Medicare Advantage

Determinations and Appeals

Part C Services

Regulatory Process[1]	**Plan Process**
Initial Decisions Claims payment determination – clean claims submitted by enrollees or non-contract providers must be paid in 30 days. All other claims submitted by non-contract providers must paid in 60 days. [42 CFR 422.520(a)] Pre-service organization determinations – Standard decisions must generally be made in 14 days.[2] [42 CFR 422.568] Expedited preservice organization determinations – Decisions must be made within 72 hours. An MAO must expedite a determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum. [42 CFR 422.572] Appeals[3] (1) Reconsideration – a reconsideration must be requested within 60 days of an adverse organization determination unless good cause is shown. [42 CFR 422.582(b) and (c)] Standard Reconsideration Decisions -- The plan must make a standard pre-service	Initial Decisions Claims payment determination – claim must be paid within the prompt payment timeframe set forth in agreement between the plan and provider. [42 CFR 422.520(b)] (Note that state prompt payment laws are preempted.) Appeals No process is prescribed by regulation. The plan process is determined by the relevant plan or by the parties through contract negotiations. Note that in reviewing Medicare Advantage plan policies, some of the largest plans (United, Humana and Anthem) offer two levels of internal appeals and no external appeals.

[1] Note that different (shorter) timeframes apply with regard to Part B drugs, but the process is the same. This chart does not address Part D drugs.

[2] The plan can extend the timeframe where i) the enrollee requests the extension; ii) the extension is justified and in the enrollee's interest due to the need for additional medical evidence from a noncontract provider that may change an MA organization's decision to deny an item or service; or iii) the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the enrollee's interest.

[3] Note that a separate process applies with regard to appeals of inpatient hospital discharge decisions and decisions concerning termination of skilled nursing facility, home health and comprehensive outpatient rehabilitation facility services.

reconsideration decision within 30 days.[2] [42 CFR 422.590(a)] The plan must make decisions about non-contract provider claims in 60 days. [42 CFR 422.590(b)] For a non-contract provider to request a reconsideration of a claim payment decision, the provider must sign a waiver of liability. Expedited preservice reconsiderations– -- The plan must make an expedited reconsideration decision within 72 hours. An MAO must expedite a reconsideration if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum. [42 CFR 422.572] Independent Review Entity (IRE) review – if the reconsideration decision is expected to be adverse to the provider or beneficiary in whole or in part or the plan fails to make a decision within the required timeframe, the matter is **automatically** forwarded to the IRE for review. No action is required on behalf of the beneficiary/provider. [42 CFR 422.590] This is part of the reconsideration process. (2) Administrative Law Judge (ALJ) appeal – An ALJ appeal must be requested by the provider or beneficiary within 60 calendar days of receipt of the notice of a reconsidered determination. In order to appeal to the ALJ the amount in controversy must meet a certain threshold ($180 in 2022). [42 CFR 422.602] (3) Medicare Appeals Council (MAC) – The plan, the provider, or the beneficiary may request a MAC review within 60 days of receiving the ALJ decision unless a good cause exception is granted. [42 CFR 405.1102] (4) Federal District Court -- The plan, the provider, or the beneficiary may request review by a Federal District Court within sixty days of receiving the MAC decision unless a good cause exception is granted. In order to appeal to the	

Federal District Court, the amount in controversy must meet a certain threshold ($1760 in 2022).	