Center for Medicare Advocacy, Inc.

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GLOSSARY OF MEDICARE APPEALS TERMINOLOGY

Administrative law judge (ALJ): A lawyer with the Office of Medicare Hearings and Appeals of the Department of Health and Human Services who presides over administrative hearings to determine whether an item or service should be paid for or provided under Medicare Part A, Part B, Part C, or Part D. The ALJ hears testimony, reviews evidence, conducts the hearing, and issues a decision about the appeal. Hearings are generally conducted by telephone or by video-teleconference.

Appeal: Procedures to review a decision by Medicare, made through a Medicare contractor, a Medicare Advantage plan, or a prescription drug plan, not to pay for or provide an item or service. Depending on the type of claim, levels of appeal include a redetermination, a reconsideration, review by an independent review entity, a hearing before an administrative law judge, review by the Medicare Appeals Council, and review by a federal court.

Carrier: A private company that contracts with Medicare to review and pay claims under Medicare Part B. The carrier performs the redetermination, the first level of appeal of a Part B claim. The carrier is also known as a Medicare contractor.

Coverage determination: A decision by a prescription drug plan whether to pay for or provide a drug under Medicare Part D. A coverage determination includes a decision whether to pay for a drug that is not on the drug plan's formulary (often called a formulary exception), to provide a formulary drug at a lower cost-sharing tier (often called a tiering exception), to cover a drug obtained at a pharmacy that is not part of the drug plan's network, or to waive a utilization management requirement (called an exception).

Exception: A request that a prescription drug plan pay for a drug that is not on its formulary, reduce the cost sharing for a formulary drug, or waive a utilization management requirement for a formulary drug.

Expedited time frames: An organization determination under Part C or a coverage determination under Part D may be expedited if applying the standard time frame may jeopardize the life or health of the beneficiary or the beneficiary's ability to regain maximum function. The Medicare Advantage plan or prescription drug plan determines whether to grant a request for expedited consideration, but such a request must be granted if made by a physician. Redeterminations and reconsiderations under Part C and Part D may also be expedited according to the same rules and standards.

Expedited determination and redetermination under Part A and Part B: Pre-termination review by the Quality Improvement Organization (QIO) of a decision to

terminate hospital care, skilled nursing facility care, hospice care, home health care, and comprehensive outpatient rehabilitation facility (CORF) care. For home health and CORF care a doctor must certify that failure to continue the services may place the beneficiary's health at significant risk.

Fast track review under Medicare Part C: Pre-termination review by the Quality Improvement Organization (QIO) of a decision to terminate hospital care, skilled nursing facility care, hospice care, home health care, and comprehensive outpatient rehabilitation facility (CORF) care. The limitation under Part A and Part B on challenges to termination of home health and CORF services does not apply under Part C.

Fiscal intermediary: A private company that contracts with Medicare to review and pay claims under Medicare Part A. The fiscal intermediary performs the redetermination, the first level of appeal of a Part B claim. The fiscal intermediary is also known as a Medicare contractor.

Grievance: A complaint or dispute with a Medicare Advantage plan or a prescription drug plan concerning the activities, operations or behavior of the plan (for examples, a rude customer service representative or long waiting times to see a doctor). A grievance does not include a complaint concerning whether an item or service should be provided or paid for by the plan; that would be an appeal.

Independent review entity (IRE): A private company under contract with Medicare to perform reconsiderations of appeals from denials of Part C and Part D claims. The IRE is also sometimes referred to as a QIC.

Initial determination: A decision by a Medicare contractor to pay or not to pay a claim under Medicare Part A or Part B.

Medicare Appeals Council (MAC): The division of the Departmental Appeals Board of the Department of Health and Human Services that reviews unfavorable administrative law judge decisions.

Medicare contractor: A private company under contract with Medicare to review and pay claims under Medicare Part A and Medicare Part B. A fiscal intermediary is the Medicare contractor that reviews Part A claims. A carrier is the Medicare contractor that reviews Part B claims.

Notice: A written statement that indicates whether Medicare will pay for an item or service and that explains how to file an appeal or to get information about filing an appeal. Some notices also include reasons why Medicare will not pay for or cover the requested item or service. Receipt of a notice starts the clock running on the time to request the next step in the appeals process.

Organization determination: A decision by a Medicare Advantage plan whether to pay for or provide an item or service the plan covers, including mandatory and optional benefits, and the amount the enrollee is required to pay.

Quality improvement organization (QIO): A private company under contract with Medicare to review appeals of hospital discharge cases and expedited determinations under Part A and Part B. The QIO also hears some complaints about qualify of care under Part A, Part B, Part C and Part D.

Qualified independent contractor (QIC): A private company under contract with Medicare to perform reconsiderations of appeals from denials of Part A and Part B claims. The independent review entity that contracts with Medicare to provide consideration of appeals from denials of Part C and Part D claims also is sometimes referred to as an IRE.

Reconsideration: (1) The first level of appeal of a Medicare Part C claim. The reconsideration is performed by the Medicare Advantage plan. (2) The second level of appeal for claims under Parts A, B and D, as well as the second level of review of a Part C claim. This level of reconsideration consists of review by a private company that has a contract to review redetermination decisions made by Medicare contractors or prescription drug plans and/or to review reconsideration decisions by Medicare Advantage plans. The contractor may be called an independent review entity (IRE) or a Qualified Independent Contractor (QIC). IMPORTANT: For Part C only, both the first level of appeal (performed by the Medicare Advantage plan) and the second level of appeal (performed by the IRE) are called reconsideration.

Redetermination: The first level of review of a claim under Medicare Part A, Medicare Part B, and Medicare Part D. Redeterminations may be conducted by fiscal intermediaries (Part A claims), carriers (Part B claims), or prescription drug plans (Part D claims).

Utilization management requirement: A limitation on a prescription drug plan's coverage of a drug on its formulary. Utilization management requirements include quantity limits on the strength or dosage or number of pills; and "fail first" or step therapy, where the beneficiary must try a less expensive drug before the drug plan will cover the prescribed formulary drug. Under "prior authorization" the drug plan must first approve use of a prescribed formulary drug before the plan will cover the drug. Some drug plans call all utilization management requirements "prior authorization."

Links to Useful Information

Medicare notices and appeals forms
http://www.medicare.gov/Basics/forms/default.asp
http://www.cms.hhs.gov/bni
http://www.cms.hhs.gov/MLNProducts/Downloads/Form_Exceptions_final.pdf

Finding the Medicare contractor, QIO, or IRE:

http://www.medicare.gov/Contacts/Include/DataSection/Questions/SearchCriteria.asp?version=default&browser=IE%7C7%7CWinXP&language=English&defaultstatus=0&pagelist=Home

Information about Administrative Law Judge hearings in the Medicare Office of Hearings and Appeals

http://www.hhs.gov/omha/