

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



# The Medicare Appeals Process

## FACT SHEET

### Overview

Section 1869 of the Social Security Act and 42 C.F.R. Part 405 Subpart I contain the procedures for conducting appeals of claims in Original Medicare (Medicare Part A and Part B).

There are five levels in the claims appeals process under Original Medicare:

1. Redetermination by a CMS contractor (carrier, fiscal intermediary or Medicare Administrative Contractor (MAC))
2. Reconsideration by a Qualified Independent Contractor (QIC)
3. Hearings before an Administrative Law Judge (ALJ) within the Office of Medicare Hearings and Appeals in the Department of Health and Human Services
4. Review by the Appeals Council within the Departmental Appeals Board in the Department of Health and Human Services
5. Judicial review in federal district court

### Appealing Medicare Decisions

- Once an initial claim determination is made by a contractor, beneficiaries, providers, and participating physicians and suppliers have the right to appeal the determination
- Physicians and suppliers who do not take assignment on claims have limited appeal rights
- Beneficiaries may transfer their appeal rights to non-participating physicians or suppliers who provide the items or services and do not otherwise have appeal rights. Form CMS-20031 (<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html>) must be completed and signed by the beneficiary and the non-participating physician or supplier to transfer the beneficiary's appeal rights
- All appeal requests must be made in writing

## First Level of Appeal

### REDETERMINATION

Contractor staff not involved in making the initial claim determination perform the first level appeal, the redetermination. The appellant (the individual filing the appeal) must file the request for redetermination with the contractor as noted on the MSN and RA within 120 days from the date of receipt of the initial determination. The initial determination is the Medicare Summary Notice (MSN) issued to beneficiaries, and the remittance advice (RA) issued to providers and suppliers. The MSN and RA also include information about how to file a request for redetermination. A minimum monetary threshold is not required to request a redetermination.

### REQUESTING A REDETERMINATION

Physicians, suppliers and beneficiaries may follow the directions on their RA or MSN to request a redetermination. In addition, a request for a redetermination may be filed on Form CMS-20027 available at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List>. A written request not made on Form CMS-20027 must include:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service and/or item(s) for which a redetermination is being requested
- Specific date(s) of service
- Name and signature of the party or the representative of the party

The appellant should attach any supporting documentation to their redetermination request. Contractors will generally issue a decision (either a letter, MSN or RA) within 60 days of receipt of the redetermination request.

**Note: If a claim contains a minor error or omission, the claim may be corrected through the reopening process rather than the appeals process.**

For information on how to correct minor errors and omissions, please see the following MLN Matters article, SE 0420, located at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0420.pdf>: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0420.pdf> on the CMS website.

## Second Level of Appeal

A party to the redetermination may request a reconsideration if dissatisfied with the redetermination. A QIC will conduct the reconsideration. The QIC reconsideration process allows for an independent review of an initial determination, including the redetermination, which may include review of medical necessity issues by a panel of physicians or other health care professionals. A minimum monetary threshold is not required to request a reconsideration.

### Requesting a Reconsideration

A written reconsideration request must be filed with the QIC within 180 days of receipt of the redetermination. A request for a reconsideration may be made on Form CMS-20033. This form can be obtained at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms-List.html>. If the form is not used, the written request must contain all of the following information:

- Beneficiary name
- Medicare Health Insurance Claim (HIC) number
- Specific service(s) and/or item(s) for which the reconsideration is requested
- Specific date(s) of service
- Name and signature of the party or the authorized or appointed representative of the party submitting the appeal
- Name of the contractor that made the redetermination

In the request for reconsideration, the appellant should clearly explain the reason for disputing the redetermination decision. A copy of the RA or MRN, and any other useful documentation should be sent with the reconsideration request. Documentation that is submitted after the reconsideration request has been filed may result in an extension of the timeframe a QIC has to complete its decision. Further, any evidence noted in the redetermination as missing and any other evidence relevant to the appeal must be submitted prior to the issuance of the reconsideration decision. Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless the appellant demonstrates good cause for submitting the evidence late.

### Reconsideration Decision Notification

Reconsiderations are conducted on-the-record and, in most cases, the QIC will send its decision to all parties within 60 days of receipt of the request for reconsideration. The decision will contain information regarding further appeal rights. If the QIC cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an ALJ.

### Third Level of Appeal

#### ADMINISTRATIVE LAW JUDGE HEARING

If at least \$140\* remains in controversy following the QIC's decision, a party to the reconsideration may request an ALJ hearing within 60 days of receipt of the reconsideration decision. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.)

Appellants must also send a copy of the ALJ hearing request to all other parties to the QIC reconsideration. ALJ hearings are generally held by video teleconference (VTC) or by telephone. If the appellant does not want a VTC or telephone hearing, the appellant may ask for an in-person hearing. An appellant must demonstrate good cause for requesting an in-person hearing.

The ALJ will determine whether an in-person hearing is warranted on a case-by-case basis. Appellants may also ask the ALJ to make a decision without a hearing (on-the-record).

Hearing preparation procedures are set by the ALJ. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing.

The ALJ will generally issue a decision within 90 days of receipt of the hearing request. This timeframe may be extended for a variety of reasons including, but not limited to, the case being escalated from the reconsideration level, the submission of additional evidence not included with the hearing request, the request for an in-person hearing, the appellant's failure to send notice of the hearing request to other parties, and the initiation of discovery if CMS is a party.

If the ALJ does not issue a decision within the applicable timeframe, the appellant may ask the ALJ to escalate the case to the Appeals Council level.

***\*Note: The amount in controversy required to request an ALJ hearing is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2013 is \$140.***

### Fourth Level of Appeal

#### APPEALS COUNCIL REVIEW

If a party to the ALJ hearing is dissatisfied with the ALJ's decision, the party may request a review by the Appeals Council. A minimum monetary threshold is not required to request Appeals Council review. The request for Appeals Council review must be submitted in writing within 60 days of receipt

of the ALJ's decision, and must specify the issues and findings that are being contested. (Refer to the ALJ decision for details regarding the procedures to follow when filing a request for Appeals Council review.)

In general, the Appeals Council will issue a decision within 90 days of receipt of a request for review. That timeframe may be extended for various reasons, including but not limited to, the case being escalated from an ALJ hearing. If the Appeals Council does not issue a decision within the applicable timeframe, the appellant may ask the Appeals Council to escalate the case to the Judicial Review level.

### Fifth Level of Appeal

#### JUDICIAL REVIEW IN U.S. DISTRICT COURT

If at least \$1,400\* or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review in federal district court. The appellant must file the request for review within 60 days of receipt of the Appeals Council's decision. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

***\*Note: The amount in controversy required to request judicial review is increased annually by the percentage increase in the medical care component of the consumer price index for all urban consumers. The amount in controversy threshold for 2013 is \$1,400.***

### For More Information

For more information about the Medicare appeals process, please visit the Original Medicare (also known as Fee-For-Service) Appeals web page located at <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index.html>.



### Medicare Learning Network

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