Medicare Appeals Processes Comparison Chart

Medicare Part A and Part B (Fee-for-Service) Appeals Process

STANDARD PROCESS

Initial Determination

Medicare Administrative Contractor (MAC) Initial Determination

1st Level of Appeal

120 days to file

MAC Redetermination
60-day time limit for decision

2nd Level of Appeal

180 days to file

Qualified Independent Contactor (QIC) Reconsideration
60-day time limit for decision

3rd Level of Appeal

60 days to file

Office of Medicare Hearings and Appeals
Amount in Controversy (AIC) =>$180[2]
90-day time limit for decision

4th Level of Appeal

60 days to file

Medicare Appeals Council
90-day time limit for decision

5th Level of Appeal (Judicial Review)

60 days to file

Federal District Court
AIC => $1,760[2]

Medicare Part C (Medicare Advantage) Appeals Process

	STANDARD PROCESS		EXPEDITED PROCESS[4]
Initial Determination	**Pre-Service:** 14-day time limit Payment: 60-day time limit[1] Part B Rx: 72-hour time limit	**Organizational Determination**	**Pre-Service:** 72-hour time limit Part B Rx: 24-hour time limit
1st Level of Appeal	Health Plan Reconsideration Pre-Service: 30-day time limit Payment: 60-day time limit Part B Rx: 7-day time limit	**60 days to file**	Health Plan Reconsideration: 72-hour time limit Part B Rx: 72-hour time limit
2nd Level of Appeal	Independent Review Entity (IRE) Reconsideration Pre-Service: 30-day time limit Payment: 60-day time limit Part B Rx: 7-day time limit	**Automatic IRE review if plan holds denial**	IRE Reconsideration: 72-hour time limit Part B Rx: 72-hour time limit
3rd Level of Appeal	**60 days to file** Office of Medicare Hearings and Appeals AIC => $180[2] No statutory time limit for processing		
4th Level of Appeal	**60 days to file** Medicare Appeals Council No statutory time limit for processing		
5th Level of Appeal (Judicial Review)	**60 days to file** Federal District Court AIC => $1,760[2]		

Medicare Part D (Drug) Appeals Process

	STANDARD PROCESS		EXPEDITED PROCESS[4]
Initial Determination	72-hour time limit[3]	**Coverage Determination**	24-hour time limit[3]
1st Level of Appeal	Prescription Drug Plan (PDP)/Medicare Advantage Prescription Drug Plan (MA-PD) Redetermination: 7-day time limit (benefits) 14-day time limit (payments)	**60 days to file**	PDP/MA-PD Redetermination: 72-hour time limit
2nd Level of Appeal	IRE Reconsideration: 7-day time limit (benefits) 14-day time limit (payments)	**60 days to file**	IRE Reconsideration: 72-hour time limit
3rd Level of Appeal	Office of Medicare Hearings and Appeals Standard Decision AIC => $180[2] 90-day time limit	**60 days to file**	Office of Medicare Hearings and Appeals Expedited Decision AIC => $180[2] 10-day time limit
4th Level of Appeal	Medicare Appeals Council Standard Decision 90-day time limit	**60 days to file**	Medicare Appeals Council Expedited Decision 10-day time limit
5th Level of Appeal (Judicial Review)	**60 days to file** Federal District Court AIC => $1,760[2]		

1 Plans must process 95% of all clean claims from out-of-network providers within 30 days. All other claims must be processed within 60 days.

2 The AIC requirement for all appeals at the Office of Medicare Hearings and Appeals (OMHA) and Federal District Court is adjusted annually in accordance with the medical care component of the Consumer Price Index. The chart reflects the CY 2021 AIC amounts.

3 A request for a coverage determination includes a request for a tiering exception or a formulary exception. The adjudication timeframes generally begin when the request is received by the plan sponsor. However, if the request involves an exception request, the adjudication timeframe begins when the plan sponsor receives the physician's supporting statement.

4 Plans may, but are not required to, expedite payment requests.

NOTE: The time to file starts when the previous decision or determination is received.