Medicare Claims Processing Manual

Chapter 29 - Appeals of Claims Decisions

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(Rev. 1676, 01-30-09)

110 - Glossary

(Rev. 381, Issued: 11-26-04, Effective: 11-26-04, Implementation: 01-10-05)

Adjudicator - The person responsible for making the decision at any level of the Medicare claim decision making process, from initial determination to the final level of appeal on a specific claim.

Administrative Law Judge (ALJ) - Adjudicator employed by the Social Security Administration's (SSA) Office of Hearings and Appeals (OHA) to resolve Medicare claims controversies at the ALJ hearing level of appeal. (See 42 CFR 405.855.)

Affirmation - A term used to denote that a prior claims determination has been upheld by the current claims adjudicator.

Although appeals through the ALJ level are de novo, CMS and its contractors often use this term when a reviewer or Hearing Officer reaches the same conclusion as that in the prior determination, even though he/she is not bound by the prior determination.

Agency Referral (formerly known as the Agency Protest Process) - The CMS will bring an ALJ's decision or dismissal to the attention of the DAB by asking the DAB to review the case under its own motion review authority. The CMS makes Agency Referrals where:

1. The ALJ's decision/dismissal does not conform to the applicable law and regulations, which are binding upon ALJ's;
2. Where there has been an abuse of discretion by the ALJ;
3. Where the ALJ's decision/dismissal is not supported by substantial evidence; or
4. Where there is a broad policy or procedural issue that may affect the general public interest.

Amount in Controversy - The dollar amount required to be in dispute to establish the right to a particular level of appeal. Congress establishes the amount in controversy requirements.

Appellant - The term used to designate the party (i.e., the beneficiary, provider, physician or other supplier, or other person showing an interest in the claim determination) or the representative of the party that has filed an appeal. The adjudicator determines if a particular appellant is a proper party or represent a proper party.

Claimant - A person or entity that submits a claim for payment or on whose behalf a claim is submitted, commonly used by the Social Security Administration. "Claimant" is purposely omitted from Medicare appeals terminology because it is not specific enough to describe a person or entity's appeals status. The term "appellant" is used by Medicare to identify the individual or entity that is appealing a claim.

De Novo - Latin phrase meaning "anew" or "afresh," used to denote the manner in which claims are adjudicated through the ALJ level of appeal. Adjudicators at each level of appeal make a new, independent and thorough evaluation of the claim(s) at issue, and are not bound by the findings and decision made by an adjudicator in a prior determination or decision.

Decisions and Determinations -If a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a "determination" or "decision." There is no apparent practical distinction between these two terms although applicable regulations use the terms in distinct contexts.

Medicare regulations use the term "determination" in the following appeals contexts:

1. Initial determination;
2. Redetermination;
3. Limitation on liability determination; and
4. Provider, physician or supplier refund determination.

A determination that is reopened and thereafter revised is called a "revised determination."

Medicare regulations use the term "decision" in the following appeals contexts:

1. HO hearing decision;
2. ALJ Hearing decision;
3. Departmental Appeals Board decision; and
4. Administrator decision.

A decision that is reopened and thereafter revised is called a "revised decision."

Departmental Appeals Board (DAB) Review - A party dissatisfied with an ALJ's decision, or with an ALJ's dismissal of his/her/their hearing request, may request DAB review within 60 days after receipt of the notice of the ALJ's hearing decision or dismissal. The DAB may deny or dismiss the request for review, or it may grant the request and either issue a decision or dismissal or remand the case to an ALJ. The DAB may take any action an ALJ could have taken. This could include, for example, vacating an ALJ decision and issuing a dismissal with respect to the request for ALJ hearing.

The DAB may also initiate its own motion review of the ALJ's hearing decision or dismissal within 60 days after the date of the hearing decision or dismissal. An Agency Referral by CMS to the DAB of an ALJ decision or dismissal may result in the review of the decision or dismissal by the DAB. This is also known as "own motion review."

The DAB may also reopen an ALJ's decision or dismissal for good cause.

The part of the DAB that reviews Medicare cases is called the Medicare Appeals Council (MAC).

Dismissal - A request for appeal may be dismissed for any number of reasons, including:

1. Abandonment of the appeal by the appellant;
2. A request is made by the appellant to withdraw the appeal;
3. An appellant is determined to not be a proper party;
4. The amount in controversy requirements have not been met; and

5. The appellant has died and no one else is prejudiced by the claims determination.

A dismissal of a request for review may not be appealed. A HO dismissal may not be appealed, however for good cause shown, a Hearing Officer may vacate (i.e., set aside or rescind) his/her order of dismissal within 6 months of the date of the dismissal.

An ALJ's dismissal may be vacated by the ALJ or the Departmental Appeals Board for good cause within 60 days after the date of receipt of the dismissal notice.

Expedited Appeals Process - A process available to a party whereby the party can request court review in place of ALJ hearing or Departmental Appeals Board review. The request must both allege that there are no material issues of fact in dispute, and it must assert that the only factor precluding a decision favorable to the party is that a statutory provision is unconstitutional, or that a regulation, national coverage decision under §1862(a)(1) of the Act, or CMS ruling is invalid.

Limitation on Liability Determination - Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers, physicians, practitioners, and other suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision." Both the underlying coverage determination and the limitation on liability determination may be challenged. For more detailed information see Chapter 30 of this Manual.

Office of Hearings and Appeals (OHA) - The organizational unit within SSA under which jurisdiction for SSA's ALJs rests. Contractors forward requests for Part A hearings to the local Hearing Officer of the SSA's Office of Hearings and Appeals. They forward requests for Part B ALJ hearing, along with the case file, to the SSA/OHA/Division of Medicare - Part B (formerly known as the "Part B Development Center"), for processing.

Party - A person and/or entity normally understood to have standing in the initial and appellate proceedings. Parties or appointed representatives to an appeal receive all applicable notices relating to the appellate proceedings.

Beneficiaries are almost always considered parties to a Medicare determination, as they are entitled to appeal any determination related to their claim(s).

Providers and Physicians or other suppliers accepting assignment are parties and may appeal any claim(s) for which they have accepted assignment.

A physician not taking assignment on a claim but who is responsible for making a refund to the beneficiary under §1842(l)(1) of the Act has party status with respect to the claim at issue.

A nonparticipating supplier responsible for making a refund to the beneficiary under §1834(a)(18) of the Act has party status with respect to the claim at issue.

A supplier of medical equipment and supplies furnishing items or services to a beneficiary not on an assigned basis and responsible for making a refund to the beneficiary under §1834(j)(4) of the Act has party status with respect to the claim at issue.

Physician or Other Supplier - As used in this section, the definition in 42 CFR 40.202 for supplier is used. Physician or Supplier includes a physician or other practitioner, supplier, or any other entity other than an institutional provider, that furnishes health care services under Medicare.

NOTE: - The term "practitioner" is generally subsumed under the term "supplier" as that term is defined.

Provider - Under 42 CFR 400.202 provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Remand - "To send back" - sending a case back to a previous appeal level, for the purpose of having some action taken there.

Reversal - Although appeals through the ALJ hearing level are de novo proceedings (i.e., a new determination/decision is made at each level), Medicare uses this term where the new determination/decision is more favorable to the appellant than the prior determination/decision, even if some aspects of the prior determination/decision remain the same.

NOTE: the term reversal describes the coverage determination, not the liability determination.

If the contractor or the HO determines the case partially in favor of the appellant (i.e., the contractor or HO issues a determination/decision more favorable to the appellant than at the last level of adjudication, but that is still less than fully favorable), Medicare calls this a "partially favorable determination/decision." Medicare does not use the term "partial denial."

Revised Determination or Decision - An initial or redetermination or Hearing Officer decision that is reopened and which results in a revised determination or decision being issued. A revised determination or decision is considered a separate and distinct determination or decision and may be appealed.

A post-payment review of an initial determination that results in an overpayment determination constitutes a revised initial determination.

The first level of appeal following an overpayment determination under Part A is a redetermination.

Under Part B, the first level of appeal following an overpayment determination is the HO hearing if at least $100 remains in controversy. If less than $100 remains in controversy, a review would be available.

200 - CMS Decisions Subject to the Administrative Appeals Process

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

A. Entitlement Determinations

In accordance with a memorandum of understanding with the Secretary, the Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. Individuals should write to (or visit) the SSA for administrative appeals involving entitlement. This would include issues that involve the question of whether the beneficiary:

- Has attained age 65 or is entitled to Medicare benefits under the disability or renal disease provisions of the law;
- Is entitled to a monthly retirement, survivor, or disability benefit;
- Is qualified as a railroad beneficiary;
- Met the deemed insured provisions; and
- Met the eligibility requirements for enrollment under the Supplementary Medical Insurance (SMI) program or for Hospital Insurance (HI) obtained by premium payment.

If a beneficiary is dissatisfied with the SSA's initial determination on entitlement, he or she may request a reconsideration with the SSA. The SSA performs a reconsideration of it's initial determination in accordance to 20 CFR part 404, subpart J. Following the reconsideration, the beneficiary may request a hearing before an HHS Administrative Law Judge (ALJ). If the beneficiary obtains a hearing before an ALJ and is dissatisfied with the decision of the ALJ, he or she may request the Departmental Appeals Board (DAB) to review the case. Following the action of the DAB, the beneficiary may be entitled to file suit in Federal district court.

B. Initial Determinations

The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment does not meet the requirements for a Medicare claim shall not be considered an initial determination. An initial determination for purposes of this chapter includes, but is not limited to, determinations with respect to:

(1) Whether the items and/or services furnished are covered under title XVIII;

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, whether the beneficiary, or supplier who accepts assignment under 42 CFR § 424.55 knew, or could reasonably have been expected to know at the time the services were furnished, that the services were not covered;

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, whether the beneficiary or supplier knew, or could reasonably have been expected to know at the time the services were furnished, that the services were not covered;

(4) Whether the deductible has been met;

(5) The computation of the coinsurance amount;

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care;

(7) The number of home health visits used;

(8) Periods of hospice care used;

(9) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, and partial hospitalization services;

(10) The beginning and ending of a spell of illness, including a determination made under the presumptions established under 42 CFR §409.60(c)(2), and as specified in 42 CFR §409.60(c)(4);

(11) The medical necessity of services, or the reasonableness or appropriateness of placement of an individual at an acute level of patient care made by the Quality Improvement Organization (QIO) on behalf of the contractor in accordance with 42 CFR §476.86(c)(1);

(12) Any other issues having a present or potential effect on the amount of benefits to be paid under Part A or Part B of Medicare, including a determination as to whether there has been an underpayment of benefits paid under Part A or Part B, and if so, the amount thereof;

(13) If a waiver of adjustment or recovery under sections 1870(b) and (c) of the Act is appropriate

(i) when an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) has been made with respect to an individual or

(ii) with respect to a Medicare Secondary Payer recovery claim against a beneficiary or against a provider or supplier.

(14) Whether a particular claim is not payable by Medicare based upon the application of the Medicare Secondary Payer provisions of section 1862(b) of the Act.

(15) Under the Medicare Secondary Payer provisions of sections 1862(b) of the Act; and, that Medicare has a recovery claim against a provider, supplier, or beneficiary with respect to services or items that have already been paid by the Medicare program, except when the Medicare Secondary Payer recovery claim against the provider or supplier is based upon failure to file a proper claim as defined in 42 CFR part 411.

C. Actions That Are Not Initial Determinations

Actions that are not initial determinations and are not appealable under this the Chapter include, but are not limited to—

(1) Any determination for which CMS has sole responsibility, for example, whether an entity meets the conditions for participation in the program, whether an independent laboratory meets the conditions for coverage of services;

(2) The coinsurance amounts prescribed by regulation for outpatient services under the prospective payment system;

(3) Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a carrier has sole responsibility under Part B, such as the establishment of a fee schedule set forth in 42 CFR, part 414, subpart B or an inherent reasonableness adjustment pursuant to 42 CFR 405.502(g) and any issue regarding the cost report settlement process under Part A;

(4) Whether an individual's appeal meets the qualifications for expedited access to judicial review provided in 42 CFR § 405.990;

(5) Any determination regarding whether a Medicare overpayment claim should be compromised, or collection action terminated or suspended under the Federal Claims Collection Act of 1966, as amended;

(6) Determinations regarding the transfer or discharge of residents of skilled nursing facilities in accordance with §42 CFR 483.12;

(7) Determinations regarding the readmission screening and annual resident review processes required by 42 CFR part 483, subparts C and E;

(8) Determinations with respect to a waiver of Medicare Secondary Payer recovery under section 1862(b) of the Act;

(9) Determinations with respect to a waiver of interest;

(10) Determinations for a finding regarding the general applicability of the Medicare Secondary Payer provisions (as opposed to the application in a particular case);

(11) Determinations under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery against a third party payer with respect to services or items that have already been paid by the Medicare program;

(12) A contractor's, QIC's, ALJ's, or DAB determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision.

(13) Determinations that CMS or its contractors may participate in or act as parties in an ALJ hearing or DAB review;

(14) Determinations that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the beneficiary or the beneficiary’s subrogee;

(15) Determinations with respect to whether an entity qualifies for an exception to the electronic claims submission requirement under 42 CFR Part 424;

(16) Determinations by the Secretary of sustained or high levels of payment errors in accordance with section 1893(f)(3)(B); and

(17) A contractor's prior determination related to coverage of physicians' services.

(18) Requests for anticipated payment under the home health prospective payment system under 42 CFR § 409.43(c)(ii)(s); and

(19) Claim submissions on forms/formats that are incomplete, invalid, or do not meet the requirements of a Medicare claim and returned or rejected to the provider or supplier.

NOTE: Duplicate items and services are not afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate.

D. Initial Determinations Subject to Reopenings

Minor errors or omissions in an initial determination may be corrected only through the contractor's reopenings process. Since it is neither cost efficient or 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 as reopenings. In situations where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for reopening. A contractor must transfer the appeal request to the reopenings unit or other designated unit for processing. See chapter 33 of the Claims Processing Manual for more information on the reopenings process.

210 - Who May Appeal

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

A person with a right to appeal an initial determination is referred to in the remainder of these instructions as a "party." These include:

- A beneficiary:

  - In addition to his/her right to appeal Medicare's decision to deny or reduce payment on the basis of §1862(a)(1) of the Act, the beneficiary becomes a party to any request for redetermination filed by the physician. Since the beneficiary and the physician may have adverse interests in a decision regarding a refund, it is essential to notify the beneficiary in any case in which the physician requests redetermination of the denial or reduction in payment or asserts that a refund is not required because one of the conditions in chapter 30 is met. It is important to note that the beneficiary is always a party to an appeal of services rendered on their behalf, at any level (except when the beneficiary has assigned his/her appeal rights to a provider). These procedures apply to the QIC reconsideration process as well.

  - In addition to his/her right to appeal Medicare's decision to deny payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act, the beneficiary becomes a party to any request for redetermination filed by the supplier. Since the beneficiary and the supplier may have adverse interests in a decision regarding a refund, it is essential to notify the beneficiary in any case in which the supplier requests redetermination of the denial or asserts that a refund is not required because one of the conditions in chapter 30 is met.

- An institutional provider

- A participating provider or physician or other supplier (i.e., one who has agreed to take assignment on all items or services payable on behalf of a Medicare beneficiary);

- A nonparticipating physician has the same rights to appeal the carrier's determination in an unassigned claim for physicians' services if the carrier denies or

reduces payment on the basis of §1862(a)(1) as a nonparticipating or participating physician has in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the physician knew or should have known that Medicare would not pay for the service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the service or, if so informed, did not sign a statement agreeing to pay. While the time limits in §240 apply for filing requests for redetermination and hearing, refunds must be made within the time limits specified in chapter 30. Section 1842(l)(1) gives party status to nonparticipating physicians, for example, where:

1. A claim for an item or service is denied as not being reasonable and necessary under §1862(a)(1);

2. Where the physician has already collected payment from the beneficiary for the item or service in question; and

3. Where the physician is claiming that he/she did not know and could not reasonably be expected to know that the item or service would be denied as not being reasonable and necessary under §1862(a)(1);

- A nonparticipating supplier has the same rights to appeal the carrier's determination in an unassigned claim for medical equipment and supplies if the carrier denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act as a nonparticipating or participating supplier has in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the item or service. While the time limits in §310 apply for filing requests for redetermination, refunds must be made within the time limits specified in chapter 30. An adverse advance determination of coverage under §1834(a)(15) of the Act is not an initial determination on a claim for payment for items furnished and, therefore, is not appealable;

- A supplier of medical equipment and supplies furnishing items or services to a beneficiary not on an assigned basis and responsible for making a refund to the beneficiary under §1834(j)(4) of the Act has party status for that claim;

- A provider or supplier who otherwise does not have the right to appeal may appeal when the beneficiary dies and there is no other party available to appeal. See §210.1 for information on determining whether there is another party available to appeal;

- A Medicaid State agency or party authorized to act on behalf of the State; and

- Any individual whose rights with respect to the particular claim being reviewed may be affected by such review and any other individual whose rights with respect to supplementary medical insurance benefits may be prejudiced by the decision (e.g., an individual or entity liable for payment under 42 CFR Subpart E 424.60 in the case of a deceased beneficiary).

Neither the contractor nor CMS is considered a party to an appeal at the redetermination or reconsideration levels, and therefore does not have the right to appeal or to participate as a party at this stage in the administrative appeals process. At times, CMS will elect to become a party to an ALJ hearing or will make an agency referral of an ALJ decision or dismissal to the Departmental Appeals Board (DAB) and ask the DAB to review the ALJ's decision or dismissal under its own motion review authority. At times, an ALJ may ask for contractor's or QIC's input to a hearing. This does not change the contractor's party status.

NOTE: While a representative may request an appeal on behalf of the party that the representative represents, the representative is not a party to the appeal solely by virtue of being a representative. (See §270 for the rights and responsibilities of a representative.)

The provider of the item or service denied may represent the individual, but may not impose any financial liability on the individual in connection with such representation.

If limitation on liability is involved, the provider of the item or service may represent the individual only if the provider waives any rights for payment from the individual with respect to the services or items involved in the appeal.

210.1 - Provider or Supplier Appeals When the Beneficiary is Deceased

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

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, the contractor must determine whether another party is available to appeal by taking either of the following actions:

- The contractor may send a letter to the last known address of the beneficiary, or to the beneficiary's estate, if known. The letter should advise the beneficiary's estate (or anyone taking responsibility for the deceased's bills for medical or other health services) of the right to appeal the claim denial. The letter also should provide information that the provider or supplier wishes to appeal. The letter should provide the beneficiary's estate with the following three options:

    - Option 1: I wish to appeal this claim.
    - Option 2: I am not available to appeal, please process the provider's appeal and let me know of the result.
    - Option 3: I am available to appeal, but do not wish to exercise my right to appeal.

The contractor should allow the estate at least 10 days to respond, or the remainder of the time frame for requesting an appeal -- whichever is greater. If the estate does not respond in the allotted time frame, the contractor should annotate the file that no other party is available to appeal and continue to process the provider's or supplier's appeal. If the estate responds that it is available and wishes to appeal, the contractor should continue with the appeal and notify the provider or supplier of the results. If the estate indicates that it is not available to appeal, then the contractor should continue to process the appeal and notify the beneficiary's estate of the decision. If the estate indicates that it is available, but does not want to appeal, the contractor should dismiss the provider or

supplier's request on the basis that there is another party available, even though the party does not intend to pursue the appeal; or

The contractor may send a letter to the provider or supplier to request written confirmation that they are not aware of any other party available to appeal. The contractor should allow the provider or supplier 10 days to provide confirmation. If the contractor does not receive written confirmation within 15 days, it should dismiss the appeal on the basis that the provider or supplier did not confirm that there was no other party available to appeal.

220 - Steps in the Appeals Process: Overview

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

Regulations at 42 CFR 405.940- 405.942 provide that a party to a redetermination that is dissatisfied with an initial determination may request that the contractor make a redetermination. The request for redetermination must be filed within 120 days after the date of receipt of the notice of the initial determination (The notice of initial determination is presumed to be received 5 days from the date of the notice unless there is evidence to the contrary). Contractors cannot accept an appeal for which no initial determination has been made. The parties specified in §210 who are dissatisfied with a determination on their Part A or B claim have appeal rights.

The appeals process consists of five levels. Each level is discussed in detail in subsequent sections. Each level must be completed for each claim at issue prior to proceeding to the next level of appeal.

The appellant must begin the appeal at the first level after receiving an initial determination. Each level, after the initial determination, has procedural steps the appellant must take before appealing to the next level. If the appellant meets the procedural steps at a specific level, the appellant is then afforded the right to appeal any determination or decision to the next level in the process. The appellant may exercise the right to appeal any determination or decision to the next higher level, until appeal rights are exhausted. Although there are five distinct levels in the Medicare appeals process, the redeterminaton, level 1, is the only level in the appeals process that the contractor performs.

When an appellant requests a reconsideration with a QIC (level 2), the contractor must prepare and forward the case file to the QIC. Further, the contractor may have effectuation responsibilities for decisions made by the QIC. The contractor, however, does not have responsibility for reviewing the QIC's decision for accuracy. When an appellant requests an Administrative Law Judge (ALJ) hearing (level 3), the QIC must prepare and forward the case file to the HHS Office of Medicare Hearings and Appeals (OMHA). Further, the contractor may have effectuation responsibilities for decisions made at the ALJ, Departmental Appeals Board (DAB), and Federal Court levels.

In the chart below, levels 1 – 5 are part of the Administrative Appeals Process. If an appellant has completed all the first 4 steps of the administrative appeals process and is still dissatisfied, the appellant may appeal to the Federal courts, provided the appellant satisfies the requirements for obtaining judicial review.

CHART 1 - The Medicare Fee-for-Service Appeals Process

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	At least $100 remains in controversy.* For requests filed on or after January 1, 2006, at least $110 remains in controversy.
4. Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of DAB decision or declination of review by DAB	At least $1,050 remains in controversy.* For requests filed on or after January 1, 2006, at least $1,090 remains in controversy.

* Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy 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.

230 - Where to Appeal

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

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

CHART 2 - Where to File and Appeal

LEVEL	WHERE TO FILE AN APPEAL	
	Part A*	Part B
Redetermination	FI	Carrier
Reconsideration	QIC	QIC
ALJ Hearing	FI or HHS OMHA Field Office if heard by a QIC	Carrier or HHS OMHA Field Office if heard by a QIC
DAB Review	DAB or ALJ Hearing Office	DAB or ALJ Hearing Office

*Includes part B claims filed with the FI.

240 - Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

A. Time Limits For Each Level of Appeal

The time limits for filing appeals varies according to type of appeal:

- **Redetermination**- The time limit for filing a request for redetermination is 120 days from the date of receipt of the Medicare Summary Notice (MSN) or Remittance Advice (RA). See §240.1-240.8 for clarifications and exceptions to this rule.)

- **QIC Reconsideration**- The time limit for filing a request for reconsideration is 180 days from the date of receipt of the notice of the redetermination.

- **ALJ Hearing**- The time limit for filing a request for ALJ hearing is 60 days after the date of receipt of the reconsideration notice.

- **Departmental Appeals Board (DAB) Review**- The time limit for filing for a review by the DAB of the decision of the ALJ presiding at the hearing is 60 days from the date of receipt of the ALJ decision.

- **Judicial Review**- The time limit for filing for judicial review is 60 days from the date of the DAB's decision. A request filed with the contractor is considered to have been filed as of the date the contractor received it.

The contractor computes the time limit for requesting a redetermination by allowing 5 additional days beyond the time limit (120 days for a redetermination) from the date of the previous notice. This allows a 5-day period for mail delivery. The contractor allows for additional time if there is evidence that the mail delivery was longer than 5 days.

These time limits may be extended if good cause for late filing is shown. (See §240.1-240.8.) When an redetermination request appears to be filed late, the contractor makes a finding of good cause using the guidelines in §240.3) before taking any other action on the appeal.

B. Extension of Time Limit for Filing a Request for Redeterminaiton

The time limit for filing a request for redetermination may be extended in certain situations. Generally, providers, physicians or other suppliers are expected to file appeal requests on a timely basis. A request from a provider, physician, or other supplier to extend the period for filing the request for redetermination should not be routinely granted and such requests warrant careful examination. For a beneficiary request, more lenience should be given.

Upon request by the party that has missed the filing deadline, the contractor may extend the period for filing the request for redetermination. The procedures for finding good cause to excuse late filing are discussed below.

240.1 - Good Cause

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

If an appeal request is filed late, the contractor may extend the time limit for filing an appeal if good cause is shown (see §240.4 and §240.6). The contractor resolves the issue of whether good cause exists before taking any other action on the appeal.

NOTE: A finding by the contractor that good cause exists for late filing for the redetermination does not mean that the party is then excused from the timely filing rules for the reconsideration.

240.2 - General Procedure to Establish Good Cause

(Rev. 1136, Issued: 12-22-06, Effective: 01-01-07, Implementation: 04-02-07)

A. Establishing Good Cause for Beneficiaries When Insufficient or No Explanation or Evidence Was Submitted

If the appellant is a beneficiary, and there is insufficient or no explanation for the delay or no other evidence that establishes the reason for late filing, the contractor dismisses the redetermination request. The contractor explains in the dismissal letter that the beneficiary can request that the contractor vacate the dismissal by providing an explanation for the late filing to the contractor within 6 months of the dismissal of the redetermination request. If an explanation or other evidence is submitted within 6 months from the dismissal that contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the contractor (as applicable) makes a favorable good cause determination. Once it makes a favorable good cause determination, it considers the appeal to be timely filed and proceeds to vacate its prior dismissal and performs a redetermination.

For the purposes of counting workload in Contractor Reporting of Operational Workload Data (CROWD), this action should be counted as a redetermination and not a reopening.

If the contractor does not find good cause, the dismissal remains in effect. The contractor issues a letter explaining that good cause has not been established and the dismissal cannot be vacated. Although the appellant may not appeal a contractor's finding that good cause was not established when the appellant requested that the contractor vacate its dismissal, the appellant maintains their right to request a reconsideration of the dismissal by a QIC.

B. Establishing Good Cause for Providers, Physicians or Other Suppliers When Insufficient Evidence/Documentation was Submitted

When a provider, physician, or other supplier has failed to establish that good cause for late filing of an appeal request exists, the contractor dismisses the appeal request as untimely filed. It explains in the dismissal letter that if the provider, physician, or other supplier can provide additional evidence or documentation that good cause for late filing exists, and that the evidence must be submitted within 6 months from the date of the notice of dismissal.

If the provider, physician, or other supplier submits evidence to the contractor within 6 months of its dismissal that supports a finding of good cause for late filing, the contractor makes a favorable good cause determination. However, for late filings of providers, physicians or other suppliers, it should not routinely find good cause. If the contractor makes a favorable good cause determination, it must consider the appeal to be timely filed. The contractor vacates its prior dismissal and issues a redetermination.

For the purposes of counting workload in CROWD, this action should be counted as a redetermination and not a reopening.

If the contractor does not find good cause, the dismissal remains in effect. The contractor issues a letter explaining that good cause has not been established and the dismissal cannot be vacated. Although the appellant may not appeal a contractor's finding that good cause was not established when the appellant requested that the contractor vacate its dismissal, the appellant maintains their right to request a reconsideration of the dismissal by a QIC.

The closed date is the date of the dismissal, and the dismissal is reported on the Appeals Report (Form CMS-2590, CMS-2591, and CMS-2592 as appropriate).

240.3 - Conditions and Examples That May Establish Good Cause for Late Filing by Beneficiaries

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

A. Conditions

Good cause may be found when the record clearly shows or the beneficiary alleges that the delay in filing was due to one of the following:

- Circumstances beyond the beneficiary's control, including mental or physical impairment (e.g., disability, extended illness) or significant communication difficulties.

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration)

to the beneficiary (e.g., a party is not notified of her appeal rights or of the time limit for filing).

NOTE: Whenever a beneficiary is not notified of his/her appeal rights or of the time limits for filing, good cause must be found;

- Delay resulting from efforts by the beneficiary to secure supporting evidence, where the beneficiary did not realize that the evidence could be submitted after filing the request;

- When destruction of or other damage to the beneficiary's records was responsible for the delay in filing (e.g., a fire);

- Unusual or unavoidable circumstances, the nature of which demonstrate that the beneficiary could not reasonably be expected to have been aware of the need to file timely;

- Serious illness which prevented the party from contacting the contractor in person, in writing, or through a friend, relative, or other person;

- A death or serious illness in his or her immediate family; or

- A request was sent to a Government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired.

B. Examples

Following are examples of cases where good cause for late filing is found. This list is illustrative only and not all-inclusive:

- Beneficiary was hospitalized and extremely ill, causing a delay in filing;

- Beneficiary is deceased. Her husband, as representative of the beneficiary's estate, died during the appeals filing period. Request was then filed late by the deceased husband's executor;

- The denial notice sent to the beneficiary did not specify the time limit for filing for the redetermination; and

The request was received after, but close to, the last day to file, and the beneficiary claims that the request was submitted timely.

240.4 - Conditions and Examples That May Establish Good Cause for Late Filing by Providers, Physicians, or Other Suppliers

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

A. Conditions

Good cause may be found when the record clearly shows, or the provider, physician or other supplier alleges and the record does not negate, that the delay in filing was due to one of the following:

- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,

- Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes.

NOTE: Failure of a billing company or other consultant (that the provider, physician, or other supplier has retained) to timely submit appeals or other information is NOT grounds for finding good cause for late filing. The contractor does not find good cause where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused the late filing.

B. Examples

Following are a few examples of cases where good cause for late filing may be found. This list is not all-inclusive:

- A fire destroys the physician's records; and

A flood closes a supplier's office for an extended period of time, or such other natural catastrophe.

240.5 - Good Cause Not Found for Beneficiary, or for Provider, Physician, or Other Supplier

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

When the contractor does not grant a request for extension of time limit for filing a request for redetermination, it must advise the beneficiary, or provider, physician or other supplier. It sends a written notice stating that the request for extension has been denied, that the request for redetermination has been dismissed, and provides the reason why good cause was not found. It advises the party whose request it has dismissed that the party may not appeal the determination as to whether good cause for late filing exists.

250 - Amount in Controversy Requirements

(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

This section is informational only since the amount in controversy requirements only apply to the ALJ and Federal Court Levels.

Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy 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.

250.1 - Amount in Controversy General Requirements
(Rev.)

250.2 - Principles for Determining Amount in Controversy
(Rev.)

250.3 - Aggregation of Claims to Meet the Amount in Controversy
(Rev.)

260 - Parties to an Appeal
(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

Any of the persons/entities referenced in §210 are parties to an appeal of a claim for items or services payable under Part A or Part B and, therefore, may appeal the initial claim determination and any subsequent administrative appeal determinations or decisions made on all claims for items or services (assuming other requirements, such as filing within prescribed time limits are met).

270 - Appointment of Representative
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

(See 42 CFR 405.912, "Appointment of Representative.")

NOTE: See also Section 270.3, "Medicare Secondary Payer (MSP) Specific Limitations or Additional Requirements With Respect to the Appointment of Representatives."

270.1 - Appointment of Representative - Introduction
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A party may appoint any individual, including an attorney, to act as his/her representative in dealings with the contractor. Although some parties may pursue a claim or an appeal on their own, others will rely upon the assistance and expertise of others. A representative may be appointed at any point in the appeals process. A representative may help the party during the processing of a claim or claims, and/or any subsequent appeal. (See §270.1.10 for information on disclosing information to third parties) The appointment of a representative is valid for one year from the date signed by both the party and the appointed representative.

NOTE: A representative must sign the appointment within 30 calendar days of the party's signature. The appointment remains valid for any subsequent levels of appeal on the item/service in question unless the beneficiary specifically withdraws the

representative's authority. (See §270.1.3.) New appeals may be initiated by the representative within the 1-year timeframe. To initiate a new appeal within the 1-year timeframe, the representative must file a copy of the CMS-1696, or other conforming written instrument, with the appeal request. In order for the appointment to be valid, it must be signed and dated by the beneficiary.

270.1.2 - Who May Be a Representative

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Any individual may be appointed to act as a representative unless he/she is disqualified, suspended, or otherwise prohibited by law from acting as a representative in proceedings before DHHS, or in entitlement appeals, before SSA. A contractor should not accept an appointment of representative if it has evidence that the appointment of representative should not be honored. It should notify the party attempting to be represented and the individual attempting to represent the party that the appointment will not be honored. A specific individual must be named as the representative. An organization or entity may not be named as a representative, but rather a specific member of that organization or entity must be named. This ensures that confidential beneficiary information is released only to the individual so named.

A provider or supplier who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative of the beneficiary. To act as the beneficiary's representative, the provider or supplier must meet the criteria set forth in this section. If the requestor is the beneficiary's legal guardian, surrogate decision-maker for an incapacitated beneficiary, or otherwise authorized under State law, no appointment is necessary, and the requestor is defined as the **authorized** representative.

NOTE: Billing clerks or billing services employed by the provider or supplier to prepare and/or bill the initial claim, process the payments, and/or pursue appeals act as the agent of the provider or supplier and do not need to be appointed as representative of the provider/supplier. Include evidence in the case file if the physician or other supplier employs a billing clerk or billing service (a screen print showing that payment is made to the billing clerk or billing service is sufficient.) If the billing clerk/billing service is not authorized to receive payment, but is authorized to process payments and/or pursue appeals, include evidence in the case file. If the agreement is on file, make a note in the case file where the agreement can be located. (See the Medicare General Information, Eligibility, and Entitlement Manual, which allows payment to be made to an agent who furnishes billing or collection services.)

The following is a list of the types of individuals who could be appointed to act as representative for a party to an appeal. This list is not exhaustive, and is meant for illustrative purposes only:

- Congressional staff members;
- Family members of a beneficiary;
- Friends or neighbors of a beneficiary;
- Member of a beneficiary advocacy group;
- Member of a provider or supplier advocacy group;
- Attorneys; and
- Physicians or suppliers.

270.1.3 - How to Make and Revoke an Appointment
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The party making the appointment and the individual accepting the appointment must either complete an appointment of representative form (CMS-1696) or use a conforming written instrument (see subsection B below, for required elements of written instruments). A party may appoint a representative at any time during the course of an appeal. The representative must sign the CMS-1696 or other conforming written instrument **within 30 calendar days** of the date the beneficiary or other party signs in order for the appointment to be valid. (See subsection A, below, for exceptions.) By signing the appointment, the representative indicates his/her acceptance of being appointed as representative.

A. Completing a valid Appointment of Representative (CMS-1696)

The CMS-1696 is available for the convenience of the beneficiary or any other party to use when appointing a representative. Following are instructions for completing the form.

1. The name of the party making the appointment must be clearly legible. For beneficiaries, the Medicare number must be provided.

2. **Completing Section I** – "Appointment of Representative"-A specific individual must be named to act as representative in the first line of this section; a party may not appoint an organization or group to act as representative. The signature, address, and phone number of the party making the appointment must be completed, and the date it was signed must be entered. Only the beneficiary or the beneficiary's legal guardian may sign when a beneficiary is making the appointment. If the party making the appointment is the provider or supplier, someone working for, or acting as an agent of, the provider or supplier must sign and complete this section.

3. **Completing Section II** – "Acceptance of Appointment"- The name of the individual appointed as representative must always be completed, and his/her relationship to the party entered. The individual being appointed then signs and completes the rest of this section.

4. **Completing Section III** – "Waiver of Fee for Representation"- This section must be completed when the beneficiary is appointing a provider or supplier as representative and the provider or supplier actually furnished the items or services that are the subject of the appeal.

5. **Completing Section IV –** "Waiver of Payment for Items or Services at Issue" – This section must be completed when the beneficiary is appointing a provider or supplier who actually furnished the items or services that are the subject of the appeal and involve issues describe in section 1879(a)(2) of the Act.

If any one of the elements listed above is missing from the appointment, the adjudicator shall contact the party (individual attempting to act as a beneficiary's representative) and provide a description of the missing documentation or information. Unless the defect is cured, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision. The adjudicator **shall not** dismiss the appeal request because the appointment of representative is not valid.

Prohibition Against Charging a Fee for Representation

A provider or supplier that furnished items or services to a beneficiary may represent that beneficiary on the beneficiary's claim or appeal involving those items or services. However, the provider or supplier may not charge the beneficiary a fee for representation in this situation. Further, the provider or supplier representative being appointed as representative must waive any fee for such representation. The provider or supplier representative does this by completing section III of the CMS-1696. Alternatively, the provider or supplier must include a statement to this effect on any other conforming written instrument being used, and must sign and date the statement.

Waiver of Right to Payment for the Items or Services at Issue

For beneficiary appeals involving the denial of the claim on the basis of §1862(a)(2) of the Act, and where a knowledge determination made under §1879 of the Act (i.e., a limitation on liability determination) and where the provider or supplier that furnished the items or services at issue is also serving as the beneficiary's representative, the provider or supplier must waive, in writing, any right to payment from the beneficiary for the items or services at issue (including coinsurance and deductibles). The provider or supplier representative does this by completing section IV of the CMS-1696 or other conforming written instrument, and must sign and date the statement.

The prohibition against charging a fee for representation, and the waiver of right to payment from the beneficiary for the items or services at issue, do not apply in those situations in which the provider or supplier merely submits the appeal request on behalf of the beneficiary or at the beneficiary's request (i.e., where the provider or supplier is not also acting as representative for the beneficiary), or where the items or services at issue were not provided by the provider or supplier representative.

B. Revoking an Appointment

The party appointing a representative may revoke the appointment by providing a written statement of revocation to the contractor at any time.

270.1.4 - When to Submit the Appointment

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A representative, beneficiary, or other party may submit the completed appointment to the contractor at the time such person files a request for appeal or at any time during the processing of the appeal. If an appeal or other motion is filed by a representative on behalf of a party to the appeal, but does not include an appointment, the contractor takes the actions specified below in §270.1.8 to secure the written appointment.

If a valid CMS-1696, or other conforming written instrument, has previously been filed with the contractor and remains valid within the time frames of §270.1.7, the representative need not submit a copy with future requests at higher levels of appeal. If a new appeal is initiated during the 1-year timeframe of the appointment, a copy of the appointment must be filed with the appeal request.

270.1.5 - Where to Submit the Appointment

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

When the appellant or representative submits the original or a copy of the signed CMS-1696 or other conforming written statement to the contractor, the contractor places it in the case file. The representative should also give the party making the appointment a copy of the completed form.

270.1.6 - Rights and Responsibilities of a Representative

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

In representing an appellant before a contractor, the representative has certain rights and responsibilities.

A. Authority of an Appointed Representative

A representative may represent a party in an appeal of a claim. An appointed representative may, on behalf of the party; obtain appeal information about the claim to the same extent as the party, submit evidence, make statements about facts and law, and make any request, or give or receive, any notice about the appeal proceedings.

When a contractor takes action or issues a redetermination, it shall send notice to only the appointed representative. Notice shall not be sent to the party if there is an appointed representative.

The contractor shall send any requests for information or evidence regarding an appeal only to the appointed representative.

See also, section 270.3 for MSP specific requirements.

B. Responsibilities of an Appointed Representative

An appointed representative must-

- Inform the party of the scope and responsibilities of the representation.

- Inform the party of the status of the appeal and the results of actions taken on behalf of the party such as notification of appeal determinations, decisions, and further appeal rights.

- Disclose to a beneficiary any financial risk and liability of a non-assigned claim that the beneficiary may have.

- Not act contrary to the interest of the party, and

- Comply with all laws and CMS regulations, CMS Rulings, and instructions.

The appointment of a representative by a party must be made freely and without coercion. The contractor should assume that a representative is not making false or misleading statements, representations, or claims about any material fact affecting any person's rights. However, if the contractor has reason to believe that the representative is making false or misleading statements, representations or claims about any material fact affecting any persons rights, it should refer the matter to the Program Safeguard Contractor (PSC). A representative will have access to personal and confidential medical and other information about a beneficiary(ies). The contractor may assume that the representative will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, it may assume that a representative is not disclosing any personal or confidential medical or other information about a beneficiary(ies) outside of the appeals process.

Unless otherwise directed by the party making the appointment, the contractor need not keep the represented party informed of the purpose of the appointment, the scope of the appointment, and exactly when/under what circumstances the appointment will be exercised, since it may assume the representative has taken on this responsibility. Further, the representative should keep the party informed on the progress of an appeal.

C. Delegation of Appointment by Appointed Representative

An appointed representative may delegate the appointment if the following conditions are met;

- The appointed representative provides written notice to the party of the appointed representative's intent to delegate to another individual. The notice must include the name of the designee and the designee's acceptance to be obligated and comply with the requirements or representation under this subpart.

- The party accepts the designation by signing a written statement to that effect. This signed statement is not required when the appointed representative and designee are attorneys in the same law firm or organization.

270.1.7 - Duration of Appointment

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

An appointment is considered valid for 1 year from the date that the CMS-1696 or other conforming written instrument contains the signatures of both the party and appointed representative. For the administrative convenience of both the party making the appointment and the representative, the representative may maintain a completed appointment on file and then submit a copy with each new appeal request. (See subsections below for more detail.)

Allowing the representative to use the same appointment for up to one year will help reduce the paperwork involved in representing parties. Requiring that a new appointment be executed on a yearly basis will help ensure that there is an ongoing relationship between the party and his/her representative.

Upon receipt of an appointment, the contractor **may** notify the representative of the need to complete a new appointment on a yearly basis. This will make both the party making the appointment and the representative aware of the need for annual filing of an appointment. The contractor **may** also place information about appointment validity in provider newsletters, bulletins, educational materials, etc.

The appointment remains valid throughout any and all subsequent levels of administrative appeal on the claim or claims at issue. Therefore, the representative need not secure a new appointment when proceeding to the next level of appeal on the same claim(s). This holds true regardless of the length of time it may take to resolve the appeal. The appointed representative may also file new appeals during the 1 year duration of the appointment, and shall submit a copy of the CMS-1696, or other conforming written instrument, with the appeal request.

270.1.8 - Curing a Defective Appointment of Representative

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If any one of the required elements named in §270.1.3 is missing, the contractor shall contact the party (the individual attempting to act as the beneficiary's representative) and provide a description of the missing documentation or information. If the defect is not cured, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

Handling these situations depends on who (what party) is attempting to make an appointment. When the beneficiary makes the appointment, the contractor provides help and assistance to the beneficiary and representative in securing the appointment, based on the time frames set forth below. When a provider or physician or other supplier makes the appointment, the contractor provides instruction on the proper and timely completion of the appointment. The following provides guidance on properly responding to a representative's attempt to submit a request for appeal.

A. Timely Filed Appeal Request With a Appointment Missing or Defective

There are different rules for missing appointments versus defective appointments.

1. Missing or Defective Appointment When Beneficiary is the Represented Party

When an individual is attempting to act as beneficiary's representative, but submits an incomplete or defective CMS-1696 or other conforming written instrument, the contractor shall advise the individual of how to complete the appointment, and shall notify the individual to submit the completed appointment to the contractor based on the time limits below. The contractor shall include in the notice any relevant information the individual should know if the individual fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, will not be the official representative). Should the CMS-1696 or written instrument not be corrected within the time limits set forth below, the contractor proceeds with processing and rendering a decision on the appeal. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the unauthorized representative. This will ensure that the beneficiary receives an appeal, as the presumption here is that the appeal originated with the beneficiary and was submitted with the beneficiary's knowledge and consent.

However, if the contractor has information or evidence that the appointment was not submitted at the request of the beneficiary, it shall not conduct the appeal unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval.

When an individual is attempting to act as a representative of an appellant who is a beneficiary but fails to complete CMS-1696 or other conforming written instrument, the contractor considers the missing appointment to be an incomplete form or written statement and follows the instructions above. In cases of appeals filed on behalf of the beneficiary, the contractor need not develop an absent appointment of representative if the request for redetermination clearly shows the beneficiary knew of or approved the submission of the request for redetermination.

When there is information or evidence that the appeal request and/or the appointment of representative was not submitted at the request of the beneficiary, the contractor shall verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary). In order to verify the wishes of the beneficiary, the contractor may have to send a letter to the beneficiary explaining the situation. The letter shall advise that if no response is received then the appointment of representative will not be honored.

The contractor notifies both the alleged representative and the party of the incomplete or defective CMS-1696 or other conforming written instrument and describes the documentation/missing information that is required to execute a valid form or statement. It allows 14 calendar days for a corrected appointment to be submitted. If, at the end of

the time allowed a corrected appointment has not been submitted, the contractor takes the appropriate action.

2. Defective or Missing Appointment When Provider or Physician, Other Supplier, or Nonbeneficiary is the Represented Party

In cases where the beneficiary is **not** the represented party, the contractor notifies both the person submitting the appointment and the appellant of the incomplete appointment. It advises the party why the appointment is defective, and describes the documentation or missing information that is required to complete the appointment. This may be done by telephone or written notification. A corrected/completed appointment may be submitted to the contractor by facsimile, at the contractor's discretion, or by mail within 14 days. Should the CMS-1696 or other conforming written instrument **not** be corrected within the time limit, the contractor **dismisses** the appeal request and notifies, in writing, both the appellant and the person submitting the appointment of the contractor's dismissal. Further, the dismissal shall state that an appeal request may be resubmitted by anyone (including the representative if the representative has properly completed the appointment) if the time limit for submitting the appeal has not expired.

If the individual is attempting to act as a representative of an appellant who is **not** the beneficiary and fails to include a CMS-1696 or other conforming written instrument with the appeal request, the prospective appointed representative lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

B. Untimely Appeal Request Submitted With an Incomplete or Defective Appointment

Because an untimely-filed appeal request is not always dismissed (e.g., there could be the finding of good cause for late filing), an incomplete or defective CMS-1696 or other conforming written instrument may, in some cases, need to be corrected. If an incomplete or defective appointment needs to be corrected, the contractor follows the instructions contained in §270.1.8, above, prior to proceeding with the appeal request.

C. Untimely Appeal Request Submitted With a Valid Appointment

These cases should be resolved solely on the basis of whether there is good cause. (See §240.1.)

270.1.9 - Incapacitation or Death of Beneficiary

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If at any time after the execution of a valid appointment or **nondurable** power of attorney the beneficiary becomes incapacitated and is unable to manage his/her affairs, the appointment becomes invalid. The contractor shall resolve who has legal authority to act on behalf of the beneficiary before disclosing any further information pursuant to the appointment or nondurable power of attorney.

If the beneficiary has executed a **durable** power of attorney that authorizes the designated person to conduct the beneficiary's affairs, or to make financial decisions on behalf of the beneficiary, the representation does not become invalid upon the beneficiary's subsequent incapacitation.

NOTE: Some durable powers of attorney do not become effective until and unless such an incapacitation occurs.

The death of a party terminates the authority of the appointed representative. However, if an appeal is in progress and another individual or entity may be entitled to receive or obligated to make payment for the items or services that are the subject of the appeal, the appointment remains in effect for the duration of the appeal. See also, section 270.3 for MSP specific limitations or additional requirements.

If the beneficiary is deceased, the legal representative of the estate may file the request. In the absence of a legal representative, any person who has assumed responsibility for settling the decedent's estate may file it. In these situations, the contractor shall obtain proof that the person has assumed responsibility for settling the decedent's estate (e.g., a will or probate court document). What is acceptable as legal documentation may vary according to State law. The contractor shall notify the person filing the appeal about the documentation needed to show the person is either the legal representative of the estate or the person who has assumed responsibility for settling the decedent's estate and describe the types of documentation needed. Allow at least 14 calendar days for the documentation to be submitted. If, at the end of the time allowed, the documentation needed is not submitted, dismiss the request. If the appellant submits the documentation after the allotted time, the contractor considers good cause for late filing. In such instances, the contractor documents the file to show the basis for that person's filing the appeal.

270.1.10 - Disclosure of Individually Identifiable Beneficiary Information to Representative

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

In accordance with the provisions of the Privacy Act, before the contractor may release beneficiary-specific information to a representative, the beneficiary or appellant must complete and sign CMS-1696, or other conforming written instrument, naming that individual as his/her representative. The contractor shall use caution in releasing beneficiary-specific information to representatives. The representative is entitled to receive only information that the party (beneficiary or appellant) would be entitled to receive (e.g., the determination letter) and that which is pertinent to the case/claim for which the representative is being appointed.

For more information about the disclosure of identifiable information about beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

270.2 – Assignment of Appeal Rights

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

(See 42 CFR 405.912, "Assignment of Appeal Rights.")

270.2.1 - Assignment of Appeal Rights – Introduction
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A beneficiary may assign his or her appeal rights to a provider or supplier who furnished an item or service to the beneficiary that is at issue in an appeal. Only providers or suppliers who are not a party to the initial determination may accept assignment of appeal rights from a beneficiary (See §210 for information on who is a party to an appeal.)

Because beneficiaries have difficulty understanding the term "assignment of appeal rights", we use the term "transfer of appeal rights" on the related form and for communication to beneficiaries. For the remainder of these instructions, we will also use the term "transfer" instead of "assignment" of appeal rights, whenever appropriate. The transfer of appeal rights is valid for the duration of the appeal, unless revoked by the beneficiary.

270.2.2 - Who May Be an Assignee
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Only a provider or supplier that is not a party to the initial determination and furnished an item or service to the beneficiary may accept the transfer of a beneficiary's appeal rights for that item or service.

An individual or entity who is not a provider or supplier may not accept the transfer. A provider or supplier that furnishes an item or service to a beneficiary may not accept the transfer for that item or service when considered a party to the initial determination.

270.2.3 - How to Make and Revoke a Transfer of Appeal Rights
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The beneficiary making the transfer (assignor) and the provider or supplier accepting the transfer (assignee) must complete the CMS standardized Transfer of Appeal Rights form (Form CMS-20031). This form is entitled, "Transfer of Appeal Rights". **No alternative written instrument may be used.** The assignee must sign the CMS-20031 **within 30 calendar days** of the date the beneficiary signs in order for the transfer to be valid.) By signing the CMS-20031, the provider indicates his/her acceptance of being the assignee. Page two of the form provides information to the beneficiary about transferring appeal rights.

A. Completing a valid Transfer of Appeal Rights Form CMS-20031

Form CMS-20031, Transfer of Appeal Rights, is the required form that beneficiaries must use to assign their appeal rights. Following are instructions for completing the form. "Transfer of Appeal Rights," Form CMS-20031)

1. The name of the beneficiary transferring appeal rights must be clearly legible. The beneficiary's Medicare number must be provided.

2. **Completing Section I** – "Transfer of Appeal Rights"-The beneficiary must complete this section. This section includes name, Medicare number, address and phone number, and the item or service that is at issue. The beneficiary must sign the transfer statement and include the date. Only the beneficiary may sign this section.

3. **Completing Section II** – "Acceptance of Appeal Rights"- The provider or supplier accepting the appeal rights must complete this section. This section includes name, address, phone number. The provider or supplier must sign this section to accept the transfer of appeal rights and agree not to collect payment from the beneficiary for the item or service at issue, except for any applicable deductible or coinsurance, or if a valid Advance Beneficiary Notice (ABN) is in effect.

4. If the form is not complete the adjudicator should contact the party and provide a description of the missing information. Unless the defect is cured, the provider or supplier lacks the authority to accept the appeal rights of the beneficiary, and is not entitled to take action regarding the appeal or obtain or receive any information related to the appeal, including the appeal decision. The adjudicator **should not** dismiss the appeal request because the transfer of appeal rights is not valid.

B. Waiver of Right to Payment for the Items or Services at Issue

The provider or supplier who accepts the appeal rights must waive the right to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form. The waiver to collect payment remains in effect regardless of the outcome of the appeal decision.

This waiver remains valid unless the transfer is revoked **by the beneficiary** as described in subsection D, below.

C. Duration of a Valid Transfer of Appeal Rights

Unless revoked, the transfer of appeal rights is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary.

D. Revoking a Transfer of Appeal Rights

The party appointing a representative may revoke the transfer of appeal rights by providing a written statement of revocation to the adjudicator at any time. If revoked, the rights to appeal revert to the beneficiary. The transfer may be revoked in the following ways:

1. In writing by the beneficiary. The revocation must be delivered to the adjudicator and the provider or supplier and is effective on the date or receipt by the adjudicator.

2. By abandonment if the assignee does not file an appeal of an unfavorable decision.

3. By an act or admission by the assignee that is determined by an adjudicator to be contrary to the financial interests of the beneficiary.

270.2.4 - When to Submit the Transfer of Appeal Rights

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A provider or supplier may submit the completed transfer of appeal rights form to the contractor at the time he or she submits an appeal request. The provider or supplier may obtain the completed transfer of appeal rights form from the beneficiary at the time that the services are provided, and file the previously signed form with the appeal.

270.2.5 - Where to Submit the Transfer of Appeal Rights
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

When the provider or supplier submits the original or a copy of the signed transfer of appeal rights form, the contractor shall place it in the case file. The provider or supplier should also give the beneficiary a copy of the completed form.

270.2.6 - Rights of the Assignee of Appeal Rights
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

When a valid transfer of appeal rights is executed, the beneficiary transfers all appeal rights involving the item or service at issue to the provider or supplier.

The transfer of appeal rights by a beneficiary must be made freely and without coercion. The contractor shall assume that a provider or supplier is not making false or misleading statements, representations or claims about any material fact affecting any person's rights. However, if the contractor has reason to believe that the assignee is making false or misleading statements, representations or claims about any material fact affecting any person's rights, it shall refer the matter to the PSC. A provider or supplier accepting the transfer of appeal rights will have access to personal and confidential medical and other information about a beneficiary. The contractor shall assume that the provider or supplier will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, it shall assume that a provider or supplier is not disclosing any personal or confidential medical or other information about a beneficiary outside of the appeals process.

A beneficiary transfers all appeal rights involving the item or service at issue to the provider or supplier, these include, but are not limited to-

1. Obtaining information about the claim to the same extent as the beneficiary;
2. Submitting evidence;
3. Making statements about facts or law; and
4. Making any request, or giving, or receiving any notice about appeal proceedings.

When a contractor takes action or issues a redetermination, it shall send notice to only the assignee. Notice shall not be sent to the beneficiary if there is an assignee.

The contractor shall send any requests for information or evidence regarding an appeal only to the assignee.

270.2.7 - Duration of Transfer of Appeal Rights
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Unless revoked the transfer of appeal rights is valid for all levels of appeal including judicial review. This transfer remains in effect even in the event of the death of the beneficiary

270.2.8 - Curing a Defective Transfer of Appeal Rights

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If any one of the elements is missing from the CMS-20031, the contractor shall contact the party and provide a description of the missing documentation or information. If the defect is not cured, the prospective assignee of appeal rights lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

The contractor shall provide help and assistance to the beneficiary and provider or supplier in securing the transfer of appeal rights, based on the time frames set forth below.

A. Timely Filed Appeal Request With a Transfer, Missing or Defective Missing or Defective Transfer of Appeal Rights

The contractor shall notify both the provider/supplier submitting the CMS-20031 and the beneficiary. The contractor shall advise them why the transfer is defective, and describes the missing information that is required to complete the transfer. This may be done by telephone or written notification. A corrected/completed transfer may be submitted to the contractor by facsimile, at the contractor's discretion, or by mail within 14 days. Should the CMS-20031 not be corrected within the time limits set forth below, the contractor proceeds with processing and rendering a decision on the appeal. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the unauthorized assignee. This will ensure that the beneficiary receives an appeal, as the presumption here is that the appeal originated with the beneficiary and was submitted with the beneficiary's knowledge and consent. However, if the contractor has information or evidence that the transfer was not submitted at the request of the beneficiary, it shall not conduct the appeal unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval.

B. Untimely Appeal Request Submitted With an Incomplete or Defective Transfer

Because an untimely-filed appeal request is not always dismissed (e.g., there could be the finding of good cause for late filing, see §240.1), an incomplete or defective CMS-20031 may, in some cases, need to be corrected. If an incomplete or defective CMS-20031 needs to be corrected, the contractor shall follow the instructions contained in Section A, above prior to proceeding with the appeal request.

C. Untimely Appeal Request Submitted With a Valid Transfer

These cases should be resolved solely on the basis of whether there is good cause. (See §240.1.)

270.2.9 - Disclosure of Individually Identifiable Beneficiary Information to Assignees

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

In accordance with the provisions of the Privacy Act, before the contractor may release beneficiary-specific information to an assignee, the beneficiary must complete and sign an CMS-20031 naming that individual as his/her assignee. The contractor shall use caution in releasing beneficiary-specific information to assignees. The assignee is

entitled to receive only information that the beneficiary would be entitled to receive (e.g., the determination letter) and that which is pertinent to the case/claim for which the assignee being appointed.

A beneficiary must explicitly authorize the release of any information that is not specific to the case/claim for which the assignee has been appointed. Any questions as to whether information needs authorization to be released to an assignee can be directed to the appropriate RO.

For more information about the disclosure of identifiable information about beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.

270.3 - Medicare Secondary Payer (MSP) Specific Limitations or Additional Requirements

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The following instructions/rules apply with respect to MSP recovery claims, not withstanding any language to the contrary in other subsections of "Section 270 Appointment of Representative."

For a MSP recovery claim involving a beneficiary debtor, the representative relationship typically arises in the context of the beneficiary's claim against a workers' compensation plan, liability insurance (including self-insurance), or no-fault insurance. The representative is not hired solely to represent the beneficiary with respect to the recovery demand letter/debt at issue on appeal; the representative is routinely hired in connection with an underlying liability, no-fault or workers' compensation claim.

For MSP recovery claims involving a debtor other than a beneficiary or a provider/supplier, follow the instructions in the MSP IOM, Pub. 100-05, Chapter 7, section 10, regarding authorization to represent a debtor. For MSP recovery claims involving a provider/supplier debtor, follow the instructions for non-MSP.

The instructions below contain exceptions or additions to the non-MSP rules for MSP recovery claims **involving a beneficiary debtor**.

A. Appointment of Representative

For MSP recovery claims involving a beneficiary debtor, the representative relationship may be established in the following ways (the document must always include the beneficiary's HICN as well as his/her name):

1. If the representative is an attorney, by –

   - A copy of the fee agreement between the beneficiary and the attorney, signed by the beneficiary and signed/countersigned by the attorney,
   - A statement on the attorney's letterhead accompanied by a release signed by the beneficiary, or
   - A document compliant with the non-MSP rules.

2. If the representative is a non-attorney, follow the non-MSP rules. However, note that information may be released to a non-representative regardless of whether or not

there is a proper appointment of representative if the individual or entity has a proper HIPAA compliant release from the beneficiary.

B. Duration of Appointment

The duration of the appointment lasts until revoked by the beneficiary absent specific language in the appointment document limiting the duration of appointment. This is true regardless of whether or not an appeal has been filed within 1 year of the date of the appointment.

C. Correspondence

Both the beneficiary and the representative shall receive copies of all correspondence (including all appeals determinations).

D. Death of a Beneficiary

The death of the beneficiary terminates the authority of any representative appointed by the beneficiary. The representative must obtain a new appointment from the beneficiary's estate or the individual assuming responsibility for the estate if there is no formally appointed executor.

280 - Fraud and Abuse

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

280.1 - Fraud and Abuse – Authority

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

To protect the Medicare program from fraud and abuse, civil and criminal violation provisions have been included in §§1107, 1128A, 1128B, 1872, and 1877 of the Act.

280.2 - Inclusion and Consideration of Evidence of Fraud and/or Abuse

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The contractor shall inquire fully into the matters at issue by receiving, in evidence, the testimony of witnesses and any documents that are relevant to the claims at issue. If the contractor believes that evidence has been tampered with it shall refer this documentation to either the medical review or the PSC units for their follow-up.

The contractor may receive evidence obtained and provided by the PSC concerning fraud or potential fraud with respect to the claim(s) at issue. If the PSC provides such evidence, it becomes part of the case file and must be made available for inspection by the appellant prior to the reconsideration. Evidence of this character is to be evaluated to determine issues such as whether, in conjunction with other credible evidence, the services in question were actually provided or were provided as billed.

280.3 - Claims Where There is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Where there is a substantial basis for determining that an item or service either was not furnished or was not furnished as billed, the contractor may deny or down-code payment, as appropriate. The reviewer must ensure that the case file clearly documents the evidence that formed the basis for the determination. Appeal rights after such a determination remain the same as they would for any other unfavorable decision. If the contractor has reason to believe or evidence to support that items or services were not furnished or were not furnished as billed, it shall send a copy of the decision to its PSC.

280.4 - Responsibilities of Adjudicators

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If, during the course of the redetermination, the reviewer suspects a civil or criminal law violation, the reviewer shall render a decision only on the coverage or payment issues raised by the redetermination request. Although the reviewer cannot make a determination of civil or criminal fraud, he/she may still deny or reduce payment if he/she believes that the items or services at issue were not rendered, or were not rendered as billed (as discussed above). In making this determination the reviewer may consider all available evidence, including witness testimony, medical records, and evidence compiled through a fraud investigation, as discussed above. (See §310.4 (B), below.) In addition to denying the claims because the services were not rendered as billed, if the reviewer suspects fraud, he/she shall forward information regarding the potential civil or criminal violation to the PSC. For further discussion on the Medicare fraud, see the Medicare Program Integrity Manual at:
http://www.cms.hhs.gov/manuals/108_pim/pim108toc.asp

280.5 - Requests to Suspend the Appeals Process

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The contractor does not have the authority to suspend redeterminations at the request of the Office of the Inspector General (OIG) or the Department of Justice (DOJ) without approval and direction from central office (CO). If the OIG or DOJ submits such a request to suspend a review or hearing, the contractor shall first bring that request to the attention of CO through the RO.

280.6 - Continuing Appeals of Providers, Physicians, or Other Suppliers Who are Under Fraud or Abuse Investigations

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Reviewers shall continue adjudicating the appeals of Medicare claims submitted by a provider, physician, or other supplier who is being or has been investigated, indicted, or convicted for fraud or abuse on other Medicare claims, or who is on Medicare payment suspension, unless the contractor has been informed that the provider, physician, or other supplier has agreed, as part of a settlement with the Government, or as the result of a prosecution, to withdraw the appealed claims or to waive the right to appeal the subject claim(s). If it has received notice of such a settlement, the contractor shall dismiss the appeal based on the fact that the appellant has waived his/her/its right to an appeal, and/or agreed to withdraw appeal of these claims as part of a settlement agreement with the Government. The contractor places a copy of the settlement document or other evidence

of a settlement in the file. A reviewer shall remain neutral in the adjudication of claims that involve a provider, physician, or other supplier who is being or has been investigated, indicted or convicted of fraud or abuse.

280.7 - Appeals of Claims Involving Excluded Providers, Physicians, or Other Suppliers

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The appeals process remains in effect for all claims with service dates prior to the effective date of exclusion, and any appeal rights of an excluded provider, physician, or other supplier may be exercised following the normal administrative appeals process.

The appeal rights of a beneficiary are present for all claims with service dates prior to the effective date of the exclusion, as well as for claims with service dates after the date of exclusion.

290 - Guidelines for Writing Appeals Correspondence

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The guidelines in this section are to be used when preparing appeals correspondence, which includes redeterminations decisions and inquiries about the status of appeals. These shall be handled as expeditiously as possible without lowering the quality of the response. General instructions on responding to beneficiary and provider/supplier communications are found in CMS Medicare Pub. 100-9. All other CMS-issued instructions on correspondence guidelines apply as well, including instructions on correspondence letterhead requirements.

290.1 - General Guidelines

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Contractors shall prepare appeals correspondence so the appellant can easily understand both the reason why any of the services were not covered or could not be fully reimbursed, and what action the appellant can take if the appellant disagrees with that decision. In addition, the following guidelines should be followed to the extent possible:

- Keep the language as simple as possible;
- Do not use abbreviations or jargon;
- Choose a positive rather than a negative tone, whenever possible. Avoid words or phrases that emphasize what cannot be done by the contractor or the appellant;
- If possible, avoid one sentence paragraphs, uneven spacing between paragraphs, etc;
- Apologize when appropriate, e.g., if the response is late. However, do not apologize for enforcing Medicare guidelines that may be adverse to the appellant's claim;
- Summarize the question before providing a response; and,
- Use correct spelling, grammar, and punctuation.

290.2 - Letter Format
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Appeals correspondence shall follow the instructions issued by CMS for contractor written correspondence letterhead requirements unless otherwise instructed and/or agreed to by CMS. In addition, please note the following:

- Numerical dates must not be used (i.e., instead of 6/16/98, use June 16, 1998);

- Type/font size smaller than 12 point must not be used (all responses are to be processed using a font size of 12 and a font style of Universal or Times New Roman or another style for the ease of reading by the beneficiary and the provider);

- When the subject matter is lengthy or complicated, bullet points should be used to clarify, if possible;

- For long letters, headings should be used to break it up (e.g., DECISION, BACKGROUND, RATIONALE);

- If procedure codes are cited, the actual name of the procedure must be associated with the code;

- Span dates may not be used for 1 day of service; and

- Letters that contain all capital letters appear impersonal and computer generated. The contractor should not use all capital letters.

Where the request for appeal involves multiple beneficiaries, the contractor shall produce separate decision or redetermination letters. This way, on requests with multiple beneficiaries each beneficiary is provided with a copy of their own determination without compromising the privacy of other beneficiaries' claims in the appeal. However, you can continue to send one consolidated letter to the provider.

290.3 - How to Establish Reading Level
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The MMA requires that appeals correspondence be written in a manner calculated to be understood by beneficiaries. Contractors shall write appeals correspondence that is understandable to beneficiaries. The purpose of this section is to provide some guidance to contractors on writing letters that are easy for beneficiaries to understand. To achieve this goal, contractors shall:

(1) Write in plain English/plain language with a clear, simple, conversational writing style with good communication of key points.

(2) Get reading levels of letters as low as you can without losing important content or distorting the meaning and without sounding condescending to the reader.

NOTE: This requirement does not apply to providers. Contractors can use a cover sheet for the beneficiary, when sending a copy of the decision.

290.3.1 - Writing in Plain Language

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The following are some tips to help contractors to write letters in plain language:

- Include definitions or explain terms you must use that are not familiar with your intended audience.

- Use heading, subheadings, or other devices to signal what's coming next. Labels for sections, headings, and subheading should be clear and informative to the intended audience.

- Write in an active voice and in a conversational style. For example, conversational style uses contractions (I'd instead of I would) and informal vocabulary (find out instead of determine).

- Use a friendly and positive tone.

- Use words that are familiar to your intended audience. Shorter words tend to be more common, and they are generally preferable. For example, use doctor instead of physician. Pay back instead of reimburse. Can get instead of eligible. There are exceptions. For example, access is a short word, but it is health care jargon that is hard for many consumers to understand. Organization is a five-syllable word, but is probably familiar to most readers.

- When a term is best known to your intended audience by its acronym, use the acronym and spell out the word that it represents in parenthesis with the letters that form the acronym in bold. For example: PCP (**P**rimary **C**are **P**rovider).

- Be on alert for words that are abstract or vague, or that may mean different things to different people. Replace these words with more specific words to be sure your readers understand the key messages.

- Keep your sentences simple and direct. Most should be reasonably short; about eight to ten words per sentence for most sentences. When sentences are long, the main point gets lost in all the words. Active voice makes the style more direct.

- Vary the length of your sentences. Somewhat longer, natural-sounding sentences of about 12 to 15 words can effectively break up the choppy effect of using many short sentences.

- Paragraphs should be relatively short. Short paragraphs are more inviting to your reader and give the visual appearance of being easier to read.

- Use simpler words rather than technical terms whenever you can without losing the content or distorting the meaning. Sometimes it's important to use a technical term, such as the words mammogram, or cholesterol.

- Appearance should be appealing at first glance. Pages should be uncluttered with generous margins and plenty of white space.

- The graphic design should use contrast, indentation, bullets, and other devices to signal the main points and make the text easier to skim.

- Use a large type and spacing between lines.

290.3.2 - Reading Levels

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Formulas are used to estimate reading level from the difficulty of the vocabulary and the sentences. While formulas are general indicators of the complexity of print materials, they shouldn't be the only indicator of difficulty. Contractors shall aim to get reading levels of letters as low as possible without losing important content or distorting the meaning and without sounding condescending to the reader. The **target** readability for decision letter is a 6th-9th grade reading level using one of the following formulas: Gunning Fog Index, Fry, SMOG, Flesh-Kincaid, or FOG.

Tips

- Formulas can produce choppy text that is actually harder to read. Don't try to make written material easier to read simply by shortening sentences and substituting shorter words for longer ones. You will end up with choppy text that is actually harder to read, despite an improved reading grade level score.

- Assume longer words are less familiar and harder to read than shorter ones, but note there are exceptions to this rule.

Use common terms where there are no alternatives. For example, for insurance industry terms or medical terms where there are no simple alternatives (e.g., hospital, mammogram, cholesterol, ambulance). Direct quotes from CMS policies can be excluded from reading level calculations as well as standard language provided by CMS, industry terms and medical terms where there are no alternatives.

290.4 - Required Elements in Appeals Correspondence

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The following should be used in all appeals correspondence:

- The name of the beneficiary/provider/physician/supplier to whom the letter is addressed rather than “Dear Sir/Madam;"

- Correspondence is identified by either the date on written correspondence or the date the written correspondence was received;

- The name of the provider, physician or supplier as well as the date(s) of service;

- When appropriate, an explanation in letters to beneficiaries, explaining why he/she is being sent a letter if the appeal came from the provider, physician or other supplier;

- The appeal determination/decision is placed in the beginning of the letter;

- Explicit rationale that describes why the items or services at issue do not meet Medicare guidelines. Merely stating that an item or service is “not medically reasonable and necessary under §1862(a)(1)” or “not medically reasonable and necessary under Medicare guidelines” does not provide any rationale. The rationale should include a description of the logic that led to the decision, references to the support for the basis of the decision, and other information that is relevant to support the decision in the case;

- When the appeals correspondence includes Medicare statutory citations, they must be related to the decision in layman’s terms. The statutory cite is listed as a parenthetical at the end of the sentence. For example, instead of beginning a sentence with, “§1879 of the Social Security Act states that...,” the sentence should start with “Under Medicare law, suppliers must....(§1879 of the Social Security Act)”;

- Whenever the person is to receive some further response, such as an MSN (if available), an estimated time frame as to when he/she will receive it is provided;

- Telephone number on all correspondence for additional questions;

- What, if anything, must be done next, and by whom;

- As appropriate, the results of any consultations with professional medical staff;

- When applicable, a statement advising the appellant that upon written request the contractor will provide them copies of regulations, statutes, and guidelines used in making the determination;

- For appeals, if the redetermination is partially or wholly favorable, an explanation about why the new determination is different from the previous determination; and

- The correspondence must be written in a clear manner and with a customer-friendly tone.

300 - Disclosure of Information
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

300.1 - General Information
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The basis for policy governing the disclosure and confidentiality of information collected by the contractor is §1106 of the Act, the Department's Public Information regulations, as well as the Privacy Act, and the Freedom of Information Act. In general, all information relating to an individual is confidential except as provided by regulation. In the interest of an appellant's right to due process, there are situations where information may be disclosed. The CMS regulations implementing §1106 of the Act can be found at 42 CFR Part 401, Subpart B. (See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.)

In addition, §1106 in title XI of the Act provides penalties for violation of the provisions concerning confidentiality of information. Activities prohibited under the provisions of the Act include, but are not limited to, making false and fraudulent statements, fraudulent concealment of evidence affecting payment benefits, false impersonation of another individual, misuse or conversion of payments for use of another, and improper disclosure of confidential information. (See the Medicare Program Integrity Manual.)

300.2 - Disclosure of Information to Third Parties
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If a beneficiary wishes to have his/her information disclosed to a third party without appointing that individual as a representative, this can be accomplished by the beneficiary or third party providing written authorization to the contractor for the release of the information. The written authorization must contain a signature of the beneficiary and an explanation of the type of information the beneficiary agrees to release to the individual. An example of this type of situation is where a beneficiary has asked a Member of Congress for assistance with his/her appeal. In this case, it may be necessary for the Member of Congress to receive the decision; however the Member of Congress does not wish to accept the responsibility associated with being the beneficiary's appointed representative or the beneficiary does not wish to appoint the Member of Congress as his/her representative. See §310.1 for more information on requests for redetermination submitted by Members of Congress. If the beneficiary wishes to appoint a representative, contractors should refer to §270.

300.3 - Fraud and Abuse Investigations
(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

Any and all evidence used by the contractor to arrive at a determination or decision shall be placed in the appeals case file (copies are fine). Information in the case file shall be made available to an appellant upon request. Therefore, the contractor shall be aware that information placed in the case file is accessible to an appellant. The PSC shall also understand that the contractor may not consider any evidence that has not been made a part of the case file. The PSC and the contractor shall therefore exercise discretion when deciding whether to place any of the following information into the appeals case file:

- The impetus behind a fraud and abuse investigation;

- The name of the beneficiary or any other person lodging the complaint that triggers the fraud and abuse investigation;

- Notes or transcripts of beneficiary interviews resulting from a fraud and abuse investigation;

- Records or information compiled for law enforcement purposes during a fraud and abuse investigation; or

- The name of a confidential source(s) when confidentiality has been promised by CMS in return for cooperation in a fraud and abuse investigation.

Where the contractor relies upon any of the above information in order to deny a claim or to render a less than fully favorable determination or decision, then an appellant has a due process right to review this information. If information is kept out of an appeals case file for confidentiality reasons, it may not be relied upon to deny or reduce payment.

300.4 - Medical Consultants Used

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The parties are entitled to know the identity and qualifications of any consultant whose evidence the contractor used to support the initial claim determination or the redetermination. If the contractor uses a consultant, it shall include the identity and qualifications of the consultant in the file for possible use by the ALJ, and for the appellant's use upon request. This applies to both external medical consultants and internal staff used to review the claim. An example of this would be the name and title of the medical consultant.

300.5 - Multiple Beneficiaries

(Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

If claims of more than one beneficiary are involved in the redetermination, and each beneficiary is being sent a copy of the decision, the contractor shall ensure the privacy of each beneficiary's records. The decision letter may be issued for each beneficiary, or the contractor may issue a basic decision letter, and include it with a cover letter to each beneficiary.

310 - Redetermination - The First Level of Appeal

(Rev. 688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

A party dissatisfied with an initial determination may request in writing that the contractor review its determination. A redetermination is the first level of appeal after the initial determination on Part A and Part B claims. It is a second look at the claim and supporting documentation and is made by a different employee. If an initial determination on a claim had not been made, there are not appeal rights on that claim (See §200 (C) for a list of actions that are not initial determinations and therefore do not have appeal rights). Previously, parties had the right to request a review or reconsideration over the telephone, however the regulations no longer provide this right. Contractors may choose to conduct telephone reopenings for clerical errors or omissions. (See §370.)

The reviewer must comply with, and is bound by, all applicable statutory and regulatory provisions. The reviewer may not overrule the provisions of the law or interpret them in a way different than CMS does; nor may the reviewer comment upon the legality, constitutional or otherwise, of any provision of the Act, regulations, or CMS policy in the review determination. The reviewer is also bound by all CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, change requests, national coverage determinations, carrier-issued local medical review policies (LMRP), regional medical review policies (RMRP), and local coverage determinations. The reviewer must consider the applicability of all CMS-issued policies and procedures (including LMRP and RMRP) to the facts of a given claim. The reviewer may not disregard or override an applicable LMRP or RMRP, nor may the reviewer change the amount required to be paid under the Physician Fee Schedule.

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 B of A initial determinations issued on or after May 1, 2005, the first level of appeal will be a redetermination. For all revised Part B initial determinations issued on or after January 1, 2006, 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).

310.1 - Filing a Request for Redetermination

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006;

Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

A request for redetermination must be filed with the contractor in writing. The request may be made by a party to the appeal as defined in §260 and/or the party's representative as defined in §270. Also, for beneficiaries there are special rules described below in subsection A.

A. Written Redetermination Requests Filed on Behalf of the Beneficiary

Someone other than an appointed representative may submit a written request for redetermination on behalf of a beneficiary. The contractor honors the request for redetermination if the request clearly shows the beneficiary knew of or approved the submission of the request for redetermination (e.g., the request is submitted with a written authorization from the beneficiary or with the beneficiary's MSN). However, if the contractor has information that the redetermination request was not submitted at the request of the beneficiary, the contractor does not conduct the redetermination unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval. The person submitting the request does not automatically become the representative until and unless an appointment of representative form or other written statement is completed (see §270 for instructions on developing an incomplete or absent appointment of representative). In cases of redeterminations filed on behalf of the beneficiary, the contractor need not develop an absent appointment of representative if the request for redetermination clearly shows the beneficiary knew of or approved the submission of the request for redetermination. However, the contractor may send the individual filing on behalf of the beneficiary a notice including information on how to become a representative of the beneficiary and what the individual should know if the individual fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, will not be the official representative).

Persons who often act on behalf of a beneficiary in filing a redetermination request include: the spouse, parent, daughter or son, sister or brother, or neighbor/friend. Beneficiary advocacy groups and Members of Congress may also submit a request for redetermination on behalf of a beneficiary (see below for further discussion on requests submitted by Members of Congress). Even though someone other than his/her appointed representative makes the redetermination request on behalf of a beneficiary, all written notices related to the appeal must be sent only to the beneficiary, not the individual making the request for redetermination.

Although the contractor may have honored a request for redetermination filed by someone other than the beneficiary or the beneficiary's appointed representative, only the beneficiary or representative should be contacted or consulted for further information when processing the redetermination and when issuing the determination (unless the requestor is the beneficiary's legal guardian, in which case no appointment is required). There will be circumstances where the mental and/or physical incapacity of the beneficiary becomes an issue. Based on all the documented medical information available, the contractor may decide to allow the person submitting the request for

redetermination to act on behalf of a beneficiary who is mentally or physically incapacitated. The contractor's decision, as well as the beneficiary's incapacitation, should be documented in the file and supported by relevant medical documentation. (See §270, for more information on this subject.)

1. Requests for Redetermination Submitted by Members of Congress

When the contractor has honored a request for redetermination filed by a Member of Congress pursuant to a Congressional inquiry made on behalf of a beneficiary or provider, physician or other supplier, the contractor may continue to provide a Member of Congress with status information on the appeal at issue. Status information includes the progression of the appeal through the administrative appeals process, including information on whether or when an appeal determination or decision has been issued and what the decision was (e.g., favorable, unfavorable, partially favorable), but does not include release of personal information about a beneficiary that the Member of Congress did not already have in his/her possession. A beneficiary may want a Member of Congress to obtain more detailed information about his/her appeal without appointing the Member of Congress as a representative. In this case it would be necessary for the beneficiary to sign a release of information. The contractor must accept any of the following as releases of information:

1. A signed copy of correspondence from the beneficiary expressing a desire for the congressional office to obtain information on his/her behalf;
2. A release of information form developed by the congressional office; or
3. A release of information form developed by the contractor for this purpose.

If the Member of Congress expresses an interest in acting as the representative of a beneficiary or of a provider, physician, or other supplier, the party must complete an appointment of representative form or written statement.

B. What Constitutes a Request for Redetermination

1. Written Requests for Redetermination Made by Beneficiaries

Beneficiaries may request a redetermination in writing by filing a completed Form CMS-20027. Beneficiaries may also request a redetermination in writing instead of using the form. Requests for redetermination may be submitted in situations where beneficiaries assume that they will receive a redetermination by questioning a payment detail of the determination or by sending additional information back with the MSN, but don't actually say: I want a review. For example, a written inquiry stating, "Why did you only pay $10.00?" is considered a request for redetermination. Common examples of phrasing in letters from beneficiaries that constitute requests for redetermination include, but are not limited to:

- "Please reconsider my claim."

- "I am not satisfied with the amount paid - please look at it again."

- "My neighbor got paid for the same kind of claim. My claim should be paid too."

Or the request may contain the word appeal or review. There may be instances in which the word review is used but where the clear intent of the request is for a status report. This should be considered an inquiry.

2. Written Requests for Redetermination Submitted by a State, Provider, Physician or Other Supplier

States, providers, physicians, or other suppliers with appeal rights must submit written requests indicating what they are appealing and why. There are two acceptable written ways of doing this:

a. A completed Form CMS-20027 constitutes a request for redetermination. The contractor supplies these forms upon request by an appellant. Completed means that all applicable spaces are filled out and all necessary attachments are attached.

b. A written request not on Form CMS-20027. The request contains the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- The specific service(s) and/or item(s) for which the redetermination is being requested;
- The specific date(s) of the service; and
- The name and signature of the party or the representative of the party.

NOTE: Some redetermination requests may contain attachments. For example, if the RA is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either (1) explicitly asks the contractor to take further action or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination. It must note the details of its actions (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.
How to handle incomplete requests: If any of the above information referenced in Section 2 is not included with the appeal request, the contractor dismisses it to the State or provider with an explanation of the information that must be included (See §310.6 for more information on dismissals). For beneficiary requests, refer to §310.1(B)(1) and §310.6.3.

2. **Letters and Calls That Are Considered Inquiries** - See CMS Pub. 100-09.The contractor considers the letter or telephone call an inquiry (i.e., not an appeal request) if:

- It is clearly limited to a request for an explanation of how Medicare calculated payment;

- It is a status request. The contractor states in its reply that it is responding to a status request. It does not use the word "review" in its reply;

- It is a request for information;

- The party asks only for a second copy of a notice; or

- There is not an initial determination.

For more information on inquiries, refer to Medicare Pub 100-09.

310.2 - Time Limit for Filing a Request for Redetermination

(Rev. 697, Issued: 10-07-05, Effective: 05-01-05, Implementation: 01-09-06)

A party must file a request for redetermination within 120 days of the date of receipt of the notice of initial determination (MSN or RA). The date of filing for requests filed in writing is defined as the date received by the contractor in the corporate mailroom. If the party has filed the request in person with the contractor, the filing date is the date of filing at such office, as evidenced by the receiving office's date stamp on the request. If the party has mailed the request for redetermination to CMS, SSA, RRB office, or another Government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired, the contractor considers good cause for late filing. (See §240 for more information on good cause.) Likewise, if the request is filed with CMS, SSA, RRB, or another Government agency in person, the contractor considers good cause for late filing.

The contractor may extend the period for filing if it finds the appellant had good cause for not requesting the redetermination timely. (See §240.2 for a discussion of good cause.) In order for good cause to be considered, the appeal request must be in writing. If the carrier finds that the appellant did not have good cause for not requesting a redetermination on time, it may, at its discretion, consider reopening. (See §370.)

310.3 - Reporting Redetermination on the Appeals Report

(Rev. 697, Issued: 10-07-05, Effective: 05-01-05, Implementation: 01-09-06)

The contractor is required to report all appeals related data and information on the CMS Appeals Report. The Report is intended to capture information on appeal requests or inquiries that are actually determined to be requests for redetermination of a claim, as referenced above. They should not be recorded as an inquiry.

310.4 - The Redetermination

(Rev. 1457; Issued: 02-22-08; Effective/Implementation: 03-24-08)

The redetermination is an independent, critical examination of a Part A or B claim made by contractor personnel not involved in the initial claim determination. In performing a redetermination of the services requested by the appellant, contractor personnel must examine all issues in the claim.

A. Timely Processing Requirements

The carrier must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of (D)(4) below). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom.

Completion is defined as:

1. For affirmations, the date the decision letter is mailed to the parties.

2. For partial reversals and full reversals, when all of the following actions have been completed:

   a. the decision letter is mailed to the parties, and
   b. the actions to initiate the adjustment action in the claims processing system are taken.

When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment.

3. For withdrawals and dismissals, the date dismissal notice is mailed to the parties.

B. Development of Appeal Case File

The reviewer must obtain and review all available, relevant information needed to make the determination. Other areas within the contractor may have information relevant to the claim(s) at issue. For example, the program integrity area (including medical review, overpayments, and fraud and abuse) may submit evidence to the reviewer for inclusion in the case file. Such evidence must be made available for inspection by an appellant upon request. Reviewers must exercise care in determining the weight to give fraud and abuse information where the source of the specified information is not provided. Although the name of the beneficiary or other source that provided the information that triggered an investigation is not always provided or necessary when reviewing the evidence, the case file must include information on the independent, subsequently developed investigation

that supports denial of the claim(s). (See subsection D, below, for instructions on development of documentation.)
The development of the case file is important not only for the redetermination, but also to prepare for a potential appeal to the QIC. Proper development of the case file will assist the contractor in timely transmitting the case file to the QIC upon request. In cases of large overpayment cases involving many claims, this case file development is extremely important. When a reconsideration request is filed with the QIC, and the QIC requests a case file for a large overpayment case, it is critical the QIC obtain the case file timely so it can begin adjudication. Therefore, it should be a priority for the contractor to adequately develop case files.

C. Elements of the Redetermination

The following elements are essential to performing an adequate redetermination:

- The reviewer must not be the same person who made the initial determination.

- How the contractor conducts its redetermination depends on the appellant's request and what is at issue. There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the amount paid, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable.

- If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed.

For appeals of a specific line item or service, the initial determination is the date of the first MSN or RA that states the decision. Adjustments to the claim that are included on later copies of the MSN or RA (and do not revise the initial determination) do not extend/change the appeal rights given under the initial determination. All other line items not yet reviewed may be reviewed within 120 days from the receipt of the initial determination, if requested.

Although the reviewer may not make a finding of criminal or civil fraud (see §280, "Fraud and Abuse"), the reviewer should review the claim to see if there is sufficient documentation and evidence supporting that the items or services were actually furnished or were furnished as billed.

If the appellant challenges the validity of the sampling methodology, the contractor reviews the claims in question as well as any statistical sampling used to extrapolate the overpayment amount. For background on how PSCs use statistical sampling to estimate

overpayments, see Pub. 100-08, chapter 3, section 10. If a reconsideration is subsequently requested, the entire case will be sent.
Per Pub. 100-06, chapter 3, sections 70 and 90, the contractor shall consider whether there was an overpayment, whether the amount of the overpayment was correctly calculated and extrapolated (if applicable), whether the appellant is liable for repayment, and whether recovery of the overpayment is waived.

Appellants must have the opportunity to submit written evidence and arguments relating to the claim at issue. This does not mean the reviewer must request such material, but he/she must accept and consider any relevant documentation submitted.

D. Requests for Documentation

1. Requesting documentation for State-Initiated Appeals

The reviewer should not request documentation directly from a provider or supplier for a State-initiated appeal. If additional documentation is needed, the reviewer should request that the submitter of the appeal (i.e., the State or the party authorized to act on behalf of the Medicaid State agency) obtain and submit necessary documentation.

2. Requesting documentation for Provider, Physician, Supplier, or Beneficiary-Initiated Appeals

For provider, physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the provider, physician, or other supplier of the timeframe the provider or supplier has to submit the documentation.

The reviewer documents his/her request in the redetermination case file. The requested documents may be submitted via facsimile, at the reviewer's discretion. In rare cases, a provider or supplier might inform the reviewer that he/she is having trouble obtaining the supporting documentation, such as hospital records. In this situation the contractor may provide the provider, physician or other supplier with assistance in obtaining records. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the reviewer conducts the redetermination based on the information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination. See 4 below for information on extension of the decision making timeframe for additional documentation that is submitted after the request.

3. Requesting documentation for Beneficiary-Initiated Appeals

For provider, physician, supplier, or beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. For beneficiary-initiated appeals, the reviewer

notifies the beneficiary (either in writing or via a telephone call) when the reviewer has asked the beneficiary's provider, physician, or supplier for additional documentation. The beneficiary is advised (either in the letter or during a telephone call) that the provider, physician, or other supplier has 14 calendar days to submit the additional documentation that has been requested, and that if the documentation is not submitted, the reviewer will decide based on the evidence in the case file. If the reviewer sends the beneficiary a letter, it must include a description of the documentation that has been requested.

4. Extension for Receipt of Additional Documentation

When a party submits additional evidence after filing the request for redetermination, the contractor's 60-day decision-making timeframe is automatically extended for 14 calendar days for each submission. This additional 14 days is allowed for all documentation submitted by a party after the request, even when the documentation was requested by the contractor. Although this extension is granted to contractor for making decisions, it should not routinely be applied unless extra time is needed to consider the additional documentation.

5. General Information

The contractor routinely includes instructions on the appropriate information to submit with appeal requests in its provider newsletters and other educational literature.

Providers, physicians and other suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.

310.5 - The Redetermination Decision

(Rev. 1276, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

The law requires contractors to conclude and mail the redetermination within 60 days of receipt of the appellant's request, as indicated in §310.4. The contractor mails an unfavorable redetermination to the appellant and copies to each party or authorized representative of the each party (as applicable). The contractor mails a fully or partially favorable redetermination to the appellant or authorized representative. Due to budget constraints, the requirement to send a fully favorable letter is not required until further notice, except in those situations where the parties will not receive notice of effectuation via a MSN or RA (MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.). For fully favorable, the contractor sends all parties the MSN or RA containing the adjustment action, if appropriate.

A. Favorable Determinations

If the determination is a full reversal (i.e., is fully favorable meaning when the Medicare approved amount minus any cost sharing provisions (insurance, deductibles, etc.) has been found payable), the contractor mails the appellant or appointed representatives a

brief notification of the decision within 60 days of receipt of the request. This requirement to send a fully favorable letter is not required until further notice due to budget constraints, except in those situations where the parties will not receive notice of effectuation via a MSN or RA (MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.). It sends an adjusted MSN or RA on the next scheduled release. The MSN provides the beneficiary with information as to his/her financial liability with regard to the claim(s) that are now payable.

If the determination is a partial reversal, the contractor sends all parties and appointed representative an adjusted MSN or RA and a redetermination letter including the rationale for the decision.

B. Determinations That Result in Refund Requirements

If, as the result of a denial, a provider or supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then the carrier must include the following language in the redetermination.

When the beneficiary is not liable, include the following language:

Therefore, you (the beneficiary) are not responsible for the changes billed by (provider's name) except for any charges for services never covered by Medicare. If you (the beneficiary) have paid (provider's name) for these service, you may be entitled to a refund. To get this refund, please contact this office and send the following items:

- A copy of this notice,
- The bill you received for the services, and
- The payment receipt, your cancelled check, or any other evidence showing that you have already paid (provider's name for the services at issue.

You should file your written request for payment within 6 months of the date of this notice.

If, as the result of a denial, a provider or supplier is required to make a refund to a beneficiary for amounts collected from the beneficiary for the items or services at issue, then the carrier must send a copy of the adjusted RA in the following situations:

1. A nonparticipating physician not accepting assignment who, based on the redetermination, now has a refund obligation under §1842(l)(1) of the Act;

2. A nonparticipating supplier not accepting assignment who is determined to have a refund obligation pursuant to §1834(a)(18), due to a denial under either §1834(a)(17)(B) or §1834(j)(4) of the Act; or,

3. A denial based on §1879(h) of the Act of an assigned claim submitted by a supplier, where it is determined under §1834(a)(18) of the Act that the supplier must

refund any payments (including deductibles and coinsurance) collected from the beneficiary.

310.6 - Dismissals

(Rev. 688, Issued: 09-23-05, Effective: FI Redetermination requests received on or after 05-01-05 and Carrier redetermination requests received on or after 01-01-06)

The contractor may dismiss a request for a redetermination under the following circumstances:

1. Request of Party

A request for redetermination may be withdrawn at any time prior to the mailing of the redetermination upon the request of the party or parties filing the request for redetermination. The request to withdraw is one of the reasons for which a case can be dismissed. A party may request a dismissal by filing a written notice of such request with the contractor or over the telephone. This dismissal of a request for redetermination is binding unless vacated by the contractor.

2. Dismissal for Cause

The contractor may dismiss a redetermination request, either entirely or as to any stated issue, under either of the following circumstances:

- Where the party requesting a redetermination is not a proper party or does not otherwise have a right to a redetermination.

3. Failure to File Timely

When a request for redetermination is not filed within the time limit required and the contractor did not find good cause for failure to file timely, it should dismiss the request.

4. Appointment of Representative is Incomplete or Absent

When an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment form and the appointment is not corrected within the time limit discussed above in §60.5.8.A.2 or when the individual fails to include an appointment with the appeal request, the contractor should dismiss the request.

NOTE: If the appellant resubmits appeal request with an appointment of representative form, the contractor does not count duplicate redetermination requests. (See chapter 6 of the Medicare Financial Management Manual, CMS Pub. 100-06.)

5. Party Failed to Make A Valid Request

When the contractor determines the provider, supplier, or State failed to make out a valid request for redetermination that substantially complies with § 310 (B) (1) or (2).

6. Beneficiary Dies While Request is Pending

When a beneficiary or the beneficiary's representative files a request for redetermination, but the beneficiary dies while the request is pending, and all of the following criteria apply:

(a) The beneficiary's surviving spouse or estate has no remaining financial interest in the case. In deciding this issue, the contractor considers if the surviving spouse or estate remains liable for the services for which payment was denied or a Medicare contractor held the beneficiary liable for subsequent similar services under the limitation of liability provisions based on the denial of payment for services at issue;

(b) No other individual or entity with a financial interest in the case wishes to pursue the appeal; and

(c) No other party filed a valid and timely redetermination request.

310.6.1 - Appeal Rights for Dismissals

(Rev. 1136, Issued: 12-22-06, Effective: 01-01-07, Implementation: 04-02-07)

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to a QIC 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 a redetermination. 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 CROWD on the 2590, 2591 and 2592 as appropiate as a "redetermination". A QIC's reconsideration of a contractor's dismissal of a redetermination request is final and not subject to any further review.

310.6.2 - Vacating a Dismissal

(Rev. 1136, Issued: 12-22-06, Effective: 01-01-07, Implementation: 04-02-07)

A party to the redetermination may also request the contractor to vacate its dismissal within 6 months of the date of the mailing of the dismissal notice if good and sufficient cause is established. The contractor determines if there is good and sufficient cause and if there is, the contractor vacates its prior dismissal and issues a redetermination. For the purposes of counting workload in CROWD, this action should be counted as a redetermination and not a reopening.

310.6.3 - Dismissal Letters

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006;

Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

The contractor must issue a written notice of dismissal to all parties to the appeal. It must include in the notice the information that, at the request of a party and for good and sufficient cause shown, it may vacate its dismissal of a request for redetermination at any time within 6 months from the date of its mailing of the notice of dismissal. The dismissal notice is sent to the party requesting the redetermination at his/her last known address, as well as to his/her representative and all other parties to the appeal. The dismissal notice includes the reason for the dismissal.

Contractors shall include the following language, or something similar, in dismissal letters (also see the model dismissal letter in Eexhibit 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 AC 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 or not the dismissal was appropriate. Send your request to:

Insert QIC Address

Incomplete Requests- The requirements for written requests for redetermination are found in §310.1(B)(2) (Note: Beneficiary requests are never considered incomplete, see §310.1(B)(1)). Contactors must handle and count incomplete redetermination requests as dismissals. The above requirements under §310.6.2 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 from 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 §310.6.4.

310.6.4 - Model Dismissal Notices

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006; Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

Medicare Number of Beneficiary:

111-11-1111 A

Model Redetermination

Dismissal Notice for Incomplete Request

Contact Information

If you have questions, write or call:

Contractor Name

Street Address

City, State Zip

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 the information 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 notice. When you file your request, please make sure you include all the above listed items. Please send your request to:

Insert AC 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 receipt 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 QIC 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 or not 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

Model Redetermination

Dismissal Notice For An Untimely Appeal

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 denial of 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 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 receipt 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 AC 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 or not the dismissal was appropriate. Please send your request to:

   Insert QIC Address

Sincerely.

Review Name
Contractor Name
A Medicare Contractor

310.7 - Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations)

(Rev. 1688, Issued: 02-20-09, Effective: 03-20-09, Implementation: 03-20-09)

The contractor uses the following Medicare Redetermination Notice (MRN) format or something similar and standard language paragraphs.

NOTE: This is a model letter and should be adjusted on a case by case basis if necessary. Contractors may also include additional resources, including their website address(es) and/or telephone number(s). Appeals that involve issues such as Medicare Secondary Payer (MSP) and overpayment recoveries may require contractors to deviate from the sample given in this manual section.

The fill-in-the-blank information (specific to each redetermination) is in italics. The contractor must ensure that the information identified in each section of the model letter below is included and addressed, as needed, in the MRN. Contractors shall include the request for reconsideration form with the MRN. The contractor must fill in the contract number and "appeal number" on each request for reconsideration form. The contract number is only required for contractors who have multiple locations in which a QIC will need to request a case file. The "appeal number" is any number used to identify the associated appeal and will be used by the QIC to request a case file. The contractor also 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 or carrier to request the case file from.

A. Redetermination Letterhead

The redetermination letterhead must follow the instructions issued by CMS for written correspondence requirements, unless otherwise instructed and/or agreed to by CMS.

Medicare Appeal Decision

MONTH, DATE, YEAR
APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

(If the appellant is a provider or supplier, in the beneficiary's letter, include the following statement:) **This is a copy of the letter sent to your provider/physician/supplier.**

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 requested 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. 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. However, if you do not wish to appeal this decision, you are not required to take any action. For more information on how to appeal, see the section of this letter entitled, "Important Information About Your Appeal Rights."

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.

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 (LCD, NCD), regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it includes 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

(Instructions: 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. Use option 1 if evidence is indicated in this section or option 2 if no further evidence is needed.)

Option 1:

Special note to Medicare physicians, providers, and suppliers only: Any additional evidence as indicated in this section should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration is issued. If all additional evidence as indicated above and/or otherwise is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the administrative law judge or further appeal unless you can demonstrate good cause for withholding the evidence from the qualified independent contractor.

NOTE: You do not need to resubmit documentation that was submitted as part of the redetermination. This information will be forwarded to the QIC as part of the case file utilized in the reconsideration process.

Option 2:

Special note to Medicare physicians, providers, and suppliers only: Any additional evidence should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration is issued. If all evidence is not submitted prior to the issuance of the reconsideration decision, you will not be able to submit any new evidence to the administrative law judge or further appeal unless you can demonstrate good cause for withholding the evidence from the qualified independent contractor.

NOTE: You do not need to resubmit documentation that was submitted as part of the redetermination. This information will be forwarded to the QIC as part of the case file utilized in the reconsideration 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 who have reviewed your claim so far. The next level of appeal is called reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from (insert: contractor 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 may write a letter. You must include: your name, your signature, the name of the beneficiary, the Medicare number, a list of the service(s) or item(s) that you are appealing and the date(s) of service, and any evidence you wish to attach. You must also indicate that (insert: contractor name) made the redetermination. You may also attach supporting materials, such as those listed in item 10 of the enclosed Redetermination Request Form, or other information that explains why this service should be paid. 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 may visit http://www.medicare.gov/basics/forms/default.asp to download the "Appointment of Representative" form, which may be used to appoint a representative. Medicare does not require that you use this form to appoint a representative. Alternately, you may submit a written statement containing the same information indicated on the form. If you are a Medicare enrollee, you may also call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

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

Contractor Name,
A Medicare Contractor

Address
City, State, Zip

Resources for Medicare Enrollees: 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 find the phone number for your SHIP in your "Medicare & You" handbook, under the "Helpful Contacts" section of www.medicare.gov Web site, or by calling 1-800-MEDICARE (1-800-633-4227). Your SHIP can answer questions about payment denials and appeals.

For general questions about Medicare, you can call 1-800-MEDICARE (1-800-633-4227), TTY/TDD: 1-877-486-2048.

Remember that specific questions about your appeal should be directed to the contractor that is processing your appeal.

Contractor Logo or CMS Logo with Contractor Name and Address	**Reconsideration Request Form**	Redetermination/ Appeals Number: XXXXXX

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, 11, & 12, but to help us serve you better, please include a copy of the redetermination notice with your request.

QIC Name Address

1. Name of Beneficiary: _____
2a. Medicare Number:_____
2b. Claim Number (ICN / DCN, if available):_____
3. Provider Name:_____
4. Person Appealing: ☐ Beneficiary ☐ Provider of Service ☐ Representative
5. Address of the Person Appealing:_____

_____

6. Item or service you wish to appeal:_____

_____

7. Date of the service: From____/_____/_____ To_____/_____/_____
8. Does this appeal involve an overpayment? ☐ Yes ☐ No

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

_____

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

□ Medical Records □ Office Records/Progress Notes

□ Copy of the Claim □Treatment Plan

□ Certificate of Medical Necessity

11. Name of Person Appealing:_____

12. Signature of Person Appealing:_____ Date:_____/____/___

Contractor Number ____ (Contractor number is optional for contractors with only one location for QICs to request case files)

310.8 - Medicare Redetermination Notice (for full favorable redeterminations)

(Rev. 1276, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

NOTE: Due to budget constraints, this activity is NOT required until further notice, except in those situations when the parties will not receive notice of effectuation via a MSN or RA (MSP overpayments, non-MSP overpayments which do not result in a refund or payment., etc.). Contractors will also have to modify the language to ensure that the letter appropriately addresses the MSP overpayment or non-overpayment situations.

The contractor uses the following redetermination format or something similar and standard language paragraphs. The fill-in-the-blank information (specific to each redetermination) are in italics. The contractor must ensure that the information identified in each section of the model letter below is included and addressed, as needed, in the MRN.

A. Redetermination Letterhead

The redetermination letterhead must follow the instructions issued by CMS for carrier written correspondence requirements, unless otherwise instructed and/or agreed to by CMS.

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

MONTH, DATE, YEAR

APPELLANT's NAME
ADDRESS
CITY, STATE ZIP

RE: Include claim identifier or appeal number

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.

Reviewer Name
Contractor Name
A Medicare Contractor

310.9 - Effect of the Redetermination

(Rev. 679, Issued: 09-16-05, Effective: FIs-05-01-05/Carrier-01-01-06, Implementation: FIs-12-19-05/Carrier-01-01-06)

In accordance with section 1869(a)(3)(D) of the act, once a redetermination is issued, it becomes part of the initial determination. The redetermination is final and binding upon all parties unless a reconsideration is completed or the redetermination is revised as a result of a reopening.

320 - Reconsideration - The Second Level of Appeal

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006; Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

Section 1869 of the Act entitles any individual dissatisfied with the contactor's redetermination to file a request, within 180 days of receipt of the redetermination, for a reconsideration. In accordance with §1869(c), reconsiderations are to be processed within 60 days by entities called qualified independent contractors (QICs). CMS is required to contract with no fewer than four QICs. When a claim is denied on the basis of §1862(a)(1)(A) of the Act, the QIC reconsideration will consist of a panel of physicians and other health professionals. When the panel reviews services or items rendered by a physician or ordered by a physician, the panel will consist of at least one physician.

320.1 - Filing a Request for a Reconsideration

(Rev. 1329, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

The request for a reconsideration made by a beneficiary, provider, supplier, or State and must be filed with the QIC specified in the redetermination notice. A request from a provider, supplier, or State must be made in writing either on a standard CMS Form (CMS-20033), the reconsideration request form included with the redetermination, or must contain the following items:

- 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.

A request from a beneficiary must be made in writing either on a standard CMS form or another written format indicating dissatisfaction with the redetermination. Requests for reconsideration may be submitted in situations where beneficiaries assume that they will receive a reconsideration by questioning a payment detail of the determination or by sending additional information back with the MSN or MRN, but don't actually say: I want a reconsideration. For example, a written inquiry stating, "Why did you only pay $10.00?" is considered a request for reconsideration. Common examples of phrasing in letters from beneficiaries that constitute requests for reconsideration:

- "Please reconsider my claim."
- "I am not satisfied with the amount paid - please look at it again."
- "My neighbor got paid for the same kind of claim. My claim should be paid too."

Or the request may contain the word appeal or review. There may be instances in which the word review is used but where the clear intent of the request is for a status report. This should be considered an inquiry.

A. Request for Reconsideration (Form CMS-20033)

The CMS provides a form for filing a request for reconsideration for the convenience of appellants, but appellants are not required to use this form.

B. Requests Submitted to the Wrong Contractor

Parties must request a reconsideration at the QIC with jurisdiction. Contractors with multiple states may have multiple QICs handling requests and, therefore, must make certain to refer the appellant to the correct QIC. The jurisdiction for all QIC appeals are dependent upon the state where the service or item was rendered. The jurisdiction for all DME Part B QIC appeals are dependent upon the state where the beneficiary resides. See §320.7 for the specific QIC jurisdictions.

There may be instances where requests for QIC reconsiderations are misrouted to a contractor location. Contractors shall have standard operating procedures to ensure that misrouted requests are sent/transmitted to the QIC, along with the appropriate case file(s), within 30 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) or by a courier service so that the case file is received by the QIC before or on the 31st calendar day after the receipt. There also may be instances where the redetermination decision is issued after May 1, 2005 (for FIs) or January 1, 2006 (for carriers and DMERCs) and the appellant mistakenly requests or misfiles a hearing officer 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 30 calendar days of receipt in the corporate mailroom. Contractors shall track all misfiled and misrouted reconsideration requests to ensure receipt at the proper QIC. The QIC will send the FI,

carrier, MAC or DME MAC an acknowledgement of receipt of any misfiled requests. Contractors shall not count such misrouted or misfiled requests as dismissals. The contractor counts the costs associated with misrouted or misfiled requests in the 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.

320.2 - Time Limit for Filing a Request for a Reconsideration

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006; Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

A party must file a request for reconsideration within 180 days of the date of receipt of the notice of the redetermination. The date of filing for requests filed in writing is defined as the date received by the QIC in their corporate mailroom. If the party has filed the request in person with the QIC, the filing date is the date of filing at such office, as evidenced by the receiving office's date stamp on the request. If the party has mailed the request for reconsideration to CMS, SSA, RRB office, or another Government agency in good faith within the time limit, and the request did not reach the appropriate QIC until after the time period to file a request expired, the QIC considers good cause for late filing (See § 240 for more information on good cause). Likewise, if the request is filed with CMS, SSA, RRB, or another Government agency in person, the QIC considers good cause for late filing.

The QIC may extend the period for filing if it finds the appellant had good cause for not requesting the reconsideration timely. (See §240 for a discussion of good cause.) In order for good cause to be considered, the appeal request must be in writing. If the QIC finds that the appellant did not have good cause for not requesting a reconsideration on time, it may, at its discretion, consider reopening. (See chapter 33.)

320.3 - Contractor Responsibilities - General

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

The contractor's responsibilities for reconsiderations are:

1 Preparing and forwarding case files upon request from a QIC in accordance with §§320.4, 320.5, 320.6 and the Joint Operating Agreement (JOA);

2 Effectuating reconsiderations when notified by the QIC of a favorable decision or unfavorable decision with a change in liability in accordance with § 320.8 and notifying the QIC of receipt of effectuation information;

3 Preparing case files and forward misrouted or misfiled reconsiderations requests in accordance with §320.1(B).

4 Entering into JOAs with the appropriate QIC(s) and Administrative QIC (AdQIC); and;

5. Complying with the appropriate JOAs.

320.4 - QIC Case File Development

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006; Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

When the QIC receives a request for reconsideration, it will request the case file from the contractor with jurisdiction using the Redetermination Case File Request Form. The QIC will send the request either by electronic mail (e-mail), telephone, fax, or by any other method agreed upon in the JOAs. (Note: Individually identifiable beneficiary information should not be given in an unsecure 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 calendar days of the date of the QIC's request. The date of QIC's request is defined as the date the phone call is made (if a message is left, it is defined as the date the message was left) or the date of the e-mail request. The case files must be sent either by an electronic means agreed upon in the JOAs or by a courier service so that the case files are received by the QIC before or on the 8th calendar days after its request. The contractor counts the costs associated with sending case files in the Contractor Administrative Budget and Financial Management (CAFM) code designated for preparing/transferring case files to the QIC.

If agreed upon in the JOAs, the following requirements apply to e-mail, fax 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. If individually identifiable information is given in the request or response, a secure e-mail account must be used. 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).

(c) Fax Requests-Contractors shall designate and maintain a fax machine for the receipt of casefile requests from the QIC.

320.5 - QIC Case File Preparation

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006;

Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

Once a party requests a reconsideration with a QIC, the QIC will need to obtain the case file from the FI, carrier, or DMERC. 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. Medical documentation does not need to be ordered chronologically, but rather can be included in the case file as submitted by the provider.

The following is a list of the documents generally included in any case file. Note that there may be others not listed here. For applicable items, the contractor includes originals and retains hard copies of any documents that are not available electronically for its records. Do not send abbreviated versions, or versions of documents that the contractor has retyped or paraphrased for purposes of shortening the document. The contractor must keep an exact copy of the file that is sent to the QIC. (Note: This applies only when documents are not otherwise available electronically.) The contractor retains the copies for at least 6 months. If it is unable to include the original documents, it includes photocopies that are true facsimiles of the original documents. It arranges the following documents, in descending date order (i.e., the claim form is on the bottom).

Procedural Documents:

- Claim form or printout, if electronically generated (facsimile and/or screen prints 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;
- Appointment of representative form (Form CMS-1696-U4 or Form SSA-1696-U4) or other written authorization, if applicable;
- All documentation related to the assessment of an overpayment.

Medical Documents:

- Medical records, separated by facility, doctor, or location of service (separated by a colored sheet or a sheet of paper with a heading);
- 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 who may have commented on the policy during the development 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;
- Copies of LCDs, newsletters, any other pertinent information that maybe used 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.); and
- Any additional evidence submitted by the appellant.

*If accessible by internet, the FI, carrier or DMERC enter into a joint operating agreement with the QIC to provide a list instead of actual copies.

Assembly Instructions:

- The contractor uses an appropriate file/folder/envelope which 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 Transmittal Form

The Reconsideration Case Transmittal Form documents the claim information and the date of the redetermination. It also identifies the FI, Carrier or DMERC 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. The QIC will provide a Reconsideration Case Transmittal Form for use in the JOA.

320.6 - Forwarding QIC Case Files

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006;

Implementation: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 2006)

Contractors shall send/transmit the case file within 7 calendar days of the date of the QIC's request. The date of QIC's request is defined as the date the phone call is made (if a message is left, it is defined as the date the message was left) or the date of the e-mail request. The case files must be sent either by an electronic means agreed upon in the joint operating agreement or by a courier service so that the case file is received by the QIC before or on the 8th calendar days after its request.

320.7 - QIC Jurisdictions

(Rev. 1136, Issued: 12-22-06, Effective: 01-01-07, Implementation: 04-02-07)

A. FI QIC Jurisdictions

The FI QIC jurisdictions are as follows:

Jurisdiction	Normal States	Exceptions
East QIC jurisdiction (Maximus)	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, Washington DC and Mutual of Omaha claims were the service was rendered in one of the above listed states.	**Chain Providers (including ESRD)**- the state where the FI processes the claim. For Mutual of Omaha claims, the jurisdiction continues to be the state were the service was rendered. **Indian Health Services Nationwide**- processed by TrailBlazers **Foreign claims**- Eastern Mexico (processed by Trailblazer), Canadian Provinces of New Burnswick, Newfoundland, Nova Scotia, Quebec, and Prince Edward Island (processed by AHS) **Rural Health Clinics Nationwide**- processed by Anthem, Highmark, TrailBlazer, and Riverbend **Federal Qualified Health Centers**- in accordance with normal jurisdiction (processed by UGS)
West QIC jurisdiction (First Coast Service Options)	Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon,	**Chain Providers (including ESRD)**- the state where the FI processes the claim. For Mutual of Omaha claims, the jurisdiction continues to be the state were the service was rendered. **Foreign claims**- Western Mexico (processed by NHIC), Canadian Provinces of Ontario (processed by UGS)

	Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, American Samoa, and Mutual of Omaha claims were the service was rendered in one of the above listed states.	Saskatchewan, Alberta Manitoba (processed by BC of Montana), British Columbia, Vancouver, and Yukon Territories (processed by Noridian). **Federal Qualified Health Centers**- in accordance with normal jurisdiction (processed by UGS)

B. Carrier and DMERC QIC Jurisdictions

One QIC processes all reconsiderations of DME claims. There are two QIC jurisdictions for Part B claims processed by carriers, a **North** and a **South** jurisdiction. Please refer to the table below.

Part B QIC Jurisdictions
South: Colorado, Connecticut, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Tennessee, Alabama, Georgia, Florida, North Carolina, South Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands. Note: Railroad Retirement Board reconsiderations are also included in this workload jurisdiction.
North: Alaska, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, District of Columbia, New York, Pennsylvania, New Jersey, Delaware, Maryland, Ohio, Kentucky, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Missouri, Iowa, Kansas, Nebraska, South Dakota, North Dakota, Wyoming, Montana, Idaho, Washington, Oregon, California, Nevada, Arizona, Utah, Hawaii, Guam, Northern Mariana Islands, American Samoa.

320.8 - Tracking Cases

(Rev. 1276, Issued: 06-29-07, Effective: 07-30-07, Implementation: 07-30-07)

Contractors shall track all incoming requests from the QICs for case files. The contractor shall keep a record of the date of the request, the format of the request (e.g., telephone, e-mails, electronic) the date the case file was forwarded to the QIC, and the means of forwarding (e.g., Fed Ex Same Day, Fed Ex overnight, UPS 2 day). If a courier service is used, the contractor shall utilize the courier service's tracking mechanism to keep a record of the date of receipt at the QIC.

Contractors shall track all misrouted and misfiled reconsideration requests to ensure receipt at the proper QIC. The QIC will send the FI, carrier or DMERC an acknowledgement of receipt of any misrouted or misfiled requests. Contractors shall keep a record of the date of receipt of the misfiled request, the date it was forwarded to the QIC, the means of forwarding, and the date of the QIC's acknowledgement.

Contractors shall track all requests from the QIC for effectuation (see §320.8). The contractor shall make a record of the date of receipt of the QIC's request for effectuation and confirm receipt of the effectuation notice with the QIC. The contractor shall also track the date of effectuation (i.e., issue payment).

320.9 - Effectuation of Reconsiderations

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

In many cases, the QIC'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 reconsideration. It takes an effectuation action only in response to a formal decision and Reconsideration Effectuation Notice from the QIC. "Effectuate" means for the contractor to issue a payment or change liability. If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, the contractor effectuates within 30 calendar days of the date of the QIC's decision.

NOTE: CMS does not anticipate that QICs will specify an amount to be paid in reconsideration notices.

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. The receipt of effectuation information shall be reported to the appropriate QIC.

Prior to paying a provider of services in fully or partially reversed reconsideration decisions for Part A claims where the beneficiary was previously liable, the FI ascertains whether the provider has been reimbursed for the previously denied services from another source and, if so, it withholds the Medicare reimbursement until the party has assured in writing that the incorrect collection has been refunded or otherwise disposed of.

The FI advises the beneficiary that he/she should expect refund from the provider if payment in excess of the deductible and coinsurance amounts had been made for the services for which Medicare will pay or for which the provider has been found to be liable.

For Part A cases where written assurance is needed, the FI effectuates within 30 days of receipt of written assurance.

330 - Administrative Law Judge (ALJ) - The Third Level of Appeal

(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)
Fiscal Intermediaries

For Part A and Part B redeterminations issued before May 1, 2005, contractors will continue to be responsible for accepting Administrative Law Judge (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 is responsible for accepting ALJ hearing requests and for preparing case files for the hearing.

Carriers & DMERCs - For Part B redeterminations issued before January 1, 2006, 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, §60, in preparing case files. For redeterminations issued on or after January 1, 2006, the QIC is responsible for accepting ALJ hearing requests and for preparing case files for the hearing.

330.1 - Right to an ALJ Hearing

(Rev. 1676, Issued: 01-30-09, Effective: 05-04-09, Implementation: 05-04-09)

There are three situations where a party can request a hearing before an ALJ: (1) A party to a QIC reconsideration may request a hearing before an ALJ if the party files a written request for an ALJ hearing within 60 days after receipt of the notice of the QIC's reconsideration and the amount in controversy requirement is met*; (2) A party who files a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the QIC's decision-making timeframe has a right to a hearing before an ALJ if the party files a written request with the QIC to escalate the appeal to the ALJ level after the adjudication period expires and the QIC does not issue a final action within 5 days of receiving the request for escalation. A party wishing to escalate an appeal must also meet the amount in controversy requirement*; and (3) A party to a QIC's dismissal of a request for reconsideration has a right to have the dismissal reviewed by an ALJ if the party meets the amount in controversy requirement*.

The amount remaining in controversy requirement for ALJ hearing requests made before January 1, *2009 is $120.* The amount remaining in controversy requirement for requests made on or after January 1, *2009 is $120.*

* For requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement is increased 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. The amount will be computed annually and CMS will notify the Medicare contractors of the new amount.

330.2 - Requests for an ALJ Hearing

(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

A. Where Parties File Requests

To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration*. The appellant must also send a copy of the request for hearing to the other parties. Failure to

do so will toll the ALJ's 90-day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing. Also, if the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the ALJ's deadline for deciding the appeal begins on the date the entity specified in the QIC's reconsideration (i.e., the appropriate Office of Medicare Hearings and Appeals (OMHA) field office) receives the request for hearing.

The QICs will specify the appropriate OMHA field office as the filing location for ALJ hearing requests.

B. Timely Filing Requirements

A party must file an ALJ request within 60 days of the date of their receipt of the QIC's decision. It is presumed that the appellant received the QIC's decision within five days of the date of the QIC's decision, unless there is a reasonable showing by the appellant to the contrary.

C. Content of the Request

The request for an ALJ hearing must be made in writing. The request must include all of the following:

1. The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed,
2. The name and address of the appellant, when the appellant is not the beneficiary,
3. The name and address of the designated representative, if any,
4. The document control number assigned to the appeal by the QIC, if any,
5. The dates of service,
6. The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

For the convenience of parties, HHS provides a form that may be used to request a Medicare ALJ hearing. The contractor provides copies of the form to parties upon request. It is not necessary, however, that this form be used to make a written request. See http://new.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf for the hearing request form used when the request follows a QIC reconsideration and http://new.cms.hhs.gov/cmsforms/downloads/cms5011a-b.pdf for the hearing request form used when the request follows a carrier hearing officer hearing or FI reconsideration.

330.3 - Forwarding Requests to HHS/OMHA

(Rev. 1229, Issued: 04-27-07, Effective: 07-02-07, Implementation: 07-02-07)

Requests for ALJ hearings are to be filed with the entity specified in the QIC's reconsideration notice. The QICs will specify the OMHA field office with jurisdiction as the filing location for hearing requests. However, there may be times when parties incorrectly file requests for hearings with either the contractor or QIC. When a contractor receives such a misfiled request, it forwards the misfiled request to the appropriate OMHA field office within 14 calendar days of receipt.

A. Address for OMHA

Requests for ALJ hearings must be filed at the following locations depending on the **place of service**. For DMEPOS claims, the place of service is defined as the beneficiary's address of record, residence, or, if the item or supply was provided in a facility, then the facility address.

HHS OMHA Field Office Mailing Address	Jurisdiction (Based on the place of service)			
• **Cleveland, Ohio** BP Tower & Garage 200 Public Square, Suite 1300 Cleveland, Ohio, 44114-2316	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	New York New Jersey Puerto Rico Virgin Islands	Pennsylvania Delaware West Virginia Kentucky	Illinois Indiana Ohio Michigan Minnesota Wisconsin
• **Miami, Florida** 100 SE 2nd Street, Suite 1700 Miami, FL 33131-2100	Alabama Florida Georgia Mississippi North Carolina South Carolina Tennessee	Arkansas Louisiana New Mexico Oklahoma Texas Puerto Rico US Virgin Islands		
• **Irvine, California** 27 Technology Drive, Suite 100 Irvine, CA 92618-2364	Iowa Kansas Missouri Nebraska	Colorado Montana North Dakota South Dakota Utah Wyoming	Arizona California Hawaii Nevada Guam Trust Territory of the Pacific Islands American Samoa	Alaska Idaho Oregon Washington
• **Arlington, Virginia** 1700 N. Moore St., Suite 1600, Arlington, VA 22209	Virginia Maryland District of Columbia			

330.4 - Review and Effectuation of ALJ Decisions

(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

The administrative QIC (AdQIC) will receive all case files and decisions from the OMHA field offices as well as any decisions and case files from the DAB. The AdQIC will fill out an effectuation form with the necessary information for the FI or carrier to effectuate the decision. The AdQIC will fax or mail this effectuation form to the carrier or FI within 10 calendar days from the date the AdQIC receives the case from OMHA or the DAB.

330.5 - Effectuation Time Limits & Responsibilities
(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

In most cases, an ALJ will either: (1) issue a decision based on the request for an ALJ hearing; or (2) issue an order of dismissal of the appellant's request for ALJ hearing; or (3) remand the case to the QIC.

The ALJ's decision will often require an effectuation action on the contractor's part. The contractor does not effectuate based on correspondence from any party to the ALJ hearing. It takes an effectuation action only in response to a formal effectuation notice from the AdQIC. "Effectuate" means for the contractor to issue a payment or change liability.

Prior to paying a provider in full or partial reversal cases where the beneficiary was previously liable, the FI must ascertain whether the provider has been reimbursed for the previously denied services from another source and, if so, will withhold the Medicare reimbursement until the party has assured, in writing, that the prior payment has been refunded.

The FI advises the beneficiary that he/she should expect refund from the provider if payment in excess of the deductible and coinsurance amounts had been made for the services for which Medicare will pay or for which the provider has been found to be liable.

For Part A cases where written assurance is needed, the FI effectuates within 30 days of receipt of written assurance.

For ALJ decisions issued by HHS OMHA 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 an effectuation notice with a summary of the affected claim headers and claim line ICNs to the appropriate contractor for effectuation.

A. No Agency Referral

If the ALJ decision is partially or wholly favorable to the appellant, gives a specific amount to be paid, and there is no agency referral to the Appeals Council, the contractor effectuates within 30 calendar days of the date of the effectuation notice from the AdQIC. The contractor must acknowledge receipt of the AdQIC effectuation form within 7 calendar days.

If the decision is partially or wholly favorable and no agency referral is made, but the amount must be computed by the contractor, it effectuates the decision within 30 days after it computes the amount to be paid to the appellant. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the effectuation notice from the AdQIC.

If clarification from the AdQIC is necessary, the contractor considers the date of the clarification the final determination for purposes of effectuation. If clarification is needed from the provider/physician/supplier (e.g., splitting charges), the carrier requests clarification as soon as possible and computes the amount payable within 30 calendar days after the receipt of the necessary clarification. The contractor considers the date of receipt of the clarification as the date of the final determination for purposes of effectuation.

B. Agency Referral

Where the AdQIC submitted an agency referral to the Appeals Council, the contractor does not effectuate until it receives notification from the AdQIC.

1. If the Appeals Council accepts the agency referral for review, the AdQIC advises the contractor to delay effectuation until the Appeals Council takes further action.

2. If the Appeals Council declines to review the agency referral, the AdQIC advises the contractor to effectuate the decision.

330.6 - Duplicate ALJ Decisions
(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

If the contractor becomes aware of a duplicate ALJ decision on the same case, it must bring this to the attention of the AdQIC immediately. In these cases the AdQIC will take the necessary steps to resolve the issue.

330.7 - Payment of Interest on ALJ Decisions
(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For guidance on how to make payment of interest subsequent to an ALJ decision, refer to chapter 3 of the Medicare Financial Management Manual.

340 - Departmental Appeals Board - The Fourth Level of Appeal
(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

The level of administrative review available to parties after the ALJ hearing decision or dismissal order has been issued, but before judicial review is available is Appeals Council review.

If a party requests the Appeals Council to review an ALJ's decision, the Appeals Council may review the decision and adopt, modify, or reverse the ALJ's decision, or remand the case to an ALJ for further proceedings. See, in general 42 C.F.R § 405.1108. However, when a party requests that the Appeals Council review an ALJ's dismissal, the Appeals Council may deny review or remand the case to an ALJ for further proceedings. In

addition, the Appeals Council will decide cases that are escalated from the ALJ level without an ALJ decision or dismissal. See 42 C.F.R § 405.1108(d).

340.1 - Recommending Agency Referral of ALJ Decisions or Dismissals

(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For ALJ decisions issued by HHS OMHA 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 contractor remains responsible for this activity.

340.2 - Effectuation of Appeals Council Orders and Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

When a contractor receives an effectuation notice from the AdQIC regarding an Appeals Council decision that requires effectuation, it initiates effectuation within 30 days of its receipt of the effectuation notice, and completes effectuation within 60 days. Any questions regarding effectuation should be directed to the AdQIC for guidance.

340.3 - Requests for Case Files

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

When the Appeals Council receives a request for review from an appellant, in most instances it will not have a copy of the ALJ's decision or dismissal, or the case file. The Appeals Council will request all case files from the AdQIC.

340.4 - Payment of Interest on Appeals Council Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

For guidance on how to make payment of interest subsequent to an Appeals Council decision, refer to chapter 3, of the Medicare Financial Management Manual.

345 - U.S. District Court Review - The Fifth Level of Appeal

(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

The circumstances allowing for an appeal or escalation to the U.S. District Court level of review are limited, and articulated in 42 CFR 405.1136.

345.1 - Requests for U.S. District Court Review by a Party

(Rev. 1676, Issued: 01-30-09, Effective: 05-04-09, Implementation: 05-04-09)

Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court. If a party files a request for court review with a contractor, the contractor must instruct the appellant to re-file with the U.S.

District Court. The amount remaining in controversy for requests made on or after January 1, *2008 is $1,180*. The amount remaining in controversy for requests made on or after January 1, *2009 is $1,220.*

If a contractor receives, either directly or by copy, a summons or complaint due to a party's request for U.S. District Court review, and it does not appear that a copy was sent to the following address, the contractor shall send the original to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, S.W.
Washington, D.C. 20201

The contractor retains a copy and notifies its RO immediately.

345.2 - Effectuation of U.S. District Court Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

The U.S. District Court may remand the case to the Appeals Council or ALJ for further proceedings. In rare cases, the U.S. District Court will issue an order that will require effectuation by a contractor. In this situation, the contractor contacts its RO appeals contact for further instructions before taking any action.

345.3 - Payment of Interest of U.S. District Court Decisions

(Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For guidance on how to make payment of interest subsequent to a U.S. District Court decision, refer to chapter 3 of the Medicare Financial Management Manual.

350 - Workload Data Analysis Program

(Rev. 675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

The basis of an effective quality improvement program is a Data Analysis program. Data analysis involves collecting relevant data, analyzing the data, identifying trends and aberrancies, and making conclusions based on the data collected. In order to perform adequate data analysis, whenever possible, contractors should use the entire universe of appeals to conduct the analysis. However, if contractors are unable to use the entire universe, contractors must, at a minimum, gather data from a 10 percent or 100 per month (whichever is less) randomly selected example of redeterminations. Data analysis should be performed, at minimum, on a monthly basis. Data analysis must be performed for each contractor site. Contractors may develop other approaches to data analysis if feasible, but these approaches must be submitted in writing to the servicing RO for approval before implementation. However, any changes to the process must result in the ability by the contractor to identify inefficiencies or problems with appeals; the original intent of the data analysis effort must not be compromised.

A. RO Examination of Redetermination Decision Letters

The fourth function of the Quality Improvement program involves RO examination of decision letters. At some point during the FY, the RO may contact contractors to make arrangements for a review of a sample of redetermination letters. The sample will consist of at least ten (10) of decision letters and will take place at the RO. The date of the review and quantity of the sample size are at the discretion of the RO. The RO may, at its discretion, arrange to review your decision letters at multiple times during the FY. The review is limited to the decision letter only.

The RO will evaluate all decision letters to determine:

- Overall clarity, responsiveness, and accuracy
- Completeness of the summary of facts and issues
- Adequacy of the rationale/explanation of the decision

Accuracy of reference to applicable laws regulations

360 - Managing Appeals Workloads
(Rev. 675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

360.1 - Standard Operating Procedures
(Rev. 675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

The priorities set forth in this section are to be used by contractors as a guide in establishing standard operating procedures for managing an appeals workload when the budget amount is insufficient to adequately perform the required functions. In general, contractors should use a first-in, first-out method to process appeals and manage workload; however, during times of limited resources it may become necessary to prioritize the processing of appeals to more efficiently manage the workload. While CMS continues to recommend the priorities listed in this section, there may be instances where contractors find it more effective and efficient to prioritize in a different manner. Also, contractors may choose to establish standard operating procedures for managing an appeals workload that deviate from the priorities listed in this section. In both these cases, contractors should submit a copy of their prioritization plan to the regional office (RO) and obtain written approval from their RO for this variation within 30 days of the fiscal year.

360.2 - Execution of Workload Prioritization
(Rev. 675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

A. Budget Related Workload Prioritization

Whenever it appears that the budget amount is insufficient to adequately perform the required functions and the need for additional funds can be adequately documented,

contractors shall submit a Supplemental Budget Request (SBR) in accordance with the Medicare Financial Management Manual, chapter 2 §120. As a result of an SBR, or during the course of CMS' evaluation of a contractor's SBR, CMS may find it necessary that the contractor execute prioritization of workload in accordance with this section or in accordance with the contractor's standard operating procedures. The contractor should discuss possible alternatives for resolution in the SBR. If it becomes necessary to abate activities, contractors must submit proper notification in accordance with the terms of the Cost of Administration Article in the Contract/Agreement and begin processing work in accordance with this PM until a final agreement is reached between the contractor and CMS. As a result of an abatement, CMS may find it necessary that the contractor continue processing work in accordance with this manual instruction.

B. Other Circumstances That May Lead to Workload Prioritization

In circumstances other than those described above, it may become apparent that prioritization of workload is necessary because a contractor is unable to complete the incoming or pending workload within the time frames described in this manual. In these situations the contractor must either consult with the RO immediately for guidance or inform their RO immediately that they plan to initiate their workload prioritization plan. An example of a situation that may lead to workload prioritization is an uncharacteristic, unanticipated increase in receipts over a two-month period, coupled with, insufficient staff or other resources that will impede you from completing the increased volume of appeals receipts in a timely manner.

360.3 - Workload Priorities

(Rev. 675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

Priority 1-- Finalize effectuation of all redetermination, reconsideration, ALJ and Departmental Appeals Board (DAB) decisions and
Process redeterminations and forward reconsideration case files to the QIC timely on overpayment determinations (including Comprehensive Error Rate Testing (CERT) contractor appeals).

Priority 2-- Prepare, assemble, and forward case files to the QIC in accordance with the timeframes described in §320.6

Priority 3-- Adjudicate redeterminations from beneficiaries or their appointed beneficiary representatives in the timeframes described in §310.4.

Priority 4-- Adjudicate requests for redeterminations from providers, suppliers, or other appellants, including States or their third party agents, that are submitted with necessary documentation in the timeframes prescribed in §320.6.

Priority 5-- Adjudicate written requests for redeterminations from providers, suppliers, or other appellants, including States or their third party agents, that are submitted without necessary documentation in the timeframes prescribed in §320.6.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R1688CP	02/20/2009	Clarification of the Medicare Redetermination Notice for Partly or Fully Unfavorable Redetermination	03/20/2009	6302
R1676CP	01/30/2009	Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals	05/04/2009	6295
R1485CP	03/28/2008	Chapter 29 Clean-Up	07/07/2008	5899
R1457CP	02/22/2008	Redeterminations of Overpayments	03/24/2008	5859
R1437CP	02/05/2008	Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals	05/05/2008	5897
R1408CP	01/11/2008	Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)	02/11/2008	5836
R1329CP	08/31/2007	Modifications to the Timeliness Requirements for Contractors Forwarding Reconsideration Requests Submitted to the Wrong Contractor	10/01/2007	5602
R1276CP	06/29/2007	Waiving Medicare Fee-for-Service Appeals Requirements	07/30/2007	5322
R1274CP	06/29/2007	Appeals of Claims Decisions: Appointment of Representatives; Fraud and Abuse; Guidelines for Writing Appeals Correspondence; Disclosure of Information	10/01/2007	5460
R1229CP	04/27/2007	Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) and the ALJ Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands	07/02/2007	5554

Rev #	Issue Date	Subject	Impl Date	CR#
R1211CP	03/30/2007	Change in the Amount in Controversy Requirement for Federal District Court Appeals	07/02/2007	5518
R1136CP	12/22/2006	Revisions to Procedure to Establish Good Cause and Qualified Independent Contractor Jurisdictions	04/02/2007	5386
R1069CP	09/29/2006	Reopenings and Revisions of Claim Determinations and Decisions	11/29/2006	4147
R985CP	06/16/2006	Appeals Updates	06/01/2006	5058
R862CP	02/17/2006	Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review	03/17/2006	4152
R724CP	10/21/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006	12/16/2005	3939
R697CP	10/07/2005	Appeals of Claims Decision: Redeterminations and Reconsiderations (Implementation Date: May 1, 2005)	01/09/2006	3942
R695CP	10/07/2005	General Appeals Process in Initial Determinations (Implementation Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006)	01/09/2006	4019
R688CP	09/23/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Dates for All Requests for Redetermination Received by FIs on or After May 1, 2005 and All Requests for Redetermination Received by Carriers on or After January 1, 2006)	12/16/2005	3944

Rev #	Issue Date	Subject	Impl Date	CR#
R687CP	09/23/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006	12/16/2005	3939
R679CP	09/16/2005	Medicare Redetermination Notice and Effect of the Redetermination	12/19/2005	4006
R678CP	09/16/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Dates for All Requests for Redetermination Received by FIs on or After May 1, 2005 and All Requests for Redetermination Received by Carriers on or After January 1, 2006)	12/16/2005	3944
R677CP	09/16/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006	05/01/2005	3939
R675CP	09/16/2005	Changes to Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date: October 1, 2005)	10/03/2005	3943
R381CP	11/26/2004	Revisions and Corrections to Chapter 29 of the IOM Claims Processing Manual-Appeals	01/10/2005	3127
R001CP	10/01/2003	Initial Release of Manual	N/A	N/A

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