



Medicare Parts A & B Appeals Process

Table of Contents

What's Changed?	3
Introduction	4
Appealing Medicare Decisions	4
Appointing a Representative	6
Transfer Appeal Rights to Non-participating Providers & Suppliers	6
First Appeal Level: MAC Redetermination	7
Second Appeal Level: Qualified Independent Contractor (QIC) Reconsideration	9
Third Appeal Level: Office of Medicare Hearings and Appeals (OMHA) Disposition	10
Fourth Appeal Level: Medicare Appeals Council (Council) Review	13
Fifth Appeal Level: U.S. District Court Judicial Review	15
Appeal Tips	15
Appeal Process Summary	16
Resources	17

What's Changed?

Note: No substantive content updates.

Introduction

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

Find more information on the [CMS Appeals](#) and [Medicare Appeals](#) webpages.

Appealing Medicare Decisions

Medicare FFS has 5 appeal process levels:

Level 1 - [MAC](#) Redetermination

Level 2 - [Qualified Independent Contractor \(QIC\)](#) Reconsideration

Level 3 - [Office of Medicare Hearings and Appeals \(OMHA\)](#) Disposition

Level 4 - [Medicare Appeals Council](#) (Council) Review

Level 5 - U.S. District Court Judicial Review

Make all appeal requests in writing.

CMS Removes Signature Requirements

In a [2019 Final Rule](#), CMS ended the requirement that appellants sign their appeal requests.

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

Helpful Terms

Amount in Controversy (AIC): The required threshold Level 3 and Level 5 appeal dollar amount remaining in dispute. CMS adjusts the AIC annually by a percentage increase tied to a consumer price index.

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

Appellant: A person or entity filing an appeal.

Attorney Adjudicator: A licensed attorney HHS OMHA employs with knowledge of Medicare coverage and payment laws and guidance, authorized to issue QIC dismissal review decisions and certain Administrative Law Judge (ALJ) hearing requests.

Determination: A decision on payment and claim liability.

Escalation: When an appellant requests moving a reconsideration pending at the QIC level (second level appeal) 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 and aggregation provisions.

Medicare Redetermination Notice (MRN): A Medicare Administrative Contractor (MAC) letter informing a party about the 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 and evidence sent with the request. There's no hearing 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, at any time to represent them during the claim or appeal process.

To appoint a representative, the party and representative must complete the [Appointment of Representative Form \(CMS-1696\)](#) or another written document that must:

- Be signed and dated by the party and representative
- Include a statement appointing the representative to act for the party
 - If the party is the patient, include a statement authorizing the adjudicator to release identifiable health information to the appointed representative
- Include a written explanation of the representative's purpose and scope
- Include the party and representative names, phone numbers, and addresses
- Include the representative's professional status or relationship to the party
- Include the represented party's unique identifier
 - If the party is the patient, include their Medicare Beneficiary Identifier (MBI)
 - If the party is a provider or supplier, include their National Provider Identifier (NPI)
- Be filed with the entity processing the party's initial determination or appeal

NOTE: Providers and suppliers representing a patient can't charge them a fee and must agree to waive the right to collect payment for items or services described in [SSA Section 1879\(a\)\(2\)](#).

The appointment is valid for 1 year from the date the party and appointed representative sign the document and remains valid for the entire appeal duration for which it was filed, unless revoked. 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 administrative appeals process levels for that appeal, unless the party revokes it.

Appointing Representatives

Get the requirements for appointing a representative at [42 CFR Section 405.910](#).

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 Form \(CMS-20031\)](#).

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?	You must request a redetermination within 120 days from the date you got the Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR) Advice that lists the initial determination. The receipt date is presumed to be 5 days after the notice date, unless there's evidence the determination, decision, or notice wasn't received within that time.
How do I file a request?	<p>File your request in writing by following instructions in the ERA or SPR. Use the Medicare Redetermination Request Form (CMS-20027), or any written document that has the required appeal elements as stated on the ERA or SPR. Send your request to the address on the ERA or SPR. For instructions on how to send your request electronically, contact your MAC.</p> <p>Get more information about redeterminations and what's required for a request on the First Level of Appeal: Redetermination by a Medicare Contractor webpage.</p> <p>Remember</p> <ul style="list-style-type: none"> • 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 uninvolved with the initial claim determination perform the redetermination.
How long does it take to decide?	<p>MACs generally issue a decision within 60 days of the redetermination request receipt date.</p> <p>Your MAC tells you its decision via a Medicare Redetermination Notice (MRN), or if they reverse the initial decision and pay the claim in full, you get a revised ERA or SPR.</p>

Table 1. Redetermination FAQs & Answers (cont.)

Question	Answer
<p>Can a MAC dismiss a redetermination request?</p>	<p>A MAC may dismiss a redetermination request:</p> <ul style="list-style-type: none"> • If the party (or appointed representative) requests appeal withdrawal • If there’s certain defects, such as: <ul style="list-style-type: none"> ◦ Party didn’t file request within appropriate time frame and didn’t show (or the MAC didn’t decide) good cause for late filing ◦ There’s no initial determination ◦ Requestor isn’t a proper party <p>Find MAC dismissal information in Medicare Claims Processing Manual, Chapter 29.</p> <p>Parties to MAC dismissals have 2 choices to dispute:</p> <ul style="list-style-type: none"> • Request QIC review dismissal within 60 days of dismissal notice receipt (second appeal level) • Request MAC vacate dismissal within 180 days of dismissal notice receipt <ul style="list-style-type: none"> ◦ The receipt date is presumed to be 5 days after the notice date, unless there’s evidence the determination, decision, or notice wasn’t received within that time

NOTE: [MLN Matters® Article SE17010](#) explains the Durable Medical Equipment (DME) suppliers process improvements for filing Medicare FFS recurring (or serial) capped claims rental items and certain Inexpensive and Routinely Purchased (IRP) items. These improvements help correct claim errors without initiating the appeals process for all claims in a series.

Second Appeal Level: Qualified Independent Contractor (QIC) Reconsideration

If you disagree with the MAC redetermination decision, you may request a QIC reconsideration. A reconsideration is a redetermination decision review.

Table 2. Reconsideration FAQs & Answers

Question	Answer
When must I file a request?	You must file a reconsideration request within 180 days of the MRN receipt date. Make QIC review requests of a MAC dismissal within 60 days of the dismissal notice receipt. The receipt date is presumed to be 5 days after the notice date, unless there's evidence the determination, decision, or notice wasn't received within that time.
How do I file a request?	<p>File your request in writing using the MRN instructions. Use the Medicare Reconsideration Request Form (CMS-20033), or any written document that has the MRN-required elements.</p> <p>Get more information about reconsiderations and what's required for a request on the Second Level of Appeal: Reconsideration by a QIC webpage.</p> <p>Remember</p> <ul style="list-style-type: none"> • Clearly explain why you disagree with redetermination decision • You or your representative must include all required information • Send: <ul style="list-style-type: none"> ◦ Copy of the Remittance Advice (RA) or MRN ◦ Patient's MBI ◦ Include any missing evidence listed on redetermination notice and other relevant evidence or documents ◦ Name of MAC that issued redetermination <p>If you send documents after you file the reconsideration request, it may extend the QIC's decision time frame.</p> <p>Make sure you send all evidence you want considered with your reconsideration request. Evidence first submitted at later appeal levels won't be considered unless you show good cause.</p>
Is there a minimum AIC requirement?	No.
Who decides?	The QIC conducts 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.

Table 2. Reconsideration FAQs & Answers (cont.)

Question	Answer
How long does it take to decide?	<p>A QIC generally sends a decision to all parties within 60 days of the reconsideration request receipt date. If the QIC can't complete its decision in the applicable time frame, it informs you of your rights and the procedures to escalate the case to OMHA.</p> <p>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. Find information on escalating your appeal to OMHA on the Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals webpage.</p>
Can a QIC dismiss a reconsideration request?	<p>A QIC may dismiss a reconsideration request:</p> <ul style="list-style-type: none"> • If the party (or appointed representative) requests appeal withdrawal • If there's certain defects, such as: <ul style="list-style-type: none"> ◦ Party didn't file request within appropriate time frame and didn't show (or the QIC didn't decide) good cause for late filing ◦ There's no redetermination ◦ Requestor isn't a proper party <p>Find QIC dismissal information at 42 CFR Section 405.972.</p> <p>Parties to QIC dismissals have 2 choices to dispute:</p> <ul style="list-style-type: none"> • Request OMHA Administrative Law Judge (ALJ) or attorney adjudicatory dismissal review within 60 days of dismissal notice receipt • Request QIC vacate dismissal within 180 days of dismissal notice receipt

NOTE: The [Formal Telephone Discussion Demonstration](#) allows selected DME suppliers and certain Part A providers who filed a reconsideration request the opportunity to participate in a formal recorded phone discussion with the DME QIC and the Part A East QIC, respectively. Demonstration activities are scheduled to continue through December 31, 2021. Find more information on the [Appeals Demonstration Part A East Appeals Demonstration](#) and [DME Appeals Demonstration](#) webpages.

Third Appeal Level: Office of Medicare Hearings and Appeals (OMHA) Disposition

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

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 make a decision based on evidence and the “administrative record of the appeal” (known as an on-the-record decision). The HHS OMHA is the third Medicare claims appeal level and is functionally and organizationally independent of CMS.

Table 3. OMHA Review FAQs & Answers

Question	Answer
When must I file a request?	<p>You must file an ALJ hearing request or a hearing waiver within 60 days of the reconsideration decision letter receipt date. If requesting escalation to OMHA, file a request with the QIC for OMHA review after the reconsideration period expires. The receipt date is presumed to be 5 days after the notice date, unless there's evidence the determination, decision, or notice wasn't received within that time.</p>
How do I file a request?	<p>Follow the reconsideration letter instructions to file your request in writing. You may also complete the Request for ALJ Hearing or Review of Dismissal Form (OMHA-100) and Multiple Claim Attachment Form (OMHA-100A), as applicable.</p> <p>If you don't want a phone hearing, you may ask for an in-person or VTC hearing, but you must demonstrate good cause.</p> <p>If you prefer to waive a hearing, select that choice in Form OMHA-100, Section 9. If you already sent your OMHA-100 form, complete a Waiver of Right to an ALJ Hearing Form (OMHA-104) and ask for an on-the-record review. If OMHA grants an on-the-record review, an OMHA adjudicator issues a disposition based on information in the administrative record and any evidence sent with the request, subject to new evidence standards of 42 CFR Section 405.1028.</p> <p>Find more information about requesting an ALJ hearing, requirements, and including additional needed forms, on the Office of Medicare Hearings and Appeals and Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals webpages.</p> <p>Remember</p> <ul style="list-style-type: none"> • You must send a copy of the ALJ hearing request to all other QIC reconsideration parties. If you request Council escalation, send a copy to all other parties and the assigned adjudicator or OMHA Central Operations (if the adjudicator isn't assigned). • The ALJ sets hearing procedures. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the involved parties.
Is there a minimum AIC requirement?	<p>Yes. You may request an ALJ hearing only if a certain dollar amount stays in controversy following the QIC's decision. CMS annually updates and publishes the AIC Threshold.</p> <p>Learn about the AIC-calculated amount on the OMHA FAQs webpage.</p> <p>Get more information on aggregating claims to meet the AIC and aggregating claims escalated from the QIC level for an ALJ hearing at 42 CFR Section 405.1006(e)(1)–(F)(2).</p>

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

Question	Answer
Who decides?	<p>The ALJ or attorney adjudicator decides and issues a disposition.</p> <p>If an ALJ or attorney adjudicator fails to issue a disposition within the applicable time frame, you may choose to escalate the appeal to the Council. Otherwise, the appeal remains pending with OMHA.</p> <p>Once the ALJ or attorney adjudicator completes action on a case, OMHA sends the decision 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 CMS’s behalf.</p> <p>If no referral is made to the Council and the ALJ or attorney adjudicator disposition overturns a previous denial (in whole or in part), the AdQIC tells the MAC it must pay the claim, in accordance with the OMHA disposition, within 30–60 days.</p>
How long does it take to decide?	<p>For Parts A and B appeals, OMHA has a 90-day time frame to complete its review and issue a disposition. Although the large volume of appeal requests previously caused delays in processing, OMHA is on track to return to a 90-day adjudication period.</p> <p>OMHA stays committed to processing ALJ hearing requests in the order they get them and as quickly as possible, given pending requests and adjudicatory resources. OMHA prioritizes expedited Part D prescription drug denial cases and Medicare patient issues.</p> <p>If OMHA doesn’t issue a disposition within the applicable time frame, you may ask OMHA to escalate the case to the Council. Find more information on escalating to the Council on the Escalation Rights webpage.</p> <p>OMHA processes new appeal requests as quickly as possible. You’ll get an Acknowledgement of Request letter after they enter your case in the OMHA case tracking system. Find more information on the Office of Medicare Hearings and Appeals and ALJ Appeal Status Information System (AASIS) webpages.</p> <p>To help reduce the number of ALJ outstanding requests, OMHA began the Settlement Conference Facilitation (SCF) (an alternative dispute resolution process that uses mediation principles) and Statistical Sampling Initiative (applies to appellants with a large volume of claim disputes).</p>
Can OMHA dismiss a review request?	<p>OMHA may dismiss a request for ALJ hearing or QIC review:</p> <ul style="list-style-type: none"> • If the party (or appointed representative) requests appeal withdrawal. • For cause authorized under the regulations. Find more information on dismissals at 42 CFR Section 405.1052. <p>OMHA mails or sends a written dismissal notice to all parties who got a copy of the hearing or review request.</p> <p>Parties to the OMHA dismissal may request the adjudicator vacate the dismissal, and request Medicare Appeals Council (the Council) review within 60 days of the dismissal notice receipt.</p>

Fourth Appeal Level: Medicare Appeals Council (Council) Review

If you disagree with the ALJ or attorney adjudicator decision, or you wish 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?	You must file a Council review request within 60 days of the OMHA decision or dismissal receipt date. The receipt date is presumed to be 5 days after the notice date, unless there's evidence the determination, decision, or notice wasn't received within that time.
How do I file a request?	<p>File your request in writing by following instructions included in the OMHA disposition package or completing a Request for Review of ALJ Medicare Decision/Dismissal Form (DAB-101). File your request electronically through the DAB E-File webpage.</p> <p>Find more information about requesting a Council review and requirements following an OMHA decision on the Medicare Appeals Council and Fourth Level of Appeal: Review by the Medicare Appeals Council webpages.</p> <p>Remember</p> <ul style="list-style-type: none"> • Explain which part of the OMHA decision you disagree with and why • You must send all parties in OMHA's disposition a copy of the Council review request
Is there a minimum AIC requirement?	No.
Who decides?	<p>The Council. The Council may adopt, modify, reverse, or remand the ALJ's or attorney adjudicator's disposition. The Council may also deny or dismiss the review request or dismiss the ALJ hearing request.</p> <p>The Council sends the decision and case file to the AdQIC, the central manager for all Council FFS Medicare claim case files.</p> <p>If the Council decision overturns an earlier denial (in whole or in part), the AdQIC tells the MAC it must pay the claim according to the Council's decision within 30–60 days.</p>

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

Question	Answer
<p>How long does it take to decide?</p>	<p>The Council generally decides within 90 days of the OMHA disposition or dismissal review request receipt date. If the Council review comes from an escalated appeal, the Council has 180 days from the escalation request receipt date to issue a decision. A decision may take longer for many reasons.</p> <p>If the Council issues no decision within the applicable time frame, you may ask the Council to escalate the case to the U.S. District Court.</p> <p>If you request U.S. District Court escalation, you must send a copy of the request to all other parties and the Council.</p>
<p>Can the Council dismiss or deny a review request?</p>	<p>The Council may dismiss or deny a review request:</p> <ul style="list-style-type: none"> ● If appeal request isn't on time ● At the party's request ● Party doesn't have a right to request Council review <p>The Council mails or sends a written notice to all parties copied on the ALJ or attorney adjudicator's Notice of Decision. Dismissal of a request for Council review, or denial of a request for review of a dismissal issued by OMHA, is binding and not subject to further review, unless the Council reopens it and it's vacated by them. The Council's hearing request dismissal is also binding and not subject to judicial review.</p>

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

If you disagree with the Council decision, or you wish 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?	You must file a judicial review request within 60 days of the Council decision receipt 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 . Find more information about requesting a Judicial Review on the Fifth Level of Appeal: Judicial Review in Federal District Court webpage.
Is there a minimum AIC requirement?	Yes. You may request judicial review only if a certain dollar amount stays in controversy following the Council decision. CMS annually updates and publishes the AIC Threshold .
Who decides?	The U.S. District Court .

Appeal Tips

Best filing appeals practices:

- Make all appeal requests in writing.
- Starting at Level 2 or 3, consolidate all similar claims into 1 appeal.
- File requests on time with the appropriate entity.
- Include a copy of the decision letter(s) or claim information issued at prior level(s).
- Include a copy of the demand letter(s) 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.

Find more information about the Medicare overpayment collection process in the [Medicare Overpayments](#) fact sheet.

Appeal Process Summary

Table 6. Appeal 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 – MAC Redetermination	Document initial claim review determination	MAC	Up to 120 days after you get initial determination	60 days	No	CMS-20027 CMS-20031
Second Level – Qualified Independent Contractor (QIC) Reconsideration	Document 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) Disposition	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 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 appeal was escalated to OMHA	Yes	OMHA-100 OMHA-100A OMHA-104
Fourth Level – Medicare Appeals Council (Council) Review	Document ALJ's review decision (you may request oral arguments)	Council	Up to 60 days after you get the OMHA's disposition notice or after expiration time frame if you don't get a decision	90 days if appealing an OMHA disposition or dismissal or 180 days if 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 Council expiration time frame if you don't get a decision	No statutory time limit	Yes	No HHS form available

Resources

- [42 CFR Part 405, Subpart I](#)
- [Medicare Claims Processing Manual, Chapter 29](#)
- [Medicare Appeals Process](#)
- [Original Medicare Appeals](#)
- [Original Medicare \(Parts A & B\) Appeals Flowchart](#)
- [SSA Section 1869](#)
- [U.S. Federal Courts](#)

[Medicare Learning Network® Content Disclaimer, Product Disclaimer, and Department of Health & Human Services Disclosure](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health & Human Services (HHS).