MA Appeals Process

Appeals Process

Standard Appeal
If a beneficiary, physician, legal representative or authorized representative does not agree with a decision made by Health Alliance, he or she may appeal.

If a member decides to proceed with the standard appeals/reconsideration process, the following steps will occur:

1. A **written request** for a reconsideration of the decision must be submitted to Health Alliance within 60 days from the date of denial notice from Health Alliance Medicare, Attn: Member Relations Coordinator, 3310 Fields South Dr., Champaign, IL 61822, or by fax to 217-902-9708. Requests for an appeal may also be sent to the Social Security Administration (SSA) office (or, if a beneficiary is a railroad retirement beneficiary, to a Railroad Retirement Benefits office). Please note that if the SSA office or the Railroad Retirement Benefits office receives a written request for an appeal, they will forward the request to us. Therefore, the timeframe within which we must conduct our review begins when we receive the request.

2. Health Alliance will conduct a reconsideration of the decision and notify the beneficiary, in writing, of the decision using the following timeframes:

   - **Request for Service**- If the appeal is for a denied service, we must notify the beneficiary of the reconsideration decision as expeditiously as the beneficiary’s health requires, but no later than 30 days after we receive the appeal. We may extend this time frame by up to 14 calendar days if the member requests the extension or if we justify the need for additional information and how the extension of time benefits the beneficiary (for example, if we need additional medical records from non-contracted providers that could change a denial decision). Again, we must make a decision as expeditiously as the beneficiary’s health requires, but no later than the end of any extension period. When we take an extension, the beneficiary will be notified of the extension in writing. If the beneficiary disagrees with our decision to take an extension, the member can file a grievance.

   - **Request for Payment**- If the appeal is for a denied claim, we must notify the beneficiary of the reconsideration determination no later than 60 days after receiving the request for a reconsideration determination.

Please note: Our reconsideration decision will be made by a medical director not involved in the initial decision. All reconsiderations of adverse organization determinations based on “lack of medical necessity” must be made by a physician with appropriate expertise in the field of medicine appropriate for the services at issue. However, that physician need not be of the same specialty or subspecialty as the treating physician. The beneficiary or another authorized
representative may present or submit relevant facts and/or additional evidence for review either in person or in writing to Health Alliance.

3. If we decide fully in the beneficiary’s favor on a request for service, we must provide or authorize the requested service as expeditiously as the beneficiary’s health requires, but no later than 30 calendar days from the date we received the request for reconsideration (or no later than upon expiration of an extension). If we decide fully in the Beneficiary’s favor on a request for payment, we must make the requested payment within 60 days of the date we received the request for reconsideration.

4. If we decide to uphold our original adverse decision, either in whole or in part, or if we fail to provide a decision on a beneficiary’s reconsideration within the relevant time frame, we will automatically forward the case file to an Independent Review Entity (IRE) for a new and impartial review. Maximus Federal Services is the current IRE contracted by CMS to review appeals involving Medicare Advantage organizations like Health Alliance. We must send Maximus Federal Services the file within 30 days of a request for service and within 60 days of a request for payment. Maximus Federal Services will either uphold or reverse our decision. If we forward the case to Maximus Federal Services, we still must notify the beneficiary of our decision within the relevant time frames discussed above. For cases submitted for review, Maximus Federal Services will make a reconsideration decision and notify the beneficiary in writing of their decision and the reasons for the decision.

5. If Maximus Federal Services decides in the beneficiary’s favor and reverses our decision, the following must occur:

   - **Request for Service:** If Maximus Federal Services decides in the beneficiary’s favor, we must authorize the service under dispute within 72 hours of the date we receive Maximus Federal Services’ notice reversing our decision, or provide the service under dispute as expeditiously as the beneficiary’s health condition requires, but no later than 14 calendar days from the date of Maximus Federal Services’ notice.

   - **Request for Payment:** If Maximus Federal Services decides in the beneficiary’s favor, we must pay for the service no later than 30 calendar days from the date we receive Maximus Federal Services’ notice reversing our decision.

Please note: If Maximus Federal Services does not rule fully in the beneficiary’s favor, there are further levels of appeal.

6. If the dollar threshold given by Maximus Federal Services is met, a beneficiary may request a hearing before an administrative law judge (ALJ) by submitting a
written request to the entity specified in the IRE Reconsideration Notice within 60 days. (This 60-day notice may be extended for good cause.) If a request for an ALJ hearing is submitted to us or to the SSA, we will forward it to Maximus Federal Services. Maximus Federal Services will then forward the ALJ hearing request and reconsideration file to the ALJ hearing office. Health Alliance will also be made a party to the appeal at the ALJ level.

7. If the member or Health Alliance disagrees with the ALJ’s decision, either may request a review of an ALJ decision by the Medicare Appeals Council (MAC), which may either review the decision or decline review.

8. If the dollar threshold given by the ALJ is met, either the member or Health Alliance may request judicial review if a decision has been made by the MAC or if the MAC has declined review of the ALJ’s decision.

9. Any initial or reconsidered decision can be reopened by the entity that made the decision (that is, Health Alliance, Maximus Federal Services, the ALJ or the MAC). Health Alliance or the member may request a reopening within one year from the date of the organization determination or reconsideration for any reason, within four years for good cause. An IRE, ALJ or MAC may reopen within 180 days from the date of reconsideration for good cause.

Unless it is reopened, the reconsidered determination is final and binding upon the Medicare Advantage organization. If the dispute involves a benefit determination, the Medicare Advantage organization cannot offer any other dispute resolution process except what is required by law.

**Expedited Review Request Process**

1. Upon receiving a request for an expedited decision, Health Alliance will determine if the request meets the definition of time-sensitive.

   a. If the request for an expedited organization determination does not meet the definition, it will be handled as expeditiously as the beneficiary’s health requires, but no later than 14 calendar days after receiving the expedited request for service.

   b. If a request for an expedited appeal does not meet the definition, it will be handled as expeditiously as the beneficiary’s health requires, but no later than 30 calendar days after we receive the expedited appeal request.

   c. The beneficiary will be informed by telephone or in person whether the request will be processed through the expedited/72-hour review or the standard review process and will also be sent a written confirmation within three calendar days of the phone call or personal contact.
d. If the beneficiary disagrees with Health Alliance’s decision to process his or her request within the standard time frame, a grievance may be filed with Health Alliance. The written confirmation letter will include instructions on how to file a grievance.

e. An extension up to 14 calendar days is permitted for a 72-hour request for organization determination/appeal if the beneficiary asks for the extension or we need more information and the extension of time benefits the beneficiary (for example, if you need time to provide us with additional information or if we need to have additional diagnostic testing completed).

2. The request must be processed as expeditiously as the beneficiary’s health requires, but no later than 72 hours if a physician calls or writes in support of an expedited/72-hour review (unless an extension is granted), and indicates that applying the standard review time frame could seriously jeopardize the beneficiary’s life, health or ability to regain maximum function.

3. Health Alliance will make a decision on the request for an organization determination or appeal and notify the member of a decision within 72 hours of receipt of the request.

   a. When the beneficiary requests an expedited determination/appeal, if the beneficiary does not hear from us within 72 hours of the request, it can be assumed the request has been denied. For an expedited determination, our failure to notify the member in a timely manner—within 72 hours—constitutes a denial, which you may appeal. For an expedited appeal, if we fail to notify the beneficiary in a timely manner—within 72 hours—the request will automatically be forwarded to Maximus Federal Services.

4. If, on reconsideration of decision, Health Alliance decides fully in the beneficiary’s favor on a request for service, we must authorize or provide the requested service under dispute as expeditiously as the beneficiary’s health condition requires, but no later than 72 hours after we receive the request for a reconsideration (or no later than upon expiration of an extension discussed above).

5. If we decide to uphold the original adverse decision, either in whole or in part, we will forward the entire case file to Maximus Federal Services for
an impartial review as expeditiously as the beneficiary’s health requires, but no later than 24 hours after our decision. Maximus Federal Services will send the beneficiary a letter with their decision within 72 hours of receiving the case from us or at the end of up to a 14-calendar-day extension.

a. If Maximus Federal Services decides in the beneficiary’s favor and reverses our decision, we must authorize or provide the service under dispute as expeditiously as the beneficiary’s health condition requires but no later than 72 hours from the date we receive Maximus Federal Services’ notice reversing our decision.

b. If Maximus Federal Services does not rule fully in the beneficiary’s favor, there are further levels of appeal as discussed above.

Expedited/72-Hour Review
If a beneficiary, physician, legal representative or authorized representative believes the beneficiary continues to need a service and believes it is a time-sensitive situation, a request for the decision to be expedited may be made. If Health Alliance decides that it is a time-sensitive situation or if any physician states that it is one, we will make a determination on the request for service on an expedited/72-hour basis.

If Health Alliance denies a beneficiary’s request for a service, the beneficiary, physician, legal representative or authorized representative may choose to submit a written or oral appeal under the expedited appeal process if the beneficiary’s health could be seriously harmed by waiting 30 days for the standard appeals process.

To proceed with the expedited/72-hour review process, the following steps should occur:

1. If any physician asks for an expedited appeal or supports the member in asking for one, we will automatically make a decision on the appeal on an expedited/72-hour basis.

2. We may extend this time frame by up to 14 calendar days if the beneficiary requests the extension or if we need additional information, and the extension of time benefits the beneficiary (for example, if we need additional medical records from non-contracted providers that could change a decision). Again, we must make a decision as expeditiously as the beneficiary’s health requires, but no later than the end of any extension period.

3. If an expedited appeal is requested without support from a doctor, we will decide if the beneficiary’s health condition requires us to make a
decision on an expedited basis. If we do not approve the expedited appeal request, we will notify the beneficiary verbally followed by written confirmation within three calendar days that we will process the appeal request as a standard appeal. If the beneficiary disagrees with our decision not to grant an expedited appeal, the beneficiary can file a grievance with us.

Examples of service decisions for which a member may request an expedited/72-hour appeal include the following:

• The beneficiary received a denial of a proposed service.
• The beneficiary thinks services are being discontinued too soon.
• The beneficiary thinks he or she is being discharged from a skilled nursing facility too soon.
• The beneficiary thinks his or her home health care is being discontinued too soon.
• The beneficiary thinks he or she is being discharged from a Hospital too soon, and has missed the deadline for a Quality Improvement Organization (QIO) review.

The procedures for requesting an expedited organization determination or an expedited appeal are described below.

Please note that the expedited procedures do not apply to requests for payment of services already furnished.

To request an expedited/72-hour review for a beneficiary, you can call, write or fax. You must ask for an expedited/72-hour review when you make your request.

Call: 1-800-500-3373 (TTY: 711) available 24/7

Write: Health Alliance Medicare
Attn: Member Relations Coordinator
3310 Fields South Dr.
Champaign, IL 61822

Fax: 1-217-902-9708
Attention: Member Relations Coordinator
8 a.m. to 5 p.m., Monday through Friday

Fast Track Appeals Review
Members receiving skilled services in home health settings, a skilled nursing facility or a comparable outpatient rehabilitation facility will receive a discontinuation
letter. This letter will be faxed to the provider of service with the expectation that the provider will hand deliver the letter to the member or their representative. The letter of Notice of Medical Non-Coverage (NOMNC) is required by the Center of Medicare and Medicaid Services (CMS) to be given no later than two days before coverage of services will end. The beneficiary or the beneficiary’s representative needs to have the signature page returned to the health plan within 24 hours of delivery. If services are expected to be fewer than two days, the letter must be delivered upon admission.

- If the beneficiary, provider, legal representative or authorized representative decides to file a fast track appeal, they have until noon of the day before services are to end to do so after they have been notified by the health plan. The NOMNC letter will have the telephone number where the call needs to be placed to initiate the appeal. **Note:** If the noon deadline is missed, the appeal can still be requested through the Expedited/72 Hour Review. The telephone number will also be listed on the NOMNC letter.

- If a “Fast Track” appeal had been registered with the Quality Improvement Organization (QIO) the Member Relations staff will be notified of the appeal and all relevant medical information needed to review the appeal will be forwarded to the QIO. If needed, the provider will be contacted by Member Relations staff at Health Alliance to ask for assistance in faxing the QIO medical records or delivering information to the beneficiary.

- Once the QIO has made a decision on the appeal, they will notify the party registering the appeal, the facility and the Medicare Advantage plan of the decision by phone and in writing. In the event the appeal is in favor of the beneficiary, the Medicare Advantage plan will also send to the appealing party and facilitate a letter of approval.

**Beneficiary Appeals Process**

Below is the process beneficiaries should follow to file an appeal:

1. You may file an appeal or have someone else file the appeal for you on your behalf. Any physician may file an expedited appeal on your behalf.

2. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:
   a. Give us your name, your Medicare number and a statement, which appoints an individual as your representative. For example: I [your name] appoint [name of representative] to act as my representative in requesting an appeal from the Medicare Advantage Organization and/or the Centers for Medicare & Medicaid Services regarding the denial or discontinuation of medical services.
   b. You must sign and date the statement.
c. Your representative must also sign and date this statement unless he/she is an attorney.

d. You must include this signed statement with your appeal.

3. A non-contracted physician or other provider who has furnished you a service may file a standard appeal of a denied claim if he/she completes a waiver of payment statement which says he/she will not bill you regardless of the outcome of the appeal.

Supporting Your Appeal
Health Alliance is responsible for gathering all necessary medical information relevant to your request for reconsideration (appeal). However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include information such as medical records or physician opinions in support of your request. To obtain medical records, you may send a written request to your Primary Care Provider (PCP). If your medical records from a specialist are not included in your medical records from your PCP, you may need to make a separate request to the specialist who provided medical services to you.

You have the opportunity to provide additional information in person or in writing. In the case of an expedited decision or appeal, you or your authorized representative may submit evidence in person, by telephone or in writing transmitted by fax at the address and telephone number referenced above under the expedited/72-hour review procedure. (Please call Health Alliance if you need additional information or help understanding the procedures for submitting evidence to support your appeal.)

Assistance With Appeals
Regardless of whether you file a standard appeal or ask for an expedited review, you can have a friend, lawyer or someone else help you. Health Alliance Member Services is available to help you between the hours of 8 a.m. and 5 p.m., Monday through Friday. Call toll-free 1-800-965-4022 (TTY: 711). There are lawyers who may be willing to not charge a fee unless you win your appeal. Groups such as lawyer referral services can help you find a lawyer. There are also groups, such as legal aid services, that will give you free legal services if you qualify. You may want to contact The Medicare Rights Center at 1-800-333-4114, Monday through Friday. You can also email them at info@medicarerights.org or write to 266 W 37th St. 3rd Floor, New York, NY 10018 or 1444 I St NW, Suite 1105, Washington, DC 20005.

Maximus Federal Services Reopening
A reopening is not an appeal right. Any of the parties to a reconsidered determination may request a reopening; however, granting a reopening is solely
at Maximus Federal Services’ discretion. The party requesting a reopening must clearly state in writing the basis on which the request is made.

All Maximus Federal Services determinations advise the parties of the standards for reopening of the case file by Maximus Federal Services. A reopening may be requested by any party to the determination if the party believes one of the following grounds for reopening is applicable:

- Error on the face of the evidence by Maximus Federal Services in its review
- Fraud
- New and additional information that was not available at the time Maximus Federal Services made its initial determination in the case

A Medicare Advantage organization’s request for a reopening does not relieve the Medicare Advantage organization of the responsibility to comply with Maximus Federal Services’ decision within the required time frames.

**Appeal Process-Medicare Part D**

A member or their representative can appeal our decision not to cover a drug, vaccine or other Part D benefit. They may also appeal our decision not to reimburse for a Part D drug that has been paid for. The member can appeal if they think we should have reimbursed them more than they received or if they asked us to pay a different cost-sharing amount than they thought they are required to pay for a prescription. Finally if we deny the Exception request the member can appeal.

If a request is denied, the member and providers involved with the coverage will receive a written decision explaining the reason why the request was denied. We may decide completely or partly against the request.

If we deny part or all in our coverage decision, the member or member’s representative may ask us to reconsider our decision. The member, member’s representative or the prescribing doctor may file a fast appeal. The request may be made in person, by phone, fax or in writing. If the appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, the doctor and member will first need to decide whether the member needs a fast appeal.

The appeal must be filed within 60 calendar days from the date included on the notice of your coverage determination. We can give more time if there is a good reason for missing the deadline.

For a fast appeal the member, member’s representative or prescribing doctor can ask us for a fast appeal (rather than a standard appeal) by calling 1-800-500-3373 (TTY: 1-800-526-0844), faxing a request to 217-902-9708, deliver in-person or send the request to Health Alliance Medical Plans, 3310
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Fields South Dr., Champaign, IL 61822. Be sure the request indicates a “fast”, “expedited” or “72-hour” review. Remember that if the prescribing doctor provides a written or oral supporting statement explaining that there is a need for the fast appeal, we will automatically treat the request as a fast appeal.

If the request is for a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug the member has already paid for and received, we have up to 7 calendar days to give a decision, but will make it sooner if the health condition of the member requires us to. If we do not make the decision within 7 calendar days, the request will automatically be submitted to an independent organization and they will review the request.

If the decision is approved in favor of the member, we must send payment to the member no later than 30 calendar days after we receive the request for reconsideration.

If the request is for a fast decision about a Part D drug that you have not received we have up to 72 hours to give a decision, but will make it sooner if the health condition of the member requires us to. If we do not make the decision within 72 hours, the request will automatically be submitted to an independent organization and they will review the request.

If the decision is approved in favor of the member, we must provide the Part D drug within 72 hours of receiving the appeal or sooner, if the member’s health would be affected by waiting this long.

If we deny any part of the appeal the member or member’s representative may ask for a review by a government contracted independent review organization. The independent review organization is an outside independent organization that has a contract with CMS, the government agency that runs the Medicare program. The independent review organization has no connection with us. The member has a right to ask us for a copy of the case file we sent to this organization.

The member or appointed representative are the only ones allowed to make a request for review by the independent review organization in writing within 60 calendar days after the date the member was notified of the decision on the 1st appeal review. The written request must be sent to the address included in the redetermination letter from Health Alliance. If the request asks for a fast review and there is a prescribing doctor’s written or oral statement explaining the need for a fast appeal, the independent review organization will automatically treat the appeal as a fast appeal.

For standard independent review the organization has 7 calendar days from the date it received the appeal request to make a decision. For a fast independent review the organization has 72 hours from the date it received the appeal.
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request to make a decision. The independent review organization will tell the member and prescribing doctor in writing about its decision and reasons for it.

If the decision is about reimbursement for a Part D drug the member has already paid for and received, we must pay within 30 calendar days from the date we receive notice reversing our coverage determination. If the decision is about a standard Part D drug the member has not received we must authorize or provide the member with the Part D drug within 72 hours from the date we receive notice reversing our coverage decision. If the decision was a fast decision about a Part D drug we have 24 hours from the date we received notice reversing our coverage decision. With all reversals, we will send a notice to the organization stating we abided by their decision.

If the independent review organization upholds our denial the parting filing the appeal will be notified in the decision letter of any other appeals levels available for continued review.

If you would like a copy of the Appeals policy, contact the Member Relations Department at 1-800-500-3373.