



MEDICARE PARTS A & B APPEALS PROCESS

Target Audience: Medicare Fee-For-Service Providers

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Overview

This booklet informs health care professionals about each level of appeal in Medicare Fee-For-Service (FFS) Parts A and B as well as resources on related topics. It describes how the Medicare appeals process applies to providers, physicians, and suppliers. In this booklet, “I” or “you” refer to parties and appellants participating in an appeal.

Find more information about appeals on the [Original Medicare \(Fee-For-Service\) Appeals](#) webpage and beneficiary-specific appeals information on the [Medicare.gov Appeals](#) webpage. This booklet does not cover Medicare Part C or Part D appeals. You can find Part C and Part D appeals resources in Table 7 at the end of this booklet.

Appealing Medicare Decisions

Medicare FFS has five levels in the claims appeal process:

- Level 1 Redetermination by a Medicare Administrative Contractor (MAC)
- Level 2 Reconsideration by a Qualified Independent Contractor (QIC)
- Level 3 Decision by Office of Medicare Hearings and Appeals (OMHA)
- Level 4 Review by the Medicare Appeals Council (Council)
- Level 5 Judicial review in U.S. District Court

Make all appeal requests in writing.

Helpful Terms

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

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

Appellant: A person or entity filing an appeal.

Attorney Adjudicator: A licensed attorney employed by the U.S. Department of Health & Human Services (HHS) OMHA with knowledge of Medicare coverage, payment laws, and guidance, who can issue decisions on reviews of QIC dismissals and some Administrative Law Judge (ALJ) hearing requests.

Determination: A decision made on payment and/or liability of a claim.

Escalation: An appellant requests moving a reconsideration pending at the QIC level (second level appeal) or higher to the next level because the adjudicator is unable to make a timely decision or dismissal. The appeal must also meet the applicable amount in controversy requirements and aggregation provisions for Level 3 and Level 5.

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

Nonparticipating: Physicians and suppliers who have not signed an agreement with Medicare, but may choose to accept or not accept Medicare assignment on a claim-by-claim basis. Nonparticipating physicians and suppliers have limited appeal rights.

On-the-Record: A decision based solely on the information within the administrative record and any evidence submitted with the request. 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

At any time, a party may appoint any individual, including an attorney, to represent them during the claim or appeal process. The representative provides assistance and expertise.

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

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. An appointment instrument submitted with an appeal request is valid beyond 1 year for subsequent levels of appeal for the items, services, or claims at issue.

Requirements for Appointment of Representatives

Find the requirements for appointing a representative in [42 Code of Federal Regulations \(CFR\) Section 405.910](#).

Transfer of Appeal Rights to Nonparticipating Physicians and Suppliers

Beneficiaries may transfer their appeal rights to nonparticipating physicians or suppliers who provide the items or services and do not otherwise have appeal rights. To transfer the appeal rights, the beneficiary and nonparticipating physician or supplier must complete and sign the [Transfer of Appeal Rights](#) (Form CMS-20031).

First Level of Appeal: Redetermination by a Medicare Administrative Contractor (MAC)

A redetermination is the first level of appeal after the initial determination on a claim. MAC staff uninformed in the initial claim determination review the claim.

Table 1. Redetermination Frequently Asked Questions (FAQs) and Answers

Question	Answer
When must I file a request?	You must request a redetermination within 120 days from the date of receipt of the Electronic Remittance Advice (ERA) or Standard Paper Remittance Advice (SPR) that lists the initial determination.
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 contains the required elements listed in the ERA or SPR. Send your request to the address on the ERA or SPR or file it in person (or follow instructions from your MAC on filing electronically).</p> <p>Find more information about redeterminations 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 your name and signature • Attach any supporting documentation • Keep a copy of all appeals documentation you send to Medicare
Is there a minimum AIC requirement?	No.
Who makes the decision?	MAC staff uninformed with the initial claim determination perform the redetermination.
How long does it take to make a decision?	<p>MACs generally issue a decision within 60 days of receiving the request for redetermination.</p> <p>Your MAC notifies you of the decision via a Medicare Redetermination Notice (MRN), or if the initial decision is reversed and the claim is paid in full, you receive a revised ERA or SPR.</p>

NOTE: MLN Matters® Article [Correction of Minor Errors and Omissions Without Appeals](#) provides Medicare rules that help you correct minor errors and omissions on claims without initiating the appeals process. MLN Matters Article [Improvements to the Adjudication Process of Serial Claims](#) provides a process improvement for Durable Medical Equipment (DME) suppliers who file claims for Medicare FFS recurring (or serial) claims for capped rental items and certain Inexpensive and Routinely Purchased (IRP) items. This improved process may help correct errors on claims without initiating the appeals process for all claims in the series.

Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)

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

Table 2. Reconsideration FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for reconsideration within 180 days of receipt of the MRN or ERA.
How do I file a request?	<p>File your request in writing by following instructions provided on the MRN or ERA. Use the Medicare Reconsideration Request (Form CMS-20033), or any written document that contains the required elements listed in the MRN.</p> <p>Find more information about reconsiderations 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 the redetermination decision • You or your representative must include your name and signature • Submit: <ul style="list-style-type: none"> ◦ A copy of the RA or MRN ◦ The beneficiary name and Medicare number ◦ Any missing evidence noted in the redetermination ◦ Any other relevant appeal evidence or documentation ◦ The name of the MAC that made the redetermination <p>Documentation submitted after you file the reconsideration request may extend the QIC’s decision timeframe.</p> <p>NOTE: Evidence not submitted at the reconsideration level may be excluded from consideration at subsequent levels of appeal unless you demonstrate good cause for submitting the evidence late.</p>
Is there a minimum AIC requirement?	No.
Who makes the decision?	The QIC conducts the reconsideration and performs an independent review of the administrative record, including the redetermination. The reconsideration may include review of medical necessity issues by a panel of physicians or other health care professionals.

Table 2. Reconsideration FAQs and Answers (cont.)

Question	Answer
How long does it take to make a decision?	<p>Generally, a QIC sends a decision to all parties within 60 days of receipt of the request for reconsideration. If the QIC cannot complete its decision in the applicable timeframe, it informs you of your rights and the procedures to escalate the case to OMHA.</p> <p>NOTE: If you do not receive a decision on the reconsideration within 60 days, consider allowing an additional 5 to 10 days for mail delays before escalating your appeal to OMHA.</p>

NOTE: The [Formal Telephone Discussion Demonstration](#) with DME Suppliers in DME MAC Jurisdictions C and D provides selected suppliers, who have filed a reconsideration request, the opportunity to participate in a formal recorded telephone discussion with the [DME QIC](#). For more information, refer to the [QIC DME: Formal Telephone Discussion Demonstration](#) webpage. The Formal Telephone Discussion Demonstration is updated to include unfavorable reconsideration decisions. As a result of analysis, the DME QIC is working to identify potential appeals for reopening that can now be resolved favorably through the [reopening process](#) under this demonstration.

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

If you disagree with the reconsideration decision or wish to escalate your appeal because the reconsideration decision timeframe passed, request one of two options under OMHA review: (1) an ALJ hearing or (2) a review of the administrative record by an OMHA attorney adjudicator. This level of appeal gives you the opportunity—via telephone, video teleconference (VTC), or occasionally in person—to explain your position to an ALJ. If you don't wish to attend a hearing, you can ask OMHA (either an 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, independent of CMS, is responsible for the Level 3 Medicare claims appeals.

Table 3. OMHA Review FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for an ALJ hearing, or a waiver of hearing, within 60 days of receipt of the reconsideration decision letter or file a request with the QIC for OMHA review after the expiration of the reconsideration period.

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

Question	Answer
<p>How do I file a request?</p>	<p>File your request in writing by following the reconsideration letter instructions. You may also request an ALJ hearing by completing the Request for ALJ Hearing or Review of Dismissal (Form OMHA-100) and the multiple claim attachment (Form OMHA-100A), as applicable. If you do not want a telephone hearing, you may ask for an in-person or VTC hearing, but you must demonstrate good cause. The ALJ determines whether the case warrants an in-person hearing on a case-by-case basis (there are exceptions to these procedures for unrepresented beneficiary appellants).</p> <p>If you prefer to waive a hearing, you may ask for an on-the-record review by completing a Waiver of Right to an ALJ Hearing (Form OMHA-104) and submitting it with Form OMHA-100. If OMHA grants an on-the-record review, an OMHA attorney adjudicator issues a decision based on the information within the administrative record and any evidence submitted with the request.</p> <p>Find more information about the requirements for requesting an ALJ hearing, including additional forms you may need, 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 parties to the QIC reconsideration. If you request escalation to the Council, send a copy of the request to all other parties and to the ALJ. • The ALJ sets hearing preparation procedures. CMS or its contractors may become a party to, or participate in, an ALJ hearing after providing notice to the ALJ and the parties to the hearing.
<p>Is there a minimum AIC requirement?</p>	<p>Yes. You may request an ALJ hearing only if a certain dollar amount remains in controversy following the QIC’s decision. The Third Level of Appeal AIC Threshold is updated annually.</p> <p>Learn how the AIC amount is calculated on the OMHA FAQs webpage.</p> <p>NOTE: For more information on aggregating claims to meet the amount in controversy and aggregating claims escalated from the QIC level for an ALJ hearing, refer to 42 CFR 405.1006(e)(1)–(F)(2).</p>

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

Question	Answer
<p>Who makes the decision?</p>	<p>The ALJ or attorney adjudicator makes the decision. If the OMHA cannot complete a decision in the applicable timeframe, it informs you of your rights and procedures to escalate the case to the Council.</p> <p>Once action on a case is completed, OMHA forwards the decision and case file to the Administrative QIC (AdQIC), the central manager for all Medicare FFS claim case files appealed to the QIC or beyond. In certain situations, the AdQIC may refer the case to the Council on CMS' 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 notifies the MAC it must pay the claim, according to the OMHA decision, within 30–60 days.</p>
<p>How long does it take to make a decision?</p>	<p>Due to a record number of appeal requests, delays continue in OMHA ALJ hearing assignments.</p> <p>OMHA remains committed to processing ALJ hearing requests in the order received and as quickly as possible, given pending requests and adjudicatory resources. OMHA prioritizes Part D prescription drug denial cases qualifying for expedited status and Medicare beneficiary issues. Additional delay can result from:</p> <ul style="list-style-type: none"> • Appellant failing to send notice of the hearing request to other parties • The discovery request process • Reconsideration-level escalations • Request for an in-person hearing • Submission of additional evidence not included with the hearing request <p>If OMHA issues no decision within the applicable timeframe, you may ask OMHA to escalate the case to the Council.</p> <p>NOTE: New appeal requests are processed as quickly as possible. You will receive an Acknowledgement of Request letter after your case is entered in the OMHA case tracking system. Find more information on these timeframes on the Office of Medicare Hearings and Appeals webpage or you may find the status of appeals by using the ALJ Appeal Status Information System (AASIS).</p> <p>NOTE: As part of the efforts to reduce the outstanding number of ALJ hearing requests, OMHA implemented the Settlement Conference Facilitation (SCF), an alternative dispute resolution process that uses mediation principles, and Statistical Sampling Initiative, which applies to appellants with a large volume of claim disputes.</p>

Fourth Level of Appeal: Review by the Medicare Appeals Council (Council)

If you disagree with the ALJ or attorney adjudicator decision, or you wish to escalate your appeal because the OMHA decision timeframe passed, you may request a Council review. The Council is a component of HHS Departmental Appeals Board (DAB).

Table 4. Council Review FAQs and Answers

Question	Answer
When must I file a request?	You must file your request for Council review within 60 days of receipt of the ALJ's decision or after the OMHA decision timeframe expires.
How do I file a request?	<p>File your request in writing by following OMHA instructions. You may also request a Council review by completing the Request for Review of ALJ Medicare Decision/Dismissal (Form DAB-101) or the electronic version accessible through the DAB E-File webpage.</p> <p>Find more information about the requirements for requesting a Council review 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 your reasons • You must send a copy of the Council review request to all the parties included in OMHA's decision
Is there a minimum AIC requirement?	No.
Who makes the decision?	<p>The Council makes the decision. The Council may deny review, or remand the case to the ALJ or attorney adjudicator. If the Council cannot complete its decision in the applicable timeframe, it informs you of your rights and procedures to escalate the case to U.S. District Court.</p> <p>The Council forwards 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 notifies the MAC it must pay the claim according to the Council's decision within 30–60 days.</p>
How long does it take to make a decision?	<p>Generally, the Council issues a decision within 90 days from receipt of a request for review of an ALJ decision. If the Council review stems from an escalated appeal, the Council has 180 days from the date of receipt of the request for escalation to issue a decision. A decision may take longer due to many reasons.</p> <p>If the Council issues no decision within the applicable timeframe, you may ask the Council to escalate the case to the judicial review level.</p> <p>If you request escalation to U.S. District Court, a copy of the request must be sent to all other parties and to the Council.</p>

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

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

Table 5. Judicial Review in U.S. District Court FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for judicial review within 60 days of receipt of the Council's decision or after the Council decision timeframe expires.
How do I file a request?	The Council's decision (or notice of right to escalation) 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 remains in controversy following the Council decision. The Fifth Level of Appeal AIC Threshold is updated annually.
Who makes the decision?	The U.S. District Court makes the decision.

Tips for Filing an Appeal

Here are some best practices when filing an appeal:

- **Make all appeal requests in writing**
- Starting at Level 1, consolidate all similar claims into one appeal
- File timely requests with the appropriate entity
- Include a copy of the decision letter(s) or claim information issued at the previous level(s)
- Include a copy of the demand letter(s) if appealing an overpayment determination
- Include all relevant supporting documentation with your first appeal request
- Include a copy of the Appointment of Representative (AOR) form if the requestor is not a party and is representing the appellant
- Respond promptly to requests for documentation
- Sign your request for appeal

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

Appeal Process Summary

Table 6 provides a summary of each appeal level.

Table 6. Appeal Process Summary

Level	Summary of review process	Who performs the review?	When must you request an appeal?	When should you get a decision?	AIC	Links to Forms
First Level – Redetermination by a Medicare Administrative Contractor (MAC)	Document review of initial claim determination	MAC	Up to 120 days after you receive initial determination	60 days	No	CMS-20027 CMS-20031
Second Level – Reconsideration by a Qualified Independent Contractor (QIC)	Document review of redetermination; submit any missing evidence or evidence relevant to the appeal	QIC	Up to 180 days after you receive MRN/RA	60 days	No	CMS-20033
Third Level – Decision by Office of Medicare Hearings and Appeals (OMHA)	May be an interactive hearing between parties or an on-the-record review	ALJ or attorney adjudicator	Up to 60 days after you receive notice of QIC decision or after expiration of the applicable QIC reconsideration timeframe if you do not receive a decision	May be delayed due to volume	Yes	OMHA-100 OMHA-100A OMHA-104
Fourth Level – Review by the Medicare Appeals Council (Council)	Document review of ALJ’s decision (but you may request oral arguments)	Council	Up to 60 days after you receive notice of OMHA’s decision or after expiration of the applicable OMHA decision timeframe if you do not receive 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 – Judicial Review in U.S. District Court	Judicial review	U.S. District Court	Up to 60 days after you receive notice of Council decision or after expiration of the applicable Council review timeframe if you do not receive a decision	No statutory time limit	Yes	No HHS form available

Resources

Table 7. Resources

Resource	Website
Appeals Laws, Regulations, and Guidance	Social Security Act, Section 1869 SSA.gov/OP_Home/ssact/title18/1869.htm 42 Code of Federal Regulations (Part 405, Subpart I) Ecf.gov/cgi-bin/text-idx?SID=4dbd011348f2dd65aca724cb847527cd&mc=true&node=pt42.2.405&rgn=div5#sp42.2.405.i Medicare Claims Processing Manual, Chapter 29 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
MAC Contact Information	Go.CMS.gov/MAC-website-list
Medicare Appeals Council	HHS.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-council
Medicare Appeals Process	HHS.gov/about/agencies/omha/the-appeals-process
MLN Matters® Article SE1521, Limiting the Scope of Review on Redeterminations or Reconsiderations of Certain Claims	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1521.pdf
OMHA	HHS.gov/about/agencies/omha
OMHA Medicare Appellant Forum	HHS.gov/about/agencies/omha/about/special-initiatives/appellant-forums
Original Medicare Appeals	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
Part C Appeals	Medicare Managed Care Appeals & Grievances CMS.gov/Medicare/Appeals-and-Grievances/MMCAG Part C Appeals: Organization Determinations, Appeals & Grievances Web-Based Training (WBT) Course CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

Table 7. Resources (cont.)

Resource	Website
Part D Appeals	<p>Medicare Prescription Drug Appeals & Grievances CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev</p> <p>Part D Coverage Determinations, Appeals & Grievances WBT Course CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html</p>
QIC Formal Telephone Demonstration: Updated	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFS/Appeals/Downloads/QIC-Formal-Telephone-Demonstration-Revised-Fact-Sheet---November-18-2016v508.pdf
QICs	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFS/Appeals/ReconsiderationbyaQualifiedIndependentContractor.html
Reopenings	<p>Reopenings and Revisions of Claim Determinations and Decisions CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4147.pdf</p> <p>Correction of Minor Errors and Omissions Without Appeals CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf</p> <p>Medicare Claims Processing Manual, Chapter 34, Reopening and Revision of Claim Determinations and Decisions CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf</p> <p>Scenarios and Coding Instructions for Submitting Requests to Reopen Claims that are Beyond the Claim Filing Timeframes CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf</p>
Settlement Effectuation Instructions for the Department of Health and Human Services' (DHHS) Office of Medicare Hearings and Appeals (OMHA) Settlement Conference Facilitation (SCF) Pilot	<p>CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1588OTN.pdf</p> <p>Part A Specific Instructions CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1633OTN.pdf</p>
U.S. District Courts	USCourts.gov/about-federal-courts/court-role-and-structure

Table 8. Hyperlink Table

Embedded Hyperlink	Complete URL
42 CFR 405.1006	https://www.ecfr.gov/cgi-bin/text-idx?SID=4c5867a1e8f1505d6ee4d21dcd018953&mc=true&node=pt42.2.405&rgn=div5%20-%20se42.2.405_1910%20-%20se42.2.405_11006%20-%20se42.2.405_11006
42 Code of Federal Regulations (CFR) Section 405.910	https://www.ecfr.gov/cgi-bin/text-idx?SID=4c5867a1e8f1505d6ee4d21dcd018953&mc=true&node=pt42.2.405&rgn=div5%20-%20se42.2.405_1910%20-%20se42.2.405_1910#se42.2.405_1910
ALJ Appeal Status Information System	https://www.hhs.gov/about/agencies/omha/filing-an-appeal/appeals-status-lookup
Appointment of Representative	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf
Correction of Minor Errors and Omissions Without Appeals	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf
DAB E-File	https://dab.efile.hhs.gov
DME QIC	https://www.c2cinc.com/QIC-DME
Fifth Level of Appeal: Judicial Review in Federal District Court	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html
Fifth Level of Appeal AIC Threshold	https://www.gpo.gov/fdsys/pkg/FR-2017-09-29/pdf/2017-20883.pdf
First Level of Appeal: Redetermination by a Medicare Contractor	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html
Formal Telephone Discussion Demonstration	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/QIC-Formal-Telephone-Demonstration-Revised-Fact-Sheet—November-18-2016v508.pdf
Fourth Level of Appeal: Review by the Medicare Appeals Council	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/05AppealsCouncil.html
Improvements to the Adjudication Process of Serial Claims	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017-Transmittals-Items/SE17010.html

Table 8. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Medicare Appeals Council	https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-council
Medicare Overpayments	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243389.html
Medicare Reconsideration Request CMS-20033	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf
Medicare Redetermination Request CMS-20027	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20027.pdf
Medicare.gov Appeals	https://www.medicare.gov/claims-appeals/file-an-appeal/filing-an-appeal-if-i-have-original-medicare
Multiple Claim Attachment OMHA-100A	https://www.hhs.gov/sites/default/files/OMHA-100A-Multiple-Claim-Attachment.pdf
Office of Medicare Hearings and Appeals	https://www.hhs.gov/about/agencies/omha
OMHA FAQs	https://www.hhs.gov/about/agencies/omha/filing-an-appeal/faqs/requesting-an-alj-hearing
Original Medicare (Fee-For- Service) Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
QIC DME: Formal Telephone Discussion Demonstration	https://www.c2cinc.com/Appeals-Demonstration
Reopening Process	https://www.c2cinc.com/Appeals-Demonstration/Reopening-Process
Request for ALJ Hearing or Review of Dismissal OMHA-100	https://www.hhs.gov/sites/default/files/OMHA-100.pdf
Request for Review of ALJ Medicare Decision/Dismissal DAB-101	https://www.hhs.gov/sites/default/files/dab/divisions/dab101.pdf

Table 8. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Second Level of Appeal: Reconsideration by a QIC	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html
Settlement Conference Facilitation	https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation
Statistical Sampling Initiative	https://www.hhs.gov/about/agencies/omha/about/special-initiatives/statistical-sampling
Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/OMHA-ALJ-Hearing.html
Third Level of Appeal AIC Threshold	https://www.gpo.gov/fdsys/pkg/FR-2017-09-29/pdf/2017-20883.pdf
Transfer of Appeal Rights CMS-20031	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20031.pdf
Waiver of Right to an ALJ Hearing OMHA-104	https://www.hhs.gov/sites/default/files/OMHA-104_Waiver_of_Right_to_an_ALJ_Hearing%200328.pdf

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