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HOW TO APPEAL DECISIONS BY MEDICARE ADMINISTRATIVE CONTRACTORS

Under Medicare Part B, if you are denied payment for services you have provided to a Medicare beneficiary, or are not paid the full amount you believe you're entitled to, there is currently a very specific five-level appeals process established for you to follow. This same appeals process applies to fee-for-service Medicare and Medicare Advantage plans. There is a thorough discussion of the appeals process on the CMS Website at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareAppealsprocess.pdf .

The Redetermination

Within 120 days after the issuance of a Medicare decision that you feel is incorrect, you may request a **redetermination** of the decision that was made. (If it can be established that there are special circumstances, appeals may be considered after the 120-day deadline.) Your written request should be sent to the Medicare Administrative Contractor (MAC) (or Carrier) whose decision you are contesting. Your letter requesting the review should state your desire to appeal the decision, and ask what other documentation you need to provide (other than what you filed with your original claim) for the review process. If the outcome of this review is unacceptable, and there is at least $100 in controversy, you can move on to the next level of the appeals process. The letter that informs you of the MAC's decision, officially known as the Medicare Redetermination Notice (MRN), should inform you about how to access a Reconsideration by a Qualified Independent Contractor, the next level of appeal.

It is important to note that many MAC redetermination decisions are overturned at subsequent levels of appeal.

Reconsideration by a Qualified Independent Contractor (QIC)

After you receive notice of the Carrier Review determination you have 180 days to request the next level of appeal, the Reconsideration hearing. This request should indicate your dissatisfaction with the review decision and your desire for further opportunity to appeal. This request must be filed in writing. The letter you received from the MAC with the denial of the first level of appeal will indicate where you should send the request to continue the appeals process. And, again, you should ask if any additional documentation (if there is any) would be helpful. If you fail to submit supportive information at this level, it may not be admitted at later levels of appeal. There is no minimum amount of money for requesting a Reconsideration.

A Reconsideration determination is binding on all parties unless there are further appeals or a reopening of the matter. What this means is that if you are not

satisfied with the results of the Fair Hearing, you can move on to the next level of appeal, the Administrative Law Judge (ALJ) Hearing (as long as the dollar amount in question meets the ALJ threshold.

The Administrative Law Judge (ALJ) Hearing

Within sixty days after your receipt of the notice of the Reconsideration decision, you can file a written request for an ALJ Hearing, using the instructions sent to you with that decision. Starting in 2005 the dollar amount required for an ALJ Hearing was set to increase by the percentage increase in the medical care component of the consumer price index for all urban consumers. The current amount can be found at http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html.

ALJ hearings are generally conducted via video teleconference or telephone, but you may request an in-person hearing for good cause. The ALJ will determine if the in-person hearing is warranted.

As with the previous levels of appeal, the ALJ Hearing decision is binding on all parties unless there are further appeals or revisions of the decision.

Further Appeals

There are two levels of appeal that beyond the ALJ Hearing, the Medicare Appeals Council Review, which is conducted by the HHS Departmental Appeals Board (DAB) Review, and the Federal Court Review, or a judicial review in a U.S. District Court. The requirements for these appeals are complex and stringent, and you should consult with a healthcare lawyer or a practice consultant before considering going on to these levels of appeal.

Note: If you receive a notice from your Medicare Administrative Contractor or Carrier stating that you owe Medicare money because of a postpayment review that determined the claim should not have been paid, you have a right to appeal that just as you would appeal a claim that is initially denied. Medicare cannot recoup the money they request while the appeal is in process, but should you lose, you will have to pay the amount owed as well as the interest that has accrued on the owed amount during the course of the appeal.