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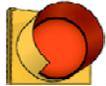
MMA - Revisions to Medicare Appeals Process for Fiscal Intermediaries (CR Title- Appeals Transition – BIPA 521 Appeals)

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

Provider Types Affected

All Medicare providers who submit claims to Medicare Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs)

Provider Action Needed



STOP – Impact to You

There is now a new level of the appeals process for Medicare Part A and Part B claims submitted to Medicare fiscal intermediaries (FIs). This new second level of appeal process is called a **reconsideration** (not to be confused with the previous first level of appeal for Part A claims). These new “reconsiderations” will be processed by Qualified Independent Contractors (QICs).

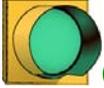


CAUTION – What You Need to Know

This change in the appeals process was governed by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 Section 521 and the Medicare Modernization Act Sections 933, 939, 940. Parties to Part A and Part B redeterminations issued by FIs on or after May 1, 2005 will have the right to appeal to a QIC. All redeterminations issued before May 1, 2005 will have appeal rights to the Administrative Law Judge (ALJ) for Part A claims and to the hearing officer (HO) for Part B claims.

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GO – What You Need to Do

For specific information pertaining to this change, please refer to the background and additional information sections. A copy of the new Medicare Appeal Decision letter is attached to CR3530 and this article will advise you how to access that document.

Background

Note: These revisions do not apply to claims submitted to Medicare carriers and/or redeterminations processed by carriers.

In addition to the new level of appeal, there are a number of other changes that will affect the process providers and FIs use for appeals of claim decisions made by FIs. This article will summarize those changes. Providers seeking full details may wish to review the official instruction (CR 3530) that Medicare issued to the FIs. That instruction is available at

<http://www.cms.hhs.gov/Transmittals/downloads/R146OTN.pdf> on the CMS website.

The key changes are as follows:

1. New Language for Redetermination Letters

For redetermination decisions issued on or after May 1, 2005, FIs will change the Medicare Redetermination Notice (MRN) as follows:

- Language on the first page of the MRN regarding the amount in controversy will be deleted as there is no longer a minimum amount in controversy required to move to the next appeal level, i.e., the QIC.
- The MRN will show that if providers disagree with the redetermination decision, they have 180 days to appeal to a QIC and such appeal must be filed in writing. (Under special circumstances, you may ask for more time to request an appeal.)
- The MRN will include a form to use in requesting the reconsideration by the QIC. The form presents all the information required to submit an appeal. If you do not use the form in CR3530 to request the appeal, you must be sure to include the required information in your letter requesting the appeal, including the name of the contractor that made the redetermination.
- The MRN will include specific language about what providers must include in their request for a reconsideration by the QIC. Providers must pay special attention to the instructions on the MRN related to submission of evidence to support their appeal. All evidence must be presented before the reconsideration is issued. If a provider does not submit all evidence at this stage, they will not be able to submit any new evidence in subsequent appeal levels unless they demonstrate good cause for not presenting evidence to the QIC.
- The MRN will contain revised language to reflect the new level of appeal.

2. Redetermination Letters for Fully Favorable Decisions

Previously, some FIs elected to notify providers of a fully favorable decision through a Remittance Advise (RA) that reflected the processed claim, instead of issuing an MRN. (Beneficiaries were advised via the Medicare Summary Notice (MSN).) However, the revised process requires FIs to issue an MRN on all

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redeterminations, favorable and unfavorable, within 60 days if the RA or MSN cannot be sent within 60 days.

Fully favorable decisions are those where the Medicare approved amount minus any cost sharing (co-insurance, deductibles, etc.) has been found payable. In these instances, which apply to all redetermination requests received by the FI on or after May 1, 2005, the FI will issue the MRN explaining that the decision is favorable and a remittance advice will follow. Exhibit 2 of CR3530 contains a model of such a favorable MRN; however, your FI may choose to include additional information on their MRN.

3. An Extension to the 60-day Decision-Making Time Frame

Should a provider submit additional evidence after filing the request for redetermination, the FI's 60 day decision-making time frame may be extended for 14 calendar days. This applies to redetermination requests received on or after May 1, 2005.

4. Telephone Requests for Redeterminations of Initial Determinations Made On or After May 1, 2005

Section 937 of the Medicare Modernization Act (MMA) provides that in the case of minor errors or omissions, providers must be given the opportunity to correct such errors/omissions without the need to initiate an appeal. Consistent with that section, the Centers for Medicare & Medicaid Services (CMS) requires the FIs to conduct reopenings rather than redeterminations to correct such errors and omissions. CMS has modified the reopening regulations to allow FIs and providers to make these corrections through the reopening process and these reopening requests may be made over the telephone. However, actual redetermination requests made on all initial determinations rendered on or after May 1, 2005 must be in writing.

5. Additional Information Requirements for Written Redetermination Requests Effective with Initial Determinations Made On or After May 1, 2005

Chapter 29, Sections 40.2.1(C) and 50.2.1(B) of the Medicare Claims Processing Manual contain the requirements for provider appeal requests. This manual may be found on the CMS web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS website

Note that for all requests for redeterminations received on or after May 1, 2005, the providers do not need to specify the date of the initial determination in their requests.

6. Consolidating Requests for Multiple Parties on Redetermination Requests Received On or After May 1, 2005

If more than one party files a redetermination request (e.g. both the beneficiary and the provider file requests) on the same claims before the FI makes a redetermination on the first request, the FI will consolidate the separate requests into one proceeding and issue one redetermination. In such cases, the 60-day decision-making time frame begins with the receipt of the second request.

Where the second request is received after a redetermination has already been made, the second request will be treated as an inquiry and the FI will inform the second requestor of the redetermination already made. The FI will also inquire, in these instances, if the party wishes to file a request for an appeal to the next level. Should the party wish to file such appeal, the FI will provide instructions for doing so.

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7. Filing Reconsideration Requests on Redeterminations Issued On or After May 1, 2005

Where Appellants Should Send Requests for Reconsideration

There are two QICs to handle reconsideration requests of redeterminations made by FIs, based on two QIC jurisdictions, east and west. The two QICs are Maximums and First Coast Service Options. Parties must request a reconsideration at the QIC with jurisdiction for the appeal. FIs with multiple states may have both QICs handling requests and therefore must make certain to refer the appellant to the correct QIC. In most instances, the jurisdiction for all Part A and Part B of A QIC appeals is dependent upon the state where the service or item was rendered, with the exception of providers with multiple locations in different states (i.e., chain providers).

Chain providers have the ability to select the FI that will process its claims regardless of the state where the service or items was rendered. In such cases, the state where the FI processes the claim will dictate the QIC jurisdiction. For claims processed by Mutual of Omaha, the jurisdiction is dependent upon the state where the service or item was rendered, with no exception for chain providers.

The following are the QIC jurisdictions for the East and West:

The East QIC jurisdiction is comprised of the following states: Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, and Washington DC. The QIC for the east jurisdiction is Maximus.

The West QIC jurisdiction is comprised of the following states: Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, and American Samoa. The QIC for the west jurisdiction is First Coast Service Options.

The address for the appropriate QIC will be located in the redetermination notice.

Requirements for Reconsideration Requests

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

A provider (or State) request for a reconsideration must either be made on a standard CMS form which will be available on the CMS website or as shown in CR3530 or must contain:

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

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8. Effectuation of QIC Decisions

(Effective Date: All Redeterminations Issued On or After May 1, 2005)

In many cases, the QIC's decision will require effectuation action by the FI. The FI will not effectuate based on correspondence from any party of the Reconsideration, but instead takes an effectuation action only in response to a formal decision from the QIC. "Effectuate" means that the FI takes the necessary actions to issue payment (i.e., make payment on the claim).

The FI will obtain written assurance from the provider if necessary. If the QIC's decision is favorable to the appellant and specifies an amount to be paid, the FI effectuates within 30 calendar days of the date of the QIC's decision or from the date written assurance from the provider is received. If the decision is favorable, but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision (or date of receipt of written assurance from the provider has been obtained).

9. New Appeal Rights for Medicare Providers & New Assignment Rights for Medicare Providers

(Effective Date: May 1, 2005)

A. New Appeal Rights for Medicare Providers

Previously, providers could only appeal a claim determination when the determination involved a finding that:

- (1) The item or service was not covered because it constituted custodial care, was not reasonable and necessary, or for certain other reasons; and
- (2) The provider knew or could reasonably be expected to know that the service in question was not covered under Medicare (that is, a finding with respect to the limitation of liability provision under section 1879 of the Act).

For initial determinations made on or after May 1, 2005, providers who submit claims to FIs will have the same right to appeal claims as beneficiaries. Accordingly, FIs will no longer use RA remark code MA44 for initial determinations made on or after May 1, 2005. This means FIs will no longer need to determine whether a provider submitting an appeal has the right to appeal. Also, FIs will no longer need to evaluate appointment of representative forms submitted by providers representing beneficiaries.

B. New Assignment Rights for Medicare Suppliers

Historically, non-participating suppliers accessed the appeals process by acting as the beneficiary's appointed representative in situations where they otherwise would not have had appeal rights. Section 1869(b)(1)(C) permits a beneficiary to assign his or her appeal rights with respect to an item or service to a provider or supplier. Such an assignment of appeal must be made using a standard form developed by CMS. This form will be made available at <http://www.cms.hhs.gov/CMSForms/> on the CMS website.

10. New Appeal Rights for Overpayments and Reopenings

(Effective Date: Revised initial determinations issued on or after May 1, 2005)

Previously, revised initial determinations had appeal rights to the hearing officer for part B claims where over \$100 remained in controversy and appeal rights to the review level for part B claims where under \$100 remained in controversy. For Part A claims with revised initial determinations, appeal rights were provided

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at the reconsideration level. For all revised initial determinations issued on or after May 1, 2005, the first level of appeal will be a redetermination. Your FI will 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).

11. New Appeal Rights for Dismissals

(Effective Date: All redeterminations issued on or after May 1, 2005)

A. Appealing a Dismissal

For redeterminations issued on or after May 1, 2005, parties to the redetermination will have the right to appeal a dismissal of a redetermination request to the QIC. A party to the redetermination may appeal the dismissal if they believe the dismissal is incorrect. The reconsideration request must be filed at the QIC within 60 days of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the FI incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the FI for reopening. It is mandatory for the FI to reopen any case that is remanded to it and issue a new decision. A QIC's reconsideration of an FI's dismissal of a redetermination request is final and not subject to any further review.

B. Vacating a Dismissal

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

C. Dismissal Letters

For any dismissal issued on or after May 1, 2005, your FI will include the following information or similar language in dismissal letters (also see the model dismissal letter in exhibit 4 of CR 3530):

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

1. If you think you have good and sufficient cause, you may ask your FI to vacate their dismissal. The FI will vacate the dismissal if it determines that you have good and sufficient cause. If you would like to request the FI to vacate this dismissal, you must file a request within six months of the date of this notice. In your request, please explain why you believe you have good and sufficient cause. Your FI will provide the address to which such a request should be sent.

2. If you think the FI has incorrectly dismissed your request, you may request a reconsideration of the dismissal by a QIC. Your request must be filed within 60 days of receipt of this letter. The QIC will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the QIC will not consider any evidence for establishing coverage of the claims(s) being appealed. Their examination will be limited to whether the dismissal was appropriate.

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D. Incomplete Requests

The requirements for written requests for redeterminations are included in the Medicare Claims Processing Manual, Chapter 29, sections 40.2.1 and 50.3.1. As noted previously, this manual may be found on the CMS Web site at <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf> on the CMS website.

For all redetermination requests received on or after May 1, 2005, providers (and States) no longer are required to include the date of initial determination in their requests. Previously, FIs were instructed to return requests that did not meet the manual requirements for a complete request. For redetermination requests received on or after May 1, 2005, FIs must handle and count incomplete redetermination requests as dismissals. The above requirements under (C) for vacating and appealing dismissals apply to incomplete requests as well. Parties to the redetermination also have the option to refile their request if any time remains in the filing period (i.e., 120 days of receipt of the initial determination).

When a request is refiled that meets the requirements, the previous dismissal is vacated and reopened. FIs must notify parties of their options in the dismissal notice. (Please see the model dismissal notice for an incomplete request in Exhibit 3 in CR 3530.)

12. Preparing Case Files for Administrative Law Judge (ALJ) Hearings

(Effective Date: All redeterminations issued on or after May 1, 2005)

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

13. Effectuation of ALJ Decisions

In many cases, the ALJ's decision will require an effectuation action on the FI's part. As with QIC decisions, the FI does not effectuate based on correspondence from any party of the ALJ hearing. It takes an effectuation action only in response to a formal decision by the ALJ. The FI will obtain written assurance from the provider if necessary. If the ALJ's decision is favorable to the appellant and gives a specific amount to be paid, the FI effectuates within 30 calendar days of the date of the ALJ's decision or from the date written assurance from the provider is received. If the decision is favorable but the FI must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the ALJ's decision (or date of receipt of written assurance from the provider).

14. Redetermination Acknowledgement Letters

(Effective Date: All redeterminations received on or after May 1, 2005)

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

Additional Information

The official instruction (CR 3530) issued to your FI regarding this change may be found by going to <http://www.cms.hhs.gov/Transmittals/downloads/R146OTN.pdf> on the CMS website.

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If you have any questions regarding these changes, please contact your FI at their toll-free number which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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