Online SHIP Counselor Training

Level 3, Course 2: Medicare Advantage Appeals

Slide 1: Title slide

Hello and welcome to the second course in Level 3 of the Online SHIP Counselor Training core curriculum: Medicare Advantage Appeals.

Remember, you can pause this course at any time and review any part of it at your convenience. Feel free to take the Course 2 quiz after this course to review what you learned. Each course also includes supplementary materials that you can use to reinforce key concepts. Now, let’s begin.

Slide 2: Learning objectives

In this course you will learn about Medicare Advantage appeals.

After taking this course, you will be able to

* One: Identify when a beneficiary may start a Medicare Advantage appeal
* Two: Explain the difference between standard and expedited appeals
* Three: Understand the steps in the different appeal processes
* Four: Help clients through all the steps of a Medicare Advantage appeal

Slide 3: Medicare Advantage appeal

A Medicare Advantage appeal is a formal coverage or payment request that a beneficiary enrolled in a Medicare Advantage Plan makes if they disagree with their plan’s coverage or payment decision on a health care service or item. Click on the boxes to learn about types of Medicare Advantage appeals.

Standard appeals can be filed either before or after a beneficiary receives care. Standard appeals follow a regular timeline.

There are two circumstances when a beneficiary may file an expedited appeal. First, they can file one before they receive care, if they need a faster decision than that offered in the standard appeals process. Second, they can file one if their hospital, skilled nursing, home health, outpatient rehab, or hospice care is set to end because of the plan’s or provider’s interpretation of Medicare coverage rules.

Note that throughout this course, we will refer to skilled nursing facilities as SNFs, home health agencies as HHAs, and comprehensive outpatient rehabilitation facilities as CORFs.

Slide 4: Organization determinations

In order for a beneficiary to appeal their Medicare Advantage Plan, the plan must first issue an organization determination. Organization determinations are decisions made by a plan or a provider acting on behalf of a plan. These include decisions related to:

* Approval for services before a beneficiary receives them
* Payment for services that a beneficiary already received
* Treatment that is reduced or discontinued

Depending on the type of organization determination, a beneficiary can either file a pre-service or post-service appeal. The important thing to note is that an organization determination must be made before a beneficiary can begin an appeal to their Medicare Advantage Plan.

Note that if a provider says that a service will not be covered, this **is** **not** an organization determination. This is because the provider, not the plan, made the decision. In this case, the beneficiary or their provider can request an organization determination from the plan with regard to coverage of that particular service. On the other hand, if a provider decides to reduce or terminate care, then their decision to do so **is** considered an unfavorable organization determination and the beneficiary can start at the first level of appeal.

Slide 5: Medicare Advantage pre-service standard appeal

In the following section you will learn about how a beneficiary can file a pre-service standard appeal.

A beneficiary can file a pre-service standard appeal if:

* They have not yet received care and
* They need prior approval from the plan before getting care, and the request for prior approval is denied. It is important for beneficiaries to be aware of the rules affecting their plan benefits. For example, a beneficiary may need to get the plan’s approval along with a doctor’s order for a particular lab test in order to have the test covered.

Slide 6: Before filing pre-service appeal

Before a beneficiary begins a standard appeal for services they have not yet received, there are certain steps that must be taken. As mentioned on the previous slide, a beneficiary can file a pre-service appeal if their plan requires them to get prior approval for a service or item and the plan denies that approval. Click on the numbers to learn what happens before a beneficiary begins their appeal.

1. First, the beneficiary contacts their plan to get prior approval for coverage of a service or item. A provider may be able to help with this step and contact the plan on the beneficiary’s behalf.
2. Next, the plan makes an organization determination about whether it will approve the care. If the plan does not approve the care, it should send the beneficiary or their provider an official denial notice in writing. This unfavorable organization determination appears in a notice called a **Notice of Denial of Medical Coverage**. A sample notice is included in the supplementary materials. The plan should send this notice in about two weeks, unless the plan informs the beneficiary in writing that it extended the deadline in order to help the beneficiary’s case. Note that at every level of this appeal, the plan has the right to extend the decision timeline up to 14 days if it believes the extended timeline will be in favor of the beneficiary.

If the beneficiary does not hear from the plan within two weeks they should contact the plan.

A beneficiary always has the right to appeal, but they may not be as likely to succeed if they appeal non-coverage of an excluded service.

For example, if a beneficiary’s Medicare Advantage Plan does not cover annual vision check-ups, which although excluded from Original Medicare coverage may be covered by some Medicare Advantage Plans, the beneficiary is unlikely to be successful if they appeal their plan for coverage of that service.

Slide 7: Level 1: Plan reconsideration

it is only after all the previous steps are completed that the beneficiary is at the first level of the appeals process: plan reconsideration. All of this information is included on the Medicare Advantage appeals flier in the supplementary materials for this course.

Click on the numbers to learn what happens during the plan reconsideration level.

1. Once the beneficiary receives a Notice of Denial of Medical Coverage, they can start their appeal. This notice is necessary to prompt the appeal process and should contain information about why the service was denied. The denial should be based on Medicare coverage criteria, and the denial notice must include the specific coverage rule or rationale for the plan’s decision. It should also say how to initiate the appeal, what to send to the plan, and where to send the appeal information. If the beneficiary has any further questions, they should contact the plan directly. The beneficiary or their provider should file an appeal within 60 days of the date listed on the denial notice.
2. During the first level of appeal, plan staff unrelated to the initial decision review the organization determination and all available evidence. The plan decides whether it will cover the service or item.

The plan should issue a decision within 30 days of getting the initial appeal. The plan can extend this decision deadline up to 14 days if it believes an extended timeline will help the beneficiary’s case. For example, a plan may extend a deadline if it needs to have a more experienced physician reviewer examine the case. Note that a beneficiary can request copies of the documents in their case file.

There are two possible outcomes:

1. A favorable decision, in which case the plan should cover the service or item.
2. An unfavorable decision, in which case the plan automatically forwards the case file to the second level of appeal.

Slide 8: Level 2: IRE Reconsideration

The second level of appeal is IRE Reconsideration. You may also see this level called external review. An Independent Review Entity, or IRE, is contracted by Medicare to reconsider Medicare Advantage appeal cases at the second level. Contact information for the IRE is included in the supplementary materials section. Click on the number to learn what happens during the IRE reconsideration level.

1. At this level of appeal, the IRE reviews the organization determination and initial reconsideration decision and decides whether the plan should cover the service or item. The IRE must issue a decision within 30 days of getting the appeal from the plan, although it may extend the deadline up to 14 days if an extended deadline will help the beneficiary’s case.

There are two possible outcomes:

1. A favorable decision, in which case the plan should cover the service or item.
2. An unfavorable decision, in which case the beneficiary can choose to move to the next level of appeal.

Slide 9: Level 3: OMHA

The third level of Medicare Advantage standard pre-service appeal is the Office of Medicare Hearings and Appeals, or OMHA, level. Click on the numbers to learn what happens during the Office of Medicare Hearings and Appeals (OMHA) level.

1. Once the beneficiary receives an IRE decision letter indicating their plan will not pay for the care, they can appeal to OMHA to request a hearing with an administrative law judge, or ALJ, within 60 days. To request this hearing, they should follow the instructions on the IRE decision letter. Keep in mind that they may want to solicit the help of a lawyer, local legal services organization, or State Health Insurance Assistance Program (SHIP) at this level. They are not required to do so and can still appear at the hearing, which is usually conducted by phone or videoconference, by themselves. They can also appear with other representatives such as family members.

The beneficiary should make sure to send their written request to the address listed on the IRE notice and follow directions carefully, since failure to do so will delay processing. The written request can be prepared as a letter written by the beneficiary or their representative, or it can be prepared by filling out a Request for Medicare Hearing by an Administrative Law Judge form. The beneficiary should note on the envelope that it is a beneficiary appeal by including “Attn: Beneficiary Mail Stop” with the address to which they send their request. Remember, beneficiaries should keep originals of all their paperwork and get a tracking number for anything they send in the mail. A sample form is included in the supplementary materials.

It is important to note that OMHA reviews the appeal only if the dollar amount for a non-covered service or item, as indicated on the IRE reconsideration notice, meets or exceeds a specific threshold requirement. This amount, called the amount in controversy, depends on the predicted cost of the service or item that the beneficiary wants the plan to cover. This threshold is determined yearly and is indicated on the IRE decision. If the amount in controversy, or the predicted cost of the service or item that is the subject of the appeal, is lower than the limit, then OMHA cannot review the appeal.

For example, if Regina is appealing a denied health care service that the plan would pay $100 for if it were covered and the amount in controversy threshold she must meet in order for OMHA to review her appeal is $150, then she is $50 short and OMHA will not review the appeal. However, she may be able to combine similar or related services to meet the amount in controversy. For example, if she will need the service twice, she may meet the amount in controversy requirement.

1. Upon receiving the request, OMHA reviews the case and sets the time and place for the hearing. The beneficiary receives a Notice of Hearing that includes information on the date, time, and location of their hearing.

They will receive this information at least 20 days before the hearing.

If the predicted cost of the service in question meets or exceeds the amount in controversy, OMHA reviews the appeal and decides whether Medicare should cover the service in question.

After receiving the Notice of Hearing, the beneficiary will also be asked to fill out a Response to Notice of Hearing form and return it to the address listed on the Notice of Hearing within five days. This will confirm the ~~ALJ~~ hearing. The hearing can be dismissed if the beneficiary fails to appear with no good cause. We will review good cause extensions later in this section. At this point, the beneficiary can request a copy of their current case file in order to see the documents that the ALJ will review. The beneficiary must copy their MA plan on anything that they send to the ALJ, including additional evidence, arguments, or letters from doctors.

1. Next, the beneficiary attends the hearing.

In most cases, a hearing is held by video teleconference. Hearings may also be held over the telephone or in person, depending on the circumstances.

During the hearing, the ALJ may question the beneficiary and any witnesses they bring to the hearing.

The ALJ may ask health care experts or other personnel to join the hearing for medical support or evidence pertaining to the case and the MA Plan may participate in the hearing as well.

1. Lastly, OMHA notifies the beneficiary of its decision. This decision should usually be mailed to the beneficiary within 90 days of OMHA receiving the hearing request. Keep in mind that there can be significant delays at this level, including delays caused by high caseloads, and that this timeframe may also be extended in certain circumstances.

Slide 10: Level 3: OMHA (continued)

There are three possible outcomes at the OMHA level:

1. A favorable decision, in which case the Medicare Advantage Plan covers the health care service or item in question. Remember, it is not OMHA that pays for the service or item, but the plan. Beneficiaries can contact 1-800-MEDICARE or their plan for questions regarding Medicare payment following a favorable OMHA decision, or to file a complaint if the plan does not pay.
2. An unfavorable decision, in which case the beneficiary can choose to move to the next level of appeal, and
3. OMHA does not issue a decision within 90 days, at which point the beneficiary can request that the appeal be forwarded to the next level in the appeal process. If this is the case, it may be helpful for the beneficiary to speak to an attorney to see if proceeding to the next level would be more beneficial than waiting for a decision.

Slide 11: Level 4: Council Review

The Medicare Appeals Council, or Council, is the fourth level in the Medicare Advantage standard pre-service appeal process. The Council reviews unfavorable OMHA decisions. Click on the numbers to learn what happens during the Council review level.

1. If OMHA upholds the IRE’s decision, the beneficiary can request a Council review within 60 days of receiving the unfavorable OMHA decision. As with the OMHA level, a written request is generally required to obtain ~~a~~ Council review. If a beneficiary has a disability that prevents them from filing a written appeal, they can request an accommodation under the Americans with Disabilities Act (ADA).

Beneficiaries may want to request an attorney or get help from a legal services organization at the Council review level.

1. Following a beneficiary request, the Council reviews the OMHA decision and decides whether the plan should cover the service or item in question. The appeal must make reference to the parts of the OMHA decision with which the beneficiary disagrees, and explain why they disagree.

The Council generally issues a decision in about 90 days of receiving the request for review.

Unlike the ALJ hearing, the Council review is an evaluation of the written record and any additional submissions in writing, meaning that the beneficiary does not have to attend a hearing.

There are three possible outcomes to Council review:

1. A favorable decision, in which case the plan should cover the service or item in question.
2. An unfavorable decision, in which case the beneficiary can choose to move to the fifth and final level of appeal, and
3. The Council does not issue a decision within 90 days, in which case the beneficiary may be able to request that the appeal be forwarded to the fifth and final step in the appeal process. If this is the case, it may be helpful for the beneficiary to speak to an attorney to see if proceeding to the next level would be more beneficial than waiting for a decision from the Council.

Slide 12: Level 5: Judicial review

Judicial review is the fifth level of the Medicare Advantage standard pre-service appeal process. Click on the numbers to learn what happens during the judicial review level.

1. First, the beneficiary requests judicial review by filing a case in their local U.S. Federal District Court.

The request must be filed with the Federal District Court within 60 days of receiving the Council ~~MAC~~ decision. Keep in mind that the Federal District Court will only consider the appeal if the projected value of the needed health care item or service meets the annual threshold requirement. This amount is determined yearly, is indicated on the Council decision, and is larger than the amount in controversy for the OMHA level.

There are many requirements for filing a case in Federal District Court. A beneficiary does not just write a letter as in the other levels of appeal. It is usually a good idea to obtain the assistance of an attorney to appeal at this level.

1. Next, the court reviews the case and decides whether the plan should cover the care.

Unlike the previous four levels of the Medicare Advantage standard pre-service appeal process, there is no timeframe for a decision at the fifth level of appeal.

There are two possible outcomes to judicial review:

1. A favorable decision, in which case the court orders the plan to pay the claim.
2. An unfavorable decision, in which case the court upholds the Medicare Appeals Council’s denial decision. The beneficiary will have to pay for the service or item in question.

Slide 13: Medicare Advantage post-service appeal

Next we will outline the second circumstance under which a beneficiary may file a Medicare Advantage standard appeal, which is when they have already received a service and the plan doesn’t pay.

A beneficiary files a standard appeal if:

* They already received a health care service or item, and
* They received notice from their plan saying that it will not cover the health care service or item they received.

Slide 14: Before filing an appeal

As with the other appeal processes, first we will review what must happen before a beneficiary can file a standard appeal for a service they already received. Click on the numbers to learn what happens before a beneficiary begins their appeal.

1. First, the beneficiary receives care from a health care provider.
2. Next, the provider bills the Medicare Advantage Plan for the care the beneficiary received.
3. The beneficiary then receives written notice that the payment has been denied. This organization determination may appear in a separate Notice of Denial of Medical Coverage, their Explanation of Benefits (EOB) statement, or an insert with the EOB mailing

Slide 15: Level 1: Plan reconsideration

Once the beneficiary has sent an appeal request to their plan they are at the first level of the appeal process: plan reconsideration. Click on the numbers to learn what happens during the plan reconsideration level.

1. The beneficiary starts their appeal by following directions on either their EOB or Notice of Denial of Medical Coverage. They need to file within 60 days of the date listed on the notice in order to have their appeal properly reviewed. Beneficiaries should note the reason for denial before starting their appeal. The denial notice must include the specific coverage rule or rationale for the plan’s decision. If the beneficiary has any further questions, they should contact the plan directly. It is also important to know that if the beneficiary receives a bill from their doctor, they can tell them that they are in the process of appealing to avoid having the bill sent to collections.
2. During this first level of appeal plan employees who were not involved in making the initial organization determination reconsider the service denial. The plan should issue a decision within 60 days of getting the initial appeal.

There are two possible outcomes:

1. A favorable decision, in which case the plan should pay for the care received.
2. An unfavorable decision, in which case the plan automatically forwards the case file to the second level: the Independent Review Entity, or IRE.

Slide 16: Level 2: Independent Review Entity (IRE) reconsideration

Click on the number to learn what happens during the IRE reconsideration level.

1. At this level of appeal, the IRE reviews the plan’s decision and decides if the plan made a mistake in denying coverage. The IRE should issue a decision within 60 days of receiving the auto-forwarded appeal.

There are two possible outcomes:

1. A favorable decision, in which case the plan should cover and pay for the care received.
2. An unfavorable decision, in which case the beneficiary can move on to the next level of appeal.

Slide 17: Levels 3, 4, and 5

The last three levels of the MA standard post-service appeal process are the same as those for MA standard pre-service appeals. If the IRE reconsideration is unfavorable, the beneficiary can appeal to the OMHA to request an ALJ hearing. If the ALJ hearing is unfavorable, the beneficiary can move on to Council review. Lastly, a beneficiary can request a judicial review if they receive an unfavorable Council decision.

Slide 18: Good cause extension

Beneficiaries can request a good cause extension if they exceed the deadline for filing an appeal at any level in the appeal process.

A beneficiary can request a good cause extension if they miss or exceed a deadline during the appeal process. Examples of good cause may include, but are not limited to, not receiving important Medicare notices, being too ill to file an appeal, or lacking sufficient documentation to support the appeal. A beneficiary may also request a good cause extension if they received their Medicare notice indicating Medicare non-payment of a service of item late. To request a good cause extension, a beneficiary should file their late appeal and also send a clear explanation of why it is late. Good cause extensions apply at each level of the Medicare appeal process and are judged on a case-by-case basis.

Slide 19: Progress

Congratulations! You have completed the standard appeals section and are halfway through this course.

Slide 20: Medicare Advantage pre-service expedited appeals

Now, we will move on to expedited appeals. A beneficiary may file an expedited appeal if they have not received care yet, or if their hospital, skilled nursing facility, home health, outpatient rehabilitation, or hospice care is set to end. In this next section we will outline the first circumstance under which a beneficiary may file a Medicare Advantage expedited appeal, which is before they receive a service.

A beneficiary files an expedited pre-service appeal if

* They have not yet received care

They need prior approval from the plan before getting care

Slide 21: Before filing pre-service expedited appeal

Now, let’s learn about the steps involved in an expedited appeal for care a beneficiary has not yet received. The steps are the same as those for a standard appeal. The only difference is the time the beneficiary has to file the appeal and the plan has to make its decisions.

As with the other appeal processes first we will review what must happen before a beneficiary starts their expedited appeal for care they have not yet received. Click on the numbers to learn what happens before a beneficiary begins their appeal.

1. First, the beneficiary contacts their plan to see if it will cover the service that their doctor ordered for them. This is called seeking prior approval from the plan. The beneficiary’s doctor can request that the plan expedite its decision about prior approval. A provider can request an expedited review if they believe that the beneficiary’s health would be at risk if their request were processed on a standard timeline. The plan would have 72 hours to make its organization determination. Note that this expedited decision only applies to the plan’s decision regarding prior approval, not to the whole appeal.
2. Next, the plan makes an organization determination about whether it will approve the care. If the plan does not approve care, it should send the beneficiary or their provider an official denial notice in writing. This adverse organization determination appears in the Notice of Denial of Medical Coverage, in the Explanation of Benefits statement, or in a separate insert in the EOB mailing. The plan should send this notice within two weeks.

Slide 22: Level 1: Expedited reconsideration

Once the beneficiary sends the plan the necessary appeal information, they are considered to be at the first level of appeal: expedited reconsideration. Click on the numbers to learn what happens during the expedited reconsideration level.

1. Once the beneficiary receives a Notice of Denial of Medical Coverage or EOB, they can start their expedited appeal. They need to file within 60 days of the date listed on the notice in order to have their appeal properly reviewed. The beneficiary’s doctor requests the expedited review, and the plan must grant one if the beneficiary’s provider shows that the beneficiary’s health, life, or ability to maintain maximum function would be at risk if they were to wait the standard timeframe. The denial notice is necessary to prompt the appeal process and should contain information about why the service was denied as well as how to initiate the appeal. Beneficiaries should note the reason for denial before starting their appeal. The denial should be based on Medicare coverage criteria, and the denial notice must include the specific coverage rule or rationale for the plan’s decision. If the beneficiary has any further questions, they should contact the plan directly.
2. Plan staff unrelated to the initial decision review the organization determination and all available evidence. Then they reconsider whether the plan will cover the service or item in question. For an expedited appeal, the plan must issue a decision within 72 hours of getting the appeal. However, a plan may extend a decision deadline up to 14 days if it believes an extended timeline will help the beneficiary’s case. Note that a beneficiary can request copies of the documents in their case file.

There are two possible outcomes:

1. A favorable decision, in which case the plan should cover the care in question.
2. An unfavorable decision, in which case the plan should automatically forward the case file to the IRE for the second level of appeal.

Slide 23: IRE Reconsideration

The second step in the expedited pre-service appeal process is IRE reconsideration. Click on the number to learn what happens during the IRE reconsideration level.

1. At this level of appeal, the IRE reviews the organization determination and initial reconsideration decision and decides whether the plan should cover the service or item the beneficiary wishes to receive. The IRE must issue a decision within 72 hours of getting the appeal from the plan.

There are two possible outcomes:

1. A favorable decision, in which case the plan should cover the care in question.
2. An unfavorable decision, in which case the beneficiary can choose to move to the next level of appeal.

Slide 24: Levels 3, 4, and 5

The expedited timeline for pre-service appeals only applies at the first two levels. The next three levels of appeal—OMHA, Council review, and judicial review—are exactly the same as those for standard appeals, and they are not carried out on an expedited timeline.

Slide 25: Medicare Advantage expedited appeal: Ending care

The last type of appeal you will learn about is a Medicare Advantage expedited appeal for care that is ending. These types of appeals may also be called Fast Track Appeals.

A beneficiary can file an expedited appeal for ending care if they fulfill two criteria:

* First, they must currently be receiving care from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehab facility, or hospice agency, and
* Second, their provider must have given them notice stating that their care is ending soon because the provider believes the Medicare Advantage Plan will not pay for continued care based on Medicare coverage rules.

Beneficiaries will not be able to appeal if their care is simply being reduced or changed, as opposed to ending completely. In addition, if the provider is ending care for reasons other than Medicare coverage rules—for instance, because there is a lack of resources or staff—then the provider is not required to give the beneficiary a notice that prompts an expedited appeal. To summarize: in order to file an expedited appeal, a beneficiary’s provider must be ending care because they believe that the beneficiary’s Medicare Advantage Plan will not pay for continued care based on Medicare coverage rules.

Also keep in mind that there are slight differences in the first few steps of filing an expedited appeal, depending on whether the beneficiary is receiving care at a hospital **or** if the beneficiary is receiving care at a SNF, HHA, CORF or hospice agency. While the first steps in the expedited appeal process vary, depending on whether hospital care or non-hospital care is ending, the last three levels of the expedited appeals process are the same as the last three levels for standard appeals.

Slide 26: Before filing an appeal

First we will review the expedited appeal process for situations where someone’s **hospital** care is ending. We will talk about the expedited appeal process for situations where SNF, HHA, CORF and hospice care is ending in a few minutes. For now, know that we are strictly talking about **hospital care** that is ending.

Before we review the different levels in the expedited appeal process for ending hospital care, let’s talk about what prompts the appeal process. You will notice that these initial steps are similar to the Original Medicare appeals process for ending hospital care. Click on the numbers to learn what happens before a beneficiary begins their appeal.

1. First, within the first two days of being admitted to the hospital, the beneficiary receives a written notice called an Important Message from Medicare. The beneficiary should read and be asked to sign this notice, which describes their rights as an inpatient. If the inpatient hospital stay lasts three days or more, the hospital will provide the beneficiary with another copy of the Important Message notice before they leave the hospital. The hospital should give the beneficiary this second notice no more than two days before their discharge date and no fewer than four hours before they are discharged.
2. Next, the hospital tells the beneficiary they are ending care.
3. If the beneficiary disagrees and believes that continued care is medically necessary, they can start an expedited appeal to challenge the hospital’s decision to end care by following the instructions on the Important Notice from Medicare. This notice includes the contact information for the Benefits and Family Centered Care Quality Improvement Organization(BFCC-QIO or QIO for short). The QIO is an independent group of doctors and professionals that contracts with Medicare to review expedited Medicare appeals and ensure that people with Medicare receive quality care. The beneficiary contacts the QIO and not their plan because the ending care notice is not a plan determination, it is a decision the provider makes based on their understanding of the plan’s coverage rules.

For continued coverage of their stay, the beneficiary must contact the QIO by their scheduled hospital discharge date and before they leave the hospital. Although they have until midnight of their discharge date to contact the QIO, they should do so as early as possible.

Contact information for the BFCC-QIOs can be found in the supplementary materials section.

1. After the beneficiary contacts the QIO, the QIO alerts the hospital of the appeal and collects information needed to review the case. Beneficiaries have a right to a copy of the information that the hospital sends to the QIO, but the hospital may charge them for it. For expedited appeals related to ending hospital care, beneficiaries need to be available to discuss their care with the QIO, generally by phone. You will learn more about this in a few minutes.

1. Once the hospital learns about the appeal, it should give the beneficiary a Detailed Notice of Discharge that explains in writing why hospital care is ending and listing any Medicare coverage rules related to their case. The hospital should give this notice to the beneficiary no later than noon of the day after the hospital was notified by the QIO of the appeal. The beneficiary should read this notice so that they are prepared for the QIO review.

If a beneficiary is too ill to take these steps to appeal, they can always appoint a representative and ask the hospital doctor to be present during the QIO Review. If a beneficiary has left the hospital or missed the deadline to request a QIO Review, they can still appeal to get coverage for any days past the discharge date that they stayed and continued to receive care. The beneficiary usually pays out-of-pocket for this care. Under these circumstances, beneficiaries have 30 days from their original discharge date to request a review. In this case, the QIO would send the beneficiary a written decision after it receives all requested information from both the beneficiary and the hospital.

Slide 27: Level 1: QIO Redetermination

The first step in the expedited appeals process for ending hospital care is the QIO review. Click on the numbers to learn what happens during the QIO redetermination level.

1. First the beneficiary discusses their case with the QIO over the phone. The beneficiary has the option of submitting evidence for the case, and they can also ask a doctor to be present for the conversation with the QIO.
2. The QIO uses information gathered from the interview to determine whether continued hospitalization meets Medicare coverage rules. The QIO should give the beneficiary a decision by phone within one day of receiving all the information it needs to make its decision. This decision will later be provided in writing as well.

There are two possible outcomes.

1. A favorable decision, in which case the plan should continue to cover the care
2. An unfavorable decision, in which case the beneficiary can leave the hospital or choose to move to the next level of appeal. Medicare will continue to cover the beneficiary’s care until noon of the day after the QIO informs them of its decision. The beneficiary may be liable for the cost of any care received after that point if they are unable to reverse the QIO’s non-coverage decision through the appeals process.

If the beneficiary receives an unfavorable decision from the QIO and has already left the hospital, they can appeal according to the standard appeal timeframe for reimbursement of their out-of-pocket costs.

Slide 28: Level 2: QIO Reconsideration

The second level of appeal is QIO Reconsideration. Click on the numbers to learn what happens during the QIO reconsideration level.

1. If the first appeal to the QIO is unsuccessful, the beneficiary can continue their appeal by filing an appeal with the QIO a second time. The beneficiary has until noon of the day following the QIO’s initial denial to file this appeal.
2. A different set of QIO staff reviews the appeal and reconsiders whether the care should be continued. The QIO will issue a second decision within 14 days of getting the appeal.

There are two possible outcomes.

1. A favorable decision, in which case the beneficiary should continue to receive care until the next time the issue arises.
2. An unfavorable decision, in which case the beneficiary can choose to move on to the third level of appeal.

This level of appeal and subsequent levels are the same as the levels in the Medicare Advantage standard appeals process. The timeline and entities that the beneficiary encounters are the same. As such, we will briefly review the last three levels of appeal at the end of this course. For now let’s go back and outline the steps for filing an expedited appeal if SNF, HHA, CORF, or hospice care is ending.

Slide 29: Before filing an expedited appeal: Non-hospital

Now we will outline the expedited appeals process for situations where an individual’s **non-hospital** SNF, HHA, CORF, or hospice care is ending. Similar to expedited hospital care appeals, these appeals can also be called Fast Track Appeals.

Before we review the different levels in the expedited appeal process for ending non-hospital care, let’s learn about what prompts the appeal process. Click on the numbers to learn what happens before a beneficiary begins their appeal.

1. First, the beneficiary receives a Notice of Medicare Non-Coverage from their provider.

If the provider feels that Medicare will not pay for care anymore and is planning on ending care, the beneficiary should receive a Notice of Medicare Non-Coverage from their health care provider no later than two days before their care is set to end. Keep in mind that beneficiaries who get home care on less than a daily basis should receive their Notice of Medicare Non-Coverage no later than the second-to-last visit before care is set to end. For example, a beneficiary who only gets home care on Tuesdays and Thursdays must get a Notice of Medicare Non-Coverage from their provider no later than Tuesday. Also note that the beneficiary will not receive this notice if their care is being reduced—they will only get this notice if their care is ending.

This notice tells the beneficiary when their care is expected to end and gives them information about the Benefits and Family Centered Care Quality Improvement Organization, known as the BFCC-QIO, or QIO for short. The QIO is the same entity that we talked about in relation to expedited appeals for ending hospital care. As with non-hospital care that is set to end, the QIO is the first entity the beneficiary will contact to start an expedited—or Fast Track—appeal.

1. Next, the beneficiary starts an expedited appeal by contacting the QIO by noon of the day before their care is set to end. However, they should contact the QIO as soon as possible.
2. After the beneficiary contacts the QIO, it alerts the provider of the appeal and collects the necessary information to review the case.
3. The beneficiary can submit their own evidence to the QIO but they are not required to do so. Once the provider learns about the appeal, the provider should give the beneficiary a Detailed Explanation of Non-Coverage that explains why their care is ending and lists any Medicare coverage rules related to their case. The provider should give this notice to the beneficiary within the same day that it learns of the appeal from the QIO.

Slide 30: Level 1: QIO redetermination

The first level of an expedited appeal for **non-hospital care** that is ending is QIO redetermination. Click on the numbers to learn what happens during the QIO redetermination level.

1. First the beneficiary speaks with the QIO over the phone or submits a statement to file an expedited appeal for ending SNF, HHA, CORF, or hospice care. The QIO will receive the information it needs to review the provider’s decision to end care. Based on that information, the QIO decides whether the care should be continued with Medicare coverage.
2. Next the QIO determines if care should be continued. The BFCC-QIO must give the beneficiary and the provider a decision in writing typically by the day the Notice of Medicare Non-Coverage said the care was set to end**.** The QIO decision can be made by telephone but must also be sent in writing.

There are two possible outcomes.

1. A favorable decision, in which case the beneficiary should continue to receive Medicare coverage of the care as long as their doctor continues to certify it. Their plan should continue to cover the care until this issue arises again, such as if the beneficiary’s provider believes that care should end again.
2. An unfavorable decision, in which case the beneficiary can move to the second level of appeal.

Slide 31: Level 2: QIO Reconsideration

The second level of an expedited appeal for non-hospital care that is ending is QIO reconsideration. Click on the numbers to learn what happens during the QIO reconsideration level.

1. If the first appeal to the QIO is unsuccessful, the beneficiary can file a second appeal with the QIO within 60 days of the date listed on the first QIO decision.
2. A different set of QIO staff reviews the appeal and decides if care should be continued. The QIO will issue its reconsideration decision regarding the case within 14 days of receiving the second appeal.

There are two possible outcomes:

1. A favorable decision, in which case their care should be continued and their plan should cover their care.
2. An unfavorable decision, in which case the beneficiary can move to the third level of appeal.

This level of appeal and subsequent levels are the same levels in the Medicare Advantage standard appeal process.

Slide 32: Levels 3, 4, and 5

The last three levels of the Medicare Advantage expedited appeal process, whether hospital or non-hospital care is ending, are the same as the last three levels of the MA standard appeal process.

This means that after receiving an unfavorable decision from the QIO, the next step in the appeal process is the OMHA level, regardless of whether the beneficiary is filing a standard appeal, an expedited hospital appeal, or an expedited SNF, HHA, CORF, or hospice appeal.

If the beneficiary receives an unfavorable decision, the next step is the Council review.

If the beneficiary receives an unfavorable Council decision, the last level in the MA appeal process is requesting judicial review in Federal District Court. Remember, a beneficiary may wish to get the help of a lawyer, a local legal services organization, or a SHIP counselor at these levels of appeal. The takeaway point here is that, in total, there are five steps in the Medicare Advantage appeal process. There are differences in the initial steps of appeal, depending on whether beneficiaries file a standard appeal, an expedited appeal for ending hospital care, or an expedited appeal for ending non-hospital care. These differences are laid out in the Medicare Advantage appeals fliers in the supplementary materials for this course.

Slide 33: Tips for appealing

SHIP counselors may be called upon to help beneficiaries with their appeals, so it is helpful to keep some of these tips in mind.

* The first tip is to follow instructions. Beneficiaries receive important notices from their plan their providers that contain important rules on how to appeal. These notices include information about what numbers to call and where to mail important appeal-related documents. Also remember that appeals will be handled more quickly if they are labeled as being from a beneficiary. This can be written on the appeals forms and/or any envelopes mailed to entities throughout the appeals process.
* Next, counselors should be sure to adhere to important deadlines. There are always deadlines when beneficiaries appeal. These timelines vary depending on the health care service and the level in the appeal process. The time in which beneficiaries have to file an appeal should be indicated on the Medicare notices they receive. If they try to appeal beyond the specified deadline, they will most likely not be able to appeal, unless they qualify for a good cause extension. Good cause extensions apply at each level of the Medicare appeal process and are evaluated on a case-by-case basis.
* Counselors should advise beneficiaries to keep original copies of any information they send out or receive. Administrative errors can occur, so it is important that beneficiaries have copies of all appeal documents for their own records. Also remember that you or the beneficiary can call Medicare or the entity listed on the notice they receive to ensure that they received the appeal.
* Let beneficiaries know that they should take well-documented notes while they are appealing. If they appeal over the phone, they should take down the date and time they call, the name of the representative they speak to, and the outcome of the call. If they speak to their doctor or send out any information, they should write this information down. Appeals can be straightforward if beneficiaries have specific and well-documented information to refer to.
* Help beneficiaries strengthen their appeal by suggesting they get a doctor or health care provider’s support in the appeal process. A doctor’s letter of support is always helpful and may add medical validity to the appeal. SHIP counselors can also help by providing the information about coverage rules that providers should address when writing these letters of support.
* Lastly, keep going! The appeal process has many levels.

Slide 34: Review

This concludes Course 2: Medicare Advantage Appeals in Level 3 of the Online SHIP Counselor Training core curriculum.

In this course, you learned about four main types of Medicare Advantage appeals, which are appeals beneficiaries make to their Medicare Advantage Plan if the plan is denying a health care service or item they receive.

We also talked about how to file different types of Medicare Advantage appeals. Medicare Advantage appeals can follow a standard or expedited timeline depending on the circumstance.

* A beneficiary can file a standard appeal either before or after they receive a health care service or item.
* A beneficiary can file an expedited appeal before they receive care, or if their hospital or non-hospital care is ending.

While reviewing the different Medicare Advantage appeals, we learned that the last few levels in the appeals process—ALJ Hearing, MAC Review and Judicial Review—are the same for all types of Medicare Advantage appeals.

Lastly, you learned some tips for helping your clients appeal in an efficient and effective way.

Remember, beneficiaries have the right to appeal any time Medicare denies coverage or payment on a health care service or item they receive. Appealing can be a straightforward process, as long as beneficiaries have an understanding of the process and the steps they should follow. Although each case is different, the general outline stays the same. It is important for SHIP counselors to encourage beneficiaries to exercise their right to appeal—even if a beneficiary is denied at the lower levels of appeal they can still be successful at higher levels.

Slide 35: End slide

Thank you for your attention throughout this course. Remember that you can always go back to review course information at any time.

Please feel free to take a look at the supplementary materials section for helpful handouts and fliers that will enrich your Medicare learning. You can also take the short quiz for this course to help you review and practice the Medicare information you just learned.