

# The Medicare Appeals Process: What You Need to Know

8/1/2025

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# Objective

After this session, attendees will have the knowledge needed to successfully navigate Medicare's appeals process and know where to go to find more information.



# Today's Presenters

- Provider Outreach and Education Consultants
  - Andrea Freibauer
  - Jeanine Gombos





# Agenda

- [Reopenings](#)
- [Appeals Process](#)
- [Appeal Levels](#)
- [References and Resources](#)
- [Questions](#)

# Reopenings

# What Is a Reopening?

- Request to reopen claim to correct clerical errors/omissions
  - Action to change initial determination **outside of appeals process**
- Submit single reopening request if reopening for multiple services on same claim (same DCN)
- Request within one year of claim's finalized date
- Occurs at NGS's discretion
  - If we decide not to reopen claim, decision not appealable

***A reopening is not an appeal***

# Valid Reopening Reasons

- Include:
  - Human or mechanical error
  - Mathematical or computational mistake
  - Transposed codes
  - Inaccurate data entry
  - Computer errors
  - Incorrect data items
    - Provider number
    - Use of modifier
    - DOS
- Does not include:
  - Omissions or failure to bill for items or services
  - Third-party payer errors



# Reopening of Partially Denied Claims

- Providers can reopen claims partially denied by automated edits for LCDs/NCDs to add/change diagnosis code(s)
  - Line-item denial reason code(s) 55A00, 55A01, 52NCD, 53NCD, 54NCD or 59xxx series
- To submit reopening request or adjustment (LN adjustment process)
  - Adjustment TOB = XX7 or XXQ
  - Adjustment reason code = LN
  - Adjustment CC = D9
  - Add/change diagnosis code
    - Must justify services automatically denied due to lack of appropriate diagnosis code per LCD/NCD

# Other Types of Reopenings

- To reopen claims partially denied for other valid reasons
  - Submit reopening request or adjustment (regular adjustment process)
    - Adjustment TOB = XX7 or XXQ
    - Adjustment reason code = As applicable
    - Adjustment CC = As applicable
    - Make necessary correction (must be clerical error/omission, e.g., correct HCPCS code)
- To reopen claims fully denied
  - Claim status/location in FISS = DB9997
  - Submit reopening request; not adjustment

# Reopening Request Options

- Via NGSConnex (preferred)
  - Refer to “Initiate a Clerical Error Reopening” instructions in [\*NGSConnex User Guide\*](#)
- In writing
  - Complete [Clerical Error/Omission Reopening Request Form](#)
  - Include:
    - Beneficiary’s name and Medicare number
    - Date of initial determination notice
    - DOS
    - Specific clerical error/omission change you would like considered
    - Requestor name, address, telephone number and relationship to beneficiary
    - NPI, PTAN and tax ID
    - Requestor’s signature and date
    - Any necessary documentation

# Reopening/Adjustment References

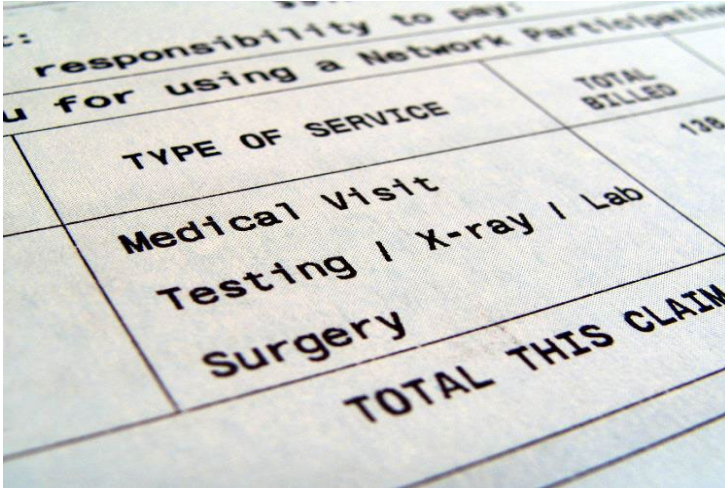
- Submit Adjustment to Correct Claims Partially Denied by Automated LCD-NCD Denials
- Reopenings for Minor Errors and Omissions
  - When mailing reopening request, use correct P.O. Box listed on bottom of form

JK Part A Providers	J6 Part A and FQHC/RHC Providers
National Government Services Appeals Dept. P.O. Box 7111 Indianapolis, IN 46207-7111	National Government Services Appeals Dept. P.O. Box 6474 Indianapolis, IN 46206-6474



# Appeals Process

# Overview



responsibility to pay: u for using a Network Participant	TOTAL BILLED
TYPE OF SERVICE	128
Medical Visit	
Testing   X-ray   Lab	
Surgery	
TOTAL THIS CLAIM	

## Review Claim Decisions Carefully

Providers and beneficiaries should review claim results and determine if they want to appeal



## Ensure Correct Claim Adjudication

Providers and beneficiaries have right to appeal most claim determinations made by NGS



## CMS Governs All Appeal Activities

Appeals process and activities are governed by CMS

# What Is an Appeal?

- Action you can take if you disagree with Medicare's coverage or payment decision
- Applies to most fully or partially denied claims
  - Review reasons for claim or claim line denial to determine if appealable
    - “Remarks” on claim in FISS
    - Claims determination letter(s)

# Who Can Submit an Appeal?

- Can be requested by
  - Provider
  - Beneficiary
  - Beneficiary's authorized representative (such as family member or attorney)
- Representative may be appointed at any point in appeals process
  - [CMS Appointment of Representative Form \(CMS 1696\)](#)
    - Valid for one year from date signed by party making appointment, or date appointment accepted by representative, whichever is later



# Examples of Possible Appealable Situations

- Coverage/medical necessity
- Deductible or coinsurance amount
- Number of days used for hospital or post-hospital extended care
- Physician certification requirement
- Beginning and ending of benefit period
- Determination of limitation of liability provision
- Issue affecting amount of benefits payable (including over- and under-payments)
- Pre-payment/post-payment probes (CERT, UPIC, SMRC, RA, QIO)

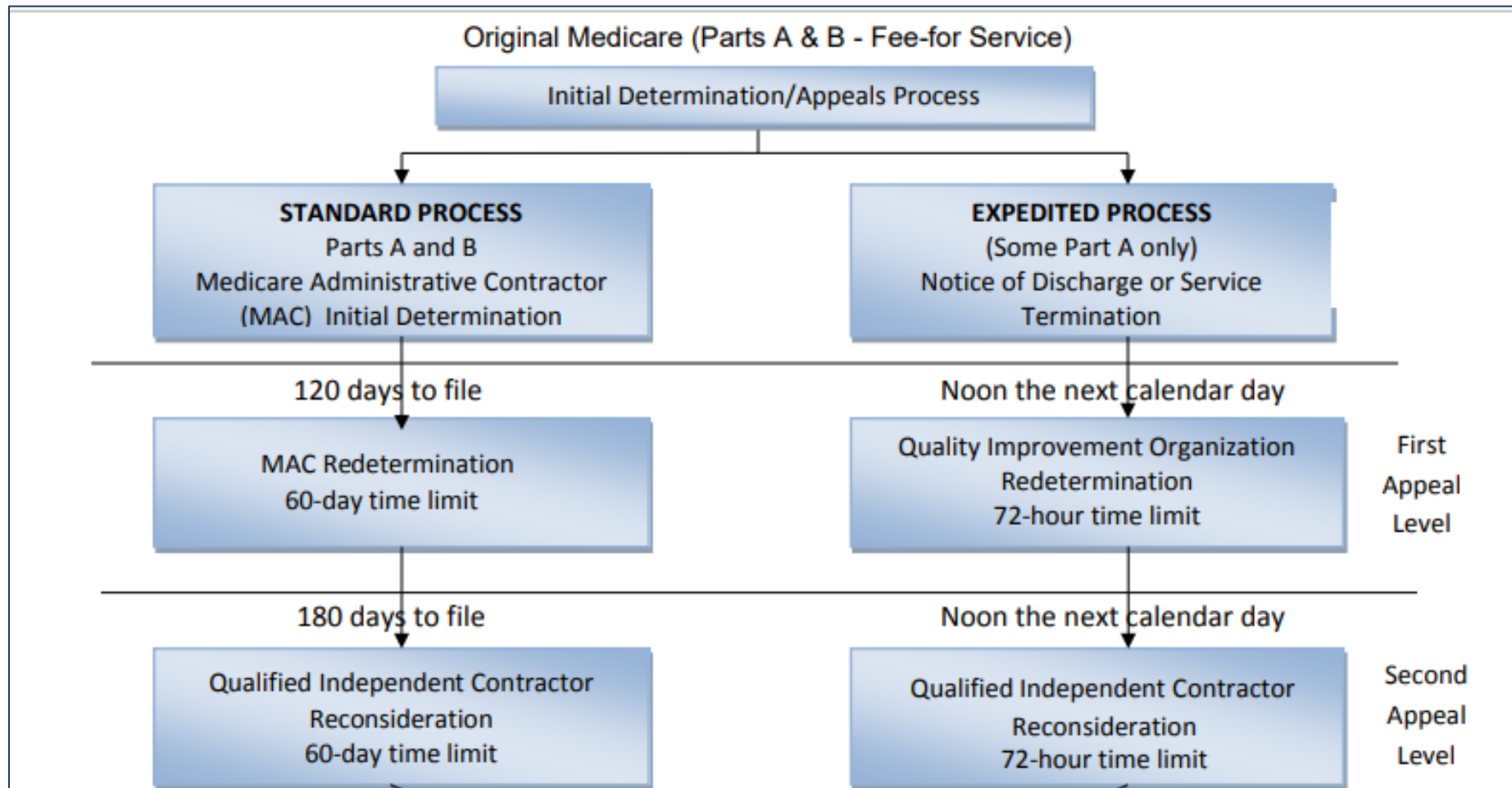
# Do Not Appeal - Primary Claims Rejected for MSP

- Claims submitted as Medicare primary reject for MSP (cost-avoid) if both apply:
  - Open MSP record in CWF exists
  - Claim does not indicate why Medicare primary
- Determine correct primary payer and submit subsequent adjustment depending on situation
  - Other payer primary
    - Bill primary payer
    - Once response received, submit adjustment to Medicare to change claim to MSP (or conditional)
  - Medicare primary
    - Have beneficiary contact [BCRC](#), if applicable, to have MSP record corrected
    - Once correction complete, submit adjustment to make Medicare primary

# Do Not Appeal - Claims Rejected for Timely Filing

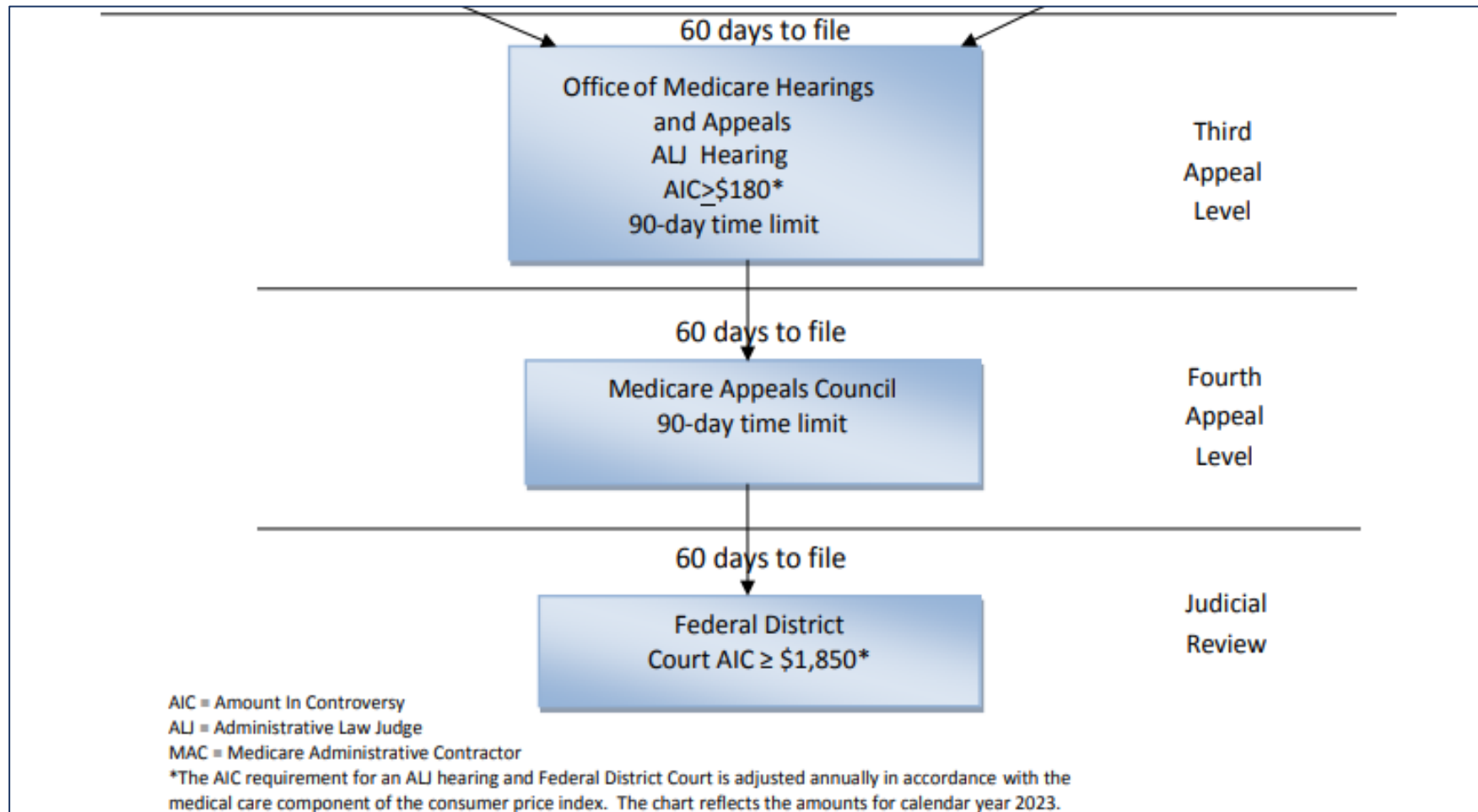
- Federal regulations mandate timely filing of claims within 365 days from DOS
- Determining if claim filed timely
  - Generally, claim “From” date used
  - Institutional claims that span DOS - “Through” date used
- Four exceptions
  - Refer to [Claim Timely Filing Job Aid](#)
  - Determine if exception met and submit adjustment if applicable

# Medicare FFS Appeals Flow Chart – Part 1





# Medicare FFS Appeals Flow Chart – Part 2



# Amount in Controversy (AIC)

- Certain appeal levels must meet monetary threshold/AIC
  - May be able to aggregate claims
  - AIC thresholds updated annually
- AIC determined by
  - Actual amount charged for items and services in question, reduced by
    - Medicare payments already made or awarded for items or services
    - Deductible and coinsurance amounts applicable

# Timely Filing of Appeals

- If you cannot file appeal within necessary timeframe, you can request extension
  - Granted by Appeals staff
  - Based on “good cause”
  - If approved, does not grant extension on next appeal level
- When good cause not established, request dismissed
  - If you disagree with dismissal, you must file next level of appeal request within appropriate timeframe from dismissal date



# Did You Know?

- Failure of billing company or other consultant to timely submit appeals or other information is **not** grounds for finding good cause for late filing!





# Examples of Good Cause

- Serious illness prevented you from contacting appeals reviewer
- Death or serious illness
- Important records destroyed or damaged by fire or other event
- Access to records affected by emergency or disaster
- Contractor or reviewer provided incorrect or incomplete information about when and how to file appeal
- Notice of determination or decision not received
- Submitted request to government agency in good faith within time limit but didn't reach appeals representative in time
- Delay because documents needed in large print, braille or other format
- Physical, mental, educational or other limitations

# Appeal Levels

# Level One: Redetermination

- Submitted to National Government Services
- Time limit to initiate redetermination
  - 120 days from receipt date of initial determination
- Time limit to complete review
  - 60 days
- Amount in controversy
  - No minimum
- [Part A Redetermination Request Form Level 1](#)

# Tip: One Appeal Request Per Claim

- Submit one redetermination request per claim
  - Do not submit request for each line
  - Only one claim per Redetermination Request Form
  - In NGSConnex, only claim indicated in "Redetermination Details" considered
    - Do not submit additional claims to be considered in "Attachments" section
- If appeal request involves overpayment determined through sampling and extrapolation
  - Identify all contested sample claims in one request and state any sampling methodology challenges

# What to Include in Redetermination

- Must include
  - Beneficiary's name
  - Beneficiary's Medicare number
  - Specific service/item provided and DOS
  - Name and signature of person requesting appeal
  - Attachments for additional information
  - All pertinent supporting medical record documentation (signed by physician)
  - Explanation of delayed request if submitting past time limit
- Make sure to include point of contact information
  - Someone who will respond promptly to document requests

# Tip: Documentation

- When requesting appeal, submit complete medical record
  - Determine type of documentation to submit
    - Previously sent records automatically incorporated; do not resend
  - Refer to [What Documents are Needed](#)
    - Listing of types of services you may appeal and medical records that may assist in supporting that services billed are coverable by Medicare
  - Include relevant supporting documents, for example:
    - Copy of decision letter(s) or claim information issued at prior level(s), if applicable
    - Copy of demand letter(s) if appealing overpayment determination



# Submit Redetermination in Writing

- **Part A Redetermination Request Form Level 1**
  - Type appropriate information into form or ensure handwriting legible
  - Complete all areas of form
    - Include attachment if more space needed
  - Attach necessary documentation
- Mail to correct address

JK Part A Providers	J6 Part A and FQHC/RHC Providers
National Government Services Appeals Dept. P.O. Box 7111 Indianapolis, IN 46207-7111	National Government Services Appeals Dept. P.O. Box 6474 Indianapolis, IN 46206-6474

# Tip: Protect PHI

- When using FedEx, UPS and/or USPS
  - Add cover sheet indicating package contains PHI and include all necessary disclaimers
  - Label boxes and envelopes clearly
  - Use reinforced boxes and secure with shipping tape
  - Confirm unrelated information not included within package/envelope

# Submit Redetermination in NGSConnex

- Access NGSConnex
  - Log in to NGSConnex with your username and password
  - Follow instructions in the [\*NGSConnex User Guide\*](#) to submit redetermination and supporting documentation
- Submit only documentation relevant to services/dates in your request
  - Submit as few attachments as possible by combining multiple supporting documents into each attachment
    - Attachment maximum size 25 MB each
    - File types not accepted = .xml, .log, and .cfg

# Tip: Do Not Submit Duplicate Requests

- Check if you previously submitted reopening/redetermination via NGSConnex by verifying Submission History
  - Submission History panel displays reopening submitted via NGSConnex on/after 2/25/2022
- Submitting duplicate reopening/redetermination requests
  - Results in processing delays
  - Abusive and costly to Medicare Program

# Submit Redetermination via esMD

- Electronic Submission of Medical Documentation (esMD)
  - CMS-developed mechanism for contractors to receive redeterminations electronically via secure gateway
- To electronically submit redetermination to NGS
  - Build a gateway or
  - Procure gateway services from HH of your choice
- Include completed/signed **Part A Redetermination Request Form Level 1**
  - First page of submission

# Level Two: Reconsideration

- Submitted through QIC assigned by CMS
- Time limit to initiate reconsideration
  - 180 days from receipt date of redetermination decision
- Time limit to complete review
  - 60 days
- Amount in controversy
  - No minimum
- [Medicare Reconsideration Request Form \(CMS 20033\)](#)



# Reconsiderations – JK Part A Providers

- [C2C Innovative Solutions, Inc. \(C2C\)](#)
- Questions on QIC Part A East
  - Call 904-224-7446
- Ways to submit reconsiderations to C2C
  - US Mail

C2C Innovative Solutions, Inc.  
QIC Part A East Appeals  
P.O. Box 45305  
Jacksonville, FL 32232-5305
  - Secure fax 904-539-4074
  - [C2C Appeals Portal](#)

# Reconsiderations – J6 Part A and FQHC/RHC

- [Maximus, Inc.](#)
- Questions on QIC Part A West
  - Call 585-348-3020 and leave message
- Ways to submit reconsiderations to Maximus
  - US Mail
    - QIC Part A West
    - Maximus, Inc.
    - Medicare Part A West
    - 3750 Monroe Ave. Suite 706
    - Pittsford, NY 14534-1302
  - Secure fax 585-869-3346
  - [QIC Appeals Portal](#)

# Level Three: ALJ

- Time limit to initiate appeal to ALJ
  - 60 days from receipt date of reconsideration from QIC
- Time limit to complete review
  - 90 days
- Amount in controversy (updated annually)
  - \$190 minimum (2025)
- [Request for ALJ Hearing or Review of Dismissal \(Form OMHA-100\)](#)

# Aggregating Claims to Meet Threshold

- To meet threshold amount, two or more claims previously reconsidered by QIC can be aggregated in request for ALJ hearing
  - Can include both Part A and Part B claims
- Can be done by individual appellant or multiple appellants
  - Individual – All aggregated claims involve delivery of similar/related services
  - Multiple – All aggregated claims involve “common issues of law and fact”
- Request for ALJ hearing must be properly filed within 60 days after receipt of all appealed reconsiderations
  - List all claims to be aggregated
  - Include reasoning why claims included involve “common issues of law and fact” or similar/related services

# ALJ – Part A and FQHC/RHC

- Through [US Department of HHS Office of Medicare Hearings and Appeals \(OMHA\)](#)
- For questions on ALJ process
  - Call 855-556-8475 or email [Medicare.Appeals@hhs.gov](mailto:Medicare.Appeals@hhs.gov)
- Ways to submit ALJ appeal requests
  - US Mail
    - OMHA Central Operations
    - 1001 Lakeside Avenue, Suite 930
    - Cleveland, OH 44114-1158
  - [OMHA e-Appeal Portal](#)
- Check status via [ALJ Appeal Status Information System \(AASIS\)](#)

# Level Four: Medicare Appeals Council

- Through DAB
- Time limit to initiate appeal to DAB
  - 60 days from receipt date of ALJ decision
- Time limit to complete review
  - 90 days
- Amount in controversy
  - No minimum
- [Request for Review of ALJ Medicare Decision/Dismissal \(Form DAB-101\)](#)

# DAB – Part A and FQHC/RHC

- [Appeals to the Medicare Appeals Council \(Council\)](#)
- For questions on DAB Medicare appeals process, call
  - Local: 202-565-0100
  - Toll free: 866-365-8204
- Ways to submit DAB Medicare appeals requests
  - US Mail

Department of Health & Human Services  
Departmental Appeals Board, MS 6127  
Medicare Operations Division  
330 Independence Ave., S.W.  
Cohen Building, Room G-644  
Washington, DC 2020
  - Fax 202-565-0227
  - [DAB Medicare Operations Division eFile](#)



# Level Five: Judicial Review

- Through Federal U.S. District Court
- Time limit to initiate Judicial Review appeal
  - 60 days from receipt date of Medicare Appeals Council DAB decision
- Time limit to complete review
  - None
- Amount in controversy (updated annually)
  - \$1,900 (2025)
- No official form required
  - Suggest submission of all other forms for appeals level one to four

# Federal U.S. District Court – Part A and FQHC/RHC

- Do not send to National Government Services!
- File in appropriate district court of the United States
  - Judicial district in which appealing party resides or where individual, institution, or agency has principal place of business



# Five Levels of Appeal Recap

Appeal Level	Monetary Threshold 2024	Monetary Threshold 2025	Time Limit for Filing	Forms
Redetermination	None	None	120 days from RA receipt date	<a href="#">Part A Redetermination Request Form Level 1</a>
Reconsideration	None	None	180 days from redetermination notice	<a href="#">Medicare Reconsideration Request Form (CMS 20033)</a>
ALJ Hearing	\$180	\$190	60 days from reconsideration notice	<a href="#">Request for ALJ Hearing or Review of Dismissal (Form OMHA-100)</a>
DAB Review	None	None	60 days from ALJ decision	<a href="#">Request for Review of ALJ Medicare Decision/ Dismissal (Form DAB-101)</a>
Judicial Review	\$1,840	\$1,900	60 days from DAB decision	No official form

# Appeal Tips

- Remember to be
  - Timely and valid in submission
  - Appropriate in submission
  - Patient
  - Forthcoming for future contact
  - Prompt
  - Thorough



# References and Resources

# Tool: NGS Appeals Calculator

- Visit [our website](#) > Resources > Tools and Calculators > Appeals Calculator

## APPEALS CALCULATOR

### Appeals Calculator

To determine the timely filing date for your appeals request:

#### Step One

Please select an option from the drop-down based upon which level of appeal you are in (see table at bottom of page).

#### Step Two

Enter the date on which you received the response to your previous appeal.

**Reminder:** The filing time limit for each level of an appeal is calculated from the date you received a response to your previous filing.

Step One \*

Please - Select One

Step Two \*

mm/dd/yyyy

Calculate

Reset

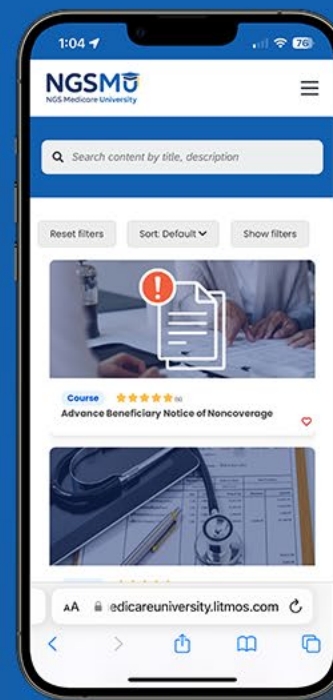
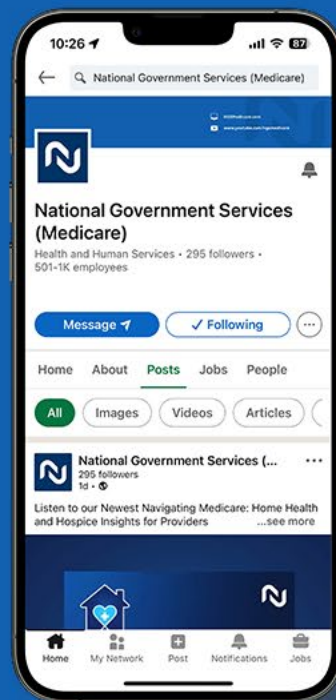
# CMS References and Resources

- [Original Medicare \(Fee-for-service\) Appeals Levels](#)
- [CMS FFS Appeals Flow Chart](#)
- [CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 29 – Appeals of Claims Decisions](#)
- [42 CFR Part 405 Subpart I - Determinations, Redeterminations, Reconsiderations, and Appeals Under Original Medicare \(Part A and Part B\)](#)
- MLN® Booklet: [Medicare Parts A & B Appeals Process](#)
- MLN® Fact Sheet: [Medicare Overpayments](#)
- MLN Matters®: [MM13846 Medicare Change of Status Notice Instructions](#)



# NGS References and Resources

- [Reopenings for Minor Errors and Omissions](#)
- [About Appeals](#)
- [Levels of Appeals and Time Limits for Filing](#)
- [NGS Appeals Forms](#)
- [What is NGSConnex?](#)
- News Articles
  - [Appealing a Denied Claim](#)
  - [Providers Using NGSConnex to Submit Appeals and Supporting Documentation](#)



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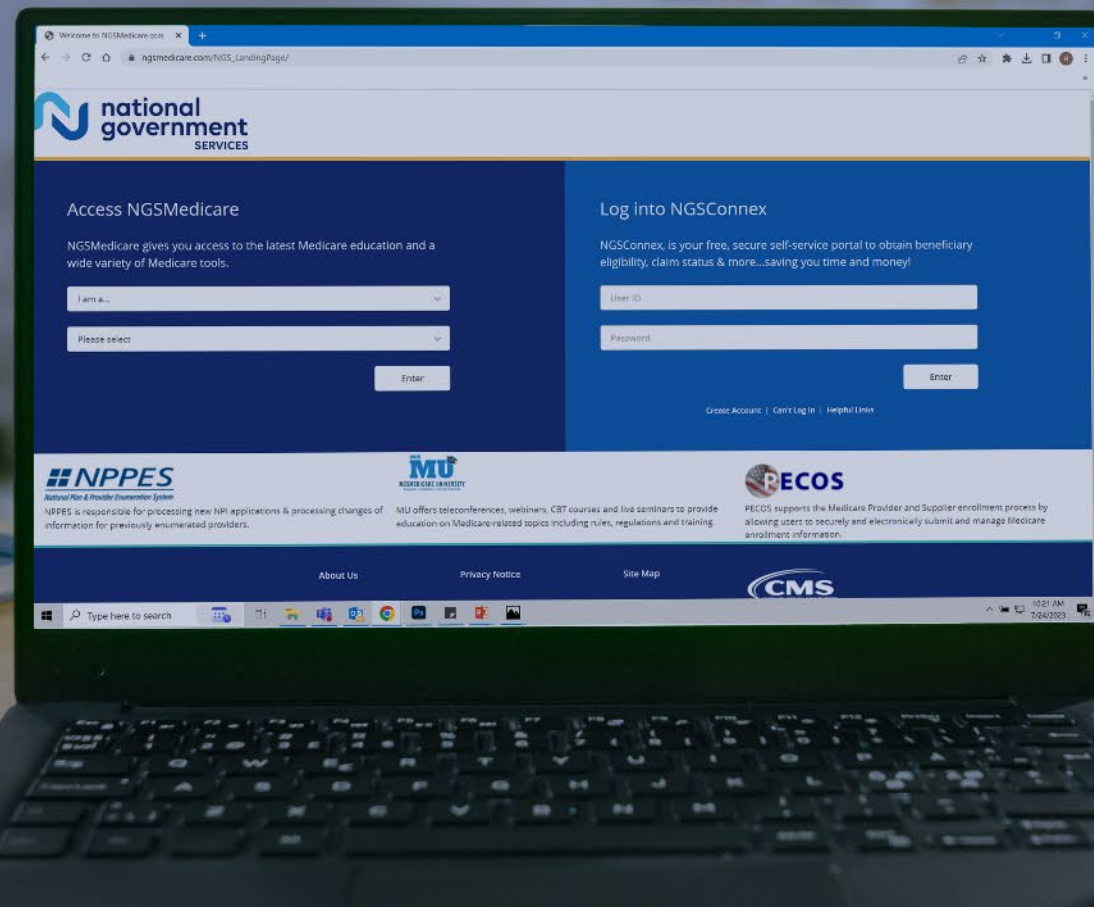


[Medicare University](#)  
Self-paced online learning



[LinkedIn](#)  
Educational Content

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The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



[NGSConnex](#)

Web portal for claim information



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# Questions?

Thank you!