

MEDICARE GRIEVANCES AND APPEALS

A PRIMER

**Prepared for Disability Law Colorado
Medicare Medicaid Advocate Program**



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Notice: This Primer has been prepared for the internal use of Disability Law Colorado and the Medicare-Medicaid Advocate; it may be shared with business partners. The document is to be considered supplemental guidance to the law, rules and policies set forth by the Centers for Medicare & Medicaid Services on Medicare grievances and appeals.

Medicare Grievances and Appeals Primer

Introduction: This document has been prepared for the Medicare-Medicaid Advocate, Regional Care Collaborative Organization (RCCO) Customer Service Representatives, Care Coordinators and Advocates who want to assist an Accountable Care Collaborative: Medicare-Medicaid Program Enrollee with a **MEDICARE** Issue. This guide addresses **MEDICARE’S FEE-FOR-SERVICE OR ORIGINAL MEDICARE** program, only. It does NOT include guidance for persons with Medicare Advantage (Part C) nor does it include information about the Colorado Medicaid appeals program. (Links to information on Medicare Advantage Appeals and Colorado Medicaid Appeals are shown below.) This document is an extract from CMS “official” policy and is intended only as a guide to help explain the basics of the Medicare grievance and multi-level appeal processes. It summarizes key information about timeframes, what kind of documentation and what dollar levels might apply to each case. Pertinent sources on the CMS.gov website are included throughout the document.

Members of Colorado’s Accountable Care Collaborative: Medicare-Medicaid Program keep their full benefits under both Medicare and Medicaid. Generally, Medicare pays for covered health services first; Medicaid is secondary payer and covers services not included in Medicare; such as transportation for medical appointments. The Regional Care Collaborative Organizations’ staff may be the first contact by the member with a Medicare grievance or a denied claim for payment that could be or should be appealed. These guidelines are provided to assist RCCO staff or others who may be supporting the member to understand the basics of the Medicare grievance and appeals process.

Difference between a Grievance and an Appeal

What is a Grievance? A formal complaint about how a provider delivered services to a Medicare beneficiary. Examples: Beneficiary was treated disrespectfully; the beneficiary encountered an unsafe condition in the hospital. A frequent complaint/grievance involves discharge from a hospital when the beneficiary or family feels the discharge is too soon.

What is an Appeal? A challenge Medicare beneficiaries file when they disagree with a decision made by the Medicare payment contractor about their health care. Examples: a service is denied; a service is only partially paid.

Links for Medicare Advantage and Colorado Medicaid Appeals

Link to the CMS guidance on Medicare Advantage Appeals

<https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/>

Link to Colorado Department of Health Care Policy and Financing, Medicaid Program Rules and Regulations

<https://www.colorado.gov/pacific/hcpf/department-program-rules-and-regulations>

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I. Grievances

A. Where is the grievance filed?

Was the service other than a prescription drug issue or durable medical equipment or prosthetic device issue?

1. If yes, the beneficiary will seek resolution from the **Beneficiary and Family Centered Care Quality Improvement Organization**. In Colorado that is KEPRO 1 844 430 9504
2. If the problem involves prescription drug issues, the beneficiary will seek resolution from the **drug plan** providing the Medicare Part D coverage.
3. If the problem concerns durable medical equipment, supplies or prosthetic devices, contact **the supplier** directly or contact the **Competitive Acquisition Ombudsman** if not satisfied. Call 1 800 MEDICARE to be connected to the Competitive Acquisition Ombudsman.

B. What are the Critical Timeframes for Filing a Grievance and Receiving a Response?

1. Grievances other than drug or equipment related

There is no specific timeframe for filing a grievance or complaint against a provider but the sooner the complaint is filed with KEPRO, the faster they will be able to investigate and seek resolution.

2. Drug Plan grievances

- The beneficiary must file the grievance within 60 days of the event that caused the problem.
- The drug plan must respond within 30 days
- If the problem is an emergency situation, the drug plan must respond within 24 hours

3. Durable Medical Equipment and Supplies, Prosthetic Devices grievances

- There is no specific timeframe for the beneficiary to file a complaint against a supplier but the sooner the better.
- Once a grievance/complaint is filed with the supplier,

Within 5 calendar days, the supplier must let the beneficiary know they got the complaint and are investigating it.

Within 14 calendar days, the supplier must send the result of the complaint and their response in writing.

C. What form does the grievance or complaint take? Must it be in writing?

1. If the complaint involves a provider other than a prescription drug plan, the complaint may be submitted in writing or by phone to KEPRO or to the medical equipment supplier as appropriate to the service in question.

KEPRO

www.keproqio.com

844-430-9504 (Toll Free)

2. If the complaint involves a prescription drug issue, there is a Medicare Complaint Form that can be completed online or the complaint can be made directly to the Drug Plan's customer service representative by phone.

Here is the link to the online complaint form for drug problems

<https://www.medicare.gov/MedicareComplaintForm/home.aspx>

Remember: A **grievance** involves a complaint about how the service was provided. An **appeal** involves how a service was paid (or not).

Reference: The following CMS publication (60 pages) contains a full explanation of the Medicare grievance and appeals process for Original Medicare, Medicare Advantage and Part D. It is written for beneficiaries and advocates.

<https://www.medicare.gov/Publications/Pubs/pdf/11525.pdf>

II. Medicare Appeals Process for Part A and B Services

A. Background:

Basically, the Medicare Appeals Process is a follow-on to the Medicare claims payment system. For Original Medicare, health care claims are submitted directly by the provider to the local Medicare Administrative Contractor (MAC). In Colorado, the MAC is Novitas. The beneficiary obtains “official” knowledge of a denial or potential denial of Medicare coverage in two ways:

1. The service is shown as denied on the **Medicare Summary Notice (MSN)** that is received quarterly. A specific section shows the “Number of Services Medicare Denied.” The Medicare Summary Notice provides a line by line description of services billed and how each was paid in the preceding calendar quarter.
2. For a service that the provider knows from experience may not be covered by Medicare, the beneficiary should (this does not always happen) be asked to read and sign an **Advance Beneficiary Notice (ABN)** that acknowledges the potential that Medicare (the MAC) will not pay for the service in whole or in part.

If the beneficiary wishes to challenge a denial of coverage, even if he or she signed an Advance Beneficiary Notice, there is a 5 step process that must be followed - in order. Each step has specific timeframes. Beginning with the 3rd step, the dollar amount in question must be higher than a specific limit which may change each year.

Designating a Representative

A beneficiary does not need an attorney to file requests for review at the first and second steps. However, the beneficiary may designate a representative to assist at any level. A specific form must be completed to designate a representative. CMS-1696.

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>

Having an attorney to assist with a request is recommended for an Administrative Law Judge review, Step 3, and all steps beyond which involve the courts. Free legal service may be available.

<http://www.coloradolegalservices.org>

NOTE: The following material does not include the appeal path for Medicare beneficiaries in a Medicare Advantage Plan. These beneficiaries do not participate in Colorado’s Medicare Medicaid Program.

B. Typical Path for Filing a Medicare Appeal for Medicare Part A and B Claims

Whether the beneficiary did or did not receive and sign an Advance Beneficiary Notice (see Section B below for criteria involving an ABN), the following steps must be taken in order and within

specified timeframes to challenge a Medicare coverage denial (in whole or in part). It is important to keep the timeframes in mind, both those for the beneficiary filing the appeal AND for the entity reviewing and responding. If the time to file at a given step in the process is missed, there may be “good cause” reasons to file anyway. And, if the reviewer fails to meet required timeframes to respond, the beneficiary may “win” on the technical aspect of that failure.

Step 1: Obtain a Redetermination from the Medicare Administrative Contractor (MAC).

The instructions for filing the request are printed on the Medicare Summary Notice. Beneficiaries receive the Medicare Summary Notice quarterly.

Timeframes:

- Beneficiary must file with the MAC within 120 days (about 4 months) from the date on the Medicare Summary Notice.
- MAC must render a decision within 60 days

Documents Needed:

- Copy of the Medicare Summary Notice showing the denied service. Circle the denied service.
- A dated, signed cover letter indicating that the beneficiary is requesting a redetermination of coverage of the denied service OR
- A form CMS-20027, Medicare Redetermination Request Form
<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20027.pdf>
Form can also be requested by calling 1 800 MEDICARE
- Any additional evidence such as a letter from the provider stating why the service should be covered and any medical records from the provider supporting coverage. Note: this additional evidence is optional at the first step. The MAC may contact the provider directly to obtain it.

The MAC for Colorado is Novitas Solutions Inc.

www.Novitas-Solutions.com

1-855-252-8782 (Toll Free)

Novitas Solutions, Inc.

Attention: Appeals

2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

Step 2: Reconsideration by a Medicare Qualified Independent Contractor (QIC)

If the beneficiary still disagrees with the decision after Step 1, A Reconsideration request can be filed with the Qualified Independent Contractor (QIC). In Colorado, the QIC is C2C Innovative Solutions – QIC. The instructions for filing this request are provided on the decision letter or form received from the MAC after Step 1. The QICs are contractors; they have no association with the MAC where the first decision and redetermination was made and they review the claim and all evidence independently.

Timeframes:

- Beneficiary must file with the QIC within 180 days (about 6 months) from the date on the denial letter from the MAC (received after Step 1 above)
- QIC must render a decision within 60 days.

Documents Needed:

Follow the instructions on the Denial Letter. Typically the beneficiary will submit:

- A copy of the Denial Letter received as a result of Step 1
- A signed, dated cover letter stating why the denied service should be covered.
The letter must include: Name, Medicare Number, service to be reviewed, the date of that service, beneficiary signature, and the date.
- CMS also provides a form to request reconsideration from the QIC:
<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf>
- Additional evidence, such as: Medical Records, Office Records/Progress Notes, Treatment Plan, Statement of Medical Necessity. These would need to be provided by the physician or appropriate provider's office.

The Quality Improvement Contractor (QIC) for Colorado is C2C Innovative Solutions Inc.

www.c2cinc.com

(904) 224-2613

C2C Innovative Solutions - QIC

PO Box 45300

Jacksonville, Florida 32232-5300

Step 3 Administrative Law Judge (ALJ) Hearing

If the beneficiary continues to disagree with the decision made at Step 2, a hearing *may* be requested before an Administrative Law Judge.

Note: at this point in the appeals process it is prudent for the beneficiary to obtain legal help. In Colorado, help may be available from Colorado Legal Services. <http://www.coloradolegalservices.org/>

Dollar Threshold:

- To proceed to the Administrative Law Judge Hearing, the amount in question must exceed \$150.
Note that dollar amounts change each year.

Timeframes:

- Beneficiary must file with the Administrative Law Judge Office within 60 days (about 2 months) from the date on the denial letter from the QIC (received after Step 2 above). The Office contact information will be printed on the Denial Letter.
- ALJ will usually render a decision within 90 days.
- NOTE: If the case has not been settled by the ALJ within 90 days of filing, the beneficiary may request that the case go directly to the Medicare Appeals Council (Step 4).

Documents Needed:

Follow the instructions on the Denial Letter from the QIC. The request for an ALJ hearing must be made in writing. The request must include all of the following:

- The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed,
- The name and address of the appellant, when the appellant is not the beneficiary,
- The name and address of the designated representative, if any,
- The document control number assigned to the appeal by the QIC, if any,
- The dates of service,
- The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and
- A statement of any additional evidence to be submitted and the date it will be submitted.

A form to request a hearing can be downloaded:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20034AB.pdf>

The Office of Medicare Hearings and Appeals serving Colorado is

OMHA Kansas City Field Office

601 E. 12th Street, Suite 221

Kansas City, MO 64106

Phone: 816-599-3300

Step 4 Medicare Appeals Council

If the ALJ issues a denial, the beneficiary *may* go to the next step – the Medicare Appeals Council. This is a group of judges different than those who hear cases in Step 3. At this step, as with Step 3, an attorney is strongly recommended to represent the beneficiary’s case.

Dollar Threshold:

- The amount in question must be \$1500 or higher

Note that dollar amounts change each year

Timeframes:

- Beneficiary must file with the Medicare Appeals Council within 60 days of the date of the denial letter from the ALJ.
- There is no time frame within which the Medicare Appeals Council must rule.

Documentation:

- The attorney representing the beneficiary will develop required documentation.

Step 5 District Court

The final step in seeking to overturn a Medicare denial is to present the case to the District Court. An attorney to represent the beneficiary’s case is almost mandatory.

Dollar Threshold:

- The amount in question must be \$1500 or higher

Note that dollar amounts change each year

Timeframes:

- None specified but timely filing is recommended
- The courts are not bound by specific times to render a judgment

Documentation:

- The attorney representing the beneficiary will develop required documentation.

References:

1. The following link is the CMS Claims Manual Chapter 29 on The Appeals Process.

It includes detailed instruction and regulatory guidance to the contractors who process grievances and appeals. This information is produced by CMS and is definitive.

<https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/clm104c29.pdf>

2. The following link takes you to The Medicare Rights Center's Fact sheet for consumers on appealing a Medicare decision. It includes form letters for doctors and tips for beneficiaries who want to file an appeal.

<http://www.medicarerights.org/fliers/Rights-and-Appeals/OM-Post-Service-General-Appeals-Packet.pdf?nrd=1>

3. The following CMS publication (60 pages) contains a full explanation of the Medicare grievance and appeals process for Original Medicare, Medicare Advantage and Part D. It is written for beneficiaries and advocates.

<https://www.medicare.gov/Publications/Pubs/pdf/11525.pdf>

C. Advance Beneficiary Notice**I. What is it?**

A fundamental criterion for coverage under Medicare is that the service or item is "Medically Necessary." Providers or suppliers should give the beneficiary notice called an Advance Beneficiary Notice or ABN if they think the service or item may not be covered by Medicare.

An ABN must be given to a beneficiary if the provider knows the service is not "Medically Necessary." However, an ABN is not required for a service that is specifically excluded from Medicare coverage - examples: eyeglasses or hearing aids. Even though ordered by a physician or other authorized Medicare provider, a supplier or lab may provide an ABN if the lab or supplier feels Medicare may not cover the ordered service.

The ABN is usually issued for professional services covered by Part B (examples: physical therapy, some laboratory tests) but there are other situations when it may be issued. Examples: Skilled Nursing care when continuing Medicare coverage is questionable, and for some situations involving Durable Medicare Equipment and Supplies or Prosthetics when not provided by a contract supplier. See Reference 1, below, for more details.

II. How does the Advance Beneficiary Notice impact the Appeals Process?

A. The form must meet Medicare requirements

The ABN is a form that must meet Medicare requirements for the information on the form and the process in which it is given to the beneficiary. For example, if the ABN is hard to read (a really bad photocopy) or it is hard to understand (it doesn't clearly describe the service that is expected to be denied) the beneficiary may not be held responsible for payment of the service.

B. The provider's process for giving the ABN to the beneficiary must meet requirements.

If the provider's process has flaws; such as, giving everyone an ABN for every service; giving a beneficiary an ABM during an emergency or immediately before a service like an MRI, the beneficiary may not be responsible for payment.

If either the form itself or the manner in which the ABN was given to the beneficiary is questionable, the beneficiary may not be responsible for payment BUT these cases must be proven by moving through the Appeals process.

C. What is good advice to beneficiaries regarding the Advance Beneficiary Notice?

1. If presented with an ABN, the beneficiary should always sign the form and date it and always select the option (which must be present on the form) for the Doctor or other provider to bill Medicare regardless. Always keep a copy of the form.
2. If a Medicare service was denied and the provider did not give the beneficiary an ABN, that fact should be clearly made known in Step 1 of the Appeals process. Let the Step 1 reviewer know that no ABN was issued. That might result in an immediate decision in the beneficiary's favor.

References:

1. The following link to CMS describes the requirements for providers regarding the form and process for giving Advance Beneficiary Notices.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf

2. The following link is to the CMS Medicare Claims Processing Manual Chapter 30, Section 50. It is the detailed and definitive information on Advance Beneficiary Notices.

<https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-CMS-Manual-Instructions.pdf>

III. Medicare Part D Appeals

A. Background:

Most beneficiaries learn of a denial of Part D coverage when they go to the pharmacy to pick up their prescription. Pharmacies are linked electronically to the Medicare Drug Plans' formularies (the list of drugs the plans cover). If the beneficiary's provider has ordered a drug NOT or NO LONGER on the drug plan's formulary, the first attempt to fill the prescription will result in a denial of coverage. The Drug Plan may also reject the request for coverage if the Plan's records show the beneficiary has not met requirements for that particular drug. The pharmacy will give the beneficiary a Notice of Denial of Medicare Prescription Drug Coverage. That form includes rights to challenge the denial.

A successful appeal of a Part D denial of coverage requires the beneficiary, usually with the cooperation of his/her physician, to review the drug ordered. The pre-appeal step is important and can eliminate the lengthy and onerous Appeals process.

When a denial is received, the beneficiary should contact the Drug Plan immediately to determine the exact cause for denial. Sometimes there is an administrative error that is corrected quickly. If the denial is because the drug is not on the Plan's formulary or because there is a coverage restriction not met, the beneficiary should first talk to the ordering physician to see if there is a comparable drug that is on the Plan formulary or that will meet the coverage restrictions criteria. If switching to another drug is not an option, the beneficiary will need to appeal but there is a first step under Part D that must be taken first. See Section B, below ff.

Designating a Representative: As with Part A and B appeals, the beneficiary may designate a representative to assist at any level. A specific form must be completed to designate a representative. CMS-1696.

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>

Having an attorney assist with a request is recommended for an Administrative Law Judge review, Step 3 and all steps beyond which involve the courts. Free legal service may be available from Colorado Legal Services. <http://www.coloradolegalservices.org/>

B. Typical path for filing a Medicare Appeal for Part D services

Pre-Appeal Step: Request an Exception to the Plan Formulary

Contact the Plan to obtain the instructions, including documentation requirements to request an Exception. The ordering physician/provider will need to assist in this process.

Timeframes:

- Exception Request must be filed within 60 days of receiving the denial at the pharmacy.
- For a standard request, the Plan must respond in 72 clock hours
- For an emergency situation, called an expedited or Fast-Track request, the Plan must respond in 24 hours. A Fast-Track request must be specifically requested.

Documentation:

- The Plan may provide instructions about documentation needed to support the request for exception.
- The ordering physician will most likely have to provide a letter of support for denied drug.

Step 1 Redetermination by the Drug Plan

If the result of Step 1 is another denial, the beneficiary can begin the formal appeals process by requesting a Redetermination. The Plan sends a Notice of Denial of Medicare Prescription Drug Coverage when it denies an exception in the Step 1 process. This form must provide directions for filing a Redetermination

Timeframes:

- The Redetermination must be filed with the Drug Plan within 60 days of the denial notice.
- The Plan must issue a decision within 7 days
- If the beneficiary asks for an expedited redetermination, the Plan must respond within 72 hours.

Documentation:

- Another letter of support must be submitted by the ordering physician/provider.

Step 2 Review by an Independent Review Entity (IRE)

This organization is under contract to CMS to provide an independent review of prescription drug denials when the beneficiary or physician, on behalf of the beneficiary, requests review of a denial of coverage.

Timeframes:

- Review by the Independent Review Entity (IRE) must be filed within 60 days of the denial notice received in Step 2.
- The IRE must issue a decision within 7 days
- If the beneficiary or physician asks for an expedited redetermination, the IRE must respond within 72 hours.

Documentation:

- Additional documentation of support for coverage of the denied drug will be required from the ordering physician/provider.

The Independent Review Entity is:

Maximus

3750 Monroe Avenue, Suite 703

Pittsford, NY 14534-1302

Step 3 Administrative Law Judge Hearing

The Independent Review Entity will issue a notice of denial that can be taken to this next step. An attorney is recommended to proceed through this and all remaining steps in the Part D Appeals process.

Timeframes:

- The appeal to the Administrative Law Judge (ALJ) must be filed within 60 days of the date on the denial notice from the IRE.
- The ALJ should respond within 90 days.

Documentation:

- The attorney assisting in the case will determine needed documentation.

The Office of Medicare Hearings and Appeals serving Colorado is

OMHA Kansas City Field Office

601 E. 12th Street, Suite 221

Kansas City, MO 64106

Phone: 816-599-3300

Step 4 Medicare Appeals Council

If the ALJ issues a denial, the beneficiary may go to the next step – the Medicare Appeals Council. This is a group of judges different than those who hear cases in Step 3. At this step, as with Step 3, an attorney is strongly recommended to represent the beneficiary's case.

Dollar Threshold:

- The value of the drug in question must be \$150 or higher

Note that dollar amounts change each year

Timeframes:

- If the case has not been settled by the ALJ within 90 days of filing, the beneficiary may request that the case go directly to the Medicare Appeals Council.
- Beneficiary must file with the Medicare Appeals Council within 60 days of the date of the denial letter from the ALJ.
- The Medicare Appeals Council usually renders a judgment within 90 days.
- A request for an expedited judgment must be returned in 5 days.

Documentation:

- The attorney representing the beneficiary will develop required documentation.

Step 5 District Court

The final step in seeking to overturn a Medicare Part D denial is to present the case to the District Court. An attorney to represent the beneficiary's case is almost mandatory. There is a steep dollar threshold to proceed to federal court.

Dollar Threshold:

- The amount in question must be **\$1500 or higher**

Note that dollar amounts change each year

Timeframes:

- None specified but timely filing is recommended
- The courts are not bound by specific times to render a judgment

Documentation:

- The attorney representing the beneficiary will develop required documentation.

References:

1. The following link contains further links to several publications, flow charts and Medicare Claims Manual issuances on Part D grievances and appeals.

<https://www.cms.gov/medicare/appeals-and-grievances/medprescriptdrugapplgriev/index.html>

2. The following CMS publication (60 pages) contains a full explanation of the Medicare grievance and appeals process for Original Medicare, Medicare Advantage and Part D. It is written for beneficiaries and advocates.

<https://www.medicare.gov/Publications/Pubs/pdf/11525.pdf>