MLN Matters
Information for Medicare Fee-for-Service Health Care Professionals

Related Change Request (CR) #: 4019 MLN Matters Number: MM4019
Related CR Release Date: October 7, 2005
Related CR Transmittal #: 695
Effective Date: May 1, 2005
Implementation Date: January 9, 2006

MMA – Changes to Chapter 29 – General Appeals Process in Initial Determinations

Note: This article was revised to contain Web addresses that conform to the new CMS website and to show they are now MLN Matters articles. All other information remains the same.

Provider Types Affected

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare

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. It 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).

CR4019 focuses on the general appeals process in Initial Determinations. CR4019 contains a considerable amount of information that is pertinent to the entire process of Medicare claims appeals, and focuses specifically on the additions of Sections 200 to 260 to Chapter 29 of the *Medicare Claims Processing Manual.*

Key Points

Centers for Medicare & Medicaid Services (CMS) Decisions Subject to the Administrative Appeals Process

The Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. These decisions are subject to appeal with the SSA.

Minor Errors and Omissions

Providers should be aware that there is no need to appeal a claim if the provider has made a minor error or omission in filing the claim, which, in turn, caused the claim to be denied. In the case where a minor error or

omission is involved, the provider can request that the Medicare contractor reopen the claim so the error or omission can be corrected, rather than having to go through the appeals process.

Who May Appeal

CR4019 (Additions to Chapter 29) defines and describes the individuals and entities who have the right to appeal a Medicare contractor's initial determination. (Medicare contractors are carriers, including Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs).) An individual who has a right to appeal is referred to as a "party."

Provider or Supplier Appeals When the Beneficiary Is Deceased

When a provider or supplier appeals on behalf of a deceased beneficiary, and the provider or supplier otherwise does not have the right to appeal, it is the contractor's responsibility to determine whether another party is available to appeal. CR4019 describes what must be done in this situation.

Parties to an Appeal

Any of the persons/entities who may appeal Medicare's decision to deny or reduce payment are parties to an appeal of a claim for items or services payable under Part A or Part B.

Steps in the Appeals Process: Overview

The process of appeal described in CR4019 is effective for all redeterminations issued on or after May 1, 2005, by Medicare FIs and all redeterminations issued on or after January 1, 2006, by carriers. The appeals process consists of five levels. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal. No appeal can be accepted until an initial determination has been made for the claim. The following chart outlines the steps in the Medicare appeal process:

The Medicare Fee-for-Service Appeals Process

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
1. Redetermination			
• Performed by the Medicare Contractor	120 days from date of receipt of the notice initial determination (MSN or RA). (The notice of initial determination is presumed to be received five days from the date of the notice unless there is evidence to the contrary.)	Part A – FI (MAC) Part B – Carrier (MAC)	None
2. Reconsideration			
• Performed by QIC • Case file prepared by the Medicare contractor and forwarded to the QIC.** • Medicare contractor may have effectuation responsibilities for decisions made by the QIC.	180 days from date of receipt of the redetermination	Part A and B – QIC	None

Appeal Level	Time Limit for Filing Request	Where to Appeal*	Monetary Threshold to be Met or Amount in Controversy (AIC)
3. Administrative Law Judge (ALJ) Hearing			
• Case file prepared by the QIC and forwarded to the HHS Office of Medicare Hearings and Appeals (OMHA). • Medicare contractor may have effectuation responsibilities for decisions made at the ALJ level.	60 days from the date of receipt of the reconsideration notice	Part A and B – HHS OMHA Field Office	At least $100 remains in controversy*** *For requests made on or after January 1, 2006, at least $110 remains in controversy*
4. Departmental Appeals Board (DAB) Review			
• Contractor may have effectuation responsibilities for decisions made at the DAB level.	60 days from the date of receipt of the ALJ hearing decision/dismissal	Part A and B – DAB	None
5. Federal Court (Judicial) Review			
• Medicare contractor may have effectuation responsibilities for decisions made at the Federal Court level.	60 days from date of receipt of DAB decision or declination of review by DAB		At least $1,050 remains in controversy*** *For requests made on or after January 1, 2006, at least $1,090 remains in controversy*

*Where to Appeal - Part A includes Part B claims filed with the FI.

** In accordance with the appropriate manual section and the Joint Operating Agreement (JOA).

***Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar Amount in Controversy (AIC) requirement will increase by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

Where to Appeal

Where a party must file an appeal depends on the level of appeal. The above chart indicates where appellants should file appeal requests for each level of appeal.

When to Appeal – Time Limits for Filing Appeals and Good Cause for Extension of the Time Limit for Filing Appeals

The time limits for filing appeals vary according to the type of appeal. The table above indicates the time limits for filing appeal requests for each level of appeal. These time limits may be extended if good cause for late filing is shown.

Good Cause - General Procedure to Establish Good Cause for Late Filing

Procedures to establish good cause are effective for all requests for redeterminations received by FIs on or after May 1, 2005, and all requests for redeterminations received by the carrier on or after January 1, 2006. The new Section 240 of Chapter 29 of the *Medicare Claims Processing Manual* lists the general procedure for establishing good cause for late filing; when a favorable decision for good cause is made; and when an unfavorable decision for good cause is made. A listing of conditions and examples that may establish good cause for late filing by beneficiaries or by providers, physicians, and suppliers, can be found in Section 240, which is attached to CR4019.

Amount in Controversy (AIC) Requirements

The amount in controversy requirements apply only to the ALJ and Federal Court Levels. The chart above indicates the amount in controversy (AIC) as well as the method of calculating the AIC, for the Medicare appeals process.

Additional Information

The official instruction issued to your FI or carrier regarding this change may be found by going to *http://www.cms.hhs.gov/transmittals/downloads/R695CP.pdf* on the CMS website.

All of the new sections of Chapter 29 of the *Medicare Claims Processing Manual* are attached to CR4019. These sections provide excellent detail that explains the revised appeals process.

Please refer to your local FI or carrier for more information about this issue. To find their toll-free phone number, go to *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.