Appeals Process Preparation

An appeal is the action you can take if you disagree with a coverage or payment decision made by Medicare or your Medicare health plan. Before you appeal there is a list of things you should research, gather and consider before undertaking the Medicare Appeals Process:

- **Get your regular doctor involved in the process.**
- **Gather copies of physicians' and other care providers' letters of support to be included in the official record.**
- **Keep records up to date.** Realize that you may be filing appeals both at the hospital and at the skilled nursing rehab facility.
- **Keep track of timing.** Each of the five Medicare Appeals levels has its own specific timeframe within which you must file your claims.
- **Make sure you know what type of Medicare the patient has.** The Appeals process differs for Original Medicare vs. Medicare Advantage Plan.
- **Identify any other health insurance coverage.** Ex: retiree coverage, employer coverage, Medicare Supplement Plan/Medigap plan.

Where Can I Get More Help?

NY StateWide Senior Action Council
275 State St.
Albany, NY 12210
1-800-333-4374
Patients Rights Helpline
www.nysenior.org

Center for Medicare Advocacy, National Office
P.O. Box 350
Willimantic, CT 06226
Phone: (860) 456-7790
Fax: (860) 456-2614
www.medicareadvocacy.org

Medicare Rights Center
520 Eighth Avenue
North Wing, 3rd Floor
New York, NY 10018
Phone: 212-869-3850
Fax: 212-869-3532
800-333-4114
National Helpline
www.medicarerights.org

Centers for Medicare & Medicaid Services (CMS)
800-633-4227 (800-MEDICARE)
TTY-TTD: 877-486-2048
www.medicare.gov

Observation Status & the Medical Appeals Process

STATE WIDE
New York StateWide Senior Action Council, Inc
275 State Street, Albany, NY 12210•(518) 436-1006•Fax (518) 436-7642
www.nysenior.org

Observation Status (OS)

Observation Status (OS) refers to the classification of a patient in a hospital as an outpatient, even though, just like a patient classified as an inpatient, the person is placed in a bed, stays overnight, and receives medically reasonable and necessary hospital care.

Whether a Medicare beneficiary has been formally admitted to the hospital OR is being treated under OS becomes a determining factor in how much Medicare will pay and how much the beneficiary will be required to pay out of pocket. That's why it is very important to keep track of your status during a hospital stay.

Be sure to ask your doctor and other hospital officials whether you are an inpatient or an outpatient being held for observation. And because your status keeps changing during your hospital stay, **KEEP ASKING THE QUESTION!**

DID YOU KNOW?

- Currently, a hospital is NOT required to notify a patient verbally or in writing whether he or she is an inpatient or outpatient under observation status.
- A hospital admittance CAN change even after discharge.

Medical Appeals Process

The formal Medicare Appeals Process has five levels.

1. **Redetermination.**
   If you disagree with the initial determination that is found on the Medicare Summary Notice (MSN) you receive, you can request a redetermination or a second look or review of your claim. You have 120 days after you get the MSN to request the redetermination.

2. **Reconsideration.**
   If you disagree with the redetermination decision in level 1, you have 180 days after you get the "Medicare Redetermination Notice" to request a reconsideration by a Qualified Independent Contractor (QIO). The QIO did not take part in the level 1 redetermination decision and will review your request for a reconsideration and make a decision.

3. **Administrative Law Judge (ALJ).**
   If you disagree with the reconsideration decision in level 2, you have 60 days after you get the "Medicare Reconsideration Notice" to request a hearing by an Administrative Law Judge (ALJ). To get an ALJ hearing your case must meet a minimum dollar amount - $140* in 2013. The ALJ will review the facts of your appeal before making a new and impartial decision.

Medical Appeals Process

4. **Medicare Appeals Council.**
   If you disagree with the ALJ's decision in level 3, you have 60 days after you get the ALJ's written decision to request a review by the Medicare Appeals Council.

5. **Federal District Court.**
   If you disagree with the Medicare Appeals Council's decision in level 4, you have 60 days after you get the Medicare Appeals Council's written decision to request judicial review by a Federal district court. In 2013, the minimum dollar amount for this level of appeal is $1400*. The judicial review by a Federal District Court is the final level of appeal available.

The Center for Medicare Advocacy's Self Help Packet for Medicare "Observation Status" details the requirements at each of the five appeals levels.

The self-help packet can be found at: www.medicareadvocacy.org/self-help-packet-for-medicare-observation-status/

*Adjusted annually in accordance with the medical care component of the consumer price index.