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Medicare Parts A & B Appeals Process

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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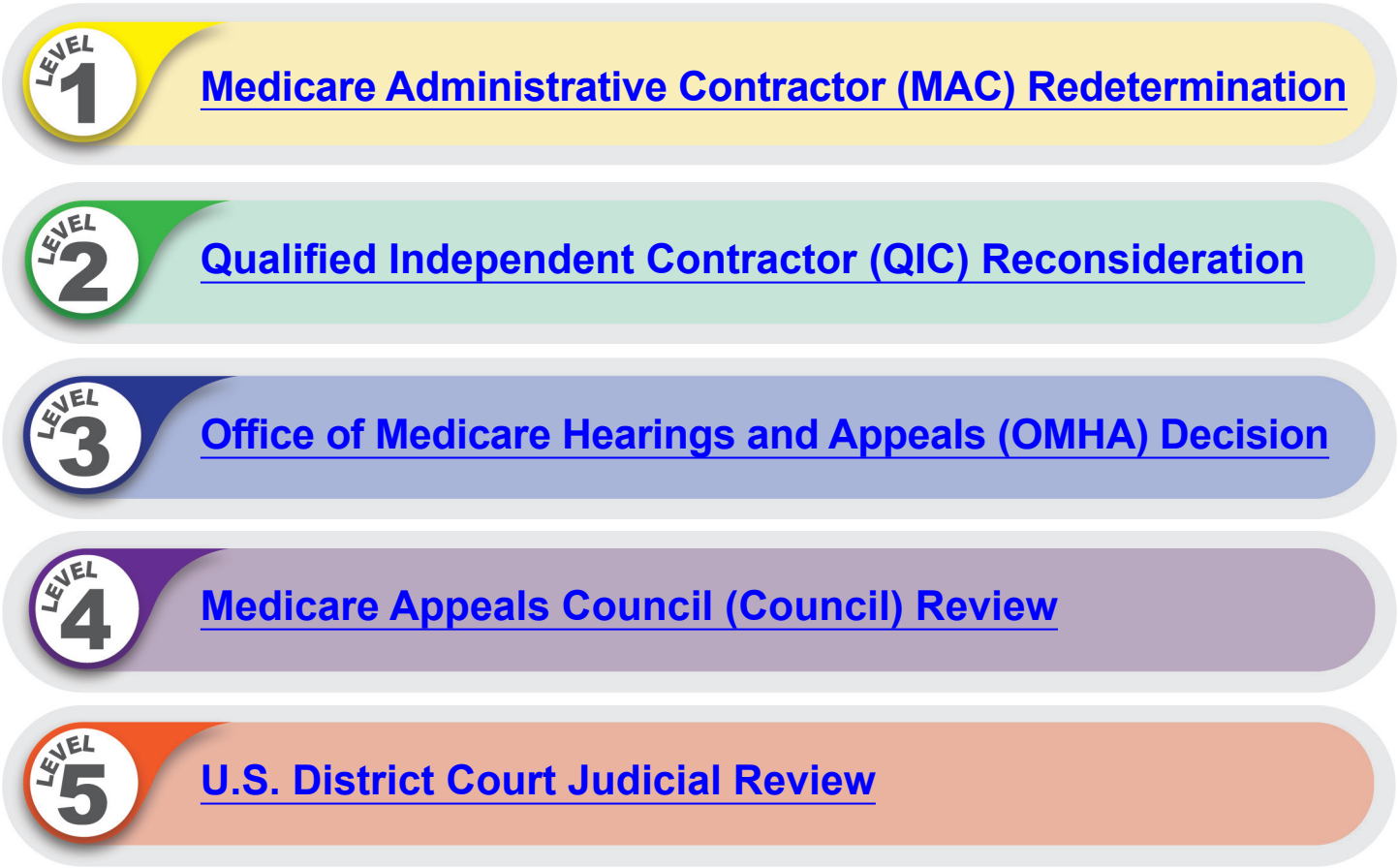
What's Changed?

Note: No substantive content updates.

This booklet informs health care providers about Medicare's 5 appeal levels in Fee-for-Service (FFS) (Original Medicare) Parts A and B and includes resources on related topics. It also describes how providers, physicians, and suppliers apply the appeals process to their services. It doesn't cover Medicare Parts C or D appeals.



Make all appeal requests in writing.

In this booklet, **I** or **you** refers to patients, parties, and appellants active in an appeal.

Helpful Terms

Amount in Controversy (AIC): The required level 3 and level 5 appeal dollar amount still in dispute. We annually adjust the AIC by a percentage increase tied to the consumer price index.

Appeal: The process used to request review when a party (for example, a patient, provider, or supplier) disagrees with an initial determination or revised determination on a claim for health care items or services.

Appellant: A person or entity filing an appeal.

Attorney Adjudicator: A licensed attorney with knowledge of Medicare coverage and payment laws who HHS OMHA employs, and who's authorized to review and issue dispositions on certain requests for an Administrative Law Judge (ALJ) hearing or review of a QIC dismissal.

Determination: A decision on coverage and claim payment and liability.

Escalation: When an appellant requests to move a reconsideration pending at the QIC level (second appeal level) or higher to the next level because the adjudicator can't make a prompt decision or dismissal. The appeal must meet the applicable AIC level 3 and level 5 requirements.

Medicare Redetermination Notice (MRN): A MAC letter informing a party about a redetermination decision.

Non-Participating: Physicians and suppliers who haven't signed a Medicare participation agreement but may choose to accept or not accept Medicare assignment on a claim-by-claim basis. Non-participating physicians and suppliers have limited appeal rights.

On-the-Record: A decision based solely on information within the administrative record. No hearing is held.

Party: A person or entity with standing to appeal an initial determination or subsequent administrative appeal determination or decision.

Appointing a Representative

A party may appoint an individual, including an attorney, to represent them at any time during the claim or appeal process.

To appoint a representative, the party and representative must complete the Appointment of Representative (CMS-1696) or any document that:

- Includes a statement appointing the representative to act for the party
  - If the party is the patient, includes a statement authorizing the adjudicator to release identifiable health information to the appointed representative
- Includes a written explanation of the representative's purpose and scope
- Includes the party and representative's names, phone numbers, and addresses
- Includes the representative's professional status or relationship to the party
- Includes the represented party's unique identifier
  - If the party is the patient, includes their MBI
  - If the party is a provider or supplier, includes their NPI
- Is filed with the entity processing the party's initial determination or appeal
- The party and representative sign and date

Note: If providers and suppliers who furnish items or services to a patient that are subject to appeal and wish to represent the patient, they can't charge the patient a fee and must agree to waive the right to collect payment for items or services described in Section 1879(a)(2) of the Social Security Act.

The appointment documentation is valid for 1 year from the date it has the signatures of both the party and appointed representative. You can use the appointment for multiple claims or appeals during that year unless the party specifically withdraws the representative's authority. Once an appointment is filed with an appeal request, the appointment is valid beyond 1 year throughout all appeal levels, unless revoked.

Appointing Representatives

42 CFR 405.910 has the requirements for appointing a representative.

Transfer Appeal Rights to Non-Participating Providers & Suppliers

Patients may transfer their appeal rights to non-participating providers or suppliers who provide the items or services and don't otherwise have appeal rights. To transfer appeal rights, the patient and non-participating provider or supplier must complete and sign the Transfer of Appeal Rights (CMS-20031).

First Appeal Level: MAC Redetermination

A redetermination is the first appeal level after the initial claim determination.

Table 1. Redetermination FAQs & Answers

Question	Answer
When must I file a request?	File a redetermination request within **120 days** of the date you get the electronic remittance advice (ERA) or standard paper remittance (SPR) advice with the initial determination. We presume the receipt date is 5 days after the notice date unless there's evidence you didn't get it within that time frame.
How do I file a request?	File your request **in writing** by following the ERA or SPR instructions. Use the Medicare Redetermination Request (CMS-20027) or any written document with the required appeal elements shown on the ERA or SPR. Send your request to the address on the ERA or SPR or find your MAC's website for instructions on how to send your request electronically. We consider the request filed on the date the contractor gets it. First Level of Appeal: Redetermination by a Medicare Contractor has more information about what's required for a request. **Remember** • You or your representative must include all required information • Attach any supporting documents • Keep a copy of all appeal documents you send to Medicare
Is there a minimum AIC requirement?	**No**
Who decides?	MAC staff who weren't involved with the initial claim determination do the redetermination.
How long does it take to decide?	MACs generally issue a decision within **60 days** of the date they get a redetermination request. Your MAC will tell you their decision with an MRN, or, if they reverse the initial decision and pay the claim in full, you'll get a revised ERA or SPR.

Table 1. Redetermination FAQs & Answers (cont.)

Question	Answer

Can a MAC dismiss a redetermination request?	A MAC may dismiss a redetermination request:
	• If the appellant party (or appointed representative) requests their appeal be withdrawn
	• If there are specific defects, like:
	  ◦ The party didn't file a request within the appropriate time frame and didn't show (or the MAC didn't decide in favor of) good cause for the late filing
	  ◦ There's no initial determination
	  ◦ The requestor isn't a proper party
	Medicare Claims Processing Manual, Chapter 29 has MAC dismissal information.
	Parties to MAC dismissals can dispute the dismissal by:
	• Requesting a QIC review of the MAC dismissal within 60 days of getting the dismissal notice (second appeal level)
	• Requesting the MAC vacate the dismissal within 180 days of getting the dismissal notice
	  ◦ We presume the receipt date is 5 days after the notice date, unless there's evidence you didn't get the determination decision or notice within that time frame

Second Appeal Level: QIC Reconsideration

If you disagree with the MAC's redetermination decision, you may request a QIC reconsideration. A QIC reconsideration is an independent review of the administrative record, including the initial determination and redetermination.

Table 2. Reconsideration FAQs & Answers

Question	Answer
When must I file a request?	File a reconsideration request within **180 days** of the date you get the notice of the redetermination decision. If the MAC dismissed your redetermination request, file your request within **60 days** of the date you get the dismissal. We presume the receipt date is 5 days after the notice date unless there's evidence you didn't get it within that time frame.

How do I file a request?	File your request **in writing** by sending it to the address on the MRN, dismissal notice, or remittance advice (RA), or find the QIC's website for instructions on how to send your request electronically. Use the Medicare Reconsideration Request (CMS-20033) or any written document with the required elements shown on the MRN, dismissal notice, or RA.
	Second Level of Appeal: Reconsideration by a QIC has more information about what's required for a request.
	Remember
	• Clearly explain why you disagree with the redetermination decision
	• You or your representative must include all required information
	• Be sure to include the following on your request:
	  • RA or MRN copy
	  • Patient's name and MBI
	  • Missing evidence listed on the redetermination notice and other relevant evidence or documents
	  • Name of the MAC that issued the redetermination
	If you send documents after you file the reconsideration request, it may extend the QIC's decision time frame.
	Make sure you send all evidence you want reviewed with your reconsideration request. If you submit evidence at later appeal levels, it won't be considered unless you show good cause.

Table 2. Reconsideration FAQs & Answers (cont.)

Question	Answer
Is there a minimum AIC requirement?	**No**
Who decides?	The **QIC** does the reconsideration and independently reviews the administrative record, including the redetermination. A panel of physicians or other health care professionals may review medical necessity issues as part of the reconsideration. A QIC review of a MAC dismissal is limited to whether the dismissal was appropriate.
How long does it take to decide?	A QIC generally issues a decision to all parties within **60 days** of the date they get a reconsideration request. If the QIC can't complete its decision within that time frame, it informs you of your rights and the procedures to escalate the case to OMHA. If you don't get a reconsideration decision within 60 days, consider allowing an extra 5–10 days for mail delays before escalating your appeal to OMHA. Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals has more information about escalating your appeal to OMHA.

Can a QIC dismiss a reconsideration request?	A QIC may dismiss a reconsideration request:
	• If the appellant party (or appointed representative) requests their appeal be withdrawn
	• If there are specific defects, like:
	  • The party didn't file a request within the appropriate time frame and didn't show (or the QIC didn't decide in favor of) good cause for the late filing
	  • There's no redetermination
	  • The requestor isn't a proper party
	
	42 CFR 405.972 has QIC dismissal information.
	
	Parties to QIC dismissals can dispute the dismissal by:
	• Requesting an OMHA ALJ dismissal review within 60 days of getting the dismissal notice
	• Requesting the QIC vacate the dismissal within 180 days of getting the dismissal notice

Third Appeal Level: OMHA Decision

If you disagree with the QIC reconsideration decision or dismissal, or you want to escalate your appeal because the reconsideration decision time frame passed, you can request an ALJ hearing or review of a dismissal.

This appeal level allows you—via phone, video-teleconference (VTC), or occasionally in person—to explain your position to an ALJ. If you don't want to attend a hearing, you can ask an OMHA ALJ or attorney adjudicator to decide based on the evidence in the "administrative record of the appeal" (known as an "on-the-record" decision). The HHS OMHA is the third appeal level and is functionally and organizationally independent from CMS.

Table 3. OMHA Review FAQs & Answers

Question	Answer
When must I file a request?	File an ALJ hearing request within **60 days** of the date you get the reconsideration decision letter or QIC dismissal notice. If you'd like an escalation to OMHA, file a request with the QIC for OMHA review after the reconsideration period expires. We presume the receipt date is 5 days after the notice date unless there's evidence you didn't get it within that time frame.
How do I file a request?	File your request **in writing** by following the instructions included with the reconsideration letter or QIC dismissal notice. The OMHA e-Appeal Portal allows you to electronically submit Medicare Part A and B appeal requests, upload documentation, and get appeal status information. If you don't want a phone hearing, you may ask for an in-person or VTC hearing. Unless you're an unrepresented Medicare patient requesting a VTC hearing, you must demonstrate good cause for a VTC or in-person hearing. The ALJ sets hearing procedures, including the time and place. If you prefer to waive a hearing, select that choice in OMHA-100, Section 9, and complete a Waiver of Right to an ALJ Hearing (OMHA-104). If you already sent your OMHA-100 form, complete a Waiver of Right to an ALJ Hearing (OMHA-104) and send it to the assigned OMHA adjudicator. If OMHA grants an on-the-record review, an OMHA adjudicator issues a decision based on information in the administrative record and any evidence sent with the request, subject to new evidence standards. Office of Medicare Hearings and Appeals and Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals has more information about requesting an ALJ hearing and the requirements, including forms.

Table 3. OMHA Review FAQs & Answers (cont.)

Question	Answer
How do I file a request?	**Remember** • Send a copy of the ALJ hearing request to all other QIC reconsideration parties. If you request a Council escalation, send a copy to all other parties and the assigned adjudicator or OMHA Central Operations (if the adjudicator isn't assigned). • CMS or its contractors may become a party to, or participate in, an ALJ hearing after notifying the ALJ and all involved parties.
Is there a minimum AIC requirement?	**Yes.** A party to a QIC reconsideration has a right to a hearing before an ALJ only if the amount remaining in controversy meets or exceeds the applicable, annually updated AIC threshold. OMHA FAQs has information about how the AIC is calculated. 42 CFR 405.1006(e)(1)–(f)(2) has more information on aggregating claims to meet the AIC requirement and aggregating claims escalated from the QIC level for an ALJ hearing.
Who decides?	**The ALJ or attorney adjudicator** decides and issues a decision. Review of a QIC dismissal is limited to whether the dismissal was appropriate. If an ALJ or attorney adjudicator doesn't issue a decision within the applicable time frame, you may escalate the appeal to the Council. Otherwise, the appeal remains pending with OMHA. Once the ALJ or attorney adjudicator completes case actions, OMHA sends the disposition package and case file to the Administrative QIC (AdQIC) (the central manager for all Medicare FFS claim case files appealed to QIC or beyond). In certain situations, the AdQIC may refer the case to the Council on our behalf. If no referral is made to the Council and the ALJ or attorney adjudicator decision overturns a previous denial (in whole or in part), the AdQIC tells the MAC it must process the claim, according to the OMHA disposition, within 30–60 days of the MAC's receipt of the AdQIC notification.

Table 3. OMHA Review FAQs & Answers (cont.)

Question	Answer
How long does it take to decide?	For Part A and B appeals, OMHA has **90 days** to complete its review and issue a decision. Although the large appeal request volume previously caused processing delays, OMHA has returned to a 90-day adjudication period. OMHA generally processes ALJ hearing requests in the order they arrive and as quickly as possible, given pending requests and adjudicatory resources. If OMHA doesn't issue a decision within the applicable time frame, you may ask OMHA to escalate the case to the Council. Escalation Rights has information on escalating to the Council. Office of Medicare Hearings and Appeals and ALJ Appeal Status Information System (AASIS) has more information.
Can OMHA dismiss a review request?	OMHA may dismiss an ALJ hearing or QIC dismissal review request: • If the appellant party (or appointed representative) requests their appeal be withdrawn • For cause authorized under the regulations 42 CFR 405.1052 has more dismissal information. OMHA sends a written dismissal notice to all parties who got a copy of the request for hearing or review. Parties to the OMHA dismissal can dispute the dismissal by: • Requesting the adjudicator vacate the dismissal • Requesting the Medicare Appeals Council (the Council) review the dismissal within 60 days after they get the dismissal notice

Fourth Appeal Level: Medicare Appeals Council (Council) Review

If you disagree with the ALJ or attorney adjudicator decision or dismissal, or you want to escalate your appeal because the OMHA adjudication time frame passed, you may request a Council review. The Council is part of the HHS Departmental Appeals Board (DAB).

Table 4. Council Review FAQs & Answers

Question	Answer
When must I file a request?	File a Council review request within **60 days** of the date you get the OMHA decision or dismissal. We presume the receipt date is 5 days after the notice date unless there's evidence you didn't get it within that time frame
How do I file a request?	You may use 1 of these methods to file a request for review: • File your request **in writing** by following the OMHA decision or dismissal instructions • Complete a Request for Review of ALJ Medicare Decision/Dismissal (DAB-101) and mail, fax, or email it following the instructions on the form • File a request **electronically** for review through DAB E-File DAB Medicare Operations Division (MOD) E-File if you're a registered user Medicare Appeals Council and Fourth Level of Appeal: Review by the Medicare Appeals Council has more information about requesting a Council review and requirements after an OMHA decision. **Remember** • Specify which part of the OMHA decision or dismissal you disagree with and why you think the ALJ or attorney adjudicator was wrong • Send a copy of the request for review to all parties that were copied on the OMHA decision or dismissal
Is there a minimum AIC requirement?	**No**

Table 4. Council Review FAQs & Answers (cont.)

Question	Answer
Who decides?	**The Council**. The Council may adopt, modify, reverse, or remand the ALJ's or attorney adjudicator's decision. The Council may also dismiss the review request, deny review, or remand the ALJ's or attorney adjudicator's dismissal, or dismiss the ALJ hearing request. Review of an OMHA dismissal is limited to whether the dismissal was appropriate. The Council sends the decision and case file to the AdQIC, the central manager for all Council FFS Medicare claim case files. If the Council overturns a previous denial (in whole or in part), the AdQIC directs the MAC to pay the claim, according to the Council's decision.
How long does it take to decide?	Generally, the Council is expected to adjudicate Part A and Part B appeals within **90 days**. However, case processing delays, including claim file defects, at the lower levels of the appeals process may impact adjudication at the Council level. If the Council review comes from an escalated appeal, the Council has **180 days** from the date they get the escalation request to issue a decision. However, various factors may prevent the Council from issuing a decision or order within the regulatory time frame. If the Council doesn't issue a decision within the applicable time frame, you may ask the Council to escalate the case to the U.S. District Court. If you request U.S. District Court escalation, you must send a copy of the request to all other parties and the Council.
Can the Council dismiss or deny a review request?	The Council may **dismiss** a review request: • If the appeal request isn't filed on time • If the party requests to withdraw the review request • If the party doesn't have a right to request Council review 42 CFR 405.1114 has more dismissal information. The Council may **deny** a review request of an ALJ's or attorney adjudicator's dismissal if the appeal request is valid and the Council finds that the ALJ or attorney adjudicator didn't error in dismissing the appellant's request for an ALJ hearing. The Council sends a written notice to all parties who were sent a copy of the ALJ's or attorney adjudicator's notice of decision. Dismissing a request for Council review of an OMHA dismissal is binding and isn't subject to further review unless the Council reopens and vacates it. The Council's notice will inform you of your rights to seek judicial review.

Fifth Appeal Level: U.S. District Court Judicial Review

If you disagree with the Council decision, or you want to escalate your appeal because the Council decision time frame passed, you may request judicial review.

Table 5. U.S. District Court Judicial Review FAQs & Answers

Question	Answer
When must I file a request?	File a judicial review request within **60 days** of the date you got the Council decision or after the Council decision time frame expires.
How do I file a request?	The Council's decision (or notice of escalation right) informs you how to file a claim in U.S. District Court. Fifth Level of Appeal: Judicial Review in Federal District Court has more information about requesting a judicial review.
Is there a minimum AIC requirement?	**Yes.** A party to a Council decision has a right to a judicial review only if the amount remaining in controversy meets or exceeds the applicable, annually updated AIC threshold.
Who decides?	**The U.S. District Court.**

Tips

- Make all appeal requests in writing
- File requests on time with the appropriate entity
- Include a copy of the decision letters or claim information issued at prior levels
- Include a copy of the demand letters if appealing an overpayment determination
- If the appeal involves an overpayment determined through sampling and extrapolation, identify all contested sample claims in 1 appeal request and clearly state any sampling methodology challenges
- Include all relevant supporting documents with your first appeal request
- Include a copy of the Appointment of Representative form if the requestor isn't a party and is representing the appellant
- Respond promptly to document requests

The Medicare Overpayments fact sheet has more information about the overpayment collection process.

Summary

Table 6. Appeals Process Summary

Level	Review Process Summary	Who Decides?	When Must I File a Request?	How Long Does it Take to Decide?	AIC	Forms
First Level: Medicare Administrative Contractor (MAC) Redetermination	Document the initial claim review determination	MAC	Up to 120 days after you get an initial determination	60 days	No	CMS-20027 CMS-20031
Second Level: Qualified Independent Contractor (QIC) Reconsideration	Document the redetermination review; send any missing appeal evidence	QIC	Up to 180 days after you get the Medicare Redetermination Notice (MRN)	60 days	No	CMS-20033
Third Level: Office of Medicare Hearings and Appeals (OMHA) Decision	May be an interactive hearing between parties or an on-the-record review	Administrative Law Judge (ALJ) or attorney adjudicator	Up to 60 days after you get the QIC decision notice or after the QIC reconsideration expiration time frame if you don't get a decision	90 days if appealing a QIC reconsideration decision or dismissal or 180 days if the appeal was escalated to OMHA	Yes	OMHA-100 OMHA-100A OMHA-104
Fourth Level: Medicare Appeals Council (Council) Review	Document the ALJ's review decision (you may request oral arguments)	Council	Up to 60 days after you get the OMHA's decision notice or after the time frame expiration if you don't get a decision	90 days if appealing an OMHA decision or dismissal or 180 days if the ALJ review time expired without an ALJ decision	No	DAB-101
Fifth Level: U.S. District Court Judicial Review	Judicial review	U.S. District Court	Up to 60 days after you get the Council decision notice or after the Council time frame expiration if you don't get a decision	No statutory time limit	Yes	No HHS form available

Resources

- 42 CFR Part 405, Subpart I
- Filing an appeal if I have Original Medicare
- Original Medicare (Fee-for-service) Appeals
- Original Medicare (Parts A & B) Appeals Flowchart
- Section 1869 of the Social Security Act
- The Appeals Process
- U.S. Federal Courts