enrollee of its coverage determination as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving an expedited request, or 72 hours after receiving a standard request. If a plan does not make a coverage determination within the applicable timeframe, the request must be forwarded to the independent review entity for review.

## *Exceptions*

An **exception** is a type of request unique to Medicare Part D. An enrollee may request a tiering exception or a formulary exception.

A **tiering exception** permits enrollees to obtain a non-preferred drug at the cost-sharing amount applicable to drugs on the preferred tier (i.e., allows them to pay preferred price for non-preferred drug). Generally, a plan must grant a tiering exception when the plan's preferred drug for treatment of the condition would not be as effective as the non-preferred, prescribed drug of the beneficiary, and/or would have adverse effects for the enrollee. A supporting statement from the enrollee's physician is required.

A **formulary exception** ensures that enrollees have access to medically necessary Part D drugs that are not included on a plan's formulary (i.e., allows them to get a drug the plan said it did not cover). The Formulary Exception also permits enrollees to request an exception to the three restrictions: Prior Authorization, Quantity Limits, and/or Step Therapy.

Generally, a plan must grant a formulary exception when its formulary drug for treatment of the same condition would not be as effective as the enrollee's prescribed drug, and/or would have adverse effects for the enrollee. As with the tiering exception, a supporting statement from the enrollee's physician is required.

Plans are prohibited from requiring enrollees to seek additional exception requests for refills.

## *Appeals*

If a Part D plan makes an adverse coverage determination, the enrollee may request an appeal. There are **five levels** of appeal available in the following sequence. See the flowchart on page 28 of this Section for time frames and minimum amounts in dispute.

### **1. Redetermination by the Part D Plan**

- Enrollees can make *expedited* requests orally or in writing.
- They must make *standard* requests in writing.
- The enrollee must be notified of the decision no later than 72 hours after receiving an expedited request, or seven days after receiving a standard request.
- If a plan does not make a redetermination within the applicable timeframe, the request must be forwarded to the Independent Review Entity (IRE) for review.
- Unfavorable decisions are appealable to the IRE, the next step.

## **2. Reconsideration by the IRE:**

- Expedited and standard requests must be made in writing.
- The enrollee must be notified of the decision no later than 72 hours after receiving an expedited request, or seven days after receiving a standard request.
- Unfavorable decisions are appealable to the Office of Medicare Hearings and Appeals (OMHA) Administrative Law Judge (ALJ).

## **3. Hearing before an OMHA ALJ:**

- Hearing requests must be in writing; unfavorable ALJ decisions are appealable to the Medicare Appeals Council (MAC).

## **4. Review by the MAC:**

- Review requests must be in writing; unfavorable decisions are appealable to federal district court.

## **5. Review by a federal district court:**

- Enrollee must file a civil action in federal district court.

## ***Grievances***

A grievance is any complaint or dispute, other than one involving a coverage determination, expressing dissatisfaction with any aspect of the operations, activities, or behavior of a plan. The enrollee should consider the following:

- ◆ Enrollee may file a grievance with the plan orally or in writing.
- ◆ Enrollee must file a grievance within 60 days of the event that gives rise to the grievance.
- ◆ Enrollee must be notified of the decision no later than 30 days after the plan receives the grievance.
- ◆ If the grievance relates to a plan's refusal to expedite a coverage determination, the enrollee must be notified of the decision no later than 24 hours after the plan receives the grievance.

# Going About a Medicare Appeal: Counseling Activities

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## Procedure

- ◆ Explain:
  - Basic coverage as applicable
  - Deductibles and coinsurance
  - The appeals process
- ◆ Have beneficiaries sign Appointment of Representative (AOR) forms giving you (the SHIBA counselor) permission to secure necessary information and documentation to represent them:
  - CMS form 1696 is the standard.
  - See page 30 in the Appendix for an example.
- ◆ Contact the intermediary and request a copy of the section of the intermediary manual used as basis for an adverse decision.
- ◆ Analyze the intermediary manual section and compare it with the facts. Does the client need more facts? Was the provider's submission of information complete and adequate and sufficient to meet the manual definition?
- ◆ Suggest that the beneficiary secure additional medical documentation.
  - The beneficiary should contact the provider and request additional documentation consistent with the manual section's criteria. The beneficiary/SHIBA volunteer may draft a letter for the provider.

## Useful Appeal Information and Documentation

**Doctors' statements** – Depending on circumstances, a statement may include detailed information about a patient's medical condition including an explanation of the diagnosis and distinctions between the care given to the patient and care given in other circumstances.

**Written orders and prescriptions** – These are helpful in appealing equipment claim denials.

**Medical records** – Copies of records regarding a patient's care in a hospital or nursing home may be helpful in establishing the existence of special circumstances and need.

**Medicare records** – Federal law provides for beneficiary access to the Part B carrier's records on his or her case. The carrier should be contacted well before the hearing to arrange a time to examine the records. A beneficiary may also obtain a free copy of the records in his or her hearing file.

**Other medical records** – Beneficiaries may have access to providers' records on the basis of a state open-record law. This right will vary from state to state. Generally, the provider is under no obligation to provide copies for free.

**Written or oral communications** – Save all bills, Explanation of Benefits or Medicare Summary Notices; it is best if they have retained the postmark-dated envelopes. Document times, dates, and names of Medicare or any plan representatives they have talked to about their case.

**Open a [mymedicare.gov](https://www.mymedicare.gov) account** if they do not already have one. They can use it to track the progress of their case, as well as to view other information about their use of the Original Medicare system.

## Types of Medicare Decisions Commonly Appealed

**Incorrect codes** – If the approved charge is more than 30% below the doctor’s actual charge, Medicare may have used an incorrect procedure code. These can be resolved by having the billing office resubmit the claim.

**Concurrent care** – If more than one doctor visits a beneficiary who is in the hospital, Medicare sometimes denies the claim for services from one of them on the grounds that the service is duplicative. Medicare will pay both doctors if the care from each was necessary.

**Services are beyond the normal level** – Medicare will deny coverage when a beneficiary makes too many visits to a provider for a covered service.

**Service is not considered reasonable and necessary** – CMS provides manuals for doctors and other providers that describe what to consider in applying the “reasonable and necessary” rule. Providers must consider the nature and length of treatment, the diagnosis, and the needs of the individual patient. A medical necessity determination is therefore subject to different opinions. What may be reasonable and necessary for one patient may not be so for another.

### ***Other decisions commonly appealed:***

- ◆ Lack of necessity for:
  - Ambulance service
  - Oxygen and equipment
  - Physical therapy
- ◆ Physical therapy denials for maintenance therapy

### ***Reopening the case***

If a beneficiary’s appeal is unsuccessful at the review and hearing stages, Medicare law does not provide for further appeal. The only alternative is to ask the carrier to reopen the case. Beneficiaries may write a letter or call the Part B carrier to request reopening.

The case may be reopened:

- ◆ If the carrier determines an error was made in the initial processing or if additional information becomes available that could alter an earlier decision.
- ◆ For any reason within 12 months of a processing date (on the MSN form) review date or hearing date.
- ◆ After 12 months, but within four years, for good cause.
- ◆ At any time if a processing error was made or fraud and/or abuse is suspected.

## **How A SHIBA Volunteer Can Assist with An Appeal**

### **1. Understand what's happening:**

- a. Find out what service is being denied Medicare coverage and why.
  - Ask if the beneficiary has received any Medicare non-coverage notices.
  - Look at the notices and, if possible, the envelopes in which the notices were delivered in order to determine whether the notice was delivered in a timely fashion as well as to calculate deadlines for submitting appeals.
- b. Decide if there are grounds to appeal the denial.
  - You can start to do this by answering the question of whether you believe that the beneficiary met the Medicare coverage criteria for the service being denied Medicare coverage.
  - Find out what the applicable laws and regulations say about the coverage criteria for the service.
- c. The Health Assistance Partnership (HAP) is a helpful SHIP partner that provides SHIBA counselors with technical support. Their guide to free online legal and medical research can help you find relevant legal and medical material. HAP's guide can be found at the Resources page on HAP's Web site, <http://www.healthassistancepartnership.org>.

## **2. Know what steps to take and when to take them:**

- a. Determine which appeals process is applicable to the beneficiary's Medicare denial. Is it
  - Original Medicare, or
  - Medicare Advantage, or a
  - National Coverage Determination or Local Medical Review Policy/Local Coverage Determination?
- b. Be familiar with the stages of a Medicare appeal and know how, when, and where to submit an appeal.
  - Be sure you know what stage in the appeal process the beneficiary's case has reached when s/he contacts you.
- c. Pay close attention to the timelines of a Medicare appeal.
  - Don't let the beneficiary miss deadlines!
- d. Keep a supply of appeal forms and Appointment of Representative forms so that you can easily help beneficiaries submit the appropriate paperwork.
  - Forms are available on the [www.medicare.gov](http://www.medicare.gov) Web site at <http://www.medicare.gov/Basics/forms/default.asp>
- e. Make sure the beneficiary keeps copies of all appeals-related documents, and mails all appeals forms by certified mail, return receipt requested, so that there is a way for you and the beneficiary to know that the appeal was received.
- f. Maintain communication with the providers so that they will know that an appeal is in process.
- g. Be prepared to help the beneficiary deal with liability and debt collection issues, or know where to refer the beneficiary for assistance with these matters, e.g., legal aid or similar resources in your community.

### 3. Build the case:

- a. Understand the medical factors involved in the beneficiary's Medicare denial in order to help craft an argument that the service Medicare has denied is reasonable and necessary.
  - Ask the treating physician and other involved health care providers to explain the beneficiary's medical situation to you.
  - Ask for help understanding why the service Medicare has denied is important to the beneficiary.
  - If you don't understand, keep asking questions until the medical factors involved in the appeal are clear to you.
  - You will need to adhere to the HIPAA Privacy Rule when asking health care providers to talk to you and share the beneficiary's records with you. For more information about the HIPAA Privacy Rule, go to the Resources page on HAP's Web site, [www.healthassistancepartnership.org](http://www.healthassistancepartnership.org).
  - Research the medical factors related to the beneficiary's Medicare denial.
- b. Work collaboratively with treating physicians and other involved health care providers to strengthen the beneficiary's case.
  - Ask the beneficiary's health care providers to prepare and submit supportive letters on behalf of the beneficiary.
  - Letters of support from health care providers should describe the beneficiary's medical condition and explain why the provider believes that the service Medicare has denied meets all relevant Medicare coverage criteria.
  - Help health care providers to understand that the more fact-based their letters are, the more persuasive weight they will carry in helping to reverse a Medicare denial.

- c. Obtain the beneficiary's medical records relevant to the Medicare denial and review them to see if the records support the claim for Medicare coverage.
  - Medical records may be submitted into evidence so that they are included in the record of the appeal.
- d. Consider attending the appeal with the beneficiary, either as the beneficiary's representative, or to be a supportive presence for the beneficiary.

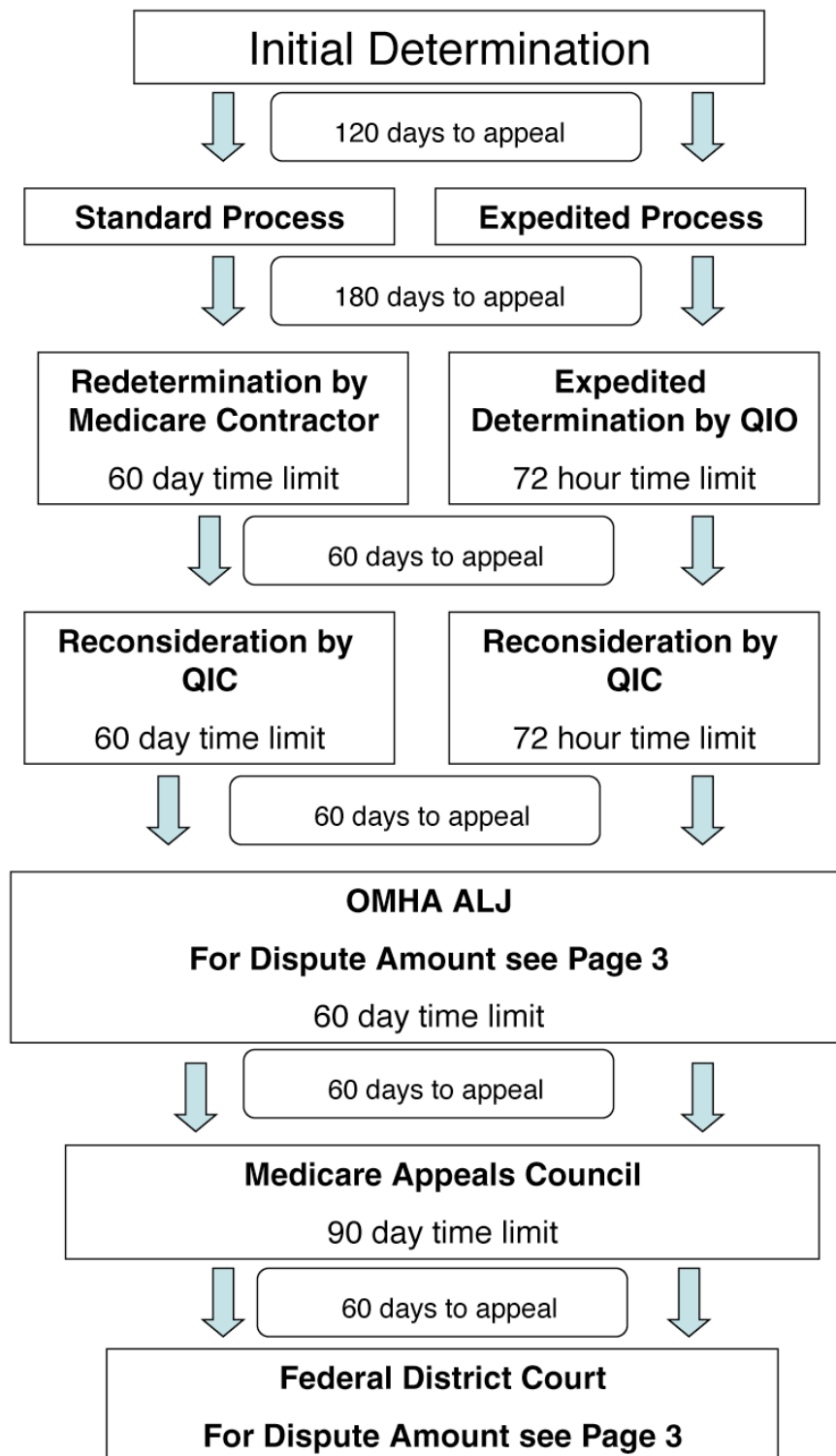
#### **4. Support the Beneficiary:**

- a. You can engage in informal advocacy with health care providers and Medicare contractors that might resolve the problem without the need to pursue a formal appeal.
  - For example, you can talk to the provider and the carrier about Medicare coverage criteria and how the beneficiary's case satisfies the coverage criteria and how the beneficiary's claim should result in an award of Medicare coverage.
  - Medicare contractors are also subject to the HIPAA Privacy Rule.
- b. Remain aware of beneficiary liability issues and offer ongoing assistance to the beneficiary throughout the lengthy appeals process.
- c. Your support and advocacy can help the beneficiary to deal with the stress and anxiety that she or he may experience while pursuing the appeal.
- d. After the third level of appeal, recommend that the beneficiary seek legal council.

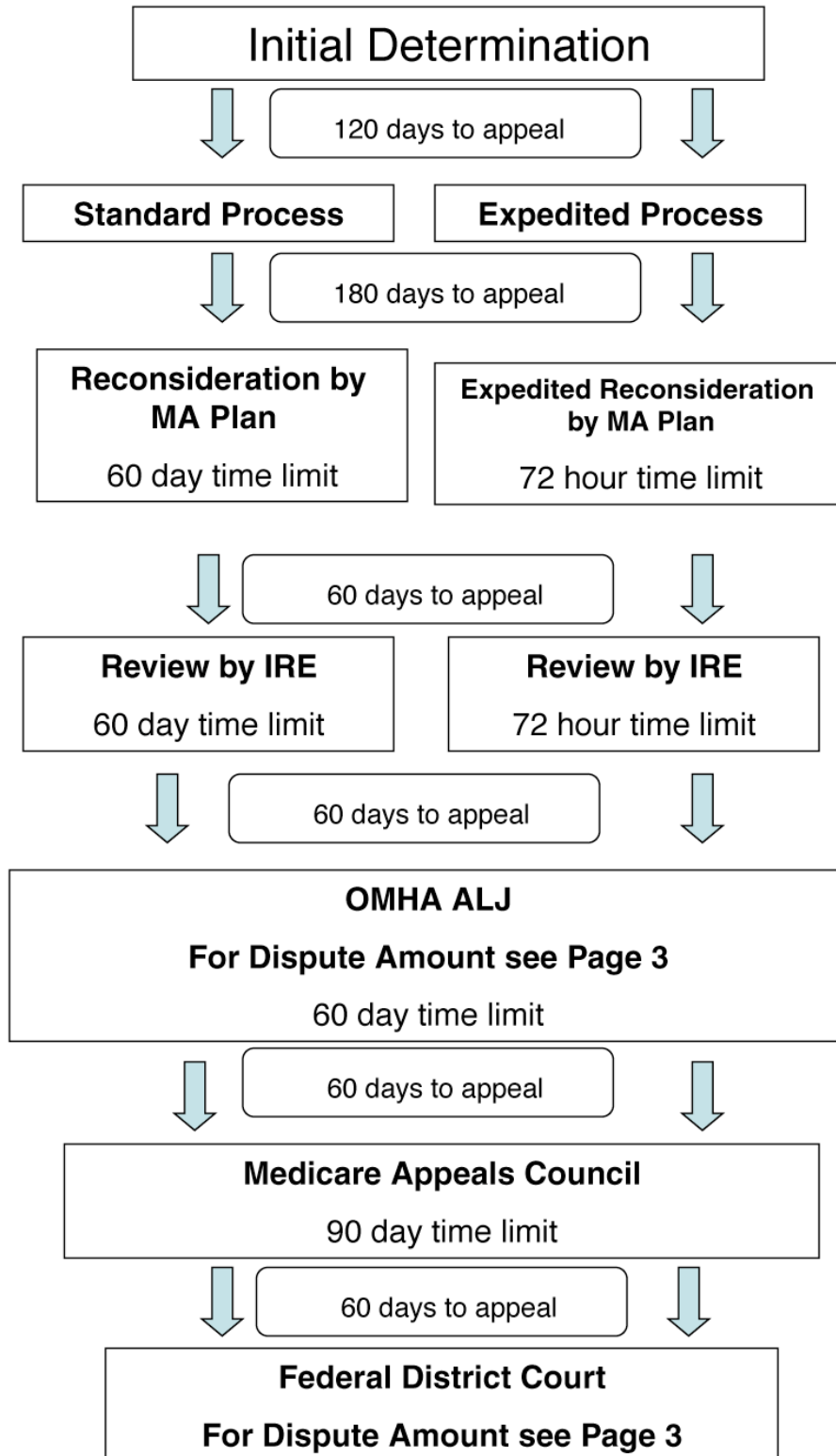
# Appendices

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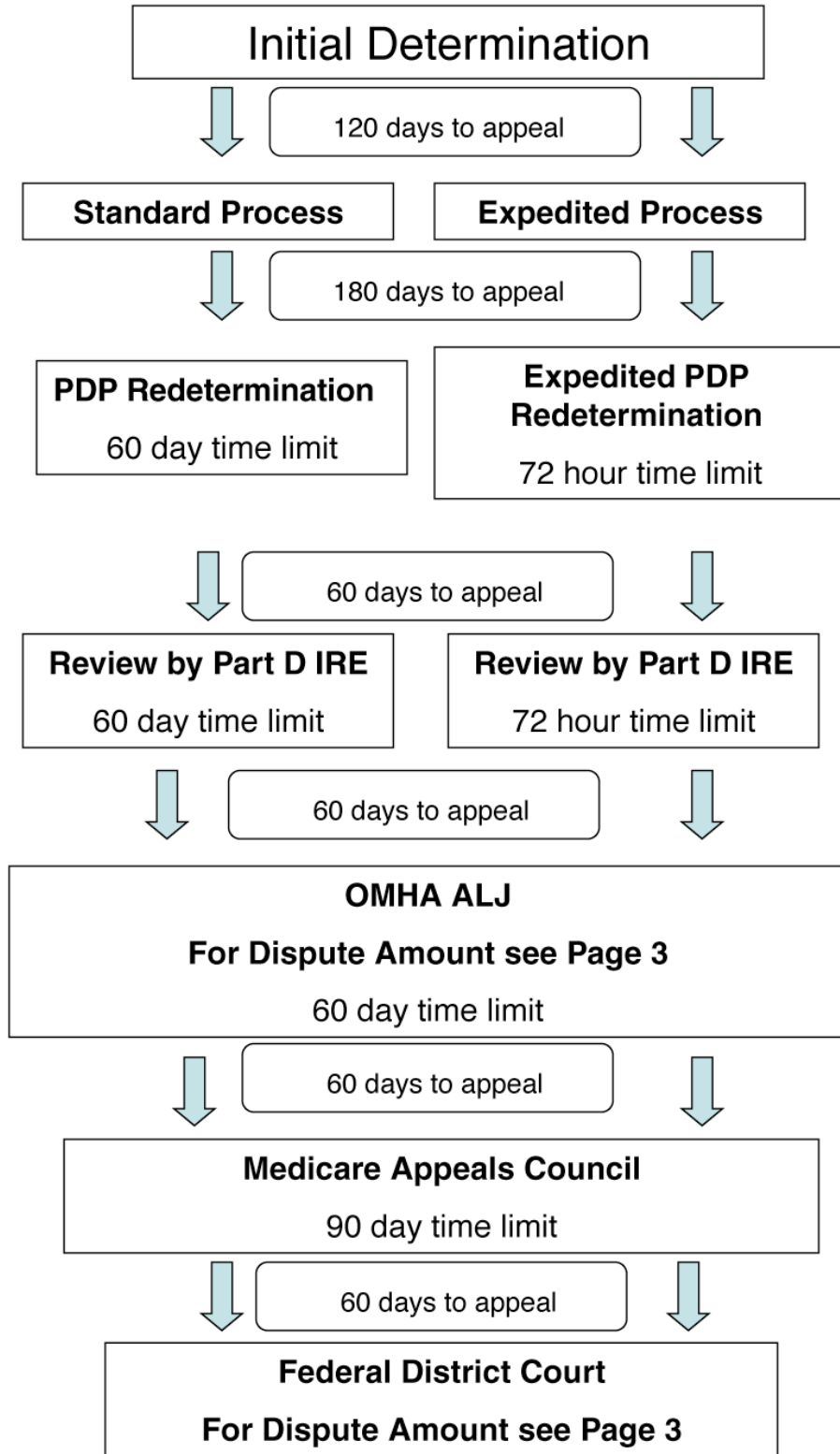
## Original Medicare (Part A & B) Appeals



# Medicare Advantage (Part C) Appeals



# Medicare Part D Appeals



# Appointment of Representative – CMS Form 1696

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved  
OMB no. 0938-0950

## APPOINTMENT OF REPRESENTATIVE

NAME OF BENEFICIARY	MEDICARE NUMBER
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### SECTION I: APPOINTMENT OF REPRESENTATIVE

**To be completed by the beneficiary:**

I appoint this individual: \_\_\_\_\_ to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the “Act”) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

SIGNATURE OF BENEFICIARY		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

### SECTION II: ACCEPTANCE OF APPOINTMENT

**To be completed by the representative:**

I, \_\_\_\_\_, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the beneficiary’s representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an \_\_\_\_\_  
(PROFESSIONAL STATUS OR RELATIONSHIP TO THE PARTY, E.G. ATTORNEY, RELATIVE, ETC.)

SIGNATURE		DATE
STREET ADDRESS		PHONE NUMBER (AREA CODE)
CITY	STATE	ZIP

### SECTION III: WAIVER OF FEE FOR REPRESENTATION

**Instructions: This form should be filled out if the representative waives a fee for such representation.**

(Note that providers or suppliers may not charge a fee for representation and thus, all providers or suppliers that furnished the items or services at issue **must** complete this section.)

I waive my right to charge and collect a fee for representing \_\_\_\_\_ before the Secretary of the Department of Health and Human Services.

SIGNATURE	DATE
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### SECTION IV: WAIVER OF PAYMENT FOR ITEMS OR SERVICES AT ISSUE

**Instructions: Providers or suppliers that furnished the items or services at issue must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act.** (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, and could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for furnished items or services at issue involving 1879(a)(2) of the Act.

SIGNATURE	DATE
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## **CHARGING OF FEES FOR REPRESENTING BENEFICIARIES BEFORE THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES**

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Department of Health and Human Services (DHHS) at the Administrative Law Judge (ALJ) or Medicare Appeals Council (MAC) level is required by law to obtain approval of the fee in accordance with 42 CFR §405.910(f). A claim that has been remanded by a court to the Secretary for further administrative proceedings is considered to be before the Secretary after the remand by the court.

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with DHHS. Where a representative has rendered services in a claim before DHHS, the regulations require that the amount of the fee to be charged, if any, for services performed before the Secretary of DHHS be specified. If any fee is to be charged for such services, a petition for approval of that amount must be submitted.

An approval of a fee is not required where the appellant is a provider or supplier or where the fee is for services (1) rendered in an official capacity such as that of legal guardian, committee, or similar court-appointed office and the court has approved the fee in question; (2) in representing the beneficiary before the federal district court of above, or (3) in representing the beneficiary in appeals below the ALJ level. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation.

### **AUTHORIZATION OF FEE**

The requirement for the approval of fees ensures that representative will receive fair value for the services performed before DHHS on behalf of a claimant while at the same time giving a measure of security to the beneficiaries. In approving a requested fee, the ALJ or MAC considers the nature and type of services performed, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

### **CONFLICT OF INTEREST**

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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