

# Understanding the ALJ Process for Healthcare-Related Appeals to Payer Denials

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## Introduction

Healthcare providers and beneficiaries sometimes receive denials from Medicare for claims or services. If initial appeals are unsuccessful, the Administrative Law Judge (ALJ) process offers a formal way to request further review. This document explains the ALJ process, focusing on Medicare appeals.

*Hint: Always check the latest instructions on the CMS and Office of Medicare Hearings and Appeals (OMHA) websites **before starting an appeal**, as requirements can change.*

## Overview of the Appeals Process

A Medicare appeal has several steps:

- **Initial Determination:** The payer reviews the claim and makes a decision (approval or denial).

If you disagree with the decision, you can follow these levels of appeal, in order:

1. **Redetermination:** First level – an internal review by the Medicare Administrative Contractor (MAC).
2. **Reconsideration:** Second level – a Qualified Independent Contractor (QIC) reviews the case.
3. **Administrative Law Judge (ALJ) Hearing:** Third level – an impartial judge reviews the case.
4. **Medicare Appeals Council:** Fourth level of appeal.
5. **Federal District Court:** Fifth level of appeal.

## When to Request an ALJ Hearing

**Eligibility:** You can request an ALJ hearing if the amount in controversy (AIC) meets the minimum threshold (\$190 for Medicare in 2025).

**Timeframe:** You must file the request within 60 days of receiving the reconsideration decision.

**Filing:** Submit the request to the Office of Medicare Hearings and Appeals (OMHA).

## The ALJ Hearing Process

## 1. Filing the Request

- If you are appealing for a patient, complete the Appointment of Representative (AOR) form (available on the CMS website).
- Fill out the Request for Administrative Law Judge (ALJ) Hearing or Review of Dismissal (OMHA-100 for Medicare).
- Include all required information: beneficiary details, provider/supplier information, claim numbers, and reasons for disagreement.
- Attach a written appeal explaining why you disagree, along with the relevant medical records and evidence to support your argument from peer reviewed documents or if a coding appeal, from coding guidance.

*Hint: Reference the date and name of the medical record document that contains the most important information for the ALJ. Example: "Initial lab findings revealed hemoglobin at 6g/dl and hematocrit at 18%." (H&P, 7/17/2025)*

- Avoid using page numbers, as the ALJ's copy may be organized differently.
- Attach a copy of the reconsideration decision.

## 2. Pre-Hearing Procedures

- **Acknowledgment:** OMHA will confirm receipt and assign a docket number.
- **Case Assignment:** An ALJ and support staff are assigned to the case.
- **Evidence Submission:** Submit all evidence in advance, usually no later than 10 days before the hearing.

*Note: New evidence (not submitted in earlier levels) is generally not accepted unless you can show good cause.*

*Hint: Submit all evidence by the second level (reconsideration) so it is not considered "new" at the ALJ level.*

- **Pre-Hearing Conference** (if needed): The ALJ may schedule this to clarify issues or address procedural matters.

## 3. The Hearing

- **Format:** Hearings can be held in person, by video, or by phone. For hospitals representing patients, hearings are usually by phone.
- **Participants:** The appellant (provider, beneficiary, or representative), payer representatives, witnesses, and the ALJ.

*Hint: The payer may have doctors, nurses, lawyers, and/or coders present.*

- **Proceedings:** The ALJ reviews the record, hears testimony, and allows for questions and arguments.

*Hints: 1. Anticipate the payer's arguments and prepare your rebuttal. 2. Listen closely to the payer's points and address anything inaccurate.*

- **Representation:** Parties may have attorneys or other qualified representatives.

#### 4. The ALJ Decision

- **Timeline:** The ALJ aims to issue a decision within 90 days of the hearing request, but delays can happen.

*Hint: You can look up the status of your appeal on the OMHA website.*

- **Content:** The decision will include findings of fact, legal conclusions, and the reasoning behind the determination.
- **Binding Effect:** The decision is binding unless you appeal to the next level.

#### 5. After the ALJ Decision

- **Favorable Decision:** The payer must pay the claim or authorize the service.
- **Unfavorable Decision:** You may appeal to the Medicare Appeals Council.
- **Further Appeals:** After the Medicare Appeals Council, you may appeal to federal court if the AIC threshold is met.

#### Best Practices for Success

- **Timely Filing:** Always meet deadlines.
- **Complete Documentation:** Submit all relevant medical records, correspondence, and evidence within the required timeframes.
- **Clear Arguments:** Clearly explain why the denial should be overturned, using Medicare policies, regulations, and peer-reviewed literature and/or coding guidance as support.

#### Summary

The ALJ process is a key step in challenging denials, offering an impartial review and a chance to present evidence and arguments. Understanding each phase and preparing thoroughly increases your chances of a favorable outcome.

#### References

Original Medicare (Fee-for-service) Appeals

Office of Medicare Hearings and Appeals (OMHA)