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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for health care professionals.

If you are a provider or a participating physician or participating supplier, you will benefit from this podcast! It provides information about the five levels of appeal in Original Medicare (Parts A and B) and how the appeals process applies to you. This podcast is based on Medicare Learning Network fact sheet, titled "Medicare Appeals Process."

Let's begin with the critical points for you to consider:

- As we will cover in this podcast, the five levels in the claims appeal process under Original Medicare are:
  - Level 1: Redetermination by a Medicare Administrative Contractor (MAC)
  - Level 2: Reconsideration by a Qualified Independent Contractor (QIC)
  - Level 3: Hearings before an Administrative Law Judge (ALJ)
  - Level 4: Review by the Medicare Appeals Council (Appeals Council)
  - Level 5: Judicial review in United States (U.S.) District Court

Please note the definitions of Helpful Terms on page 1 of the fact sheet.

- The fact sheet presents tables with answers to your frequently asked questions about each of the five levels and the URLs to the forms mentioned in this podcast.
- All appeal requests must be in writing.
- At any time, you may appoint any individual, including an attorney, to represent you during the processing of a claim or appeal. The representative will help provide you assistance and expertise.
  - The appointment is valid for one year. During this year, the representative may present you in subsequent appeal levels on the initial appeal, and for any appeals for other claims.
  - To appoint a representative, you or the representative must complete Form CMS-1696 on the CMS website or another written document with the same information.
    - The form or document must include the following six items:
      - One: Be in writing;
      - Two: Be signed and dated by you and your representative (the representative's signature must be dated within 30 days of your signature);
      - Three: A statement appointing the representative to act for you;
      - Four: Both your and your representative's names, phone numbers, and addresses;

- Five: Your representative's professional status or relationship to you; and
- Six: The provider's National Provider Identifier (NPI) number.

Beneficiaries can transfer appeal rights to non-participating physicians or suppliers. For more information see page 2 of the fact sheet.

Table 1 illustrates the First Level - Redeterminations

- A redetermination is the first level of appeal after the initial determination on a claim. It is actually a second look at the claim.
- You must file a request for redetermination within 120 days from the date of receipt of the Remittance Advice that lists the initial determination.
- You may file a request for Redetermination by completing the CMS- Form 20027. Please remember:
  - You, or your representative, must include your name and signature on the form.
  - Attach any supporting documentation to your redetermination request.
  - For the requirements for a written request or to access Form CMS-20027, visit the CMS website.
- The decision is made by MAC staff unassociated with the initial claim determination. They generally issue a decision within 60 days of the receipt of the request of the redetermination.
- You will receive a notice of the decision via a Medicare Redetermination Notice (MRN) from your MAC.

The Second Level - Reconsiderations is presented in Table 2 in the fact sheet

- If you disagree with the MAC Redetermination Decision then you may request for Reconsideration by QIC. A Reconsideration is a review of the Redetermination Decision.
- You must file a request for reconsideration within 180 days from the date of receipt of the MRN that lists the initial determination.
- You may file for Reconsideration by following the instructions provided on the MRN.
- Alternatively, you may file by completing the CMS-20033 Form. For the requirements for a written request or to access Form CMS-20033, visit the CMS website.
  - **Please remember:**
    - To clearly explain why you disagree with the redetermination decision.
    - You, or your representative, must include your name and signature.
    - To submit:
      - A copy of the RA or MRN;
      - Any evidence noted in the redetermination as missing;
      - Any other evidence relevant to the appeal; and
      - Any other useful documentation.
    - Please note that any documentation submitted after you file the reconsideration request may extend the QIC's decision timeframe.
    - Please also note that evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you demonstrate good cause for submitting the evidence late. There is no minimum AIC requirement.
- The QIC conducts the Reconsideration, which is an independent review of the redetermination. The reconsideration may include review of medical necessity issues by a panel of physicians or other health care professionals. They generally will send a decision to all parties within 60 days of receipt of the request for reconsideration.

- If the QIC cannot complete its decisions in the applicable timeframe, it will inform you of your rights and the procedures to escalate the case to an ALJ.

PLEASE NOTE

- Before escalating your appeal to an ALJ if you do not receive a decision on the reconsideration within 60 days, consider allowing an additional 5 to 10 days for mail delays.

Table 3 in the fact sheet presents the Third Level of Appeal - ALJ Hearing

- You must file a request for an ALJ hearing within **60 days** of receipt of the reconsideration decision letter or after the expiration of the reconsideration period.

- If you disagree with the reconsideration decision or wish to escalate your appeal, you may request an ALJ hearing.
- This will give you the opportunity, via video teleconference (VTC), telephone, or occasionally in person, to explain your position to an ALJ.
- The U.S. Department of Health & Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA), which is independent of CMS, is responsible for the Level 3 Medicare claims appeals.
- File your request in writing by following the instructions provided in the reconsideration letter.
- Alternatively, you may request an ALJ hearing by completing Form CMS-20034 A/B. For the requirements for a written request, tips on filing an ALJ hearing request, or to access Form CMS-20034 A/B, visit http://www.hhs.gov/omha on the HHS website
- If you do not want a VTC or telephone hearing, you may ask for an in-person hearing, but you must demonstrate good cause. The ALJ determines whether the case warrants an in-person hearing on a case-by-case basis. You may also ask the ALJ to make a decision without a hearing (on-the-record).
- Please remember:
    - You **must** send a copy of the ALJ hearing request to all other parties to the QIC reconsideration. If you are requesting the case be escalated to the Appeals Council, a copy of the request must be sent to all other parties **and** to the ALJ.
    - The ALJ sets hearing preparation procedures. 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.

- There is a minimum Amount in Controversy (AIC) requirement for Level 3. You may only request an ALJ hearing if a certain dollar amount remains in controversy following the QIC's decision. The AIC threshold is updated annually. For the current amount, refer to the URL provided in the fact sheet.
- If the ALJ cannot complete its decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to the Appeals Council.
- The Office of Medicare Hearings and Appeals (OMHA) oversees all Level 3 Medicare appeal hearings. OMHA processes ALJ hearing requests in the order received and as quickly as possible, given pending requests and adjudicatory resources.
- Due to a record number of appeal requests, if 22 weeks have not lapsed since your initial AJH hearing submission request, please do not resubmit your request. For more information on these timeframes, refer to the URL provided in the fact sheet.
- For more information about reasons for additional delay from OMHA, please see Table 3 in the fact sheet.

Next, Table 4 in the fact sheet illustrates the Fourth Level of Appeal - the Medicare Appeals Council Review

If you disagree with the ALJ decision, or you wish to escalate your appeal because the ALJ ruling timeframe passed, you may request a Medicare Appeals Council review. The HHS Departmental Appeals Board (DAB), Medicare Operations Division administers the Appeals Council review. Table 4 provides questions and answers about Appeals Council reviews.

- You must file your request for Medicare Appeals Council review within **60 days** of receipt of the ALJ's decision or after the ALJ ruling timeframe expires.
- You may file your request in writing by following the instructions provided by the ALJ.
- Alternatively, you may request an Appeals Council review by completing Form DAB-101. For the requirements for a written request, tips on filing a request for Appeals Council review following an ALJ decision or dismissal, or to access Form DAB-101, refer to the URL provided in the fact sheet.
    - Remember:
        - Explain which part of the ALJ decision you disagree with and your reasons for the disagreement.
        - You must send a copy of the Appeals Council review request to all the parties included in the ALJ's decision. If you are requesting escalation to U.S. District Court, a copy of the request must be sent to all other parties and to the Appeals Council.

The Appeals Council makes the decision.

- If the Appeals Council cannot complete its decision in the applicable timeframe, it will inform you of your right and procedures to escalate the case to U.S. District Court.
- Generally, the Appeals Council issues a decision within 90 days from receipt of a request for review of an ALJ decision. If the Appeals Council review stems from an escalated appeal, then the Appeals Council has 180 days from the date of receipt of the request for escalation to issue a decision. A decision may take longer due to a variety of reasons.
- 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.

Finally, Table 5 in the fact sheet discusses the Fifth Level of Appeal - Judicial Review in U.S. District Court

If you disagree with the Appeals Council decision, or you wish to escalate your appeal because the Appeals Council ruling timeframe passed, you may request judicial review. Table 5 provides questions and answers about judicial reviews in U. S. District Court.

- The U.S. District Court makes the decision.
- You must file a request for judicial review within 60 days of receipt of the Appeals Council's decision or after the Appeals Council ruling timeframe expires.
- To file for a claim in U.S. District Court, follow the instructions provided in The Appeals Council's decision.
- There is an AIC minimum requirement. You may only request judicial review if a certain dollar amount remains in controversy following the Medicare Appeal Council decision. The AIC threshold is updated annually. For the current amount, refer to the URL provided in the fact sheet.

Tips for filing an appeal an appeal are given on the bottom of page 8 in the fact sheet.

A summary of the five appeal levels is provided in Table 6. The table includes the level, what happens, who performs the review, how many days you have to request an appeal, in how many days you should get a decision, and if there is an AIC minimum requirement. Following the summary in the fact sheet are Tips For Filling an Appeal and then a list of resources for additional information.

More questions? To learn more about the Medicare Appeals Process contact your Medicare Administrative Contractor or visit the CMS website at www.cms.gov and search for Medicare Learning Network®. From that page, search for MLN Multimedia to view the podcast transcript.

Be on the lookout for future Medicare Learning Network® podcasts on subjects of interest to you.