Medicare Appeals Process
(5 Levels of Appeal)

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The healthcare industry is experiencing a significant increase in Medicare Part A and Medicare Part B (Fee for Service) **Medical Record Reviews** by The Centers for Medicare and Medicaid Services (CMS). Typically, the process begins with an **Additional Development Request (ADR)** or a **Targeted Probe and Education (TPE)** seeking portions of the medical record that supports the rationale for skilled services under the Medicare Part A and Medicare Part B Insurance benefit.

The Centers for Medicare and Medicaid Services (CMS) contracts with **Medicare Administrative Contractors (MACs)** to assist with local claims processing and to review the first level appeals adjudication functions.

These Medical Record Reviews are prompted by an item on the UB-04, **specific to the patient**, such as the:

- HIPPS Code,
- ICD-10 Code, or
- Dates of Service,

to name a few. In these cases, the health care provider may receive requests for a few patients, in the range of **2 to 5 claims** per provider.

Other times, the Medical Record Reviews may be part of a **widely diffused request** for items from the medical record to discover information about the billing practices or patterns of an organization. These types of reviews are known as **"Probe Reviews"** in which MACs may assess **20 to 40 claims** per provider for **"provider-specific"** issues.

MACs also perform **widespread prove reviews** including around **100 claims** per provider. These types of audits are triggered when there is a perceived outlier in the provider's billing practice, such as an abrupt, sharp increase in billing for a specific procedure.

Although It is customary for providers to receive requests from MACs, providers need to pay close attention to these requests and ensure that there is an **effective system** in place to track timeliness and accuracy of the data submission. Even when providers submit all the requested data, it is not uncommon for the MAC to deny a portion of, if not the entire claim.

When any part of a claim is denied, the provider has the right to petition a second opinion. The **appellant** is the individual filing the appeal. (For **procedures for conducting appeals** of claims in Traditional Medicare, i.e., Medicare Part A and Part B, see Section 1869 of the Social Security Act and 42 C.F.R. Part 405 Subpart I.)

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The claim appeals process has **five levels**:

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

Further relevant details on requesting appeals, for each of the five levels, is summarized below.

1.) **Redetermination** (First Level of Appeal) **Form CMS-20027**

For the First Level of Appeal **(traditional),** the MAC is involved in deciding the results of the redetermination. The appellant (the individual filing the appeal) must file the request for redetermination with the contractor **within 120 days** from the **date of receipt of the initial determination.** The appellant should attach any supporting documentation to their 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.**

The request for a redetermination may be filed on **Form CMS-20027**.

Response:

- The **initial determination** is the **Medicare Summary Notice (MSN)** issued to beneficiaries, and the **Remittance Advice (RA)** issued to providers and suppliers.
- A minimum **monetary threshold** is **not required** to request a redetermination.
- A decision will be rendered within **60 days** of receipt of the redetermination request. The results will be communicated via a **letter, Medicare Summary Notice (MSN)** or a **Remittance Advice (RA).**

Note: EXPEDITED Medicare Part A Redetermination (Notice of Discharge or Service Termination)

For the First Level of Appeal **(expedited),** the MAC is not involved in deciding the results of the redetermination. A **Qualified Independent Contractor (QIC)** is involved in deciding the results of the redetermination. The appellant must file the request for redetermination with the contractor **by noon the next calendar day** from the **Notice of Discharge or Service Termination.**

Response:

- A decision will be rendered within **72 Hours** of receipt of the redetermination request.

2.) **Reconsideration** (Second Level of Appeal) **Form CMS-20023**

If the appellant is dissatisfied with the results of the redetermination, the appellant may enter the Second Level of Appeal and request a reconsideration to be conducted by a **Qualified Independent Contractor (QIC)**.

The appellant must file a written reconsideration request **within 180 days** of receipt of the redetermination.

The **Qualified Independent Contractor (QIC)** reconsideration process allows for an **independent review** of an initial determination, which may include review of medical necessity issues by a panel of health care professionals.

In the request for reconsideration, the appellant should clearly explain the reason for disputing the redetermination decision. A copy of the **Remittance Advice (RA)** or **Medicare Redetermination Notices (MRN),** and any other useful documentation should be sent with the reconsideration request. Any evidence noted in the redetermination and all 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.

A request for a reconsideration may be made on the **Form CMS-20023**.

Response:

- A minimum **monetary threshold** is **not required** to request a reconsideration.

- A decision will be rendered within **60 days** of receipt of the request for reconsideration.

- **Documentation** that is submitted **after the reconsideration** request has been filed may result in an extension of the decision-making timeframe for the **Qualified Independent Contractor (QIC)**.

- If the **Qualified Independent Contractor (QIC)** cannot complete its decision in the applicable timeframe, it will inform the appellant of their right to escalate the case to an **Administrative Law Judge Hearing (ALJ)**.

- The decision will contain information regarding further appeal rights.

3.) **Administrative Law Judge Hearing (ALJ)** (Third Level of Appeal) **Form OMHA-104**

If the minimum monetary threshold is met and remains in controversy following a **Qualified Independent Contractor's (QIC's)** decision, a party to the reconsideration may request an Administrative Law Judge Hearing (ALJ) hearing **within 60 days of receipt of the reconsideration decision**. The reconsideration decision letter provides details regarding the procedures for requesting an Administrative Law Judge Hearing (ALJ) hearing.

The request for an **Administrative Law Judge Hearing (ALJ)** may be filed on **Form OMHA-104** which is called **"Waiver of Right to an Administrative Law Judge (ALJ) Hearing"** form.

Appellants must also send a copy of the Administrative Law Judge Hearing (ALJ) hearing request to all other parties to the QIC reconsideration.

Administrative Law Judge Hearing (ALJ) hearings are generally held by **video teleconference (VTC)** or by **telephone.**

- If the appellant does not want a VTC or telephone hearting, 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 Administrative Law Judge Hearing (ALJ) to decide without a hearing (on-the-record).

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

Response:

- A minimum **monetary threshold** is required to request an Administrative Law Judge Hearing (ALJ). For calendar year 2022, the amount in controversy is **$180.00.**

- The **Administrative Law Judge Hearing (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 **Administrative Law Judge Hearing (ALJ)** does not issue a decision within the applicable timeframe, the appellant may ask the Administrative Law Judge Hearing (ALJ) to escalate the case to the Appeals Council level.

- The **monetary threshold** to request an Administrative Law Judge Hearing (ALJ) hearing is **increased annually** by the percentage increase in the medical care component of the consumer price index for all urban consumers.

4.) **Appeals Council Review** (Fourth Level of Appeal) **Form DAB 101**

If a party to the **Administrative Law Judge Hearing (ALJ)** hearing is dissatisfied with the ALJ's decision, the party may request a review by the **Appeals Council.** 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 **finding**s that are being contested.

The request for an **Appeals Council Review** may be filed on **Form DAB 101**.

Response:

- A minimum **monetary threshold** is not **required** to request an **Appeals Council Review**.

- 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.

5.) **Judicial Review in U.S. District Court** (Fifth Level of Appeal) **Form 1696**

If the provider is dissatisfied with 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** and must specify the issues and findings that are being contested. The Appeals Council's decision will contain information about the procedures for requesting judicial review.

Response:

- A minimum **monetary threshold is required** to request a reconsideration. For 2022, the minimum dollar amount is $1,760. Appellant may be able to combine claims to meet this dollar amount.

- The Judicial Review will issue a decision **within 90 days of receipt of a request for review**.

- The **monetary threshold** to request a **Judicial Review in U.S. District Court** is **increased annually** by the percentage increase in the medical care component of the consumer price index for all urban consumers.

In closing, HHI hopes this article helps clarify any confusion on the **Medicare Medical Record Reviews and Appeals Process**.

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Attachments:

- ✓ LEVEL 1: Redetermination (First Level of Appeal) Form CMS-20027
- ✓ LEVEL 2: Reconsideration (Second Level of Appeal) Form CMS-20023
- ✓ LEVEL 3: Administrative Law Judge Hearing (ALJ) (Third Level of Appeal) Form OMHA-104
- ✓ LEVEL 4: Appeals Council Review (Fourth Level of Appeal) Form DAB 101
- ✓ LEVEL 5: Judicial Review in U.S. District Court (Fifth Level of Appeal) Form 1696
- ✓ Appeal Level Flow Chart