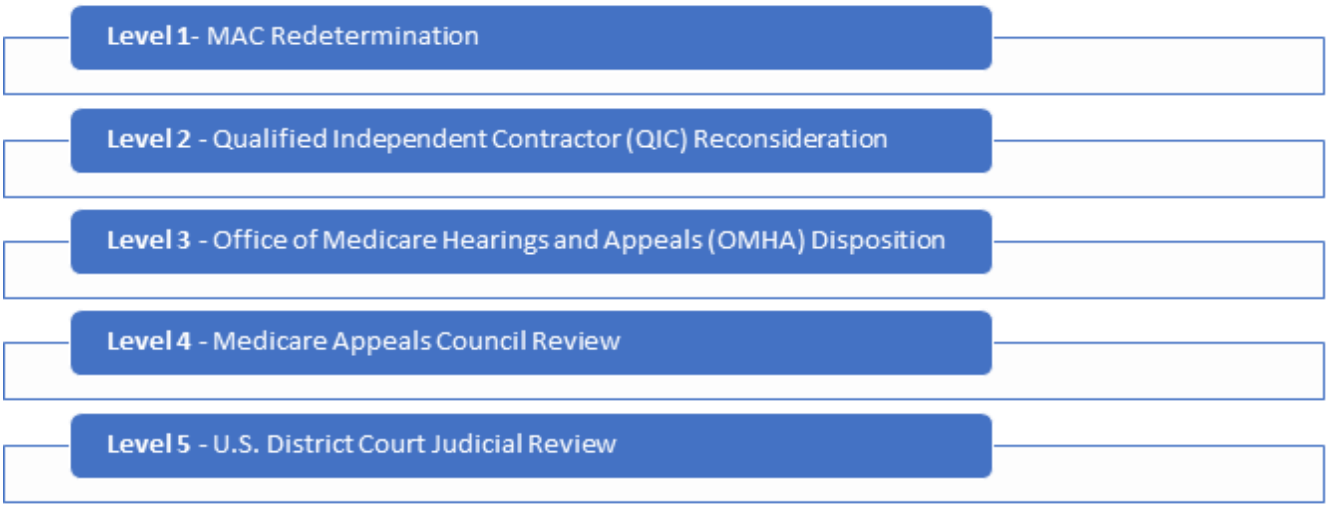
# Medicare Appeals Process

Medicare has a five-level appeals process. Denial of a claim under Part A or Part B may be reversed at any of these levels. Detailed information about the appeals processes and the appropriate forms can be found at the Centers for Medicare and Medicaid Services website. The five levels of appeal are as follows:




## Types and Levels of Appeals

| Level | Process | Who | Deadline | Timeframe | AIC |
|---|---|---|---|---|---|
| Redetermination | Document Review | MAC | 120 days | 60 days | No |
| Reconsideration | Document review | QIC | 180 days | 60 days | No |
| Disposition | Interactive hearing | ALJ | 60 days | 90 or 180 days | Yes |
| Council Review | Decision Review | Council | 60 days | 90 days or 180 days | No |
| U.S. District Court | Judicial Review | U.S. District Court | 60 days | No time limit | Yes |

## Redetermination

"Appeals Level 1: Company handling Medicare claims redetermination."
Medicare.gov
Timely filing: 120 days

There are two ways to file a redetermination appeal:

1. Use the Redetermination Request form available on the appropriate MAC website OR
2. Complete a generic Medicare Redetermination Request form. The forms should be sent to the Medicare contractor at the address or fax listed by the MAC or by portal (if available).
   a. Follow the instructions for sending an appeal. The request for redetermination must be sent to the company that handles claims for Medicare. The website for the MAC can be found on the MAC Contact Info Document on the Medicare Program Page.
   b. Indicate the item(s) and/or services you disagree with on the medical summary notice.
   c. Provide a written rationale regarding the disagreement with the decision on the form or write it in a separate document, along with your Medicare number, and attach it to the form.
   d. Include the beneficiary's name, address, phone number, and Medicare Number.
   e. Include medical documentation supporting the services provided.
   f. Include any other information about the appeal with the medical summary notice.

The decision is usually rendered within 60 days of the receipt of the request.

## Reconsideration

"Appeals Level 2: Qualified Independent Contractor (QIC) Reconsideration"
Medicare.gov
Timely filing: 180 days from the MRN receipt date

There are two ways to submit a reconsideration request:

1. Complete a "Medicare Reconsideration Request Form" or use the form included in the Redetermination response.
2. Submit a written request to the QIC that includes:
   a. Name and Medicare Number.
   b. The specific item(s) or service(s) for which a reconsideration is requested and the specific date(s) of service.

c. The name of the company that made the redetermination (the company that handles claims for Medicare).
d. An explanation of why you disagree with the redetermination decision.
e. Patient, provider, or representative signature. If the appeal is being filed by someone other than the patient, they should review the "Appointment of Representative Form."
f. Include any missing appeal documentation that was not submitted with the original redetermination.

The decision is usually rendered within 60 days of the receipt of reconsideration request.

## Hearing Before an Administrative Law Judge

"Appeals Level 3: Hearing before Administrative Law Judge"
Medicare.gov
Timely filing: 60 days from the reconsideration decision letter receipt date

A hearing before an Administrative Law Judge (ALJ) can be requested in one of two ways:

1. Complete a "Request for Medicare Hearing by an Administrative Law Judge" form.

2. Follow the reconsideration letter instructions and submit a written request to the Office of Medical Hearings and Appeals (OMHA) that will handle the ALJ hearing that includes:
   a. Beneficiary name, address, and Medicare Number. If the beneficiary has appointed a representative, include the representative's name and address.
   b. The appeal number included on the QIC reconsideration notice, if any.
   c. The dates of service for the items or services being appealed.
   d. An explanation of why you disagree with the reconsideration decision being appealed.

It is important to note additional information cannot be reconsidered if it was not submitted with the previous appeals.

An ALJ hearing can only be requested if a certain dollar amount is in question. Refer to the AIC Thresholds for the annual amount. The administrative law judge or attorney adjudicator usually issues a decision within 90 days of the receipt for a hearing request.

## Review by Medicare Appeals Council

"Appeals Level 4: Review by Medicare Appeals Council"
Medicare.gov
Timely filing: 60 days of the OMHA decision or dismissal receipt date

To request that the Medicare Appeals Council (Appeals Council) review the ALJ's decision in the case, follow the directions in the ALJ's hearing decision received in level 3. The request must be sent to the address listed in the ALJ's hearing decision. A request for Appeals Council review can be filed by:

1. Follow instructions included in the OMHA disposition package or fill out a "Request for Review of an Administrative Law Judge (ALJ) Medicare Decision/Dismissal" form with the following information:
   a. Beneficiary name and Medicare number. If the beneficiary has appointed a representative, include the name of the representative.
   b. The specific item(s) and/or service(s) and specific date(s) of service being appealed. See the MSN or the ALJ hearing decision for this information.
   c. A statement identifying the parts of the ALJ's decision with which you disagree and a rationale.
   d. The date of the ALJ decision.
   e. Beneficiary signature. If a representative has been appointed, include the signature of the representative.
   f. If a request is made for the case to be moved from the ALJ to the Appeals Council because the ALJ has not issued a timely decision, include the hearing office in which the request for hearing is pending.

2. File electronically through the E-file webpage.

### Judicial Review by a Federal District Court

After the Appeals Council's decision, an appellant may request judicial review before a U.S. District Court judge if a threshold monetary amount is in controversy. The amount is adjusted annually. A request for judicial review must be filed within 60 days after receiving the Appeals Council's decision. Each Appeals Council decision contains details about how to seek judicial review.

## Resources

### Centers for Medicare and Medicaid Services

Filing an Appeal if I have Original Medicare
Medicare Parts A and B Appeals Process