

# THE HMO APPEALS PROCESS

## **Before the appeal begins**

It is best to begin a paper trail as early as possible. When your HMO denies payment for Medicare-covered services or refuses to provide Medicare-covered services that you request, it must give you a written notice with a full explanation of your appeal rights. If you do not receive this notice, you should demand it of the HMO. While it is ideal to contest a written denial, you may also contest a verbal denial.

## **First level appeals: Reconsideration within the HMO**

Ask, in writing, for a "reconsideration" of your denial within 60 days from the date of the HMO's denial notice. Mail the request to your HMO, local Social Security Office, or the Railroad Retirement Board if you get Medicare as a Railroad retiree. The HMO must reconsider its decision within 30 days if you need care or 60 days if you are appealing for payment for care you already received. You can present supporting evidence in person or in writing. If the HMO decides in your favor, it issues you a notice and the appeal is finished.

## **How and when to expedite your appeal**

If your HMO denies and/or terminates urgently needed care, the delay of which could seriously jeopardize your life, health, or ability to regain maximum function, you can obtain an **expedited appeal** within 72 hours of your request.

- Ask your doctor to request an expedited appeal from the HMO. Upon any doctor's request—regardless of whether the doctor works for the HMO—your HMO must expedite the appeal.
- You can also make the request on your own. In this situation, the HMO will determine whether your condition is sufficiently endangered by the denial to require an expedited appeal.

## **Second level appeals:**

If the HMO does not find 100% in your favor, it must forward your file to an Independent Review

**Reconsideration  
(Review by the  
Independent  
Review Entity  
(IRE)**

Entity (IRE), an independent contractor that performs impartial reconsiderations. IRE may uphold the HMO's decision, partially overturn it, fully overturn it, or (in the case where you never understood the HMO rules on seeing only doctors and hospitals within the network except for emergency and urgent-care cases) retroactively disenroll you from the HMO. If you are appealing a preservice denial, the IRE has to decide your case in 30 days, or within 72 hours in the case of an expedited appeal. If you are appealing for payments for services you already received, IRE has 60 days to decide your case.

**Third level  
appeals:  
Administrative  
Law Judges**

If the IRE reaches a decision against you and your case has more than \$110 in dispute (in 2007), you may appeal to the Administrative Law Judge (ALJ). You must request an ALJ hearing within 60 days of receiving the decision from the IRE. A hearing can take up to a year to schedule.

**Further levels of  
appeal**

The fourth stage is appealing to the Medicare Appeals Council (MAC). The amount in question does not matter. The final stage is an appeal in federal district court, which requires a minimum amount in controversy of \$1,130 (in 2007).

**Disenrollment**

If your HMO has denied urgently needed services that you know you can get under Original Medicare, at certain times during the year you may be able to disenroll from the HMO and return to Original Medicare to obtain the service, while lodging a complaint against the HMO. If you disenroll, you may have difficulty obtaining Medigap insurance in many states. Your Original Medicare coverage is effective the first day of the month after the HMO or Social Security receives your disenrollment request.

**Getting help for  
the appeals  
process**

You do not need a lawyer to appeal an HMO denial. Most appeals are straightforward enough to do yourself. For extra help you may try contacting the Legal Services office in your area or your [State Health Insurance Assistance Program](#) (SHIP).

Despite the 60 day rule, appeals in Medicare HMOs can take up to 120 days at each stage.

With patience and perseverance, however, you can obtain the care and coverage that you need from your HMO.

### Case Flash

**Question:** When Mrs. R's HMO abruptly terminated her home health care, her daughter was very concerned. Mrs. R had recently come out of difficult surgery, and her daughter, who lived far away from her mother, believed Mrs. R's home health care needed to be reinstated. What should she do?

**Answer:** First, Miss R should call her mother's physician, who can place a request with the HMO for an expedited appeal. The HMO would then be required to review Mrs. R's case, and reach a decision within 72 hours. In order for Mrs. R's home health care to continue, her doctor needs to recertify that she meets the criteria for home health care. If she was still "homebound" and presented a "skilled" need on a part-time or intermittent basis, her home health care could be continued.