Traditional Medicare Appeals
The 5-Level Appeal Framework for Physician Advisors

Purpose of This Reference

Traditional Medicare (TMCR) appeals follow a statutorily defined, five-level process established by federal regulation. While Physician Advisors are not responsible for managing the administrative mechanics of appeals, they play a critical role in clinical support, documentation clarification, and strategic decision-making throughout the process.

This reference document is intended to define each appeal level clearly, explain the focus of review at each stage, and clarify where Physician Advisor involvement is most impactful.

Why Traditional Medicare Appeals Are Different

Unlike Medicare Advantage or Commercial plans, Traditional Medicare appeals are regulatory-driven, based on public standards, and reviewed through progressively independent bodies. Clinical judgment regains prominence at higher appeal levels, particularly when decisions are evaluated prospectively rather than through retrospective outcomes.

Overview of the Five-Level Appeal Structure

Level 1 — Redetermination (Medicare Administrative Contractor)

The first level of appeal is conducted by the Medicare Administrative Contractor (MAC). This review focuses on regulatory compliance, documentation sufficiency, and application of CMS guidance.

Physician Advisor role: clarify clinical reasoning, ensure physician expectation and risk are documented, and identify documentation gaps early. This level often functions as a documentation correction stage.

Level 2 — Reconsideration (Qualified Independent Contractor)

The second level is an independent review performed by a Qualified Independent Contractor (QIC). This level focuses on medical necessity, regulatory interpretation, and consistency with Medicare coverage rules.

Physician Advisor role: strengthen the clinical narrative, explicitly articulate prospective risk and uncertainty, and directly address the prior denial rationale. This is often the most important appeal level for Physician Advisors.

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Level 3 — Administrative Law Judge (ALJ)

At the third level, an Administrative Law Judge reviews the case. This level emphasizes clinical reasonableness, physician judgment, and contextual testimony.

Physician Advisor role: support physician testimony, clarify clinical decision-making, and reinforce the prospective standard of care. This is where clinical judgment is most likely to be heard.

Level 4 — Medicare Appeals Council

The fourth level is reviewed by the Medicare Appeals Council, part of the Departmental Appeals Board. The focus is on legal and regulatory interpretation and consistency with Medicare law.

Physician Advisor role: minimal direct involvement. Clinical arguments carry less weight at this stage.

Level 5 — Federal District Court

The fifth and final level involves review by the federal judiciary. This level addresses statutory interpretation and legal precedent.

Physician Advisor role: typically none. This level is rarely pursued due to cost and complexity.

Strategic Teaching Points for Physician Advisors

Not every Traditional Medicare denial should progress through all five appeal levels. Physician Advisors add the most value at Levels 1 through 3, particularly at the QIC and ALJ stages. Understanding where clinical judgment remains influential prevents wasted effort and preserves credibility.

Key Takeaway

Traditional Medicare appeals are structured, progressive, and regulation-driven. Physician Advisors should understand the framework, recognize where their input matters most, and support appeals strategically rather than reflexively.

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