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

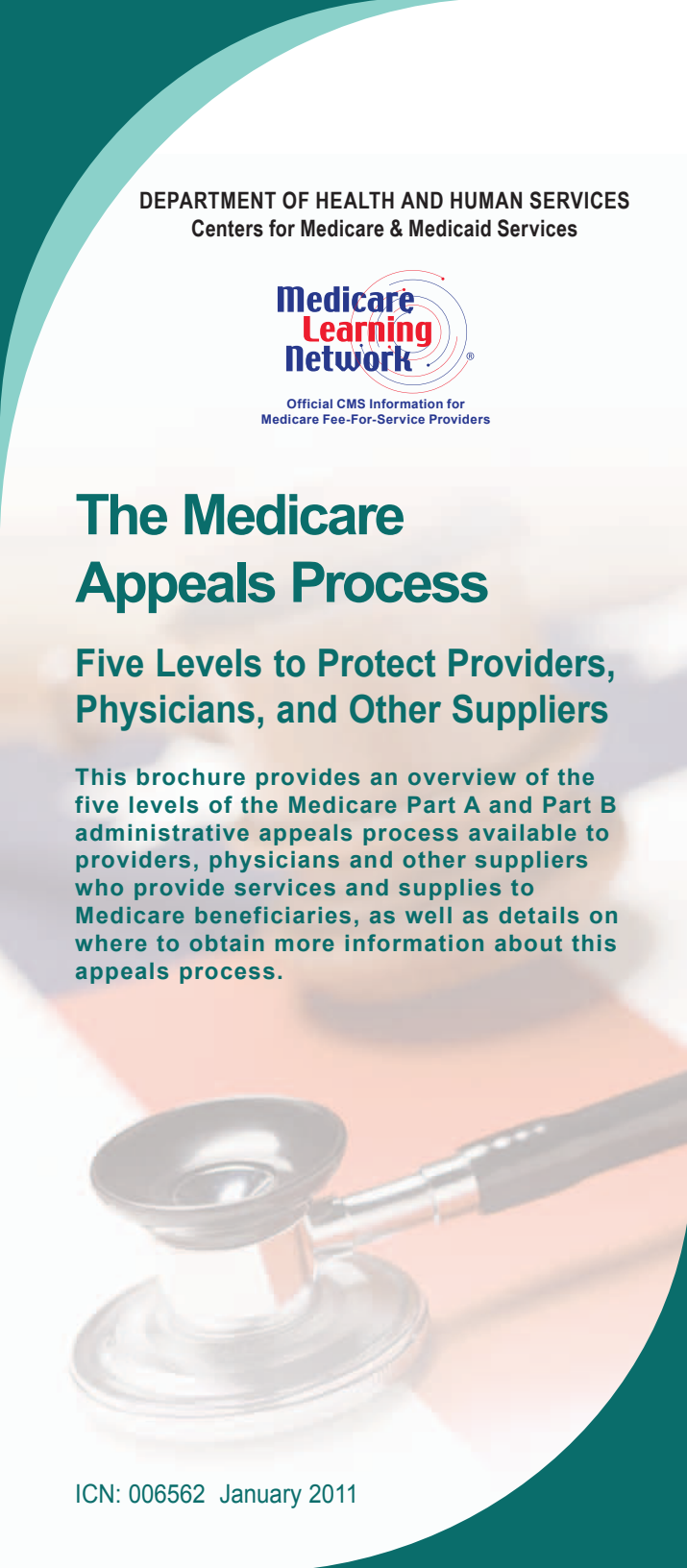
Medicare Learning Network®

Official CMS Information for
Medicare Fee-For-Service Providers

The Medicare Appeals Process

Five Levels to Protect Providers, Physicians, and Other Suppliers

This brochure provides an overview of the five levels of the Medicare Part A and Part B administrative appeals process available to providers, physicians and other suppliers who provide services and supplies to Medicare beneficiaries, as well as details on where to obtain more information about this appeals process.



ICN: 006562 January 2011

Background

Section 521 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included provisions aimed at improving the Medicare fee-for-service appeals process. Part of these provisions mandate that all second-level appeals (for both Part A and Part B), also known as reconsiderations, be conducted by Qualified Independent Contractors (QICs).

The reconsiderations that are conducted by the QICs have replaced the Hearing Officer Hearing process for Medicare Part B claims and established a new second level of appeal for Medicare Part A claims.

Medicare Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies (called carriers for Part B, fiscal intermediaries (FIs) for Part A, or Medicare Administrative Contractors (MACs) to perform many processing functions on behalf of Medicare, including local claims processing and the first level appeals adjudication functions.

NOTE: Medicare Contracting Reform (MCR) Update—In Section 911 of the Medicare Prescription Drug, Improvement, and Moderniza ion Act of 2003 (MMA), Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at *http://www.cms.hhs.gov/MedicareContractingReform/* on the CMS website.

Appealing Medicare Decisions

- Once an initial claim determination is made, providers, participating physicians and other suppliers have the right to appeal.
- Physicians and other suppliers who do not take assignment on claims have limited appeal rights.
- Beneficiaries may transfer their appeal rights to non-participating physicians, or other suppliers who provide the items or services and do not otherwise have appeal rights. Form CMS-20031 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.

Five Levels in the Appeals Process

Medicare offers five levels in the Part A and Part B appeals process. The levels, listed in order, are:

- Redetermination by an FI, carrier or MAC
- Reconsideration by a QIC
- Hearing by an Administrative Law Judge (ALJ)
- Review by the Medicare Appeals Council within the Departmental Appeals Board, (hereinafter "the Appeals Council")
- Judicial review in U.S. District Court

First Level of Appeal: Redetermination

A redetermination is an examination of a claim by the FI, carrier or MAC personnel who are different from the personnel who made the initial determination. The appellant (the individual filing the appeal) has 120 days from the date of receipt of the initial claim determination to file an appeal. A minimum monetary threshold is not required to request a redetermination.

Requesting a Redetermination

A request for a redetermination may be filed on Form CMS-20027 available at *http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage.* 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 or a revised remittance advice) within 60 days of receipt of the redetermination request. The redetermination request should be sent to the contractor that issued the initial determination.

NOTE: Contractors can no longer correct minor errors and omissions on claims through 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.hhs.gov/MLNMattersArticles/downloads/SE0420.pdf on the CMS website.

Second Level of Appeal: Reconsideration

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 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 within 180 days of receipt of the redetermination. To request a reconsideration, follow the instructions on your Medicare Redetermination Notice (MRN). A request for a reconsideration may be made on Form CMS-20033. This form will be mailed with the MRN. 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
- Name of the contractor that made the redetermination

The request should clearly explain why you disagree with the redetermination. A copy of the MRN, and any other useful documentation should be sent with the reconsideration request to the QIC identified in the MRN. 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 you show 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 detailed information on further appeals rights if the decision is not fully favorable. 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 $130* 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. (Refer to the reconsideration decision letter for details regarding the procedures for requesting an ALJ hearing.) Appellants must also send notice of

the ALJ hearing request to all parties to the QIC reconsideration and verify this on the hearing request form or in the written request.

ALJ hearings are generally held by video-teleconference (VTC) or by telephone. If you do not want a VTC or telephone hearing, you 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 all 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, you 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 he consumer price index for all urban consumers. The amount in controversy threshold for 2011 is $130.

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. There are no requirements regarding the amount of money in controversy. 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, you 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 $1,260* or more is still in controversy following the Appeals Council's decision, a party to the decision may request judicial review before a U.S. District Court judge. 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 2011 is $1,300.

For More Information

For more information about the Medicare appeals process, please visit the Medicare Fee-For-Service Appeals web page located at *http://www.cms.hhs.gov/OrgMedFFSAppeals/* on the CMS website.

Medicare Learning Network

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at *http://www.cms.hhs.gov/MLNGenInfo/* on the CMS website.