MEDICARE RIGHTS CENTER
Getting Medicare right

Appealing to the Office of Medicare Hearings and Appeals (OMHA)

The Office of Medicare Hearings and Appeals (OMHA) handles Original Medicare, Medicare Advantage, and Part D appeals. You can appeal to the OMHA level after you receive a denial for either health care services or prescription drugs:

- From the Qualified Independent Contractor (QIC) if you are appealing an Original Medicare coverage decision
- From the Independent Review Entity (IRE) if you are appealing a Medicare Advantage or Part D coverage decision

After you receive a denial, you must appeal to OMHA within 60 days of the date on the denial notice. To request an OMHA appeal, you should write a letter to the address listed on your QIC or IRE decision. The letter should include:

- Your appeal request
- Your name
- Your Medicare number
- The name of your plan
- Your plan ID number

Make sure to keep a copy of all documents sent and received during the appeal process. If possible, send your appeal certified mail or delivery confirmation. Do not send the original copies of important documents.

Preparing for the hearing

It may take a few months before OMHA schedules your hearing. Before your hearing, you will receive a notice titled Response to Notice of Hearing, which you should complete and return **within five calendar** days of receipt. This form indicates whether you plan to be present at the time and place of a scheduled hearing. Keep in mind that you do not need to go to court for OMHA appeals. These hearings are usually held over the phone. The notice will also ask you to provide a telephone number where you can be reached.

After you receive your Response to Notice of Hearing:

- You should contact OMHA and ask for a full copy of the court's record. The record contains all the information that OMHA will use to make a decision. You may already have some of the documents contained in the record. Make sure that there is no missing information. If something important is missing, mail of fax them to OMHA immediately.
- You will have **10 days to submit any additional evidence or written argument** before your hearing. If you are having trouble meeting this deadline, contact OMHA to request an extension.

You may want to contact a lawyer or legal services organization to help you with this step of your appeal–but it is not required. You can also appoint a friend, family member, doctor, or lawyer to be your representative during the hearing if you think you will need help.

The hearing

On the day of your hearing, you will receive a call from OMHA. Be sure to be available at least 10 minutes before the scheduled time. At the start of the call, the OMHA adjudicator may ask you questions such as:

- Do you have a representative?
- Will you provide testimony?
- Do you understand that you will be under oath?

The adjudicator should explain that the hearing will be recorded. If you are testifying, you will be asked to take an oath to speak truthfully. You should explain the steps you took to access care and why the care was important.

If you are appealing a decision from your Medicare Advantage or Part D plan, your plan may have a plan representative or lawyer participating in the hearing. The plan is allowed to present their argument and you or your representative will be given the chance to respond afterwards. The plan will also be given an opportunity to respond to your argument.

Note that your argument is different from your testimony. Your argument should explain why the service or treatment is covered by Medicare, and should be supported by your testimony and evidence from the law, regulations, or plan handbook.

Case example

Plan X denied payment for a doctor's visit. During the hearing, Plan X's representative explains that you went to see an out-of-network provider.

During your testimony, you tell the story of what happened. You are a member of Plan X in New York. You were in California visiting a relative when you fell and were taken to a hospital to be treated for emergency care.

During your argument, you explain that under Medicare law a plan is required to cover emergency care provided by an out-of-network doctor. You understand that you received out-of-network services, however you needed emergency treatment.

After your hearing, it may take two to three weeks before you receive a mailed decision. The adjudicator is not allowed to announce a decision over the phone.