mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

MEDICARE PARTS A & B APPEALS PROCESS

Level 1 - Redetermination by a Medicare Administrative Contractor (MAC)

Level 2 - Reconsideration by a Qualified Independent Contractor (QIC)

Level 3 - Administrative Law Judge (ALJ) Hearing or Review 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

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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OVERVIEW

This booklet 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, physicians, and suppliers. In this booklet, 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 appeals information on the Medicare.gov Original Medicare Appeals webpage. This booklet does not cover Medicare Part C or Part D Appeals. However, you may find Part C Appeals and Part D Appeals resources in the Resources section of this booklet (Table 7).

APPEALING MEDICARE DECISIONS

Original Medicare 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 - Administrative Law Judge (ALJ) Hearing or Review 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 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.

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 is authorized to issue decisions on reviews of QIC dismissals, and decisions when an ALJ is not conducting a hearing.

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.

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

Nonparticipating: Physicians and suppliers who choose to either 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 along with any evidence submitted with the request for OMHA review. A hearing will not be 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 him or her 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 (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) must be included.

The appointment is valid for 1 year from the date it contains the signatures of both the party and appointed representative, and can be used for multiple claims or appeals during this 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 the Medicare Claims Processing Manual, Chapter 29, Section 270.

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. It is a look at the claim by MAC staff not involved in the initial determination.

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. You may use the Medicare Redetermination Request (Form CMS-20027), or any written document, so long as it contains the required elements listed 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). 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 • Keep a copy of everything you send to Medicare as part of your appeal
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: MLN Matters® Article 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 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 RA.

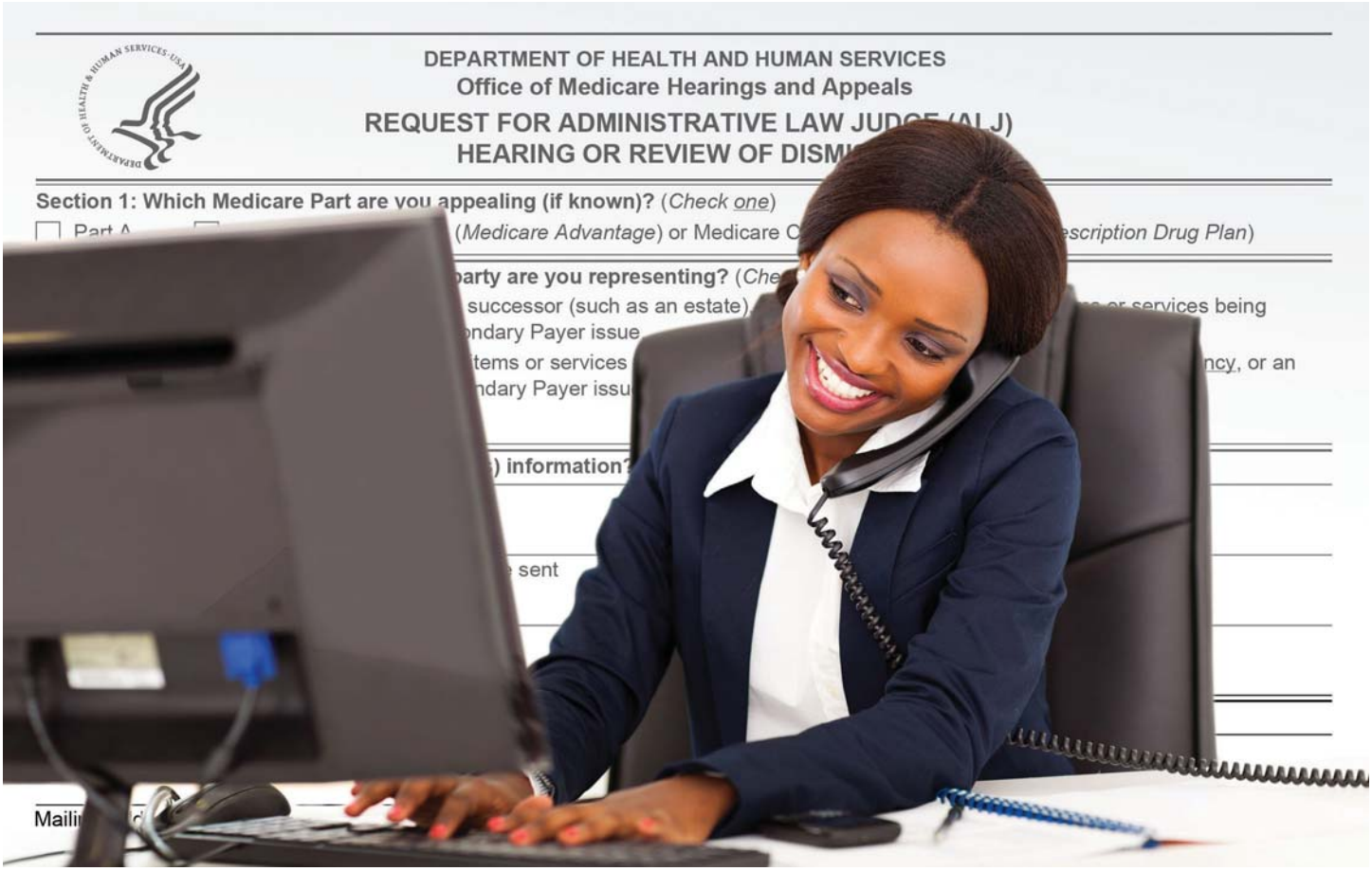
How do I file a request?	File your request **in writing** by following instructions provided on the MRN or RA. You may use the Medicare Reconsideration Request (Form CMS-20033), or any written document, so long as it contains the required elements listed in the MRN.
	Find more information about the requirements 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 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?	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 OMHA. **NOTE:** Before escalating your appeal to OMHA, 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, the Centers for Medicare & Medicaid Services (CMS) launched a new Demonstration with Durable Medical Equipment (DME) Suppliers in DME MAC Jurisdictions C and D 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. Effective October 31, 2016, CMS expanded the Telephone Discussion Demonstration to include all appeal types not subject to another initiative.



THIRD LEVEL OF APPEAL: ADMINISTRATIVE LAW JUDGE (ALJ) HEARING OR REVIEW BY OFFICE OF MEDICARE HEARINGS AND APPEALS (OMHA)

If you disagree with the reconsideration decision or wish to escalate your appeal because the reconsideration period passed, you may request one of two options under OMHA review: (1) an ALJ hearing or (2) an OMHA ALJ attorney adjudicator decision. 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, which is 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.
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 the Request for ALJ Hearing or Review of Dismissal (Form OMHA-100) and the multiple claim attachment (Form OMHA-100A) as needed. These forms are new as of January 2017. 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). If you would prefer to not have a hearing, you may ask for an on-the-record review by filling out the Waiver of RIght to an ALJ Hearing form (Form OMHA-104) and submitting it with the OMHA-100 form. If an on-the-record review is granted, an OMHA attorney adjudicator will issue a decision based on the information within the administrative record along with any evidence submitted with the request. 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 webpage. **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 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. OMHA Review 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 or attorney adjudicator** makes the decision. If the OMHA cannot complete a decision in the applicable timeframe, it will inform you of your rights and procedures to escalate the case to the Council. The ALJ or attorney adjudicator forwards the decision and case file to the Administrative QIC (AdQIC), which serves as the central manager for all OMHA Original Medicare claim case files. In certain situations, the AdQIC may refer the case to the Council on CMS' behalf. If no referral is made to the Council, and the ALJ or attorney adjudicator decision overturns a previous denial (in whole or in part), the AdQIC notifies the MAC it must pay the claim, according to the OMHA 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 OMHA does not issue a decision within the applicable timeframe, you may ask OMHA to escalate the case to the 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: 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 HHS Departmental Appeals Board (DAB) Medicare Operations Division conducts the Council review.

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?	File your request **in writing** by following the instructions provided by OMHA. 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. Find more information about the requirements for requesting a Council review following an OMHA decision on the Medicare Appeals Council webpage. **REMEMBER** • **Explain** which part of the OMHA decision you disagree with and your reasons for the disagreement • 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?	The Council makes the decision. If the 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 Council forwards the decision and case file to the AdQIC, which serves as the central manager for all Council Original Medicare claim case files. 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.

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

Question	Answer
How long does it take to make a decision?	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, then 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 a variety of reasons. If the Council does not issue a decision within the applicable timeframe, you may ask the 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 Council.

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 ruling 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 ruling timeframe expires.
How do I file a request?	The 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 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:

- **Make all appeal requests in writing!**
- Starting at Level 1, consolidate as many similar claims as possible into one appeal
- File timely requests with the appropriate contractor
- Include a copy of the decision letter(s) or claim information issued at the previous level
- 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 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 booklet.

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	Links to Forms
1st 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
2nd 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
3rd Level – Administrative Law Judge (ALJ) Hearing or Review 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
4th 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
5th 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

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 SSA.gov/OP_Home/ssact/title18/1869.htm 42 Code of Federal Regulations (Part 405, Subpart I) GPO.gov/fdsys/pkg/CFR-2016-title42-vol2/pdf/CFR-2016-title42-vol2-part405-subpartI.pdf Medicare Claims Processing Manual, Chapter 29 CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
MAC Contact Information	CMS.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map
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® 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	Medicare Prescription Drug Appeals & Grievances CMS.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev Part D Coverage Determinations, Appeals & Grievances WBT Course CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
QIC Formal Telephone Demonstration: Updated	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/QIC-Formal-Telephone-Demonstration-Revised-Fact-Sheet-–-November-18-2016v508.pdf
QICs	CMS.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html
Reopenings	Reopenings and Revisions of Claim Determinations and Decisions CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM4147.pdf Correction of Minor Errors and Omissions Without Appeals CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0420.pdf Medicare Claims Processing Manual, Chapter 34, Reopening and Revision of Claim Determinations and Decisions CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c34.pdf 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
Settlement Effectuation Instructions for the Department of Health and Human Services' (DHHS) Office of Medicare Hearings and Appeals (OMHA) Settlement Conference Facilitation (SCF) Pilot	CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1588OTN.pdf Part A Specific Instructions CMS.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1633OTN.pdf
U.S. District Courts	USCourts.gov/about-federal-courts/court-role-and-structure

Table 8. Hyperlink Table

Embedded Hyperlink	Complete URL
ALJ Hearing or Review of Dismissal OMHA-100	https://www.hhs.gov/sites/default/files/OMHA-100%20Request%20for%20Hearing%20or%20Review%20of%20Dismissal%200329.pdf
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
Expanded the Telephone Discussion Demonstration	https://www.c2cinc.com/Telephone-Demonstration
Fifth Level of Appeal AIC Threshold	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
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
Medicare Appeals Council	https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-council
Medicare Claims Processing Manual, Chapter 29	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c29.pdf
Medicare Overpayments Booklet	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 Original Medicare Appeals	https://www.medicare.gov/claims-and-appeals/file-an-appeal/original-medicare/original-medicare-appeals.html

Table 8. Hyperlink Table (cont.)

Embedded Hyperlink	Complete URL
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
Request for Review of ALJ Medicare Decision/Dismissal DAB-101	https://www.hhs.gov/sites/default/files/dab/divisions/dab101.pdf
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
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