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 to help provide additional information.
- **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 you have.** The Appeals process differs for Original Medicare vs. Medicare Advantage Plan. Ex: retiree coverage or employer coverage
- **Read all the letters and notices** you receive from Medicare or your plan once your appeal is underway.

Where Can I Get More Help?

NY StateWide Senior Action Council
275 State St.
Albany, NY 12210
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

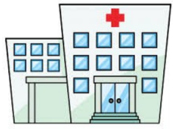
Medicare Rights Center
266 West 37th Street
3rd Floor
New York, NY 10018
Phone: 212-869-3850;
Fax: 212-869-3532
800-333-4114
National Helpline
www.medicarerights.org

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

LIVANTA Medicare's Quality of Care & Appeals Discharge Non-Coverage Hotline
866-815-5440

Observation Status & the Medicare Appeals Process

Observation Status (OS)



Observation Status is a billing designation used by hospitals to bill Medicare. Observation services are hospital outpatient services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Just like a patient classified as an inpatient, an outpatient under observation is placed in a bed, stays over-night, and receives medically reasonable and necessary hospital care.

Your hospital status – whether you are an inpatient or an outpatient – affects how much you pay out of pocket for hospital services and prescription drugs and may affect whether Medicare will cover skilled nursing facility (SNF) costs following your hospital stay. If you need SNF care, be sure to ask your doctor and other hospital officials to be admitted as an inpatient. And, because your status keeps changing during your hospital stay, **KEEP ASKING QUESTIONS!**

DID YOU KNOW?

- Hospitals are **required** to inform a patient verbally and in writing within 24 hrs. of being placed on observation status?
- To file a complaint, you can contact the NYS Dept. of Health at 800-804-5447.

Medicare Appeals Process

The Formal Medicare Appeals Process has 5 Levels

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.

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 (QIC). The QIC did not take part in the level 1 redetermination decision and will review your request for a reconsideration and make a decision.

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-$160* in 2019. The ALJ will review the facts of your appeal before making a new and impartial decision.

Medicare Appeals Process

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.

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 2019, the minimum dollar amount for this level of appeal is $1,630*. The judicial review by a Federal District Court is the final level of appeal available.

Currently, Medicare has no official method to appeal Observation Status so trying to fix it is difficult and can take time. The Center for Medicare Advocacy's Self-Help Packet for Medicare "Observation Status" can help. The 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.

Patient's Rights, Medicare, Medicare Fraud, EPIC Helpline

1-800-333-4374