Appeals Process for Medicare Providers

Medicare Appeals – Information for Providers of Covered Services

This guide was specifically developed to assist dental offices wishing to treat individuals with Part B Medicare coverage (i.e., individuals with certain medical conditions who quality for a medically necessary dental benefit in Part B).

Overview - Standard Appeals Process

Once an initial claim determination is made, any party to that initial determination, such as beneficiaries, providers, and suppliers – or their respective appointed representatives – has the right to appeal the Medicare coverage and payment decision. Pay very close attention to the timeframes outlined on CMS' website for each level as late appeals will result in a dismissal.

Section 1869 of the Social Security Act and 42 CFR part 405 subpart I contain the procedures for conducting appeals of claims in Original Medicare (Medicare Part A and Part B).

There are five levels in the Medicare Part B appeals process. The levels are:

1. **First Level of Appeal:** Redetermination by a Medicare Administrative Contractor (MAC)
2. **Second Level of Appeal:** Reconsideration by a Qualified Independent Contractor (QIC)
3. **Third Level of Appeal:** Decision by the Office of Medicare Hearings and Appeals (OMHA)
4. **Fourth Level of Appeal:** Review by the Medicare Appeals Council
5. **Fifth Level of Appeal:** Judicial Review in Federal District Court

Common Questions When Getting Started

Q: When must I file a request?
A: You must file a redetermination request within 120 days from the date you got the Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR) Advice listing the initial determination. The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.

Q: How do I file a request?
A: File your request in writing using the ERA or SPR instructions. Use the Medicare Redetermination Request (CMS-20027) or any written document with the required appeal elements stated on the ERA or SPR. Send your request to the address on the ERA or SPR. Find your Medicare Administrative Contractors (MACs) website for instructions on how to send your request electronically. The request is considered filed on the date the contractor gets it.

First Level of Appeal: Redetermination by a Medicare Contractor webpage has more information about redeterminations and what's required for a request.

Please Note:

- You or your representative must include all required information
- Attach any supporting documents (May need to include peer reviewed Evidence Based Medical Literature depending on the reason for a denial).
- Keep a copy of all appeal documents sent to Medicare

Q: Who decides on the appeal?
A: MAC staff not involved with the initial claim determination do the redetermination.

Q: How long does it take to decide?
A: MACs generally issue a decision within 60 days of the date they get the redetermination request. Your MAC will tell you about its decision with an MRN, or, if they reverse the initial decision and pay the claim in full, you will get a revised ERA or SPR.

Looking for more information? Answers to the above questions and much more can also be found in the CMS Medicare Learning Network's brochure titled "Medicare Parts A & B Appeals Process". This resource is designed as a reference guide to the Medicare claims appeals process for providers, physicians and other suppliers.

Dentists may also want to view this CMS diagram of the original Medicare (fee-for-service) standard and expedited appeals process.