



Medicare Parts A & B Appeals Process



Table of Contents

What’s Changed?	3
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: QIC Reconsideration.....	9
Third Appeal Level: OMHA Decision	11
Fourth Appeal Level: Medicare Appeals Council (Council) Review	14
Fifth Appeal Level: U.S. District Court Judicial Review.....	16
Appeal Tips	16
Appeal Process Summary	17
Resources	18

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.

[CMS Appeals](#) and [Medicare Appeals](#) webpages have more information.

Appealing Medicare Decisions

Original Medicare has 5 appeal process levels:

LEVEL
1

[Medicare Administrative Contractor \(MAC\) Redetermination](#)

LEVEL
2

[Qualified Independent Contractor \(QIC\) Reconsideration](#)

LEVEL
3

[Office of Medicare Hearings and Appeals \(OMHA\) Decision](#)

LEVEL
4

[Medicare Appeals Council \(Council\) Review](#)

LEVEL
5

[U.S. District Court Judicial Review](#)

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 threshold Level 3 and Level 5 appeal dollar amount still in dispute. CMS annually adjusts 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 HHS OMHA employs with knowledge of Medicare coverage and payment laws and guidance, and who is authorized to review and issue dispositions on certain requests for an Administrative Law Judge (ALJ) hearing or review of 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 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.

Medicare Redetermination Notice (MRN): A 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. 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 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 signs and dates

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 section 1879(a)(2) of the [Social Security Act](#).

The appointment is valid for 1 year from the date the party and appointed representative sign the document. 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 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 \(CMS-20031\)](#).

LEVEL 1

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 file a redetermination request within 120 days from the date you got the Electronic Remittance Advice (ERA) or Standard Paper Remittance (SPR) Advice listing the initial determination. The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.
How do I file a request?	<p>File your request in writing using the ERA or SPR instructions. Use the Medicare Redetermination Request (CMS-20027) or any written document with the required appeal elements stated on the ERA or SPR. Send your request to the address on the ERA or SPR. Find your MAC's website for instructions on how to send your request electronically. The request is considered filed on the date the contractor gets it.</p> <p>First Level of Appeal: Redetermination by a Medicare Contractor webpage has more information about redeterminations and what's required for a request.</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 sent to Medicare
Is there a minimum AIC requirement?	No.
Who decides?	MAC staff not involved with the initial claim determination do the redetermination.
How long does it take to decide?	<p>MACs generally issue a decision within 60 days of the date they get the redetermination request.</p> <p>Your MAC tells you its decision with an 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 appellant party (or appointed representative) requests appeal withdrawal • If there are 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 in favor of) good cause for late filing • There's no initial determination • Requestor isn't a proper party <p>Medicare Claims Processing Manual, Chapter 29 has MAC dismissal information.</p> <p>Parties to MAC dismissals can dispute in the following ways:</p> <ul style="list-style-type: none"> • Request QIC review of the MAC 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"> • Notice receipt date is presumed to be 5 days after the notice date, unless there's evidence you didn't get the determination decision, or notice within that time

Note: [MLN Matters® Article SE17010](#) explains the durable medical equipment (DME) suppliers' process improvements for filing claims for Medicare FFS recurring (or serial) capped 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.



LEVEL
2

Second Appeal Level: 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 from the date you got the MRN. Make QIC review requests of a MAC dismissal within 60 days of getting the dismissal notice. The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time.
How do I file a request?	<p>File your request in writing using the MRN instructions. Use the Medicare Reconsideration Request (CMS-20033) or any written document with the required elements stated on the MRN.</p> <p>Second Level of Appeal: Reconsideration by a QIC webpage has more information about reconsiderations and what's required for a request.</p> <p>Remember</p> <ul style="list-style-type: none"> • Clearly explain why you disagree with the redetermination decision • You or your representative must include all required information • Send: <ul style="list-style-type: none"> • Remittance Advice (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 <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 reviewed with your reconsideration request. If you submit evidence at later appeal levels, it won't be considered unless you show good cause.</p>
Is there a minimum AIC requirement?	No.

Table 2. Reconsideration FAQs & Answers (cont.)

Question	Answer
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.
How long does it take to decide?	<p>A QIC generally sends a decision to all parties within 60 days of the date they get the reconsideration request. 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. Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals webpage has more information on escalating your appeal to OMHA.</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 appellant party (or appointed representative) requests appeal withdrawal • If there are 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 in favor of) good cause for late filing • There's no redetermination • Requestor isn't a proper party <p>42 CFR 405.972 has QIC dismissal information.</p> <p>Parties to QIC dismissals can dispute in the following ways:</p> <ul style="list-style-type: none"> • Request OMHA Administrative Law Judge (ALJ) dismissal review within 60 days of getting the dismissal notice • Request QIC vacate dismissal within 180 days of getting the dismissal notice


 LEVEL
3

Third Appeal Level: OMHA Decision

If you disagree with the reconsideration decision or QIC dismissal, or 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 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?	You must file an ALJ hearing request within 60 days from the date you got the reconsideration decision letter or QIC dismissal notice. 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 you didn't get it within that time.
How do I file a request?	<p>File your request in writing using the appeal 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.</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. The ALJ sets hearing procedures, including the time and place of the hearing.</p> <p>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 in 42 CFR 405.1028.</p> <p>Office of Medicare Hearings and Appeals and Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals webpages have more information about requesting an ALJ hearing and requirements, including needed forms.</p>

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

Question	Answer
How do I file a request?	<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 as indicated above 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 providing notice to the ALJ and the involved parties.
Is there a minimum AIC requirement?	<p>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 AIC threshold. We annually update and publish the AIC Threshold. Learn about the AIC-calculated amount on the OMHA FAQs webpage. 42 CFR 405.1006(e)(1)–(f)(2) has more information on aggregating claims to meet the AIC and aggregating claims escalated from the QIC level for an ALJ hearing.</p>
Who decides?	<p>The ALJ or attorney adjudicator decides and issues a decision.</p> <p>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.</p> <p>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 CMS's behalf.</p> <p>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, in accordance with the OMHA disposition, within 30–60 days of the MAC's receipt of the AdQIC notification.</p>

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

Question	Answer
<p>How long does it take to decide?</p>	<p>For Parts 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 is on track to return to a 90-day adjudication period.</p> <p>OMHA generally processes ALJ hearing requests in the order they arrive and as quickly as possible, given pending requests and adjudicatory resources. OMHA prioritizes expedited Part D prescription drug denial cases and appeals initiated by a Medicare beneficiary or enrollee.</p> <p>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 webpage has information on escalating to the Council.</p> <p>Office of Medicare Hearings and Appeals and ALJ Appeal Status Information System (AASIS) webpages have more information.</p>
<p>Can OMHA dismiss a review request?</p>	<p>OMHA may dismiss an ALJ hearing or QIC dismissal review request:</p> <ul style="list-style-type: none"> • If the appellant party (or appointed representative) requests appeal withdrawal • For cause authorized under the regulations <p>42 CFR 405.1052 has more dismissal information.</p> <p>OMHA mails or sends a written dismissal notice to all parties who were sent a copy of the request for hearing or review.</p> <p>Parties to the OMHA dismissal can dispute in the following ways:</p> <ul style="list-style-type: none"> • Request the adjudicator vacate the dismissal • Request Medicare Appeals Council (the Council) review the dismissal within 60 days after they received the dismissal notice



**LEVEL
4**

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?	You must file a Council review request within 60 days from the date you got the OMHA decision or dismissal. The receipt date is presumed to be 5 days after the notice date unless there's evidence you didn't get it within that time
How do I file a request?	<p>File your request in writing using the OMHA decision instructions or completing a Request for Review of ALJ Medicare Decision/Dismissal (DAB-101). You can mail or file your request electronically through the DAB E-File webpage.</p> <p>Medicare Appeals Council and Fourth Level of Appeal: Review by the Medicare Appeals Council webpages have more information about requesting a Council review and requirements after an OMHA decision.</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 decision 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 decision. 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 a previous denial (in whole or in part), the AdQIC tells the MAC it must pay the claim, in accordance with the Council's decision, within 30–60 days of the MAC's receipt of the AdQIC notification.</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 date they get the OMHA decision or dismissal review request. 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. A decision may take longer for many reasons.</p> <p>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.</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 the appeal request isn't filed on time • At the party's request • Because the party doesn't have a right to request Council review <p>The Council mails or sends a written notice to all parties who got a copy of the ALJ or attorney adjudicator's Notice of Decision. Dismissing a request for Council review or denying a request for review of an OMHA dismissal is binding and not subject to further review unless the Council reopens and vacates it. The Council's dismissal of a request for review is also binding and not subject to judicial review.</p>



LEVEL 5

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?	You must file a judicial review request within 60 days from 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 webpage has more information about requesting a Judicial Review.
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 AIC threshold. We annually update and publish the AIC Threshold .
Who decides?	The U.S. District Court .

Appeal Tips

- Make all appeal requests in writing
- 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

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

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: Medicare Administrative Contractor (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) 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 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 decision notice or after time frame expiration if you don't get a decision	90 days if appealing an OMHA decision 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 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](#)
- [Medicare Appeals Process](#)
- [Original Medicare Appeals](#)
- [Original Medicare \(Parts A & B\) Appeals Flowchart](#)
- [Section 1869 of the Social Security Act](#)
- [U.S. Federal Courts](#)

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