CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 146 **Date: MARCH 25, 2005**

CHANGE REQUEST 3530

SUBJECT: Appeals Transition- BIPA Section 521 Appeals

I. SUMMARY OF CHANGES: The purpose of this CR is to notify Fiscal Intermediaries (FIs) about the upcoming transition to the new second level appeal process.

NEW/REVISED MATERIAL - EFFECTIVE DATE *: see policy section for specific dates
IMPLEMENTATION DATE: April 25, 2005

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 146	Date: March 25, 2005	Change Request 3530

SUBJECT: Appeals Transition- BIPA Section 521 Appeals

I. GENERAL INFORMATION

A. Background: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration. This new "reconsideration" is different from the previous first level of appeal for Part A claims performed by Fiscal Intermediaries (FIs). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

The purpose of this CR is to notify FIs about the upcoming transition to the new second level of the appeals process. For Part A and Part B redeterminations issued and mailed by FIs on or after May 1, 2005, the parties to the redetermination will have the right to appeal to a QIC. All redeterminations issued and mailed before May 1, 2005 will have appeal rights to the Administrative Law Judge (ALJ) for Part A claims and to the hearing officer (HO) for Part B claims.

Note: This CR does not apply to carriers and/or redeterminations processed by carriers with the exception of section 12(B).

B. Policy:

1. Redetermination Letters - New Language (Effective Date: All redeterminations issued on or after May 1, 2005)

For redetermination decisions issued on or after May 1, 2005, FIs shall change the language in the Medicare Redetermination Notice (MRN) as follows (see model in exhibit 1):

(a) Contractors shall remove language on the first page of the notice regarding the amount in controversy. This is no longer needed, as there is not a minimum amount in controversy required for a QIC reconsideration.

(b) Contractors shall change the level of appeal insert to a Qualified Independent Contractor and change the time frame to appeal to 180 days of receiving this letter. The new paragraph should read as follows:
"More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to a Qualified Independent Contractor. You must file your appeal, in writing, within 180 days of receiving this letter."

(c) Contractors shall include the request for reconsideration form with the MRN.

(d) Contractors shall include the following text in the "What to Include in Your Request for an Independent Appeal Section ":

"**Special Note to Medicare Providers Only**: Any evidence indicated in this notice must be submitted to the QIC. It should accompany the request for reconsideration. All evidence, including evidence that is not indicated in this notice, must be presented before the reconsideration is issued. If all evidence is not submitted, you will not be able to submit any new evidence in subsequent appeals unless you can demonstrate good cause for not presenting the evidence to the QIC. This evidence requirement also applies to providers who represent beneficiaries in the appeals process."

(e) Contractors shall change the language on the "Important Information About Your Appeal Rights" page as follows:

(i) Section Title "Your Right to Appeal this Decision"

"If you do not agree with this decision, you may file an appeal. An appeal is a review performed by people independent of those that have reviewed your claims so far. The next level of appeal is called a reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from <Insert Contractor's name>." (Note: Contractors shall delete the language about the amount in controversy and aggregation.)

(ii) Section Title "How to Appeal"

To exercise your right to appeal, you must file a request within 180 days of receiving this letter. Under special circumstances, you may ask for more time to request an appeal. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you can write a letter. You must include: your name, your signature, the name of the beneficiary if you are not the beneficiary requesting the appeal, the Medicare number, a list of the service(s) or item(s) that you are appealing and the date(s) of service, and any and all evidence you wish to submit. You must also indicate that *(insert: the name of the contractor*) made the redetermination. You may also attach supporting materials such as medical records, doctors' letters, or other information that explains why this service should be paid.
If you want to file an appeal, you should send your request to:

QIC Name
Address
City, State, Zip

(iii) Section titled "Aggregating Claims"

Contractors shall delete this section.

2. Redetermination Letters for Fully Favorable Cases (Effective Date: All redeterminations requests received on or after May 1, 2005)

Previously, some contractors had elected to notify parties of a fully favorable decision through the Medicare Summary Notice (MSN) and the Remittance Advice (RA) rather than a formal decision letter. Section 1869(a)(3)(C)(ii) of the Act, however, requires that all decisions be mailed within 60 days of receipt of the redetermination request. Accordingly, contractors will need to mail a fully favorable decision, as well as, all unfavorable decisions within 60 days. Fully favorable means the Medicare approved amount minus any cost sharing provisions (co-insurance, deductibles, etc.) has been found payable. If contractors are not able to notify parties of fully favorable decisions through the MSN or RA within 60 days, then contractor will need to send a redetermination notice. While it is not necessary for contractors to send the complete MRN for fully favorable decisions, contractors must send a brief written notification to the appellant informing them that the redetermination is favorable and that a MSN and/or RA will follow. If the appellant has a representative, then the notification must be sent to the representative. For Medicare Secondary Payer cases, the notification must be sent to both the appellant and the representative. See exhibit 2 for a model of a fully favorable redetermination. Please note that exhibit 2 is only a model and contractors may choose to include additional information. Contractors may choose to meet this requirement by using a post card as long as individually identifiable information is not given. This change is effective for all redetermination requests received on or after May 1, 2005.

3. Reporting a Redetermination (Effective Date: All redeterminations requests received on or after May 1, 2005)

Clearing a Redetermination - Previously, contractors considered an appeal cleared (i.e., completed) when the final determination was printed or typed, or upon notification of withdrawal by the appellant. Consistent with section 1869(a)(3)(C)(ii), a redetermination must be mailed before the conclusion of the 60-day period. Accordingly, a redetermination should be reported as cleared under line 6 of the CMS 2591 when the redetermination is mailed to the appellant or parties, as applicable.

Extension of Evidence – When a party submits additional evidence after filing the request for redetermination, the contractor's 60-day decision-making time frame may be extended for 14 calendar days for the submission.

4. Telephone Requests for Redeterminations (Effective Date: All initial determinations made on or after May 1, 2005)

Section 937 of the MMA provides that in the case of minor errors or omissions, providers must be given an opportunity to correct such an error or omission without the need to initiate an appeal. Previously, the regulations allowed for reviews to be requested over the telephone to address these types of clerical errors. Consistent with section 937 of the

MMA, contractors must conduct reopenings rather than redeterminations to process clerical errors. We have revised the reopening regulations to allow contractors and providers to make these corrections through the reopenings process. Since it is neither cost efficient nor necessary for contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed through the reopenings process rather than through appeals. Such reopenings may be conducted over the telephone.

The new regulations require all redetermination requests to be in writing. This change is effective for all initial determinations made on or after May 1, 2005. Written requests provide a reliable record of the request and promote the submission of the evidence to support the request. The requirements for written requests are found in the Medicare Claims Processing Manual (Pub. 100-4), Chapter 29, §§ 40.2.1 & 50.3.1. All requests for redeterminations made on or after May 1, 2005 must be in writing.

5. Requirements for Written Redetermination Requests (Effective Date: All initial determinations made on or after May 1, 2005)

For requests made by beneficiaries, see the Medicare Claims Processing Manual, Chapter 29, §§ 40.2.1(B) and 50.3.1(A). See the Medicare Claims Processing Manual, Chapter 29, §§ 40.2.1(C) and 50.2.1(B), for the requirements for provider and State appeal requests. For all requests for redeterminations received on or after May 1, 2005, provider and State appellants do **not** need to specify the date of initial determination in their requests.

6. Consolidating Requests for Multiple Parties (Effective Date: All redetermination requests received on or after May 1, 2005)

If more than one party timely files a request for a redetermination on the same claim before a redetermination is made on the first timely filed request, the contractor shall consolidate the separate requests into one proceeding and issue one redetermination. The second timely request shall not be dismissed. Contractors have 60 days from receipt of the second request to mail a redetermination notice. If the second request is received after a decision has been issued on the first request, the second request shall be resolved as an inquiry. The contractor shall inform the party that a redetermination has already been completed and inquire as to whether the party wishes to file a request for the next level of appeal. If the party indicates they would like to appeal to the next level, contractors shall provide instructions on how and where to file a request.

7. Reconsideration Requests (Effective Date: All redeterminations issued on or after May 1, 2005)

A. Where Appellants Should Send Requests for Reconsideration

Parties must request a reconsideration at the QIC with jurisdiction for the appeal. FIs with multiple states may have both QICs handling requests, and therefore, must make certain to refer the appellant to the correct QIC. In most instances, the jurisdiction for all Part A and

Part B of A QIC appeals is dependent upon the state where the service or item was rendered, with the exception of providers with multiple locations in different states (i.e., chain providers). Chain providers have the ability to select the FI which will process its claims regardless of the state where the service or items was rendered. In such cases, the state where the FI processes the claim will dictate the QIC jurisdiction. For claims processed by Mutual of Omaha, the jurisdiction is dependent upon the state where the service or item was rendered, with no exception for chain providers. The following are the QIC jurisdictions for the East and West:

> The East QIC jurisdiction is comprised of the following states: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC. The QIC for the east jurisdiction is **Maximus**.
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> The West QIC jurisdiction is comprised of the following states: Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, and American Samoa. The QIC for the west jurisdiction is **First Coast Service Options**.

There may be instances where requests for QIC reconsiderations are misrouted to your location. Contractors shall have standard operating procedures to ensure that misrouted requests are transmitted to the QIC, along with the appropriate case file(s), within 14 calendar days of receipt in the corporate mailroom. The case file must be sent either by an electronic means agreed upon in the joint operating agreements (JOAs) addressed in section 8 of this document, or by a courier service so that the case file is received by the QIC before, or on, the 15th calendar day after receipt of the appeal request. Case files sent to the QIC should be prepared in accordance with Section 9 of this document.

There also may be instances where the redetermination is issued after May 1, 2005, and the appellant mistakenly requests a hearing officer hearing or ALJ hearing. Contractors shall have standard operating procedures to ensure that these requests are identified and transmitted to the QIC, along with the appropriate case file(s) within 14 calendar days of receipt in the corporate mailroom. Contractors shall track all misfiled reconsideration requests to ensure receipt at the proper QIC. The QIC will send the FI an informal acknowledgement of receipt of any misfiled or misrouted requests. Contractors shall not count such misrouted or incorrectly filed requests as dismissals. The contractor counts the costs associated with misrouted or incorrectly filed requests in the Contractor Administrative Budget and Financial Management (CAFM) line designated for preparing/transferring case files to the QIC*. To avoid misrouted requests for QIC reconsiderations, contractors shall employ provider education efforts with an emphasis on the dates for transition and filing locations.

*An amendment to the Budget Performance Requirements (BPRs) for will be made to add a new code for reporting costs associated with this activity.

B. Requirements for Reconsideration Requests

Only the QIC has the authority to dismiss a request for a reconsideration. This applies even when it appears that the request does not meet the requirements for requesting a reconsideration (e.g., the timely filing requirements do not appear to have been met). Even though the FI cannot dismiss a reconsideration request that does not meet the requirements, it should be aware of these requirements so that it can inform providers and States of the requirements. The same manual requirements for beneficiary requests for redeterminations also apply to reconsideration requests.

A provider or State request for a reconsideration must either be made on a standard CMS form or must contain:

- The beneficiary's name;
- Medicare health insurance claim number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name and signature of the party or representative of the party; and
- The name of the contractor that made the redetermination.

8. Joint Operating Agreements (Effective: Upon issuance.)

FIs are required to enter into joint operating agreements (JOAs) with the QIC(s) in their jurisdiction (See the above section for a list of jurisdictions). FIs are also required to enter into a JOA with the Administrative Qualified Independent Contractor (AdQIC). The AdQIC is Q^2 Administrators (Q^2A) located in Columbia, SC. The AdQIC's function is to oversee the QIC process, develop training and protocols for the QICs, perform data analysis on QIC decisions, and to review ALJ decisions for referrals to the Departmental Appeals Board (DAB). The AdQIC will have interaction with the FIs when ALJ decisions or DAB decisions need to be effectuated. JOAs delineate each contractor's roles and responsibilities, including how each organization operates and collaborates in carrying out converging activities. CMS will monitor both the QIC and the AdQIC for the duration of their contracts. The AdQIC has developed templates to assist the QIC and FIs in developing JOAs.

9. Policies for creating case files (Effective Date: All redeterminations issued on or after May 1, 2005)

Once a party requests a reconsideration with the QIC, the QIC will need to obtain the case file from the FI. The foundation for an effective, efficient and accurate appeals system is the case file. It is essential that the case file contain all relevant information and evidence concerning an appeal so that the QIC can make a correct and fair determination. The contractor builds the case file from the bottom up, with the oldest set of documents on the bottom, and the most recent set of documents at the top. However, it does not place the medical documentation on the bottom. Medical documentation goes in a separate and distinct section of the case file.

The following is a list of the documents generally included in any case file. Note that there may be others not listed here and some of the items may not be applicable. For applicable items, the contractor includes originals and retains hard copies of any documents that are not available electronically for its records. The contractor retains the copies of items not imaged in accordance with record retention standard established by CMS. If it is unable to include the original documents, it includes facsimiles of the original documents. It arranges the following documents, in descending date order (e.g., the claim form is on the bottom). The QIC may provide a check-off form to assist the contractor in case file preparation.

Procedural Documents

- Claim form or printout, if electronically generated (facsimile and/or screen prints (e.g., screen 3, 7, and 15 with line item detail summary and remarks) are acceptable);**
- MSN/RA - older files may contain EOMBs or Denial Letters, which must also be included. (Facsimile and/or screen prints are acceptable);
- Redetermination request;
- Redetermination notice; and
- Appointment of representative form (Form CMS-1696-U4) or other written authorization, if applicable.

Medical Documents

- Medical records, separated by facility or doctor, in chronological order (most recent on top);
- Referral to/from contractor medical staff (with professional qualifications of the reviewer noted in the document, if applicable);
- Contractor medical policies and opinions relevant to claim(s). (In addition to contractor medical policy, the contractor should include in the case file any information it has as background to the particular policy at issue. For example, findings of the Contractor Advisory Committee (CAC) with regard to the policy, including professional publications relied upon to support the policy, opinions from professional medical societies that may have commented on the policy during the developmental phase, etc.) (See the Program Integrity Manual for additional information.);*
- A list of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, and CMS manuals or other program guidance;
- Copies of regional medical review policies, local medical review policies, local coverage determinations, newsletters, any other information needed by the QIC;*
- Any other exhibits that the contractor may consider important for the QIC to consider (e.g., certification of reasonable charge, fee schedule information, notices of noncoverage, contractor publications, etc.); and
- Any additional evidence submitted by the appellant.

*If accessible by Internet, the FI may enter into a JOA with the QIC to provide a list instead of actual copies.
**An exception *may* be allowed if the QIC has read-only access to the FISS system.

Assembly Instructions:

- The contractor uses an appropriate file/folder/envelope that will contain necessary documents in proper order, if the case file is not transmitted electronically.
- For combined requests filed by a beneficiary, the contractor keeps the documents relating to treatment from each provider, physician, or supplier together. It separates the documents relating to each provider, physician or supplier by a blank sheet of paper;
- For combined requests filed by a provider, physician, or other supplier, the contractor keeps the documents relating to each beneficiary together and organized alphabetically by beneficiary last name. It separates the documents relating to each beneficiary by a blank sheet of paper. It provides a complete set of procedural documents for each beneficiary; and
- The contractor groups procedural documents together in chronological order and groups medical documents together in chronological order.

Reconsideration Case Summary Sheet

The Reconsideration Case Summary Sheet documents the claim information and the date of the redetermination. It also identifies the FI that made the redetermination and the QIC with jurisdiction for the reconsideration. The summary sheet should be placed on top of the documents in the case file. See exhibit 5 for a model Reconsideration Case Summary Sheet.

10. Sending Case Files to the QICs (Effective Date: All redeterminations issued on or after May 1, 2005)

When the QIC receives a request for reconsideration, it will request the case file from the contractor with jurisdiction. The QIC will send the request either by electronic mail (e-mail), by telephone, or by any other method agreed upon in the JOA. (Note: Individually identifiable beneficiary information should not be given in an e-mail). If another method is agreed upon in the JOAs, it must meet the privacy requirements of HIPAA. Contractors shall send/transmit the case file within 7 calendars days of the date of the QIC's request. The date of the QIC's request is defined as the date the phone call is made, the date the message was left, the date the fax was received, or the date of the e-mail request. The case files must be sent either by an electronic means agreed upon in the JOA or by a courier service so that the case file is received by the QIC before or on the 8th calendar day after its request. The contractor counts the costs associated with sending case files in the CAFM code designated for preparing/transferring case files to the QIC.

If agreed upon in the JOAs, the following requirements apply to e-mail and phone requests:

(a) E-mail requests-Contractors shall maintain an e-mail account specifically for the receipt of case file requests from the QIC. Contractors must check this e-mail account at

least once daily (every business day). When contractors receive e-mail requests from the QIC, they shall notify the QIC of receipt.

(b) Phone Requests-Contractors shall designate and maintain a phone extension specifically for the receipt of case file requests from the QIC. Contractors shall designate a main contact person and back-up contact that is available to take phone calls during core business hours on all business days unless otherwise agreed upon in the JOAs.

11. Effectuation of QIC Decisions (Effective Date: All redeterminations issued on or after May 1, 2005)

In many cases, the QIC's decision will require effectuation action by the contractor. The contractor does not effectuate based on correspondence from any party of the reconsideration. It takes an effectuation action only in response to a formal decision from the QIC. "Effectuate" means for the contractor to take the necessary actions to issue payment (i.e., make payment on the claim). The FI will obtain written assurance from the provider if necessary. If the QIC's decision is favorable to the appellant and specifies an amount to be paid, the contractor effectuates within 30 calendar days of the date of the QICs decision or from the date written assurance from the provider is received. If the decision is favorable, but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision (or date of receipt of written assurance from the provider has been obtained). The amount of payment and date of payment shall be reported to the appropriate QIC within 14 days of the date of payment.

12. New Appeal Rights for Medicare Providers & New Assignment Rights for Medicare Providers (Effective Date: May 1, 2005)

A. New Appeal Rights for Medicare Providers

Previously providers could only appeal a claim determination when the determination involved a finding that (1) the item or service was not covered because it constituted custodial care, was not reasonable and necessary, or for certain other reasons; and (2) the provider knew or could reasonably be expected to know that the service in question was not covered under Medicare (that is, a finding with respect to the limitation of liability provision under section 1879 of the Act). For initial determinations made on or after May 1, 2005, providers who submit claims to FIs will have the same right to appeal claims as beneficiaries. Accordingly, contractors will no longer use RA remark code MA44 for initial determinations made on or after May 1, 2005. This means contractors will no longer need to determine whether a provider submitting an appeal has the right to appeal. Also, contractors will no longer need to evaluate appointment of representative forms submitted by providers representing beneficiaries.

B. New Assignment Rights for Medicare Suppliers

Historically, non-participating suppliers accessed the appeals process by acting as the beneficiary's appointed representative in situations where they otherwise would not have had appeal rights. Section 1869(b)(1)(C) permits a beneficiary to assign his or her appeal

rights with respect to an item or service to a provider of supplier. Such an assignment of appeal must be made using a standard form developed by CMS. This form will be made available to contractors at http://www.cms.hhs.gov/forms/.

13. New Appeal Rights for Overpayments and Reopenings (Effective Date: Revised initial determinations issued on or after May 1, 2005)

Previously, revised initial determinations had appeal rights to the hearing officer for part B claims where over $100 remained in controversy and appeal rights to the review level for part B claims where under $100 remained in controversy. For Part A claims with revised initial determinations, appeal rights were provided at the reconsideration level. For all revised initial determinations issued on or after May 1, 2005, the first level of appeal will be a redetermination. Contractors shall change appeals language in all demand letters or other notices of revised initial determinations (including Remittance Advice (RA) notices and Medicare Summary Notices (MSN) if used) in accordance with this section. Additional instructions regarding changes to the MSN and RA remarks will be forthcoming (e.g., revising the terminology for the levels of appeal and time frames to appeal).

14. New Appeal Rights for Dismissals (Effective Date: All redeterminations issued on or after May 1, 2005)

A. Appealing a Dismissal- For redeterminations issued on or after May 1, 2005, parties to the redetermination will have the right to appeal a dismissal of a redetermination request to the QIC. A party to the redetermination may appeal the dismissal if they believe the dismissal is incorrect. The reconsideration request must be filed at the QIC within **60 days** of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the contractor incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the contractor for reopening. It is mandatory for the contractor to reopen any case that is remanded to it and issue a new decision. The new decision is counted in Contractor Reporting of Operational and Workload Data (CROWD) on the 2591 as a "post-review reopening" or "post-reconsideration reopening." A QIC's reconsideration of a contractor's dismissal of a redetermination request is final and not subject to any further review.

B. Vacating a Dismissal- A party to the redetermination may also request the contractor to vacate its dismissal if good and sufficient cause is established. The contractor determines if there is good and sufficient cause and if there is, the contractor reopens the dismissal and issues a new decision. If a QIC reconsideration has been requested, the contractor no longer has jurisdiction and cannot vacate a dismissal unless directed to do so through a QIC remand.

C. Dismissal Letters- For any dismissal issued on or after May 1, 2005, contractors shall include the following or similar language in dismissal letters (also see the model dismissal letter in exhibit 4):

If you disagree with this dismissal, you have two options:

1. If you think you have good and sufficient cause for <insert reason for dismissal>, you may ask us to vacate our dismissal. We will vacate our dismissal if we determine you have good and sufficient cause. If you would like to request us to vacate this dismissal, you must file a request within **6 months** of the date of this notice. In your request, please explain why you believe you have good and sufficient cause. Please send your request to:

Insert Address

2. If you think we have incorrectly dismissed your request (for example, you believe <*insert reason (e.g. you did file your request on time, you were a proper party, the contractor did issue an initial determination on the claim)*>), you may request a reconsideration of the dismissal by a Qualified Independent Contractor. Your request must be filed within **60 days** of receipt of this letter. The Qualified Independent Contractor will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the Qualified Independent Contractor will not consider any evidence for establishing coverage of the claims(s) being appealed. Their examination will be limited to whether the dismissal was appropriate. Please send your request to:

Insert Address

D. Incomplete Requests- The requirements for written requests for redeterminations are included in the Claims Processing Manual, Chapter 29, sections 40.2.1 and 50.3.1. For all redetermination requests received on or after May 1, 2005, providers and States no longer are required to include the date of initial determination in their requests. Previously, contractors were instructed to return requests that did not meet the manual requirements for a complete request. For redetermination requests received on or after May 1, 2005, contactors must handle and count incomplete redetermination requests as dismissals. The above requirements under (C) for vacating and appealing dismissals apply to incomplete requests as well. Parties to the redetermination also have the option to refile their request if any time remains in the filing period (i.e., 120 days of receipt of the initial determination). When a request is refiled that meets the requirements, the previous dismissal is vacated and reopened. Contractors must notify parties of their options in the dismissal notice. Please see the model dismissal notice for an incomplete request in Exhibit 3.

15. Preparing Case Files for ALJ Hearings (Effective Date: All redeterminations issued on or after May 1, 2005)

For Part A and Part B redeterminations issued before May 1, 2005, contractors will continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing. Contractors shall continue to follow instructions in the Claims Processing Manual, Chapter 29, §§ 50 and 60 in preparing case files. For redeterminations issued on or after May 1, 2005, the QIC will be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.

16. Effectuation of ALJ Decisions (Effective Date: All ALJ decisions issued by HHS ALJs)

In many cases, the ALJ's decision will require an effectuation action on the contractor's part. The contractor does not effectuate based on correspondence from any party of the ALJ hearing. It takes an effectuation action only in response to a formal decision. "Effectuate" means for the contractor to take the necessary actions to issue payment (i.e.,pay the claim). The FI will obtain written assurance from the provider if necessary. If the ALJ's decision is favorable to the appellant and gives a specific amount to be paid, the contractor effectuates within 30 calendars days of the date of the ALJ's decision or from the date written assurance from the provider is received. If the decision is favorable but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the ALJ's decision (or date of receipt of written assurance from the provider). The amount of payment and date of effectuation shall be reported to the **AdQIC** within 14 days of the date of effectuation.

Clearinghouse function- For ALJ decisions issued by HHS ALJs, the AdQIC will function as the clearinghouse. Once the AdQIC receives the case file and the ALJ decision for a favorable case, the AdQIC will forward the official decision and a summary of the affected claim headers and claim line ICNs to the appropriate contractor.

17. Agency Referrals (Effective Date: All ALJ decisions issued by HHS ALJs.)

For ALJ decisions issued by HHS ALJs, the AdQIC will be responsible for reviewing ALJ decisions and determining whether an agency referral is appropriate. For all ALJ decisions issued by SSA ALJs, the FI remains responsible for this activity. The FI will no longer be responsible for reviewing ALJ decisions issued by HHS ALJs.

18. Remittance Advice and Medicare Summary Notices

Changes to the RA and MSN, including remark codes and messages, will be described in a forthcoming.

19. Redetermination Acknowledgement Letters (Effective Date: All redeterminations received on or after May 1, 2005)

Contractors are not required to send or mail acknowledgment letters for redetermination requests received on or after May 1, 2005.

20. Redetermination Notices for Overpayment Cases (Effective Date: All redeterminations issued on or after May 1, 2005)

In overpayment cases involving multiple beneficiaries who have no liability, the contractor may issue a written notice of the redetermination only to the appellant. It is not necessary to forward a copy of the decision to beneficiaries who are not liable.

21. Quality Improvement and Data Analysis

Beginning on May 1, 2005, contractors must no longer perform all quality improvement and data analysis activities related to hearing officer hearings and ALJ hearings.

Contractors will not be required to perform any data analysis or quality improvement on QIC reconsiderations.

C. Provider Education:

A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3530.1	**FIs shall make necessary language changes to the MRN.**	X	X			X				
3530.1.2	FIs shall include the reconsideration request form with the MRN.	X	X			X				
3530.1.2.1	FIs shall include the contractor logo or CMS logo with the contractor name and address on the reconsideration request form for identification purposes. This logo will be used by the QIC to identify which FI to request the case file from.	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3530.1.2.2	FIs shall include an appeal number on the reconsideration request form for identification of the associated appeal. This number will be used by the QIC to request a case file.	X	X			X				
3530.2	**FIs shall mail notification of a fully favorable redetermination within 60 days of receipt of the request.**	X	X			X				
3530.3	**FIs shall report a redetermination cleared under line 6 of the CMS 2591 when the redetermination is mailed to the appellant or parties, as applicable.**	X	X			X				
3530.4	**FIs shall require that all redetermination requests be in writing.**	X	X			X				
3530.5	**FIs shall apply the manual requirements for content of redetermination requests made by providers and suppliers with the exception of the date of initial determination.**	X	X			X				
3530.6	**FIs shall consolidate requests from multiple parties on the same claim into one redetermination.**	X	X			X				
3530.7	**FIs shall take the appropriate actions to ensure that requests for QIC reconsideration are filed at the QIC.**	X	X			X				
3530.7.1	FIs shall notify parties of the appropriate QIC's address in the MRN.	X	X			X				
3530.7.2	FIs shall have standard operating procedures for misrouted requests.	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3530.7.3	FIs shall transmit misrouted QIC requests along with the appropriate case file(s) within 14 calendar days of receipt in the corporate mailroom.	X	X			X				
3530.7.4	FIs shall identify misfiled hearing officer and ALJ hearing requests and forward them along with the appropriate case file(s) to the QIC within 10 calendar days of receipt in the corporate mailroom.	X	X			X				
3530.7.5	FIs shall track all misfiled reconsideration requests to ensure receipt at the proper QIC.	X	X			X				
3530.7.6	FIs shall not count misrouted misfiled requests as dismissals.	X	X			X				
3530.8	**FIs shall enter into joint operating agreements with QIC(s) assigned to their jurisdiction, as well as the AdQIC.**	X	X			X				
3530.9	**FIs shall create case files in accordance with the instructions in this CR.**	X	X			X				
3530.10	**FIs shall have standard operating procedures for receiving requests for case files from the QICs.**	X	X			X				
3530.10.1	FIs shall maintain an e-mail account specifically for the receipt of case file requests from the QIC.	X	X			X				
3530.10.2.1	FIs shall check this e-mail account at least once daily (every business day).	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3530.10.2.2	FIs shall respond to e-mail requests received to notify the QIC of receipt.	X	X			X				
3530.10.3	FIs shall designate a phone extension specifically for the receipt of case file requests from the QIC.	X	X			X				
3530.10.3.1	FIs shall designate a main contact person and back-up contact that is available to take phone calls during core business hours.	X	X			X				
3530.10.4	FIs shall send/transmit the case file within 7 calendar days of the date of the QIC's request.	X	X			X				
3530.11	**FIs shall appropriately effectuate all QIC decisions.**	X	X			X				
3530.11.1	FIs shall effectuate all QIC decisions, where the decision gives a specific amount to be paid, within 30 calendar days of the date of the QIC's decision.	X	X			X				
3530.11.2	FIs shall effectuate all other decisions within 30 calendar days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision.	X	X			X				
3530.12	**FIs shall accept appeal requests from providers in accordance with the instructions in this CR.**	X	X			X				
3530.13	**FIs shall notify providers of the correct appeal rights for revised initial determinations and reopenings.**	X	X			X				

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3530.14	**FIs shall include new language in dismissal letters for dismissals issued on or after May 1, 2005.**	X	X			X				
3530.15	**FIs shall continue to prepare ALJ case files for all redeterminations issued before May 1, 2005.**	X	X			X				
3530.16	**FIs shall continue to effectuate all ALJ decisions received from the clearinghouse including the AdQIC.**	X	X			X				
3530.17	**FIs shall continue to review ALJ decisions and make agency referrals, as appropriate, for all ALJ decisions issued by SSA ALJs.**	X	X			X				

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date *: see policy section **Implementation Date:** April 25, 2005 **Pre-Implementation Contact(s):** Jennifer Eichhorn Frantz, JFrantz@cms.hhs.gov **Post-Implementation Contact(s):** Jennifer Eichhorn Frantz, JFrantz@cms.hhs.gov or Maria Ramirez, MRamirez@cms.hhs.gov	**Medicare Contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Attachments

Exhibit 1: Model Redetermination Notice

Medicare Number of Beneficiary:
111-11-1111 A

Contact Information
If you have questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

MEDICARE APPEAL DECISION

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

Dear *Appellant's Name*:

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you made an appeal for *(insert: name of item or service)*.

The appeal decision is
(*Insert either:* ***unfavorable.*** *Our decision is that your claim is not covered by Medicare.*
OR ***partially favorable****. Our decision is that your claim is partially covered by Medicare.*
More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to a qualified independent contractor. You must file your appeal, in writing, within 180 days of receiving this letter.

A copy of this letter was also sent to *(Insert: Beneficiary Name or Provider Name)*. *(Insert: Contractor Name)* was contracted by Medicare to review your appeal. For more information on how to appeal, see the section titled "Important Information About Your Appeal Rights."

Summary of the Facts
Instructions: You may present this information in this format, or in paragraph form.

Provider	Dates of Service	Type of Service
Insert: Provider Name	*Insert: Dates of Service*	*Insert: Type of Service*

- A claim was submitted for (*insert: kind of services and specific number)*.
- An initial determination on this claim was made on (*insert: Date)*.
- The *(insert: service(s)/item(s) were/was*) denied because (*insert: reason*).
- On (*insert: date)* we received a request for a redetermination.
- *(Insert: list of documents)* was submitted with the request.

Decision
Instructions: Insert a brief statement of the decision, for example "We have determined that the above claim is not covered by Medicare. We have also determined that you are responsible for payment for this service."

Explanation of the Decision
Instructions: This is the most important element of the redetermination. Explain the logic/reasons that led to your final determination. Explain what policy (including local medical review policy, regional medical review policy, and/or national coverage policy), regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it included an explanation of why the claim can or cannot be paid. Statements such as "not medically reasonable and necessary under Medicare guidelines" or "Medicare does not pay for X" provide conclusions instead of explanation, and are not sufficient to meet the requirement of this paragraph.

Who is Responsible for the Bill?
Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

What to Include in Your Request for an Independent Appeal
Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim.

Special Note to Medicare Providers Only: Any evidence indicated in this notice must be submitted to the QIC. It should accompany the request for reconsideration. All evidence, including evidence that is not indicated in this notice, must be presented before the reconsideration is issued. If all evidence is not submitted, you will not be able to submit any new evidence in subsequent appeals unless you can demonstrate good cause for not presenting the evidence to the QIC. This evidence requirement also applies to providers who represent beneficiaries in the appeals process.

Sincerely,

Reviewer Name
Contractor Name
A Medicare Contractor

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision: If you do not agree with this decision, you may file an appeal. An appeal is a review performed by people independent of those that have reviewed your claim so far. The next level of appeal is called a reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from <Insert Contractor's name>.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within 180 days of receiving this letter. Under special circumstances, you may ask for more time to request an appeal. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you can write a letter. You must include: your name, your signature, the name of the beneficiary if you are not the beneficiary requesting the appeal, the Medicare number, a list of the service(s) or item(s) that you are appealing and the date(s) of service, and any and all evidence you wish to submit. You must also indicate that *(insert: contractor name)* made the redetermination. You may also attach supporting materials such as medical records, doctors' letters, or other information that explains why this service should be paid. If you are a beneficiary, your doctor may be able to provide supporting materials.

If you want to file an appeal, you should send your request to:

QIC Name
Address
City, State Zip

Who May File an Appeal: You or someone you name to act for you (your **appointed representative**) may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you.

If you want someone to act for you, you and your appointed representative must sign, date and send us a statement naming that person to act for you. Call us to learn more about how to name a representative.

Help With Your Appeal: If you want help with an appeal, or if you have questions about Medicare, you can have a friend or someone else help you with your appeal. You can also contact your State Health Insurance Assistance Program (SHIP). You can call 1-800-MEDICARE (1-800-633-4227) for information on how to contact your local SHIP. Your SHIP can answer questions about payment denials and appeals.

Other Important Information: If you want copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, please write to us at the following address and attach a copy of this letter:

Contractor Name,
A Medicare Contractor
Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of phone number, e.g. on the front of this notice).

Other Resources To Help You:

1-800-MEDICARE (1-800-633-4227), TTY/TDD: 1-800-486-2048

Contractor Logo

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form or a **copy** of this form to:

QIC Name
Street Address
City State Zip

1. Provider Name:_____

2. Name of Beneficiary:_____

3. Medicare Number:_____

4. Your Address:_____

---

5. Item or service you wish to appeal:_____

6. Date of the service:_____

7. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary.) _____

_____

8. Signature:_____ 9. Date: _____

You may also include any supporting material to assist your appeal. Examples of supporting materials include:

- ☐ Medical Records
- ☐ Copy of the Claim
- ☐ Certificate of Medical Necessity
- ☐ Office Records/Progress Notes
- ☐ Treatment Plan

Contractor Number: XXX (optional)

Appeal Number:
XXXXXX

Exhibit 2: Model Fully Favorable Redetermination Notice

MEDICARE APPEAL DECISION

Medicare Number of Beneficiary:
111-11-1111 A

Contact Information
If you have questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

MONTH, DATE, YEAR

APPELLANT's NAME
ADDRESS
CITY, STATE ZIP

RE: *Include claim identifier*

Dear *Appellant's Name*:

This letter is to inform you of the decision on your Medicare Appeal. This appeal decision is **fully favorable** to you. Our decision is that your claim is covered by Medicare. More information on this decision, including the amount Medicare will pay, will follow in a future Remittance Advice or Medicare Summary Notice.

Sincerely.

Review Name
Contractor Name
A Medicare Contractor

Medicare Number of Beneficiary:
111-11-1111 A

Contact Information
If you have questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

Exhibit 3: Model Redetermination Dismissal Notice for Incomplete Request

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

Dear *Appellant's Name*:

This letter is in response to your redetermination request that was received in our office on *(insert date)*. The redetermination was requested for the following dates of service *(insert date(s))*. Your redetermination request has been dismissed because it did not contain all of the information that we need to process your request. In order to process a redetermination request, we need the following pieces of information:

- The beneficiary's name;
- The Medicare health insurance claim number of the beneficiary;
- The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service; and
- The name and signature of the person filing the redetermination request.

Your request has been dismissed because it did not contain *(insert the item that was missing)*.

You may file your request again if it has been 120 days or less since the date of receipt of the initial determination. When you file your request, please make sure you include all of the above listed items. Please send your request to:

Insert Address

If you disagree with this dismissal, you have two additional options:

1. If you think you have good and sufficient cause for failing to include all these items in your request, you may ask us to vacate our dismissal. If you would like us to vacate our dismissal, ***you must file a request within 6 months of the date of this notice***. In your request, please explain why you believe you have good and sufficient cause for failing to include the proper information in your request. Please send your request to:

   Insert Address
2. If you think we have incorrectly dismissed your request (that is, you believe you did include all the above listed items in your request), you may request a reconsideration of the dismissal by a Qualified Independent

Contractor. Your request must be filed within **60 days** of receipt of this letter. The Qualified Independent Contractor will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the Qualified Independent Contractor will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether the dismissal was appropriate. Please send your request to:

Insert address

Sincerely,

Review Name
Contractor Name
A Medicare Contractor

Medicare Number of Beneficiary:
111-11-1111 A

Contact Information
If you have questions, write or call:
Contractor Name
Street Address
City, State Zip
Phone Number

Exhibit 4: Model Redetermination Dismissal Notice

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

Dear *Appellant's Name*:

This letter is in response to your redetermination request that was received in our office on *(insert date)*. The redetermination was requested for the following dates of service *(insert date(s))*. Your redetermination request has been dismissed because the date(s) of service in question is/are past the time limit to file a request for a redetermination. A redetermination must be requested within 120 days of receipt of the initial determination date on the Medicare Remittance Advice Notice or the Medicare Summary Notice.

When we receive a request that has been filed late, we consider whether the appellant had good cause for filing late. In special circumstances, we may allow additional time to file. In this case, we did not find good cause for filing your request late.

If you disagree with this dismissal, you have two options:

1. If you think you have good and sufficient cause for filing late, you may ask us to vacate our dismissal. We will vacate our dismissal if we determine you have good and sufficient cause for filing late. If you would like to request us to vacate this dismissal, ***you must file a request within 6 months of the date of this notice***. In your request, please explain why you believe you have good and sufficient cause for filing late. Please send your request to:

   Insert Address

2. If you think we have incorrectly dismissed your request (for example, you believe you did file your request on time), you may request a reconsideration of the dismissal by a Qualified Independent Contractor. Your request must be filed within **60 days** of receipt of this letter. The Qualified Independent Contractor will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the Qualified Independent

Contractor will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether the dismissal was appropriate. Please send your request to:

Insert address

Sincerely.

Review Name
Contractor Name
A Medicare Contractor

Reconsideration Case Summary Sheet

1. QIC Name:

QIC Name
Address
City, State, Zip

Exhibit 5: Model Reconsideration Case Summary Sheet

2. Name of Fiscal Intermediary:

FI Name
Department
Address
City, State, Zip

3. Name of Contact at FI: _____
   Phone Number:_____
   E-mail: _____
   Fax: _____

4. Claim Information

	HIC #	Claim #	Date of Redetermination	Beneficiary Eligible (Y/N)	Provider Eligible to Receive Payment (Y/N)
1.	_____-_____-_____	_____	_____-_____-_____	_____	_____
2.	_____-_____-_____	_____	_____-_____-_____	_____	_____
3.	_____-_____-_____	_____	_____-_____-_____	_____	_____
4.	_____-_____-_____	_____	_____-_____-_____	_____	_____
5.	_____-_____-_____	_____	_____-_____-_____	_____	_____
6.	_____-_____-_____	_____	_____-_____-_____	_____	_____
7.	_____-_____-_____	_____	_____-_____-_____	_____	_____
8.	_____-_____-_____	_____	_____-_____-_____	_____	_____
9.	_____-_____-_____	_____	_____-_____-_____	_____	_____
10.	_____-_____-_____	_____	_____-_____-_____	_____	_____