and the difference between the billed amount and the Medicare-allowed amount (less any outstanding deductible) is $100 or more. A Medicare-appointed Hearing Officer (HO) will conduct the hearing and determine if the carrier's decision followed guidelines.

Filing a Hearing Request

A written hearing request must be filed within six months of the redetermination. Upon request by the affected party, the HO may extend the period for filing the request for a hearing if good cause is shown. The request must clearly explain why the redetermination was unsatisfactory, and specify the type of hearing requested. The request, a copy of the MRN, and any other useful documentation should be sent to the address of the local carrier's HO. There are three types of hearings: on-the-record, in-person, and telephone.

Preliminary On-The-Record (POTR) Hearing

Where either an in-person or telephone hearing has been requested, the HO may first prepare a decision based on the information in the file, including any information the appellant wishes to submit. The HO may conduct a POTR hearing and issue a decision unless:

- The POTR could significantly delay the in-person or telephone hearing;
- The HO believes that the facts can be clarified only through oral testimony;
- A different HO would not be available to conduct the in-person or telephone hearing should the appellant not be satisfied with the POTR hearing decision; or
- Workload considerations do not support conducting POTR hearings.

In-person Hearing

In-person hearings allow the appellants and/or representatives to present oral testimony and written evidence supporting the claim and challenging the information the carrier used to deny the claim.

Telephone Hearing

Telephone hearings are a convenient and less costly alternative to in-person hearings. Oral testimony and oral challenges may be conducted, and other evidence may be submitted by mail or facsimile.

On-The-Record (OTR) Hearing

OTR hearings and decisions are identical to those rendered in the hearings described above and follow the same instructions. The major advantage is the speed with which an OTR hearing can be held and a decision rendered. When an appellant specifically requests an OTR hearing, the resulting decision is not a POTR decision and the appellant does not have the further option of requesting an in-person or telephone hearing.

HO Decision Notification

The HO will notify the appellant of the HO hearing decision in writing and provide him or her with information on further appeals rights if the decision is not fully favorable.

Third Level of Appeal: Administrative Law Judge

If at least $100 remains in controversy following the HO's decision, a request can be made within 60 days of receipt of the HO determination for an Administrative Law Judge (ALJ). The HO decision will include instructions for obtaining an ALJ hearing. Hearing preparation procedures are set by the ALJ.

Fourth Level of Appeal: Departmental Appeals Board Review

If the appellant is dissatisfied with the ALJ's decision, he or she may request a review by the Departmental Appeals Board (DAB). There are no requirements regarding the amount of money in controversy. The request for a DAB review must be submitted within 60 days of receipt of the ALJ's decision, and should specify the issues and findings by the ALJ being contested.

Fifth Level of Appeal: Judicial Review in US District Court

If $1,000 or more is still in controversy following the DAB's decision, judicial review before a US District Court judge can be considered. The appellant must request a US District Court hearing within 60 days of receipt of the DAB's decision.

For More Information

For more information about the appeal process, please visit www.cms.hhs.gov on the Web.

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare providers. For additional information visit our website at http://www.cms.hhs.gov/medlearn.

Medicare Learning Network

Centers for Medicare & Medicaid Services

The Medicare Appeals Process

Five Levels to Protect Physicians and Other Suppliers

CMS
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The Medicare Appeals Process

Overview

Medicare offers an extensive appeals process to assist physicians, suppliers, and others who work with the Part B Program. This brochure discusses ways to obtain claim information and appeal claim denials.

Inquiries and Claims Information

The Centers for Medicare & Medicaid Services (CMS) contracts with private insurance companies (called carriers) to perform local provider enrollment, Part B claims processing, and adjudication functions on behalf of Medicare. Customer Service Representatives (CSRs) are available to answer questions, assist with inquiries, and help with billing issues. The toll-free numbers for Medicare carriers are listed at: www.cms.hhs.gov/medlearn/tollnums.asp

Carriers also use an Automated Response System (ARS) that can provide physicians and suppliers with information such as:

- Claim status;
- Number of pending and finalized claims;
- Date/number of physician's or supplier's most recent check;
- Year-to-date amount paid to physician or supplier; and
- Educational messages about hot topics.

The ARS is usually accessible 24 hours a day. The local carrier can furnish physicians and suppliers with specific details regarding the information that may be available via the ARS.

Appealing Medicare Decisions

Once the initial claim determination is made, physicians and suppliers may have the right to appeal. The right to appeal claim denials generally depends on whether the claim was assigned or unassigned.

- For assigned claims, the physician or supplier may request a redetermination.
- For nonassigned claims, typically only the beneficiary or his/her representative can request a redetermination. A physician or supplier may request a redetermination if he or she was liable for services that were denied or reduced based on medical necessity guidelines. The physician or supplier may also request a redetermination on behalf of the beneficiary with the beneficiary's signed authorization.

Five Levels in the Appeals Process

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

- Redetermination;
- Hearing Officer (HO) hearing;
- Hearing with an Administrative Law Judge (ALJ);
- Departmental Appeal Board review; and
- Judicial review in US District Court.

First Level of Appeal: Redetermination

A redetermination is an examination of a claim made by carrier personnel that are independent of those originally involved. The appellant (the individual making the appeal) has 120 days from the date of the initial claim determination to file an appeal. **A redetermination can be requested in writing or over the telephone to the local Medicare carrier.** No monetary threshold is required to be met.

Requesting a Redetermination in Writing

A request for a redetermination can be filed on Form CMS-1964 (available at www.cms.hhs.gov/forms) or in any other format that includes:

- Beneficiary name;
- Medicare Health Insurance Claim (HIC) number;
- Name and address of physician or supplier;
- Date of initial determination;
- Date(s) of service the initial determination was issued;
- Which item(s) if any, and/or service(s) are at issue in the appeal; and
- Signature of the appellant.

With a written request, the appellant should attach any supporting documentation.

Requesting a Redetermination by Telephone

When requesting a redetermination by telephone, the appellant should have the information ready for filing a written request plus the beneficiary's date of birth. For more information, contact the Customer Service line of the local Medicare contractor.

Requesting a telephone redetermination does not ensure that the request will be resolved during the call. Some claim denials are typically resolved after the telephone request, through a written process. If this happens, the appellant will be notified of the results through a written decision letter, a Remittance Advice (RA), or a Medicare Summary Notice (MSN).

Redetermination Decision Notification

When the redetermination request is received from an appellant (for assigned claims), a written response will be sent:

If…	*Then…*
The original decision is upheld…	A detailed letter will be sent explaining why additional payment cannot be allowed.
The original claim decision can be changed (full reversal) and payment is due…	The beneficiary will receive an adjusted MSN, and the physician or supplier will receive an adjusted RA. A check will be issued for the service(s)/item(s).
A portion of the claim can be allowed (partial reversal)…	The beneficiary will receive an adjusted MSN, and the physician or supplier will receive an adjusted RA. A Medicare Redetermination Notice (MRN) will be sent explaining the rationale for the decision. A check will be issued for the allowed service(s)/item(s).

Second Level of Appeal: Hearing Officer Hearing

A hearing may be requested if the appellant is dissatisfied with the redetermination decision