The recently updated appeals process is now the same for both Medicare Part A and Part B claims with respect to the amount of time the provider has in which to file an appeal. The current appeals process is depicted in Figure 7-1.

Please note that the appeals process will continue to undergo modification as proposed changes are implemented and future changes are made in Medicare law. Before initiating an appeal, providers should confirm the current appeals process, including time limits and Amounts In Controversy (AICs) with their Medicare Contractor [Fiscal Intermediary (FI), Carrier, or Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC)].

As of 2005, the AIC requirement for an ALJ hearing and Federal District Court Review will be adjusted in accordance with the medical care component of the Consumer Price Index (CPI). The AIC threshold amounts for the 2006 Calendar Year (CY) are listed above.
Updated Appeals Policy Information


Information regarding Medicare Advantage Fast Track Appeals and grievances for a physician or supplier billing for a beneficiary whose Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) coverage is about to end is available at www.cms.hhs.gov/MMCAG/ on the CMS website.

CAN A MINOR CLAIM ERROR BE CORRECTED WITHOUT A FORMAL APPEAL?

Section 937 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allows for providers, physicians, and other suppliers to correct minor errors and omissions without the need to initiate a formal appeal. Reopenings are separate and distinct from the appeals process. Medicare Contractors must process clerical errors and omissions as a reopening, rather than as a redetermination. Such reopenings may be handled over the telephone or in writing. As necessary, the Medicare Contractor may ask providers, physicians, or other suppliers to fax in additional documents to support changes and/or error corrections.

The following list provides examples of some errors that can be corrected during a reopening:

- Add, change, or delete certain modifiers
- Correct the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) code(s)
- Correction to date(s) of service

Correcting Minor Claims Errors/Omissions

Information on correcting minor errors is available in the Medlearn Matters (MLN) article at www.cms.hhs.gov/MLNMattersArticles on the Centers for Medicare & Medicaid Services (CMS) website. Search for MLN article SE0420.

The request to reopen a claim must be made within one year from the date of the notice of the initial determination. However, if good cause exists, a provider has after the 1 year but before the 4-year time frame to initiate a reopening after the date of the initial determination.

If the Medicare Contractor receives a request for reopening and disagrees that the issue is a clerical error, the Medicare Contractor must dismiss the reopening request and advise the part of any appeal rights, provided the time frame to request an appeal on the original denial has not expired.
Assigning Medicare Appeals Rights to a Provider or Supplier

When Medicare denies a claim, the beneficiary has the right to legally assign appeal rights to a provider or supplier who were not already a party to the initial determination. This provider or supplier can then proceed with appealing the denied claim. The assignment of appeals rights must be made in writing using Transfer (Assignment) of Appeal Rights Form CMS-20031, which is available at [www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage](http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage) on the CMS website.

**WHAT IS THE FIRST LEVEL OF APPEAL?**

After the initial determination has been made on a submitted Medicare claim, the first level of appeal is a redetermination. The purpose of a redetermination request is to contest the initial determination made on a Medicare claim. A redetermination is a new look at the claim and its supporting documentation by a Medicare Contractor who is independent of the reviewers who were originally involved with the initial claim determination.

**FILING A REDETERMINATION REQUEST**

The appellant (the individual filing the appeal) must file a redetermination request in writing with the Medicare Contractor that processed the claim within 120 calendar days from the date the appellant receives the initial determination. There is no Amount in Controversy (AIC) threshold at this level of appeal. Medicare Contractors have 60 calendar days to render a decision.

There are two acceptable written ways of submitting a redetermination request:

1. Complete Form CMS-20027 and submit with all necessary attachments.

Form CMS-20027 is available at [www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage](http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage) on the Centers Medicare & Medicaid Services (CMS) website.

2. Submit a written request without using Form CMS-20027. The request must contain the following information:

   - Beneficiary’s name
   - Beneficiary’s Medicare Health Insurance Claim Number (HICN)
   - Identification of the item or service for which the redetermination is being requested
   - The specific date of service
   - Name and signature of the requestor or the requestor’s appointed representative

If any of the information listed above is missing from the redetermination request, the request will be returned to the provider with an explanation of what must be included.

**Reconsideration by Qualified Independent Contractors (QICs)**

As of May 1, 2005, all redeterminations for Part A claims are subject to QIC reconsideration, which may include a panel of medical professionals (see Section 7, What Is The Second Level of Appeal, of this guide). These appeals typically involve services furnished by hospitals, Skilled Nursing Facilities (SNFs), and Home Health Agencies (HHAs).

As of January 1, 2006, all redeterminations for Part B claims are also subject to QIC reconsideration.

Additional information on QICs is available at [www.medicare.gov/Basics/finalqicfactsheet.pdf](http://www.medicare.gov/Basics/finalqicfactsheet.pdf) on the Web.
SUBMITTING SUPPORTING DOCUMENTATION

It is very helpful and always necessary to submit an indication of why the service should be paid. The provider must include any documentation that is needed to conduct the redetermination, especially when submitting a written request for redetermination. Supporting documentation may include, but is not limited to:

- Nursing notes and initial assessments
- Physician progress notes
- Physician history and physicals
- Medication records
- A letter from the physician

If documentation that is needed to make a redetermination is not included with the request, the documentation may be requested from the provider. The provider must submit any supporting documentation at the redetermination level, unless there is good cause that prevented timely submission of the evidence. In the case where documentation is presented after the request has been submitted, the Medicare Contractor's 60-day decision-making time frame is extended for 14 calendar days for each submission.

NOTIFICATION OF REDETERMINATION OUTCOME

Written notification of the outcome of the redetermination will be mailed to all parties to the appeal. Notification will be sent within 60 calendar days of receipt of the appellant’s request for review (unless applicable extensions apply). This notification will be in the form of a letter, a Medicare Summary Notice (MSN) sent to the beneficiary, or a Remittance Advice (RA). If all services in question are paid, then the parties will receive a revised MSN or RA; however, if any service in question is partially or fully denied, the outcome of the redetermination will come in the form of a letter.

WHAT IS THE SECOND LEVEL OF APPEAL?

A reconsideration is the second level of appeal for participating providers who are dissatisfied with the outcome of a redetermination. For all redeterminations issued on or after May 1, 2005, appellants have the right to request reconsideration by a Qualified Independent Contractor (QIC) within 180 calendar days from the date the appellant receives notice of the redetermination decision. QICs are independent contractors who have been awarded contracts to review denied claims for Part A, Part B, or Durable Medical Equipment (DME) within the specific geographical area of the United States for which the QIC will process claims appeals. The request must be filed with the QIC specified in the Medicare Redetermination Notice (MRN). If the QIC does not issue a reconsideration within the established 60-day limit, the appellant can escalate the appeal to the Administrative Law Judge (ALJ) level.

FILING A RECONSIDERATION REQUEST

The following requirements must be met to receive a reconsideration:

- A request for hearing must be in writing and signed by the requestor.
- The request must be filed with the QIC within 180 calendar days from the receipt date of the redetermination outcome or within the requested time frame extension as the QIC might allow for good cause.
- The request for reconsideration can be submitted using Medicare Reconsideration Request Form CMS-20033 available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the Centers for Medicare & Medicaid Services (CMS) website.
Per Section 405.964(b) of Regulation 42 CFR updated in the Interim Final Rule, the following information must be included within a written reconsideration request that is not submitted on Form CMS-20033:

- Beneficiary’s name
- Beneficiary’s Medicare Health Insurance Claim Number (HICN)
- Identification of the item or service for which the reconsideration is being requested
- Name and signature of the requestor or the requestor’s appointed representative
- Name of the Medicare Contractor that made the redetermination

If any of the information listed above is missing from the reconsideration request, the request will be returned to the provider with an explanation of what must be included.

**NOTIFICATION OF RECONSIDERATION OUTCOME**

Written notification of the outcome of the reconsideration will be mailed or otherwise transmitted to all parties who filed the request for reconsideration. Notification will be sent within 60 calendar days of receipt of the appellant’s request for review (unless applicable extensions apply).

If the reconsideration results in the issuance of supplemental payment to a provider or supplier, the Medicare Contractor must also issue an electronic or paper Remittance Advice (RA) notice to the provider or supplier. In the event of an overpayment case involving multiple beneficiaries who have no liability, the QIC may issue a written notice only to the appellant.

**WHAT IS THE THIRD LEVEL OF APPEAL?**

For Part B redeterminations issued on or after January 1, 2006, the Qualified Independent Contractor (QIC) is responsible for accepting Administrative Law Judge (ALJ) hearing requests and for preparing case files for the hearing. If a party to the reconsideration hearing is dissatisfied with the decision and the AIC is at least $100, the party can request a hearing before the Office of Medicare Hearings and Appeals (OMHA) ALJ. As of January 1, 2005, the AIC is adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI) for all urban consumers and rounded to the nearest multiple of $10. For Calendar Year (CY) 2006, the AIC must be at least $110. The request must be submitted within 60 calendar days of his or her receipt of the reconsideration decision. This function is currently performed by ALJs employed by the OMHA.

The ALJ hearing results in a new decision by an independent adjudicator. If the OMHA ALJ does not reach a decision within the 90-day deadline beginning on the date the request for hearing is received by the entity specified in the QIC’s reconsideration notice, the party may request a Medicare Appeals Council (MAC) review by the Department of Appeals Board (DAB). Expedited access to MAC review can be granted if the MAC does not have authority to decide questions of law or regulation relevant to matters in controversy and there is no material issue of fact in dispute.
FILING AN ALJ HEARING REQUEST

To request an ALJ hearing, the requestor must file a written request for an ALJ hearing within 60 calendar days from the date of receipt of the QIC’s reconsideration. The request must be filed with the OMHA specified in the QIC’s reconsideration. The requestor should use Request for Medicare Hearing by an Administrative Law Judge Form CMS-20034A/B to submit a request, available at www.cms.hhs.gov/CMSForms/CMSForms/list.asp#TopOfPage on the CMS website.

Per Section 405.1014(a) of Regulation 42 CFR updated in the Interim Final Rule, the following information must be included within a written ALJ hearing request that is not submitted on Form CMS-20034A/B:

- Beneficiary name and address
- Medicare Health Insurance Claim Number (HICN) of the beneficiary whose claim is being appealed
- Name and address of the appellant when the appellant is not the beneficiary
- Name and address of the designated representative, if any
- Document control number assigned to the appeal by the QIC, if any
- Specific dates of service
- Reason(s) for appeal of the QIC’s reconsideration
- Statement of any additional evidence to be submitted and the date it will be submitted

If the request is not submitted within the 60-day limit and the requestor can demonstrate there is good cause that prevented timely submission of the request, the time frame for filing will be extended.

SUBMITTING EVIDENCE BEFORE THE ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

All written evidence should be submitted with the request for the hearing (or within 10 days of receiving notice of the hearing). If a party submits evidence after the 10-day period, the period between the time the evidence was submitted and the time the evidence is received is not counted toward the 90-day adjudication deadline. Any evidence submitted by a provider, supplier, or beneficiary represented by a provider or supplier that is not submitted prior to issuance of the QIC’s reconsideration determination must be submitted with a statement explaining why the evidence was not previously submitted to the QIC or a prior decision-maker.

NOTICE OF ADMINISTRATIVE LAW JUDGE (ALJ) REVIEW DECISION

Unless the ALJ has dismissed the hearing, a decision will be mailed to all parties to the hearing, to the QIC that issued the reconsideration determination in question, and to the Medicare Contractor that issued the initial determination. For overpayment cases involving multiple beneficiaries where there is no beneficiary liability, the ALJ may send written notice only to the appellant. In the event a payment will be made to a provider or supplier in conjunction with the ALJ decision, the Medicare Contractor must also issue a revised electronic or paper RA to that provider or supplier.
**WHAT IS THE FOURTH LEVEL OF APPEAL?**

After an Administrative Law Judge (ALJ) hearing decision has been made on a Medicare claim, the next level of appeal is a Medicare Appeals Council (MAC) review by the Departmental Appeals Board (DAB). A request for MAC review must be filed with the DAB within 60 calendar days of receipt of the ALJ hearing decision or dismissal. There is no Amount in Controversy (AIC) to meet at this level of appeal. The request for MAC review must be submitted in writing using Request for Review of Administrative Law Judge (ALJ) Medicare Decision/Dismissal Form DAB-101.

Per Section 405.1112(a) of Regulation 42 CFR updated in the Interim Final Rule, the following information must be included within a written MAC review by DAB request that is not submitted on Form DAB-101:

- Beneficiary name and address
- Medicare Health Insurance Claim Number (HICN) of the beneficiary whose claim is being appealed
- Specific dates of service
- Specific service(s) or item(s) for which the review is requested
- Date of the ALJ’s final action (if any) or the hearing office in which the appellant’s request for hearing is pending (if requesting escalation from the ALJ to the MAC)
- Name and signature of the party or representative of the party to the appeal

If the request is not submitted within the 60-day limit and the requestor can demonstrate there is good cause that prevented timely submission of the request, the time frame for filing will be extended.

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**Obtaining a Request for Review of Administrative Law Judge (ALJ) Medicare Decision/Dismissal Form**


**Submitting a MAC Review by the DAB**

A request for a MAC review should be submitted to the following address:

Department of Health and Human Services
Department of Appeals Board, MS 6127
Medicare Operations and Appellate Divisions and the DAB Chair
300 Independence Avenue, SW,
Room G-644
Washington, D.C. 20201

A request for review can also be faxed to 202-565-0238. After submitting a request for a MAC review, inquiries regarding the request can be directed to 202-565-0200.

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**SUBMITTING ADDITIONAL EVIDENCE**

When a MAC is reviewing an ALJ’s decision, the MAC is limited to reviewing only evidence contained in the record of the proceedings before the ALJ. However, if the hearing decision decides a new issue that the parties were not afforded an opportunity to address at the ALJ level, the MAC considers any evidence related to that issue that is submitted with the request for review.

If the MAC determines that additional evidence is needed to resolve the issue(s) of a case and the hearing record indicates that previous decision-makers did not attempt to obtain the evidence, the MAC may remand the case to the ALJ to obtain the evidence and issue a new decision.
If the appeal is a result of an appellant’s request for escalation, the ALJ will base their decision on the record constructed at the Qualified Independent Contractor (QIC) level and any additional evidence (including oral testimony) entered into the record by the ALJ before the case was escalated.

For additional information regarding the submission of evidence at the MAC level of appeal, please refer to the Interim Final Rule dated March 8, 2005, which is available at www.cms.hhs.gov/quarterlyproviderupdates/downloads/CMS4064IFC.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

NOTIFICATION OF MEDICARE APPEALS COUNCIL (MAC) REVIEW DECISION

The MAC decision will be mailed within 90 calendar days of submission of the request for MAC review to all parties. If the MAC fails to provide a decision to the entity or entities that filed the request for MAC review within 90 calendar days of receipt of the appellant’s request for review (unless applicable extensions apply), the appellant may submit a request for escalation to the next level of appeal. For overpayment cases involving multiple beneficiaries where there is no beneficiary liability, the MAC may choose to send written notice only to the appellant. In the event the decision will result in payment to a provider or supplier, the Medicare Contractor must issue an electronic notice or paper Remittance Advice (RA) to that provider or supplier.

WHAT IS THE FIFTH LEVEL OF APPEAL?

If a requestor is dissatisfied with the Medicare Appeals Council’s (MAC's) decision, he or she must then commence civil action and request a Federal District Court Review within 60 calendar days of receipt of the MAC’s decision. As of January 1, 2005, the Amount in Controversy (AIC) is adjusted annually in accordance with the percentage increase in the medical care component of the Consumer Price Index (CPI) for all urban consumers and rounded to the nearest multiple of $10. For CY 2006, the AIC must be at least $1,090 to request a Federal District Court Review. The requestor must file the complaint with the United States District Court, not the Medicare Contractor.

If the request is not submitted within the 60-day limit and the requestor can demonstrate there is good cause that prevented timely submission of the request, the time frame for filing will be extended.

NOTIFICATION OF FEDERAL DISTRICT COURT REVIEW DECISION

The Federal District Court may either reach a final decision or remand the case to the MAC or Administrative Law Judge (ALJ) for further proceedings. In any case, written notification will be sent to all involved parties of the court’s decision or remand. If the case is remanded to the MAC or ALJ, all parties will be notified in writing of the MAC or ALJ decision.

HOW CAN NATIONAL COVERAGE DETERMINATIONS (NCDS) AND LOCAL COVERAGE DETERMINATIONS (LCDS) BE CHALLENGED?

On December 8, 2003, the Centers for Medicare & Medicaid Services (CMS) implemented a process that permits certain Medicare beneficiaries to challenge coverage policies that may prevent access to items and services or that have resulted in claim denials. These changes were required by Congress per Section 522 of the Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000. Under this policy, a beneficiary who qualifies as an “aggrieved party” may challenge an LCD or an NCD (or specific provisions therein). Medicare defines an “aggrieved party” in 42CFR Section 426.110 as follows.
Aggrieved party means a Medicare beneficiary, or the estate of a Medicare beneficiary, who:

- Is entitled to benefits under Part A, enrolled under Part B, or both (including an individual enrolled in fee-for-service Medicare, in a Medicare Advantage Plan, or in another Medicare managed care plan)
- Is in need for coverage for a service or item that is denied based upon an applicable LCD (in the relevant jurisdiction) or an NCD, regardless of whether the service or item was received
- Has obtained documentation of the need by the beneficiary’s treating physician

As of January 1, 2004, any Medicare Contractor that denies a claim based on an LCD or NCD must notify the beneficiary of the denial and the reasons for the denial on the Medicare Summary Notice (MSN).

How to Challenge an LCD or NCD

A beneficiary that qualifies as an aggrieved party may challenge an LCD or an NCD by filing a complaint with the office designated by CMS. Beneficiaries may obtain information regarding how to file a complaint by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

How to Challenge an LCD or NCD if Only a Beneficiary can Submit a Request for Review

Providers may continue to participate in the process of developing, revising, or discontinuing an LCD or NCD under existing policies. Section 4 of this guide addresses the policy development process. Information for challenging an LCD or NCD is available at www.cms.hhs.gov/DeterminationProcess/Downloads/FR11072003.pdf on the CMS website. Contact the local Medicare Contractor for additional information regarding how to challenge an LCD or NCD.

In this process, an aggrieved party may not assign legal rights to request a review of an LCD or an NCD to a third party (including a provider). However, a provider is permitted to assist the beneficiary in developing the initial request for review and in navigating the review process. This involvement of a third-party to offer assistance is not mandatory, and unless a provider is subpoenaed under existing regulations, there will be no monetary expenses reimbursed by Medicare.

CMS does not believe that the provisions of this process will have a significant effect on providers since Congress developed the BIPA 522 policy review process for beneficiaries. Providers may be requested, however, to supply documentation that an aggrieved party may need that pertains to a specific service, and to assist in representing an aggrieved party. In addition, the documentation necessary for the review may be in the form of an order or other existing language from the beneficiary’s medical record, and need not be newly-created material. Overall, CMS believes that this rule will result in an insignificant economic impact on health care providers or the health care industry as a whole.

A favorable decision for the beneficiary may result in a previously denied claim being paid by Medicare. In addition, this process may result in a policy change in an LCD or NCD that will affect other beneficiaries in the future. However, the right to challenge NCDs and LCDs is distinct from the existing appeal rights for the adjudication of claims discussed in Section 7, What Is The Fifth Level of Appeal?, of this guide. Thus, a beneficiary may elect to pursue a claims denial through the claims appeal process, seek review of an LCD or an NCD using this process, or both.