

Medical Determinations - Part C

Appeals

As a Mercy Care Advantage member, you have the right to file an appeal (called a “reconsideration”) with MCA if you receive notice of any of the following:

- MCA denied payment for renal dialysis services you received while temporarily outside of the MCA service area
- MCA denied payment for emergency services, post-stabilization care or urgently needed services you received while temporarily outside of the MCA service area
- MCA denied payment for any other health services furnished by a provider that you believe should be covered
- MCA refused to authorize, provide or reimburse you for services, in whole or in part, that you believe should be covered
- MCA discontinued a service or benefit that you believe is incorrect
- MCA failed to approve, furnish, arrange for, or provide payment for health care services in a timely manner

Once you receive a written notification, you may file an appeal within 60 days from the date of the notification letter. You can call or write a letter to Mercy Care Advantage to file an appeal. A special team will review your appeal to determine if we made the right decision. For authorization decisions, we will notify you in writing of the results of our reconsideration not later than 30 calendar days from the date your appeal was received. For payment decisions, we will notify you in writing not later than 60 calendar days.

If more time is needed to gather medical records from your physicians, we may file a 14-day extension. You may also request an extension if you need more time to present evidence to support your appeal. We will notify you in writing if an extension is required.

If you or your doctor thinks your health could be seriously harmed by waiting for a standard reconsideration about an authorization, you may ask MCA for a fast (expedited) appeal. If we agree that a standard reconsideration review would seriously harm your health, we will notify you by telephone of our reconsideration not later than 72 hours from the date and time we received the appeal. If we do not agree that the reconsideration should be expedited, we will notify you in writing and automatically move your appeal to the standard reconsideration process.

There are five levels to the Medicare Advantage appeals process for denied services and payment:

	APPEAL LEVEL	STANDARD REVIEW	EXPEDITED (FAST) REVIEW
1.	Reconsideration by MCA	Upon receipt of your appeal, MCA will send you a letter to confirm the basis of the appeal. The reconsideration will be evaluated by an Appeals specialist, with a clinical expert when necessary.	Only available for reconsiderations for services not yet received. Subject to expedited review criteria. MCA will notify you if the appeal does not meet expedited review criteria.

		MCA will notify you not later than 30 calendar days for service requests (plus 14 days if an extension is filed) or not later than 60 calendar days for payment reconsiderations.	MCA will notify you of the reconsideration decision as fast as your condition requires, but not later than 72 hours after receiving your appeal.
2.	Reconsideration by the Independent Review Entity (IRE)	If MCA agrees with the original denial, in whole or in part, your file is automatically forwarded for reconsideration by IRE. The IRE will review your appeal and notify you of their decision within 30 days for service requests and 60 days for payment requests of receipt of the appeal file from MCA.	If MCA agrees with the original denial, in whole or in part, your file is automatically forwarded to the IRE for reconsideration within 24 hours. The IRE will review your appeal and notify you of their decision within 72 hours of receipt of the appeal file from MCA.
3.	Administrative Law Judge (ALJ)	If the IRE decision is unfavorable and the amount in dispute meets the appropriate threshold, you may request a hearing with the ALJ. You must follow the instructions on the notice from the IRE.	Same as standard appeal.
4.	Medicare Appeals Council (MAC)	If the ALJ decision is unfavorable, you may appeal to the MAC, which is within the Department of Health and Human Services, which reviews ALJ's decisions.	Same as standard appeal.
5.	Judicial Review	If the MAC denied your request for appeal, and the amount in dispute meets the requirements, you may request judicial review of the ALJ decision. If the MAC decision is unfavorable, and the amount meets the minimum requirement, you may request judicial review of the MAC decision. The MAC will provide you will instructions on how to request a judicial review.	Same as standard appeal.

Appointment of Representative

You may to appoint someone (your doctor, family member, friend, etc.) to act on your behalf during the Appeals process. Both you and the person you selected must fill out and sign an [Appointment of Representation Form](#) and mail it or FAX it to the Appeals Department with your appeal at the address or FAX number listed below. Click [HERE](#) for the form and instructions on how to fill out the form. The completed and signed form is valid for one (1) year.

If your representative holds durable power of attorney or guardianship papers, an Appointment of Representative form is not required.