

Appeals Process Quick Reference

Appeal Level	Time Limit for Filing Request	Monetary Threshold to Be Met
1. Redeterminations	120 days from the date of receipt of the initial determination notice	None
2. Reconsiderations	180 days from the date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	Increased to \$120 for requests made on or after January 1, 2008
4. Medicare Appeals Council (MAC) Review (part of the Departmental Appeals Board)	60 days from the date of receipt of the ALJ hearing decision	None (Providers are unable to proceed to the next level unless the amount in controversy is \$1,180 or more.)
5. Judicial Review in U.S. District Court	60 days from the date of receipt of DAB decision or declination of review by DAB	Increased to \$1,180 for requests made on or after January 1, 2008

Helpful Hints

- Each level of appeal must be completed before appealing to the next level.
- A completed Form CMS-20027 constitutes a request for a redetermination.
- A written request **not** on Form CMS-20027 **must** contain:
 - Beneficiary's name.
 - Beneficiary's Health Insurance Claim Number (HICN).
 - Dates of service at issue.
 - Specific service(s) or item(s) for which the redetermination is being requested.
 - Name and signature of the party or representative of the party.
- Documentation included with a request should include:
 - Operative notes.
 - Progress notes.
 - Office notes.
 - A letter from the physician (if applicable).