DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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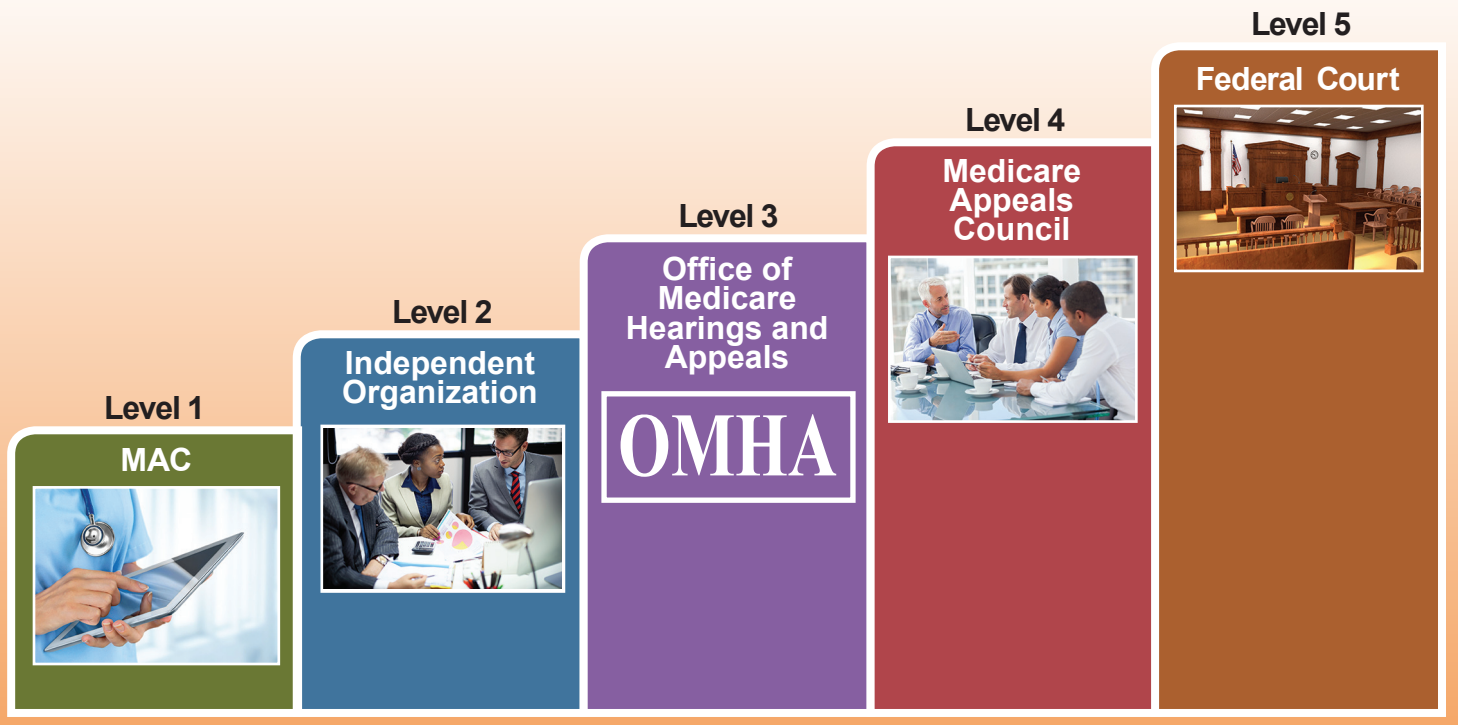
Medicare Parts A & B Appeals Process



Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, Table 8, at the end of this document, provides the complete URL for each hyperlink.

ICN 006562 May 2016

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List of Tables

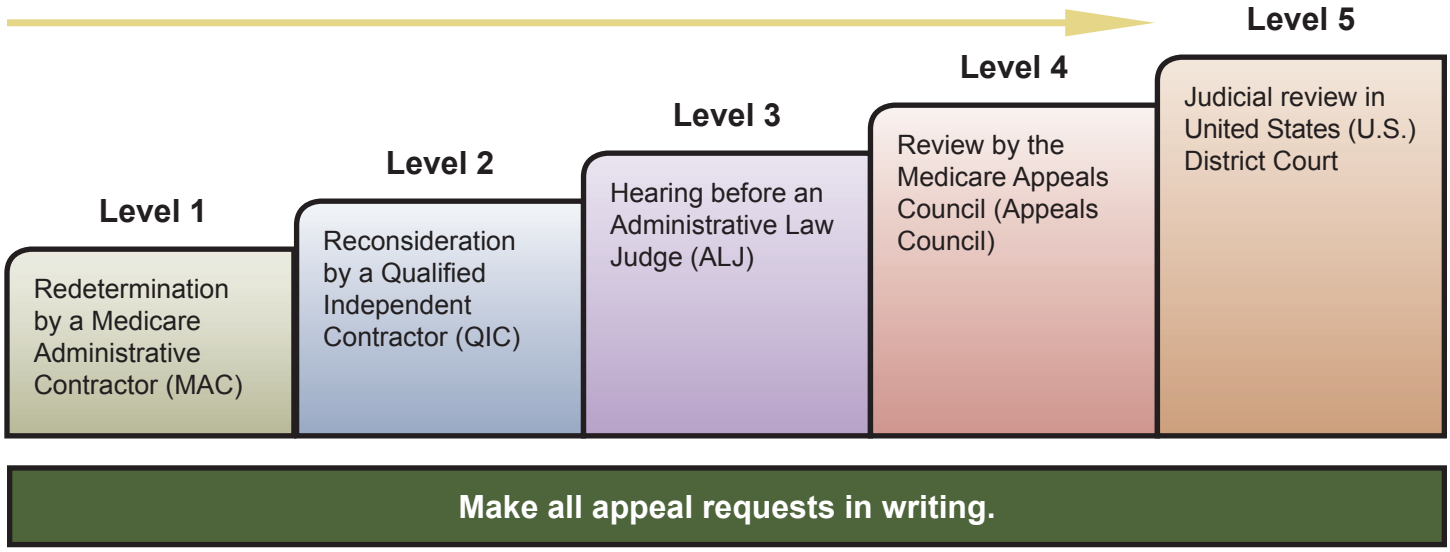
Overview

This publication provides health care professionals with information about each level of appeal in Original Medicare (Parts A and B), as well as additional resources for information on related topics. It describes how the Medicare appeals process applies to providers and participating physicians and suppliers. In this publication, the pronouns "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 information about appeals on the Medicare.gov Original Medicare Appeals webpage.

Appealing Medicare Decisions

There are five levels in the claims appeal process under Original Medicare:



Make all appeal requests in writing.

Helpful Terms

Amount in Controversy (AIC): The threshold dollar amount remaining in dispute that is 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.

Determination: A decision made to pay in full, pay in part, or deny a claim.

Escalation: When an appellant requests that an appeal pending at the QIC level or higher be moved to the next level because the adjudicator was not able to make a decision within a specified time.

Non-Participating: Physicians and suppliers who choose to either accept or not accept Medicare assignment on a claim-by-claim basis. Non-participating physicians and suppliers have limited appeal rights.

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

Appointing a Representative

At any time, a party may appoint any individual, including an attorney, to represent him or her during the processing of a claim or appeal. The representative helps the party by providing assistance and expertise.

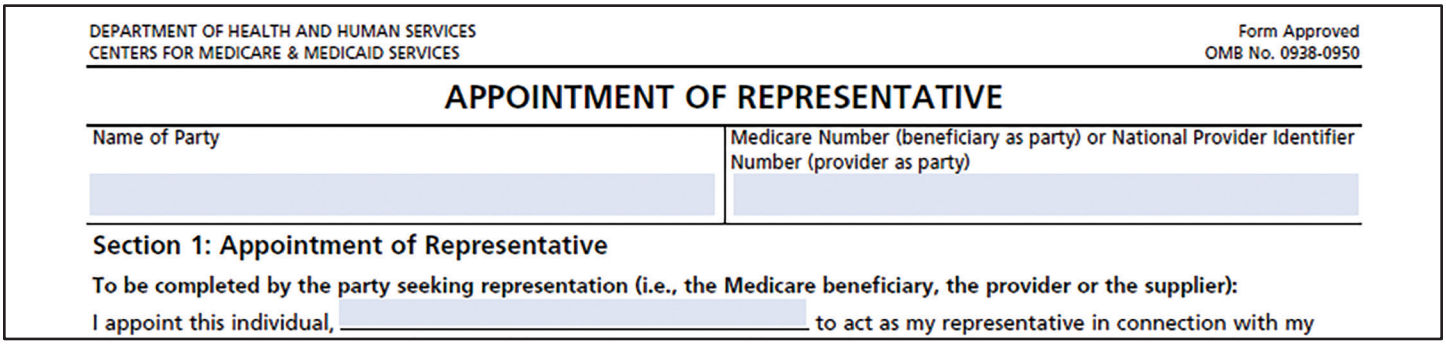
To appoint a representative, the party or representative must complete Form CMS-1696 (Appointment of Representative) or another written document with the same information. The form or other document must:

- Be in writing
- Be signed and dated by the party and the representative (the representative's signature must be dated within 30 days of the party's signature)
- Include a statement appointing the representative to act for the party
- Include a written explanation of the purpose and scope of the representation
- Include the names, phone numbers, and addresses of both the party and the representative
- Include the representative's professional status or relationship to the party
- Contain a unique identifier of the represented party
    - If the party is the beneficiary, the Medicare number must be included. If the party is a provider or supplier, the National Provider Identifier (NPI) number is requested.

The appointment is valid for 1 year. During this year, the representative may represent the party in subsequent appeal levels on the initial appeal and for any appeals of other claims, unless the party specifically withdraws the representative's authority.

Requirements for Appointment of Representatives

Find the requirements for appointing a representative in the Medicare Claims Processing Manual, Chapter 29, Section 270.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0950

APPOINTMENT OF REPRESENTATIVE

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier Number (provider as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my

Transfer of Appeal Rights to Non-Participating Physicians and Suppliers

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

First Level of Appeal: Redetermination

A redetermination is the first level of appeal after the initial determination on a claim. It is a second look at the claim. Table 1 provides questions and answers about redeterminations.

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

Question	Answer
When must I file a request?	You must file a request for redetermination within **120 days** from the date of receipt of the Remittance Advice (RA) that lists the initial determination.
How do I file a request?	File your request **in writing** by following instructions provided in the RA. Your request must be sent to the address listed on the RA or filed in person (or follow instructions from your MAC on filing electronically). You may also file a request for redetermination by completing Form CMS-20027 (Medicare Redetermination Request Form – 1st Level of Appeal). Find more information about the requirements for requesting a redetermination on the First Level of Appeal: Redetermination by a Medicare Contractor webpage. **REMEMBER** • You, or your representative, must include your **name and signature** • Attach any supporting documentation to your redetermination request
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	**MAC staff** unassociated with the initial claim determination perform the redetermination.
How long does it take to make a decision?	MACs generally issue a decision within **60 days** of receipt of the request for redetermination. You will receive notice of the decision via a Medicare Redetermination Notice (MRN) from your MAC, or if the initial decision is reversed and the claim is paid in full, you will receive a revised RA.

NOTE: The MLN Matters® Article SE0420, Correction of Minor Errors and Omissions Without Appeals provides information about Medicare rules that enable you to correct minor errors and omissions on claims without initiating the appeals process.

Second Level of Appeal: Reconsideration

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 provides questions and answers about reconsiderations.

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 RA.

How do I file a request?	File your request **in writing** by following instructions provided on the MRN or RA. You may also file a request for reconsideration by completing Form CMS-20033 (Medicare Reconsideration Request Form – 2nd Level of Appeal).
	Find more information about the requirements for requesting reconsideration on the Second Level of Appeal: Reconsideration by a QIC webpage.
	REMEMBER
	• **Clearly explain** why you disagree with the redetermination decision
	• You, or your representative, must include your **name and signature**
	• You should submit:
	  ◦ A copy of the RA or MRN
	  ◦ Any evidence noted in the redetermination as missing
	  ◦ Any other evidence relevant to the appeal
	  ◦ Any other useful documentation
	Documentation submitted after you file the reconsideration request may extend the QIC's decision timeframe.
	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.

Is there a minimum AIC requirement?	**No.**
Who makes the decision?	The **QIC** conducts the reconsideration, which is an independent review of the initial determination, including the redetermination and all issues related to payment of the claim. The reconsideration may include review of medical necessity issues by a panel of physicians or other health care professionals.
How long does it take to make a decision?	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 will inform you of your rights and the procedures to escalate the case to an ALJ. **NOTE:** Before escalating your appeal to an ALJ, if you do not receive a decision on the reconsideration within 60 days, consider allowing an additional 5 to 10 days for mail delays.

NOTE: On January 1, 2016, CMS launched a new Demonstration with Durable Medical Equipment (DME) Suppliers called the Formal Telephone Discussion Demonstration. The Demonstration provides selected suppliers who have filed a reconsideration request the opportunity to participate in a formal recorded telephone discussion with the DME QIC.

Third Level of Appeal: ALJ Hearing

If you disagree with the reconsideration decision or wish to escalate your appeal because the reconsideration period passed, you may request an ALJ hearing. The ALJ hearing gives you the opportunity—via video teleconference (VTC), telephone, or occasionally in person—to explain your position to an ALJ. The U.S. Department of Health & Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA), which is independent of CMS, is responsible for the Level 3 Medicare claims appeals. Table 3 provides questions and answers about ALJ hearings.

Table 3. ALJ Hearing FAQs and Answers

Question	Answer
When must I file a request?	You must file a request for an ALJ hearing within **60 days** of receipt of the reconsideration decision letter or after the expiration of the reconsideration period.
How do I file a request?	File your request **in writing** by following instructions provided in the reconsideration letter. You may also request an ALJ hearing by completing Form CMS-20034 A/B (Request for Medicare Hearing by an Administrative Law Judge). Find more information about the requirements for requesting an ALJ hearing on the Office of Medicare Hearings and Appeals webpage. If you do not want a VTC or telephone hearing, you may ask for an in-person hearing, but you must demonstrate good cause. The ALJ determines whether the case warrants an in-person hearing on a case-by-case basis. You may also ask the ALJ to make a decision without a hearing (on-the-record). **REMEMBER** • You **must** send a copy of the ALJ hearing request to all other parties to the QIC reconsideration. If you are requesting the case be escalated to the Appeals Council, you must 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.

Table 3. ALJ Hearing FAQs and Answers (cont.)

Question	Answer
Is there a minimum AIC requirement?	**Yes.** You may only request an ALJ hearing if a certain dollar amount remains in controversy following the QIC's decision. The Third Level of Appeal AIC threshold is updated annually. Find out how the AIC amount is calculated on the OMHA FAQs webpage.
Who makes the decision?	The **ALJ** makes the decision. If the ALJ cannot complete its decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to the Appeals Council. The ALJ forwards the decision and case file to the Administrative QIC (AdQIC), which serves as the central manager for all ALJ Original Medicare claim case files. In certain situations, the AdQIC may refer the case to the Appeals Council on CMS' behalf. If no referral is made to the Appeals Council, and the ALJ decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC that it must pay the claim, according to the ALJ decision, within 30–60 days.
How long does it take to make a decision?	Due to a record number of appeal requests, there continues to be a delay in OMHA ALJ hearing assignments. 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 that qualify for expedited status and Medicare beneficiary issues. Additional delay can result from: • Appellant's failure 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 If the ALJ does not issue a decision within the applicable timeframe, you may ask the ALJ to escalate the case to the Appeals Council. **NOTE:** New appeal requests are processed as quickly as possible. You will receive an Acknowledgement of Request letter after your case is entered in to the OMHA case tracking system. Find more information on these timeframes on the Office of Medicare Hearings and Appeals webpage. **NOTE:** As part of the efforts to reduce the outstanding number of ALJ hearing requests, OMHA implemented two pilot programs, Settlement Conference Facilitation (SCF) and Statistical Sampling Initiative. SCF is an alternative dispute resolution process that uses mediation principles. Statistical Sampling Initiative applies to appellants with a large volume of claim disputes.

Fourth Level of Appeal: Medicare Appeals Council Review

If you disagree with the ALJ decision, or you wish to escalate your appeal because the ALJ ruling timeframe passed, you may request a Medicare Appeals Council review. The HHS Departmental Appeals Board (DAB) Medicare Operations Division administers the Appeals Council review. Table 4 provides questions and answers about Appeals Council reviews.

Table 4. Medicare Appeals Council Review FAQs and Answers

Question	Answer
When must I file a request?	You must file your request for Medicare Appeals Council review within **60 days** of receipt of the ALJ's decision or after the ALJ ruling timeframe expires.
How do I file a request?	File your request **in writing** by following the instructions provided by the ALJ. You may also request an Appeals Council review by completing Form DAB-101 (Request for Review of ALJ Medicare Decision/Dismissal). Find more information about the requirements for requesting an Appeals Council review following an ALJ decision or dismissal on the Medicare Operations Division webpage. **REMEMBER** • **Explain** which part of the ALJ decision you disagree with and your reasons for the disagreement • You **must** send a copy of the Appeals Council review request to all the parties included in the ALJ's decision
Is there a minimum AIC requirement?	**No.**
Who makes the decision?	The **Appeals Council** makes the decision. If the Appeals Council cannot complete its decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to U.S. District Court. The Appeals Council forwards the decision and case file to the AdQIC, which serves as the central manager for all Appeals Council Original Medicare claim case files. If the Appeals Council decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC that it must pay the claim according to the Appeal Council's decision within 30–60 days.
How long does it take to make a decision?	Generally, the Appeals Council issues a decision within **90 days** from receipt of a request for review of an ALJ decision. If the Appeals Council review stems from an escalated appeal, then the Appeals 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 a variety of reasons. If the Appeals Council does not issue a decision within the applicable timeframe, you may ask the Appeals Council to escalate the case to the judicial review level. If you are requesting escalation to U.S. District Court, a copy of the request must be sent to all other parties **and** to the Appeals Council.

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

If you disagree with the Appeals Council decision, or you wish to escalate your appeal because the Appeals Council ruling timeframe passed, you may request judicial review. Table 5 provides questions and answers about judicial review in U.S. District Court.

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 Appeals Council's decision or after the Appeals Council ruling timeframe expires.
How do I file a request?	The Appeals Council's decision (or notice of right to escalation) contains information on how to **file a claim in U.S. District Court**.
Is there a minimum AIC requirement?	**Yes.** You may only request judicial review if a certain dollar amount remains in controversy following the Medicare Appeals 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

Now that we have discussed the five levels in the claims appeals process, here are some best practices when filing an appeal:

- Starting at Level 1, consolidate into one appeal as many similar claims as possible
- File timely requests with the appropriate contractor
- Include a copy of the decision letter(s) issued at the previous level
- Include a copy of the demand letter(s) if appealing an overpayment determination
- Include a copy of the Appointment of Representative (AOR) form if representing a provider/supplier/beneficiary
- Respond promptly to the contractor requests for documentation
- Sign your request for appeal

Find more information about the Medicare overpayment collection process in the Medicare Overpayments Publication.

Appeal Process Summary

A summary of each appeal level is provided in Table 6.

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
1st Level - Redetermination	Document review of initial claim determination	MAC	Up to 120 days after you receive initial determination	60 days	No
2nd Level - Reconsideration	Document review of redetermination (you should submit any evidence not previously presented at this level)	QIC	Up to 180 days after you receive MRN/RA	60 days	No
3rd Level - ALJ Hearing	May be an on-the-record review or an interactive hearing between parties	ALJ	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*
4th Level - Medicare Appeals Council Review	Document review of ALJ's decision or dismissal (but you may request oral arguments)	Appeals Council	Up to 60 days after you receive notice of ALJ's decision or after expiration of the applicable ALJ hearing timeframe if you do not receive a decision	90 days if appealing an ALJ decision or 180 days if ALJ review time expired without an ALJ decision	No
5th Level - Judicial Review	Judicial review	U.S. District Court	Up to 60 days after you receive notice of Appeals Council decision or after expiration of the applicable Appeals Council review timeframe if you do not receive a decision	No statutory time limit	Yes*

* The AIC threshold is updated annually. For the current amount, refer to the Related Links section for Third Level of Appeal or Fifth Level of Appeal webpages.

Resources

For more information, refer to the resources in Table 7.

Table 7. Resources

Resource	Website
Appeals Laws, Regulations, and Guidance	Social Security Act, Section 1869 https://www.ssa.gov/OP_Home/ssact/title18/1869.htm 42 Code of Federal Regulations (Part 405, Subpart I) https://www.gpo.gov/fdsys/pkg/CFR-2015-title42-vol2/pdf/CFR-2015-title42-vol2-part405-subpartI.pdf Medicare Claims Processing Manual, Chapter 29 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
Appeals Process by Medicare Part	https://www.hhs.gov/about/agencies/omha/the-appeals-process
MAC Contact Information	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
Medicare Appeals Council	https://www.hhs.gov/dab/divisions/medicareoperations
Medicare Learning Network® (MLN) Guided Pathways	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf
MLN Matters® SE1521 Limiting the Scope of Review on Redeterminations or Reconsiderations of Certain Claims	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1521.pdf
OMHA	https://www.hhs.gov/about/agencies/omha
OMHA Medicare Appellant Forum	https://www.hhs.gov/about/agencies/omha/about/special-initiatives/appellant-forums
Original Medicare Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals
Part C Appeals	Medicare Managed Care Appeals & Grievances https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG “Part C Appeals: Organization Determinations, Appeals & Grievances” Web-Based Training (WBT) Course https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html

Table 7. Resources (cont.)

Resource	Website
Part D Appeals	Medicare Prescription Drug Appeals & Grievances https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev "Part D Coverage Determinations, Appeals & Grievances" WBT Course https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
QICs	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html
Reopenings	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4147.pdf https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1426.pdf
Settlement Effectuation Instructions for the Department of Health and Human Services (DHHS) Office of Medicare Hearings and Appeals (OMHA) Settlement Conference Facilitation (SCF) Pilot	https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1588OTN.pdf Part A Specific Instructions https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1633OTN.pdf
U.S. District Courts	http://www.uscourts.gov/about-federal-courts/court-role-and-structure

Table 8. Hyperlink Table

Embedded Hyperlink	Complete URL
Correction of Minor Errors and Omissions Without Appeals	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf
Demonstration with Durable Medical Equipment (DME) Suppliers	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/Formal-Telephone-Demonstration-Fact-Sheet-2016.pdf
Fifth Level of Appeal AIC Threshold	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html
Fifth Level of Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html
First Level of Appeal: Redetermination by a Medicare Contractor	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html
Form CMS-1696	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html
Form CMS-20027	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20027.pdf
Form CMS-20031	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20031.pdf
Form CMS-20033	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf
Form CMS-20034 A/B	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20034AB.pdf
Form DAB-101	https://www.hhs.gov/dab/divisions/dab101.pdf
Medicare Claims Processing Manual, Chapter 29	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
Medicare Operations Division	https://www.hhs.gov/dab/divisions/medicareoperations
Medicare Overpayments Publication	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243389.html
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

Table 8. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
Original Medicare Appeals	https://www.medicare.gov/claims-and-appeals/file-an-appeal/original-medicare/original-medicare-appeals.html
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 AIC threshold	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html
Third Level of Appeals	https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html

Check out CMS on: