Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

Table of Contents
(Rev. 862, 02-17-06)

Crosswalk to Old Manuals

01 - Foreword

10 - CMS Decisions Subject to the Administrative Appeals Process

20 - Who May Appeal

20.1 - Provider or Supplier Appeals When the Beneficiary is Deceased

30 - Where to Appeal and Initial Determinations

30.1 - Social Security Office (SSO)

30.2 - Part A Fiscal Intermediary (FI)

30.2.1 - FI Initial Determinations With Respect to Beneficiaries

30.2.2 - Provider's Right to Appeal Certain Initial Determinations

30.2.3 - Appeals That Involve an Adverse Utilization Review Committee (URC) Decision

30.3 - Part B Carrier (or FI Acting as a Carrier)

30.4 - Quality Improvement Organization (QIO)

30.4.1 - QIO Reconsiderations and Appeals

30.5 - Managed Care Organizations - Health Maintenance Organizations (HMO) and Medicare+Choice Organizations

30.6 - The Regional Office (RO) Responsibility

30.6.1 - Assisting FIs to Obtain Documentation

30.6.2 - Congressional Requests for Part A Reconsideration

30.7 - Time Limits for Filing Appeals

30.8 - Amount in Controversy Requirements

30.9 - Limitation on Liability

40 - Part A Appeals Procedures

40.1 - Finding Good Cause for the Late Filing of Part A Redetermination Requests

40.1.1 - General

40.1.2 - Establishment of Time Limit for Filing

40.1.3 - Conditions Which Establish Good Cause

40.1.4 - Procedures to Establish Good Cause

40.1.5 - Examples of Situations Where Good Cause Exists

40.1.6 - Where Good Cause Is Not Found
40.1.6 - Assisting Handicapped Beneficiaries
40.2 - Reconsideration of a Part A Payment Determination
40.2.1 - Place and Manner of Filing Requests for Reconsideration and What Constitutes a Request for Reconsideration
40.2.2 - Assisting a Beneficiary to Complete Form CMS-2649, Request for Reconsideration of Part A Health Insurance Benefits
40.2.3 - Routing the Reconsideration Request
40.2.4 - Acknowledging Receipt
40.2.5 - Transferring and Dismissing Requests Which Involve Partial or No Jurisdiction, More Than One Component, Stay, or Issue
40.2.6 - Handling of Request - Beneficiary Appeals Before Initial Determination Is Made or After Initial Favorable Determination Is Made, But Before They Are Notified
40.2.7 - Withdrawal of Request
40.2.8 - Notifying Provider or Beneficiary Where There Is a Withdrawal
40.3 - Documenting Part A Reconsideration Requests
40.3.1 - Documentation Sources
40.3.2 - Assembling the File
40.3.3 - Development
40.4 - Evaluating the Evidence and Making the Reconsideration Determination
40.4.1 - Evaluating the Evidence
40.4.2 - Review Prior to Reversal of Initial Payment Determination
40.4.3 - Preparing the Determination
40.4.4 - Completing the Determination
40.4.5 - Notice of Further Appeal Rights
40.4.6 - Preventing Duplicate Payment in Reversal Cases
40.4.7 - Effect of a Reconsideration Determination and Effectuation
40.4.7.1 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is “Confined to Home” - Regional Home Health Intermediaries (RHHIs) Only
40.4.8 - Reconsideration Guide Language
40.4.8.1 - Sample Paragraphs to Be Used by FIs in Sequence as Shown Below
40.4.8.2 - Model Medicare Redetermination Notice
40.5 - Request for Hearing Under Part A
40.6 - Right to Representation Under Part A
40.7 - Reconsiderations, Hearings, and Appeals Where a QIO Has Review Responsibility

40.7.1 - Reconsiderations

40.7.2 - Hearings

40.7.3 - Appeals of Institutional Supplementary Medical Insurance (Part B) Claim Decisions

40.8 - Effect of Court Decisions

40.9 - Right to Representation Under Part A

50 - Part B Appeals Procedures for FIs and Administrative Law Judge Instructions for FIs

50.1 - Redetermination and Hearings Officer (HO) Hearing - Supplemental Medical Insurance

50.2 - Extension of Time Limit for Filing An Appeal

50.3 - Redetermination

50.3.1 - What Constitutes a Request for Redetermination & Handling Beneficiary Inquiries

50.3.2 - Elements of a Redetermination

50.3.3 - Actions Prior to Reversal of Initial Payment Decision

50.4 - The Hearing

50.4.1 - Types of Hearings

50.4.2 - Issues Determined at the Hearing

50.4.3 - Request for Hearing

50.4.4 - Hearing Officer (HO)

50.4.5 - Preparation for the Hearing

50.4.6 - Conduct of an In-Person or Telephone Hearing

50.4.7 - Parties to the Hearing

50.4.8 - In-Person and Telephone Hearing Procedures

50.4.9 - On The Record Decision

50.4.10 - Hearing Decision

50.4.11 - Content of Hearing Decision

50.4.12 - Style of Hearing Decision

50.4.13 - Effectuation of HO Decision

50.5 - RO Examination Of Hearing Decisions

50.6 - Fraud and Abuse

50.6.1- Disclosure of Information

50.7 - Requests for Hearing Before An ALJ

50.7.1 - Scope and Effect of ORA, Social Security Administration (SSA) ALJ Decisions Under Part A

50.7.2 - Determining the Amount in Controversy for ALJ Hearing

50.7.3 - Requests Filed With SSA

50.7.4 - Request for Hearing Filed With the FI

50.7.5 - Action on Incoming Requests for ALJ Hearing

50.7.6 - Request for Claim File (Sent by Hearing Officer)

50.7.7 - Examination of Claim File

50.7.8 - Prehearing Case Review

50.7.9 - Routing the ALJ Hearing Claim File

50.7.10 - Effectuating Decisions

50.7.11 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home" - Regional Home Health Intermediaries (RHHIs) Only

50.7.12 - Effectuation of Reversal of Decision Where There Was Subsequent Utilization of Benefits in the Same Benefit Period

50.7.13 - Effect of Court Decisions

50.7.14 - Standard Exhibits Referred to in Sections 40.5 - 50.7

60 - Part B Appeals Procedures - Carriers

60.1 - Initial Determination

60.2 - Steps in the Appeals Process: Overview

60.3 - FI and Carrier Correspondence With Beneficiaries or Other Parties Regarding Appeals

60.4 - Parties to an Appeal

60.5 - Appointment of Representative

60.5.1 - Appointment of Representative - Introduction

60.5.2 - Who May Be a Representative

60.5.3 - How to Make and Revoke an Appointment

60.5.4 - When to Submit the Appointment

60.5.5 - Where to Submit the Appointment

60.5.6 - Rights and Responsibilities of a Representative

60.5.7 - Validity of an Appointment Over Time

60.5.8 - Timeliness of an Appeal Request and Completeness of Appointment

60.5.9 - Powers of Attorney

60.5.10 - Incapacitation or Death of Beneficiary

60.5.11 - Disclosure of Individually Identifiable Beneficiary Information to Representative

60.6 - Amount in Controversy

60.6.1 - Amount in Controversy Defined

60.6.2 - Amount in Controversy General Requirements

60.6.3 - Principles for Determining Amount in Controversy
60.6.4 - Additional Considerations for Calculation of the Amount in Controversy
60.6.5 - Aggregation of Claims to Meet the Amount in Controversy
60.7 - Extension of Time Limit for Filing a Request for Review or Hearing Officer Hearing
60.7.1 - Good Cause
60.7.2 - General Procedure to Establish Good Cause
60.7.3 - Conditions That May Establish Good Cause for Late Filing by Beneficiaries
60.7.4 - Examples of Situations Where Good Cause for Late Filing Exists for Beneficiaries
60.7.5 - Conditions That May Establish Good Cause for Late Filing by Providers, Physicians, or Other Suppliers
60.7.6 - Examples of Situations Where Good Cause for Late Filing Exists for Provider, Physician, or Other Suppliers
60.7.7 - Good Cause Not Found for Beneficiary, or for Provider, Physician, or Other Supplier
60.8 - Fraud and Abuse
60.8.1 - Fraud and Abuse - Authority
60.8.2 - Inclusion and Consideration of Evidence of Fraud and/or Abuse
60.8.3 - Claims Where There Is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed
60.8.4 - Responsibilities of Reviewers and Hearing Officers (HOs)
60.8.5 - Requests to Suspend the Appeals Process
60.8.6 - Continuing Appeals of Providers, Physicians, or Other Suppliers Who are Under Fraud or Abuse Investigations
60.8.7 - Appeals of Claims Involving Excluded Providers, Physicians, or Other Suppliers
60.9 - Guidelines for Writing Appeals Correspondence
60.9.1 - General Guidelines
60.9.2 - Letter Format
60.9.3 - How to Establish Reading Level
60.9.4 - Required Elements in Appeals Correspondence
60.10 - Disclosure of Information
60.10.1 - General Information
60.10.2 - Disclosure of Information to Third Parties
60.10.3 - Fraud and Abuse Investigations
60.10.4 - Medical Consultants Used

60.10.5 - Multiple Beneficiaries
60.11 - Review - The First Level of Appeal
60.11.1 - Filing a Request for Review
60.11.2 - Time Limit for Filing a Request for Review
60.11.3 - Recording of Inquiries and Other Actions on the Carrier Appeal Report (FI - Form CMS-2591, Carrier - Form CMS-2590)
60.11.4 - The Review
60.11.5 - The Review Determination
60.11.6 - Review Determination Letter
60.11.7 - Effect of the Review Determination
60.12 - Telephone Review Procedures
60.12.1 - Informing the Beneficiary and Provider Communities About the Telephone Review Process
60.12.2 - Issues for Telephone Reviews
60.12.3 - Issues During the Telephone Review
60.12.4 - Time Limit for Requesting a Telephone Review
60.12.5 - Review Requests Made on Behalf of the Party on the Telephone
60.12.6 - Conducting the Telephone Review
60.12.7 - Documenting the Call
60.12.8 - Timely Processing Requirements
60.12.9 - Review Determination Letters
60.12.10 - Education
60.12.11 - Monitoring Telephone Reviews
60.13 - Hearing Officer Hearing - The Second Level of Appeal
60.13.1 - Filing a Request for a Hearing Officer Hearing
60.13.2 - Time Limit for Filing a Request for a Hearing Officer Hearing
60.13.3 - Request for a Hearing Officer Hearing Filed Prior to a Review Determination
60.13.4 - Exceptions to Filing Requirements
60.14 - Request for a Hearing Officer Hearing
60.14.1 - Timely Processing Requirements
60.14.2 - Contractor Responsibilities - General
60.14.3 - Requests for Transfer of In-Person Hearings
60.14.4 - Acknowledgment of Request for a Hearing Officer Hearing
60.14.5 - Case File Development
60.14.6 - Case File Preparation
60.15 - Types of Hearing Officer Hearings
60.15.1 - In-Person Hearing
60.15.2 - Telephone Hearing

60.15.3 - On-the-Record (OTR) Hearing and Decision
60.15.4 - Preliminary On-The-Record (POTR) Hearing and Decision
60.16 - Hearing Officer (HO) Authority and Responsibilities
60.16.1 - Hearing Officer Authority
60.16.2 - Qualifications and General Responsibilities
60.16.3 - Disqualification of HO
60.17 - Hearing Officer Hearing Procedures
60.17.1 - Preparation for the Hearing Officer Hearing
60.17.2 - Scheduling the Date, Time, and Place of Hearing
60.17.3 - Adjournment and/or Postponement of Telephone or In-Person Hearing
60.17.4 - Pre-Hearing Review of the Evidence
60.17.5 - Forwarding Copy of Case File Prior to Telephone Hearing
60.17.6 - In-Person and Telephone Hearing Officer Hearing Procedures
60.17.7 - The Hearing Officer Hearing Decision Timeliness
60.18 - Effectuation of Hearing Officer Hearing Decisions
60.18.1 - General Rule
60.18.2 - Delaying Effectuation
60.18.3 - Elements of Written Request for Reopening
60.18.4 - Notice to Parties of Reopening Request
60.18.5 - HO Reply to Reopening Request
60.18.6 - Notice to Parties of HO Determination
60.18.7 - Payment of Interest on HO Decisions
60.19 - Requests for Part B Administrative Law Judge (ALJ) Hearing
60.19.1 - Right to Part B ALJ Hearing
60.19.2 - Forwarding Requests to SSA/OHA
60.19.3 - Case File Preparation
60.19.4 - Case Tracking System
60.19.5 - Acknowledgment of Request for Part B ALJ Hearing
60.19.6 - Model Format for Acknowledgment of ALJ Hearing Request
60.20 - Effectuation of Part B ALJ Decisions/Dismissals
60.20.1 - Review and Effectuation of ALJ Decisions - General
60.20.2 - Effectuation Time Limits
60.20.4 - Misrouted ALJ Case Files
60.20.5 - Duplicate ALJ Decisions
60.20.6 - Payment of Interest on ALJ Decisions
60.21 - Recommending Agency Referral of Part B ALJ Decisions or Dismissals to the CMS RO

60.21.1 - Time Limits for Forwarding Agency Referral Memorandum to CMS RO
60.21.2 - Guidelines for Reviewing ALJ Decisions/Dismissals
60.21.3 - Draft Agency Referral Memorandum Content
60.21.4 - Draft Memorandum Format
60.21.5 - Submission of Draft Agency Referral Memorandum to CMS RO
60.22 - Effectuation of Departmental Appeals Board (DAB) Orders and Decisions
60.22.1 - Background
60.22.2 - Requests for Case Files
60.22.3 - Contractor Effectuation Responsibilities
60.22.4 - Payment of Interest on DAB Decisions
60.23 - Request for U.S. District Court Review by a Party
60.24 - Effectuation of U.S. District Court Decisions
60.24.1 - Payment of Interest on U.S. District Court Decisions
60.28 - List of Exhibits
Exhibit 16 - Model Language to Supplier or Independent Practitioner
Exhibit 17 - Recommended Responses to Requests for Reopenings
Exhibit 18 - Special Notice to Providers, Physicians, Suppliers and Other Independent Practitioners
Exhibit 19 - Reopenings Policy
70 - Glossary
70.1 - Workload Data Analysis Program
70.2 - Quality Improvement Activities
70.3 - Submitting Summary Reports to CMS
80 - Managing Appeals Workloads
80.1 - Standard Operating Procedures
80.2 - Execution of Workload Prioritization
80.3 - Workload Priorities
90 - Reopening and Revision of Claim Determinations and Decisions
90.1 - Development of Appeals
90.2 - How Issues May Arise
90.3 - Summary of Conditional Under Which a Determination or Decision May be Reopened
90.4 - Determining Date of Initial or Appeal Determination or Decision
90.5 - Who May Reopen an Initial Appeal Determination or Decision

90.6 - Actions to Permit Reopening Within the 1-Year or 4-Year Period

90.7 - Good Cause for Reopening

90.8 - Definitions

90.9 - Unrestricted Reopening

90.10 - Reopening an Initial Decision

90.11 - Reopening a Redetermination

90.12 - Reopening a Hearing Officer Hearing Decision

90.13 - Notice of Results of Reopening

90.14 - Exception to Sending Notice of Revision to Parties - Cases Involving Limitation to Recovery From Beneficiary

90.15 - Refusal to Reopen is Not an "Initial Determination"

90.16 - Revised Determination or Decision

90.17 - Reopened HO Decision as a Result of an ALJ Remand

100 - List of Exhibits

Exhibit 17 - Recommended Responses to Requests for Reopenings

Exhibit 18 - Special Notice to Providers, Physicians, Suppliers and Other Independent Practitioners

Exhibit 19 - Reopenings Policy

110 - Glossary

200 - CMS Decisions Subject to the Administrative Appeals Process

210 - Who May Appeal

210.1 - Provider or Supplier Appeals When the Beneficiary is Deceased

220 - Steps in the Appeals Process: Overview

230 - Where to Appeal

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

240.1 - Good Cause

240.2 - General Procedure to Establish Good Cause

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

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

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

250 - Amount in Controversy Requirements

250.1 - Amount in Controversy General Requirements

250.2 - Principles for Determining Amount in Controversy

250.3 - Aggregation of Claims to Meet the Amount in Controversy

260 - Parties to an Appeal

270 - Appointment of Representative

270.1.1 - Appointment of Representative - Introduction

270.1.2 - Who May be a Representative

270.1.3 - How to Make and Revoke an Appointment

270.1.4 - When to Submit the Appointment

270.1.5 - Where to Submit the Appointment

270.1.6 - Rights and Responsibilities of a Representative

270.1.7 - Duration of Appointment

270.1.8 - Curing a Defective Appointment of Representative

270.1.9 - Incapacitation or Death of Beneficiary

270.1.10 - Disclosure of Individually Identifiable Beneficiary Information to Representative

270.2.1 - Assignment of Appeal Rights - Introduction

270.2.2 - Who May be an Assignee

270.2.3 - How to Make and Revoke a Transfer of Appeal Rights

270.2.4 - When to Submit the Transfer of Appeal Rights

270.2.5 - Where to Submit the Transfer of Appeal Rights

270.2.6 - Rights of the Assignee of Appeal Rights

270.2.7 - Duration of Transfer of Appeal Rights

270.2.8 - Curing a Defective Transfer of Appeal Rights

270.2.9 - Disclosure of Individually Identifiable Beneficiary Information to Representative

280 - Fraud and Abuse

280.1 - Fraud and Abuse - Authority

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

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

280.4 - Responsibilities of Adjudicators

280.5 - Requests to Suspend the Appeals Process

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

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

290 - Guidelines for Writing Appeals Correspondence

290.1 - General Guidelines

290.2 - Letter Format

290.3 - How to Establish Reading Level

290.4 - Required Elements in Appeals Correspondence

300 - Disclosure of Information

300.1 - General Information

300.2 - Disclosure of Information to Third Parties

300.3 - Fraud and Abuse Investigations

300.4 - Medical Consultants Used

300.5 - Multiple Beneficiaries

310 - Redetermination - The First Level of Appeal

310.1 - Filing a Request for Redetermination

310.2 - Time Limit for Filing a Request for Redetermination

310.3 - Reporting Redeterminations on the Appeals Report

310.4 - The Redetermination

310.5 - The Redetermination Decision

310.6 - Dismissals

310.6.1 - Appeal Rights for Dismissals

310.6.2 - Vacating a Dismissal

310.6.3 - Dismissal Letters

310.6.4 - Model Dismissal Notices

310.7 - Medicare Redetermination Notice (for partly or full unfavorable redeterminations)

310.8 - Medicare Redetermination Notice (for fully favorable redeterminations)

310.9 - Effect of the Redetermination

320 - Reconsideration - The Second Level of Appeal

320.1 - Filing a Request for a Reconsideration

320.2 - Time Limit for Filing a Request for a Reconsideration

320.3 - Contractor Responsibilities - General

320.4 - QIC Case File Development

320.5 - QIC Case File Preparation
320.6 - Forwarding QIC Case Files
320.7 - QIC Jurisdictions
320.8 - Tracking Cases
320.9 - Effectuation of Reconsiderations
330 - Administrative Law Judge (ALJ) - The Third Level of Appeal
330.1 - Right to an ALJ Hearing
330.2 - Requests for an ALJ Hearing
330.3 - Forwarding Request to HHS/OMHA
330.4 - Review and Effectuation of ALJ Decisions
330.5 - Effectuation Time Limits & Responsibilities
330.6 - Duplicate ALJ Decisions
330.7 - Payment of Interest on ALJ Decisions
340 - Departmental Appeals Board - The Fourth Level of Appeal
340.1 - Recommending Agency Referral of ALJ Decisions or Dismissals
340.2 - Effectuation of Departmental Appeal Board Orders and Decisions
340.3 - Requests for Case Files
340.4 - Payment of Interest on DAB Decisions
345 - U.S. District Court Review - The Fifth Level of Appeal
345.1 - Requests for U.S. District Court Review by a Party
345.2 - Effectuation of U.S. District Court Decisions
345.3 - Payment of Interest of U.S. District Court Decisions
350 - Workload Data Analysis Program
360 - Managing Appeals Workloads
360.1 - Standard Operating Procedures
360.2 - Execution of Workload Prioritization
360.3 - Workload Priorities

01 – Foreword

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

This manual provides instructions for the Medicare appeals process. These instructions describe the decisions that may be appealed, by whom and how, and include instructions for FIs (including RHHIs) and carriers (including DMERCS) for processing the various types of appeals.

About the organization of this chapter:

- **Sections 10-30** apply to **FIs and carriers** and contain general information about parties to appeals, initial determinations, and where to appeal.
- **Section 40** applies to **FIs** in processing redeterminations on part A claims. FIs follow other sections when there is a cross reference noted. (Example: section 40.1.3 on conditions which establish good cause refers to §60.7.5 for conditions which establish good cause for providers and suppliers who are representing beneficiaries. This means FIs must also follow §60.7.5.)
- **Section 50** contains instructions for **FIs** in processing part B redeterminations and hearings. The FIs follow instructions in §60 when there is a cross reference noted.
- **Section 50** also contains instructions for **FIs** for processing both part A and part B instructions for ALJ requests received by FIs. The FIs follow instructions in section 60 when there is a cross reference noted.
- **Section 60** contains instructions for **carriers** in processing appeals. The FIs follow this section when there is a cross reference noted in section 40 or 50.
- **Section 70** contains instructions for **FIs and carriers** on review and analysis of initial determinations and appeal decisions.
- **Section 80** contains instructions for **FIs and carriers** on managing appeals workloads.
- **Section 90** contains instructions for **FIs and carriers** on reopenings.
- **Section 100** contains the exhibits.
- **Section 110** contains the glossary.

10 - CMS Decisions Subject to the Administrative Appeals Process

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

See §30.1 for Part A and Part B initial determinations with respect to entitlement and enrollment and §30.2 for initial determinations made by FIs (including part B determinations made by FIs), § 30.3 for initial determinations made by carriers, §30.4 for initial determinations made by QIOs, and §30.5 for initial determinations made by HMOs and M+COs.

20 - Who May Appeal

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

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 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. These procedures apply to the hearing 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 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. These procedures apply to the hearing process as well.
- An institutional provider, to the extent the services have been denied as not being reasonable or necessary, and neither the beneficiary nor the provider knew or could reasonably have been expected to know the services were not covered, and the beneficiary has been found not liable or indicates in writing an intention to not appeal the decision. (If the beneficiary appeals the initial determination, the provider is made a party to the appeal.);
- 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 §30.7 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 §30.7 apply for filing requests for redetermination and hearing, 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 §20.1 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 any level of the administrative appeals process, and therefore does not have the right to appeal or to participate as a party at any stage in the administrative appeals process. At times, CMS will make an agency referral of an Administrative Law Judge (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. (See §60.21.) At times, an ALJ may ask for contractor 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 §60.5.6 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.

20.1 - Provider or Supplier Appeals When the Beneficiary is Deceased

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

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.

30 - Where to Appeal and Initial Determinations

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

- The Social Security Office (SSO) - See §30.1.
- Part A Intermediary (FI), including regional home health intermediary (RHHI), hereafter referred to as FI - See §30.2.
- Part B Carrier, including durable medical equipment regional carrier (DMERC), hereafter referred to as carrier - See §30.3.
- Quality Improvement Organization (QIO) - See §30.4.
- Health Maintenance Organization (HMO) - See §30.5.
- Railroad Retirement Board for RRB retirees.

30.1 - Social Security Office (SSO)

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

In accordance with a memorandum of understanding with the Secretary, SSA makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. Individuals should write to (or visit) the SSO 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.

30.2 - Part A Fiscal Intermediary (FI)

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

The FI makes initial determinations and provides administrative appeal procedures for adverse decisions regarding the initial determinations it makes with respect to both beneficiaries and providers.

30.2.1 - FI Initial Determinations With Respect to Beneficiaries

(Rev. 1. 10-01-03)

A3-3781.1

An initial determination with respect to a beneficiary is any determination concerning a request for payment under Part A relating to:

- Coverage of furnished items and services;

- Amount of the deductible;
- Application of the coinsurance provision;
- The number of inpatient hospital days used towards the 190-day lifetime limitation of inpatient psychiatric hospital covered days;
- The number of lifetime reserve days utilized;
- The number of SNF days utilized;
- The physician certification requirement;
- The request for payment requirement;
- The beginning and ending of a benefit period;
- The medical necessity of the services;
- A determination with respect to the limitation on liability provision (see §1879 of the Act); and
- Any issue(s) affecting the amount of benefits payable, including overpayments and underpayments.

NOTE: The Physician Fee Schedule and the unadjusted copayment amount under §1833(t)(3) of the Act are not appealable.

30.2.2 - Provider's Right to Appeal Certain Initial Determinations

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

Section 1879(d) of the Act establishes that the provider has a limited right to challenge, through the appeals process and the courts, an FI decision that items or services furnished are not covered because they:

- Are not reasonable and necessary;
- Were not intermittent;
- Constituted custodial care; and
- The patient was not homebound.

Such challenge may be made only if the ultimate liability rests with the provider or, under certain circumstances, with the beneficiary. The provider and the FI should attempt to resolve mutually any differences involving payment that arise from the application of the cost formula or the amount payable in a specific case. The Medicare Provider Reimbursement Manual (PRM) §§2426, addresses the provider's right to request a hearing on disputed cost reports. The provider may appeal an initial determination only if:

- Items or services are not covered because they are not reasonable and necessary or constituted custodial care;
- Neither the beneficiary nor the provider knew or could reasonably have been expected to know that the services were not covered; and

- The beneficiary has been found not liable for the cost of the service(s) under limitation on liability or indicates in writing that he/she does not intend to request redetermination of the FI's initial determination. A determination is made that the beneficiary will not exercise his/her appeal rights if:
    - The beneficiary's liability was not waived for a portion of the items or services, and the beneficiary has stated in writing that he/she does not intend to request a redetermination; or
    - The beneficiary's liability was entirely waived in the initial determination.

If the beneficiary appeals the FI's initial determinations, the provider is made a party to the appeal.

NOTE: The Physician Fee Schedule and the unadjusted co-payment amount under §1833(t)(3) of the Act are not appealable.

30.2.3 - Appeals That Involve an Adverse Utilization Review Committee (URC) Decision

(Rev. 1. 10-01-03)

A3-3781.4, HO-287.4.C

A decision rendered by a URC is essentially a medical decision made by the provider to assure proper utilization of inpatient facilities. Inherent in such a decision are certain coverage implications for the program, e.g., that the individual required only a noncovered level of care or that no further care of any kind was necessary. While the findings of the URC are evidence that must be considered in making a determination and must be given great weight, they are not CMS determinations. Therefore, the beneficiary may not appeal to CMS either the URC's findings or any **provider** actions resulting from such findings (e.g., a request by the hospital to the beneficiary to leave). If the provider has internal appeal procedures, the beneficiary may appeal to the provider.

The beneficiary may require that the provider submit a demand bill to Medicare anyway; but this is not considered an appeal. See Chapter 1 for a discussion of demand bills.

While the URC is responsible for making a medical finding, the FI is responsible, under the terms of its contract with the Secretary, for determining the **coverage** of services on a claim. In most cases, through an exchange of information among institutions, physicians, URCs, and FI medical staff, the medical finding made by the URC and the coverage determination coincide. Regardless of whether the adverse coverage determination was precipitated by a negative finding of a URC, the beneficiary has a right to file a request for reconsideration.

If a beneficiary, while still dealing with the provider, disagrees with a finding regarding entitlement to health insurance benefits, the denial of reimbursement, with the amount of reimbursement, or with the promptness of payment for items or services furnished under hospital or medical insurance, and the problem is simply amenable to explanation or correction; the provider should handle it. If the patient wishes to protest the health insurance determination on his/her request for payment or the promptness of payment, the provider refers him/her to the FI. The FI will offer the beneficiary assistance in

determining his/her appeal rights, answer specific questions about the appeal procedures, and assist the individual in completing the necessary forms for requesting the appeal.

For issues involving entitlement, the referral is to the SSO.

30.3 - Part B Carrier (or FI Acting as a Carrier)

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

The carrier makes the first adjudication (judgment) following a request for Medicare payment for Part B claims under Title XVIII of the Act. A notice of initial determination provides appropriate appeals information to the parties. (See §20.)

Examples of determinations that are initial determinations regarding claims for benefits under Medicare part B include:

- Whether the deductible has been met;
- Whether the services furnished are covered; and
- Whether the charges for items or services furnished are reasonable.

Two specific instances that are **not** initial determinations regarding claims for benefits under Medicare part B are:

- Any determination that CMS or SSA has sole responsibility for making, e.g.,
  - CMS - Whether an independent laboratory meets the conditions for coverage of services; whether a Medicare overpayment claim should be compromised or a collection action terminated or suspended:
  - SSA - Whether the individual has attained 65; whether the individual is qualified as a railroad beneficiary; and
- Any issue or factor that relates to hospital insurance benefits under Medicare Part A.

Further, a party may not appeal a contractor's use of the Physician Fee Schedule or other payment systems.

The initial determination is binding unless a party to the initial determination, such as the beneficiary or a physician or other supplier, requests an appeal. The Medicare Part B administrative appeals process is available to resolve beneficiary, provider, physician, or other supplier questions/concerns about payment and coverage decisions. In instances where appeal rights have been exhausted or lapsed, the contractor may have the authority to reopen its determination. (See §90 and 42 CFR 405.841.)

NOTE: Under §1842(l) of the Act, nonparticipating physicians and other suppliers have limited appeal rights. (See §60.4, below, for more information on parties to an appeal.)

Nonparticipating physicians and suppliers (A physician or supplier who does not accept assignment on all Medicare claims) who have **not** taken assignment (agreed to accept Medicare's fee as full payment) do **not** have appeal rights just because they are now receiving initial determination notices. It is important to be aware that nonparticipating physicians and suppliers now have access to more

beneficiary information through the remittance advice notice than they had before. Therefore, in the situation where a nonparticipating physician or supplier states that he/she is filing an appeal on behalf of a beneficiary, the contractor must confirm that the nonparticipating physician or supplier has either been designated as an appointed representative of a party or is indeed filing at the request of the beneficiary.

See §30.2.2 for provider's rights to appeal certain initial determinations.

30.4 - Quality Improvement Organization (QIO)

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

The Tax Equity and Fiscal Responsibility Act of 1982 modified Part B of Title XI of the Act to establish the QIO utilization program. The QIO reviews inpatient hospital care provided to Medicare beneficiaries to ensure that the care is medically necessary, reasonable, provided in the appropriate setting, and meets professionally recognized standards of health care. It also reviews home health, SNF, and hospital outpatient care (other than ambulatory surgery) to ensure that the care meets professionally recognized standards of health care.

The QIO denies payment only for inpatient hospital or outpatient ambulatory surgical services. In addition, the QIO makes limitation on liability determinations for the claims it reviews.

30.4.1 - QIO Reconsiderations and Appeals

(Rev. 1. 10-01-03)

QIO-7410

Payment determinations made by a QIO may be reconsidered only by the QIO. If the denial was made because the provider circumvented the Prospective Payment System (PPS) system through inappropriate transfers or admissions, the denial notice goes only to the provider and physician. If the denial was made because the services were not medically necessary, or because the care should have been provided in a different setting; the beneficiary, the provider, and the physician receive notice of the reconsideration determination. Only the beneficiary may appeal. If, after it is determined the services were not medically necessary, or should have been provided in a different setting, it is also determined that the provider knew or should have known the services would not be covered and, therefore, is found to be liable, the provider may appeal only the waiver determination. Where a QIO reverses a prior determination, it communicates the result to the FI. Where appropriate, the FI informs the provider to submit the necessary bill.

For more information about QIO appeals, see the Medicare QIO Manual, Part 7.

30.5 - Managed Care Organizations - Health Maintenance Organizations (HMO) and Medicare+Choice Organizations

(Rev. 1. 10-01-03)

HMO-2403, MMCM, Chapter 13, Section 3

An initial determination for an HMO is:

A. A determination concerning the rights of an enrollee with regard to services covered by Medicare that are furnished by the organization; and

B. Any determination made concerning the following items:

- Reimbursement for emergency or urgently needed services;
- Any other health services furnished by a provider or supplier other than the organization that the enrollee believes are Medicare covered and should have been furnished, arranged for, or reimbursed by the organization; or
- The organization's refusal to provide services the enrollee believes the organization is obligated to cover, and the enrollee has not obtained them elsewhere

An initial determination for a Medicare+Choice (M+C) organization is any determination (i.e., an approval or denial) made by the M+C organization, or its delegated entity, with respect to the following:

- Payment for temporarily out-of-area renal dialysis services;
- Payment for emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider (other than the M+C organization), that the enrollee believes
  - Are covered under Medicare, or
  - If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the M+C organization;
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the enrollee believes should be furnished or arranged by the organization;
- Discontinuation of a service that the enrollee believes should be continued because he/she believes the service to be medically necessary, in accordance with this chapter; and
- Failure of the M+C organization to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

The Managed Care Organization, whether it be an HMO or a Medicare+Choice Organization, issues a written notice for all initial determinations and resolves all disputes involving initial determinations through the appeals procedures.

30.6 - The CMS Regional Office (RO) Responsibility

(Rev. 1. 10-01-03)

RO2-3600

30.6.1 - Assisting FIs to Obtain Documentation

(Rev. 1. 10-01-03)

RO2-3600

Sometimes one FI must obtain evidence from a provider serviced by another FI; e.g., in a skilled nursing facility case, the hospital discharge summary might be needed. In such instances the FI handling the reconsideration contacts the FI servicing the other provider in writing (§§40.3 - 40.3.1). The CMS instructs the servicing FI to process the request as expeditiously as possible.

If the requesting FI has not received a reply within 21 days, it sends a copy of its request to the RO. The RO then contacts the servicing FI, or if it is not in the region, the RO servicing the other FI. The contact to request that the matter be expedited should be made by telephone. If a delay of more than 15 days is expected, the RO notifies the requesting FI. If the reconsideration FI has not received a reply from the assisting FI or a status report from the RO after 15 days (20 days when another region is involved), the reconsideration FI follows up with the RO by telephone. For the second follow-up, the RO should use its discretion whether to utilize the telephone or letter.

FIs that have found that it is more expeditious to have the provider that submitted the original claim contact the other provider may continue to do so. The RO will not become involved in this type of request.

Where the issue concerns emergency inpatient hospital services in a nonparticipating hospital, the FI sends the request for reconsideration to the RO for a determination of accessibility. After the RO makes its determination, it routes the request for reconsideration to the designated FI.

30.6.2 - Congressional Requests for Part A Reconsideration

(Rev. 1. 10-01-03)

RO2-3610

Congressional inquiries received by the RO that involve the denial of Part A Medicare benefits are forwarded to the appropriate FI for a direct response to the Member of Congress.

When the contractor has honored a request for reconsideration filed by a Member of Congress pursuant to a Congressional inquiry made on behalf of a beneficiary, provider, or 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, but does not include release of personal information about a beneficiary that the Member of Congress did not already have in their possession. 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.

30.7 - Time Limits for Filing Appeals

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

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

- Redetermination - The time limit for filing a request for redetermination is 120 days from the date of receipt of the notice of initial determination (Medicare Summary Notice (MSN) or Remittance Advice (RA)). (See §40.1.5 or §60.7 for clarifications and exceptions to this rule.) (See Chapters 21 and 22,);
- Part B Hearing Officer Hearing - The time limit for filing a request for a Part B Hearing Officer Hearing is six months from the date of the redetermination letter;
- ALJ Hearing - The time limit for filing a request for ALJ hearing is 60 days after the date of receipt of the redetermination notice, or 60 days after the date of receipt of the Part B hearing officer (HO) hearing decision letter, as applicable;
- 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; and
- 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 with SSA as of the date the contractor received it.

The contractor computes the time limit for requesting redetermination and a Part B Hearing Officer Hearing by allowing 5 additional days beyond the time limit (120 days for a redetermination or Part B Redetermination, 6 months for Part B Hearing Officer Hearing) from the date of the previous notice. This allows a 5-day period for mail delivery.

These time limits may be extended if good cause for late filing is shown. (See §40.1.5.) When an appeal (redetermination or HO hearing) request appears to be filed late, the contractor makes a finding of good cause using the guidelines in §40.1.5) before taking any other action on the appeal.

For Part B appeals of initial determinations made on or after October 1 2002, contractors are to grant extensions of up to 60 days in the 120 day filing deadline, provided that the appeal request includes a credible explanation from the appellant that the time was needed to gather the necessary supporting records. Once a final regulation to implement all BIPA provisions is issued, CMS will issue further instructions regarding the granting of such extensions.

If the request is for an ALJ hearing, the ALJ makes the good cause determination. If the request is for DAB review, the DAB makes the determination.

30.8 - Amount in Controversy Requirements

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

- For a Part A or Part B redetermination, there is no amount in controversy requirement.

- For a Part B Hearing Officer hearing, or an ALJ hearing for either a Part A claim or a Part B claim, the amount in controversy for initial determinations made on or after October 1, 2002 must equal or exceed $100. *
- For Part B initial determinations made prior to October 1, 2002, the amount in controversy for an ALJ hearing is $500.
- There is no amount in controversy for a DAB review.
- For a hearing in Federal District Court, the amount in controversy for either a Part A or a Part B claim is $1,000. * ($1,050 when judicial court review is requested on or after January 1, 2005)

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

30.9 - Limitation on Liability

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

Procedures for applying Limitation on Liability

Automatic Consideration on Initial Determination, Redetermination, Hearing, or Reopening

The decision of whether the liability of the beneficiary and the provider, physician or supplier can be limited is made at the initial determination. It is also made at the time of a redetermination, hearing, or reopening. The parties to the redetermination, hearing, or reopening determination may seek a Part B hearing on both the coverage and limitation of liability issues. In the reopening, redetermination, or hearing process, a limitation of liability determination is made when items or services have been denied as not reasonable and necessary whether either party--the beneficiary or the supplier accepting assignment--has directly raised the issue. In some cases, it will be necessary for the reviewer to obtain additional statements or other evidence from one or both parties to make the limitation of liability determination.

In every reopening, redetermination, or hearing, where the limitation of liability provision is applicable, the determination consists of two stages. The first stage is a new, independent and critical reexamination of the facts regarding the coverage issue. If the original decision regarding coverage was appropriate, the second stage is the decision whether to limit the liability of the beneficiary and, if so, whether to also limit the liability of the physician or supplier.

Redeterminations in assignment cases are conducted at the request of either the beneficiary or the assignee. Frequently, the redetermination request is received from only one of these parties and the only notice to the other party that a redetermination has been requested is a copy of the determination, i.e., after the fact. In assigned claims involving

limitation of liability, the parties may have adverse interests in the limitation of liability decision, since a physician or supplier may seek to show reason why the beneficiary's liability should not be limited in order to be able to collect a fee from the beneficiary. Therefore, when you receive a request for a redetermination (on a case involving limitation of liability on an assigned claim), send a notice that a request has been filed to the other party to the redetermination indicating that that party may submit additional evidence. Allow the other party 14 days to provide any evidence. This is necessary to satisfy the statutory requirement that both parties be informed of their rights and privileges in the redetermination process. These procedures extend to the hearing process as well. If the decision on the case will be fully favorable based on new information or evidence, it is not necessary to provide the other party with the opportunity to submit additional evidence.

40 - Part A Appeals Procedures

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

A party dissatisfied with the FI's initial determination is entitled by law and regulations to specified appeals. Medicaid State agencies and parties authorized to act on behalf of Medicaid State agencies may submit an appeal request on behalf of beneficiaries entitled to Medicare and eligible for Medicaid. The State agency should cease submitting beneficiary authorization forms or other beneficiary representation forms with the appeal request.

The first level of appeal is redetermination (42 CFR 405.700, et seq.). If the party is dissatisfied following redetermination and the amount in controversy is at least $100, the party is entitled to a hearing before a Federal ALJ (§1869(b)(2)(A) of the Act).

NOTE: Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

If the dissatisfaction continues after the ALJ's decision, the appellant may request the DAB to review the decision. The DAB may, on its own motion, review an ALJ decision. After DAB review or its denial of review, an appellant who is dissatisfied may file a civil action in the U.S. District Court for a review of the final administrative decision if the amount in controversy is $1,000 ($1,050 if requested on or after January, 1, 2005) or more.

A Adjustments

Following an initial determination, the FI may receive an oral or written inquiry concerning its determination. If an error was made that adversely affects payment but does not require medical review and that would result in payment if corrected, the FI processes an adjustment chargeable to the initial claims processing. Where there is an adjustment, the FI notifies the party that it is revising the initial determination.

If the adjustment constitutes a partial reversal, the FI informs the party that it will conduct a redetermination if the party is dissatisfied with the revised determination. If the contact

is a formal written request for redetermination, the FI notifies the party that it is proceeding with the redetermination and will notify the party of the results.

NOTE: If medical review is required, the FI does not make an adjustment. It conducts a redetermination.

B Reopenings and Revisions

Refer to §90.

C QIO and HMO Appeal Requests

Refer to §40.10

D Part A Redetermination

NOTE: Beginning on October 1, 2004, reconsiderations will be called "redeterminations."

A redetermination is a reevaluation of the facts and findings of a claim by a separate entity within the FI's organization (e.g., Redetermination Unit) to determine whether the initial decision was correct and to make appropriate revisions.

40.1 - Finding Good Cause for the Late Filing of Part A Redetermination Requests

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

40.1.1 - General

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

The FI extends the 120 day time limit for filing a redetermination if good cause is shown. If a redetermination request is filed late, the FI resolves the issue of whether good cause exists for the delay prior to taking any other action. In addition to the time limit for filing the redetermination, the FI allows 5 days beyond the date of the notice for mail delivery. (See subsection B.) For example, a beneficiary who received a notice of an initial claim decision dated June 17, 2004, had through October 15, 2004, (120 days from June 22 through October 20 including 5 days for mail delivery of the initial determination notice (6/17/04 through 6/22/04)) to file timely. If, however, the request is filed late and the FI determines that good cause exists, it accepts the redetermination and handles it as a regular case.

40.1.2 - Establishment of Time Limit for Filing

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

The FI, Hearing Officer, ALJ, or DAB computes the end of the period for filing the redetermination as follows:

Full Denial - When the initial determination was a full denial, the FI counts the 120 day period from the date of receipt by the party of the determination, normally 5 days after the mailing date of the denial notice. Ordinarily, a copy of the notice will have been attached to the redetermination request by the party or by the SSO. However, since some

beneficiaries will not keep the notice or include it with the redetermination request, it is essential for the FI to have a copy of the denial notice in its file.

Partial Denial - When an initial determination was a partial denial, the FI counts the 120-day period from the date the party receives the MSN or RA, normally 5 days after the mailing date of the notice.

Alternative Method in Full or Partial Allowance Cases - The FI applies this method where the MSN or RA is not attached to the request and the request was filed more than 6 months after the date of the notice. The FI develops the case for good cause. If it finds good cause, it processes the redetermination. It annotates the Form CMS-2649 in Item 10, Remarks, of page 2 "timely filing questionable" and explains the reason for good cause.

Beneficiary Alleges Later Date of Receipt - Where the beneficiary establishes that he/she could not have received the notice advising him/her of his/her appeal rights until a date later than the presumed delivery date (e.g., the beneficiary was away from home for an extended period), the FI counts the 120 days from the earliest date on which receipt could reasonably be established.

40.1.3 - Conditions Which Establish Good Cause

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

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

- Circumstances beyond the individual's control, including mental or physical impairment (e.g., disability, extended illness), or significant communication difficulties;
- The death of the individual or his/her advanced age (advanced age is met automatically if the individual attains age 75 prior to the date services began in the contested claim);
- Incorrect or incomplete information about the subject claim furnished by official sources (SSA, CMS, or the FI) to the individual, e.g., whenever a beneficiary is not notified of his/her appeal rights or the time limit for filing;
- Delay resulting from efforts by the individual to secure supporting evidence where the individual did not realize that such evidence could be submitted after filing a redetermination;
- Unusual or unavoidable circumstances, the nature of which demonstrate that the individual could not reasonably be expected to have been aware of the need to file timely; or
- Destruction by fire, or other damage, of the individual's records when the destruction was responsible for the delay in filing.

NOTE: When the beneficiary's claim is being handled by a representative of the beneficiary (§60.5.6), these conditions apply to the representative. For conditions which establish good cause for late filing by providers or suppliers who are representing a beneficiary, see §60.75.

40.1.4 - Procedures to Establish Good Cause

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

When a Form CMS-2649, request for redetermination, is filed after the expiration of the time period, the FI uses the following procedures.

- If the request contains the reasons for delay (or other evidence that establishes the reason), the FI bases the determination of whether good cause may be found primarily on the statement. When there is no adequate statement and there is no other sufficient evidence in the file, it obtains an explanation of the reason(s) for delay from the party.
- The FI annotates the redetermination request with the remark "time limit for filing expired." Where the alternative method for finding good cause is used, it enters the remark "timely filing questionable."
- The FI makes the good cause finding on the basis of a review of the statement by the beneficiary or his/her representative of the reasons for delay, any other evidence already in file or received with the request that relates to the late filing issues, and any documentation in file regarding the particular claim. (Additional documentation regarding the claim need not be requested from the provider until the good cause finding is made.)
- Where the reasons for delay are not controverted by other evidence and/or are substantiated by the record, the FI accepts the statement as written in finding good cause. If evidence in the record leads the FI to doubt the veracity of the statement, it obtains a statement from the beneficiary or his/her representative. Evidence that a proper notice was mailed is not sufficient reason to conclude that the notice was received.
- On the redetermination request, the FI enters the reason for the delay and its finding relative to good cause.

40.1.5 - Examples of Situations Where Good Cause Exists

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

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

- Beneficiary was hospitalized and extremely ill, causing a delay in filing. Statement indicates that he planned to appeal. Request was filed fewer than 60 days late. The FI would find good cause by reason of extended illness or disability;
- Beneficiary is deceased. Her husband, who would be the likely person to file as her next of kin, died during the period for filing the redetermination. Request was filed 2 months late by the deceased husband's executor. The FI would find good cause by reason of the death of the representative;
- Beneficiary is 76 years old and is not represented. The FIs would find good cause by reason of advanced age;

- Evidence substantiates that the beneficiary was collecting additional documentation prior to filing. The FI would find good cause by reason of lack of awareness that evidence could be submitted after filing;
- Beneficiary is deceased. His wife, who would be the likely person to file as his next of kin, is not fluent in English and did not comprehend the denial notice. Her daughter-in-law filed immediately on learning that no appeal had been made. Request was 3 months late. The FI would find good cause by reason of circumstances demonstrating that the individual could not reasonably be expected to have been aware of the need to file timely;
- The denial notice sent to the beneficiary did not specify the time limit for filing for redetermination. The FI would find good cause by reason of incomplete information furnished by official sources.

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

- The initial notice denied payment; a subsequently issued notice incorrectly indicated that payment was allowed. The beneficiary assumed the second notice was correct. The FI would find good cause by reason of the incorrect information furnished to the beneficiary.

40.1.5.6 - Where Good Cause Is Not Found

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

Where good cause for the late filing of a redetermination request (Form CMS-2649) is not found, the FI would advise the beneficiary (Good cause findings for appeal requests beyond the level of the redetermination are not the FI's responsibility). The FI would send a written notice stating that the request for redetermination has been dismissed and give the reason for the dismissal, e.g., the redetermination request was not filed within the time limit as required and good cause was not found for the failure to file timely. The notice includes an explanation of the initial determination. A copy of this notice is attached to the redetermination request.

NOTE: Where good cause is not established, the FI would examine the case to determine whether there would be any basis for reopening and revising the initial determination. If reopening and revision were undertaken (see §90), the notice of dismissal of the redetermination request would not be sent.

40.1.6 - Assisting Handicapped Beneficiaries

(Rev. 1. 10-01-03)

A3-3781.7

If the FI becomes aware that a beneficiary may have trouble filing an appeal because of a handicap, it offers to assist in the filing process. It completes the appeal request from information taken over the telephone and mails it to the beneficiary to sign and return. If it determines the beneficiary needs additional assistance to file, it provides that assistance.

40.2 - Redetermination of a Part A Payment Determination

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

NOTE: Reconsiderations requests received on or after October 1, 2004 will be called "redeterminations." The new timeliness standard for completing redeterminations is 60 days. 100% of redeterminations received on or after October 1, 2004 must be completed in 60 days of receipt.

40.2.1 - Place and Manner of Filing Requests for Redetermination and What Constitutes a Request for Redetermination

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

The request for redetermination must be in writing and must be filed at the office of the servicing FI, or at an office of CMS (this includes any FIs office), or at an SSO; or in the case of a railroad retirement beneficiary, at an office of the RRB.

Medicaid State agencies and parties authorized to act on behalf of Medicaid State agencies may submit an appeal request on behalf of beneficiaries entitled to Medicare and eligible for Medicaid without first obtaining a signed statement from the beneficiary authorizing the State agency or the party authorized to act on behalf of the State agency to represent the beneficiary.

Most requests will be filed on the prescribed Form CMS-2649, Request for Redetermination of Part A Health Insurance Benefits. (This form is located on the CMS' Web site at http://www.cms.hhs.gov/forms.) Other requests for redetermination must meet the requirements outlined in B or C below depending on who is requesting the redetermination.

Providers/suppliers, Medicaid State agencies, or the party authorized to act on behalf of the Medicaid State agency are responsible for submitting documentation, if any, that supports the contention that the initial determination was incorrect under Medicare coverage and payment policies. This documentation should be supplied with the appeal request or at the request of the FI. Failure to submit requested documentation in a timely manner may result in processing delays.

A. Oral Contacts and Unsigned Written Requests

If the explanation the FI supplied at the time of the party's personal visit to, or telephone conversation with, the FI's office answers the complaint to the satisfaction of the party, no further action is required. If, after the explanation has been given, the party believes that the determination was incorrect, (i.e., not in accordance with the law and regulations), the FI will assist the party in filing a request for Redetermination of Part A health insurance benefits, Form CMS-2649. If the form is not available, the FI will take a dated, written statement signed by the beneficiary expressly requesting that the initial determination be reconsidered and stating briefly the reason for dissatisfaction.

If the initial contact was by telephone, or if the party failed to sign the written request, the FI sends a Form CMS-649, and explains that the form must be completed, signed, and returned.

The FI informs the party that the local SSO or railroad retirement office will provide assistance if desired.

B. Written Complaint or Inquiry Made by Beneficiaries

A written communication from a beneficiary relating to a claim may constitute an expressed request for a redetermination, a statement indicating dissatisfaction with the determination, or simply a request for information. If there is any doubt about what the beneficiary intends, the FI must resolve that doubt.

Beneficiaries may request a redetermination in writing by filing a completed Form CMS-2649. 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 do not actually say "I want a redetermination." For example, an inquiry (either written or verbal) stating, "Why did you pay only $10.00?" where there are noncovered charges, should be considered a request for redetermination. Further, if the beneficiary calls it a "reopening" or asks the FI to reopen its decision, but the request is submitted within the time limit for filing a request for redetermination, the FI should consider this a request for a redetermination. Common examples of phrasing in letters from beneficiaries that constitute requests for redetermination:

- "Please reconsider (review) my claim."
- "Will you please review this denial to see if more payment can be made?"
- "I am not satisfied with the payment decision; please look at it again."
- "My neighbor got paid for the same kind of claim. Mine should be paid also."
- "Last year I was hospitalized for the same condition and the claim was paid for by Medicare."
- "According to my doctor I needed hospitalization, and yet my claim was denied."

The FI treats letters from beneficiaries that contain such phrases as requests for a redetermination. This list is not all-inclusive. If the FI is not certain whether the party has requested additional information or a redetermination, the FI contacts the party by telephone to determine the intent.

If the communication is neither an expressed nor an implied request for redetermination, the FI responds to the issues raised. It might respond to simple matters by telephone, preparing a report of contact, and including it in the claim file along with the written inquiry. Similarly, it includes a copy of any written response to the inquiry in the claim file and retains all such communications and responses in accordance with Chapter 1, "General Billing Requirements" to protect the beneficiary's filing date if it is later determined that a request for redetermination was intended or the same issues are raised. If, during the course of a telephone conversation, a party indicates a desire for a redetermination, the FI sends the appropriate form with instructions for completing, signing and returning it.

C. Written Requests for Redetermination Submitted by a Provider or State

Providers or States with appeal rights (see §20) must submit written requests indicating what they are appealing and why. There are two acceptable written ways of doing this.

1. A completed Form CMS-2649 constitutes a request for redetermination. The FI supplies these forms upon request by an appellant. Completed means that all applicable spaces are filled out and all necessary attachments are attached.

2. The appellant submits a written request for appeal not on a Form CMS-2649, but containing the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of provider of service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form);
- Which item(s), if any, and/or service(s) are at issue in the appeal; and
- Signature of the appellant.

NOTE: Some redetermination requests may contain attachments. For example, if the RA is attached to the redetermination request that does not contain 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 FI concerning the initial determination instead of filing a Form CMS-2649. How to handle such letters depends upon their content and/or wording. A letter serves as an appeal request if it contains the information listed above and either (1) explicitly asks the FI to take further action, or (2) it indicates dissatisfaction with the FI's decision. The FI counts the receipt and processing of the letter as an appeal only if it treats it as an appeal request. The FI must note the details of its actions (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.

If any of this information is not included within the appeal request, the FI returns it to the provider **or** State with an explanation of what information must be included.

D. Beneficiary's Complaint

QIOs have the authority to review written complaints from beneficiaries (or their representatives) about the quality of professional medical services. If the FI receives a beneficiary complaint regarding the quality of professional medical services received in a hospital, SNF, HHA, or in the outpatient department of a hospital, it refers it to the RO. The RO screens it to determine if the complaint requires QIO review of the medical aspects of care.

E. Dismissed Request for Hearing Is an Implied Request for Redetermination

When an ALJ dismisses a request for hearing on the ground that no redetermination has taken place, the dismissed request constitutes an implied request for redetermination. When the FI or the QIO receives the dismissed request, it notifies the responsible FI or QIO to institute a redetermination. The QIO or FI notifies the party who requested the hearing that it is processing the dismissed request as a request for redetermination. **Exceptions:** A request for hearing dismissed for any other reason (e.g., lack of timeliness or the party is not eligible to request a hearing on beneficiary's behalf) does not constitute an implied request for redetermination. A party who requested a redetermination previously and the request was dismissed does not constitute an implied request (e.g., the request was untimely or the appellant was not a party).

40.2.2 - Assisting a Beneficiary to Complete Form CMS-2649, Request for Reconsideration of Part A Health Insurance Benefits

(Rev. 1. 10-01-03)

A3-3782.2

Following are guides for completing the Form CMS-2649 when the FI assists a beneficiary in filing for reconsideration:

ITEM l. Beneficiary's Name

The FI enters the name of the beneficiary who received the services.

ITEM 2. Health Insurance Claim Number

It shows the claim number (including the suffix) of the beneficiary.

ITEM 3. Representative's Name

If the party has a representative, it shows his/her name and his/her relationship to the party. If a provider is filing, it checks the appropriate box.

ITEM 4. A Copy of the Notice

If it is available, the FI attaches a copy of the MSN or RA the party received.

NOTE: Most information required in Items l-9 may be ascertained from the notice.

ITEM 5. This Claim Is For

The FI checks the appropriate box. It checks "emergency hospital" when the services are covered only under the emergency services or border resident services provisions. (See the Medicare General Information, Eligibility and Entitlement Manual). It checks "health maintenance organization" in every case where the services were rendered or covered by an HMO, or where the issue is HMO coverage of services.

ITEM 6. Name and Address of Provider

It gives the complete name and address of the provider and its number.

ITEM 7. Name of FI

It gives the name, city, state, and the number of the FI that made the initial determination.

ITEM 8. Date of Admission or Start of Services

It shows the date that the inpatient stay began or (for home health) the date that services were first rendered.

ITEM 9. Date(s) of the Notice(s) You Received

It shows the date of any notice received by the party.

ITEM 10. Reason for Disagreement

The party or his/her representative should state specifically why he/she believes the initial determination to be incorrect. If a provider is filing, the following language is used: "Filed by (provider's name) in accordance with §1879 because _____."

ITEM 11. Additional Evidence

The FI indicates what additional evidence, if any, the party is submitting.

ITEM 12. Timely Filing

If the request is not made within 120 days (plus 5 days mailing time) of the date of the party's notice, the FI checks "No" and obtains the reason(s) for the delay so that a determination on good cause can be made.

ITEM 13. Signature.

The form may be signed by either the beneficiary or his/her representative if applicable, or by the provider's representative. The FI checks the appropriate block.

NOTE: When a written communication forms the basis of the reconsideration request, the check in the signature block indicates whether the written communication (which should be attached to the Form CMS-2649) was signed by the beneficiary or the representative. On the signature line, the FI prints or types:

FORM COMPLETED BY FI - SIGNED REQUEST ATTACHED.

When the provider files, the FI checks the appropriate block. It types or prints the name and title of the provider's representative in the signature area in addition to the required signature.

ITEM 14. Address

The FI shows the address of the person who signed the request.

ITEM 15. Witness

The witness block is on the reverse of page l. If the request is signed by mark, the signature and addresses of two persons witnessing the signing must appear in blocks 15B and 15C.

NOTE: FI employees may act as witnesses when a request is completed in the FI's office.

ITEM 16. Routing

The FI checks the block that indicates the component with jurisdiction over the reconsideration. Space is provided to show the name of the FI.

ITEM 17. Additional Information

The FI uses this space to provide any other information that may be pertinent.

ITEM 18. Date Stamp

The FI date stamps every request with the date of receipt. It makes sure this is reproduced on all copies. (On FI completed forms, this is the date of receipt of the written communication.)

40.2.3 - Routing the Reconsideration Request

(Rev. 1. 10-01-03)

A3-3782.3

Whenever the FI receives the reconsideration request directly (that is, not through a SSO), it returns page 2 of the request with the acknowledgment letter to the appellant.

Page l, plus any additional information, statements, etc., becomes the basis for the reconsideration. This is routed according to the FI's regular system for processing such requests.

(See §40.2.5 for transferring, dismissing, and canceling controls on requests for reconsideration filed on a Form CMS-2649 that involve issues or services over which the FI has either **no** jurisdiction or only **partial** jurisdiction.)

40.2.4 - Acknowledging Receipt

(Rev. 1. 10-01-03)

A3-3782.4

Upon receipt of a written request for reconsideration, the FI acknowledges receipt within 10 days. It advises the party that the reconsideration will be conducted and a reconsidered determination issued as soon as possible. It includes a copy of its acknowledgment in the reconsideration file.

When the provider initiates a request for reconsideration, and the beneficiary's liability was not waived for any part of the stay, the FI asks the beneficiary or his/her representative whether a request for reconsideration will be filed. The FI explains that even if the beneficiary does not file a reconsideration request, he/she will be a party to the determination and, therefore, may submit additional information and will receive a copy of the determination.

The initial determination of noncoverage for an inpatient stay may have allowed Medicare payment under the limitation on liability provision for part of the stay but either the beneficiary or the provider was liable for the remainder (see Chapter 30). If the provider requests a reconsideration for the entire noncovered stay, the FI accepts the request and treats it as described in §40.1.4.

40.2.5 - Transferring and Dismissing Requests Which Involve Partial or No Jurisdiction, More Than One Component, Stay, or Issue

(Rev. 1. 10-01-03)

A3-3782.5

The FI may receive a Form CMS-2649 that involves multiple issues or matters over which it has no jurisdiction. Such issues may involve: emergency services (RO jurisdiction), entitlement issues (which must be referred to a SSO), services that must be adjudicated by another FI that serves a different provider (which must be referred to that FI), more than one stay at a provider, more than one period of home health services, or a Part B appeal for services adjudicated by a carrier (which requires transfer to the carrier).

A. Acknowledging Receipt of Form CMS-2649

Where multiple issues are raised, the FI makes copies of the Form CMS-2649 sufficient to send a copy to each organization that has jurisdiction over an issue in the appeal. It sends an acknowledgment letter to the beneficiary or person who filed the request. It advises him/her of the transfer(s) and the reasons, and that he/she will receive a separate determination on each issue. It sends a copy of the acknowledgment letter with the request for reconsideration and copies of any related material to each organization having jurisdiction over an issue in the appeal request.

B. Receiving FI Has Partial Jurisdiction

When the FI has verified all Form CMS-2649 data, and there are issues involving other jurisdictions, it keeps and adjudicates the original form and takes the following actions.

1. Reconsideration Involving Another FI - The FI that adjudicates the original Form CMS-2649 prepares a separate Form CMS-2649 for each partial jurisdiction. Additional Forms CMS-2649 need not be signed, provided the beneficiary's signature appears on the original Form CMS-2649, letter, or statement requesting reconsideration. The FI that adjudicated the original Form CMS-2649 attaches photocopies of the signed request to all unsigned Forms CMS-2649 and forwards them to the other FI with a copy of the letter to the filer acknowledging receipt of the request and advising the filer of its disposition.

2. Reconsideration Involving RO - The FI prepares a separate Form CMS_2649 for the RO where emergency services are involved and forwards it to the RO with a copy of the letter to the filer acknowledging receipt of the request.

3. Reconsideration Involving SSO - The FI photocopies page l of the original Form CMS-2649 it is retaining and forwards the copy to the appropriate SSO with a copy of the acknowledgment letter advising the filer of this referral and the reason. The FIs acknowledgement letter should request the SSO to resolve the issue.

4. Reconsideration Involving Part B Carrier - The FI photocopies page l of the original Form CMS-2649 it is retaining, and forwards the copy to the appropriate carrier with a copy of the acknowledgment letter. The FIs acknowledgement letter requests the carrier to resolve the issues.

C. Receiving FI Has No Jurisdiction

When the FI has verified all Form CMS-2649 data and established that it has no jurisdiction over any issue, the FI takes the following actions:

> **1. Issues Involving Another FI -** The FI forwards the original Form CMS--2649 to the FI having jurisdiction over the issue under appeal with a copy of the acknowledgment letter advising the filer of the transfer and the reasons for it.
>
> **2. Issues Involving RO -**The FI forwards the original Form CMS_2649 to the RO having jurisdiction over the emergency services issue under appeal with a copy of the acknowledgment letter advising the filer of the transfer and the reasons for it.
>
> **3. Issues Involving SSO -**The FI forwards the original Form CMS-2649 to the SSO for processing of the entitlement issues under appeal with a copy of the acknowledgment letter which advised the filer of the transfer and the reasons for it.
>
> **4. Issues Involving Carrier -** The FI forwards the original Form CMS-2649 to the appropriate carrier operation for processing of the Part B medical insurance claim issue under appeal with a copy of the acknowledgment letter that advised the filer of the transfer and the reasons for it.

40.2.6 - Handling of Request - Beneficiary Appeals Before Initial Determination Is Made or After Initial Favorable Determination Is Made, But Before They Are Notified

(Rev. 1. 10-01-03)

A3-3782.7

A request for reconsideration may be filed before the FI makes an initial determination. If an initial determination has not been made, the request and any information associated with it is sent to claims.

A request for reconsideration may also be filed after the FI makes a favorable initial coverage determination, but before the beneficiary is notified. When a request for reconsideration is filed, the FI first ensures that an initial determination has been made. If it has, the FI contacts the beneficiary and explains that unless the beneficiary still wants a reconsideration, the FI plans to treat the request as an inquiry because it has issued a fully favorable determination. If the beneficiary still wants a reconsideration, the FI completes one. The FI does not dismiss the reconsideration request in either situation.

40.2.7 - Withdrawal of Request

(Rev. 1. 10-01-03)

A3-3782.8

The party that files a request for reconsideration (or their authorized representative) may withdraw the request. The request for withdrawal must be in writing, signed, and filed with the FI, CMS, SSA, or the RRB.

When the FI receives a withdrawal request directly, or from another source, it sends a letter to the beneficiary, representative, or provider acknowledging its receipt and advising that reconsideration action will be terminated. The FI annotates "WITHDRAWAL" in item 17 of the Form CMS-2649 and prong-files the original withdrawal request, a copy of its acknowledgment letter, and the Form CMS-2649 in a case file.

If a provider wishes to withdraw more than one request, the FI sends one letter of acknowledgment to the provider, including the name and Health Insurance Claim Number (HICN) of each beneficiary and each stay involved in the request. The FI makes a photocopy of the request and acknowledgment a part of each individual's file.

40.2.8 - Notifying Provider or Beneficiary Where There Is a Withdrawal

(Rev. 1. 10-01-03)

A3-3782.9

If a provider was made a party to a request for reconsideration (see §40.1.2) that is subsequently withdrawn, it may request reconsideration per §40.1.3. The FI advises the provider of its appeal rights. This can be done via a short notice similar to the following:

> This is to advise your facility that (beneficiary's name) has withdrawn his/her request for a reconsideration of the claim about which we advised you in our letter of (date).
>
> Since the Medicare program has not assumed full liability for payment of the noncovered services rendered at your facility, you now have the right to file a request for reconsideration on behalf of your institution. You have 120 days from the date you receive this letter to file that request.

If a provider submits a request for withdrawal, and the beneficiary has asked to be a party, the FI prepares a short notice to the beneficiary or his/her representative similar to the following:

> This is to advise you that (facility's name) has withdrawn its request for reconsideration of the claim about which we advised you in our letter of (date).
>
> Since the Medicare program has not assumed full liability for payment of the noncovered services you received at (facility's name), you now have the right to file a request for reconsideration. You have 120 days from the date you receive this letter to file that request.

40.3 - Documenting Part A Reconsideration Requests

(Rev. 1. 10-01-03)

A3 3783

Following denial of a Part A claim, the party is entitled to a reconsideration if the request is made in writing within 120 days following the receipt of the initial determination. FIs must process 75 percent of the reconsiderations within 60 days and 90 percent within 90 days.

The FI bases the reconsideration decision upon information in its possession when the initial determination was made including statements or information submitted by the party or parties plus the medical and other records acquired during the reconsideration. If the evidence is not clear and convincing, the FI obtains a statement discussing the issues from the provider.

40.3.1 - Documentation Sources

(Rev. 1. 10-01-03)

A3-3783.1, AB-00-122

A reconsideration constitutes the FI's final review of its earlier determination. It is in the interests of all parties that all relevant information be available to the FI. It will urge the provider to submit documentation timely.

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

The FI may use its own representative to secure information. The SSO may be utilized to obtain additional information. Since the provider prepares and submits the claim, it generally submits the medical documentation.

The FI charges all activities directly related to reconsiderations, including the written request, to appeals (line 2) on the Administrative Budget and Cost Report; i.e., medical development, whether or not the actions result in an adjustment.

However, it does not charge to appeals any oral requests for reconsideration or for further information. It charges such requests to initial claims processing (line 1).

40.3.2 - Assembling the File

(Rev. 1. 10-01-03)

A3-3783.2

The FI places all reconsideration requests (formal or informal) in folders as soon as possible. It enters the beneficiary's HICN on the top line of the folder tab. It enters the beneficiary's last name, first name, and middle initial, if any, beneath the number.

EXAMPLE

HICN 300-00-7777A
Doe, Mary A.

40.3.3 - Development

(Rev. 1. 10-01-03)

A3-3783.3, AB-00-122

The provider is responsible for providing the information needed to support its reconsideration request. The FI will develop information that is in its files, or in CMS or SSA files. If the party is the beneficiary, the FI will develop supporting documentation.

The FI will inform providers of the processing time limits that are in effect and why it benefits all concerned parties when supporting documentation is submitted timely. If the party is unsuccessful in securing the information from another provider, the FI will assist the party. If necessary, it will remind the uncooperative provider of its responsibilities under its Provider Agreement, as enunciated in §1866 of the Act and Federal Regulations at 42 CFR Part 489.

NOTE: The FI will advise providers that any evidence they submit relating to the claim may be revealed to the beneficiary unless it includes medical advice to the contrary.

If providers request assistance, the FI will help them. However, it will not assume responsibility for gathering the information. Its primary role is to assist providers in gathering information from other providers.

The FIs should not request documentation from a provider for a State-initiated appeal. If additional documentation is needed, FIs 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 the necessary documentation.

The FI will prong-file in chronological order by type of evidence all material pertaining to the services in question, including the envelope in which the request for reconsideration was received if the postmark is relevant **and** including original documents whenever possible.

The FI stamps the date of receipt on each document received. Unless the format of a particular document or the FI's claim processing system dictates otherwise, the FI stamps the receipt date in the upper right-hand corner. It builds the file by placing the oldest document of a particular category on the bottom for that category, and the most recent document of a particular category on the top for that category.

The eight major categories within the file, listed in order (the first category appears on the bottom of all other documents), are:

- All billing forms or summaries;
- Report of Eligibility;
- Doctor's orders;
- Progress note;
- Nurses' notes;
- Medication charts;
- Laboratory reports and other studies; and
- Therapy treatment plan and treatment record.

40.4 - Evaluating the Evidence and Making the Redetermination

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

The redetermination reviewer makes a new, independent, and thorough evaluation of the evidence and prior findings. On redetermination, the reviewer does not rely on any screening assumptions, presumptions, or tolerances. Rather, the evidence in file must be

sufficient to convince the reviewer and support the finding of the fact that the services were or were not covered under the law. The redetermination process, therefore, is not a mechanical application of the same screening guides and tolerance rules that were used in arriving at the initial determination. The reviewer considers all the facts pertaining to the claim as a whole to reach the redetermination.

A. Timely Processing Requirements

The FI must process 75 percent of the **reconsiderations** within 60 days of receipt in the corporate mailroom and 90 percent within 90 days of receipt in the corporate mailroom. The FI must process all **redeterminations** (a redetermination is any request for first level appeal received after October 1, 2004) within 60 days of receipt in the corporate mailroom. FIs consider a reconsideration processed/complete when:

1. For **affirmations**, upon the completion of the process that generates the decision letter for mailing to the parties.

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

a. The process that generates the decision letter for mailing to the parties is completed, and

b. When either:

- The actions to initiate the adjustment action in the claims processing system are taken, or
- Written assurance is requested, if applicable. When written assurance is necessary, initiate the adjustment action in the claims processing system within 30 days of receipt of written assurance.

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 **full reversals**, when either:

a. the actions to initiate the adjustment action in the claims processing system are taken, or

b. written assurance is requested, if applicable. When written assurance is necessary, initiate the adjustment action in the claims processing system within 30 days of receipt of written assurance.

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.

4. For **withdrawals and dismissals**, upon the completion of the process that generates the dismissal notice for mailing to the parties.

B. Obtaining an Independent Review

If possible, the FI maintains a separate and distinct unit to process redeterminations; however, CMS allows it to use experienced claims reviewers who have had no part in the initial adjudication of the particular claim for which the redetermination request has been

filed. The FI gives the redetermination reviewer complete independence to revise the initial determination, if appropriate.

If the FI has more than one physician-consultant involved in the Medicare claims process and, under the guidelines in subsection B, a physician must review the case, a physician-consultant not involved at the initial processing level reviews the claim.

If, however, the FI has only one physician-consultant, the case may be referred to that consultant again for expert medical opinion evidence, to a physician from another program the FI administers, or to an outside physician consultant. For this purpose, physician having the same specialty as the attending physician is ideal and offers the most persuasive evidence.

The evidence is evaluated independently by the redetermination reviewer, together with all other evidence in the case to make the determination.

C. Consulting-Physician Review

If the FI judges that the opinion of a physician is needed, it refers the following types of medical issue cases to its consulting physician for expert medical opinion evidence:

- Hospital inpatient stay cases in which the FI's redetermination reviewer concludes that the full denial of the entire hospital stay should be affirmed;
- Partial denial hospital cases and all SNF cases in which the amount in controversy (see §50.7) is over $1,000; and
- There is a question concerning the medical facts as presented.

If the attending physician or the provider has submitted new information, the FI gives strong consideration to having the case reviewed by a physician-consultant. Nonjudgmental issues based on technical or statutory provisions, such as a qualifying hospital stay, extent of available benefits, and exclusions contained in the Medicare Benefit Policy Manual or the National Coverage Determinations Manual, are decided by the redetermination reviewer.

D. Processing Additional Evidence

The FI processes cases where the beneficiary's attending physician has submitted additional evidence (e.g., a statement giving his/her medical opinion or additional clinical findings) in accordance with the following:

- Where the attending physician has submitted evidence other than the provider's medical record supporting a covered level of care, and it is consistent with the body of evidence obtained from the provider and any other sources, the FI would reverse the initial denial;
- If the physician's statement that care was "covered" or was "skilled nursing care" is not supported by the medical facts described in the rest of the evidence obtained, and that evidence established that the services were not covered under the program, the FI would affirm the initial denial decision;
- Where the physician submits evidence which is consistent with the preponderance of the evidence obtained from the provider, although there may be some isolated

facts, which in the absence of the remaining evidence would support a denial (e.g., the nurses' notes indicate that the patient was able to sit up or the doctor's orders show "may soon be ready for discharge"), the FI gives the physician's evidence sufficient weight to overcome the reviewer's doubts regarding reimbursement for the services; and

- If the attending physician has submitted a statement, but in light of the other evidence, a conflict exists so that the redetermination reviewer is unable to draw a conclusion regarding the coverage of the services, the reviewer requests the attending physician to clarify the matter. If the physician does not respond, the provider may be able to furnish clarifying information.

E. Documentation Resulting from Physician's Review

Upon completion of the FI's consulting physician's review, each case should contain the following:

- A summary of the pertinent facts obtained from the medical record (this may be written by the nonmedical redetermination reviewer, a nurse or other medical reviewer or the consulting physician). Any reports or summaries must be signed by the person preparing the report, with identifying professional titles (e.g., M.D., R.N.). Consulting physicians must furnish their qualifications upon request;
- A statement of the medical significance of the facts; and
- A convincing rationale in which the reasons for the physician's conclusion are explained. (These items may be prepared by a nonmedical person in consultation with the physician but the rationale must be signed by the latter.) A mere statement of the consulting physician's conclusion pertaining to the coverage issue adds very little to the evidence in the case. The conclusion must be related to the beneficiary and the facts of the case. The rationale must state why the specific denied service was not medically necessary for that beneficiary.

The FI will neither affirm nor reverse a redetermination case where a conflict of evidence exists.

40.4.1 - Evaluating the Evidence

(Rev. 1. 10-01-03)

A3-3784.1

The reconsideration reviewer examines the evidence with an open mind. How much weight the reviewer gives to one piece of evidence as compared to another depends upon its factual content relative to the primary issue. (For example, the treating physician's opinion that the beneficiary needed a covered level of care, while given considerable weight, is not conclusive in the face of other evidence to contrary, e.g., nurses' notes showing that the beneficiary needed assistance only in meeting the activities of daily living.) What the reviewer looks for is evidence and rationale that is clear and convincing.

If the reviewer is not convinced, or believes that additional evidence is needed to establish the facts, he/she will obtain the additional evidence. Such evidence might be

obtained by soliciting the attending physician to answer specific questions in writing. Where, after careful and reasonably complete documentation, the question of coverage is still in doubt, the reviewer pays the claim.

A. Consultation With CMS

In reconsideration cases in which a question of law or policy arises that is not provided for in instructions, the FI will request advice from CMS. It directs such requests to the appropriate RO. In very complex cases, it forwards the reconsideration file with its inquiry.

B. Correctness of Initial Determination Is Questioned

On occasion, an independent review of an initially denied portion of a stay may raise questions as to the correctness of the initial decision. It is not intended that the appeals procedure be used as a vehicle to audit favorable initial determinations to the detriment of the party that is appealing the denied portion of the claim. Since the beneficiary and the provider would have been notified that part of the stay and services were covered, a subsequent reversal of the initial favorable action could generate serious problems affecting not only the beneficiary and the provider, but also the FI and CMS.

A reconsideration determination more adverse to the party than the initial determination might cause the party to feel penalized for requesting that the claim be reconsidered. Very sensitive questions could be raised as to why such corrections are made only when the party is appealing the denied part of the claim. In addition, negative conclusions regarding the integrity of the initial adjudicative process might be drawn. The FI will undertake every effort to dispel such impressions.

40.4.2 - Review Prior to Reversal of Initial Payment Determination

(Rev. 1. 10-01-03)

A3-3784.2

To assure that the closest professional attention is given to reconsideration cases that appear to warrant a reversal of the initial payment decision, the FI makes the following multi-level review procedure part of its claim processing operation before the reconsideration determination is completed.

It reviews the file carefully to determine whether there was any evidence that supported the decision with respect to the prior allowed services. The reconsideration reviewer uses the adjudication principles that existed when the initial decision was made.

If the issue is a medical one, the FI will consider referring it to its consulting physician for an expert medical opinion. If the reviewer cannot justify the initial payment decision in whole or in part, the reviewer refers the initial payment decision to the consulting physician for an expert opinion on whether the initially approved stay was, in fact, covered.

Where a case has been reviewed as indicated, and despite documentation the question of coverage is still in doubt, the FI will let the initial payment decision stand.

40.4.3 - Preparing the Determination

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

A. Contents of the Determination

For model language and format, see §40.4.8.2.

The redetermination will include:

- A brief introductory statement indicating that a redetermination was conducted;
- A brief restatement of the issues;
- The FI's determination;
- A succinct rationale explaining the FI's decision;
- Explanation of limitation on liability (if it applies);
- Liability determination;
- Further appeal rights if the amount in controversy exceeds $100*;
- Statement advising the claimant of the availability to qualifying claimants of legal services organizations that provide legal services free of charge; and
- Statement that a copy of the laws, regulations, and policies, upon which the decision was based is available upon request.

* Beginning in 2005, for requests made for an ALJ hearing, 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.

Whenever possible, the FI writes the determination using the guide determination outlines and Sample Paragraphs furnished by CMS. Individual case circumstances may warrant certain adaptations in the standard material. The FI exercises judgment in these cases.

In all cases, the FI makes it clear that a fair and reasonable evaluation took place.

B. Rationale

The rationale portion explains, based on the law, regulations, guidelines, and the facts, the reasons for the decision reached. The rationale describes the weight attributed to those items in the medical evidence determined to be significant in arriving at the decision. The FI reconciles any significant inconsistency or conflict. It is fully responsive to the beneficiary's and, if applicable, the attending physician's allegations. It relates the rationale to the beneficiary, i.e., it does not use a statutory citation as its sole rationale. It explains how the statutory citation relates to the claim and to the beneficiary.

C. Sensitive Issues

The inclusion of sensitive medical information, such as that regarding psychiatric illness or malignancy, requires special care. If the harmful evidence is material to the case, but the beneficiary's physician has stipulated that it is not to be revealed to the beneficiary,

the FI will ask the beneficiary to designate a representative, such as an attorney or physician, to receive the determination and insure that the beneficiary's best interests are represented without disclosing the information to the beneficiary.

40.4.4 - Completing the Determination

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

A redetermination that noncovered care will be totally or partially paid under the limitation on liability provision requires a full determination and cover letter, since the coverage decision remains unfavorable, and any subsequent payment is not considered a reversal.

A Signature

The redetermination and/or notice bears the signature of the supervisor of the person writing it.

B Copies

Three copies are prepared. The original goes to the party that initiated the redetermination request, one copy is placed in the case file, and one copy is kept by the FI. Additional copies are required if there is another party involved.

40.4.5 - Notice of Further Appeal Rights

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

A. Beneficiary

The notice of the redetermination notifies the beneficiary that if he/she believes that the determination is not correct, and the amount of benefits in question is $100* or more, he/she has a right to a hearing. The hearing must be requested within 60 days of the date of receipt of the redetermination notice. If the FI receives any post-redetermination correspondence requiring a reply, it includes in its reply a statement informing the beneficiary of his/her right to a hearing, the date of the original redetermination notice, and an appropriate explanation where the time limit has expired or is nearing expiration. (See §40.1.5.).

* Beginning in 2005, for requests made for an ALJ hearing, 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.

B. Provider in Waiver of Liability Cases

A provider dissatisfied with the redetermination made pursuant to its request or to which it is a party, has the same right to a hearing as the beneficiary, providing that statutory requirements are met.

NOTE: See §§40.10 if a QIO determination is involved.

40.4.6 - Preventing Duplicate Payment in Reversal Cases

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

Prior to paying a provider in full or partial reversal cases where the beneficiary was previously liable, the FI will 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.

40.4.7 - Effect of a Reconsideration Determination and Effectuation

(Rev. 1. 10-01-03)

A3-3784.8

A reconsideration determination is a final and binding determination of the Secretary unless it is revised, or unless a hearing is requested by an eligible party. Where a reconsideration determination revises an initial determination, the FI will effectuate the reconsideration determination as soon as possible. It will not delay the effectuation because a hearing has been requested.

40.4.7.1 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is “Confined to Home” - Regional Home Health Intermediaries (RHHIs) Only

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

See §50.7.11

40.4.8 - Reconsideration Guide Language

(Rev. 1. 10-01-03)

A3-3784.9

This contains language similar in many respects to the initial denial language except for the listing of statutory citations. Additionally, it contains an outline of the proper paragraphs and sequence for use, determination letters for use in technical denials, cover letters, and a reconsideration status form.

The materials, as guide language and model cover letters, are subject to some modification by the FI without CMS approval. These sample paragraphs are not used in place of a rationale for the FI’s determination.

40.4.8.1 - Sample Paragraphs to Be Used by FIs in Sequence as Shown below

(Rev. 1. 10-01-03)

If additional or optional guide language paragraphs are used, FIs insert them as necessary in the standard sequence.

General Hospital Services: Sample Paragraphs: 1, 2, 3, 17 - 20

Rehabilitation Hospital Services: Sample Paragraphs: 1, 2, 3, 7, 17 - 20

Psychiatric Hospital Services: Sample Paragraphs: l, 2, 3, 4 or 4A or 4B, 17 - 20

Private Room Services: Sample Paragraphs: 2, 5, 16, 17, 18, 20

Dental Inpatient Hospital Services: Sample Paragraphs: 1, 2, 6, 17, 18, 20

Inpatient Diagnostic Study Services: Sample Paragraphs: 1, 2, 7, 17 - 20

Cosmetic Surgery Hospital Services: Sample Paragraphs: 1, 2, 8, 17, 18, 20

SNF Level of Care Services: Sample Paragraphs: 1, 2, 9, 14, 16, 18-20

Home Health Services Sample Paragraphs: 1, 2, 10 (A Through G), 16, 17 - 20

Late Transfer to SNF from Hospital - (Medical Appropriateness Allegations): Sample Paragraphs: 1, 2, 11, 14, 16, 18, 19, 20

SNF Care Not a Continuation of Treatment: Sample Paragraphs: 1, 2, 12, 14, 16, 18, 19, 20

NOTE: Where Someone Other than the Patient Was Notified, the FI inserts the Patient's Name and "His" or "Her" or "He" or "She" Instead of "You" or "Your," as needed.

Standard Sample Paragraphs for Reconsideration Determinations

Sample Paragraph 1

1. The FI uses this paragraph if there is no program payment and Limitation on liability (Section 1879) applies, i.e. the provider is liable for all of stay.

> On (date) we notified you/M that hospital insurance benefits could not be allowed for your/his/her stay at (name of provider) (from date through date). The notice also stated that the provider must bear the cost for these services.

2. The FI uses this paragraph if there is no program payment and Limitation on liability (Section 1879) applies, with the provider liable for part of the stay and the patient is liable for the remainder of the stay.

> On (date) we notified you/M that hospital insurance benefits could not be allowed for you/his/her stay at (name of provider) from (date through date). The notice also stated that the provider must bear the cost of these services from (date through date) and that you/he/she are responsible for the remainder of your/his/her/inpatient stay.

3. The FI uses this paragraph if there is partial program payment (part of the stay was paid for under the Limitation on liability provisions; the provider is liable for part of the stay; and the patient is liable for the remainder of the stay).

> On (date) we notified you/M_____ that Medicare would pay for the services provided at (name of provider) from (date through date) but the cost of services provided from (date through date) would be the provider's responsibility. You/he/she are responsible for the remainder of the stay.

4. The FI uses this paragraph if partial program payment (some of the services were noncovered and the patient is liable).

> On (date) the (name of provider) notified you/M that Medicare benefits would be paid for the services you/he/she received from (date through date), but the services you/he/she received after that date were not covered and you/he/she/ are

responsible for the charges. On (date), we also notified you/him/her of this decision.

5. The FI uses this paragraph if there is partial program payment (some of the services were noncovered and the provider is liable).

On (date) we notified you/M that Medicare would pay for the services provided at (name of provider) from (date through date) but the services you/he/she received after that were not covered. The notice also stated that the cost of these services was the provider's responsibility.

6. The FI uses this paragraph if there is no program payment (patient is liable for all of stay).

On (date) the (name of provider) notified you/M that the services you/he/she/received from (date through date) were not covered by Medicare. On (date) we advised you/him/her/ that we agreed with that decision.

7. The FI uses this paragraph if there is no program payment (waiver does not apply).

On (date) we notified you/M that hospital insurance benefits could not be paid for your/his/her stay at (provider) beginning (date).

Sample Paragraph 2

1. Beneficiary Filed

On (date) you/M requested reconsideration of your/his/her claim for hospital insurance benefits, including the determination as to the party liable for the services. On (date) we wrote to (name of provider) that you/M had filed the reconsideration request, and that it is a party to the reconsideration decision.

2. Provider Filed

On (date) you requested reconsideration of your/his/her claim for hospital insurance benefits including the determination as to the party liable for the services. On (date) we wrote you/him/her that the request had been filed and that you are (he/she is) a party to the reconsideration decision.

Sample Paragraph 3

There are two issues that must be considered in this determination. The first is whether the level of inpatient hospital care the beneficiary received is covered by Medicare. Inpatient hospital care furnished a patient is covered under Medicare, but only if it is reasonable and necessary for the treatment or diagnosis of the patient's illness or injury and is a type that can be provided only on an inpatient hospital basis. Inpatient hospital care is not considered reasonable and necessary if it can be safely and adequately provided in a skilled nursing or less costly type of facility or on an outpatient basis. The second issue, if the case is found to be noncovered, is whether (M) and/or (name of provider) knew or could reasonably be expected to know that the services he/she/you received for the period in question were not covered by the Medicare program.

Sample Paragraph 4

There are two issues that must be considered in this determination. The first is whether the inpatient psychiatric hospital care the beneficiary received is covered by §1814(a)(2)(A) of Title XVIII of the Social Security Act. Inpatient care in a psychiatric hospital is covered by Medicare only if it constitutes "active treatment." "Active treatment" means that the patient received physician-supervised and evaluated services under an individual treatment or diagnostic plan that are expected to improve the patient's condition.

The second issue, if the case is found to be noncovered, is whether (M) and/or (name of provider) knew or could reasonably be expected to know that the services (he/she/you) received for the period in question were not covered by the Medicare program.

Sample Paragraph 4A

There are two issues that must be considered in this determination. The first is whether the inpatient psychiatric hospital care the beneficiary received is covered under §1814(a)(2)(A) of Title XVIII of the Social Security Act. Inpatient care in a psychiatric hospital for a patient needing nonpsychiatric medical or surgical care is covered by Medicare if a hospital level of care is required, the hospitalization in a psychiatric rather than a general hospital is required due to the patient's mental condition, and a physician certifies that these conditions are met. The second issue, if the care is noncovered, is whether (M_____) and/or (name of provider) knew or could reasonably be expected to know that the services (he/she/you) received for the period in question were not covered by the Medicare program.

Sample Paragraph 4B

There are two issues that must be considered in this determination. The first issue is whether payment can be made under §1812(b)(3) of the Social Security Act for inpatient psychiatric hospital care the beneficiary received after (date of beneficiary's 190th psychiatric hospital day). Medicare will make payment for up to 190 days of covered care in a participating psychiatric hospital during a beneficiary's lifetime. The second issue, if the case is found to be noncovered, is whether (M) and/or (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Sample Paragraph 5

The issue is whether the beneficiary's use of a private room was medically necessary. When Medicare makes payment under the provisions of §1861(v)(2)(A) of Title XVIII of the Social Security Act to a hospital or skilled nursing facility for care provided in a private room, the provider may charge the beneficiary an additional amount for private accommodations requested by the beneficiary unless ordered by a physician for reasons of medical necessity. Medical reasons exist where semiprivate accommodations:

1. Would endanger the beneficiary's health or recovery;

2. Would endanger another patient's health or recovery;
3. Would be inappropriate because the beneficiary suffers from a communicable disease; or
4. Are not available and the beneficiary requires immediate inpatient care.

Sample Paragraph 6

The issue is whether the inpatient care the beneficiary received is covered by Medicare, or is excluded under §1862(a)(12) of Title XVIII of the Social Security Act as services provided in connection with the care, treatment, filling, removal, or replacement of teeth or structure directly supporting teeth. Inpatient hospital services in connection with noncovered dental care are covered by Medicare only when a beneficiary requires active inpatient treatment of an underlying medical condition.

Sample Paragraph 7

The issue is whether the level of inpatient hospital care the beneficiary received is covered under §1862(a)(1) of Title XVIII of the Social Security Act. Inpatient hospital care furnished a patient is covered by Medicare only if it is reasonable and necessary for the treatment or diagnosis of the patient's illness or injury and can be provided only on an inpatient hospital basis. Inpatient hospital service in connection with a diagnostic study would be considered reasonable and necessary only if the patient's condition or the nature of the diagnostic procedures requires the constant availability of physicians as well as the use of complex medical equipment and the type of care generally associated with inpatient hospitalization.

Sample Paragraph 8

The issue is whether the inpatient hospital services the beneficiary received are covered by Medicare or excluded by a provision of the law (§1862(a)(10) of Title XVIII of the Social Security Act) which prohibits payment for services received in connection with cosmetic surgery not required for the prompt repair of an accidental injury or for improvement of the functioning of a malformed body member.

Sample Paragraph 9 **(For Stays Prior to 01/01/89)**

There are two issues that must be considered in this determination.

The first is whether the care the beneficiary received is covered by Medicare. Skilled nursing benefits are covered under §1814(a)(2)(B) of Title XVIII of the Social Security Act for individuals, who, following hospitalization, need inpatient skilled nursing services on a daily basis for a condition treated in the hospital. Skilled nursing benefits are also covered under the same section of the Act for individuals who, following hospitalization, need, on a daily basis, skilled rehabilitation services which as a practical matter can be provided only in a skilled nursing facility on an inpatient basis. Skilled services must be furnished by, or under, the general supervision of professional medical personnel to assure the safety of the patient and to achieve the medically desired result. When individuals do not require such skilled services on a daily basis following

hospitalization (or within 30 days following the last day of a covered period of extended care services) or when, as a practical matter, the provision of such services does not require that they be admitted as inpatients to a skilled nursing facility, their care in such a facility is not covered by Medicare.

The second issue, if the care is found to be noncovered, is whether (M) and/or (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Sample Paragraph 10

A-01-21

There are two issues that must be considered in this determination. The first issue is whether the home health services the beneficiary received are covered under §1861(o) of Title XVIII of the Social Security Act.

1. An individual is eligible for home health benefits only if he or she requires intermittent skilled nursing care or physical, speech or occupational therapy. Skilled nursing care is that type of service that must be performed by, or under the direct supervision of, a licensed nurse to assure the safety of the patient and to achieve the medically desired results. Services that can be rendered safely and effectively by a nonmedical person may not be considered skilled nursing services, regardless of who actually performs or supervises them.
2. An individual is eligible for home health benefits only if he or she requires skilled nursing care on an intermittent basis or physical, speech or occupational therapy. “Intermittent” is generally defined as the need for a medically predictable skilled nursing service at least once every 60 days. Where a condition exists that would clearly establish that the recurring need for skilled nursing services is medically predictable less frequently than once every 60 days such services are usually not covered by Medicare.
3. An individual is eligible for home health benefits only if he or she requires skilled nursing care on an intermittent basis, or physical, speech, or occupational therapy. Physical therapy is defined as those services prescribed by a physician that require the skills of a qualified physical therapist and are performed by, or under the supervision of such a therapist.
4. For home health benefits to be covered by Medicare, a beneficiary must be confined to his or her home. Generally speaking, a patient will be considered to be homebound if he/she has a condition due to an illness or injury that restricts his/her ability to leave his/her place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated. Specific exceptions are:

i. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day care services in the State shall not negate the beneficiary's homebound status for purposes of eligibility.

ii. Any absence for religious service is deemed to be an absence of infrequent or short duration and thus does not negate the homebound status of the beneficiary. This new statutory provision does not imply that Medicare coverage has been expanded to include adult day care services.

5. To be covered by Medicare, home health services must be furnished in a place of residence used as the beneficiary's home. A beneficiary's home may include an apartment, a relative's home or a home for the aged. A hospital or skilled nursing facility, whether participating in Medicare or not, may not be considered a place of residence.

6. Home health services are covered under Medicare only if a person needs intermittent skilled nursing care or physical, speech, or occupational therapy services.

7. Home health benefits are covered by Medicare only if an individual requires skilled nursing care on an intermittent basis or physical, speech, or occupational therapy. The giving of intramuscular injections of medication is considered skilled nursing care. However, for the services of the nurse to be covered under Medicare, the injection must be a reasonable and necessary treatment for the condition for which it is given. Vitamin B-12 injections are considered an effective treatment for only certain medical conditions such as certain anemias, gastrointestinal disorders or neuropathies. If vitamin B-12 injections are not given to treat one of these conditions, the injections are not considered to be reasonable and necessary.

The second issue, if the care is found to be noncovered, is whether (M) and/or (name of provider) knew or could reasonably be expected to know that the services (you/he/she) received for the period in question were not covered by the Medicare program.

Sample Paragraph 11 - **(For Stays Prior to 01/01/89)**

The issue is whether the admission of the beneficiary to the skilled nursing facility after discharge from the qualifying hospital or earlier SNF stay was a timely admission as defined in §1861(i) of Title XVIII of the Social Security Act. Skilled nursing services are covered by Medicare only if admission to the skilled nursing facility and the receipt of a covered level of skilled nursing care occur within a specified period of time. Admission and receipt of covered care must occur:

- Within 30 days after discharge from a 3-day qualifying hospital stay; or
- Within such time as it would be medically appropriate to begin an active course of treatment where the patient's condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a qualifying hospital stay."

Sample Paragraph 12

The issue is whether the care the beneficiary received is covered under §1814(a)(2)(C) of Title XVIII of the Social Security Act, for the period in question. Medicare does not cover skilled nursing care unless it is required for the continued treatment of a condition for which the patient received covered inpatient hospital care prior to transfer to a SNF or it is care for the treatment of a condition which arose while the patient was receiving covered care in a SNF (Effective 01/01/89; the hospital stay is not needed.)

Sample Paragraph 13

Following a stay at _____ Hospital from MM/DD/YY through MM/DD/YY, M____ was admitted to the skilled nursing facility on MM/DD/YY with the diagnosis/diagnoses of _____.

Sample Paragraph 14

Following a stay at _____ Hospital/Skilled Nursing Facility from MM/DD/YY through MM/DD/YY, M _____ began receiving home health services on MM/DD/YY.

Sample Paragraph 15

The medical evidence in M_____ file shows. (The FI continues with recitation of pertinent medical evidence with appropriate paragraphing).

Sample Paragraph 16

The medical evidence in M_____ file shows that M_____ was admitted to _____ Hospital on _____ with the diagnosis/diagnoses of ____. (The FI continues with recitation of pertinent medical evidence with appropriate paragraphing).

Sample Paragraph 17

A review of the medical records shows ____(The FI continues with recitation of pertinent medical evidence with appropriate paragraphing).

Sample Paragraph 18

Medicare cannot pay for the days (dates of noncovered care) since inpatient care (reason(s) for non coverage).

In conclusion, it is determined that:

NOTE: (The FI discusses specifics)

Sample Paragraph 19 - **Limitation on liability Decision**

Because we determined that care (dates of noncovered care) was (not reasonable and necessary/custodial), we must determine, in accordance with §1879 of Title XVIII of the Social Security Act, whether he/she/you and/or (hospital) knew or could reasonably have been expected to know that the services would not be covered under Medicare.

Sample Paragraph 19.1 - **Neither Party Liable**

We decided that neither (beneficiary) nor (provider) knew or could reasonably have been expected to know that the noncovered days would not be allowed.

Sample Paragraph 19.2 - **Provider Liable**

We decided that (name of provider) knew or could reasonably have been expected to know that Medicare would not pay for more hospital days and that (name of beneficiary) did not know and could not have been reasonably expected to know that Medicare would not pay for more hospital days.

NOTE: The FI follows this paragraph with specific rationale.

Sample Paragraph 19.3 - **Beneficiary Liable**

We decided that (name of beneficiary) knew or could reasonably have been expected to know that Medicare would not pay for more hospital days and that (name of provider) did not know and could not have been reasonably expected to know that Medicare would not pay for more hospital days.

NOTE: The FI follows this paragraph with specific rationale.

Sample Paragraph 19.4 **- Provider and Beneficiary share liability.**

We decided that the hospital should have known and should have told you on (date) that Medicare would not pay for more hospital days. Since they did not tell you until (date), you do not have to pay for (dates for which beneficiary is not liable). You are liable for the care they provided you (dates of service for which beneficiary is liable).

Sample Paragraph 20

Write us or contact any Social Security office within 60 days of the date you receive this letter if you wish a hearing before an Administrative Law Judge of the Social Security Administration. The amount of benefits in question must be $100 or more in order to have a hearing.

40.4.8.2 - Model Medicare Redetermination Notice

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

MEDICARE APPEAL DECISION

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

Dear Appellant's Name:

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

The appeal decision is (Insert either: unfavorable. Our decision is that your claim in not covered by Medicare and over/under $100 remains in controversy. OR partially favorable. Our decision is that your claim is partially covered by Medicare and over/under $100 remains in controversy).

More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to (insert: an Administrative Law Judge (for Part A), a Hearing Officer (for part B)). You must file your appeal, in writing, within (insert: 6 months (for Part B) or 60 days (for Part A) of receiving this letter.

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

Summary of the Facts

Instructions: You may present this information in this format, or in paragraph form.

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

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

Decision

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

Explanation of the Decision

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

Who is Responsible for the Bill?

Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

When the beneficairy 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.

What to Include in Your Request for an Independent Appeal

Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim.

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 (insert: a Hearing Officer hearing or an Administrative Law Judge (ALJ) Hearing)

The law requires that at least $100 remain in controversy for you to request (insert: a Hearing Officer hearing or an ALJ Hearing). If less than $100 remains in controversy, you may combine the claim or claims that are the subject of this decision with claims from other recently issued redetermination decisions. This is called "aggregating claims." For more information, see the section on aggregating claims below.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within (insert: 60 days for Part A or 6 months for Part B) of receiving this letter. Under special circumstances, you may ask for more time to request an appeal.

You should include: your name, address, Medicare number, reasons for appealing, and any evidence you wish to attach. You may also attach supporting materials such as medical records, doctors' letters, 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:

Contractor Name
Address
City, State Zip

Aggregating Claims: To "aggregate claims" EACH CLAIM included in your request for (insert: Hearing Officer hearing or ALJ hearing) must be appealed within (insert: six (6) months or 60 days) from the date the decision was issued on the claim and each claim must have already received a redetermination decision.

If you wish to request a (insert: Hearing Officer hearing or ALJ hearing) by combining the amounts remaining in controversy from other claims, you MUST clearly state on your request that you are "aggregating claims", AND you must list the specific claims that you are aggregating.

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

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

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

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

Contractor Name,
A Medicare Contractor
Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of address).

Other Resources To Help You:
1-800-MEDICARE (1-800-633-4227)
TTY/TDD: 1-800-486-2048

40.5 - Request for Hearing Under Part A

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

Refer to §50.7.

40.6 - Right to Representation Under Part A

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

See §§60.5.

40.7 - Reconsiderations, Hearings, and Appeals Where a QIO Has Review Responsibility

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

A. General

The Tax Equity and Fiscal Responsibility Act of 1982 modified Part B of Title XI of the Act to establish the utilization QIO program. The QIOs review inpatient hospital care provided to Medicare beneficiaries to ensure that the care is medically necessary, reasonable, provided in the appropriate setting, and meets professionally recognized standards of health care. In addition, QIOs perform these reviews of ambulatory surgical care rendered to hospital outpatients and in ASCs. They also review home health, SNF, and hospital outpatient care (other than ambulatory surgery) to ensure that the care meets professionally recognized standards of health care.

QIOs deny payment only for inpatient hospital or outpatient ambulatory surgical services. In addition, QIOs make limitation on liability determinations for claims they review.

B. QIO Reconsiderations and Appeals

Determinations made by a QIO may be reconsidered only by the QIO. If the denial was made because the provider circumvented the PPS system through inappropriate transfers or admissions, the denial notice goes to only the provider and physician. If the denial was made because the services were not medically necessary, or because the care should have been provided in a different setting, the beneficiary, the provider, and the physician receive notice of the Reconsideration decision. Only the beneficiary may appeal. If, after it is determined the services were not medically necessary, or should have been provided in a different setting, it is also determined that the provider knew or should have known

the services would not be covered and, therefore, is found to be liable, the provider may appeal only the waiver determination.

Where a QIO reverses a prior determination, the result is communicated to the FI. Where appropriate, the FI informs the provider to submit the necessary bill.

For more information about QIO appeals, see the Medicare QIO Manual, Part 7.

40.7.1 - Reconsiderations

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

There may be a dual system of appeals at the Reconsideration stage, depending upon the issue. That is, a claim may be denied by both the QIO and the FI on different issues and be subject to Reconsideration by each to the extent of its responsibility. A Reconsideration requested by a party entitled to do so must be processed to completion no matter what the other entity may determine in the areas of its responsibility, except that an ALJ may halt the FI's Reconsideration and decide the issue in controversy if a request for hearing has been filed on a completed QIO Reconsideration decision.

A. FI Reconsiderations

The FI continues to make determinations on all issues for which it has responsibility. However, a patient's hospital stay might be determined to be medically necessary by the QIO, but fall under an exclusion other than medical necessity (e.g., cosmetic surgery, dental surgery), or not be payable because benefits are not available. Thus, the FI might deny and reconsider a case approved by the QIO. FIs make such determinations at the appropriate times and notify beneficiaries of their decisions and beneficiary appeal rights.

If an ALJ notifies an FI that he/she is taking jurisdiction because a hearing has been requested on a QIO determination, the FI assembles the file and sends it to the ALJ. Once the QIO issue is decided, the ALJ will remand the claim to the FI for completion, and effectuation of the ALJ decision.

B. FI Reconsideration Notices

When FIs perform a Reconsideration, they notify all parties to the determination of the results. The notice is on FI company letterhead. Whether the Reconsideration decision consists of a letter or a cover letter with a separate determination, it must contain the following language where a QIO is responsible for the medical necessity/appropriateness of care decisions.

> This determination relates only to issues for which the FI is responsible. Because the Quality Improvement Organization (QIO) has responsibility for the medical necessity and appropriateness of care decisions on this claim, you will receive notification with respect to any denial on those issues from the QIO.

The notice also includes the beneficiary's appeal rights.

C. Misfiled Reconsideration Requests

When FIs receive a request for Reconsideration or review relating to a QIO's initial or reconsidered determination, they acknowledge its receipt and advise the party that they are forwarding it and a copy of their records relating to the claim, to the QIO. They

immediately send the file, including a copy of their acknowledgment letter and the original request to the QIO with a brief explanation.

When a QIO receives a request for Reconsideration relating to a determination for which an FI was responsible, it forwards it to the FI immediately.

The SSOs forward requests for Reconsideration to the appropriate entity. Upon receipt, FIs scan them to identify those that should be directed to a QIO. They forward them to the QIO with their file.

40.7.2 - Hearings

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

The QIO legislation provides any beneficiary who is entitled to benefits under Title XVIII of the Act with the right to a hearing by the Secretary if the beneficiary is dissatisfied with the QIO's Reconsideration decision, and the amount in controversy is met*.

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

A. Time and Place of Filing the Request for Hearing

A hearing request must be signed and filed in writing within 60 days of receipt of the Reconsideration decision. The CMS regulations define the starting date for the 60 days to be five days after the date of the Reconsideration notice. The time limitation may be extended by an ALJ for good cause.

A request for hearing may be filed with the QIO responsible for the initial and reconsidered determination, with an ALJ, in the case of a social security beneficiary, at any office of the SSA, or in the case of a RRB annuitant, at any RRB office. Any requests for hearing FIs receive are routed to an office designated to receive requests for hearings.

B. What Constitutes a Request for Hearing

Any written, signed expression of dissatisfaction with the results of a Reconsideration, or request for another look, review, Reconsideration, or similar term, is a request for a hearing unless the writer is clearly requesting only a clarification or explanation of some point in the Reconsideration decision. FIs resolve any question as to the intent of the writer in favor of considering the document as a request for hearing. Since a determination as to what constitutes "good cause" for late filing is within the purview of the ALJ, FIs do not delay, or cease action on a request whether specific or implied, because it does not appear to be timely filed.

C. Routing Requests for Hearing

The FIs forward requests for hearings on QIO determinations involving Medicare beneficiaries to the QIO. The QIO compiles the claim folder and forwards the file to the appropriate hearing office. If the FI Reconsideration is pending on an issue, the FI forwards its entire file to the QIO for inclusion in the file to be transmitted to the ALJ. If

the FI has a pending request for an ALJ hearing, it sends its material to the ALJ for the hearing, sends copies to the QIO, and advises the QIO of the FI's pending hearing.

40.7.3 - Appeals of Institutional Supplementary Medical Insurance (Part B) Claim Decisions

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

See §§50. for FI instructions relating to appeals by beneficiaries, providers, physicians, and other suppliers of Supplementary Medical Insurance claims.

40.8 - Appeals by Hospitals of Diagnosis Related Group (DRG) Assignments Under PPS - Review of Initial DRG Assignments

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

Under the Prospective Payment System (PPS), the amount of payment to hospitals for inpatient hospital services is determined prospectively on a per case basis. A single payment amount is paid for each type of case identified by the diagnosis related group (DRG) into which each is classified. In accordance with Chapter 3, a DRG is assigned to each hospital discharge by use of a computer software program, the DRG Grouper, from data elements reported by the hospital.

If the hospital disagrees with the DRG assigned, it may submit additional billing data for that case. The FI will review the resubmitted data and adjust the DRG, if necessary.

The beneficiary is not entitled to a review of the DRG assignment since the assignment does not constitute a denial of benefits. Beneficiary liability is limited to deductibles and/or coinsurance and payment for services not covered by Medicare. The beneficiary retains the full range of appeal rights specified in §40.1.1 for cases involving denial of benefits.

50 – Part B Appeals Procedures for FIs and Administrative Law Judge Instructions for FIs

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

50.1 - Redetermination and Hearing Officer (HO) Hearing - Supplemental Medical Insurance

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

Since FIs also make payment for medical insurance items and services furnished by, and under arrangements with, providers, they must be prepared to handle complaints and to furnish the redetermination and hearings necessary under the medical insurance program.

A party to an appeal under the Supplementary Medical Insurance Program (one entitled to appeal the claim determination) may be any of those entities mentioned in §20, above.

The FI must provide the party with a redetermination when he or she is dissatisfied with the FI's determination denying a request for payment, or a hearing when he or she believes that the request for payment is not being acted upon with reasonable promptness (see §60.13.4A).

The law further provides an appeal to an ALJ from the FI's decision if the amount in controversy exceeds $100*, and judicial review if the amount in controversy equals or exceed $1,000* ($1,050 if requested on or after January 1, 2005). Two or more claims can be combined by a party to reach the $100* requirement if the request for an ALJ hearing is timely for all such claims at issue.

* 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.

The FI uses the following principles in scheduling and conducting a redetermination or hearing. These guidelines permit limited flexibility; yet assure that the methods and procedures employed are consistent with national policy.

A. Parties to a Redetermination or Hearing

See §20 above for the definition of a party. Following a redetermination, the party has a right to a HO hearing if the amount in controversy is at least $100.

B. Time Limit for Filing an Appeal Request

See §30.7 & §60.11.2 for the time limits for filing appeals. The FI is responsible for deciding whether a redetermination request is filed timely, and for deciding whether good cause exists for late filing if the redetermination request is not filed timely. The HO makes these decisions regarding a HO hearing request.

50.2 - Extension of Time Limit for Filing An Appeal

(Rev. 1. 10-01-03)

See §§60.7.

50.3 - Redetermination

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

Review requests received on or after October 1, 2004 will be called "redeterminations." The new timeliness standard for completing redeterminations is 60 days. 100% of redeterminations received on or after October 1, 2004 must be completed in 60 days of receipt.

A dissatisfied party to the FI's initial determination may request the FI to review it. A request for redetermination should be in writing and filed with the FI, an SSO, or the RRB. The appellant must sign the request.

The appellant must request the redetermination within 120 after the date of the notice of initial determination as indicated on the MSN, (To allow for mail delivery, the contractor computes the time limit for requesting a redetermination by allowing 5 additional days beyond the time limit). The FI may extend the period if it finds the appellant had good cause for not requesting the redetermination on time. If the FI finds that the appellant did not have good cause for not requesting the redetermination on time, the FI may, at its option, treat the request as a request for reopening.

The redetermination is an independent reexamination of the entire claim and the first level of appeal following denial. To conduct it, the FI uses staff that did not participate in the initial decision. The FI considers a written request for a reopening following an initial determination a request for redetermination.

50.3.1 - What Constitutes a Request for Redetermination & Handling Beneficiary Inquiries

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

A. Written Requests for Redetermination Made by Beneficiaries

See §60.11.1 B 1

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

See §60.11.1 B 2

C. Letters and Calls That are Considered Inquiries

See §60.11.1 B 3

D. Telephone Requests for Redetermination from Beneficiaries

If the FI has a telephone redetermination process in place, beneficiaries may request a redetermination by telephone at a number designated by the FI for receipt of redetermination requests. The FI follows instructions in §60.11.1(B)(2) for what to consider a request for redetermination. Although the beneficiary may request that the redetermination be performed by telephone, the FI makes the decision as to whether or not the redetermination should be conducted over the telephone. (See §60.12 for more information on telephone redeterminations.)

E. Telephone Requests for Redetermination from Providers

If the FI has a telephone redetermination process in place, providers **with appeal rights** may request a redetermination by the telephone at a number designated by the FI for receipt of redetermination requests. Although providers may request that the redetermination be performed by telephone, the FI makes the decision as to whether or not the redetermination should be conducted over the telephone.

The appellant must provide the following information at the beginning of the phone call in order to request a redetermination:

- Beneficiary Name;
- Beneficiary Date of Birth;
- Medicare health insurance claim (HIC) number;
- Name and address of provider/supplier of item/service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions;

ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form); and

- Which item(s), if any, and/or service(s) are at issue in the appeal.

50.3.2 - Elements of a Redetermination

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

The following are the essential elements of an adequate redetermination.

The redetermination is an independent, critical reexamination of the claim file made by FI personnel not involved in the initial claim decision. The reviewer reexamines each aspect of each service in the claim. The following conditions must be met:

- The reviewer may not be the same person who made the initial determination.
- The redetermination request must be specific, identifying the service(s), and the issue(s) being appealed.
- The FI reviews all aspects of the service in question.
- If there is **any doubt** about whether the request is specific or general, the FI performs a general redetermination. (However, services that have been fully reimbursed need not be reviewed.)

The FI refers the appellant to an SSO for assistance in writing out his/her complaint. The SSO staff will give the appellant general program information, and if he/she wishes to request a redetermination, will help him/her complete a Form CMS-1964.

See § 60.11.5(D) for instructions on dismissal of redetermination requests.

A. Requests for Documentation

The FI should not request documentation directly from a provider or supplier for a State-initiated appeal. If additional documentation is needed, the FI requests 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.

For providers or beneficiary initiated appeals, when necessary documentation has not been submitted, the FI advises the provider to submit the required documentation. It notifies them of the timeframe they have to submit the documentation. The FI documents its request in the redetermination case file. The requested documents may be submitted to the FI via facsimile, at its discretion. In rare cases, a provider might inform the FI that he/she is having trouble obtaining the supporting documentation, such as hospital records. In this situation the FI may provide the physician or other supplier with assistance in obtaining records. If the additional documentation that was requested is not received within the designated time frame (at least 14 calendar days from the date of request), the FI conducts the redetermination based on the information in the file. The FI must consider evidence that is received after the deadline but before it has made and issued its redetermination. The same standards apply for requests for redetermination made over the telephone.

The FI shall continue to routinely include instructions on the appropriate information to submit with appeal requests in FI provider newsletters and other educational literature. Providers are responsible for providing all the information required by the FI in order to adjudicate the claim (s) at issue. Although providers are to provide all necessary documentation when filing the claim, if he/she fails to provide documentation at the initial determination and then appeals the FI's initial determination, he/she should provide all relevant information and documentation at the time the appeal is requested.

B. The Redetermination

Since one of the purposes of instituting the redetermination is to reduce unnecessary costs, the redetermination does not provide for personal appearance and testimony of the appellant.

The redetermination is the final determination unless a hearing is requested or it is revised in accordance with §90.

The FI includes all evidence it considered and its findings in the redetermination of a claim in the appellant's file. This includes all memoranda of conversations with medical consultants, papers, requests, reports, etc. arising out of the claim redetermination process. The FI forwards the file to the HO if a hearing is requested.

1. Timely Processing Requirements

See § 60.11.4 A

2. The Redetermination Letter

For review/redetermination requests received on or after October 1, 2004, the FI follows instructions in CR 2620.

The FI mails to the appellant a determination that does not reverse the original determination in whole.

When the beneficiary request a redetermination, the FI writes the redetermination letter at a 7.9th grade reading level or below so that the beneficiary-appellant can understand the reason why any of the services are not covered or cannot be fully reimbursed, and what action can be taken if he or she disagrees with the redetermination. When the contractor determines that the incoming request from the beneficiary is written above a 7.9 grade reading level, the contractor prepares the response to the approximate level of the incoming request. (Redetermination letters addressed to assignees do **not** have to be written at a 7.9 grade reading level.) To ascertain the reading level of the redetermination letter, the FI uses the following formula which is an accepted procedure for measuring readability. The formula measures two factors - the average sentence length and a hard-word factor (words of three syllables or more).

The FI follows these steps to establish the reading level.

- It counts the total number of words in the letter. It divides this total number by the number of sentences. The result is the average sentence length. (Generally, a sentence should not have more than 12-15 words.)
- It counts the number of words that include three syllables or more. There are exceptions—it does not count words that are normally capitalized, combinations

of short, easy words, or verb forms which result in three syllables by adding “ed,” “ing,” “ly,” or “es.” (it counts hyphenated words as separate words. It does not count numbers or words which are part of the structure of the letter. It counts numbers, abbreviations and acronyms as one-syllable words.) It takes the number of hard words and divides by the total number of words in the letter to determine the percentage of hard words.

- It does not include paragraphs supplied by CMS guidelines in the calculation to determine average reading level.
- It totals the above factors (average sentence length and percentage of hard words) and multiplies by .4. The resulting figure is the reading level. The reading level should be no higher than a 7.9, which is comparable to a 7th grade reading level. If reference is desired, consult “The Technique of Clear Writing” by Robert Gunning, McGraw-Hill, New York, Publisher (1952).

Medicare Number of Beneficiary:
111-11-1111 A

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

MEDICARE APPEAL DECISION

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

Dear Appellant's Name:

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

The appeal decision is (Insert either: unfavorable. Our decision is that your claim in not covered by Medicare and over/under $100 remains in controversy. OR partially favorable. Our decision is that your claim is partially covered by Medicare and over/under $100 remains in controversy)

More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to (insert: an Administrative Law Judge (for Part A), a Hearing Officer (for part B)). You must file your appeal, in writing, within (insert: 6 months (for Part B) or 60 days (for Part A) of receiving this letter.

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

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

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

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

Decision

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

Explanation of the Decision

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

Who is Responsible for the Bill?

Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

What to Include in Your Request for an Independent Appeal

Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim.

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 (insert: a Hearing Officer hearing or an Administrative Law Judge (ALJ) Hearing)

The law requires that at least $100 remain in controversy for you to request (insert: a Hearing Officer hearing or an ALJ Hearing). If less than $100 remains in controversy, you may combine the claim or claims that are the subject of this decision with claims from other recently issued redetermination decisions. This is called "aggregating claims." For more information, see the section on aggregating claims below.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within (insert: 60 days for Part A or 6 months for Part B) of receiving this letter. Under special circumstances, you may ask for more time to request an appeal.

You should include: your name, address, Medicare number, reasons for appealing, and any evidence you wish to attach. You may also attach supporting materials such as

medical records, doctors' letters, 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:

Contractor Name
Address
City, State Zip

Aggregating Claims: To "aggregate claims" EACH CLAIM included in your request for (insert: Hearing Officer hearing or ALJ hearing) must be appealed within (insert: six (6) months or 60 days) from the date the decision was issued on the claim and each claim must have already received a redetermination decision.

If you wish to request a (insert: Hearing Officer hearing or ALJ hearing) by combining the amounts remaining in controversy from other claims, you MUST clearly state on your request that you are "aggregating claims", AND you must list the specific claims that you are aggregating.

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

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

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

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

Contractor Name,
A Medicare Contractor
Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of address).

Other Resources To Help You:
1-800-MEDICARE (1-800-633-4227)

TTY/TDD: 1-800-486-204

50.3.3 - Actions Prior to Reversal of Initial Payment Decision

(Rev. 1. 10-01-03)

As a result of the FI's review, it may question the initial payment decision. Since it has already notified the appellant that part of the bill was covered, a subsequent denial action could cause serious problems. If the FI thinks the initial payment decision should be reversed, it shall proceed as follows. It shall document its actions:

- The FI shall review the file carefully, with particular attention to the evidence that supported the original payment decision. It shall use the adjudicative principals in force when the initial decision was made.
- If the FI cannot justify the initial payment decision in whole or in part, and the issue is a medical one, it shall refer it to a consulting physician for an expert opinion on whether the disputed service or services were covered.
- If the physician thinks the initial payment decision was incorrect, the FI shall refer the case to the Health Insurance Coordinator for review and written evaluation.
- If the FI questions a case involving nonmedical issues and thinks there is no basis for the initial payment, it refers the case to the Health Insurance Coordinator.
- Upon completion of its review, if the FI still doubts the coverage of the services, it lets the initial payment determination stand. If, however, it is clear that payment was erroneous, the FI shall recoup the overpayment.
- If the FI plans to recoup an overpayment, it shall advise the appellant of the waiver process. If the appellant pursues waiver, the FI shall curtail efforts to recoup the overpayment until the waiver decision is made.

50.4 - The Hearing

(Rev. 1. 10-01-03)

Section 1842(b)(3)(C) of the Act provides that FIs must establish and maintain hearing procedures for individuals or providers dissatisfied with the FI's review determination. The purpose of the hearing process is to give a dissatisfied appellant an opportunity to present reasons for the dissatisfaction and to receive a new determination based on the record developed at the hearing. A appellant who requests a hearing has the right to be represented by a representative of his/her choice. The FI shall notify the appellant of his/her right to a hearing if $100 or more is in controversy, a statement of the issues in controversy, the method of requesting a hearing, the time limit for requesting it, and the right to send a representative, or to have a decision based on the record.

The FI applies the following principles.

50.4.1 - Types of Hearings

(Rev. 1. 10-01-03)

See §§60.15 through 60.15.3 for a description of the types of hearings.

50.4.2 - Issues Determined at the Hearing

(Rev. 1. 10-01-03)

Section 20, above, lists the CMS decisions that are subject to the administrative appeals procedures The FI uses the HO hearing procedures only to settle a controversy involving benefits under Part B. .It shall not resolve other issues that may arise. For example, specific issues to consider at the hearing may relate to such factors as whether services are medically necessary; whether items and services furnished are covered; whether the deductible has been met; or whether payment can be made under the waiver of liability provision.

- The HO may not make determinations with respect to any issue or factor for which CMS or SSA has sole responsibility. Some examples:
    - Whether or not an individual is entitled to coverage under supplementary medical insurance (Part B);
    - Whether an outpatient clinic meets the conditions for coverage of services;
    - Whether a appellant qualifies for railroad retirement benefits; or
    - Issues related to hospital insurance benefits under Part A.

Because the hearing decision is based on **all** available and material information, the HO considers **all** aspects (i.e., technical and coverage) relating to the claim to prevent the emergence of a new problem not previously raised which could delay effectuation or require reopening.

If an HO receives a request for hearing concerning an issue that does not involve a Part B benefit, he/she forwards it to the RO without delay and advises the appellant of the referral. When a hearing request is received which encompasses several issues, one or more of which is outside the HO's responsibility, the HO refers the request to the RO for consideration of those aspects of the request that are outside the HO's jurisdiction. The HO proceeds with the hearing on matters within his/her jurisdiction, provided that a decision on that portion of the request is not dependent on a determination on other issues. Where such dependency exists, the hearing is postponed pending decision on the other issues, and the appellant notified of the delay.

50.4.3 - Request for Hearing

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

Any individual dissatisfied with a redetermination, may request a hearing in accordance with subsection C. A qualified representative may file the request on behalf of an individual he/she represents. A representative or executor of a deceased appellant's estate may file it.

Each request for hearing must be disposed of by the HO in one of the following ways:

- Conducting the hearing;
- Dismissing the request;
- Remanding the claim to the FI for payment or dismissal;
- Accepting a withdrawal at the request of the appellant or representative;

- Transferring the request to another FI's HO if an out-of-area hearing has been requested (requestor is not in the area of this HO carrier); or
- Transferring the request to the RO where the issues are outside the HO's responsibility.

A. FI and HO Responsibility in Handling a Request for Hearing

Whether or not the FI has arrangements with a carrier to perform the FI's Part B hearings, the FI is responsible for the timeliness of the hearings and the quality of the decisions for evaluation purposes. The following is the division of responsibility between the FI and the HO:

1 FI

The FI or HO acknowledges the hearing request as soon as possible, but no later than 21 days after its receipt in the corporate mailroom. It forwards all material to the HO. It notifies the appellant that the HO will contact him/her regarding the hearing. If, while assembling the file, the FI sees that the claim is payable in full, it notifies the HO that the claim is payable, and asks the HO to dismiss the hearing request. The FI does not make payment until the HO disposes of the hearing request. The FI does not encourage the appellant to withdraw on the ground that withdrawal will expedite payment. If the FI finds that the hearing request belongs to a different FI, it transfers the misrouted request for a hearing to the appropriate FI.

2 HO

The HO informs the appellant that the HO has the hearing request. If the appellant requested an in-person hearing, the HO explains that the HO is scheduling it, and will notify him/her of the date. (See §50.4.5 D for circumstances in which the FI offers a telephone hearing when an in-person hearing is requested.) The FI explains that it will prepare a determination based upon the information in the file, including any information the appellant submits. The FI explains that this "On The Record" decision is based upon a full and thorough review of all available relevant information, is less costly and faster than an in-person or telephone hearing, and resolves a significant percentage of appeals. The FI encourages the appellant to submit relevant evidence within 14 calendar days.

The FI makes it clear that the in-person hearing has been scheduled, and will be conducted, using a different HO. If the appellant is satisfied with the OTR decision, or wishes to proceed to the next level of appeal (the ALJ hearing), the appellant cancels the scheduled in-person carrier HO hearing by returning a postcard enclosed with the OTR decision letter. Otherwise the appellant returns the postcard confirming the scheduled time and place for the HO hearing.

The FI makes it clear that even if the OTR decision reduces the amount in controversy to less than $100.00, the party has the right to the in-person HO hearing.

The FI does not conduct the preliminary OTR if:

- It will significantly delay the in-person hearing requested;
- The facts of the case can be developed only through oral testimony; or

- You do not have a different HO to conduct the in-person hearing.

If, based upon the HO's preliminary review (before the OTR), he/she decides that a full reversal is warranted, he/she notifies the FI to pay the claim and to notify the appellant that the claim is being paid and that the HO is dismissing the request.

B. Party Not Within the FI's Geographic Area

The CMS requires specialty FIs to handle certain types of services. If the specialty FI and the appellant are located in different FI servicing areas, or if a specialty FI is not involved, but the party appealing the claim decision has moved, and therefore is unable to attend a hearing in the initial FI's servicing area and requests an in-person hearing, or if the appellant's representative has been designated by the appellant to appear on the appellant's behalf, but does not reside in the appellant's FI service area, it is unfair to require the appellant/representative to travel an unreasonable distance (usually more than 70 miles) for an in-person hearing. Therefore, a appellant's request for an in-person hearing is handled by the FI servicing the appellant's (or appellant's representative's, as applicable) area. If the amount in controversy is less than $100, the FI that handled the original determination dismisses the request. Otherwise, that FI conducts an OTR and proceeds as follows:

- If the file has been forwarded and the OTR results in a full reversal, the initial FI notifies the FI servicing the appellant's (appellant's representative's) geographic area that the in-person hearing is no longer needed.
- If the amount in controversy before the OTR was at least $100, the FI includes in the decision letter a preaddressed postage paid postcard on which the appellant may request an ALJ hearing, confirms that he/she intends to attend the in-person hearing scheduled, or declines the hearing, being satisfied with the OTR decision.

If the party requests an in-person hearing, the initial FI, based on the party's new address, should arrange to have the hearing request and all file materials transferred to the appropriate FI. That FI then furnishes a HO and schedules a hearing at a time and place convenient to the party and the HO. If the FI that services the beneficiary does not service the provider, the FI with jurisdiction for the hearing is the one that services the beneficiary. The FI contacts the RO to resolve conflicts or problems.

The initial FI does not transfer the claim and file if a telephone hearing is requested. Instead, it conducts the hearing and renders a decision.

If a hearing request is received which involves several combined claims reviewed by more than one FI, the FI receiving the request forwards the request to the FI HO where the party (or the party's representative, as applicable) currently resides, if a personal appearance by the party is expected. Where a request involves claims reviewed by several out-of-area FIs and the party's attendance is not a factor, the FI receiving the request forwards it to the FI with the most money in controversy. The HO selected to hold a hearing for another FI under this procedure acts as the initial FI's HO and communications with the party, including the decision, reflect this.

EXAMPLE: A beneficiary, while in Florida, incurs $200 in expenses for an outpatient service. His claim is denied on the basis that the services are not medically necessary.

The appellant, some time after the redetermination affirms the initial denial, moves to New York City and requests a hearing. Since he/she is not returning to Florida and wants an opportunity to appear personally before a HO, he/she asks that the hearing be held in New York.

The Florida FI contacts the New York FI for assistance in obtaining a HO and forwards the request for hearing and all pertinent information and documents to the New York FI, which selects the HO. The New York FI advises the Florida FI of the time and place of the hearing.

Meanwhile, the Florida HO prepares the OTR decision. If the OTR decision results in a full reversal, the Florida HO notifies the New York HO that the in-person hearing is no longer required and that further action is not necessary. If the OTR decision affirms the redetermination, the Florida HO includes in the decision letter a postage paid postcard pre-addressed to the New York HO, which the appellant must return to confirm the scheduled hearing time and place, or to indicate that the in-person hearing is no longer needed. The Florida HO forwards the file to the New York HO. That HO conducts the hearing unless the appellant returns the postcard canceling it.

If the New York HO requires any additional development, information or documents for handling the case, he/she may deal directly with the initial FI. The initial FI responds within 30 days with the requested information. If any problems arise, the HO may contact the RO.

The Florida FI is bound by the New York HO's decision, but only relative to the particular case. The decision does not create a precedent.

NOTE: Whether expenses for conducting the hearing are incurred by in-house personnel or by an outside attorney, the New York FI includes the hearing expense as part of its administrative costs.

C. Manner of Requesting a Hearing

The request for a hearing must be in writing and signed by the party or his/her representative. It must state the dissatisfaction with the FI's redetermination, or with the timeliness in which the request for payment was acted upon, and a desire to appeal the matter. The request must be filed at the FI's office, an SSO, or CMS.

Form CMS-1965, Request for Hearing, may be used. Use of this form is not essential. Any written expression is valid provided it meets the requirements discussed in this section. Where doubt exists whether the party is asking for a hearing or for information only, the FI resolves it by considering the communication a request for hearing. If the request does not explicitly request an in-person or telephone hearing, the FI contacts the appellant to determine the kind of hearing requested.

When a Form CMS-1965 is filed with the FI, it date stamps each copy. The FI returns the stamped, completed acknowledgment portion to the appellant.

When a representative has filed an appeal, the FI files a copy of the SSA-1696-U4 (Appointment of Representative) with the Form CMS-1965.

D. Late Filing

The time limit for filing a hearing request is six months from the date of the notice of the redetermination or revised determination. Where claims are combined to meet the $100 requirement, all redetermination or revised determinations must meet the 6-month period before the date of the hearing request. However, in certain circumstances, the HO may find good cause for late filing of the hearing request, and the request handled as one that has been timely filed. (See §60.7 for discussion of finding good cause.)

E. Eligibility for a Hearing

A party to the FI's redetermination is entitled to a hearing if a written request is filed timely and if the amount in controversy at the time the request is filed is $100 or more. A redetermination is a prerequisite of a hearing, except where the FI takes an unreasonable time to act on the initial claim. Where a request for a hearing has been filed prior to a redetermination (except where the issue is reasonable promptness), the FI need not forward the file to the HO. The FI treats it as a request for redetermination and issues a redetermination. The FI notifies the appellant that the requested hearing will not be held because the redetermination has not yet occurred. If the appellant is dissatisfied with the redetermination, a hearing can be requested.

F. Amount in Controversy is Less than $100

If the amount in controversy is reduced to less than $100 as a result of a redetermination, the appellant is not entitled to a hearing. In the case of a revised initial determination on the FI's own motion, i.e., a reopening, the appellant is entitled to a redetermination. However, payment under the Limitation on Liability provision, does not reduce the amount in controversy.

G. Determination of Amount in Controversy

The HO determines the amount in controversy upon receipt of the hearing request and the claim file. If needed, the HO obtains current deductible information from the FI.

The HO compares the amount billed less the amount paid. From this result the HO subtracts any deductible or coinsurance charged. The result is the amount in controversy.

EXAMPLE: $1000 is billed. $640 is paid based on $800 reasonable cost. The amount in controversy is ($1000 - $640) - $160 (20% of $800 reasonable cost) = $200.

The HO dismisses the hearing request without ruling on the substantive issues if the $100 requirement is not met. The dismissal notice states that although the $100 qualification amount has not been met, the claim(s) can be added to previous or subsequent claims decisions with which the appellant is dissatisfied, as long as the 6-month time limit from the date of the redetermination notice(s) to the date of the hearing request is met.

H. Combining Claims to Meet the $100 Limitation

A hearing may be conducted on more than one claim at a time; i.e., the appellant may have a hearing on several claims involving different services. The HO determines the total amount in controversy for all claims in which the appellant has requested the hearing. It is not necessary that there be $100 in controversy for each. To combine claims to meet the $100 limitation, the following requirements must be met:

- They must all belong to the same beneficiary or provider;

- Those submitted by a provider may be for several beneficiaries.
- They must have been through the redetermination process, except when an initial payment request has not been acted upon with reasonable promptness.
- The 6-month filing time limit must be met for all claims involved; and
- The hearing request must identify them.

A beneficiary may combine claims from different providers to meet the $100 limitation. Likewise, a provider may combine claims from different beneficiaries to meet the minimum dollar amount.

I. Request for Payment Not Acted Upon With Reasonable Promptness

If the FI does not act upon a request for payment within 60 calendar days from the day it received it (i.e., the FI received the claim but took no action to make an initial determination), the appellant has the right to request a hearing. The appellant or his/her representative completes the hearing request and sends it to the HO.

Upon receipt of the hearing request, the HO determines whether the request for payment was filed more than 60 days earlier and the FI had taken no action prior to the request for hearing. If so, the HO directs the FI to notify the appellant of the reason for the delay and to begin processing the claim within l0 days. Upon receiving a copy of the FI's notice to the beneficiary, the HO dismisses the hearing because action is being taken on the initial payment request.

If the FI does not comply with the HO's request, the HO prepares for a hearing and sends notice of the time and place of hearing to the party and a copy to the FI. If appropriate, the HO may perform an OTR.

J. Withdrawal of Hearing Request

A request for hearing may be withdrawn, with approval of the HO, at any time prior to the mailing of the hearing decision, either upon the appellant's written application, or by the party or his/her representative orally requesting withdrawal at the hearing. A documented telephone request prior to the hearing is acceptable.

The HO acknowledges the withdrawal request by notice to the party (or to the representative) at the last known address.

K. Dismissal of Hearing Request

The HO dismisses a request for hearing if:

- The party or his/her representative has requested an in-person hearing but does not appear and within 10 days after the mailing of notice to the individual by the HO, does not show good and sufficient cause for not having appeared or for not having notified the HO that he/she could not appear;
- The appellant or representative has requested a telephone hearing, but fails to participate at the scheduled time and does not show good and sufficient cause for

not having participated or for not having notified the HO that he/she could not participate;

- The appellant is not a proper party or is otherwise not entitled to a hearing;
- The appellant died and there is no information before the HO showing that any one else may be prejudiced by the FI's last determination;
- No prior redetermination or revised determination has been rendered; or
- After the redetermination is complete, the FI decides the entire claim could have been paid. (In this case, if a hearing has been requested, the FI transfers the file to the HO with an explanation that the FI can pay the claim if the HO dismisses the request for hearing and transfers the file.)

The HO handles the dismissal formally and sends a letter to the last known address of the party or to his/her representative, if any. The letter includes the reason(s) for the dismissal.

The HO may vacate a dismissal of a request for a hearing if there is good cause and if, within six months of the mailing of the notice of dismissal to the parties, a party to the haring requests the HO to vacate the dismissal.

L. Timely Processing Requirements

See 60.14.1

50.4.4 - Hearing Officer (HO)

(Rev. 1. 10-01-03)

A. Authority

The HO occupies a significant position in the administrative appeals process. Authority of the HO is limited to the extent that he/she must comply with all provisions of title XVIII of the Act and regulations issued thereunder, as well as with CMS rulings, general instructions and other guides. The HO may not overrule the provisions of the law or interpret them in a way different than CMS does when he/she disagrees with their intent; nor may he/she use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations. See §60.16.1.

B. Qualifications and General Responsibilities

See §60.16.2.

The FI may designate as a HO an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology. The HO must be independent and have a thorough knowledge of the Medicare program and the statutory authority and regulations upon which it is based, as well as rulings, policy statements, and general instructions issued by CMS.

The HO must not have been involved in any way with the determination in question and neither have advised nor given consultation on any request for payment that is a basis for the hearing. Since the proceedings are nonadversary in nature, the HO should be particularly responsive to the needs of unrepresented parties. He/she must protect the

party's rights, even if counsel represents the party. The HO must also safeguard the rights of all parties to the hearing while protecting the Government's interest.

The HO schedules the hearing to render a decision within 120 days after receipt of the request. For the HO to perform his/her function properly, adequate prehearing preparation is essential. (See §50.4.5.) The HO brings unusual problems he/she encounters to the attention of the RO. He/she differentiates between requests for policy clarification or updates, versus "ex parte" CMS opinion with respect to a specific case. The FI shall not restrict the HO from obtaining clarification from CMS on policy matters, or from discussing problems with the RO.

The HO exercises control and conducts the hearing with order and dignity, regardless of the type. He/she analyzes and evaluates evidence adduced at the hearing, including testimony, documents or other written evidence included in the record. He/she encourages the submittal of facts from individuals without causing unnecessary friction, and is objective and free of any influence that might affect impartial judgment. He/she is patient with older persons and those with physical or mental impairments. The HO makes an independent and impartial decision, and writes a clear and concise decision memorandum.

The HO fully documents, in the file, any reasons for delays in holding the hearing or in rendering a decision, if it appears that a decision will be rendered more than 120 days after the request for hearing was received.

The HO considers all relevant and material facts. The written decision contains a statement of the issues, evidence, rationale, specific findings of fact and a conclusion, within the framework of applicable statute, regulations, and guidelines.

C. Disqualification of HO

See §60.16.3

The HO disqualifies himself/herself from acting in a case in which he/she might be considered prejudiced or partial; or with respect to any matter in which he/she has a personal interest; or in which a party raises a valid objection. Disqualification is appropriate where a HO was involved in any way in the initial or review determination.

Reluctance to handle a particular case is not justification for disqualification. Neither is participation in a factually similar or related case. The HO withdraws only for cogent reasons, keeping in mind primarily the objective that a appellant be afforded the opportunity for an impartial hearing.

Appellants sometimes argue for the HO to be dismissed because he/she is a FI employee. This is not good cause for disqualification. The U.S. Supreme Court has upheld this principle ("Schweiker v. McClure," decided April 20, 1982). The HO indicates that although he/she is not an officer of the Federal Government he/she is nevertheless acting on its behalf and must comply with the provisions of the Medicare statute, regulations, and instructions.

If a party to a hearing suggests disqualification of the HO, the HO includes the party's request, and its basis, as part of the record. The record shows how the HO disposed of the suggestion. If the HO, on his/her own volition or upon objection of a party,

disqualifies himself/herself, he/she prepares and inserts in the hearing file a signed statement explaining the reasons.

If the HO withdraws on his/her own volition prior to scheduling the case for hearing, notice to the parties of such withdrawal is not necessary. If the HO disqualifies himself/herself as a result of a party's objection, the HO informs the parties of his/her withdrawal and that in due course the case will be heard by another HO. If a notice of hearing is issued prior to withdrawal, the HO notifies all parties in writing, informing them that the date set for the hearing has been canceled (if cancellation is necessary) and that an amended notice of hearing will be forwarded from the HO to whom the case is reassigned. If the motion for withdrawal and withdrawal occur at the hearing, the oral statements made part of the record are sufficient.

If a party's prehearing protest is considered and the HO decides to conduct the hearing, the HO notifies the protesting party in writing, explaining his/her reasons. He/she sends a copy of this notice to any other appropriate party. If he/she makes his/her ruling not to withdraw at the hearing, he/she includes a statement in the record.

50.4.5 - Preparation for the Hearing

(Rev. 1. 10-01-03)

See §§60.17.1 through 60.17.4.

For the HO to be fully informed, he/she must consider certain aspects of the claim prior to the hearing and, preferably, before the notice of hearing is mailed. The first step in preparing for the hearing is an examination of all the evidence, including material submitted with the hearing request. Once the HO ascertains the completeness of the evidence and the issues to be determined, he/she examines the applicable sections of the law, regulations, rulings, policy statements, general instructions and any other formal guides pertaining to the issues. However, if evidence is not submitted within a reasonable amount of time, the HO conducts the hearing based on the information in file. Additional information may be submitted during the hearing.

A. Notice of Time and Place of Hearing

An appellant who requests either an in-person or telephone hearing must be given adequate written notice of the time and place set for the hearing and information regarding the specific issues to be determined. The HO sends the notice as promptly as possible, subsequent to his/her review of the evidence.

If the hearing was requested by counsel or other representative of the beneficiary, the HO that person. The HO schedules the hearing to be mutually convenient to the appellant and the appellant's representative. If the beneficiary's representative is attending the hearing on the beneficiary's behalf, the HO conduct the hearing in a location convenient to the beneficiary's representative. In some instances, a beneficiary's physical condition may require the HO to schedule a hearing at a hospital or other convenient location, so there is no infringement of the beneficiary's right to a hearing. In such situations, the HO reminds the beneficiary that a telephone hearing or a HO decision based on the record is a viable alternative.

If the hearing is to be in-person or by telephone, the HO sends the notice of hearing at least 14 calendar days prior to the date of the hearing. Notice content depends on the kind of hearing requested. If, for example, the party has requested an in-person or telephone hearing, the HO provides sufficient information about the procedures for the parties to prepare effectively. The HO explains the beneficiary's right to be represented by a representative of the beneficiary's choice. Failure to adequately inform the appellant of the nature and purpose of the hearing with specificity as to the points at issue, may result in denying the appellant an essential element of the hearing. Therefore, the HO phrases this information so the wording can be easily understood by a layman while being technically correct and complete.

The notice for an in-person hearing must contain the following elements. The notice for a telephone hearing includes the items with an asterisk.

* o The time of the hearing;
  - o The place of the hearing, giving: city, state, street address, floor and designated room;
* o The purpose of the hearing and a statement of the issues;
* o A brief statement of the consequences of the proceeding and of the decision which will follow;
* o If appropriate, reference to the particular statute or regulation which is authority for the hearing;
* o If appropriate, particular procedural rights to present briefs or affidavits in lieu of testimony; right to present oral argument; the effect of abandonment or failure to appear, etc.;
* o Right to present oral argument;
* o Right to the identity and qualifications of any consultant the HO plans to rely on for expert testimony, and the right to submit written questions to such consultants;
* o Parties may be represented by counsel or other representative;
* o Parties may bring witnesses;
* o Parties to bring or send all evidence in their possession, including pertinent records, documents or other writings affecting the issues; and
* o Notification that the beneficiary should promptly notify the HO in writing of any circumstances preventing the beneficiary from participating in the hearing at the time and place cited.
  - o If an attorney or other person will be representing the beneficiary, send a copy of a Form SSA-l696-U4 (Appointment of Representative) with instructions that the form should be completed.

The HO includes a copy of the notice of time and place of hearing in the hearing file. For an OTR request, instead of the above notice, the HO sends a letter acknowledging the request.

B. Adjournment and Postponement of Telephone or In-person Hearing

For good and sufficient reason, the HO may fix a new time and/or place for the hearing or adjourn on his/her own motion upon reasonable notification to the parties. Good and sufficient reason includes, but is not limited to, sickness of a party, interpreter, or witness; difficulty in scheduling a witness; or a delay in obtaining additional evidence. Include a statement in the record explaining the reasons for postponing the hearing.

An appellant may repeatedly request postponement. The HO evaluates the reasons. If the HO thinks the reasons are frivolous, he/she need not grant the postponement. If, after the third postponement, the HO cannot justify continued rescheduling, give notice to the appellant that a decision will be based on the record. Include the reasons for your actions and issue the decision based on the record.

C. Review of the Evidence

Once a request for hearing has been filed, submit to the HO all evidence pertaining to the claim. Your rationale for denying a payment request is an issue for the HO to resolve. Comply with all requests for evidence by the HO.

While the appellant is responsible for securing the needed evidence to establish his/her claim, the HO protects the appellant's rights by making every effort to insure that sufficient evidence is obtained, particularly when the case is based "on the record." Nevertheless, if the appellant is a provider, the FI is not to develop information. If the appellant is unable to secure necessary information from a provider, the FI assists to the extent it can.

The HO evaluates the evidence in the file and any other that the parties submit before the hearing, from the standpoint of adequacy, to select the evidence to be used as exhibits in the record.

If the HO sees that evidence on some point is conflicting, inconclusive, or wholly lacking, he/she should consider how the desired evidence may best be procured before scheduling the hearing. This includes whether or not there is the need for a consultative physician or other expert. In order to avoid delay that might result from the absence of a key witness or the lack of some essential evidence, he/she makes every effort to ensure that all evidence and witnesses will be available. The HO obtains the necessary additional evidence through appropriate channels from the FI, the physician, hospital, or other source.

If the HO does not receive the requested evidence or information after two 30-day follow-up requests, he/she makes a decision based on the evidence. Should he/she receive the evidence after the decision has been rendered, if the amount in controversy is less than $500 he/she may reopen the decision; otherwise, he/she advises the appellant that the hearing is complete, and further appeal must be to an ALJ if the requirements are met.

If necessary, the HO may request the Regional Administrator to issue a subpoena directing a witness to appear and testify.

Because the hearing is relatively informal, evidence may be considered even though it might be inadmissible under rules of evidence applicable to the courts. The pertinence,

materiality, and relevance of the evidence are the controlling criteria with respect to admissibility, rather than the particular form in which it appears.

The HO resolves doubts about a particular document as an exhibit by including it.

Determining the issues and selecting the documentary evidence are especially important if the decision is based on the record.

D. Telephone Hearing

The HO offers an appellant a telephone hearing following an adverse review determination. Even though the appellant requests an in-person hearing, the HO offers a telephone hearing if the following criteria are met.

- Telephone equipment used permits a complete record of the hearing to be made.
- Hazardous weather, repeated reschedulings by the participants, or the beneficiary's physical health, or long distance travel make an in-person hearing overly expensive and extremely inconvenient to the appellant.
- There are times when the above criteria are met but a telephone hearing is not appropriate. These are:
- The beneficiary has again requested an in-person hearing or an on-the-record hearing;
- Overpayment hearing requests;
- Hearing requests by providers when claims of more than three beneficiaries are involved, and the beneficiaries may be liable;
- Witnesses are involved and the telephone equipment available does not permit more than a two-way conversation or a witness is reluctant to participate in a telephone hearing.

At no time may a HO require a telephone hearing. Telephone hearings are designed only to lower costs and eliminate delays.

If the above conditions are met, the HO includes an explanation of the telephone hearing option in the "notice of time and place of hearing," and asks the appellant to reply concerning his/her preference for an in-person or telephone hearing.

All relevant materials in the HO's file are copied, subject only to the guidelines on disclosure, and sent to the appellant prior to the hearing. Any information in the hearing file, or received subsequently, which may or may not be to the appellant's disadvantage is furnished to the appellant or to his/her representative.

If the appellant has evidence to present at the telephone hearing, the HO arranges to receive the evidence before the hearing, acknowledges its receipt, and returns a copy to the appellant for use during the hearing. If evidence is introduced during the hearing, the HO asks the appellant to explain for the record those portions he/she considers important. The HO identifies the evidence so that it can be properly associated with the hearing record when received by the HO. If the appellant has documentary evidence to submit after the hearing, the documents should be submitted as soon as possible but no later than the date set by the HO. The record is kept open until their receipt. If evidence submitted

after a hearing reveals unresolved issues or raises new ones, another hearing may be required.

The HO sends instructions for the telephone hearing to the appellant before the hearing, outlining the procedure to be used and the number to call to start the hearing. (See §50.4.5A.) If necessary, the HO provides additional information at the time of the telephone hearing. (See §§50.4.8A-50.4.8H.)

50.4.6 - Conduct of an In-Person or Telephone Hearing

(Rev. 1. 10-01-03)

The conduct of the hearing and admission to it are within the purview of the HO who admits the parties and such other persons as he/she deems necessary and proper.

The HO guides the progress of the hearing, observes witnesses, and develops all the facts necessary to reach a just decision. In telephone hearings, the HO is deprived of visual cues. Consequently, he/she uses oral cues in guiding the hearing, especially in keeping the participants from introducing extraneous topics. The HO builds a record on the disputed points which will sustain a decision. He/she is primarily responsible for questioning the witnesses and at the same time, ensuring that the parties to the hearing are permitted to ask pertinent questions and provide testimony that has not been previously elucidated. He/she may also request the attendance of witnesses whom the parties have not suggested, if such witnesses(s) testimony appears to be necessary. He/she is charged with the responsibility of setting proper limits, in each case, to the argument that the parties are permitted to make. If there are two or more participants (parties, consultants, representatives, etc.), the HO asks each to identify himself/herself before speaking.

The control of disorderly or contemptuous conduct rests with the HO. If difficult situations arise, the HO may exercise appropriate controls, including adjournment.

50.4.7 - Parties to the Hearing

(Rev. 1. 10-01-03)

The regulations, at 42 CFR 405.802, define the term "party" as "a person enrolled under Part B of title XVIII, his/her assignee, or other entity having standing in the initial or appellate proceedings." A party to the hearing is any person (or persons) who was a party to the review or revised determination and any other person whose rights to benefits may be prejudiced by the hearing decision. These include members of the beneficiary's immediate family or the executor or heirs of a decedent's estate. The beneficiary who received the medical services is always a party to the hearing, as well as a physician or other person who furnished services **and** who has accepted assignment. Further, a physician not accepting assignment, but held liable for indemnification under §1842(l)(1)(A) may be a party. See §50.1.

A. Representatives of the Party

A party to the hearing may appoint an attorney or other individual to act as his/her authorized representative, unless prohibited by law. See §40.9.

If the appeal involves services that are not reasonable and necessary, requiring the HO to consider the limitation on liability provisions under §1879 of the Act, the provider

representative must waive, in writing, any right to payment from the beneficiary for the services. The HO obtains the written waiver even if the claim is initially paid under the limitation on liability provision, i.e., if the HO finds that neither the provider nor the beneficiary was liable.

A provider representative (including an attorney) cannot charge the beneficiary a fee for such representation.

B. Waiver of Right to Appear

If the parties waive their right to an in-person or telephone hearing, the HO makes a decision based upon the record. A waiver of the right to appear can be recorded on the Form CMS-1965, Request for Hearing Part B Medicare Claim, or stated in writing and filed with the HO or the FI. A waiver may be withdrawn at any time prior to the rendering of the hearing decision. A request for a telephone hearing or an on-the-record decision is deemed to be a waiver of the right to an in-person hearing.

C. Disability or Death of Party

If a party cannot execute a request for payment because of a mental or physical condition, his/her representative or any other individual acting on his/her behalf may file the request. A provider may not represent a deceased beneficiary without a signed authorization from the legal representative of the beneficiary's estate. (See Chapter 5 of the Medicare General Information, Eligibility and Entitlement manual.) If the party who files a hearing request dies before the hearing or before completion of the record, any individual (immediate family member, executor, etc.) who might be prejudiced by the FIs review determination may request that the HO proceed with the hearing. If a party to a hearing dies subsequent to the hearing or prior to completion of the record, the HO issues a decision in the regular manner. If the HO does not know the name and address of the party's next of kin, he/she mails the party's copy of the decision to the last known address.

D. Other Persons Present at Hearing

1 Witnesses

A person who attends a hearing as a witness may not insist on testifying, interpose objections, or make comments during the proceeding. The HO decides the subject matter and scope of the individual's testimony under evidentiary rules applicable to administrative proceedings, allowing considerable latitude and permitting any party or his/her representative to question any witness following his/her testimony.

The HO may permit witnesses to remain as spectators either before or after they have testified. However, the HO excludes any witness whose subsequent testimony might be influenced by what is transpiring, or whose presence might disrupt the hearing. If the HO determines it to be necessary, he/she asks a witness to be present at the hearing only during his/her testimony. If the HO's pre-hearing review of a case reveals that the expert opinion of a medical or other specialist will be needed, he/she arranges with the FI to acquire such expert opinion. The cost, if any, of a consultative opinion is an administrative cost to be borne by the FI. Apart from fees provided for an expert witness or for translation services, there is

no provision for reimbursement of fees or other related expenses incurred by hearing participants.

2 FI Witness

An employee or a consultant who testifies at a hearing does so with the status of a witness, and he/she is bound by the restrictions placed on witnesses, despite the fact that the FI's witness will have specialized information to offer. The HO follows normal procedures with the witness and avoids informal discussion.

An FI witness is occasionally necessary to explain the reasoning behind FI's initial and review determinations and to answer the appellant's questions. If a provider expert witness is to be present, the presence of an FI consultant of the same specialty may be required to rebut his/her testimony.

3 Interpreters

A party may be unable to speak or understand English well enough to express himself/herself, which might prejudice the rights of the appellant. If the HO or the appellant decides that an interpreter is needed, the FI obtains the services of a qualified person.

The interpreter is a technical aide to the HO. If possible, the FI should obtain a professional interpreter. If the HO uses, as a translator, an individual proficient in the foreign language, but with no previous interpreting experience, the HO should emphasize the importance of translating as exactly as possible and of refraining from interpolation. If a party to the hearing is deaf and can utilize the services of an interpreter for the deaf, i.e., someone who can use sign language, the FI should obtain the services of a qualified person. A national registry of qualified people who can sign is available through:

The National Registry of Interpreters for the Deaf
P.O. Box l339,
Washington, D.C. 200l3.

The HO arranges for the translating services through the FI. If the hearing is held outside the locality of the FI's office, the HO may ask the local SSO to assist. The SSO will not hire the interpreter, but will relay information to the HO about available interpreters. If a professional interpreter is not available, an FI employee proficient in the language may be used. A SSO located near the hearing site will have an authorized translator among its employees who may be able to provide assistance.

50.4.8 - In-Person and Telephone Hearing Procedures

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

The hearing is not adversarial in nature in that neither you, nor CMS is in opposition to the party but is interested in seeing that a proper decision is made. Formal objections and other accepted court procedural tactics are not appropriate. Rules of evidence and proof

are less restrictive, and their emphasis is different from those used in court. The HO's role is that of a trier of the facts. He/she considers as evidence any testimony or documentation enabling a fair decision. During hearings, the HO questions participants to develop evidence and establish facts. New evidence may be presented throughout the hearing, witnesses may be asked to testify again, parties need not make a final statement, and a party always has the right of rebuttal after evidence adverse to his/her case has been presented.

A Rights of a Party at the In-Person or Telephone Hearing

The rights a party may exercise are:

- To present oral arguments and/or written statements as testimony;
- To be represented by an attorney or other qualified individual of choice;
- To bring witnesses to testify on his/her behalf;
- To bring, and present, evidence in his/her possession, including pertinent records, documents, or other information affecting the issues;
- To question witnesses and other parties;
- To examine the evidence prior to the hearing; and
- To object to the inclusion of any document in the record.

The parties at the hearing should be aware of these rights at the time the hearing commences. However, if it appears that a party is not being afforded due process because he/she is not exercising his/her rights, the HO reviews them for his/her benefit.

Have the parties inspect the evidence before the hearing, so they may prepare. However, if the hearing itself is the only time available, have them inspect the evidence before testimony. The HO or his/her designee supervises a party examining evidence to insure that nothing is removed, defaced, or added. When additional information is furnished after the hearing, parties have the opportunity to read and comment upon it.

B. Opening the Hearing

The HO formally starts the hearing with an opening statement. (See subsection C, below.) Before making the opening statement, the HO identifies the parties, their representatives and witnesses, and enters their names, official titles and interest in the record. The HO introduces himself/herself and his/her stenographer, and explains that he/she will preside and that the stenographer will record the testimony. In lieu of a stenographer, the HO makes a tape recording of the hearing.

Before taking testimony, the HO briefly summarizes its purpose and the issues. If any party, or his/her representative, disagrees with the summary of the purpose and the issues, he/she is heard. After hearing the reasons for disagreeing, the HO modifies the summary if warranted.

C. Opening Statement

See 60.17.6 C

D - Oaths, Affirmations, and the Penalty Provision

See §60.17.6 D

E. Principles of Questioning

Usually, the HO does the bulk of the questioning, to facilitate the proceedings by pinpointing the issues and eliminating the irrelevant and immaterial. Less questioning is needed if all parties are represented by counsel. Careful questioning helps make a fair and complete hearing decision. This may prevent the need for a second hearing. The HO questions witnesses as necessary. Generally, the requesting party begins with his/her testimony or that of his/her witness(es).

When evaluating the documentation submitted, the HO considers the reliability of the source, the factors present which may limit the impartiality or accuracy of the statements, and whether the evidence is compatible, or in conflict, with other evidence. The HO determines the completeness of the evidence, and, if a difference of opinion exists, whether there is sufficient documentation to make an impartial judgment on the issue.

F. Transcript of Hearing

The HO makes a transcript. It may either be typewritten or tape-recorded.

Ordinarily, there will be little reason to go off the record. It may be desirable to do so for clarification, simplification, or to eliminate discussion on a matter about which there is no dispute. The record includes an explanation for going off the record if this procedure is used.

When directed by the HO or CMS, the FI reproduces copies of the hearing testimony and other documentary evidence. When the RO requests a hearing transcript for sample review purposes, the initial FI transcribes the hearing.

If the appellant or his/her representative request a copy, the FI provides one. If the appellant requests a typewritten copy, the FI provide it if the appellant pays the cost. However, the FI waives the charge if the cost is $25 or less, in accordance with the DHHS Privacy Act Regulation (45 CFR Part 5b.13).

G. Continuance

The following circumstances warrant a continuance:

- Testimony or a document submitted at the hearing has taken the appellant or party by surprise, is adverse to his/her interests, and presents evidence which he/she could not reasonably have anticipated and is not prepared to meet;
- The HO enlarges the issues and either the appellant, a party, or the HO needs additional evidence; or
- New evidence is submitted during a telephone hearing, so all parties can examine and evaluate it and respond if appropriate. (See §50.4.5.D.)

If the affected party requests a continuance so that he/she may present additional oral testimony, the HO grants the request unless other available means of rebuttal are clearly adequate. Also, the HO continues the hearing if, he/she discovers the need for testimony from an absent witness who would be available at another time.

H. Closing

Some participants may not be aware of the procedure followed. The HO advises them that he/she will not give the decision at the hearing. He or she will write a decision stating the findings and the reasons therefore; and advise the parties that he/she will make the decision as quickly as possible and send each party and representative a copy.

Before declaring the hearing closed, the HO asks whether there is further evidence to be presented, either immediately or later, and whether the appellant and other parties want to examine any evidence that may have been received. The HO then states that the hearing is closed. If, after the hearing is over, the HO receives evidence that could affect the determination, he/she may reopen the hearing.

50.4.9 - On The Record Decision

(Rev. 1. 10-01-03)

Regardless of the type of hearing requested (telephone, in-person, or on the record), the HO prepares and sends to the appellant a decision based upon the facts in the record (OTR), unless one of the following circumstances apply:

- The OTR would significantly delay the hearing;
- Oral testimony and cross-examination would clarify the facts; or
- The FI cannot provide a different HO for the requested hearing.

If the appellant requested an in-person or telephone hearing, the HO includes as the first paragraph in the OTR decision letter a statement that he/she has scheduled the requested hearing, but, meanwhile, has rendered this decision based on the evidence in the file. The HO includes a postage paid, preaddressed postcard for the appellant to return, either confirming the time and date scheduled for the in-person hearing, or indicating that the in-person hearing is not needed. The postcard provides for the appellant to indicate plans to proceed directly to the next level of appeal, the ALJ hearing. If the appellant does not return the postcard, the HO contacts the appellant to determine any plans to attend the scheduled hearing. If the HO cannot contact the appellant, the HO does not proceed with the scheduled hearing.

The HO prepares an OTR decision with no option for an in-person or telephone hearing if the appellant requests postponement of the in-person or telephone hearing three times.

In some cases a decision on the record may be contraindicated even though requested by a party. If the HO decides that an in-person or telephone hearing would help make an equitable decision, he/she notifies the parties of the time and date and explains why the parties should be present. If the HO takes this action and the parties do not attend, the HO renders a decision on the record.

50.4.10 - Hearing Decision

(Rev. 1. 10-01-03)

As soon as practicable after the close of the hearing, but no later than 30 days after its close, the HO makes a decision based upon the documents, requests, papers, and other written evidence in the hearing record.

A. Limitations

The HO's decision must comply with the provisions of title XVIII of the Act and related regulations, as well as with policy statements, instructions, and other guides issued by CMS.

In accordance with 42 CFR 405.835, the HO's decision is final and binding upon all parties to the hearing unless it is reopened and revised or appealed to an ALJ. However, the HO's decision is not a precedent decision and does not affect subsequent hearing decisions or alter your payment determinations on future claims.

B. Actions Prior to Issuing a Decision More Adverse Than the Review Determination

The hearing decision is a "de novo" consideration of the claim, including the review determination. While the appeals procedures are not to be used to audit favorable review determinations to the detriment of beneficiaries, on occasion the HO's decision may be more adverse than the review determination was. Such a decision may cause the beneficiary to feel penalized for requesting a hearing. To assure that the beneficiary receives due consideration where an adverse decision appears warranted, the HO reexamines the case to determine whether there is any evidence that supports the prior allowed items or services using the adjudicative principles which existed at the time the initial determination was made. If a case has been reviewed and the question of coverage is in doubt, the doubt is resolved in favor of letting the review determination stand. However, if the evidence indicates that items or services are not covered, the HO rules accordingly.

C. Copies

The HO mails a cover letter, indicating the results of the hearing with the decision attached, to the last known address of each party or authorized representative. The HO retains one copy of the cover letter and the decision for his/her records and incorporates copies in the hearing file.

If a decision has been rendered on an assigned claim and the beneficiary (assignor) has been found liable for the payment, the beneficiary receives a copy of the hearing decision. If an assigned claim involves several beneficiaries who have been found liable for the overpayments, each receives a copy of the hearing decision as it relates to his/her particular claim.

50.4.11 - Content of Hearing Decision

(Rev. 1. 10-01-03)

The decision includes:

- A statement of the service(s) and issue(s);
- A summary of the pertinent facts;
- The decision;
- A brief explanation of its basis;

- A statement that copies of the applicable law, regulations, and policy upon which the decision is based are available upon request; and
- A statement providing any further appeal rights the appellant may have.
- A statement advising the claimant of the availability to qualifying claimants of legal services organizations that provide legal services free of charge.

The notice must convey the impression that a full and reasoned evaluation took place.

50.4.12 - Style of Hearing Decision

(Rev. 1. 10-01-03)

The HO writes the decision in a formal and impartial tone, using simple and clear language. The explanation of the decision must be easily understood.

The HO does not sacrifice accuracy for simplicity. Where law or regulations support a point in the decision, they are cited.

50.4.13 - Effectuation of HO Decision

(Rev. 1. 10-01-03)

If a HO's decision results in additional payment to the appellant, notify the HO in writing when payment has been made.

If the FI thinks a hearing decision should not be implemented because the HO exceeded his/her authority, the FI asks the HO to reopen the determination, citing specific applicable law, regulations, and general instructions supporting its request.

The FI contacts the RO if uncertainty exists as to whether the HO exceeded his/her authority. If the RO agrees that the HO exceeded his/her authority, the FI asks the HO to reopen the case. If the matter cannot be resolved at the regional level, the RO contacts Central Office

50.5 - RO Examination Of Hearing Decisions

(Rev. 1. 10-01-03)

ROs examine HO's decision letters. The RO uses the following procedures in its review.

- It contacts the FIs in its region and works out its own arrangements for review of Part B hearing decision letters.
- It reviews a sample of HO's decision letters.
- Each year, it reviews sixteen decision letters (4 per quarter) for each HO who has decided, dismissed or accepted withdrawal of a hearing request. If the HO has made fewer than four decisions in a given quarter, the RO reviews all of that HO's decision letters for the quarter. The review is limited to the decision letter, and does not look behind the letter to the claim file.
- It determines whether the hearing decision letter:
    - Is clear;

- Is complete in summarizing facts and issues;
- Provides an adequate rationale supporting and explaining the decision;
- Makes proper reference to applicable laws and regulations, as necessary;
- Contains an offer to provide, upon request, copies of the law, regulations, and/or policy on which the decision is based; and
- Supplies any further appeal rights.

- At the end of each fiscal year's quarter, the RO sends the results of its evaluation to CMS CO.

50.6 - Fraud and Abuse

(Rev. 1. 10-01-03)

To protect the Medicare program from fraud and abuse, civil and criminal violation provisions are incorporated in §§1107, 1872, and 1128B. Section 1872 makes §§206, 216(j), and subsections (a), (d), (e), (h), (i), (j), (k), and (l) and §205, title II, applicable to title XVIII.

In addition, §1106 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, the making of false and fraudulent statements, the fraudulent concealment of evidence affecting payment benefits, the false impersonation of another, the misuse or conversion of payments for use of another, and the improper disclosure of confidential information.

See §§60.8 – 60.8.6 for a discussion of FI action in the event that the FI suspects fraud or abuse.

If, during the course of the hearing, the HO suspects a civil or criminal violation, he/she renders a decision on only the issues raised by the hearing request, as he/she has no jurisdiction over fraud and abuse issues. He/she forwards information regarding a potential civil or criminal violation to the RO for referral to the OIG.

50.6.1- Disclosure of Information

(Rev. 1. 10-01-03)

See §60.10.

Administrative Law Judge (ALJ) Hearings For Part A and Part B

50.7 - Requests for Hearing Before An ALJ

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

If the appellant is dissatisfied with the redetermination (Part A) or HO's hearing decision (Part B) and the amount remaining in controversy is at least $100*, the appellant is entitled to a hearing before an ALJ. To receive a hearing, the appellant must file the request with the FI in writing within 60 days following the date on which the appellant received the redetermination (Part A) or the HO's decision (Part B).

* Beginning in 2005, for requests made for an ALJ hearing, 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.

NOTE: See § 40.10. if a QIO determination is involved. The FI acknowledges the appellant's request for an ALJ hearing within 30 calendar days of receipt of the request in the corporate mailroom.

50.7.1 - Scope and Effect of OHA, Social Security Administration (SSA) ALJ Decisions Under Part A

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

A. Authority of Office of Hearings and Appeals

The ALJ has delegated authority from the Secretary of DHHS to exercise all duties, functions, and powers relating to holding hearings and rendering decisions in connection with administrative appeals from determinations made under Titles II and XI (beneficiaries only for claim determinations) and Title XVIII (beneficiaries, and under certain circumstances, Medicaid State Agencies or their authorized representatives, providers and suppliers of services) of the Act as amended.

B. Responsibility of the ALJ

When a request for hearing is filed, jurisdiction of the case passes to the ALJ. The ALJ considers the case file presented by CMS, any additional documentation, and any evidence presented at the hearing by the party and his or her witnesses. The ALJ may, at his/her discretion, develop additional evidence or ask the FI to develop additional evidence.

C. Effect of ALJ Disposition

The ALJ disposes of each case either by dismissing the request or by rendering a decision. The ALJ notifies the party in writing of the decision/dismissal, places a copy of the decision/dismissal in the case file, and sends the case file to the FI or the ALJ clearinghouse. If the ALJ changes the redetermination, the FI effectuates the change in accordance with § 50.7.10.

The FI will not initiate any communication about a particular ALJ decision with the provider involved pending receipt of the notice to effectuate the decision. However, if a provider requests the status of the case, the FI will advise the provider of the ALJ's disposition.

A disposition of a claim by an ALJ is not a precedent opinion. If the RO requests the FI to effectuate an ALJ's disposition, the FI effectuates it only with respect to the case to which the disposition applies. ALJ dispositions (both decisions on the merits of a case and dismissals of requests for ALJ hearing) that are significant may be published by CMS in the CMS rulings and other pertinent publications. The rulings contain preceding case dispositions, statements of policy and interpretations of the law and regulations that FIs are to follow. A ruling is not applicable to other cases where the facts are not

substantially the same as those in the ruling. In applying the rulings, FIs consider the effect of subsequent legislation, regulations, court decisions, and rulings. Rulings may be modified or superseded by subsequent rulings.

D. DAB Review of ALJ Dispositions

A party dissatisfied with an ALJ's disposition (including a dismissal of the request for an ALJ hearing) can request the DAB of the Department of Health and Human Services (HHS) to review the disposition. While CMS does not have a similar right to appeal a disposition, each disposition is reviewed closely by CMS to determine whether it is in conformity with the law and regulations.

The DAB may, within 60 days from the date of the notice of an ALJ's disposition, review the disposition on its own motion. This action is discretionary, and party(ies) dissatisfied with the action of the ALJ can not rely on the DAB to take this action. If dissatisfied with the hearing decision, the appellant must file the request for review within 60 days.

The DAB reviews a case on its own motion or grants a request for review if:

- The ALJ has made a legal error, such as failure to follow the statute, regulations, or a binding CMS Ruling or national coverage determination;
- The ALJ's decision is not supported by substantial evidence;
- There appears to be an abuse of discretion by the ALJ; or
- There is a broad policy or procedural issue that may affect the general public interest.

A party dissatisfied with the DAB's disposition of the ALJ decision (including refusal to review it) may institute action in a Federal district court if the amount in controversy is $1,000 or more ($1,050 if requested on or after January 1, 2005).

E. Requests from the DAB for Case Files & Procedures for Master Case Retrieval for the DAB

See §§60.22

50.7.2 - Determining the Amount in Controversy for ALJ Hearing

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

The Office of Hearings and Appeals of SSA conduct hearings. The ALJ decides whether the amount in controversy requirement is met.

50.7.3 - Request Filed With SSA

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

After the SSA takes a request for hearing (Request for Hearing Part A Health Insurance Benefits - Form CMS-5011A), or if the hearing request is sent to the SSO by mail, the copies of the Form CMS-5011A are distributed immediately as follows:

> Claim File (White) - To the FI, QIO, or HMO. If a copy of the redetermination is available, it is attached.

Hearing Office (Pink) - To the appropriate ALJ according to geographic location of the SSO.

District Office (Yellow) - Retained or mailed to resident SSO if the hearing request was filed in a nonresident office.

FI, QIO, or HMO (Blue) - Mailed to the FI, QIO, or HMO

Regional Office (White) - To the appropriate RO according to geographical location.

Party's/Representative's (White) - Given or mailed to party/representative.

50.7.4 - Request for Hearing Filed With the FI

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

A request for hearing must be in writing and signed by the beneficiary or his/her representative and indicate the reason(s) for disagreement.

When correspondence is received from a beneficiary, the FI determines whether beneficiary wants a further explanation of the notice or if he/she is requesting a hearing. If the correspondence is treated as a request for information or clarification of a notice, the FI explains the determination to the beneficiary in greater detail. It resolves any doubt as to whether the beneficiary's correspondence is an implied hearing request by treating it as a hearing request. If the beneficiary contacts the FI in person and states he/she wishes to file for a hearing, the FI takes a written request to that effect. When a beneficiary contacts the FI by telephone to request a hearing, the FI refers the beneficiary to the SSO.

50.7.5 - Action on Incoming Requests for ALJ Hearing

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

Upon receiving a request for hearing, the FI screens the incoming material to insure that the request for hearing is applicable to a Part A claim for which a redetermination was held or to a Part B claim for which a Hearing Officer hearing was held. To insure that hearing offices receive claim files within a reasonable period of time, (21 calendar days for appeals involving a single appellant, 45 calendar days for appeals involving multiple appellants), after receipt of the hearing request, the FI establishes control procedures during the pre-screening of cases.

50.7.6 - Request for Claim File (Sent by Hearing Office)

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

The FI reviews the hearing request material received from the hearing office to establish whether or not the request is premature, valid or invalid, pertains to other benefits, or is not within its jurisdiction. This usually requires coordination with the hearing office to determine what information may be available about the claim at issue. The FI returns the request to the hearing office according to the action taken.

50.7.7 - Examination of Claim File

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

The FI carefully examines the files before it sends them to the hearing office in order to assure that they contain all the pertinent documents available.

A. Additional Evidence Requested by Hearing Office

The hearing office, after receiving a claim folder, may request additional evidence or records, even though the required documentation is in the file. It may request the information from the RO, which in turn contacts the FI. When the FI receives the material, it forwards it immediately to the hearing office. If the timeframe to request a redetermination or Hearing Officer hearing has expired, see F below.

B. Amount In Controversy Less Than $100

Where the amount in controversy after redetermination is less than the required amount for an ALJ hearing, the FI routes the file to the hearing office for dismissal action. See §50.7.1.

C. Request for Hearing Not Timely Filed

When a request for hearing is not timely filed the FI forwards the folder to the hearing office.

D. Hearing Request Prematurely Filed

If all prior levels of appeal have not been exhausted (i.e., either a HO hearing or a redetermination has not been conducted), the contractor treats the request for ALJ hearing as a request for a HO hearing or for redetermination and processes the appeal request.

E. Redetermination in Process But Not Completed

When a hearing request is received and a redetermination is in process that cannot be completed within 30 working days after receipt of the hearing request, the FI routes the request to the hearing office. The FI notifies the hearing official that the redetermination is in process, and asks that the ALJ hearing request be dismissed. The FI informs the party that the hearing request has been sent to the ALJ, but that the FI also has the request for a redetermination and is completing the redetermination. The FI advises the party that, since he/she/they filed for an ALJ hearing before receiving the redetermination, the ALJ will probably dismiss the request, but he/she/they can make it again within 60 days after receipt of the redetermination.

F. No Valid Request for Redetermination or Hearing Officer Hearing Received and Timeframe Expired

When a hearing request is received and the time frame to request one has expired, the FI routes the claim file to the hearing office for a dismissal.

G. Other Jurisdictional Problems

In any situation that existing procedures are not adequate to deal with a particular claim or hearing request, the FI uses its best judgment as to the proper disposition of material at hand.

50.7.8 - Prehearing Case Review

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

The FI does not perform a prehearing case review except for the actions described above in § 50.7.5. Once the party has requested an ALJ hearing, the ALJ has jurisdiction. The FI immediately assembles and transmits the file to the ALJ.

50.7.9 - Routing the ALJ Hearing Claim File

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

The FI sends all cases to:

SSA/Office of Hearings and Appeals
Division of Medicare-Part A
5107 Leesburg Pike
Skyline Tower
Falls Church, VA 22041-3255

Requests for Part B ALJ hearing (other than QIO or HMO/CMP) must be forwarded, along with the case file (see below for the case file requirements), to:

SSA/Office of Hearings and Appeals
Division of Medicare-Part B
5107 Leesburg Pike, Suite 502
Skyline Tower
Falls Church, VA 22041-3255

Phone inquiries about the status of a request for Part B ALJ hearing should be directed to:

Division of Medicare - Part B
(703) 605-8550

Appellants requesting an ALJ hearing for Part B (other than QIO or HMO/CMP) may aggregate any series of claims as long as the request for hearing is timely filed for each of the claims at issue.

See §60.19.3 for ALJ "Case File Preparation" instructions.

See §60.19.4 for "Case Tracking System" requirements.

See §60.19.5 for instructions regarding acknowledgement of ALJ hearing requests.

See §§60.20 for instructions regarding effectuation of ALJ decisions.

See §60.21 for instructions for recommending Agency referral of Part A or B ALJ decisions or dismissals to the CMS RO.

See §60.22 for instructions regarding effectuation of Departmental Appeals Board (DAB) orders and decisions.

See §60.23 for instructions regarding requests for U.S. district court review.

See §60.24 for instructions regarding effectuation of U.S. district court decisions.

See §70 regarding review and analysis of initial determinations and appeal decisions

50.7.10 - Effectuating Decisions

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

1. Part A Claims- Written Assurance-Prior to paying a provider of services in fully or partially reversed hearing decision cases 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. In beneficiary-filed emergency service claims, the FI sends an explanatory notice to the party with any payment due as a result of the ALJ's, or DAB's decision.

2. ALJ Decisions

- A favorable ALJ decision that gives a specific amount to be paid (with no agency referral to the DAB) is effectuated by the FI within 30 days of receiving the offical ALJ decision.
- A favorable ALJ decision where the amount payable must be calculated (with no agency referral to the DAB), is effecutated by the FI within 30 days from the date the amount to be paid is computed. The amount must be computed by the FI as soon as possible, but no later than 30 calendar days from its receipt of the offical ALJ decision (**NOTE:** FIs may reieve an official decision from either the ALJ or from the ALJ clearinghouse. The FI effecutates from the first received offical decision, however if it is unable to effectuate because it needs information from the case file to calculate the amount payable, it effectuates within 30 days of receipt of the case file).
- An unfavorable ALJ decision (with no agnecy referral to the DAB), is effectuated by the FI within 30 days of receipt of the case file from the ALJ clearinghouse.
- For Part A cases where written assurance is needed, the FI effectuates within 30 days of receipt of written assurance.
- If clarification from the ALJ is necessary, the FI considers the date of the clarification the final determination for purposes of effectuation. If clarification is needed from the provider/supplier (e.g. splitting charges), the FI requests clarification as soon as possible and computes the amount payable within 30 calendar days after the receipt of the necessary clarification. The FI considers the date of receipt of the clarification the final determination for purposes of effecutation.

3. DAB decisions- The FI initiates effectuation within 30 days from its receipt of the DAB decision and completes effectuation within 60 days. For cases where written assurance is needed, it effectuates within 30 days of receipt of writtn assurance.

50.7.11 - Effectuating Favorable Final Appellate Decisions That a Beneficiary is "Confined to Home" - Regional Home Health Intermediaries (RHHIs) Only

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

A. General Information

The following provides direction as to how RHHIs should effectuate a favorable final appellate decision that a beneficiary is "confined to home."

B. Definitions

For purposes of decisions involving "confined to home":

- A favorable decision is a decision that is favorable to the beneficiary; and
- A final appellate decision is a decision at any level of the appeals process where the regional office (RO) has finally determined that no further appeals will be taken or where no appeal has been taken and all time for taking an appeal has lapsed.

C. Instructions

RHHIs will take the following steps when a favorable final appellate decision that a beneficiary is "confined to home" is rendered on or after July 1, 2000.

They will:

- Promptly pay the claim that was the subject of the favorable final appellate decision.
- Promptly pay or review based on the review criteria below:

All claims that have been denied that are properly pending in any stage of the appeals process;

All claims that have been denied where the time to appeal has not lapsed; and

All future claims submitted for this beneficiary.

- For favorable final appellate decisions issued during a 1-year grace period starting on July 1, 2000, and ending on June 30, 2001, reopen all denied claims that are subject to the 12-month reopening provision. Promptly pay or review, based on the review criteria below, these reopened claims.
- Establish procedures to ensure that medical review of a beneficiary's claim, after the receipt by that beneficiary of a favorable final appellate decision related to "confined to home," is reviewed based on the review criteria below.
- Notify the beneficiary and the affected home health agency that the favorable final appellate decision related to "confined to home" will be given "great weight" in evaluating if the beneficiary is "confined to home." Inform them of what steps should be taken if they believe a claim has been denied in error.
- Maintain records containing information on beneficiaries receiving a favorable final appellate decision related to "confined to home." These records should include at a minimum the beneficiary's name, HICN, the service date of the claim that received the favorable final appellate decision, and the date of this decision. This information should be made available to CMS upon request.

D. Review Criteria

The RHHI will afford the favorable final appellate decision that a beneficiary is "confined to home" great weight in evaluating whether the beneficiary is confined to the

home when reviewing services rendered after the service date of the claim addressed in the favorable final appellate decision **unless** there has been a change in facts (such as medical improvement or an advance in medical technology) that has improved the beneficiary's ability to leave the home. All medical review that is done on claims for services performed after the service date of the claim that is addressed in the favorable final appellate decision should determine if:

a. There has been a change in facts (as noted above) that affects the beneficiary's ability to leave the home; and

b. If services provided meet all other criteria for home health care.

If there have been no changes in facts that affect the beneficiary's ability to leave the home and if all other criteria for home health services are met, the claim would ordinarily be paid. Medical review staff should generally adhere to the following examples, if applicable, in effectuating this review.

EXAMPLE 1:

A quadriplegic beneficiary receives a favorable final appellate decision that he is confined to the home even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight" in future medical redeterminations, with the result that the beneficiary would therefore be treated as "confined to the home" in those determinations.

EXAMPLE 2:

A diabetic beneficiary with a severely broken leg that is not healing well receives a favorable final appellate decision that he is confined to home, even though he leaves home several times a week for personal reasons. This decision would ordinarily be given "great weight," with the result that the beneficiary would therefore be treated as "confined to the home" for subsequent medical review decisions. However, if upon review, evidence showed that the beneficiary's medical condition had changed, and the ability to leave the home had improved, then the favorable final appellate decision would no longer be given "great weight" in determining if the patient was "confined to home." Medical review of these cases should be done periodically to determine if there are changes in facts that have improved the beneficiary's ability to leave home.

50.7.12 - Effectuation of Reversal of Decision Where There Was Subsequent Utilization of Benefits in the Same Benefit Period

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

NOTE: For inpatient stays beginning after December 31, 1988, these instructions apply only to SNF benefits. See CMS Pub. 100-1, Chapter 3 for deductibles, coinsurance amounts, and benefit limitations.

Where the FI, ALJ, DAB, or Federal Court reverses a denial and there was subsequent utilization of benefits in the same benefit period that would otherwise prevent the decision from being fully effectuated, the FI will apply the following:

It will pay as though the claim had been approved initially, i.e., pay the days of service as full days, coinsurance days, or lifetime reserve days, depending upon the benefits which

were available at the time the services were rendered. This may result in the creation of an overpayment for the subsequent stay, e.g., where subsequent services that had been reimbursed in full became coinsurance days because an earlier denied stay was allowed. (See Chapter 3.) It does not recover such overpayments from any party. Therefore, it does not include in the notice to the beneficiary of the reversal decision any reference to the subsequent services or the resulting overpayment.

Although payment is made for the subsequently allowed stay as if it had been allowed initially, the bill is only for the benefit days available at the time of effectuation. The FI will maintain a separate record of amounts paid in such cases so that a proper adjustment may be made in the departmental charges for the provider's final cost settlement.

EXAMPLE: Mr. D. was a patient at Valley Hospital from July 6, 1995, to August 31, 1995, a total of 56 days. Initially the program paid for 20 days (from July 6 through July 25) but denied benefits from July 26, 1995, through August 31, 1995, on the basis that the latter services constituted custodial care. On September 25, 1995, Mr. D. was admitted to State hospital. State hospital was paid for 63 covered days (40 days in full and 23 coinsurance days). Subsequently, an ALJ ruled that the services furnished by Valley Hospital from July 26, 1995, through August 31, 1995, were covered.

The FI effectuates the ALJ's decision as follows:

The FI sends Valley Hospital full reimbursement for the entire 56-day stay (20 days initially approved and 36 days approved as a result of the ALJ's decision).

However, the bill should be for seven coinsurance days and 29 lifetime reserve days (based on the amount of benefits shown as available on CMS' records at the time of effectuation). To assure, however, that Valley Hospital receives proper credit in the final cost report, the FI keeps a record of the amounts paid so that a proper adjustment may be made to the provider's final cost report. State hospital is relieved of liability for the resulting overpayment because it was without fault in billing for and accepting the overpayment. The overpayment is not recovered from the beneficiary.

50.7.13 - Effect of Court Decisions

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

A decision by the Supreme Court of the United States is unqualifiedly binding and is a precedent for all similar cases. A decision of a lower Federal Court is binding only for that case. Although other courts within the territorial jurisdiction of the court rendering the decision may use it as a precedent in similar cases, each case must be filed, and an individual court decision made. The Secretary determines whether, and to what extent, the ruling is to be followed in other similar cases.

Where CMS asks the FI or QIO to effectuate a court decision, whether of the Supreme Court or a lower court, the decision will be effectuated only with respect to that case. The CMS issues any necessary revisions or modifications of policies for application to other cases. Until such instructions are received, FIs will continue to follow existing instructions.

50.7.14 - Standard Exhibits Referred to in Sections 40.5 - 50.7

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

The following are examples of the forms used in the pre-hearing review function. FIs complete the required entries.

> **Exhibit No. 1**: Form CMS-5011A - Request for Hearing Hospital Insurance Benefits Payable Under Part A of Title XVIII (at http://www.cms.hhs.gov/forms/)
>
> **Exhibit No. 2:** Form CMS-383 Health Insurance Case Summary (at http://www.cms.hhs.gov/forms/)
>
> **Exhibit No. 3:** Form CMS-636 Transmittal Notice - Hearing Office (at http://www.cms.hhs.gov/forms/)
>
> **Exhibit No. 4:** Sample acknowledgment letter to beneficiary/representative when hearing is sent to the hearing office (see below.)

Exhibit No. 4: Sample Acknowledgment Letter to Beneficiary/representative When Hearing Is Sent to the Hearing Office.

Date

Name of Beneficiary/Representative

Dear _____:

Re: HICN

This is in reply to your request for a hearing.

We received your request on (date), and forwarded it and your claims file to the hearing office whose address is shown below on (date).

(Show address of hearing office here.)

You will be notified by that office as to the time and place of the hearing. If you have further questions concerning this matter, that office will be glad to assist you.

Sincerely yours,

Health Insurance Coordinator

(or Equivalent)

60 - Part B Appeals Procedures - Carriers

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

This section explains the Medicare Part B administrative appeals process available to beneficiaries and Medicaid State Agencies or their authorized representatives, providers and suppliers dissatisfied with initial determinations and appeal determinations/decisions. It is applicable to all Part B claims processed by a carrier (including DMERC). It details the levels in the process, along with the procedural steps that must be taken by the appellant at each level. A glossary of Medicare Part B administrative appeals terminology, as defined by CMS, is included at the end of this chapter as an aid in

clarifying the Part B administrative appeals process. Also included in §60.11.6 is a model redetermination letter and in §60.17.7 is a model Hearing Officer decision letter. See §20 for a discussion of the circumstances required for a provider to have appeal rights.

60.1 - Initial Determination

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

Refer to §30.3.

60.2 - Steps in the Appeals Process: Overview

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

Regulations at 42 CFR 405.807 provide that a party to an initial determination that is dissatisfied with such initial determination may request that the contractor make a redetermination. The request for redetermination must be filed within 120 days after the date of the notice of the initial determination. Contractors cannot accept an appeal for which no initial determination has been made.

The following parties dissatisfied with a determination on their Part B claim have appeal rights:

- Providers (including physicians), as defined in 42 CFR 400.202, with appeal rights as specified in regulation at 42 CFR405.710(b).
- Physicians and Suppliers with appeal rights as specified in regulations at 42 CFR 405.801(b), accepting assignment on the claim at issue, and suppliers with refund requirements under §1842(l)(1), 1834(a)(18), or 1834(j)(4) of the Act.
- Beneficiaries and their authorized representatives.
- After December 7, 2000, the Medicaid State agency or the party authorized to act on behalf of the Medicaid State agency

The Part B 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, except in two specific situations, discussed in §60.13.4, Exceptions to Filing Requirements.

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 Part B appeals process, the Hearing Officer hearing, level 2, is the last level in the appeals process that the contractor performs.

When an appellant requests an Administrative Law Judge (ALJ) hearing (level 3), the contractor must prepare and forward the case file to the Social Security Administration's Office of Hearings and Appeals (see §60.19.2). 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 - 4 are part of the Administrative Appeals Process. If an appellant has completed all the 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 Part B Fee-for-Service Appeals Process

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
1. Redetermination*	120 days from date of the notice of the initial determination (allow an additional 5 days for mail delivery)	None
2. Hearing Officer hearing	6 months from date of redetermination (allow an additional 5 days for mail delivery)	At least $100 remains in controversy
3. Administrative Law Judge (ALJ) Hearing	Filed within 60 days of receipt of HO hearing decision	At least $100 remains in controversy**
4. Departmental Appeals Board (DAB) Review	Filed within 60 days of receipt of ALJ hearing decision /dismissal	None
5. Federal Court Review	Filed within 60 days of receipt of DAB decision or declination of review by DAB	At least $1,050 remains in controversy**

*Beginning on October, 1, 2004, "reviews" will be termed redeterminations.

** 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.

60.3 - FI and Carrier Correspondence With Beneficiaries or Other Parties Regarding Appeals

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

This section refers to inquiries about appeals. The purpose of this section is to provide guidance for inquiries that are specific to appeals and the appeal process. When an inquiry is made about the appeals process or with regard to a specific case, it is not counted as appeals workload (See Medicare Pub 100-09 for more details on beneficiary and provider services related to other types of inquiries.)

Inquiries regarding the status of appeals must be handled as expeditiously as possible without lowering the quality of the response. Valid appeal requests are not considered inquiries. In order to ensure that all inquiries are handled adequately, see Medicare Pub 100-09.

60.4 - Parties to an Appeal

(Rev. 1. 10-01-03)

B3-12002

Any of the persons/entities referenced in §20 are parties to an appeal of a claim for items or services payable under 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, for example, are met).

60.5 - Appointment of Representative

(Rev. 1. 10-01-03)

A3-3789, B3-12004

(See 42 CFR 405.870, "Appointment of Representative," 42 CFR 405.871, "Qualifications of Representative," and 42 CFR 405.872, "Authority of Representative.")

60.5.1 - Appointment of Representative - Introduction

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

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 60.10.2 for information on disclosing information to third parties) The appointment of a representative is valid for one year from either (1) the date signed by the party making the appointment, or (2) the date the appointment is accepted by the representative, whichever is later. If a newly submitted appointment of representative is valid at the time of the Hearing Officer hearing request, consider it valid for the hearing.

NOTE: A representative must sign (see exceptions below for attorney representative) the appointment within 30 calendar days of the party's signature. The appointment remains valid for any subsequent levels of appeal on the claim/service in question unless the beneficiary specifically withdraws the representative's authority. (See §60.5.7.) In order for the appointment to be valid, it must be signed and dated by the beneficiary.

60.5.2 - Who May Be a Representative

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

Any individual may be appointed to act as a representative unless he/she is disqualified or suspended from acting as a representative in proceedings before CMS or is otherwise prohibited by law. A contractor should not accept an appointment of representative if it has evidence that the appointment of representative should not be honored. It notifies 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.

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 HO 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 HO 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

60.5.3 - How to Make and Revoke an Appointment

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

The party making the appointment and the individual accepting the appointment must either complete an appointment of representative form (Form CMS-1696-U4) or submit a written statement (see subsection C, below, for required elements of written statements). A party may appoint a representative at any time during the course of an appeal. The representative must sign the appointment form or written statement **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. Attorney Representatives

If the person representing the party is an attorney, the attorney is not required to sign the representative form or a written statement. (See 20 CFR 404.1707(b) and 42 CFR 405.870.) However, the party appointing the attorney representative must either sign a completed representative form or must sign the written statement appointing the attorney representative. If it is not evident that the individual representing the party is an attorney from his/her correspondence, the contractor must verify that the individual is an attorney. This may be verified by requesting a business card or letterhead that indicates the person is an attorney or by asking the attorney to submit a written statement stating that he/she is an attorney.

1. Use caution in releasing beneficiary-specific information to attorney representatives. Attorney representatives can receive only information that is specific to the case/claim in which he/she is the representative and information that the party being represented is entitled.
2. When an attorney has not signed the appointment, the contractor considers that the attorney accepted the appointment 30 days from the date of the party's signature. The contractor uses that date to determine how old an appointment of representative form or written statement is.
3. If the contractor assumes that the attorney accepted the appointment because there was no action within 30 days of the party's signature, it sends a letter to the beneficiary stating the name of the attorney representing him/her.
4. The contractor may not assume that the attorney accepted the appointment if it has documentation and/or evidence that negate this assumption or if it has received information from the beneficiary or guardian that the attorney cannot or will not represent the beneficiary. In this situation the contractor should proceed with processing and rendering a decision on the appeal. It sends the appeal decision to the parties only (not to the attorney). It includes an explanation in the decision letter of the reason why the appointment was not accepted and what needs to be done if the party wishes to obtain a representative for further levels of appeals. At the contractor's discretion, it may also wish to send a letter to the attorney advising the attorney of the reasons why the appointment was not accepted.

A representative should keep a completed appointment on file and submit a copy with each claim appealed (subject to certain restrictions discussed in §60.5.7).

B. Completing the Appointment of Representative (Form CMS-1696-U4)

Form CMS-1696-U4, Appointment of Representative form, 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. (See §100, Exhibit 1, "Appointment of Representative," Form CMS-1696-U4.)

1. The name of the party making the appointment must be clearly legible. For beneficiaries, the HICN must be provided. For providers and suppliers, the provider number must be provided in the HICN space.
2. **Completing Section I -** 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 -** 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.

NOTE: The attorney exception discussed in §60.5.3.A, above, applies here. Therefore, an attorney need not sign or date the appointment. However, the attorney must provide the contractor with his/her name, address, and phone number. This may be done by completing this section, or it may be done by submitting his/her business card or using his/her letterhead or anything that identifies him/her as an attorney.

4. **Completing Section III -** This section must be completed only 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. In this case only, the individual signing for the provider or supplier in Section II would then also sign and date Section III.
5. **Waiver of Right to Payment from the Beneficiary for the Items or Services at Issue -** This waiver is not present on Form CMS-1696-U4, but must be submitted along with the completed Form CMS-1696-U4 in certain limited situations. (See discussion of this waiver in §60.5.3.C, below, for complete instructions.)

C. Appointment Made on Other Than Form CMS-1696-U4

The contractor may not require the use of Form CMS-1696-U4. Any other form or written statement containing all required elements must be accepted as a valid appointment of representative. The required elements are provided in subsection 2, below.

1. Groups (such as a beneficiary advocacy group) or individuals may use their own form or written statement. If all the required elements (see subsection 2, below) are contained on the form, the contractor should accept the form. Although a form developed by an advocacy group may be used, it must meet CMS guidelines to be accepted. One specific problem that has been encountered with such self-developed forms is that the form is set up to routinely allow someone other than

the beneficiary to sign the appointment form on behalf of the beneficiary. For example, some forms provide space for the family member to sign for the beneficiary, without any documentation of why the beneficiary was unable to sign and absent proof that the person signing on behalf of the beneficiary has the authority to do so. Such a form would not meet CMS guidelines. Only the beneficiary may sign the form unless there is proof that the person signing on behalf of the beneficiary has the authority to do so.

2. **Required Elements** - The following information must be included on an appointment of representative form or written statement:
    - Name/Address/Phone Number of party (i.e., the beneficiary or provider, or supplier).
    - HICN, when the party making the appointment is a beneficiary.
    - Medicare Provider or Physician/Supplier Number, when the party making the appointment is a provider or supplier.
    - Name/Address/Phone Number of the **individual** being appointed as representative.
    - A statement that the party (i.e., the beneficiary or the provider or supplier) is authorizing the representative to act on their behalf for the claims at issue and a statement authorizing disclosure of individually identifying information to the representative (in cases where the representative is not the provider of services).
    - Signature of the party making the appointment, and the **date signed**.
    - Signature of the **individual** being appointed as representative, accompanied by a statement that the individual accepts the appointment, and the **date signed**; however, if the individual being appointed as representative is an attorney, the attorney need not accept the appointment in writing. (See §60.5.3.A.)

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 acknowledge that he/she will not charge the beneficiary a fee for such representation. The provider or supplier representative does this by including a statement to this effect on the form or written statement, and then signs and dates it.

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

For beneficiary appeals involving the denial of the claim on the basis of §1862(a)(1) or (a)(9), or §1879(g) 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 including a statement to this effect on the form or written statement, and then signs and dates it.

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.

D. 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.

60.5.4 - When to Submit the Appointment

(Rev. 1. 10-01-03)

B3-12004.4

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 §60.5.8.A to secure the written appointment.

Note that a completed appointment of representative form or written statement, or a copy of such form or statement, must be submitted with each appeal request.

60.5.5 - Where to Submit the Appointment

(Rev. 1. 10-01-03)

B3-12004.5

When the appellant or representative submits the original or a copy of the signed appointment of representative form or written statement to the contractor, the contractor places it in the claims/appeals case file. The representative should also give the party making the appointment a copy of the completed form.

60.5.6 - Rights and Responsibilities of a Representative

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

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

A. Rights of a Representative

A representative may exercise any and all rights given to parties on behalf of the person represented. For example, the representative may submit arguments, evidence or other materials on behalf of the appellant. The representative may obtain information from the contractor on the claim(s) and/or appeal(s) at issue, elicit evidence from the appellant or witnesses, make statements about fact and law relating to the case, and request or give

notice about proceedings before the contractor. The representative, the party, or both may participate or attend at all levels of appeal.

Notices sent to any party on any action, determination, or decision, including the Medicare Summary Notice (MSN) or remittance advice (RA), and all requests sent to any party for the production of evidence, **must also** be sent to the representative of such party. In all such notices or requests, the appellant is the addressee, with the representative receiving a copy of such notice or request.

NOTE: If the claims processing system does not have the automated functionality to send representatives a copy of notices sent to the beneficiary, this action must be completed manually.

B. Responsibilities of a Representative

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 its internal fraud unit for development. The fraud unit may contact the RO about disqualifying the representative from appearing before the contractor.

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.

In cases of attorney representatives, since the attorney is representing the beneficiary or other party, the attorneys is expected to provide all relevant information to the respective party(ies). Where an attorney is representing large, multiple appeals or aggregation of claims, the contractor need not send notices on actions other than determinations to appellants. It is sufficient for the attorney to receive them.

NOTE: The contractor must always send the appellant the appeal determination/decision or dismissal when issued, taking care in situations involving multiple beneficiaries to protect beneficiary privacy rights. (See §60.10.4.) It sends a copy of the determination or decision to the attorney representative. The determination or decision or dismissal notice must be addressed to the appellant with the representative receiving a copy of the notice.

A provider or supplier who has provided items or services to the beneficiary and who is acting as representative for the beneficiary with respect to those items or services may not charge the beneficiary a fee for such representation.

Finally, the contractor should assume that the representative will provide the beneficiary or other party making the appointment with a copy of the appointment at the time it is completed.

60.5.7 - Validity of an Appointment Over Time

(Rev. 1. 10-01-03)

B3-12004.7

A new appointment of representative form or written statement need not be executed each time an appeal is filed by the same representative who is representing the same party. 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.)

A. Appointment of Representative More Than One Year Old

An appointment submitted must be no more than one year old from the date it was signed by the party making the appointment or from the date accepted by the representative, whichever is later. When an appointment is more than one year old and the representative submits a new appeal on a new claim, the representative must secure a newly executed appointment. 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 form 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.

B. Subsequent Appeals of the Same Claim(s)

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.

60.5.8 - Timeliness of an Appeal Request and Completeness of Appointment

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

There will be times where the appeal request is timely, but the appointment is incomplete or inaccurate in some way. 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 appointment of representative form or written statement, the contractor must advise the individual of how to complete the appointment, and must notify the individual to submit the completed appointment to the contractor based on the time limits below. The contractor should 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, etc.). Should the form or statement 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 will 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 an appointment of representative form or a written statement, the contractor considers the missing appointment to be an incomplete form or written statement and follows the instructions above. In cases of redeterminations filed on behalf of the beneficiary, see §60.11.1.A, 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.

At the HO hearing level, the contractor HO may **not** do an in-person or telephone hearing at the request of a family member, friend or other person wishing to act as representative **without** a valid appointment of representative. If the HO does not receive a valid appointment of representative within the time limits specified below, the HO should conduct a preliminary on-the-record (POTR) decision following the instructions in §60.15.4.

When there is information or evidence that the appeal request and/or the appointment of representative form was not submitted at the request of the beneficiary, the contractor must 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 should include a return envelope (or be sent out certified mail) and should 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 form or statement 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 them 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 form or statement **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 must 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. In cases of a HO hearing request, the contractor should route the case to the HO for an appropriate dismissal.

If the individual is attempting to act as a representative of an appellant who is **not** the beneficiary and fails to include an appointment of representative form or a written statement with the appeal request, the contractor dismisses the request. It provides the appellant with an explanation of the reason(s) for the dismissal and advises the appellant how to complete an acceptable appointment. It advises the appellant of the amount of time remaining, if any, in which an appeal request must be filed to be considered timely.

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, see §60.7), an incomplete or defective form or statement 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 §60.5.8, 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 §60.7.)

60.5.9 - Powers of Attorney

(Rev. 1. 10-01-03)

B3-12004.9

The contractor treats a power of attorney as a valid appointment if all the required elements (see §60.5.3, above) of a valid appointment are present and the power of attorney authorizes the designated person to conduct the beneficiary's affairs. This can include authorization to conduct personal and financial matters, or a general authorization, or it may include a very specific authorization to pursue benefits under the Medicare program or under Government entitlement programs, for example.

NOTE: A power of attorney that is a valid appointment is exempt from the 1-year validity rules described above in §60.5.7.

The contractor does not treat a power of attorney that authorizes the designated person to make health care or medical care decisions as an appointment if the document does not also authorize the designated person to conduct the beneficiary's affairs, as discussed above, or to make financial decisions on behalf of the beneficiary.

Powers of attorney may be durable (i.e., surviving the incapacitation of the beneficiary) or nondurable (i.e., automatically revoked upon the incapacitation of the beneficiary). (See §60.5.10, below.)

60.5.10 - Incapacitation or Death of Beneficiary

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

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 must 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, as discussed in §60.5.9, above, 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.

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 must 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 should 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. (See 42 CFR Part 424, Subpart C, "Claims for Payment" and 42 CFR Part 424, Subpart D, "To Whom Payment is Ordinarily Made.")

60.5.11 - Disclosure of Individually Identifiable Beneficiary Information to Representative

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

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 either complete and sign an appointment of representative form naming that individual as his/her representative or must sign the written statement appointing the attorney representative. The contractor must 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.

It is not always necessary to receive written authorization from a beneficiary to release case-specific information to a representative; however, a beneficiary must explicitly authorize the release of any information that is not specific to the case/claim for which the representative has been appointed. Any questions as to whether information needs authorization to be release to a representative can be directed to the appropriate RO.

For more information about the disclosure of information about identifiable beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6, and §60.10, below.

60.6 - Amount in Controversy

(Rev. 1. 10-01-03)

B3-12006

60.6.1 - Amount in Controversy Defined

(Rev. 1. 10-01-03)

B3-12006.1

The **Amount in Controversy** is the dollar amount at issue that must remain to establish the right to a particular level of appeal. Congress establishes amount in controversy requirements. (See 42 CFR 408.815, "Amount in Controversy for HO Hearing, ALJ Hearing, and Judicial Review and 42 CFR 405.817, "Principles for Determining Amount in Controversy.")

60.6.2 - Amount in Controversy General Requirements

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

There is no minimum amount in controversy requirement for a redetermination. For a HO hearing conducted by a contractor HO or an ALJ* hearing for Medicare Part B claim(s), at least $100 must remain in controversy. There is no amount in controversy required for DAB review. For judicial review, at least $1,000* ($1,050 when judicial review is

requested on or after January 1, 2005) must remain in controversy. (See 42 CFR 405.815.)

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

Payments made under the limitation on liability provisions (§1879 of the Act) do not reduce the amount in controversy. In other words, the amount in controversy is calculated without regard to payment that was made for the denied item or service under the limitation on liability provisions.

See §60.6.4 if the appellant wishes to include more than one claim in the appeal request.

60.6.3 - Principles for Determining Amount in Controversy

(Rev. 1. 10-01-03)

B3-12006.3

The amount in controversy is computed as the actual amount charged the beneficiary for the item(s) and/or service(s) being appealed, less any allowed amount and less any deductible and coinsurance amounts applicable to the particular claim or claims involved. The decision about whether the amount in controversy requirement has been met is made by the HO at the HO hearing level, and by the ALJ at the ALJ level. (See 42 CFR 405.818, Principles for determining the amount in controversy.")

A. General Calculation

Step 1:

	Total amount charged for items/services in dispute
-	Total amount allowed for items/services in dispute
=	Difference

Step 2:

	Difference (from Step 1)
-	Unmet deductible
=	Balance

NOTES: The Balance in Step 2 is the amount that remains in controversy if the services are not subject to coinsurance. For services subject to coinsurance, proceed to Step 3. Unmet deductible refers to any unmet Part B blood deductible, if applicable, as well as the routine Part B cash deductible.

Step 3:

	Balance (from Step 2)
X	.80 (80%)
=	Amount that remains in Controversy, for services subject to coinsurance

B. Calculating the Amount in Controversy for Overpayments

The amount in controversy for an overpayment is the actual amount of the overpayment contained in the demand letter. This amount is not subject to reduction due to coinsurance and deductibles that have already been paid.

C. Exclusions

Calculation of the amount in controversy may take into account only those claims and items/services that are part of the review decision. In a HO hearing, the HO may not consider claims included in a later appeal request, except in cases of aggregation of claims, discussed below.

60.6.4 - Additional Considerations for Calculation of the Amount in Controversy

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

A request for a HO hearing may include multiple claims. Where the HO issues a single decision involving more than one claim, extra care must be used in calculating and stating the amount in controversy as a result of the HO's decision:

If the appeal involves claims that were previously denied and are now found to be covered/medically reasonable and necessary, the HO's decision should use language along the following lines:

> As indicated above, the following claims will be paid by Medicare (indicate claim control number(s) or dates of service): _____. You will be notified of the specific payment amount separately. The following claims will not be paid by Medicare (indicate claim control number(s) or dates of service): _____. The amount that remains in controversy for these claims is $_____. (Add routine language regarding aggregation, where appropriate.) (See below.)

NOTE: The contractor should modify the above language if coverage is at issue for some of the claims involved in the appeal while the amount of payment is at issue for other claims involved in the appeal.

If the appeal involves the amount that Medicare will pay for the item(s) or service(s), the HO determines the amount in controversy based upon all of the claims on appeal, indicating those claims where the payment amount was changed by the HO's decision. All claims will have an amount in controversy unless payment has been approved at the billed amount or if all claims in an overpayment are assessed to be fully reversed.

60.6.5 - Aggregation of Claims to Meet the Amount in Controversy

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

Under the aggregation rules contained in 42 CFR 405.815, claims with an amount in controversy greater than $0 may be combined to meet the amount in controversy requirements. The calculation is the same as that discussed above in §60.6.3, "Principles for Determining Amount in Controversy." The decision about whether the amount in controversy requirement has been met is made by the HO at the HO level, and by the ALJ at the ALJ level. (See 42 CFR 405.817, "Principles for Determining Amount in Controversy.")

A. The Appeal Request

When requesting a HO hearing or an ALJ hearing, the appellant MUST clearly state that he/she is aggregating claims to meet the amount in controversy requirement AND the appellant must specify in his/her appeal request the specific claims that are being aggregated (this information may be obtained from any attachments submitted with the request), see 42 CFR 405.817(5), "Principles for Determining Amount in Controversy." The contractor must notify appellants of this requirement as part of the appeals language advising them of aggregation rights on the redetermination and HO hearing decision. If an appellant's request for HO hearing does not specifically state that the claims are being aggregated, the contractor treats each claim as an individual request for HO hearing, dismissing those that do not meet the amount in controversy. Where the appellant is a beneficiary, the contractor uses its discretion to accept implied requests for aggregation of claims to meet the amount in controversy. If it is not sure if aggregation is intended, it makes an effort to contact the beneficiary to determine his/her intent.

B. Handling Aggregated Claims at Hearing Officer Hearing

The regulations do not require that claims that were aggregated for the purpose of meeting the amount in controversy requirement be addressed in a single HO hearing and/or a single HO hearing decision. In other words, although a party may choose to aggregate claims to meet the amount in controversy requirement for the HO hearing level, the HO may hold separate hearings, and may issue separate hearing decisions, as appropriate. For example, it would be appropriate for claims that are aggregated by one physician/supplier and which include multiple beneficiaries **and** unrelated issues to be separated. However, in most cases, the hearing should be completed the way it comes to the HO.

C. Aggregation Rules at Hearing Officer Hearing

Two or more claims may be combined by an individual appellant (i.e., either a beneficiary, or a provider or physician or other supplier with appeal rights) to meet the amount in controversy requirement at the HO hearing level **IF** each claim has had a redetermination issued (or a revised initial determination, or a revised redetermination) **AND** the request for HO hearing is timely-filed for all of the claims included in the aggregation request. The HO makes the decision about whether or not the aggregation requirements have been met.

D. Aggregation Rules at ALJ Hearing

A party requesting an ALJ hearing for Part B (other than QIO or HMO/CMP) may aggregate claims to meet the amount in controversy requirement for an ALJ hearing in one or more of the following ways:

- Two or more claims may be combined by an individual appellant (i.e., either a beneficiary, or a provider or a physician or other supplier with appeal rights) to meet the amount in controversy requirement **IF** each claim has had a HO hearing decision issued **AND** the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request;
- Two or more beneficiaries may combine their claims for services received from either the same or different provider, physician or other supplier **IF** the claims involve **common issues of law and fact**, **AND** each of the claims has had a HO hearing decision issued **AND** the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request;
- Two or more providers, physicians or other suppliers with appeal rights may combine claims **IF** the claims involve the delivery of **similar or related services** to the same beneficiary **AND** each of the claims has had a HO hearing decision issued **AND** the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request; or
- Two or more providers or physicians or other suppliers with appeal rights may combine their claims **IF** the claims involve **common issues of law and fact** for services furnished to two or more beneficiaries **AND** each of the claims has had a HO hearing decision issued **AND** the request for ALJ hearing is timely-filed for all of the claims included in the aggregation request.

At the ALJ level of appeal, it is the ALJ who is responsible for deciding whether the aggregation requirements have been met, including determining what constitutes common issues of law and fact and what constitutes similar or related services.

60.7 - Extension of Time Limit for Filing a Request for Review or Hearing Officer Hearing

(Rev. 1. 10-01-03)

B3-12008

The time limit for filing a request for review or HO hearing 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 review or HO hearing 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 or the HO may extend the period for filing the request for review or HO hearing. The procedures for finding good cause to excuse late filing are discussed below.

NOTE: Good cause should not be considered over the phone and is not applicable to telephone reviews.

60.7.1 - Good Cause

(Rev. 1. 10-01-03)

If an appeal request is filed late, the contractor or the HO may extend the time limit for filing an appeal if good cause is shown (see §60.7.3 and §60.7.5). 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 review does not mean that the party is then excused from the timely filing rules for the HO hearing.

60.7.2 - General Procedure to Establish Good Cause

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

For a request for redetermination or HO hearing that is not timely filed, and which contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the contractor makes a favorable good cause determination. Contractors must document the good cause determination in the appeals case file and include the following items: the date the appeal request was received, the last date on which the appeal request could have been timely filed, the evidence that was submitted to support the finding of good cause for untimely filing, and the favorable determination. If the contractor or the HO makes a favorable good cause determination, the appeal should be considered timely filed, and the contractor or HO should proceed with conducting the redetermination or HO hearing.

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 explains in the dismissal letter that the beneficiary can show that good cause exists for late filing, that the beneficiary may forward the explanation to the contractor within 120 days (or within 6 months of a Hearing Officer dismissal) from the date of the contractor's mailing of the notice of dismissal. If an explanation or other evidence is then submitted that contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the contractor or HO (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 with conducting the redetermination or HO hearing.

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

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, then they the provider, physician, or other supplier must submit the evidence

within 120 days (or within 6 months of a Hearing Officer dismissal) from the date of the contractor mailing of the notice of dismissal.

If the provider, physician, or other supplier submits evidence to the contractor within 120 days 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 it or the HO makes a favorable good cause determination, it must consider the appeal to be timely filed and proceed with conducting the redetermination or HO hearing. If it or the HO does not find good cause, the dismissal remains in effect. There is no appeal of a finding that good cause was not established.

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

60.7.3 - Conditions That May Establish Good Cause for Late Filing by Beneficiaries

(Rev. 1. 10-01-03)

B3-12008.3

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 (e.g., beneficiary does not speak or read English or Spanish; although the contractor wouldn't find good cause in those cases where an individual speaks and reads Spanish and receives a Spanish MSN, it would find good cause where a Spanish-speaking beneficiary does not read Spanish);
- 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; or
- 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.

60.7.4 - Examples of Situations Where Good Cause for Late Filing Exists for Beneficiaries

(Rev. 1. 10-01-03)

B4-12008.4

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 review or HO hearing; and
- The request was received after, but close to, the last day to file, and the beneficiary claims that the request was submitted timely.

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

(Rev. 1. 10-01-03)

B3-12008.5

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 review or HO hearing. 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.

60.7.6 - Examples of Situations Where Good Cause for Late Filing Exists for Provider, Physician, or Other Suppliers

(Rev. 1. 10-01-03)

B3-12008.6

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.

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

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

When the contractor does not grant a request for extension of time limit for filing a request for redetermination or HO hearing, 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 or HO hearing 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.

NOTE: If the HO does not find good cause for late filing, the HO may refer it to the contractor to consider reopening. Also, if the contractor does not find good cause for the late filing of a request for redetermination, it may examine the case to determine whether it has any basis for reopening and revising its determination.

60.8 - Fraud and Abuse

(Rev. 1. 10-01-03)

B2-12009

60.8.1 - Fraud and Abuse - Authority

(Rev. 1. 10-01-03)

B3-12009.1

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.

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

(Rev. 1. 10-01-03)

B3-12009.2

The contractor and the HO should 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 or the HO believes that evidence has been tampered with it should refer this documentation to either the Medical Review or Fraud and Abuse units for their follow-up.

The contractor or the HO may receive evidence obtained and provided by the fraud unit concerning fraud or potential fraud with respect to the claim(s) at issue. If the fraud unit provides such evidence, it becomes part of the case file and must be made available for inspection by the appellant prior to the hearing. 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.

60.8.3 - Claims Where There Is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed

(Rev. 1. 10-01-03)

B3-12009.3

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 or HO 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 or the HO has reason to believe or evidence to support that items or services were not furnished or were not furnished as billed, it should send a copy of the decision to its fraud unit.

60.8.4 - Responsibilities of Reviewers and Hearing Officers (HOs)

(Rev. 1. 10-01-03)

B3-12009.4

If, during the course of the review or HO hearing, the reviewer or HO suspects a civil or criminal law violation, the reviewer or HO must render a decision only on the coverage or payment issues raised by the review or hearing request. Although the reviewer or HO 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 or HO may consider all available evidence, including witness testimony, medical records, and evidence compiled through a fraud investigation, as discussed above. (See §60.11.4.B and §60.14.6.A, below.)

In addition to denying the claims because the services were not rendered as billed, if the reviewer or HO suspects fraud, he/she must forward information regarding the potential civil or criminal violation to the fraud unit. For further discussion on the Medicare fraud units, see the Medicare Program Integrity Manual at: http://www.cms.hhs.gov/manuals/108_pim/pim108toc.asp

60.8.5 - Requests to Suspend the Appeals Process

(Rev. 1. 10-01-03)

B3-12009.5

Neither the contractor nor the HO has the authority to suspend reviews or HO hearings at the request of the Office of the Inspector General (OIG) or the Department of Justice (DOJ) without approval and direction from CMS Central Office (CO). If the OIG or DOJ submits such a request to suspend a review or hearing, the contractor must first bring that request to the attention of CMS CO through the RO.

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

(Rev. 1. 10-01-03)

B3-12009.6

Reviewers and HOs must 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 and the HO must 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.

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

(Rev. 1. 10-01-03)

B3-12009.7

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 some claims with service dates after the date of exclusion.

60.9 - Guidelines for Writing Appeals Correspondence

(Rev. 1. 10-01-03)

B3-12010

The guidelines in this section are to be used when preparing appeals correspondence, including review determinations and HO hearing decisions and inquiries about the status of appeals. These must 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.

60.9.1 - General Guidelines

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

Contractors must 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. For redeterminations, the unique paragraphs of the appeals correspondence may be written at a comprehension level equal to the comprehension level of the appellant's request for appeal. For redeterminations, if there is doubt as to the appellant's comprehension level, and the appellant is the beneficiary, the contractor should write correspondence below the eighth grade reading level.

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, and
- Summarize the question before providing a response.
- Use correct spelling, grammar, and punctuation.

60.9.2 - Letter Format

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

Appeals correspondence (including the redetermination-telephone and written-determination and HO hearing decision) must 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;
- 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 is split, the contractor may produce separate decision or determination 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.

60.9.3 - How to Establish Reading Level

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

See §50.3.2(B)(2)

60.9.4 - Required Elements in Appeals Correspondence

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

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. (See §60.17.7.E for an example.) 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" is conclusive and does not provide any rationale. Rationale includes 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....(See §1879 of the Social Security Act)";
- Whenever the person is to receive some further response, such as an MSN, 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, statues, and guidelines used in making the determination;
- For appeals, if the determination 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.

60.10 - Disclosure of Information

(Rev. 1. 10-01-03)

B3-12011

60.10.1 - General Information

(Rev. 1. 10-01-03)

B3-12011.1

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.)

60.10.2 - Disclosure of Information to Third Parties

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

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 § 60.11.1(A)(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 § 60.5.

60.10.3 - Fraud and Abuse Investigations

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

Any and all evidence used by the contractor or the HO to arrive at a determination or decision must be placed in the appeals case file (copies are fine). Information in the case file must be made available to an appellant upon request. Therefore, the contractor's fraud unit must be aware that information placed in the case file is accessible to an appellant. The fraud unit should also understand that the contractor and the HO may not consider any evidence that has not been made a part of the case file. Fraud units should 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.

60.10.4 - Medical Consultants Used

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

The parties are entitled to know the identity and qualifications of any consultant whose evidence either the contractor, or the HO, used to support the initial claim determination, the redetermination, or the HO hearing decision. If the contractor or the HO uses a consultant, it must 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.

60.10.5 - Multiple Beneficiaries

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

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

60.11 - Redetermination* - The First Level of Appeal

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

* Beginning on October 1, 2004 "reviews" will be termed "redeterminations."

A party dissatisfied with an initial Part B determination may request by telephone or in writing that the contractor conduct a redetermination of its initial determination. (See 42 CFR 405.807(b), "Place and method of Filing a Request.") A redetermination is the first level of appeal after the initial determination on a Part B claim. 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 has not been made, there are no appeal rights on that claim, except in one limited circumstance. (See §60.13.4.A.)

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 redetermination. The reviewer is also bound by all CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, program memoranda, national coverage determinations, carrier-issued local medical review policies (LMRP) and regional medical review policies (RMRP). 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.

60.11.1 - Filing a Request for Redetermination

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

A request for redetermination can be filed with the contractor in writing or by telephone. A written request may also be filed with CMS, the Railroad Retirement Board (RRB) for RRB retirees, or SSA. A telephone request may be made by telephone to the number designated by the contractor for receipt of requests for redetermination. The request may be made by a party to the appeal as defined in §20 and/or the party's representative as defined in §60.5. 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 appointment 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 §60.5.8(A)(1) 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, etc.).

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 §§60.5.9 and 60.5.10, 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-1964. 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, an inquiry (either written or verbal) stating, "Why did you only pay $10.00?" is considered a request for redetermination. Further, if the beneficiary calls it a "reopening" or asks the contractor to reopen its decision, but it is submitted within the time limit for filing a request for redetermination, the contractor considers this a request for redetermination.

Common examples of phrasing in letters from beneficiaries that constitute requests for redetermination:

- "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-1964 constitutes a request for redetermination.** The contractor supplies these forms upon request by an appellant. (See http://www.cms.hhs.gov/forms/ for Form CMS-1964, "Request for Review of

Part B Medicare Claim.") Completed means that all applicable spaces are filled out and all necessary attachments are attached.

b. **A written request not on Form CMS-1964.** The request contains the following information:

- Beneficiary name;
- Medicare health insurance claim (HIC) number;
- Name and address of provider/physician/supplier of item/service;
- Date of initial determination;
- Date(s) of service for which the initial determination was issued (dates must be reported in a manner that comports with the Medicare claims filing instructions; ranges of dates are acceptable only if a range of dates is properly reportable on the Medicare claim form);
- Which item(s), if any, and/or service(s) are at issue in the appeal; and
- Signature of the appellant.

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-1964. 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 is not included with the appeal request, the contractor returns it to the State or provider with an explanation of the information that must be included. Count this as an incomplete request, but not as a completed appeal or dismissal.

3. **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.

4. Telephone Requests for Redetermination from Beneficiaries - Beneficiaries may request a redetermination by telephone at a number designated by the contractor for receipt of redetermination requests. The contractor follows instructions above in (1) for what to consider a request for redetermination. Although the beneficiary may request that the contractor perform the redetermination by telephone, the contractor makes the decision as to whether or not the redetermination should be conducted over the telephone. (See §60.12 for more information on telephone redeterminations.)

5. Telephone Requests for Redetermination from a State, Provider, Physician or other Supplier - States, providers, physicians or other suppliers with appeal rights may request a redetermination by the telephone at a number designated by the contractor for receipt of redetermination requests. Although a State, provider, physician or supplier may request that the contractor perform the redetermination by telephone, the contractor makes the decision as to whether or not the redetermination should be conducted over the telephone. (See §60.12 for more information on telephone redeterminations.)

The appellant must provide the information listed in §60.12.6 in order to request a telephone redetermination.

60.11.2 - Time Limit for Filing a Request for Redetermination

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

A party must file a request for redetermination within 120 days of the date 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 minus five days to allow for normal mail delivery time. (For example, if the contractor receives a request for redetermination in the corporate mailroom on August 10, it subtracts five days from the date received. In this case, the date of filing is August 5.) If the party has filed the request in person with the contractor, CMS, or SSA, or with the RRB for RRB beneficiaries, 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 a CMS, SSA, or RRB office, the date of filing is the postmarked date on the envelope. The date of filing for telephone requests for redetermination is defined as the date the phone call is received.

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

The contractor may extend the period for filing if it finds the appellant had good cause for not requesting the redetermination timely. (See §60.7 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 §90.)

60.11.3 - Recording of Inquiries and Other Actions on the Carrier Appeal Report (FI - Form CMS-2591, Carrier - Form CMS-2590)

(Rev. 1. 10-01-03)

B3-12012.3, AB-00-122

The contractor does not record written or telephone inquiries as requests for review unless they contain stated requests for review as explained above. Where a request is recorded as an appeal, it is not also recorded as an inquiry.

60.11.4 - The Redetermination

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

The redetermination is an independent, critical examination of the Part B claim made by contractor personnel not involved in the initial claim determination. Since Federal regulations do not provide for personal appearance of the appellant, the redetermination procedures do not include such personal appearances.

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 95 percent of requests for review within 45 days of receipt of the request. The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom for written requests and as the date the request was received on the telephone for telephone requests.

The carrier must complete all requests for **redetermination** within 60 days of receipt of the request. The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom for written requests and as the date the request was received on the telephone for telephone requests.

NOTE: In accordance with SSA § 1842(a) and 42 CFR 405 subpart H, FIs function as carriers when processing Part B redeterminations.

Completion is defined as:

1. For **affirmations**, upon the completion of the process that generates the decision letter for mailing to the parties.

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

a. the process that generates the decision letter for mailing to the parties is completed, 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 **full reversals**, when 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.

4. For **withdrawals and dismissals**, upon the completion of the process that generate the dismissal notice for mailing to the parties.

For redeterminations conducted on the telephone (see §60.12 for a discussion of telephone redeterminations), the date the telephone redetermination is completed is defined the same as above for written redeterminations (most telephone redeterminations should be adjudicated the same day as received on the phone; however, it may take a few days to complete the written determination).

B. Development of Appeal Case File

The reviewer must secure 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.)

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 correctness of the reasonable charge, 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 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 initial determination, if requested.

- Although the reviewer may not make a finding of criminal or civil fraud (see §60.8, "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.
- 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.
- Correctness of Initial Determination is Questioned- While it is not the intent of the appeals process to audit favorable initial determinations, there may be times when the contractor questions the correctness of the initial payment decision. Since the contractor already notified the parties that part of the claim was covered, a subsequent denial could cause problems affecting the physician or other supplier and/or the beneficiary. When the contractor discovers that a claim or line items was previously paid in error, the contractor must take action to resolve the issue. If the contractor has reason to believe the initial determination should be reversed (i.e., ultimately making it more adverse to the party than the initial determination), it proceeds as follows:
    - It reviews the file carefully, with particular attention to the evidence that supported the original payment decision. It uses the payment policies that were in effect at the time the initial determination was made or the date of services as applicable.
    - If it believes that payment of a previous claim or line item(s) is not justified and this issue involved complicated medical reason, it refers the case to a consultant for an opinion on whether the service(s)/item(s) was/were covered.
    - When the appeals staff confirms that a claim or line item(s) was/were paid in error, it should make a decision only on the originally noncovered services at issue in the redetermination. Next it should return the claim to overpayments to collect the overpayment and to issue a demand letter.

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. The same standards apply for requests for redetermination made over the telephone.

3. Requesting documentation for Beneficiary-Initiated Appeals

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 other 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. 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. Although providers, physicians and other suppliers are to provide all necessary documentation when filing the claim, if they fail to provide documentation at the initial determination and then appeals the initial determination, they should provide all relevant information and documentation at the time the appeal is requested.

60.11.5 - The Redetermination Decision

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

The law requires carriers to complete the **review** and render a decision within 45 days of the appellant's request, as indicated in §60.11.4.A.(**NOTE:** In accordance with SSA § 1842(a) and 42 CFR 405 subpart H, FIs function as carriers when processing Part B redeterminations.) The contractor sends the review decision to the appellant and copies

to each party and authorized representative (as applicable) if the determination is either partially or wholly unfavorable.

The law requires carriers to complete the **redetermination** and render a decision within 60 days of the appellant's request, as indicated in §60.11.4.A. The contractor sends the redetermination to the appellant and copies to each party and authorized representative (as applicable) if the determination is either partially or wholly unfavorable.

A. Calculating the Amount in Controversy

For all claims where the prior denial is upheld in full or in part, the contractor must include in the determination letter a statement as to whether the amount in controversy remaining is above or below $100. (See §§60.6.)

B. 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 sends all parties and appointed representatives an adjusted MSN or RA. It need not issue a redetermination letter. 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.

C. Determinations That Result in Refund Requirements - Carriers

If, as the result of a denial, a physician, or other 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.

D. Dismissals of Redetermination Requests

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. A party may request a dismissal by filing a written notice of such

request with the contractor or by orally stating such request during a telephone redetermination. 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; or
- Where the party who filed the redetermination request dies and there is no information showing that an individual who is not a party may be prejudiced by the contractor's initial determination.

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 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: The contractor does not count duplicate redetermination requests or redetermination requests received before it has made an initial determination on a claim. (See Chapter 6 of the Medicare Financial Management Manual, CMS Pub 100-06.)

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 120 days 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. The dismissal notice includes the reason for the dismissal.

60.11.6 - Redetermination Letter

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

A. Redetermination Format and Standard Language

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.

B. 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.

Medicare Number of Beneficiary:
111-11-1111 A

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

MEDICARE APPEAL DECISION

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

Dear Appellant's Name:

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

The appeal decision is (Insert either: unfavorable. Our decision is that your claim in not covered by Medicare and over/under $100 remains in controversy. OR partially favorable. Our decision is that your claim is partially covered by Medicare and over/under $100 remains in controversy)

More information on the decision is provided below. You are not required to take any action. However, if you disagree with the decision, you may appeal to (insert: an Administrative Law Judge (for Part A), a Hearing Officer (for part B)). You must file your appeal, in writing, within (insert: 6 months (for Part B) or 60 days (for Part A) of receiving this letter.

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

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

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

- A claim was submitted for (insert: kind of services and specific number).

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

Decision

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

Explanation of the Decision

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

Who is Responsible for the Bill?

Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.

What to Include in Your Request for an Independent Appeal

Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim.

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 (insert: a Hearing Officer hearing or an Administrative Law Judge (ALJ) hearing)

The law requires that at least $100 remain in controversy for you to request (insert: a Hearing Officer hearing or an ALJ hearing). If less than $100 remains in controversy, you may combine the claim or claims that are the subject of this decision with claims from other recently issued redetermination decisions. This is called "aggregating claims." For more information, see the section on aggregating claims below.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within (insert: 60 days for Part A or 6 months for Part B) of receiving this letter. Under special circumstances, you may ask for more time to request an appeal.

You should include: your name, address, Medicare number, reasons for appealing, and any evidence you wish to attach. You may also attach supporting materials such as medical records, doctors' letters, 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:

Contractor Name
Address
City, State Zip

Aggregating Claims: To "aggregate claims" EACH CLAIM included in your request for (insert: Hearing Officer hearing or ALJ hearing) must be appealed within (insert: six (6) months or 60 days) from the date the decision was issued on the claim and each claim must have already received a redetermination decision.

If you wish to request a (insert: Hearing Officer hearing or ALJ hearing) by combining the amounts remaining in controversy from other claims, you MUST clearly state on your request that you are "aggregating claims", AND you must list the specific claims that you are aggregating.

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

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

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

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

Contractor Name,
A Medicare Contractor
Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of address).

Other Resources To Help You:
1-800-MEDICARE (1-800-633-4227)

TTY/TDD: 1-800-486-2048

60.11.7 - Effect of the Review Determination

(Rev. 1. 10-01-03)

B3-12012.7

The review determination is binding upon all parties to the review unless either a HO hearing decision is issued or the review determination is reopened and revised in accordance with contractor reopening authority.

60.12 - Telephone Review Procedures

(Rev. 1. 10-01-03)

B3-12013

A telephone review is a review that is requested on the telephone and also is performed entirely on the phone or through a follow up telephone call to the appellant. Telephone reviews are subsequently completed through a review determination letter or other notice (see §§60.11.5 and 60.11.6 for information on review determination requirements). Whether a request for review is made by telephone or is conducted and completed as a telephone review depends on the issues at hand and the complexity of the matters involved.

A party dissatisfied with the contractor's initial Part B determination may request a review of the determination by telephone. For some of these requests, the contractor may be able to perform the review on the telephone or through a follow-up call. Receiving review requests and conducting reviews on the telephone should expedite and simplify the review. The contractor will transfer other requests made by telephone to the appropriate department for written reviews. Requesting a review on the telephone provides quick and easy access to the appeals process for appellants.

The contractor must have the capacity to take all requests for review on the telephone, however it need not complete all reviews over the phone. Those review requests that cannot be handled over the phone must be transferred to the written reviews section.

The contractor must ensure that the Privacy Act is applied to its telephone review process. All telephone reviewers must be trained on the Privacy Act requirements.

The contractor applies the same standards to telephone reviews for how a review is conducted and what documentation is needed as it applies to written reviews.

60.12.1 - Informing the Beneficiary and Provider Communities About the Telephone Redetermination Process

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

The contractor must inform beneficiaries, providers, physicians, and other suppliers of its telephone redetermination process 30 days prior to initiation and annually thereafter or when making significant changes to its process. It must provide information about its process through means such as bulletins/newsletters, newspaper articles; meet with senior citizens groups and beneficiary outreach groups; maintain customer service/inquiry and provider relations departments; conduct seminars, etc.

Information it publishes about its telephone redetermination process should include:

- How to access the process (telephone number, hours of operation, etc.);
- Any limitations (such as certain issues, number of claims/issues per call, etc.);
- Specific instructions that the party must state that he/she is requesting a telephone redetermination;
- Type of documentation that appellant should have on hand when calling in to request a redetermination;
- How to submit additional documentation (fax, mail, etc.) and any timeframes;
- The types of issues the contractor might be able to handle over the telephone and the types of issues it will not handle over the telephone.

NOTE: Issues that require input from other than the redetermination analyst should not be handled over the telephone; and

- Appellants have 120 days after the date of the notice of initial determination to request a redetermination by telephone (allow 5 additional days for mail delivery).

60.12.2 - Issues for Telephone Reviews

(Rev. 1. 10-01-03)

B3-12013.2

Telephone reviews (requests for review where a decision can be rendered on the phone) should be limited to resolving minor issues and correcting errors. As with any appeal, a telephone review is applicable only if an initial determination has been made. Claims that have received no initial determination are not appealable. (See Chapter 1 regarding unprocessable claims.)

At a minimum, when an appellant requests a review (appeal) over the telephone, the contractor should be able to complete a review over the telephone of the following types of issues (list is not all-inclusive):

- Number of services/ units;
- Add, change or delete certain modifiers;
- ICD-9 Diagnosis codes;
- Erroneous denials (as duplicates);
- Procedure codes;
- Place of service; and
- Dates of service.

NOTE: As necessary, the contractor asks providers to fax in the proof to support changes and error correction.

Telephone reviews are **generally inappropriate** for the following issues:

- Limitation on liability;

- Potential overpayments;
- Medical necessity denials and reductions; or
- Analysis of documents such as operative reports and clinical summaries.

NOTE: If the contractor has tight management controls in place to handle these types of reviews, including a means of receiving all appropriate documentation to support conducting the appeal over the telephone, it may choose to handle some of these issues over the phone as appropriate. However, the more complicated the issue, the more important it is to have proper documentation in the file to support the decision.

In all cases, telephone reviews are **inappropriate** for the following issues:

- Claims requiring the input of medical staff or other entities outside of the review department such as provider enrollment, CWF, or CMS, etc; and
- Provider number/ name.

NOTE: Even though telephone reviews are inappropriate for some issues the contractor must be able to take requests for reviews on these issues over the telephone.

60.12.3 - Issues During the Telephone Review

(Rev. 1. 10-01-03)

B3-12013.3

Whether or not the contractor conducts a review on the telephone subsequent to a request for review made on the telephone depends on what is at issue. For example, an issue that requires a complex review must be accepted as a review request; however, the contractor need not conduct the review on the telephone.

A. Issues That Cannot be Resolved During the Telephone Review

There may be instances where an issue cannot be resolved during the telephone review. An issue may not be resolvable on the telephone because: (1) the issue becomes too complex to be handled over the telephone and/or it is in the best interest of the appellant to have a more in-depth review performed; or (2) there is a need for additional medical documentation from the provider, physician, or other supplier and the information cannot be faxed in during the telephone review or within a reasonable time (48 hours or the equivalent of 2 full business days). (See §60.11.4.D for information on requests for documentation that is needed to make a determination.)

If the issue cannot be resolved due to one of the preceding reasons, the contractor advises the appellant that review cannot be handled over the telephone. The contractor must conduct the review; however the appellant need not submit his/her request in writing. The contractor transfers or forwards the request for review to the written appeals section. The contractor gives the appellant a confirmation/control number to confirm the request for review was made and was filed timely. It considers the date of the telephone call to be the date of the request for review. In order to expedite and make more efficient the transfer from the telephone review unit to the written review unit, the contractor may wish to develop a form for such transfers, and instruct its telephone review staff to include this form in the case file.

B. Issues That Can be Resolved During the Telephone Review

In situations when the necessary information/documentation can be faxed during or prior to the telephone review or within a reasonable time (48 hours or the equivalent of two full business days) and a decision can be made (the issue is not too complex to be handled over the telephone and/or the appellant does not need a more in-depth review to be performed), the contractor informs the appellant of its decision at the conclusion of the call or via a follow-up phone call. The date of its decision is considered the day of the requesting phone call for reviews that are handled during the same call as the request and the day of the follow-up phone call for reviews where a decision cannot be made on the day of the request but can still be handled over the telephone. The contractor follows instructions in §60.12.8 for information that must be provided to the appellant on the phone and in the determination letter.

60.12.4 - Time Limit for Requesting a Telephone Review

(Rev. 1, 10-01-03)

B3-12013.4

A party must request a review by telephone within 120 days of the date of the initial determination as indicated on the MSN or RA. The date of filing for a telephone review is considered the date of the phone call.

Requests for extensions to this period for good cause must be requested in writing and are not applicable for telephone reviews. If a party wishes to have good cause considered over the telephone, the contractor will advise him/her that he/she must submit the request for review along with a request for good cause consideration in writing. (See §60.7 for a discussion on good cause.) The contractor counts the request as a dismissal.

60.12.5 - Review Requests Made on Behalf of the Party on the Telephone

(Rev. 1. 10-01-03)

B3-12013.5

In cases where the beneficiary wishes to have a representative, the contractor follows the instructions in §60.5 on Appointment of Representative. A completed Form CMS-1694-U4 (or other substitution described in §60.5.3.C.) must either be faxed during the phone call or before the phone call is placed and later mailed for the case file.

If the form cannot be faxed, the contractor advises the caller that the review cannot be conducted over the phone. In this situation it must transfer the request to the written review unit. The caller need not submit a new request for review. The contractor follows the instructions in §60.5.8.A.1 and instructs the caller that he/she has 14 days to submit the appointment in order for the designated individual to represent the beneficiary.

60.12.6 - Conducting the Telephone Review

(Rev. 1. 10-01-03)

B3-12013.6

Prior to conducting a telephone review, the caller must provide the following three items:

- Beneficiary name;
- Beneficiary date of birth; and
- Medicare HICN.

The following items must be obtained/recorded/confirmed during telephone review:

- Date of call;
- Name of caller;
- Phone number of appellant;
- Name of provider/supplier of item or service;
- Date of initial determination;
- Dates of service for which the initial determination was issued;
- Which items(s) or service(s) are at issue in the appeal;
- Reason for the review request;
- Any new information that is received during the telephone call;
- Rationale for decision or dismissal;
- Name of Reviewer; and
- Confirmation number, if applicable.

60.12.7 - Documenting the Call

(Rev. 1. 10-01-03)

B3-12013.7

The information received during the telephone review (especially the date of the call) must be either: (1) documented on a review documentation form; or (2) logged into the contractor's computer system.

All documentation must be assigned a review control number. Any additional documentation received must be recorded into the contractor system or attached to the review form. The telephone review control number is recorded on all documents received that are associated with the telephone review. The documents are included in the file.

The documentation must be made a part of the file and be available if a further appeal is filed or other post-adjudication action is necessary. If the request is later transferred to the written review unit, this documentation must be included in the file in place of the written request for review. All documentation should be maintained in a manner that allows for future audits.

60.12.8 - Timely Processing Requirements

(Rev. 1. 10-01-03)

B3-12013.8

See §60.11.4 for timely processing requirements.

60.12.9 - Redetermination Letters

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

The contractor informs the appellant of its decision at the conclusion of the call if it has completed the redetermination. It also advises him/her of his/her rights to the next level of appeal if the decision is not fully favorable or lets the caller know that a full description of appeal rights will be included in the decision letter. It informs him/her that he/she will receive a written confirmation of the decision in the form of either a redetermination letter, or an adjusted RA/MSN, whichever is appropriate. It sends a redetermination letter using the instructions located in **§§60.11.6** and **60.11.5** to the appellant with copies to each party and authorized representative when the initial determination is not fully favorable. If the determination is a full reversal (i.e., is fully favorable), the contractor sends all parties and appointed representatives an adjusted MSN or RA. In this case, it need not issue a redetermination letter. The MSN provides the beneficiary with information as to his/her financial liability with regard to the claim(s) that are now payable. The contractor includes in the determination and/or MSN or RA a statement advising the appellant that the telephone conversation constituted a Part B redetermination and decision. The written determination must contain a statement advising the appellant of his/her rights with respect to further administrative appeal. (See **§§60.11.5** and **60.11.6** for more information about redeterminations.)

60.12.10 - Education

(Rev. 1. 10-01-03)

B3-12013.10

The contractor develops a process to decrease the occurrence of reviews involving repeated issues by educating provider personnel as well as providing feedback on clerical errors to its own claims examiners. Where possible and applicable, it uses the telephone review as an opportunity to educate appellants and correct systemic problems.

60.12.11 - Monitoring Telephone Reviews

(Rev. 1. 10-01-03)

B3-12013.11

The contractor develops a process to monitor telephone reviews. At a minimum, it monitors 45 telephone reviews or five percent of telephone reviews per quarter, whichever is less. It monitors the sample of telephone reviews for accuracy, customer service, and adherence to the Privacy Act as well as to ensure that appellants are informed of their rights to the next level of appeal if the decision is not fully favorable. If the contractor randomly monitors calls, it must make sure the reviewer informs the appellant that the telephone call may be monitored.

Also, the contractor must develop a process to perform ongoing quality checks to ensure accuracy of information, to ensure payment is correct and to ensure information regarding further appeal rights are provided at the end of the call for all upheld and partially reversed decisions.

It documents and retains any reports it generates through its quality control process. It retains this information in accordance with its normal document retention procedures.

60.13 - Hearing Officer Hearing - The Second Level of Appeal

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

A party dissatisfied with the contractor's redetermination, where at least $100 remains in controversy, may request a HO hearing. The HO hearing is the second level of appeal, performed after the contractor has issued a redetermination. It is a new and independent redetermination of the claim by a HO. If a redetermination has not been issued, there is no right to a HO hearing, except in the two specific cases (claims for payment not acted upon with reasonable promptness by the contractor, and appeals of revised initial determinations where $100 or more remains in controversy), discussed below.

NOTE: (This applies to documentation received by medical review absent a request for redetermination) When the medical review department issues an Additional Documentation Request (ADR) and no response is received within 45 days of the date of the request (or extension), the medical review department will deny the services as not reasonable and necessary. If the medical review department received the requested documentation after an initial determination has been issued, but within a reasonable number of days (see PIM Chapter 3 §4.1.4), the contractor may reopen the claim. For purposes of this section and under 42 CFR 405.842, this type of reopening conducted by medical review shall not have the right to a HO hearing before a redetermination is issued.

The contractor must establish and maintain hearing procedures for individuals dissatisfied with its redeterminations. The hearing process gives a dissatisfied party an opportunity to present the reasons for his/her dissatisfaction and to receive a new decision based on all the evidence developed at the hearing. A party to a redetermination is entitled to a hearing if a written request is filed timely and if the amount remaining in controversy at the time the request is filed is $100 or more.

60.13.1 - Filing a Request for a Hearing Officer Hearing

(Rev. 1. 10-01-03)

B3-12014.1

The request for a HO hearing can be filed with the contractor, CMS, or an office of the SSA, or with the RRB for RRB beneficiaries. The request must be made in writing and signed by the party making the request. A representative may also file the request. The request may state that the appellant is dissatisfied with the review determination and wishes to appeal the matter further, or it may merely be a second request for appeal, and contractor records indicate that a review has previously been conducted. A request may be any clear expression, in writing, by a party (or his/her representative) that states, in effect, that he/she is dissatisfied with the review determination and contains the necessary information to complete the appeal.

A. Request for Hearing - Part B Medicare Claim (Form CMS-1965)

The CMS provides a form for filing a request for hearing for the convenience of appellants, but use of the form is optional. The contractor provides these forms upon request by an appellant. When a request for hearing is filed using Form CMS-1965, the contractor date stamps the form with the date that the request is received in the corporate mailroom and attaches the envelope or an image of the envelope that the request was mailed in to the request.

See §60.28, Exhibit 3 for a copy of Form CMS-1965.

B. Other Written Requests

As use of Form CMS-1965 is optional, any written and signed statement of dissatisfaction and desire to appeal the matter further that contains the same information that the form would supply is sufficient. The contractor follows instructions in §60.11.2 for requests made by beneficiaries. Upon receipt, it date stamps the request with the date that it is received in the corporate mailroom, and attaches the envelope or an image of the envelope to the request.

NOTE: In situations where the contractor thinks timeliness may become an issue, it must maintain the envelope in the case file. If the appeal request is submitted in a box, the contractor must make an image of or copy the postmark date and any other identifying information.

C. Request Submitted to the Wrong Contractor

Sometimes an appellant may incorrectly submit a request for a HO hearing to a contractor that did not make the initial or review decision/determination. If the initial determination and review determination were correctly processed by another contractor, the contractor receiving the request for a hearing should not automatically consider it a request for transfer. It should forward the request as soon as possible to the contractor with jurisdiction over the claim.

60.13.2 - Time Limit for Filing a Request for a Hearing Officer Hearing

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

A party must file a request for a HO hearing within 6 months of the date of the notice of the redetermination, or revised initial or redetermination. (To allow for mail delivery, the contractor computes the time limit for requesting a hearing by allowing 5 additional days beyond the time limit) The date of filing is defined as the date the party mailed the request for a HO hearing, as evidenced by the postmark on the envelope. Therefore, the envelope or an image of the envelope must be attached to the request in the corporate mailroom. In situations where the contractor thinks timeliness may become an issue the envelope must be attached to the request. The envelope itself or the image of the envelope becomes part of the development of the appeals case file. If the party has filed the request in person with either the contractor, CMS, or an office of the SSA, or with an office of the RRB for RRB beneficiaries, then it 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 hearing to a CMS, SSA, or RRB office, the date of filing is the postmarked date on that envelope.

Where claims are combined to meet the $100 amount in controversy requirement, all redeterminations must have been issued within 6 months of the filing of the hearing request.

The contractor may, upon request by the party, extend the period for filing the request for hearing. If it finds good cause for late filing of the hearing request exists then the contractor should handle the request as if it had been timely filed. (See §60.7.)

If the appeal request was not timely filed, but it appears from the case file that the claim(s) should have been paid in whole or in part, although the HO must dismiss the request for a HO hearing, the HO may forward the case file to the contractor with a note explaining why the HO believes the claim(s) may be payable. In the letter, the HO may ask the contractor to determine whether there is authority to reopen the redetermination under the reopening authority. (See §60.17.1 (A)(7).)

60.13.3 - Request for a Hearing Officer Hearing Filed Prior to a Redetermination

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

A redetermination is a prerequisite for a HO hearing, except in the two specific exceptions discussed in §60.13.4, below. When the contractor receives a request for a HO hearing filed prior to a redetermination, it transfers the request to the redetermination department. It must not dismiss the case. The contractor should handle a request for a HO hearing filed prior to a redetermination as a request for redetermination.

60.13.4 - Exceptions to Filing Requirements

(Rev. 1. 10-01-03)

B3-12014.4

Although in most cases a request for a HO hearing filed prior to a review determination will result in the appeal being handled as a request for review, there are two specific exceptions to this requirement.

A. Claim for Payment Not Acted Upon with Reasonable Promptness

If the contractor does not process a claim within 60 consecutive days from the day it received it, a party has the right to a HO hearing if there is any clear expression in writing submitted by the party asking for a hearing to adjudicate the claim. (See 42 CFR 405.801 and 405.802).

The contractor determines whether the request for payment was filed more than 60 days earlier and determines whether it has taken any action before the hearing request was received. If it has not taken any action, the HO assigned the request will direct the contractor to notify the beneficiary of the reason for the delay and to begin processing the claim within 10 working days. If it complies with the HO's request and also provides the HO with a copy of its notice to the beneficiary, then the HO dismisses the hearing because action is being taken on the initial payment request.

If it does not comply with the HO's request, then the HO prepares for a hearing, and provides the contractor with a copy of all notices sent to the beneficiary. If appropriate, the HO may perform a preliminary on-the-record (POTR) hearing.

B Reopened Determinations (revised initial determinations)

Following contractor issuance of a revised initial or review determination (pursuant to its reopening authority), all parties to the revised determination have a right to a hearing if they meet the requirements for filing a request for a HO hearing (i.e., they meet the time limits for filing and the amount remaining in controversy is $100 or more).

If the revised initial determination was issued as a result of actions initiated by the contractor, and less than $100 remains in controversy after the contractor issues a revised initial determination, all parties have a right to request a review.

60.14 - Request for a Hearing Officer Hearing

(Rev. 1. 10-01-03)

B3-12016

60.14.1 - Timely Processing Requirements

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

Carriers must issue ninety percent of final determinations within 120 days of the date of receipt of the request for a HO hearing. (**NOTE:** In accordance with § 1842(a) of the Act and 42 CFR 405 subpart H, FIs function as carriers when processing Part B Hearing Officer hearings.) The date of receipt for the purpose of this standard is the date the request for HO hearing is received in the mailroom of the affiliated carrier that adjudicated the underlying claim. For telephone or in-person hearings, the HO must issue a decision no later than 30 days after the date the hearing was held. An exception to this 30-day rule can be made when the appellant has additional documentation he/she wishes to consider after the telephone or in-person hearing). Consider a complete/cleared:

- for **on-the-record**, **telephone**, or **in-person hearings**, when the decision is signed.
- for a **preliminary on-the-record hearings** when the appellant elects not the have a telephone or in-person hearing, after the 14 calendar days for requesting the in-person or telephone hearing have passed.
- for **dismissals and withdrawals**, upon the completion of the process that generates the dismissal notices for mailing.

NOTE: At its discretion, the carrier may consider and honor requests for immediate hearings for reasons such as threat of bankruptcy or other emergency situations.

60.14.2 - Contractor Responsibilities - General

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

The contractor must assign the hearing request to the assigned Hearing Officer, as soon as possible but no later than 30 calendar days after its receipt of the request in the

corporate mail room. Relevant material includes, but is not limited to, all information used to make the initial and redeterminations and copies of, or references to, any relevant statutes/regulations/coverage determinations used in making the redetermination, including all pertinent LMRP or RMRP and relevant manual provisions in effect at the time the initial determination was made. The suggested contents of the appeals case file are discussed in detail later in this section.

If, while assembling the file for forwarding to the HO, the contractor notices that a denied claim is payable in full (i.e., Medicare allowable amount) based on new information not previously available it must notify the HO that the claim is payable and why. If the HO agrees and an OTR has been requested, the HO may then conduct a OTR hearing and issue the full reversal. If the appellant requested a telephone or in-person hearing, the HO may conduct a POTR and issue the full reversal or the HO may contact (via fax, e-mail, US mail, or telephone) the appellant and if the appellant waives their right to an in-person or telephone hearing, the HO may issue an OTR decision. Notate this action in the case file. If while assembling the file for forwarding to the HO, you notice that a denied claim is payable in full based on evidence in the redetermination file, refer to 60.17.1 A7.

60.14.3 - Requests for Transfer of In-Person Hearings

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

Transfer is primarily intended to accommodate beneficiary appeal requests for an in-person hearing. (See 42 CFR 405.825(a), "Location of Carrier Hearing.")

A. Beneficiary Requests

Transfer may be used to accommodate either:

1. Beneficiaries who live in one part of the country part of the year, but spend an extended period of time in another part of the country for part of the year; or,
2. Beneficiaries who are being represented by a son/daughter/relative where the representative lives in one part of the country, and the beneficiary lives in another.

Other similar situations may exist that would warrant approval of a beneficiary's transfer request. The overriding consideration is to provide access for a beneficiary to an in-person hearing.

Following receipt of a transfer request from a beneficiary, the contractor may advise the beneficiary that a telephone hearing is available, although it may not require that the beneficiary accept a telephone hearing in place of an in-person hearing.

B. Provider, Physician and Other Supplier Requests

Transfer has very limited application for providers, physicians or other suppliers. Providers, Physicians or other suppliers with appeal rights are expected to pursue their appeals through the contractor that processes their claims. For transfer requests from providers, physicians or other suppliers, there must be extenuating circumstances present for granting a request for transfer.

NOTE: Extenuating circumstances does not include the desire by a provider, physician, or other supplier to have a particular representative from another state or area of the

country represent him/her/it. There is a strong presumption that there are competent/suitable representatives available to a provider, physician, or other supplier in the contractor's service area.

C. Applicable Medical Review and other Coverage and Payment Policies

The coverage, medical review, and other payment policies in place at the contractor that processed the initial claim for payment are binding upon the HO at the receiving contractor that will be conducting the in-person HO hearing. The transferring contractor is responsible for fully developing the case file prior to forwarding to the receiving contractor, and providing all relevant documents needed to adequately review and rule on the claim for payment.

D. Procedure for Processing and Handling Approved Transfer Requests

When a transfer request is granted, the primary contractor is responsible for developing the case file. It forwards the request and case file within 21 calendar days of the transfer request. If the primary contractor conducts a POTR, the primary contractor counts the hearing as part of their workload up until it is transferred to the secondary contractor. If the secondary contractor performs the hearing, it is counted as part of their workload. The primary contractor must not "recount" the request when it is transferred back to them. The secondary carrier must complete the in-person hearing within the 120 day timely processing standard (which started running when the primary carrier received the request for HO hearing). The secondary carrier returns the case file and the HO hearing decision to the primary carrier for effectuation.

1. Preliminary On-The-Record (POTR) Hearing Decisions

The contractor may, at its discretion, conduct a POTR hearing. If it does, and the decision is **favorable**, it sends a copy of the POTR hearing decision to the appellant. It follows the procedures for issuing POTR hearing decisions in <u>§60.15.4</u>, below. If, after following the procedures for issuing POTR hearing decisions, the appellant advises that he/she still wants an in-person hearing, then the primary contractor forwards the case file to the contractor closest to the appellant (e.g., closest to where the beneficiary is temporarily residing or where the relative/representative resides) within seven calendar days of its receipt of the notice from the appellant that an in-person hearing is still desired.

If the POTR hearing decision is **unfavorable**, the primary contractor transfers the case file, including the POTR hearing decision, to the contractor closest to where the appellant is located (e.g., closest to where the beneficiary is temporarily residing or where the relative/representative resides). It sends the case file to the secondary contractor within 14 calendar days of the appellant advising the primary contractor that he/she does not accept the POTR hearing decision. The secondary contractor must complete the in-person hearing within the 120-day timely processing standard (which started running when the primary contractor received the request for a HO hearing). The secondary contractor returns the case file and HO hearing decision to the primary contractor for effectuation.

E. Special Rules for Durable Medical Equipment Regional Carriers (DMERCs)

The DMERCs should accept transfer of in-person hearing requests from other DMERCs. Transfers are necessary among the DMERCs because claims processing jurisdiction is

determined based on beneficiary location. For that reason, suppliers must request hearings from the DMERC that processed the claim at issue. In some cases, this involves national suppliers with satellite offices across the country who wish to have all appeals handled in a corporate location, or mail-order companies located outside the jurisdiction of the claim processing DMERC. The DMERC with claims processing jurisdiction does process both OTR and telephone hearings for supplier's located outside their area of geographical jurisdiction. DMERCs are not required to transfer out-of-area in-person hearings if they are able to accomplish the workload without doing so. Prior to transferring a case to another DMERC, the hearings coordinator or other designated person, shall review the hearing request, and any associated documentation, to ascertain whether a full reversal is indicated either on the face of the evidence submitted, or as a result of an error at the previous level. If a full reversal is warranted, the receiving DMERC should issue a preliminary OTR hearing decision. In the case of a fully favorable preliminary OTR decision, the hearing request should only be transferred if the appellant supplier requests a follow-up in-person hearing.

For purposes of workload reporting, the receiving DMERC should use the date it received the transfer as the date received, thereby starting the 120 day clock at that time. Although it will not always be feasible, the receiving DMERC should make an effort to complete the hearing within 120 days of the date the request was originally received at the transferring DMERC.

60.14.4 - Acknowledgment of Request for a Hearing Officer Hearing

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

Within 21 **calendar** days of receipt of the request in the corporate mailroom, the contractor or the HO assigned the request must send a letter to the appellant acknowledging receipt of the hearing request.

A. Acknowledgment Letter

The acknowledgement letter is sent on the contractor’s letterhead. The contractor or HO uses the following language and format for acknowledging receipt of the request for a HO hearing. The language will need to be modified, depending upon whether it is the contractor or the HO assigned to the case that is sending out the acknowledgment.

A copy of the acknowledgement letter sent to the appellant must be sent to all other parties to the hearing regardless of whether the type of hearing desired is specified in the hearing request. The contractor writes the acknowledgement letter in accordance with the following specifications:

- If the type of hearing desired is not specified in the request, the contractor advise the other party(s) of his/her right to participate in an in-person or telephone hearing if one is requested. The contractor informs the other party that he/she must contact it within ** days if he/she would like to participate in the hearing (It is at your discretion to establish a reasonable timeframe). If the party contacts the contractor and would like information on when the hearing is scheduled, the contractor sends the party a copy of the scheduling letter. If an on-the-record hearing is requested, the contractor informs the party.

o If the appellant requested an on-the-record hearing in the request, the contractor simply sends a copy of the acknowledgement letter to the parties.

o If an in-person or telephone hearing is requested, the contractor may combine the scheduling letter and the acknowledgement letter as long as the letter is sent within 21 calendar days of the receipt of the hearing request. If the contractor does not combine the scheduling letter and the acknowledgement letter, it informs the other parities in the acknowledgement letter of their right to participate in the hearing. The contractor lets the party know that he/she must contact it with XX days if he/she would like information on when the hearing is scheduled. If the party contacts the contractor and would like to participate in the hearing, the contractor sends the party a copy of the scheduling letter.

NOTE: The contractor may use its discretion to determine how many days to allow a party to inform it that he/she would like information on when the hearing will take place.

MODEL ACKNOWLEDGMENT LETTER FORMATION

CMS alpha representation

PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

ACKNOWLEDGMENT OF REQUEST FOR PART B HEARING OFFICER HEARING [On a copy of the acknowledgement letter addressed to other parties, include a statemnt indicating that this is a copy of the acknowledgment of a request for a Part B Hearing Officer Hearing]

Date:

Appellant's Name

Appellant's Address

Appellant's Party Status (either beneficiary, physician, or other supplier)

RE:
Beneficiary:
Health Insurance Claim No.:
Claim Control No.:
Provider, Physician/Supplier Name:
Date(s) of service:
Type(s) of Service:

Dear Name of Appellant:

Your request for a Hearing Officer hearing was received on [date that hearing request was received in the corporate mailroom].

[If inserting paragraphs A1, A2, or A3, use one of the following sentences:]

A Hearing Officer will be assigned to this case who will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit. [OR]

I am the Hearing Officer assigned to this case, and I will make a new and independent decision based on the evidence in the case file and on any additional evidence that you would like to submit.

[**NOTE:** The HO inserts the appropriate "A" paragraph, found at the end of this section, here:

If an on-the-record was requested, the HO inserts A1.
If no specific type of hearing was requested, the HO inserts A2.
If appellant requests an in-person or telephone hearing, the HO inserts A3.]

[**NOTE:** The HO inserts the following two paragraphs if the appellant is a beneficiary:]

If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify.

In addition, volunteers at Medicare peer counseling programs in your area. See your Medicare Handbook for Insurance Counselors in your area or call 1-800-MEDICARE. [The HO completes the letter by providing their name and a phone number, as follows]:

If you need more information or have any questions, please do not hesitate to call the number provided at the top of this letter or to write to the address provided at the bottom of this letter.

Sincerely,

(Name of Individual)
(Title)
cc:
Beneficiary(s) [when beneficiary is not the appellant]
[Protect privacy if case involves multiple beneficiaries]
Provider/Physician/supplier
[if provider, physician, or other supplier has appeal rights or is acting as representative of the beneficiary] Representative [when applicable]

Medicare Government Services
12345 Dogwood Way, P.O. Box 567
Anytown, USA 09876-5432

A CMS CONTRACTED CARRIER

Standard "A" Paragraphs for Acknowledgment Letter

A1 - On-the-record decision requested

"You asked for a decision based on the record rather than an in-person or telephone hearing. Therefore, your file will be examined and a decision made based on the information we have. If you have additional information about your case that you want considered, please forward it to the above address as soon as possible. In most cases, a decision will be issued within 120 days of your request."

A2 - No specific type of hearing requested

"In your request you did not specify if you would prefer an in-person hearing, a telephone hearing, or a decision based on the information already in the file (called an On-the-Record Hearing). If you have additional information about your case that you want considered, please forward it to the above address as soon as possible. [At your discretion, you may send a self addressed, pre-paid post card that contains a checklist of hearing options with short explanations from which the appellant can choose. Or, you can call or otherwise contact the appellant to determine the type of hearing requested. If the appellant is a State agency, provider, physician, or other supplier, you may advise the appellant to contact you to state which type of hearing is being requested. Allow the physician or other supplier 14 days to indicate their preference. Notify the appellant that if his/her response is not receive in the allotted time, then an OTR hearing will be conducted.] In the copy to parties include: "**NOTE:**You have the right to participate in an in-person hearing or telephone hearing if one is requested. If you would like to participate in an in-person or telephone hearing if one is scheduled, please contact us within XX days."

A3 - In-Person or Telephone Hearing Requested

"A notice will be sent to you about your [indicate in-person OR telephone] hearing. The notice will contain information concerning the conduct of the hearing, the submission of evidence, and the issues to be decided. In most cases, your hearing will be held and a decision will be issued within 120 days of your request. If you have not received notice about scheduling your hearing within 90 days of submitting your request, contact us at the number above. If you have additional information about your case that you want considered, please forward it to the above address as soon as possible." {In copies sent to other parties (when the scheduling and acknowledgement letter are not combined) include: "If you would like to participate, please contact us within XX days so that we can provide you with the scheduling information."

60.14.5 - Case File Development

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

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 HO can make a correct and fair determination. Incomplete, missing or unintelligible evidence will inevitably lead to poor decisions and the incorrect payment or denial of Medicare claims. In addition, poorly developed case files can cause poor or incorrect appeal decisions at subsequent levels of appeal. Therefore, the contractor insures that all relevant evidence is included in the case file. This includes all evidence concerning the initial determination, including but not limited to: Medical Review, Fraud units, Coverage, Payment Policy, and other areas. If it maintains procedures and policies online, it may wish to note in the file where a specific policy and/or procedure resides in the system. This will make for easy download during the appeals process.

At the HO level, the HO must make every effort to ensure that all **relevant** information is included in the case file, and if the evidence is absent, the HO should instruct the carrier to provide the missing information. To facilitate this responsibility, when assembling the case file for the HO hearing, you or the HO must complete, sign, and attach to every hearing case file a Case File Summary Sheet. This sheet must have all of the information contained in the Model Case File Summary Sheet found below.

In addition to the above, the HO must make every effort to coordinate with the areas responsible for medical review (including pre- and post-payment review activities), and fraud and abuse units, in order to determine if there exists additional evidence for the case file as to why the claim was denied, and to provide such areas the opportunity to submit the most recent evidence, documentation, etc., into the appeals case file.

Evidence originating from the fraud unit should be included in the case file if it will not jeopardize a fraud investigation. If information from the fraud file is included in the file, then the appellant has a right to review that information. However, the adjudicator may not use such evidence to make an actual fraud determination, as the HO does not have legal authority to make a finding of fraud. However, this evidence may be used to determine whether the services in question were rendered, or were rendered as billed, or to assess the credibility of any party or representative. Such evidence may also be used to make coverage or payment determinations.

60.14.6 - Case File Preparation

(Rev. 1. 10-01-03)

B3-12016.6

The amount and variety of information that should be included in the case file can be quite extensive. To secure all relevant information, all areas that deal with claims processing and the review and denial of claims must coordinate among themselves. In order to promote standardization across all contractors, all evidence/documentation should be put into the case file in a set order prior to the HO hearing.

A. Coordination with Other Areas

The HO hearings area works with other areas to develop a mechanism to provide notification of requests for a HO hearing. Interested areas include, but are not limited to, the medical review and fraud units, MSP, overpayments, etc. The purpose of this mechanism is to secure and place in the case file all evidence or other documentation relevant to the appeal. It is within the contractor's discretion how it develops and implements this mechanism. For example, it may determine that the appeals unit will notify the medical review unit only when the appeal involves an overpayment determination that exceeds a certain dollar threshold. Or, for example, it may have the appeals unit develop a log-in of all requests for a HO hearing, that other units within the contractor can access and track.

B. Recommended Case File Order

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 on top. However, it does not place the medical documentation on the bottom. Although this documentation should generally be the oldest (as it presumably existed before the claim was submitted), it places it in a separate and distinct section about mid-way from the bottom. The bottom set of documents of the case file would generally contain all of the documentation from the initial claim determination.

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 copies for its records. If it is unable to include the original documents, it includes copies that are true facsimiles of the original documents. It arranges the following documents, in descending date order (i.e., claim form is on the bottom):

Procedural Documents

- Claim form or printout, if electronically generated (facsimile and/or screen prints are acceptable, include an explanation of what the fields mean if necessary);
- MSN/RA - older files may contain EOMBs or Denial Letters, which must also be included. (Facsimile and/or screen prints are acceptable, include an explanation of what the fields mean if necessary);
- Review request;
- Review determination;
- Hearing Officer hearing request [including envelope or image of the envelope];
- Acknowledgment of Request for a HO hearing; and
- Appointment of representative form (Form CMS-1696-U4 or Form SSA-1696-U4) or other written authorization, if applicable.

Medical Documents

- Medical records, separated by facility or doctor, in chronological order (most recent on top);
- Referral to/from contractor medical staff, with professional qualifications of the reviewer noted in the document, if applicable;

- Contractor medical policies and opinions relevant to claim(s). (In addition to contractor medical policy, the contractor should include in the case file any information it has as background to the particular policy at issue. For example, findings of the Contractor Advisory Committee (CAC) with regard to the policy, including professional publications relied upon to support the policy, opinions from professional medical societies who may have commented on the policy during the development phase, etc.) (See the Program Integrity Manual for additional information.);
- Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, regional medical review policies, newsletters, any other information used by the Hearing Officer;
- Any other exhibits that the contractor may consider important for the HO to consider (e.g., certification of reasonable charge, fee schedule information, notices of noncoverage, contractor publications, etc.); and
- Any additional evidence submitted by the appellant.

NOTE: This is the suggested case file order; the contractor is not required to use this order. However, it should make every effort to ensure that the appropriate documentation is in the case file. Using this case file order and arrangement will assist the HO in making correct and fair determinations and will expedite the process of preparing cases if appealed to the ALJ.

C. Recommended Method for Assembling the Hearing Officer Hearing File

1. The contractor uses a standard 9” x 12” folder or accordion folder. If a tape of the hearing transcript is included, it places it in an envelope and staples the envelope securely to the left hand side of the folder;
2. For aggregate 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;
3. For aggregate 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
4. The contractor groups procedural documents together in chronological order and groups medical documents together in chronological order.

D. Case File Summary Sheet

The Case File Summary Sheet documents the evidence included in the case file. It provides consistency and order to all the documents that are used to make the HO hearing decision. It allows anyone picking up the case file to quickly determine what documents are contained in the case file. The case file summary sheet itself is placed on top of the documents.

Following the HO hearing, there may be documents that the HO will add to the case file. The HO adds documents to the top of the case file, assigns an exhibit number, and amends the case file summary sheet to reflect the added documents. The contractor marks exhibits so that the last received have the highest number or letter. The HO may reference documents contained in the Case File Summary Sheet exhibits list in the HO decision.

E. Model Case File Summary Sheet

The attached model summary sheet should be printed on contractor letterhead, thereby providing easy identification of the contractor preparing it.

Model Case File Summary Sheet

1. Contractor Name:_____

2. Control No's._____

3. HIC#:____-___-____

4. Bene. Name (last, first):_____

5. Provider, Physician, Supplier No.:_____

6. Provider, Physician, Supplier Name: _____

7. Date(s) of Svs. (mm/dd/yy): ___/___/___ ___/___/___ ___/___/___

8. Appellant (check): Provider, Physician, Supplier: ___ Bene.: ___

8a. Rep's. Name _____ Rep for:_____

9. Claim(s): Assigned ___ Unassigned: ___

10. Hearing Requested: ____ ____On the Record

    ____ In Person _____Not indicated ____Telephone

11. Exhibits List:

    a) Claim form or printout, if electronically generated;

    b) MSN/RA;

    c) Review request;

    d) Review determination letter or MSN/RA;

    e) Hearing Officer hearing request;

f) Acknowledgment of request for a HO hearing

g) Appointment of representative form (Form CMS-1696-U4 or Form SSA-1696-U4) or other written authorization;

h) Medical records, separated by facility or doctor, in chronological order (most recent on top);

i) Referral to/from contractor medical staff, with professional qualifications of the reviewer noted in the document;

j) 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 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.)

k) Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, regional medical review policies, newsletters, any other information used by the Hearing Officer; and

l) Any other exhibits that the contractor may consider important for the HO to consider (e.g., certification of reasonable charge, fee schedule information, notices of noncoverage, carrier publications, etc.).

m) Additional evidence submitted by the appellant.

n) Other (describe or list)

12. Coordination with Other Areas:

MR Unit? Yes____ or No_____

Fraud Unit? Yes____ or No_____

Other_____? Yes____ or No_____

13. Form Completed By: _____ Phone No:_____

14. Date Completed:_____

NOTICE: THIS FORM AND ALL ATTACHMENTS ARE INCLUDED IN THE APPEALS CASE FILE AND ARE AVAILABLE FOR INSPECTION BY ALL PARTIES, BOTH BEFORE, DURING AND AFTER THE HO HEARING IS HELD.

Additions to Exhibits List (by HO)

Date Added: _____ Signature: _____

Instructions for Completion of a Hearing Officer Hearing Case File Cover Sheet

1. Self-explanatory

2. Control No.: Enter control numbers (optional)

3. through 10. Self explanatory

For multiple beneficiaries, see below.

11. Exhibits List:

Attach all applicable documents, either directly or by reference. Attachments should be collated and tabbed in the same order as they are shown on this form, with the oldest document or set of documents on the bottom, and the most recent document or set of documents on top.

12. Coordination with other areas:

Signifies notification of the Medical Review unit and Program Integrity unit(s) of requests for a HO hearing. It is the MR and PI units' responsibility to submit all relevant evidence not already contained in the case file.

13. Self-explanatory

NOTE: This form is intended to develop a full and complete appeals case file. The contractor attaches a separate sheet if additional space is needed.

Multiple Beneficiary Information

For cases involving multiple beneficiaries, the contractor attaches a separate sheet and includes the following information:

Beneficiary HIC#
Beneficiary Name
Date(s) of Service
Control No. (Optional)

THIS FORM AND ALL ATTACHMENTS ARE AVAILABLE FOR INSPECTION BY THE APPELLANT. CONTRACTOR DOES NOT INCLUDE ANY PROTECTED/PROPRIETARY MATERIAL IN THE HEARING PACKAGE

60.15 - Types of Hearing Officer Hearings

(Rev. 1. 10-01-03)

B3-12017

There are three kinds of hearings that an appellant may request: in-person, telephone, and on-the-record (OTR). The nature of the hearings differ with respect to the requirements they impose on the contractor, the hearing officer and the appellant(s), the method of presenting testimony, and the speed with which they can be conducted and a decision rendered.

In terms of development, use of consultants, and consideration and evaluation of the facts, the hearings are similar. The purpose of the hearing is to arrive at the correct decision about the issues in dispute. The appellant must be given the opportunity to decide the type of hearing that is best for the appellant. For administrative convenience in processing requests for a HO hearing, a POTR hearing and decision may, at times, be conducted by hearing officers, as appropriate. (See §60.15.4, below.)

60.15.1 - In-Person Hearing

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

The appellant and/or his/her representative is afforded the opportunity to present both oral testimony and written evidence supporting the claim, and to refute or challenge the information used to deny the claim or prior payment determination. An in-person hearing may not always be desired or requested by an appellant because it can be time-consuming, inconvenient, or unnecessary.

When an appellant does not request in-person hearing, the HO may hold an in-person hearing if the HO believes that the personal appearance and testimony of the party or parties, and/or of other witnesses, would assist the HO to ascertain the facts at issue in the case. The HO gives notice of the date, time and place to all parties, and conducts the in-person hearing. Failure of a party or the parties to appear at such in-person hearing is not the sole cause for a finding of abandonment. If the party fails to appear and fails to notify the HO that he/she could not appear, the party must show good cause for his/her failure either to appear or notify the HO that he/she could not appear. If a party fails to appear, the HO must mail a notice to the party giving him/her the opportunity to show good cause for not appearing. The HO allows the party 5 days to respond. If within 10 days, the party does not show good cause for failure to appear or notify the HO prior to the hearing, the HO dismisses the request based on abandonment by the party. (See 42 CFR §405.832(b) & §60.17.1.A.2, below.)

60.15.2 - Telephone Hearing

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

Telephone hearings offer a convenient and less costly alternative to some appellants and/or their representatives. They differ from in-person hearings by eliminating the need for the appellant or his/her representative to appear in-person. Oral testimony is presented and the opportunity exists for oral challenge. The appellant and/or his/her representative may also submit additional written evidence by mail or fax. Like in-

person hearings, telephone hearings are not for everyone, particularly those who may have difficulty presenting their cases. Some, for various reasons, may elect not to present oral testimony. In this situation, an OTR hearing is an available alternative.

Whereas telephone hearings are designed to lower costs and eliminate delays in conducting hearings, the HO may not require that a telephone hearing be held if an in-person hearing has been requested. However, the HO may offer a telephone hearing if:

- Telephone equipment (e.g., tape recorder, speaker phone, conference capability) permits a complete record of the hearing; and,
- Hazardous weather, or repeated rescheduling by the participants, or the appellant's physical health, or long distance travel, make an in-person hearing expensive and inconvenient to the party.

When an appellant does not request a telephone hearing, and has not requested an in-person hearing, the HO may hold a telephone hearing if the HO believes that the live, interactive testimony of the party or parties, and/or of other witnesses, would assist the HO to ascertain the facts at issue in the case. The HO gives notice of the date, time and call number to all parties, and conducts the telephone hearing. Failure of a party or the parties to participate in such a telephone hearing is not the sole cause for a finding of abandonment. If the party fails to call and fails to notify the HO that he/she could not call, the party must show good cause for his/her failure either to call or notify the HO that he/she could not call. If a party fails to call, the HO must mail a notice to the party giving him/her the opportunity to show good cause for not calling. The HO allows the party 5 days to respond. If within 10 days, the party does not show good cause for failure to call or to notify the HO prior to the hearing, the HO dismisses the request based on abandonment by the party (See 42 CFR § 405.832(b) & §60.17.1.A.2, below.)

There are times when the above criteria are met but a telephone hearing is not appropriate. These include:

- The beneficiary has requested an in-person or OTR hearing;
- Overpayment hearing request;
- Hearing request by assignees if the claims of more than three beneficiaries are involved, and the beneficiaries may be liable; or
- Witnesses are involved and the telephone equipment available does not permit more than a two-way conversation or a witness is reluctant to participate in a telephone hearing.

If the above conditions are met, the HO includes an explanation of the telephone hearing option in the "notice of time and place of hearing," and asks that the party reply concerning his/her preference for an in-person or telephone hearing.

If the party has evidence to present, the HO arranges to receive the evidence before the hearing and acknowledges its receipt. The acknowledgement can be by telephone or in writing (via fax, e-mail, or US mail). Include a notation in the case file of the action taken to acknowledge the receipt of evidence. If evidence is introduced during the hearing, the HO asks the party to explain, for the record, the portions the party considers important. The evidence should be identified so that it can be properly associated with

the hearing record. The documents should be submitted as soon as possible. The record is kept open until their receipt. If evidence submitted after a hearing reveals unresolved issues or raises new ones, another hearing may be requested.

The HO sends instructions for the telephone hearing to the party before the hearing, outlining the procedure to be used and the number to call to start the hearing. If necessary, the HO provides additional information at the time of the hearing.

60.15.3 - On-the-Record (OTR) Hearing and Decision

(Rev. 1. 10-01-03)

B3-12017.3

OTR hearings and decisions are identical to those rendered in the hearings described above, and follow the same instructions. The major advantage is the speed with which an OTR hearing can be held and decision rendered. The decision is based on the facts that are in the file, including any additional information obtained by, or furnished to, the hearing officer. If the appellant requests an OTR hearing, then the hearing officer will render an OTR hearing decision unless the HO decides that an in-person or telephone hearing would help the HO reach a better, fairer decision. If so, the HO will notify all parties of the time and date of either an in-person or telephone hearing, and explain why an in-person or telephone hearing will yield a better HO hearing decision. If the appellants refuse to appear or participate, then the HO renders an OTR hearing decision based on all the evidence the HO has gathered, including any expert or other testimony that has been gathered.

NOTE: Where an appellant specifically requests an OTR hearing, the resulting OTR hearing decision is not a POTR decision and the appellant does not have the further option of then requesting an in-person or telephone hearing.

60.15.4 - Preliminary On-The-Record (POTR) Hearing and Decision

(Rev. 1. 10-01-03)

B3-12017.4

Where either an in-person or telephone hearing has been requested, the HO may first prepare a decision based on the information in the file, including any information the appellant wishes to submit. This is called a POTR hearing decision. Whereas POTR hearings are useful in situations where the HO is able to issue a decision favorable to the appellant; that is not their only use. They may also be useful in situations where particular appellants routinely appeal the HO's decision to the ALJ level. They should be viewed as a tool to help the contractor and the HO manage the HO hearings caseload.

The HO may conduct a POTR hearing and issue a decision unless one of the following exceptions applies:

- Conducting the POTR hearing will significantly delay holding the in-person or telephone hearing;
- The HO believes that the facts of the case can be developed only through oral testimony (for example, in certain medical necessity cases);

- A different HO would not be available to conduct the in-person or telephone hearing should the appellant not be satisfied with the POTR hearing decision; or,
- Workload considerations do not support conducting POTR hearings. Such considerations would include information that the majority of OTR hearing decisions are not being accepted and appellants are requesting that an in-person or telephone hearing be conducted.

A. POTR Hearing

POTR hearings are designed as an administrative convenience in order to shorten the HO hearing process and to help the contractor and HOs manage their caseload. Appellants do not have the right to request a POTR hearing, nor is the decision of the HO to not issue a POTR hearing a decision subject to appeal. Hearing officers should evaluate the usefulness of issuing POTR hearing decisions on a case-by-case basis, but may not make a decision never to conduct POTR hearings (subject to the exceptions noted above).

B. Issuing POTR Hearing Decision

When issuing a POTR hearing decision, HOs use the same procedures for issuing a HO hearing decision, subject to the following requirements. The HO includes as the first paragraph in the POTR hearing decision a statement that although the appellant requested an in-person or telephone hearing, the hearing officer has rendered a decision based on the evidence in the file. The hearing officer includes a postage paid, pre-addressed postcard for the appellant or his/her representative to return (the postcard is included in the decision sent to the appellant if there is no representative, but is sent to the representative when there is a representative), either confirming that the appellant still wants an in-person or telephone hearing, or indicating that the in-person or telephone hearing is no longer desired.

NOTE: Instead of including a postcard, the contractor may advise the appellant or representative to respond to it by other means, including by phone, fax, or electronic mail.

If the amount in controversy after the POTR hearing decision is $100 or more, the postcard (or other means) shall also ask the appellant or representative to indicate whether the appellant plans to proceed directly to the next level of appeal, the Administrative Law Judge hearing. The HO explains in the OTR hearing decision that if the postcard is not returned or other means of contact initiated within 14 calendar days of the appellants receipt of the decision (and receipt is presumed to be within 5 days of the date on the OTR hearing decision), the POTR hearing decision will become final, and the appellant will lose his/her/their right to an in-person or telephone hearing. However, if the appellant contacts the contractor within 6 months from the date of mailing of the POTR hearing decision and requests an in-person or telephone hearing, the HO has the authority to hold the in-person or telephone hearing if the appellant can show that good and sufficient cause existed for not responding within 14 calendar days. Refer to §50.7 to determine if good cause has been demonstrated. If the appellant establishes good cause for not responding within 14 days of receiving the POTR hearing decision, the case is counted as a new case and allowed the full 120 days to conduct.

For workload reporting purposes, the contractor does not report the POTR hearing decision as final until after the 14 calendar days for requesting the in-person or telephone hearing have passed.

60.16 - Hearing Officer (HO) Authority and Responsibilities

(Rev. 1. 10-01-03)

B3-12018

60.16.1 - Hearing Officer Authority

(Rev. 1. 10-01-03)

B3-12018.1, AB-01-44

The HO occupies a significant position in the administrative appeals process. The authority of the HO is limited to the extent that the HO must comply with, and is bound by, all provisions of, and regulations issued under title XVIII of the Act. The HO may not overrule the provisions of the law or interpret them in a way different than CMS does if the HO disagrees with their intent; nor may the HO use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations.

The HO is also bound by CMS rulings, national coverage determinations, other policy statements, instructions, and guides issued by CMS, and contractor-issued local medical review policies (LMRP) and regional medical review policies (RMRP). The HO must consider the applicability of all LMRP or RMRP to the facts of a given claim, and the HO may not disregard or override an applicable LMRP or RMRP.

The HO hearing decision is a new and impartial consideration of the claim, and although the prior review determination is not binding upon the HO, it should be reviewed as part of a thorough review of the evidence contained in the case record.

60.16.2 - Qualifications and General Responsibilities

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

The contractor may designate as a HO an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology. The HO must be independent of the CMS contractor. The HO must have a thorough knowledge of the Medicare program and of the statutory authority and regulations upon which it is based, as well as CMS rulings, policy statements, and other instructions issued by CMS.

The following lists, in priority sequence, the type of experience that would be helpful to a Hearing Officer:

- Substantial experience with issues surrounding Medicare benefits;
- Experience working with adjudication of insurance claims;
- Experience working in a clinical setting; and
- Experience with administrative hearing procedures.

The individual selected must not have been involved in any way with the initial or redetermination at issue. Because the proceedings are nonadversarial, the HO should be particularly responsive to the needs of beneficiaries not represented. The HO must protect each party's rights, even if counsel represents them. The HO must safeguard the rights of all parties to the hearing while protecting the Government's interest.

The HO may bring unusual problems he/she encounters to the attention of the RO. The HO must differentiate between requests for policy clarification or updates versus "ex parte" communications with CMS staff with respect to a specific claim before him/her. "Ex parte" contact is forbidden. See §60.17.7 (A) (1) for examples of ex parte communication. The contractor may not restrict a HO from obtaining clarification from CMS on policy matters, nor from discussing problems with the RO.

The HO exercises control and conducts the hearing with order and dignity, regardless of the hearing type. The HO analyzes and evaluates evidence produced at the hearing, including testimony, documents or other written evidence in the record. The HO encourages the submittal of facts from individuals without causing unnecessary friction, and is objective and free of any influence that might affect impartial judgment. The HO is patient with all parties and witnesses, being particularly aware that Medicare beneficiaries are either older persons or those with physical and/or mental disabilities.

60.16.3 - Disqualification of HO

(Rev. 1. 10-01-03)

B3-12018.3

The HO should disqualify himself/herself from acting in a case in which he/she believes that he/she will have a personal prejudice against, or partiality toward, either the appellant and/or the representative; or with respect to any matter in which the HO has a personal interest; or in which a valid objection is raised by a party. (See 42 CFR 405.824, "Disqualification of Carrier Hearing Officer.") Disqualification is mandatory when a HO was involved in any way in the initial or review determination.

Reluctance to handle a particular case is not justification for disqualification. The HO should not disqualify himself/herself due to past or present participation in cases involving the same or similar issues or the same or similar parties and/or representatives. The HO withdraws only for the above reasons, keeping in mind that the primary objective of the HO hearing is to provide an appellant an impartial hearing.

Appellants have sometimes argued that the HO must be disqualified or dismissed because the HO is a contractor employee or is performing duties on the contractor's behalf. This is not good cause for disqualification. The U.S. Supreme Court has upheld the use of carrier employees as hearing officers for HO hearings ("Schweiker v. McClure," 456 U.S. 188 (1982)). The HO indicates that although he/she is not an officer of the Federal Government, he/she is nevertheless acting on the Federal Government's behalf and must comply with the provisions of the Medicare statute, regulations, and instructions.

If a party to a hearing suggests disqualification of the HO, the contractor includes the party's request and its basis in the record. The record will show the HO decision regarding the suggestion of disqualification and the basis for that decision. If the HO, on

his/her own initiative or upon objection of a party, disqualifies himself/herself, the HO informs the parties and advises them that the hearing will be rescheduled with a different HO. The HO must prepare a signed, written statement explaining the reasons for disqualification, and include the statement in the case file. If the HO does not withdraw, the objecting party may present objections at any time prior to issuance of the decision. The HO will include a justification for non-disqualification in the case file.

If the HO withdraws prior to scheduling the case for hearing, notice to the parties is not necessary. If a notice of hearing is issued prior to withdrawal, the HO notifies all parties in writing, informing them that the date set for the hearing has been canceled (if cancellation is necessary) and that an amended notice of hearing will be sent by the HO to whom the case is reassigned. If the motion for withdrawal and withdrawal occur at the hearing, the oral statements made as part of the record are sufficient.

If a party's pre-hearing objection is considered and the HO decides to conduct the hearing, the HO notifies the objecting party in writing, explaining the reasons and sends a copy of this notice to the other parties, e.g., beneficiaries, witnesses, representatives, etc. If the ruling not to withdraw is made at the hearing, the statement is included in the record.

60.17 - Hearing Officer Hearing Procedures

(Rev. 1. 10-01-03)

B3-12019

60.17.1 - Preparation for the Hearing Officer Hearing

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

For the HO to be fully informed, he/she must examine the claim prior to the hearing and, preferably, before the notice of hearing is mailed. The first step in preparing for the hearing is an examination of the evidence, including material submitted with the hearing request. Once the HO completes the examination of the evidence and the issues to be determined, he/she examines the applicable sections of the statutes, regulations, rulings, policy statements, general instructions and other formal guides. Additional information may be submitted during the hearing.

A. Dismissal of Hearing Request

The HO has authority to dismiss the request for a HO hearing under any of the following circumstances:

1. **Request of Party -** With the approval of the HO, a request for hearing may be withdrawn or dismissed at any time prior to the mailing of the hearing decision upon the request of the party or parties filing the request for such hearing. A party may request a dismissal by filing a written notice of such request with either the contractor, the HO, or by orally stating such request at the hearing. The dismissal of a request for hearing is binding unless vacated by the HO. (See subsection B, below.)
2. **Abandonment by Party -** The HO may dismiss a party's request for a hearing if both (a) and (b) are met: (a) neither the party nor the party's representative

appears at the time and place fixed for an in-person hearing or fails to call in for a scheduled telephone hearing; and (b) within 10 days after the mailing of a notice to the party by the HO to show cause for not appearing/calling, such party does not show good cause for his/her failure to appear/call and for his/her failure to notify the HO prior to the hearing that he/she could not appear/call. See 42 CFR § 405.832(b) and § 60.15.1.

3. **Dismissal for Cause -** The HO may, on his/her own motion, dismiss a hearing request, either entirely or as to any stated issue, under either of the following circumstances:

   Where the party requesting a hearing is not a proper party or does not otherwise have a right to a hearing; or

   Where the party who filed the hearing request dies and there is no information before the HO showing that an individual who is not a party may be prejudiced by the contractor's initial or redetermination.

4. **Amount in Controversy -** The HO may on the his/her own motion dismiss a hearing request where the amount in controversy is less than $100.

5. **Appointment of Representative Absent or Invalid -** The HO may dismiss when an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment 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.

6. **Failure to File Timely -** The HO may dismiss when the hearing request is not filed within the time limit required and the HO does not find good cause for failure to file timely.

7. **It is Clear the Claim Should Be Paid-** If it is clear based on the evidence in the redetermination file that the claim should have been paid, the HO may dismiss the case and order the contractor to adjust the claim to make payment in full

NOTE: In addition the HO or the hearing department is responsible for ensuring that the payment has been made in accordance with the HO's order.

B. Vacation of Dismissal

The HO may, on request of a party and for good and sufficient cause shown, vacate any dismissal of a request for hearing at any time within 6 months from the date of mailing the notice of dismissal to the party requesting the hearing. If the HO vacates the dismissal, the contractor counts it as a new case.

C. Dismissal Notice

The HO issues the written notice of dismissal to all parties to the appeal. The HO must include in the notice the information that at the request of a party and for good and sufficient cause shown, the HO may vacate his/her dismissal of a request for hearing at any time within 6 months from the date of the HO mailing of the notice of dismissal. The dismissal notice is sent to the party requesting the hearing at that party's last known

address, as well as to his/her representative. The dismissal notice includes the reason for the dismissal.

D. What Does Not Count as a Dismissal

The following is a list of items that do not count as dismissals:

(1) The contractor does not count misrouted correspondence as a dismissal.

(2) The contractor does not count a duplicate request for hearing as a dismissal. A duplicate request is considered an inquiry.

(3) The contractor does not count a hearing request received before a redetermination has been rendered as a dismissal, rather the contractor considers it an inquiry, unless the party has the right to a hearing in accordance with § 60.13.4 (claims for payment not acted upon with reasonable promptness and appeals of revised initial determinations where $100 or more remains in controversy.) When a hearing request is made before a redetermination has been processed, the contractor forwards the request to the redetermination unit and does not count a dismissal.

If the contractor incorrectly counted such correspondence as a hearing, it must use line 2 of the 2590 (adjustments to pending) to correct the count.

NOTE: If a decision and a duplicate request are crossed in the mail (e.g., the date of the decision and the post-marked date on the duplicate request are the same), no response or dismissal is needed.

60.17.2 - Scheduling the Date, Time, and Place of Hearing

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

An appellant who requests either an in-person or telephone hearing must be given adequate notice of the date, time and place of the hearing and the specific issues to be determined. The HO works with the appellant, or his/her representative, to schedule the date and time and, for in-person hearings, the place, as promptly as possible, subsequent to the HO's review of the evidence. The HO holds the in-person hearing at a location reasonably convenient to the appellant and the HO.

NOTE: All references to the appellant include references to the appellant's representative, when present. That is, if the appellant has appointed a representative, the representative becomes the primary contact for the HO, and it is the responsibility of the representative to keep the appellant properly informed of the proceedings and the appellant's responsibilities, if any.

The HO provides notice of the hearing at least 14 calendar days prior to a scheduled date. However, if the date and/or time set by the HO is not convenient for the appellant, the HO may contact the appellant by phone to determine a mutually acceptable time. With the appellant's concurrence, the HO may schedule a hearing with less than 14 days notice. If a non-appellant party wishes to participate in the hearing, then that should be considered in scheduling the hearing. The HO may schedule the hearing by sending written notice of the date and time and, for in-person hearings, place, or may contact the appellant by telephone, facsimile, or electronic mail in order to schedule the hearing, as long as the contact and agreement is documented in the case file. For notices by

facsimile or e-mail, the contractor must take care to include no information in the notice that is not permitted by the Privacy Act.

If the HO rendered a POTR hearing decision, although an in-person hearing or telephone hearing had been requested, and the appellant indicated an intention to proceed with the requested type of hearing, the contractor assigns a different HO to conduct it. That HO advises the appellant of the arrangements immediately upon confirming them.

NOTE: Where the appellant is a beneficiary**,** there may be rare cases where the beneficiary's physical condition may require the HO to schedule the hearing at a hospital or other convenient location, so that there is no infringement of the beneficiary's right to a hearing. In such situations, the HO advises the beneficiary that a telephone hearing is also available, but may not require it.

A. Written Notice of Hearing

The HO must provide a written notice to the appellant, and his/her representative, before conducting the in-person or telephone hearing. The notice provides information that the appellant will need to prepare effectively for the hearing. Failure to adequately inform the appellant of the nature and purpose of the hearing, including specific information as to the points at issue, may result in denying the appellant an essential element of the hearing. Therefore, the HO phrases this information to be easily understood by a layman while being technically correct and complete. The HO may transmit this notice to the appellant through the mail, by facsimile, or by electronic mail (no identifying information should be included in the fax or e-mail in accordance with the Privacy Act). The notice must get to the appellant before the hearing takes place and with sufficient time to allow the appellant to thoroughly review the notice and take any necessary actions in preparation for the hearing.

B. Elements of Written Notice of Hearing

The written notice sent to the appellant before the hearing must contain at least the following elements, as appropriate:

For Telephone Hearings

- Instructions for the telephone hearing, outlining the procedure to be used and the time and date when the call will take place. As necessary, the HO provides additional information at the time of the telephone hearing.
- Information about whether the HO will initiate the call or whether the participants are to call in, and what phone number will be used (e.g., whether the HO will call the appellant(s), or whether the appellant(s) are to call in) - this information can also be communicated by the HO to all appellants, witnesses, representatives, etc., via a phone call; the HO must document such communications in the case file.
- Notification of an appellant's right to request a copy of the case file prior to the telephone hearing.
- Notification prior to the start of the hearing that the proceedings will be electronically recorded. This should also be part of the opening statement made at the start of the telephone hearing.

- Notification that an interpreter can be used, if necessary, upon request of the appellant.
- Notification that the POTR hearing decision, if applicable, will prevail if the appellant does not appear for the scheduled hearing.

For In-Person Hearings

- Notification must include the place of the hearing, i.e., city, state, street address, floor, and designated room, as well as a telephone number of someone at the contractor/hearings office in case the appellant or someone else needs to contact the HO before the hearing.
- Notification that an interpreter can be used, if necessary, upon request of the appellant.

For both telephone and in-person hearings, the notice must

- State the purpose of the hearing and include a statement of the issues.
- Include a brief statement of the consequences of the proceeding and of the decision that will follow.
- State the right of the appellant to present briefs or affidavits in lieu of testimony.
- Inform the appellant of the effect of abandonment or a failure to appear at a scheduled hearing.
- Inform the appellant of his/her right to present oral argument.
- Inform the appellant of his/her right to be represented by counsel or other representative.
- Inform the appellant of his/her right to bring witnesses.
- Inform the appellant of his/her right to bring or send all evidence in his/her possession, including pertinent records, documents or other writings affecting the issues.
- Inform the appellant of his/her right to inspect the hearing file prior to the scheduled hearing.
- Inform the appellant that his/her representative has all the same rights and responsibilities as the appellant.
- Inform the appellant of his/her responsibility to promptly notify the HO in writing of any circumstances preventing the appellant from participating in the hearing as scheduled.
- Notification that an interpreter can be used, if necessary, upon request of the appellant.
- Notification that the POTR hearing decision, if applicable, will prevail if the appellant does not appear for the scheduled hearing.

NOTE: If an appellant indicates that his/her representative will pursue the appeal, and the file does not already contain sufficient documentation of representation, the HO must

either send Form CMS-1696-U4, Appointment of Representative form (see §100, Exhibit 1), or advise the appellant of the information that must be included on a written appointment of representative.

A copy of the written notice of hearing must be placed in the hearing case file.

60.17.3 - Adjournment and/or Postponement of Telephone or In-Person Hearing

(Rev. 1. 10-01-03)

B3-12019.3

As provided for in regulation, the HO may, for good and sufficient reason, schedule a new time and/or place for the hearing or adjourn on the HO's own motion upon reasonable notification to the parties. Good and sufficient reasons include, but are not limited to: sickness of a party, interpreter, or witness; difficulty in scheduling a witness; a person at the hearing (e.g., a party, a witness, or a representative) becoming verbally and/or physically violent or abusive; or, a delay in obtaining additional evidence. The HO includes a statement in the record explaining the reasons for adjourning or postponing the hearing.

A. Violent/Abusive Persons

The HO may immediately adjourn a telephone or in-person hearing if a person (e.g., a party, a witness, or a representative) becomes verbally abusive and/or physically violent during the course of the hearing. The contractor should consult with its RO on next steps. The RO may advise it to conclude an in-person hearing via telephone, and to conclude a telephone hearing by conducting an OTR hearing based on the evidence in the case file.

When an HO is scheduling a hearing for a party that has exhibited a history of verbal abuse and/or physical violence at prior hearings or in prior dealings with the HO or the contractor, the HO should schedule a hearing that provides for the safety of the HO and contractor staff. The contractor should consult with its RO in these situations.

B. Repeated Requests for Postponement

An appellant might repeatedly request postponement. The HO must evaluate the reasons that the appellant requested the postponements. If the HO determines that the appellant does not have a good and sufficient reason for the postponement, the HO need not grant the postponement. If the HO cannot justify rescheduling the hearing, and a POTR hearing was conducted, the HO notifies the appellant (in writing or verbally) that the POTR hearing decision will prevail if the appellant does not appear for the scheduled hearing.

If a POTR hearing has not been performed, the HO notifies the appellant (in writing or verbally) that a decision will be made based on the existing record, as well as any supplemental evidence added to the record, if the appellant does not appear for the scheduled hearing. The HO documents such notification to the appellant and the reasons for the HO's action in the file. When the HO believes that additional information is necessary, the HO should hold the hearing, and supplement the record as necessary. This could include obtaining oral testimony from, for example, a medical expert, or other

witnesses. In this situation, the HO gives the appellant advance notice that the telephone or in-person hearing will take place as scheduled, and advises the appellant that the appellant may participate.

60.17.4 - Pre-Hearing Review of the Evidence

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

The request for a HO hearing is filed with the contractor that processed the claim. If the request is filed elsewhere, e.g., with the local SSO, it is transferred to the contractor that processed the claim. This contractor sends the claim file to the part of its organization that conducts HO hearings, along with any additional evidence it thinks will support its decision. If the HO believes he/she needs more evidence from the contractor, e.g., more medical evidence, he/she makes the request to the appropriate department within the contractor. The contractor must comply with all requests for evidence made by the HO. The HO evaluates the evidence in the file, as well as any other documentary evidence the parties submit, before the hearing is scheduled. When evaluating the documentation submitted, the HO considers the reliability of the source, the factors present that may limit the impartiality or accuracy of the statements, and whether it is compatible or in conflict with other evidence. The HO determines whether there is sufficient documentation to make an impartial decision on the issue.

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 HO for inclusion in the case file. If other areas have information, the HO allows them no more than 2 weeks to submit the relevant information. Such evidence must be made available for inspection by an appellant upon request. The HO 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).

A. Witnesses

The HO may invite contractor witnesses to the hearing to clarify and/or explain a policy. Such witnesses could include, for example, the Contractor Medical Director, or a staff member from the medical review or fraud unit. The HO may also invite witnesses outside the contractor. The HO may not discuss a specific claim/appeal with contractor staff or outside persons without including all appellants and representatives in such discussion. See 60.16.2 for a discussion of ex parte communication. If the HO requests written information or opinion from a witness, the HO must provide copies to the appellant and representatives. This is to ensure that all information used or gathered by the HO is available to all appellants.

As necessary, the HO may ask the CMS Regional Administrator to issue a subpoena directing a witness to appear and testify.

B. Beneficiary Protection

Although the appellant is responsible for securing the needed evidence to support his/her claim, the HO works to protect a beneficiary-appellants rights by making every effort to insure that sufficient evidence is obtained, particularly when the decision is based "on-the-record." To the extent possible, the HO and the contractor help beneficiaries secure necessary information.

C. Conflicting Evidence

If the HO sees that evidence on some point is conflicting, inconclusive, or wholly lacking, the HO considers how it may best be resolved before scheduling the hearing. The HO may advise the appellant of the problem with the evidence and give the appellant an opportunity to resolve the conflict in evidence, the inconclusiveness of the evidence, or the complete lack of evidence. The HO may also consider obtaining the assistance of a consultative physician or other expert. To avoid delay that might result from the absence of a key witness or the lack of some essential evidence, the HO must make every effort to ensure that all evidence and witnesses will be available. The HO obtains additional necessary evidence to complete development of the case through appropriate channels from the contractor, the provider or supplier, or from any other source.

D. Admissibility of Evidence

Evidence may be considered even though it might be inadmissible under rules of evidence applicable to the courts. The materiality and relevance of the evidence are the controlling criteria with respect to admissibility of evidence at hearings, rather than the particular form in which it appears. The HO resolves doubts about including a particular document as an exhibit by including it, but determines the weight to be given to the evidence. Determining the issues and selecting the documentary evidence is especially important if the decision is based on-the-record.

60.17.5 - Forwarding Copy of Case File Prior to Telephone Hearing

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

The appellant has the right to request a copy of the case file prior to the telephone hearing. The appellant should be advised of this in the notice of the hearing. The contractor may also notify the appellant in the acknowledgement letter. (See §60.17.2.B.) Upon receiving such a request, the HO provides an appellant a copy of all documents in the case file, except the HO does not provide copies of documents that are already in the possession of the appellant or the appellant's representative (such as medical records that were received from the appellant). The contractor or HO includes a statement where documentation has been omitted because it is already in the appellant's possession. The HO sends documents to the appellant prior to the telephone hearing.

If the appellant has documentary evidence to present, the HO arranges to receive a copy of the evidence before the telephone hearing, and acknowledges its receipt either in writing (mail or fax) or via telephone. If documentary evidence is introduced during the hearing, the HO asks the appellant to explain, for the record, the portions the appellant considers important. The evidence should be identified so that it can be properly associated with the hearing record. If the appellant has documentary evidence to submit

after the hearing, the documents should be submitted as soon as possible but no later than the date set by the HO. The record is kept open until the documents are received, but will be closed if they are not received within the time limit set by the HO at the hearing. If evidence submitted after a hearing (but before a decision is issued) reveals unresolved issues or raises new ones, the initial hearing should be continued with an explanation why to the appellant.

60.17.6 - In-Person and Telephone Hearing Officer Hearing Procedures

(Rev. 1. 10-01-03)

B3-12019.6

The HO notifies the appellant or representative that there are major differences between a Hearing Officer hearing and a formal court proceeding. The hearing is nonadversarial in nature in that neither the contractor nor CMS is in opposition to the appellant, but is interested in a proper decision. Therefore, formal objections and other accepted court procedural tactics are not appropriate. Rules of evidence and proof are less restrictive than those used in court. The HO's role is that of an impartial trier of the facts, and the HO considers as evidence any testimony or documentation that enables him/her to make a correct decision.

During hearings, the HO questions participants to develop evidence and establish facts. For example: new evidence may be presented throughout the hearing; witnesses may be asked to testify more than once; appellants do not need to make a final statement; and, an appellant has the right of rebuttal after evidence adverse to the appellant's case has been presented.

A. Rights of a Party at the In-Person or Telephone Hearing

The rights that a party may exercise at a hearing stem from the basic right to due process. They include, but are not limited to, the right:

- To present oral arguments and/or written statements as testimony;
- To be represented by an attorney or other qualified individual (e.g., appointed representative (See §60.4), etc.);
- To bring witnesses to testify on the appellant's behalf;
- To bring and present all evidence in the appellant's possession, including pertinent records, documents, or other information;
- To question witnesses and other parties;
- To examine the evidence prior to and during the hearing, as well as to examine and comment on any evidence added to the record subsequent to the hearing, regardless of who supplies the evidence;
- To register objections to the inclusion of any document in the record; and,
- To respond to evidence adverse to the appellant's case.

The HO is responsible for making sure the parties are aware of their rights before the hearing begins. Usually this has already been done in the Notice of Time and Place of

the Hearing. (See §60.17.2, above.) However, if it appears to the HO that a party is not exercising his/her rights, the HO may also review one or more or all of them at any time during the hearing for the benefit of those present.

The HO gives all parties an opportunity to inspect the evidence before the hearing, so they may prepare for the case. However, for an in-person hearing, if the hearing itself is the only time available to review the evidence, the HO gives them an opportunity to inspect the evidence before the testimony begins. The HO or the HO's designee must always supervise a party examining evidence to ensure that nothing is removed, defaced, or added. When additional information is furnished after the hearing, parties have the opportunity to read it and offer comments.

B. Opening the Hearing

The HO opens the proceedings by stating that the hearing will be tape-recorded. The HO then introduces himself/herself, and explains that he/she will preside at the hearing. Next, the HO identifies the parties, their representatives and witnesses, and enters their names, official titles and interest into the record by giving their full names and their purpose in attending (e.g., Mr. John Jones is the beneficiary-appellant, and Dr. Ellen Smith is an expert witness). In rare circumstances, a stenographer will be used, in which case the stenographer should also be introduced.

The HO then formally opens the hearing with an opening statement. (See subsection C, below.) One purpose of the opening statement is to allow the HO to briefly summarize the purpose of the hearing and the issues involved. Appellants or representatives who disagree with the summary of the purpose and the issues are then given an opportunity to briefly respond if they disagree. After listening to the reasons for disagreeing, the HO then modifies the summary if necessary.

Once the opening statement has been read and agreed to, the HO begins taking testimony.

C. Opening Statement

The HO begins the hearing with an "opening statement," which sets the tone for the hearing, focuses attention upon its purpose and the issues involved, and explains how it will be conducted. The HO prepares the statement in writing in advance of the hearing.

Although the HO draws the contents of the opening statement from the facts of the specific case, the following is also included:

- Identification of the hearing by beneficiary's name and HICN(s), issue(s) involved, and the statement that the hearing is now open;
- The regulatory citation that provides for a party's right to a hearing, which, at time of publication, was: 42 CFR Part 405, Subpart H, 405.822 ;
- Identification of the HO in a statement of authorization for conduct of the hearing;
- A statement that the hearing will be conducted in an informal manner, and that the formal rules of evidence are not applicable;
- The procedural history concerning pertinent facts and dates, including facts revealed by documents in the contractor's file, e.g., entitlement to coverage under the supplemental medical insurance plan, deductible met, services covered, etc.;

- The issues to be resolved, the pertinent sections of the statutes and regulations, and how the two relate;
- Discussion of the penalty provision (see subsection D, below) for providing false or misleading statements;
- The need to speak clearly for the record as the hearing is being recorded; and,
- An explanation of the formal aspects of the hearing, including the following:
    - A formal record of the proceeding will be made;
    - The record will consist of the documentary evidence and the testimony;
    - Only one person will testify at a time;
    - The witnesses may be examined or cross-examined by the parties, their representatives, and the HO; and,
    - The parties may submit a statement or brief of proposed findings at the end of the testimony or after the close of the hearing.

Circumstances may require modification of the written opening statement. The HO includes in the statement any relevant occurrence or situation that warrants special mention.

After reading the opening statement, the HO asks the participants whether the opening statement is a correct and accurate account. If any misunderstandings are evident in the participant's responses, the HO clarifies them by offering suitable explanation(s). For hearings where no beneficiaries are participating or attending, the HO may decide to waive the reading of the opening statement into the record, but only if the appellant and all those present have been provided with a copy of the opening statement.

D. Oaths, Affirmations, and the Penalty Provision

The HO has no authority to administer oaths or affirmations. However, at some point during the opening statement, the HO advises the parties and witnesses of the penalties for false statements and/or misrepresentations. Since the following language may frighten/confuse some appellants, the HO does not have to read it verbatim, as long as the parties and witnesses are made aware of the penalties. However, the HO must read §1128B(a) to all provider or supplier appellants, even when the HO does not read the opening statement.

> Section 1128B(a) of the Social Security Act prohibits the making of false statements or representations of material fact in any application for a benefit or payment under Title XVIII; the concealment or failure to disclose any facts concerning benefits; or the conversion of payments made under Title XVIII for one person to the benefit of another. A provider, physician, or other supplier of items or services who takes such action may be found guilty of a felony and may be fined not more than $25,000 or imprisoned for not more than 5 years, or both. Any other individual who takes such action may be found guilty of a misdemeanor and fined up to $10,000 or imprisoned for not more than 1 year, or both.

E. Principles of Questioning

Generally, it is the HO who does the bulk of the questioning. This facilitates the proceedings by pinpointing the issues and eliminating those that are irrelevant or immaterial. This also helps hesitant and inarticulate witnesses. Where counsel is present, less questioning may be needed. Careful questioning helps ensure a fair and complete hearing record and decision. This may prevent the need for a second hearing. Generally, the requesting party begins with their testimony or that of their witness(es).

F. Record of the Hearing

The HO makes a record of the hearing. In most cases, the hearing will be tape-recorded. For both in-person and telephone hearings, the HO is responsible for making certain that a clear and audible tape recording is made of the hearing. In rare cases, the hearing will be recorded by other means. A typewritten copy may sometimes be made of the hearing.

Ordinarily, there will be little reason to go off the record. It may be desirable to do so for clarification, simplification, or to eliminate discussion on a matter that is not in dispute. The record is to include an explanation for going off the record if this procedure is used.

When directed by an ALJ, the Departmental Appeals Board, or CMS, the HO or the contractor should arrange for reproduction of copies of the hearing testimony and other documentary evidence.

When the RO requests a copy of the record of the hearing for sample review purposes, the contractor will provide a copy of the tape of the hearing (or a transcript, at the RO's request).

If the appellant or his/her representative requests a copy of the tape recording of the hearing record, the HO provides a duplicate cassette. The appellant may request a transcript of the hearing (even though the hearing was recorded on tape). The appellant must pay the cost of transcribing the tape recording of the hearing. The contractor waives the cost if it will cost $25.00 or less to provide a copy of the tape or to transcribe the hearing. It charges the full amount if it will cost more than $25.00. (See 42 CFR 405.833, "Record of Carrier Hearing.")

G. Continuance of Hearing

The following items may warrant a continuance:

- Evidence (e.g., certain testimony or a document) submitted at the hearing has taken the appellant or other party by surprise, is adverse to that party's interests, and presents evidence that the party could not reasonably have anticipated and is not prepared to meet;
- The HO expands the scope of the issues and either the appellant, another party or the HO needs to obtain additional evidence;
- New and material evidence is submitted during the hearing, and the HO and/or a party wants the opportunity to examine and evaluate it and respond, if appropriate; or,
- When the appellant is a provider, physician or supplier, there has been a limitation on liability determination pursuant to §1879 of the Act, and the issue of whether

the beneficiary knew or should have known that the item or service would not be covered is alleged by the provider, physician or supplier, then the beneficiary must be notified of the provider, physician or supplier's request for hearing and given an opportunity to respond to the issue.

If the affected party requests a continuance so that he/she may present additional oral testimony, the HO may grant the request unless other available means of rebuttal are clearly adequate. The HO continues the hearing if the HO discovers the need for testimony from an absent witness who would be available at another time.

H. Closing the Hearing

At the close of the hearing, the HO advises the participants that he/she will write a decision setting forth his/her findings of fact and rationale for the decision, and that he/she will send a copy to each party and each party's representative. The HO further explains that he/she will not make a decision at the hearing.

The HO then asks whether there is or will be further evidence to be presented, and whether the appellant and other parties will want to examine any evidence that may be received. If there is no response, the HO states that the hearing is closed.

If there is further evidence to be presented, the HO may leave the record open until after the evidence becomes part of the record. The documents should be submitted as soon as possible, but no later than the date set by the HO. The further evidence may also be faxed at the discretion of the HO. If necessary, the contractor requests that the information be mailed to it.

If, after the hearing is over but before the HO makes a decision, the HO receives additional evidence that could affect the decision to the disadvantage of any of the parties, the HO must give the affected party an opportunity to review and respond to the evidence. If the new evidence does not adversely affect any of the parties, the HO must still determine whether to reevaluate the hearing decision based on this evidence.

60.17.7 - The Hearing Officer Hearing Decision Timeliness

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

Ninety percent of all HO hearing decisions must be **issued** within 120 days of receipt of the request for a HO hearing (the 120 days starts on the date of receipt of the request in the corporate mail room). (See §1842(b)(2)(B)(ii) of the Act.)

The HO schedules hearings to meet the above timely processing requirement. As soon as practicable, but no later than 30 days after the hearing, the HO issues a decision based on the record developed at the hearing.

A Evidence Submitted After the Hearing

1. Evidence received after the hearing but before the decision is issued. Any evidence submitted by the appellant or other party after the hearing is held but prior to issuing the hearing decision should be considered by the HO (and may be considered by the contractor). Ex parte communications between the HO and contractor personnel is prohibited (also see §60.16.2). An example of ex parte communication is an off-the-record discussion between a HO and the medical director on the facts or merits of an

individual case. When this type of communication takes place, it must be on the record and offered to the appellant for examination and/or rebuttal. Discussions between a HO and contractor personnel regarding general clarification on a particular LMRP or coding issue do not rise to the level of ex parte communication as long as the communication does not involve the facts and/or merits of the case.

2. Evidence received after the hearing is held and after the decision is issued. Should the HO receive evidence after a decision is issued, and the amount in controversy is less than the required amount for an ALJ hearing or the period for filing a request for ALJ hearing has expired, the HO may reopen his/her decision (provided the conditions for reopening are met). Otherwise, the HO advises the appellant that further appeal is to the ALJ level. If an ALJ hearing has been requested, the HO does not retain jurisdiction and may not reopen the case, under any circumstance.

B. Limitations

In accordance with regulations, the HO's decision is binding upon all parties to the hearing unless it is reopened and revised by the HO, or appealed to an ALJ. However, the HO's decision is not a precedent decision and does not affect subsequent hearing decisions or alter contractor payment determinations on other claims.

C. Copies

The contractor or the HO mails the decision letter to the last known address of each party and authorized representative. The contractor or the HO retains a copy for the hearing file.

D. Letterhead for Written Correspondence

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

All HOs (including contractual and consultants) must use contractor letterhead for all notices and correspondence, including the hearing decision, and the letterhead must meet the letterhead written correspondence requirements referenced above. In addition, all notices, decision letters, etc., must state that the HO is an authorized HO for the contractor (include the name of the contractor in this statement). This statement can be added as part of the decision letter, and does not have to be pre-printed onto the letterhead itself.

E. Model Format and Required Elements for Hearing Officer Hearing Decision

The contractor's hearing area uses the following format and standard language paragraphs, as applicable, for HO hearing decisions.

Bold "NOTE:" indicates information for the contractor, and is not to be included in the decision letter itself.

Information contained in brackets ([which are underlined]) is to assist the contractor with specific information that must be added to the letter for each hearing decision.

- Bullet items contain guidance to assist the contractor with the content that will be specific and unique for each hearing decision. The guidance contained in the bullet items should also be removed from the decision letter itself.

CMS alpha representation

MEDICARE

PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

This is your MEDICARE PART B HEARING OFFICER (HO) HEARING DECISION

Date

Appellant's Name

Appellant's Address

Appellant's Party Status (either beneficiary, provider, physician, or supplier)

RE:

Beneficiary:

Health Insurance Claim No.:

Claim Control No.:

Provider, Physician/Supplier Name:

Date(s) of service:

Type(s) of Service:

Hearing Case No.:

NOTE: The HO uses one of the following:

This decision is **FULLY FAVORABLE**. You will receive a(n) [Explanation of Your Medicare Part B Benefits/Medicare Summary Notice/Remittance Advice] within [estimated time frame]. Please see below regarding further appeal rights**.**

OR

This decision is **PARTIALLY FAVORABLE**. You will receive a(n) [Explanation of Your Medicare Part B Benefits/Medicare Summary Notice/Remittance Advice] within [estimated time frame]. Please see below regarding further appeal rights**.** [If beneficiary is the appellant add a statement about financial liability.]

OR

This decision is **UNFAVORABLE.** Please see below regarding further appeal rights. The amount remaining in controversy is:_____. [If beneficiary is the appellant add a statement about financial liability.]

Dear [Name of Appellant]:

If the HO is issuing a preliminary on-the-record decision, but an in-person or telephone hearing was requested, the HO inserts the following:

> We guarantee you the hearing of your choice. However, first we prepare a decision based on the record because many appeals can be resolved this way**.** If you still want an in-person or telephone hearing, please use the enclosed pre-addressed postcard to indicate your choice. Please complete, sign and date this postcard in the spaces shown, and return the postcard within 14 days.
>
> If you wish to go forward with an in-person or telephone hearing, a new hearing officer will conduct the hearing**.** I will have no influence on the new decision. You or your representative will be able to provide information before, and submit additional evidence to, the new hearing officer.

NOTE: Introductory paragraph should include:

Type of hearing held, when and where;

For telephone and in-person hearings, who was present (if different from those testifying) and who testified;

Statement that the decision was made and on what basis, e.g., "This letter contains my decision based on...."

FACTS:

The HO includes all the relevant factual data that was part of the file prior to the hearing. This can include, but is not limited to:

- One sentence summary statement of the beneficiary's diagnoses (disease, ailment, etc.) for which the service/supply in question is being heard, if relevant to the decision.
- Brief mention of related events or history considered to be relevant to the decision in the case.
- Other relevant factual data bearing on the decision, including the date(s) and type(s) of service (or supply purchased); stated reason for initial determination; and date of contractor redetermination and the resulting determination; mention of relevant testimony and/or documents provided.
- Clear explanation of the actual amount of money allowed or adjusted.

ISSUE(S):

The issue(s) should be specific to the case rather than generic (i.e., the HO identifies the beneficiary, the provider and the specific service/supply as appropriate). The issue(s) statement should be stated as a question. For example, "Was _____(the service or item/supply received) covered under Part B of Medicare?" or "What is the appropriate allowed amount for _____(the services or items/supplies)?"

- For all claims where assignment has been taken and the denial is based upon §1862(a)(1) or (a)(9) or §1879(g), the HO must make a limitation on liability **determination** under §1879 of the Act (see §30.9) This analysis determines who is responsible for the noncovered services. The HO keeps in mind that

§1862(a)(1) denials are generally "medically reasonable and necessary" denials, but this section also includes other types of denials, such as denials for screening mammographies or screening pap smears when the number of tests performed in a given time period exceeds the frequency standards.

- For cases involving overpayments, the HO must determine who is financially responsible for the overpayment under §1870 of the Act (i.e., the without fault provision/waiver of recovery). This must be addressed as a separate issue. (See the Medicare Financial Management Manual, chapter 3, section 100.2 for more information in 1870).
- For cases involving physician refund issues, §1842(l)(1) of the Act must be addressed. (See the Medicare Financial Management Manual.)

In multi-issue cases, each issue for which a decision is made should be completely discussed before proceeding to the decision on the next issue.

DECISION:

A direct and unequivocal statement of the HO's decision. It should answer the question(s) asked under the **ISSUE(S)** section, above.

RATIONALE:

The HO gives a narrative description of the logic that led the HO to make the decision. Note again that statements such as "not medically reasonable and necessary under Medicare guidelines" or "Medicare does not pay for X" are conclusive in nature, and are not sufficient.

- The rationale may include, but is not restricted to:
    - Appellant's allegation, if any, constituting the reason for the hearing request, e.g., "You have alleged that the DME supplier did not inform you that the seat-lift chair may not be covered for Medicare payment."
    - Citations of the statutes, regulations, CMS rulings, national coverage decisions, Medicare Policy and Claims Processing Manuals, and local or regional medical review policies relevant to and surrounding the subject matter and issues involved in the hearing. When using Medicare manual language be sure it supplements a previously cited statute/regulation/coverage decision/ruling reference.

Narrative description of how these statutes, regulations, etc. relate to the specific case.

References to statutes, regulations, CMS rulings and national coverage decisions, should be case specific and should supplement or support the basis for the decision. For example, if the issue is home use oxygen, and the reason for denial is that the condition is angina pectoris, with no hypoxemia, the letter does not have to quote the whole discussion of that subject in the Medicare National Coverage Determinations Manual. The reference might simply state that, "CMS will not cover home use oxygen for angina pectoris in the absence of hypoxemia (See the National Coverage Determinations Manual, Chapter 4)."

- Other information that is relevant to support the decision in the case.

FURTHER APPEAL RIGHTS: ADMINISTRATIVE LAW JUDGE HEARING

If you are satisfied with this decision, you do not need to take further action. If you are not satisfied with this decision, and you meet the requirements for requesting an Administrative Law Judge hearing, you must act quickly to appeal.

The law requires that at least $100* remain in controversy for you to appeal this decision to the Administrative Law Judge (or ALJ) hearing AND that your request for ALJ hearing be made within sixty (60) days after your receipt of this decision.

If less than $100* remains in question, you may be able to combine the claim or claims that are the subject of this HO decision with claims from other recently issued HO decisions you have received (or may receive) to meet the $100* amount remaining in controversy requirement. This is called "aggregating claims" and more information is provided below.

You or your authorized representative (if you have appointed a representative) may write to request an ALJ hearing.

If you qualify for, and wish to request an ALJ hearing, you can request an ALJ hearing by writing to this office at the address below, to any CMS office, or to any Social Security Office within 60 days after you receive this decision. A qualified Railroad Retirement Board beneficiary may send a request for ALJ hearing to an office of the Railroad Retirement Board. Although you may include additional evidence with your request for ALJ hearing, you may also present evidence supporting your claim at the ALJ hearing itself.

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

HO inserts Contractor Address Here

YOUR AMOUNT IN CONTROVERSY [Optional for fully favorable decisions]: (If the appeal involves claims that were previously denied and are now found to be covered/medically reasonable and necessary, the HO's decision should use language along the following lines.)

As indicated above, the following claim(s) will be paid by Medicare (indicate claim control number(s) or date(s) of service): _____. You will be notified of the specific payment amount separately. The following claim(s) will not be paid by Medicare (indicate claim control number(s) or dates of service): _____.

The amount that remains in controversy for this/these claim(s) is $_____.

NOTE: The language in the above bullet will need to be modified if coverage is at issue for some of the claims involved in the appeal while the amount of payment is at issue for other claims involved in the appeal. In determination letters to beneficiaries where the provider or physician/supplier has aggregated claims involving numerous different beneficiaries, the HO does not include this section.

RULES FOR AGGREGATING CLAIMS:

To "aggregate claims" each claim included in your request for ALJ hearing must be appealed within sixty (60) days from the date the HO decision was issued on the claim, and each claim must have already received a HO hearing decision.

If you wish to request an ALJ hearing by combining the amounts remaining in controversy from other claims, you must state on your request for ALJ hearing that you are "aggregating claims," and you must list the claims on your request.

A party may aggregate claims to meet the required amount remaining in controversy requirement for an Administrative Law Judge hearing in one or more of the following ways:

1. An individual beneficiary may combine claims from two or more providers, physicians or other suppliers to meet the amount remaining in controversy requirement **IF** each claim has had a HO hearing decision issued **AND** the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request;
2. An individual provider, physician, or other supplier may combine claims from two or more beneficiaries to meet the amount remaining in controversy requirement **IF** each claim has had a HO hearing decision issued **AND** the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request;
3. Two or more beneficiaries may combine their claims for services received from either the same or different provider, physician, or other supplier **IF** the claims involve **common issues of law and fact**, **AND**, each of the claims has had a HO hearing decision issued, **AND**, the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request;
4. Two or more providers, physicians, or other suppliers may combine their claims **IF** the claims involve the delivery of **similar or related services** to the same beneficiary, **AND**, each of the claims has had a HO hearing decision issued, **AND**, the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request; or,
5. Two or more providers, physicians or other suppliers may combine their claims **IF** the claims involve **common issues of law and fact** for services furnished to two or more beneficiaries, **AND**, each of the claims has had a HO hearing decision issued, **AND**, the request for Administrative Law Judge hearing is timely-filed for all of the claims included in the aggregation request.

The Administrative Law Judge is responsible for deciding what are "common issues of law and fact" and what are "similar or related services." You may wish to include in your request for Administrative Law Judge hearing an explanation of why you think the claims that you have combined seem to involve either "common issues of law and fact" or why the claims are for "similar or related services."

NOTE: The language for aggregating claims may be modified when the amount in controversy for an ALJ hearing is met based on the HO decision or when the HO decision

is fully favorable (meaning when the Medicare approved amount minus any cost sharing provisions has been found payable). The modified language must state that the appellant has the option to aggregate claims to meet the amount in controversy requirement for an ALJ hearing and that the appellant may write or call the contractor if they would like further information on how to aggregate claims. The contractor must provide a phone number and address of where the appellant may request information on how to aggregate claims if the Rules for Aggregating Claims are modified in the decision letter.

HELP WITH YOUR APPEAL:

If the appellant is the beneficiary, the HO inserts the following paragraphs:

> If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, that will provide free advisory services if you qualify.
>
> In addition, volunteers at Medicare peer counseling programs in your area can also help you. If you would like more information on how to get in touch with a counselor, see your Medicare handbook for insurance counselors in your area or call 1-800-MEDICARE.

If the appellant is anyone other than the beneficiary and the decision is partially or wholly unfavorable, insert the following paragraph:

> If you want help with your appeal, there are groups, such as legal aid services, that will provide free advisory services if you qualify.

For all hearing decisions, conclude with the following**:**

> This decision applies only to the services and circumstances I considered on the claim(s) in question. If you want copies of the applicable statute, regulations and/or CMS Coverage Manual sections used in this decision, please let me know. Please attach a copy of this letter to your request. If you need more information or have any questions regarding your case, please contact me (or the hearing coordinator) at the above address (or add a telephone number of the hearing coordinator)**.**

Sincerely,

(Name of Hearing Officer)
(Medicare Hearing Officer)

HO Telephone Number _____cc:

Beneficiary
Send copy to beneficiary if the appellant was the provider, physician or other supplier. Protect beneficiary privacy if the case involves multiple beneficiaries.

Representative

As applicable, of beneficiary and/or of provider or supplier.

Provider/Physician/Supplier
As applicable, if appellant was the beneficiary and the provider/physician/ supplier has appeal rights or refund obligations.

60.18 - Effectuation of Hearing Officer Hearing Decisions

(Rev. 1. 10-01-03)

B3-12020

60.18.1 - General Rule

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

The contractor is to initiate effectuation of HO hearing decisions within 30 calendar days of the date of the decision, and effectuate 100 percent within 60 calendar days of the date of the decision. "Initiate Effectuation" for purposes of this section means the contractor completes the actions necessary to initiate the adjustment action in the claims processing system. 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 proper payment.

60.18.2 - Delaying Effectuation

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

If the contractor (which includes staff from the medical review unit, fraud unit, overpayments unit, etc.) believes that an HO's decision on a particular case is incorrect due to an error in interpretation of statute, regulation, manual, etc. it may ask the HO to reopen his/her decision. This is subject to the time limits and other parameters established by regulations and these instructions, below, and in §90. If an ALJ hearing has been requested, the HO does not retain jurisdiction and may not reopen the case.

It is not sufficient grounds for requesting a reopening if the contractor simply disagrees with the conclusion reached by the HO, but cannot show a legally supportable basis for its disagreement. Reopening is not to be pursued in situations where persons could reasonably reach different conclusions based on the evidence in the case file. If a contractor is confused, it may consult the RO for advice on whether a reopening is necessary.

NOTE: If the HO has dismissed a request for a HO hearing, the contractor may ask the HO to vacate the dismissal order.

60.18.3 - Elements of Written Request for Reopening

(Rev. 1. 10-01-03)

B3-12020.3

The contractor must provide a copy of its request for reopening to the head of the hearings department, or such unit in its organization that oversees the HO hearing function. The request itself must state the specific grounds on which the contractor believes that the HO's decision is incorrect. This could include citations to applicable statutes, regulations, CMS rulings, national coverage determinations, CMS instructions, and local or regional medical review policies issued by the contractor or the RO.

60.18.4 - Notice to Parties of Reopening Request

(Rev. 1. 10-01-03)

B3-12020.4

The contractor must provide written notice to all parties to the HO decision that it has asked the HO to reopen the HO decision. (See 42 CFR 405.842, "Notice of Reopening and Revision.")

60.18.5 - HO Reply to Reopening Request

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

If the HO determines that a revised HO hearing decision is necessary, based upon the reopening authority instructions contained in §90, then the HO must issue such revised HO hearing decision within 120 calendar days of receipt of the written request for reopening. The revised HO hearing decision is sent to all parties. In the case of a revised HO hearing decision, all parties have the right to request an ALJ hearing if they are not satisfied with the revised HO hearing decision and if they meet all requirements for requesting ALJ hearing.

If the HO determines that revision of the HO hearing decision is not appropriate, based upon the reopening authority instructions contained in §90, then the HO must advise the contractor in writing within 15 days of receipt of the written request for reopening.

60.18.6 - Notice to Parties of HO Determination

(Rev. 1. 10-01-03)

B3-12020.6

If the HO issues a revised HO hearing decision, it is sent to the parties. If the HO determines that he/she will not revise the hearing decision, the HO must advise all parties in writing that the HO hearing decision has not been revised.

60.18.7 - Payment of Interest on HO Decisions

(Rev. 1. 10-01-03)

For guidance on how to make payment of interest subsequent to a Carrier or FI HO decision, refer to Chapter 3 of the Medicare Financial Management Manual.

60.19 - Requests for Part B Administrative Law Judge (ALJ) Hearing

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

If a party to the HO hearing is dissatisfied with the HO's hearing decision and the amount remaining in controversy is $100* or more, the party is entitled to a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration. (See 42 CFR 405.815 - Amount in controversy for the HO hearing, ALJ hearing and judicial review.) This function is currently performed by ALJs employed by the Social Security Administration's Office of Hearings and Appeals (SSA/OHA). The ALJ hearing results in a new decision by an independent reviewer.

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

60.19.1 - Right to Part B ALJ Hearing

(Rev. 1. 10-01-03)

B3-12026.1

To receive an ALJ hearing, the party must file a written request for a Part B ALJ hearing with the contractor, at an office of the RRB (in the case of a qualified RRB beneficiary), or with CMS, or at an office of the SSA, within 60 days of the date of their receipt of the HO's decision. It is presumed that the appellant received the HO's decision within 5 days of the date of the HO's decision, unless there is a reasonable showing by the appellant to the contrary.

For the convenience of parties, CMS provides a form that may be used to request a Medicare Part B ALJ hearing. The contractor provides copies of the form to parties upon request. (See §60.28, Exhibit 4.) It is not necessary, however, that this form be used to make a written request.

60.19.2 - Forwarding Requests to SSA/OHA

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

Requests for Part B ALJ hearings are forwarded with the case file to the "SSA/OHA Division of Medicare - Part B" at the address below.

Only the ALJ or the DAB has the authority to dismiss a request for ALJ hearing. This applies even when it appears that the request does not meet the jurisdictional requirements for requesting an ALJ hearing (e.g., the amount remaining in controversy or timely filing requirements do not appear to have been met).

However, if all prior levels of appeal have not been exhausted (i.e., either a HO hearing or a redetermination has not been conducted), the contractor treats the request for ALJ hearing as a request for a HO hearing or for redetermination and processes the appeal request.

A. Address for Office of Hearings and Appeals

With the exception of "Big Box" cases, the FI forwards all requests for Part A ALJ hearings, with the case file, to the local hearing office of the SSA's Office of Hearings and Appeals. If necessary, the FI obtains this address from the SSO. The FI sends "Big Box" cases to:

SSA/Office of Hearings and Appeals
Division of Medicare-Part A
5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

Requests for Part B ALJ hearing (other than QIO or HMO/CMP) must be forwarded, along with the case file (see below for the case file requirements), to:

SSA/Office of Hearings and Appeals
Division of Medicare-Part B

5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

Phone inquiries about the status of a request for Part B ALJ hearing should be directed to:

Division of Medicare - Part B
(703) 605-8550

B. Time Limit for Forwarding

The contractor forwards a request for Part B ALJ hearing, along with the appeals case file, within 21 calendar days of its receipt of the request in the corporate mail room. For aggregated cases that exceed 40 beneficiaries or claims, it forwards the case file within 45 calendar days.

C. Implied Requests for ALJ Hearings

Sometimes appellants will send a letter to the contractor after a HO hearing expressing their dissatisfaction with the hearing results, but do not clearly state that they are requesting an ALJ hearing. In this instance, the contractor must contact the appellant and clarify whether the appellant wishes to request an ALJ hearing. The contractor informs the appellant of what the appellant needs to do to request an ALJ hearing, and advises the appellant that the letter he or she sent protects the filing date.

60.19.3 - Case File Preparation

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

The documents in the case file should be arranged in the order indicated below. The contractor places any additional documentation in the case file prior to forwarding the file to SSA/OHA. It confirms that all applicable documents listed on the case file summary sheet are included in the case file, or if not included, that the case file summary sheet indicates that the document was not received. It may include its analysis of why the request does not meet the jurisdictional requirements for requesting a Part B ALJ hearing. This may be included in a cover sheet or other transmittal document submitted with the case file.

The contractor does not modify the order that documents appear on the exhibit list, and uses tabs for where each exhibit would appear, even if it is not available for the file. Behind each tab, it places the exhibit, or, where the exhibit does not exist, a statement saying that the exhibit is missing or was not provided by either the contractor or the provider, physician, or other supplier, as appropriate. It includes a statement that “these are the complete records submitted to Medicare from the provider, physician, or other supplier as of this date _____,” and places this on top of the medical records and behind the appropriate tab.

It uses a standard 9” x 12” folder or accordion folder. It attaches the entire case file to the right side of the folder. It leaves the left side empty.

As resources allow, the contractor makes a folder for each beneficiary or for each claim at issue with all of the information (documentation, relevant regulations, contractor instructions, rulings, etc.) contained in that folder. This becomes important when an ALJ or the DAB either makes a determination or issues a remand order on some, but not all,

of the claims in an appeal. This ensures that information on each claim stays with the claim/appeal.

The contractor includes in the case file a Contacts List identifying which unit(s) within the contractor originally worked on the case (e.g., medical review, fraud & abuse, overpayments, Medicare secondary payer, etc.) and lists the name, phone number, fax number, and E-mail address of staff in these unit(s) who can be contacted for further information. It lists its Web site along with other useful Web sites (e.g., www.cms.hhs.gov, www.ssa.gov, www.hhs.gov.)).

Finally, as appropriate, it may include a list of expert witnesses in the geographic area who are available to testify.

The contractor sends all information together in one package. It avoids sending information in piecemeal to OHA. It is very difficult for OHA to track down to whom the files have been sent and therefore cannot associate documentation that comes in late or in separate envelopes with the original case file. When a case involves multiple boxes, the contractor numbers them as part of a set (i.e., box 1 of 5, box 2 of 5, etc.)

A. Documents in the Appeals Case File

The case file must contain the items listed below, arranged in descending date order (i.e., oldest on bottom and most recent on top with all procedural documents preceding all medical documents). Form CMS-3509 (version 8/02 or more current) must be placed on front cover of the case file. The contractor disregards earlier versions of this form. Aggregated cases containing 40 beneficiaries/claims or more and $40,000 or more in controversy (considered "big box cases") are assembled using a **Primary File** as described below.

NOTE: For applicable items, the contractor sends **originals** and retains copies for its records. If it is unable to send the original documents, it sends copies along with a letter on contractor letterhead and signed by a manager certifying that the copies are true facsimiles of the original documents.

Whether the hearing request is for Part A or Part B, the contractor includes the following.

Procedural Documents

Claim form or printout, if electronically generated (facsimile and/or screen prints are acceptable, with an explanation of what the fields mean included if necessary);

- Medicare Summary Notice (MSN)/ Remittance Advise (RA) - older files may contain EOMBs or Denial Letters, which must also be included. (Facsimile and/or screen prints are acceptable, with an explanation of what the fields mean included if necessary);
- Redetermination request;
- Redetermination;
- HO hearing request, if applicable;
- HO hearing decision, if applicable;

- Original request for Part A or Part B ALJ hearing (including envelope or image of the envelope); and
- Appointment of representative form (Form CMS-1696-U4 or Form SSA-1696-U4) or other written authorization, if applicable;

Medical Documents

- Medical records, separated by facility or doctor in chronological order (most recent on top);
- Referral to/from contractor medical staff, with professional qualifications of the reviewer noted in the document, if applicable;
- Copies of FI, carrier, or program safeguard local medical review policies, or regional medical review policies upon which the HO relied, if applicable;
- Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, newsletters, any other information used to make a determination; and
- Any other exhibits that the contractor considers important for the ALJ to consider (e.g., some cases will involve fee schedule information, some will have tape-recorded hearings).

B. Case File Assembly for "Big Box Cases"

For aggregated requests filed by a provider, physician, or other supplier that involve 40 beneficiaries/claims or more, and $40,000 or more in controversy, the contractor organizes the case file in the following manner:

1. It creates a **Primary File** (sometimes referred to a master file) using all the documentation that is common to all the aggregated claims. It clearly identifies on the file cover that it is the Primary File. The information in this file should include:
    - Copies of FI, carrier or program safeguard contractor local medical review policies, or regional medical review policies upon which the HO relied;
    - Copies of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, CMS manuals, newsletters, any other information used to make a determination;
    - HO hearing request, if the same for all beneficiaries;
    - HO hearing decision, if the same for all beneficiaries;
    - Request for Part A or Part B ALJ hearing including envelope; and
    - Tape of the HO hearing in labeled envelope with identifying information stapled securely to the inner left hand side of the file, if applicable.

    The **Primary File** number should correspond with the HIC number of the first case in the group of aggregated claims organized alphabetically by beneficiary last name. The contractor places this beneficiary's individual claim information, as described below, in this folder preceding the information that is common to all

aggregated cases. It separates this information with a tab or blank sheet of paper. It labels the tab or blank sheet of paper with the full name of the beneficiary, Medicare HICN, and date(s) of service involved.

Form CMS-3509 (version 9/02 or more current) must be placed on front cover of the case file. The contractor places a list of all the aggregated cases on top of the documents located in the primary file.

2. The contractor creates **individual claim folders** using all the documentation that is **specific to each individual beneficiary**. In creating individual claim folders the contractor adheres to the following guidelines:

   - It separates medical documents for each beneficiary into separate folders. If the documentation is minimal, it may use tabs to separate the documentation.
   - It labels each folder cover or tab with the name of the beneficiary. It includes the beneficiary's full name, Medicare HICN, and date(s) of service involved on the folder cover or sheet of paper.
   - It identifies the Primary File on the folder cover or sheet of paper.
   - It organizes the medical documents for each beneficiary in descending date order (i.e., oldest on the bottom and most recent on the top).
   - It organizes the aggregated cases alphabetically by beneficiary last name.
   - It provides a complete set of procedural documents for each beneficiary excluding any documentation that is common for all the aggregated cases (e.g., if the same hearing decision and laws apply for all beneficiaries in the case, it includes only one set in the master file).
   - It makes sure each individual beneficiary folder in the "big box case" makes reference to and identifies the **Primary File** to which it is associated.

   The individual folders must contain **all** the procedural and medical documents listed and be organized in the same order as described above in subsection (A), excluding any of the documents that are common to all the aggregated cases.

   NOTE: Subsequent adjudicators do not have access to the fee schedule database. The HO that relied upon this database in making the HO hearing decision should either include a copy in the case file, or be ready to produce it upon request by any subsequent adjudicator.

C. Assembling the File

The contractor assembles the file in the following manner:

- It uses a standard 9" x 12" folder or accordion folder. If a tape of the hearing is included, it places it in an envelope, labels the envelope with identifying information, and staples the envelope securely to the inner left hand side of the folder;

- For aggregated requests filed by a beneficiary, it 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;
- It groups procedural documents together in chronological order and groups medical documents together in chronological order. (Most recent on top and oldest on bottom.); and
- It attaches the most current version of the Form CMS-3509 to the front cover of the file.

D. Requests for Information

It is within the authority of an ALJ to request contractor input, or to request documentation from the contractor. If the contractor is invited to attend and/or testify, or to submit additional information, at an ALJ hearing, it shall do so (as its resources allow). It works with all its interested staff (e.g., medical review, fraud and abuse, overpayments, to provide additional documentation, witnesses, etc. in response to the request. If it has any questions regarding its participation, it shall contact its regional office for guidance. However, it may not disregard a subpoena issued by an ALJ, unless otherwise instructed by CMS CO or RO.

60.19.4 - Case Tracking System

(Rev. 1. 10-01-03)

AB-02-126

Contractors must establish a uniform case tracking system for the preparation and mailing of case files from the contractor's Appeals Unit to the OHA.

A. Package Preparation

After preparing case files for transmittal to OHA (which includes attaching Form CMS-3509 on the front of all files), the contractor must prepare a spreadsheet (the Document Index) which identifies each file that will be included in the mailing (i.e., box or envelope) to OHA and the following details about each file:

- Beneficiary name;
- Beneficiary HICN;
- Provider name and number;
- Contractor's document control number (DCN);
- Dates of service;
- Reconsideration or Hearing Officer hearing decision date;
- Date request for ALJ hearing was received;
- Claim count and an indicator if the service was Part A or Part B (i.e., 100-A);
- Amount in controversy;
- Docket number, where applicable (space is left blank for OHA to fill in); and

- Single-file case or multi-file case (include reference to single- or multi- and the number of files involved, i.e.,- a multi-file case with 100 files would be denoted as Multi-100).

Contractors may not change the heading titles or order of the headings when developing the document index spreadsheets.

Contractors must place all headings on the spreadsheet in the order above, as listed above, horizontally across the top of the spreadsheet, with specific file information appearing below the columns. For example: Beneficiary Name	Beneficiary HICN	Provider Name and Number	Document Control Number	Date(s) of Service	Recon/Hearing Officer Hearing Decision	Date Request for ALJ Hearing Received	Claim Count and A/B	Amount in Controversy	Docket Number (if Applicable)	Single file or Multi-file

Contractors must place this Document Index on top of all of the files in the mailing. When OHA receives the mailing, it reviews the spreadsheet and the contents of the mailing to ensure that all of the files listed on the spreadsheet are present. The contractor must continue to provide its contractor name and number, a contact name, mailing address, and phone number on the Form CMS-3509. It must include its fax number as a header or footer to the spreadsheet. Once OHA has checked the mailing for completeness and has assigned Docket Numbers (if applicable) to the case files, OHA fills in the docket numbers on the spreadsheet and mails and/or faxes the completed spreadsheets back to the contractor on a flow basis, with the average length of time being monthly. If contractors do not receive the spreadsheet after 45 days have elapsed, they should contact the courier service to ensure that the package was delivered. If the package was delivered, then they should contact OHA and request a status. With the implementation of this process, both OHA and the contractor will have access to the case tracking numbers each uses at their respective organizations, so that if a file is missing, sufficient information is available to begin a search.

NOTE: If a contractor is transmitting unrelated case files (i.e., some consisting of multi-file cases and some containing single-file cases) in the same mailing, it must make certain that cases with multiple files are physically separated from single file cases. For example, if there are 100 file folders that make up 1 case, those file folders should be bound by a rubber band or a cord before being placed with the other files in the package.

B. Mailing

When mailing the package of files to OHA, contractors shall utilize a courier service that provides ground tracking of the packages they deliver. The courier service must be able

to track every package and be able to provide the package's location upon request. Contractors should retain the tracking slip in the event the package becomes lost.

60.19.5 - Acknowledgment of Request for Part B ALJ Hearing

(Rev. 1. 10-01-03)

B3-12026.4, AB-01-62

The contractor acknowledges the appellant's request for ALJ hearing by sending the ALJ a letter that utilizes the format and Sample Paragraphs contained in §60.19.6, below, within 30 calendar days of its receipt of the request in its corporate mail room.

60.19.6 - Model Format for Acknowledgment of ALJ Hearing Request

(Rev. 1. 10-01-03)

B3-12026.5

CMS alpha representation

MEDICARE
INTERMEDIARY
or
PART B CARRIER
or
PART B DMERC (A/B/C/D)
Appeals Phone Number

Date

Appellant's Name

Appellant's Address

Appellant's Party Status (either beneficiary, provider, physician, or supplier)

RE:

Beneficiary:
Health Insurance Claim No.:
Claim Control No.:
Provider/Physician/Supplier Name:
Provider/Physician/Supplier Medicare Number:
Date(s) of service:
Type(s) of Service:
Hearing Case No.:

Dear (Name of Appellant):

We have received your request dated [date of ALJ hearing request] for a Part B administrative law judge (ALJ) hearing. We are forwarding your file to the Social Security Administration's Office of Hearings and Appeals (SSA/OHA) in Falls Church, VA, for processing. SSA/OHA will assign an ALJ to your case who will then contact you regarding the time and date of your ALJ hearing.

If you have any questions about your request, you may contact SSA/OHA directly at: (703) 605-8550.

Or you may write to SSA at the following address:

SSA/Office of Hearings and Appeals
Division of Medicare-Part B
5107 Leesburg Pike, Suite 502
Falls Church, VA 22041-3255

If there is anything else that I can help you with, please do not hesitate to call me at [phone number at contractor].

Sincerely,

(Name of Contact Person at Contractor)

cc:

Representative [if applicable]

Beneficiary [if appellant is the provider, physician or other supplier; be sure to protect beneficiary privacy if the case involves multiple beneficiaries]

Provider, Physician, Physician or other Supplier [if appellant is the beneficiary and the provider/physician/supplier has appeal rights]

60.20 - Effectuation of Part B ALJ Decisions/Dismissals

(Rev. 1. 10-01-03)

B3-12028

The ALJ will either: (1) issue a decision based on the request for Part B ALJ hearing; or (2) issue an order of dismissal of the appellant's request for Part B ALJ hearing.

The contractor is required to review each ALJ decision in a timely manner in order to determine whether there are effectuation responsibilities. As part of this review, it is to identify those ALJ decisions and dismissals that meet the guidelines for recommending Agency Referral (formerly known as the Protest Process). Its responsibilities relative to recommending Agency Referral are contained in §60.21, below.

60.20.1 - Review and Effectuation of ALJ Decisions - General

(Rev. 1. 10-01-03)

B3-12028.1

In many cases, the ALJ's decision will require an effectuation action on the contractor's part. The contractor does not effectuate based on correspondence from any party of the hearing. It takes an effectuation action only in response to a formal decision. "Effectuate," for purposes of this section, means for the contractor to complete the necessary action relative to complying with the decision. In most cases, it will be clear what action is required in order to effectuate the ALJ's decision. If it is not clear, or the contractor cannot determine how to effectuate the decision, it should contact its RO for guidance. As necessary, its RO may send a letter to the ALJ asking for clarification on

how to effectuate the decision. If a clarification from the ALJ is necessary, the contractor should consider the clarification the final determination for purposes of effectuation. If effectuation of a favorable or partially favorable determination will be delayed, the contractor advises the appellant that a clarification of the ALJ decision has been requested.

Some ALJ decisions will be straightforward and effectuation will be relatively simple. For others, the decision may require extensive research on the contractor's part. When effectuating an ALJ's decision the contractor uses the payment policies in effect on the date the claim was first submitted for processing, unless specifically directed otherwise.

60.20.2 - Effectuation Time Limits

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

A. No Agency Referral

If the ALJ decision is partially or wholly favorable, gives a specific amount to be paid, and there is no agency referral to the DAB, the contractor effectuates within 30 days of receipt of the official ALJ decision. The official ALJ decision is a signed copy of the ALJ decision.

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 official ALJ decision.

NOTE: Carriers may receive an official decision from either the ALJ or from the ALJ clearinghouse. The carrier effectuates from the first received official decision, to effectuate because it needs information from the case file to calculate the amount payable, it effectuates within 30 days of receipt of the case file.

If the decision is unfavorable, it effectuates within 30 days of receipt of the case file from the ALJ clearinghouse.

If clarification from the ALJ is necessary, the carrier considers the date of the clarification the final determination for purposes of effectuation. If clarification is needed from the 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 carrier considers the date of receipt of the clarification the final determination for purposes of effectuation.

B. Agency Referral

Where CMS submitted an agency referral to the DAB, the contractor does not effectuate until 30 days after the DAB decision or when advised by the RO, whichever is sooner.

1. If DAB accepts the agency referral for review, CMS advises the contractor to delay effectuation until DAB takes further action.
2. If DAB declines to review agency referral, CMS advises the contractor to effectuate the decision.

60.20.4 - Misrouted ALJ Case Files

(Rev. 1. 10-01-03)

B3-12028.4

There may be times when the contractor receives a case file or ALJ decision that has been misrouted to it. If it receives a case file that does not belong to it, it forwards the case file back to the ALJ clearinghouse (the contractor who has responsibility for tracking ALJ cases). It sends a transmittal letter along with the case file stating that the case file has been misrouted to it. It lists any easily identifiable information on the transmittal sheet, such as the docket number. It sends a copy of the transmittal letter to the NY RO office at:

Centers for Medicare & Medicaid Services
New York Regional Office
Division of Beneficiaries, Health Plans and Providers
Attention: ALJ Decision Tracking
26 Federal Plaza, Room 3800
New York, NY 10278-0063

The contractor may want to consider keeping a log of misrouted ALJ case files indicating the date received, date sent back to the ALJ clearinghouse, and any easily obtainable identifying information, such as the docket number, beneficiary name(s), Provider name, service date(s), ALJ decision date, DCN, etc.

60.20.5 - Duplicate ALJ Decisions

(Rev. 1. 10-01-03)

B3-12028.5

If the contractor receives duplicate ALJ decisions on the same case, it must bring this to the attention of its RO and OHA immediately. In these cases the OHA will take the necessary steps to resolve the issue. For example, one ALJ may vacate their decision. The contractor takes the necessary steps to advise the appellant of its actions.

60.20.6 - Payment of Interest on ALJ Decisions

(Rev. 1. 10-01-03)

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

60.21 - Recommending Agency Referral of Part B ALJ Decisions or Dismissals to the CMS RO

(Rev. 1. 10-01-03)

B3-12029

The process of CMS recommending agency referral of a Part B ALJ decision or dismissal to the DAB is initiated by the contractor or by CMS. If the contractor determines that an ALJ's decision/dismissal should be forwarded to the DAB, it prepares a draft Memorandum of Agency Referral and forwards it to the CMS RO.

60.21.1 - Time Limits for Forwarding Agency Referral Memorandum to CMS RO

(Rev. 1. 10-01-03)

B3-12029.1

The contractor has 30 days from the date of the ALJ decision/dismissal to review the ALJ decision or dismissal, develop the recommended agency referral memorandum, and forward the draft memorandum and case file to the lead CMS RO for its region. The lead RO may grant an extension to it of the 30-day timeframe on a case-by-case basis. However, the RO must get agency referral to the DAB by the 40th day.

NOTE: Problems concerning time limitations, or nonreceipt of case files, should be brought to the attention of the RO in a memorandum separate from any recommended agency referral.

60.21.2 - Guidelines for Reviewing ALJ Decisions/Dismissals

(Rev. 1. 10-01-03)

B3-12029.2

The DAB may review an ALJ's decision/dismissal if

- There was an error of law;
- The ALJ's decision/dismissal was not supported by substantial evidence;
- The ALJ abused their discretion; or
- There is a broad policy or procedural issue that may affect the general public. This could include an LMRP or RMRP that is well supported by the medical standards and practice in the contractor's jurisdiction but which the ALJ has disregarded for insufficient reasons or without explanation.

The ALJs are required to follow the Act and applicable regulations issued thereunder, CMS rulings, and all national coverage decisions based on §1862(a)(1) which have been published in either a CMS manual or the "Federal Register."

NOTE: In order to assist in the review of ALJ decisions by the DAB, material (i.e. the decision and case file) for decisions not favorable to the appellant or cases dismissed by the ALJ will be held for 120 days by a CMS designated specialty contractor. If the appellant requests a DAB review, the DAB will request that the designated specialty contractor forward the material to it. If, after 120 days, the DAB has not requested any material, the CMS designated specialty contractor will forward the material to the contractor servicing the appellant.

60.21.3 - Draft Agency Referral Memorandum Content

(Rev. 1. 10-01-03)

B3-12029.3

If a contractor is dissatisfied with a decision, or with the ALJ's order of dismissal, it should suggest to the lead RO that the decision/dismissal be referred to the DAB. The agency referral memorandum should clearly set out the reasons why:

1. There appears to be an abuse of discretion by the ALJ;
2. There is an error of law;
3. The action, findings or conclusions of the ALJ are not supported by substantial evidence; or
4. There is a broad policy or procedural issue that may affect the general public interest.

The contractor writes the memorandum using a formal tone, does not reference the regulations that govern the DAB taking own motion review, and avoids using confrontational or accusatory language.

The DAB considers new and material evidence if it relates to the period on or before the date of the ALJ decision or dismissal. If new and material evidence is submitted, the DAB considers the additional evidence only if it relates to the period on or before the date of the ALJ's decision or dismissal.

The contractor does not include complaints concerning the time limitations for submission of agency referrals or of nonreceipt of ALJ decisions/dismissals or case files in the draft memorandum.

Each memorandum should name only one beneficiary, unless the ALJ decision or dismissal lists more than one name. The contractor uses care to ensure the privacy of each beneficiary. If the RO submits the agency referral memorandum to the DAB, a copy of the agency referral memorandum is sent by the RO to all parties to the appeal. To comply with privacy requirements, a general memo can be prepared, and the contractor can attach a list of beneficiaries. The RO will then be able to send a separate letter with the memorandum to each beneficiary.

60.21.4 - Draft Memorandum Format

(Rev. 1. 10-01-03)

B3-12029.4

The contractor uses the following format and guidelines for the memorandum sent to the lead RO:

Date _____

From _____

Subject Recommended Agency Referral of Medicare ALJ Decision Dated _____

To CMS Regional Office

Refer to

Beneficiary:

HIC No.:

Docket No.:

Provider, Physician or Other Supplier:

Processing FI, RHHI, Carrier or DMERC:

Date of ALJ Decision

Summary: This ALJ decision or dismissal is recommended for agency referral because _____
_____
_____
_____.

The basis for recommending agency referral is:

_____
_____
_____.

The contractor includes signature, title, date and phone number of person submitting memorandum to RO at the end of the memorandum.

60.21.5 - Submission of Draft Agency Referral Memorandum to CMS RO

(Rev. 1. 10-01-03)

B3-12029.5

The contractor sends the draft memorandum and case file to the lead RO within the time limits discussed above. The Dallas RO has the lead for submitting agency referrals for the Dallas region. The Atlanta RO has the lead for submitting agency referrals for the Atlanta region. The New York RO has the lead for submitting agency referrals for the other eight regions. The CMS region with oversight of each contractor is a valuable resource for helping the contractor determine whether to recommend agency referral of an ALJ decision or dismissal, and should be utilized.

If CMS sends the agency referral to the DAB, the RO will send a copy of the memorandum (including any attachments) to the following:

- The beneficiary (or their estate);
- The beneficiary's representative, if applicable;
- The provider, physician, or other supplier providing the item or service;
- The servicing contractor;
- Anyone else to whom the ALJ issued a copy of the decision or dismissal; and
- The CMS Central Office appeals area

60.22 - Effectuation of Departmental Appeals Board (DAB) Orders and Decisions

(Rev. 1. 10-01-03)

B3-12032

60.22.1 - Background

(Rev. 1. 10-01-03)

B3-12032.1

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 Departmental Appeals Board (DAB) review. The DAB reviews requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs. (See 42 CFR 405.856.)

60.22.2 - Requests for Case Files

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

When the DAB 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 DAB will request all case files from the specialty contractor who has responsibility to receive and store the files sent by ALJs following their decisions. In some cases, where the file is not available from this contractor, the DAB must then determine which Medicare contractor has the case file and must then ask that contractor to forward the case file to the DAB. Each contractor must comply with the DAB's request for the case file, supplying the actual case file in the exact order and manner as it received it from SSA/OHA. It forwards the requested case file within 21 calendar days of receipt of the DAB's request to the DAB. It is responsive to DAB requests. It maintains a log of all requests made by the DAB for case files, noting the date of the request, the manner in which it was made, the name of the contact, any identifying information given, and its response.

If the contractor is unable to locate a case file that falls under its jurisdiction, it must recreate the case file within 60 days. If it determines that the case file does not fall under its jurisdiction, it must notify the DAB in writing within 14 calendar days of receipt of the DAB's request, with a copy to the contractor's RO.

A. Procedures for Master Case Retrieval for the DAB

A master record/master file is a single beneficiary claim (already identified by an SSA-assigned docket number or HICN) that is identified by the ALJ as the master record as a result of a consolidated hearing addressing a large number of claims. The ALJ places the generally applicable documents in the master (record) file as enumerated exhibits. This is done to formally enter the material into the administrative record.

If, following the issuance of the ALJ's decision(s), an appeal or agency referral is filed with regard to any claim addressed in a consolidated proceeding, the DAB must retrieve the appealed/referred claim(s) as well as the related master record in order to review all portions of the administrative record. Accordingly, the contractor must give precedence

to DAB requests for master records. The DAB will identify master records, if known, when making folder requests. When the DAB requests master records from it, the contractor forwards the master record files as compiled by the ALJ, including all hearing tapes, to the DAB as expeditiously as possible (no later than 21 days from the DAB request). If a copy is made, the contractor retains the copy and sends the original ALJ compilation to the DAB.

60.22.3 - Contractor Effectuation Responsibilities

(Rev. 1. 10-01-03)

B3-12032.3

When a contractor receives a decision from the DAB that requires effectuation on its part, it initiates effectuation within 30 days of its receipt of the DAB decision, and completes effectuation within 60 days. Should it have any questions regarding effectuation, it contacts its RO for guidance.

60.22.4 - Payment of Interest on DAB Decisions

(Rev. 1. 10-01-03)

For guidance on how to make payment of interest subsequent to a DAB decision, refer to Chapter 3 of the Medicare Financial Management Manual.

60.23 - Request for U.S. District Court Review by a Party

(Rev. 1. 10-01-03)

B3-12033

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 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:

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

Then the contractor sends a copy to that address and notifies its RO immediately.

60.24 - Effectuation of U.S. District Court Decisions

(Rev. 1. 10-01-03)

B3-12034

The U.S. District Court (Court) may remand the case to the DAB or ALJ for further proceedings.

In rare cases, the Court will issue an order that will require effectuation by a contractor. In this situation, the contractor contacts its CMS RO appeals contact for further instructions before taking any action.

60.24.1 - Payment of Interest on U.S. District Court Decisions

(Rev. 1. 10-01-03)

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.

60.28 - List of Exhibits

(Rev. 1. 10-01-03)

B3-12999

Exhibit 1 Appointment of Representative - Form CMS-1696-U4
(**Available at** http://www.cms.hhs.gov/forms/)

Exhibit 2 Request for Review - Part B Medicare Claim - Form CMS-1964
(**Available at** http://www.cms.hhs.gov/forms/)

Exhibit 3 Request for Hearing - Part B Medicare Claim - Form CMS-1965
(**Available at** http://www.cms.hhs.gov/forms/)

Exhibit 4 Request for Part B Medicare Hearing by an ALJ - Form CMS-5011B
(**Available at** http://www.cms.hhs.gov/forms/)

Exhibit 16 Model Letter to Supplier or Independent Practitioner

Exhibit 17 Recommended Responses to Requests for Reopenings

Exhibit 18 Special Notice to Physicians Suppliers and Other Independent Practitioners

Exhibit 19 Reopenings Policy

Exhibit 16 - Model Language to Supplier or Independent Practitioner

(Rev. 1. 10-01-03)

If you decide to appeal this decision, we ask that you submit documentation to support your appeal. Forwarding this information **with your appeal** will facilitate processing and payment, if appropriate.

Only you can decide on the documentation that best supports your claim. Nevertheless, you may want to consider the following:

- X-Ray reports
- Test results
- Medical history
- Documentation of severity or acute onset
- Consultation reports
- Billing forms
- Referrals
- Plan of treatment
- Nurse’s notes
- Copies of communications between physician and/or beneficiary, hospital, contractor laboratory, etc.

If you are unsuccessful in obtaining information, let us know. We will assist to the extent we can.

Exhibit 17 - Recommended Responses to Requests for Reopenings

(Rev. 1. 10-01-03)

Model Paragraphs

Additional Information - Refusal to Reopen - Appeals Process Available

You are not entitled to a reopening as specified in Federal regulations since there are administrative appeals available to you. We are, therefore, considering your letter a request for (here, specify the type and level of appeal, e.g., reconsideration, review, HO hearing, or hearing by an Administrative Law Judge).

Additional Information - Refusal to Reopen

We understand that you are still dissatisfied with the final decision in your case and that you have exhausted your appeal rights. Medicare policy, however, is to reopen final decisions only to correct clear errors in those decisions. These errors include:

- Factual errors which are found when new and material evidence, which was not available when the final decision was made, is presented;
- Clerical or computational errors;
- Errors on the face of the evidence; and
- Errors caused by fraud or similar fault.

Since your present request for reopening does not include evidence to indicate that any of these types of errors were made in your case, we are denying your request to reopen. If, however, you have such evidence, please submit it to us, and we will consider your request for reopening again.

Exhibit 18 - Special Notice to Providers, Physicians, Suppliers and Other Independent Practitioners

(Rev. 1. 10-01-03)

The purpose of this notice is to inform you of your appeal rights under Part B of the Medicare Program.

Appeals

Law and regulations provide specific redress for parties who are dissatisfied with Medicare determinations. Through these appeals, the Government seeks to ensure the correct payment is made, or a clear and adequate explanation is given as to why payment is not made.

Part B Appeals

As a provider, physician or supplier providing items and services to Medicare beneficiaries payable under Part B, you may appeal an initial determination if you:

- Accepted assignment on the claim; or
- The provider/physician/supplier did not accept assignment on the claim and we denied the claim as not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the service would not be covered, requiring you to return to the beneficiary any money you have collected for these services; or
- You are acting as the duly authorized representative of the beneficiary.

If you are dissatisfied with Medicare's initial determination and the determination is subject to appeal, you may request a review. This request must be in writing, signed, and filed within 120 days after the date of the initial determination.

If you remain dissatisfied after the review determination, and the amount in controversy is at least $100, you may request a Hearing Officer (HO) hearing. Requests for HO hearings must be filed, in writing, within 6 months following the date of the review determination. You may combine this claim with other claims to meet the $100 amount in controversy requirement as long as the appeal is timely filed for all claims at issue and all claims at issue are at the proper level of appeal. You may request a hearing in-person, by telephone, or on-the-record. If you request an in-person or telephone hearing, it will be scheduled, but in the interim the Hearing Officer will make a decision based on the claim record, including any information you submit with the hearing request.

If you are still dissatisfied following the on-the-record decision, you will receive the hearing previously scheduled. Moreover, a different hearing officer will be assigned to preclude any possibility of prejudice.

If you are still dissatisfied with the determination made by the hearing officer, and the amount in controversy is at least $100, you may request an in-person hearing before an Administrative Law Judge of the Social Security Administration. The request must be in writing and filed within 60 days of the date of the contractor's HO hearing decision of record.

You may combine this claim with other claims to meet the $100 amount in controversy requirement as long as the appeal is timely filed for all claims at issue and all claims at issue are at the proper level of appeal.

Development of Appeals

For individual claims submitted by providers, physicians, and others who furnish items and services to Medicare beneficiaries, the responsibility for gathering and submitting documentation that supports claims and appeals rests with the provider/physician/supplier. We will offer guidance and assistance as necessary, but the responsibility for identifying what is needed and where it is located is your responsibility. If you have made efforts to secure essential documentation, but are unable to secure the information, we will try to assist you. Attached is a list of documentation sources that have proven useful to providers/physicians/suppliers. If you have any questions on other kinds of information that may be necessary, let us know. We will assist to the extent we can.

Reopenings

Reopenings are not, in a legal sense, appeals. They are actions taken after a claim is closed to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed.

Reopenings should be done rarely, on individual cases, or on a group of cases adversely affected by a systems error.

Some FIs and carriers have developed a variety of informal procedures under the general heading of “reopenings.” These informal actions can extend the appeals process by subjecting claims to unnecessary and superfluous levels of review which delay access to the formal levels of appeal, with their respective procedural safeguards.

The cause for these reopenings has frequently been the failure of parties to submit supporting documentation on time. The timely submittal of documentation not only negates the perceived need for “reopenings,” but also helps to ensure the timely payment of claims.

The effect on you as appellants will be minimal because you may appeal through the regular appeals process. Reopenings are not appeals. They are discretionary actions, initiated by us at our own volition or in response to a request by a beneficiary or provider, physician, or other supplier, and then only after the appeal rights provided by law are exhausted.

Exhibit 19 - Reopenings Policy

(Rev. 1. 10-01-03)

Reopenings Policy

This paper outlines the legal and policy bases for our position on contractor reopenings, and for the restriction on quasi-appeals (informal reopenings) of claims.

Parties with appeal rights may wish to revisit the determination once these appeal rights are exhausted. However, although the party has the right to request a reopening, the case law makes it clear that a reopening is not a matter of right, but is a decision left to the discretion of the Secretary. The Supreme Court has held that the Secretary's decision not to reopen a case is entirely a matter of the Secretary's discretion, and is not an appealable determination. "Califano v. Sanders," 430 U.S. 99, 97 S. Ct. 980 (1977); "Lopez v. Heckler," 469 U.S. 1082, 105 S. Ct. 583 (1984). (Although the regulations specifically authorize the Secretary to reopen decisions within one year for any reason, the Supreme Court has held that the Secretary's decision not to reopen a case, unless challenged on constitutional grounds, is entirely a matter of the Secretary's discretion, not reviewable by the courts.) "Califano v. Sanders, supra."

Thus, the Secretary can be held to only his own criteria for reopening, as set forth at 42 CFR 405.841, and the good cause provision in 20 CFR 404.989.

A reopening of a contractor claim decision, irrespective of the level to which the decision is appealed, is conducted at the discretion of the Secretary or the Secretary's agents (Contractors, Hearing Officers, Administrative Law Judges, and the DAB).

The 42 CFR 405.841 permits the contractor to reopen:

1. Within 12 months of the date of the initial or revised determination for any reason acceptable to it.
2. After 12 months, but before four years of the date of notice of the initial or revised determination, for good cause, which is defined at 20 CFR 404.989 as:
    a. New and material evidence;
    b. Clerical or computational error; or
    c. The evidence that was considered clearly shows on its face that an error was made.
3. At any time:
    a. When a decision is unfavorable, to correct a clerical error or error on the face of the evidence;
    b. For fraud or similar fault; or
    c. In response to a court order.

The CMS policy is to reopen only after appeal rights are exhausted, or the time limit for requesting an appeal has expired.

If the reason for denial is appealable to SSA rather than to you, refer the reopening request to SSA, and advise the party of your action. Following are the two denial reasons appealable to SSA:

a. Beneficiary is not entitled to Part B; and

b. Beneficiary is not eligible for benefits.

70 - Part A and Part B Quality Improvement and Data Analysis Activities

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

There are administrative costs associated with conducting each level of appeal, with the cost increasing at each subsequent level. Therefore, contractors should try to resolve appeals at the lowest level possible. Establishing and maintaining a Quality Improvement program based on a Data Analysis program is an operational tool to help contractors achieve the goal of identifying and eliminating unnecessary appeals. Such a tool can assist contractors in identifying deficiencies in the appeals process and enable contractors to take the necessary steps to correct them. A well developed Quality Improvement/Data Analysis program also allows contractors to provide feedback to other program areas, including provider education, program integrity, and medical review.

In general, contractors' approaches to quality improvement should be evolving and adaptable to the issues that they are dealing with at their site and in the current claims/appeals environment. As a contractor finds and resolves issues, its focus should change to another area requiring attention. Similarly, methods of resolving problems should change periodically. While the reports have standard information requirements, the contents will change as improvements are made and new issues surface.

70.1 - Workload Data Analysis Program

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

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. For Hearing Officer (HO) hearings, contractors must, at a minimum, gather data from a 10 percent or 50 per month (whichever is less) randomly selected sample, and for Administrative Law Judge (ALJ) cases, at a minimum, a 10 percent or 10 per month (whichever is less) randomly selected sample. 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.

Data should be collected from each level of appeal as follows:

A. Data Analysis of Part A Redeterminations

Data Analysis on redeterminations shall focus on identifying:

- The reasons for full or partial reversals, such as:

    - Submission of documentation that should have been submitted with the initial claim
    - Submission of documentation that was previously requested by Medical Review (MR) through an Additional Documentation Request (ADR)
- Claims that were denied due to medical review edits and the outcomes of these claims on appeal
- Providers who submit a high volume of requests for redeterminations and whose initial claim denials are frequently reversed at the redetermination level
- Reasons for dismissals
- Types of services and/or issues that are appealed most frequently
- Types of services and/or issues that are overturned most frequently
- The percentage of redeterminations that result in full reversals, partial reversals, and complete affirmations (e.g. no change was made)

B. Data Analysis of Redeterminations

Data Analysis on redeterminations should focus on identifying:

- The reasons for full or partial reversals, such as:
    - Initial claims processing system errors,
    - Initial claims processing errors made by the physician/supplier/provider, such as incorrect diagnosis codes
    - Submission of documentation that should have been submitted with the initial claim
    - Submission of documentation that was previously requested by MR through an ADR
- Claims that were denied due to medical review edits and the outcomes of these claims on appeal
- Providers, suppliers and/or physicians who submit a high volume of requests for redeterminations and whose initial claim denials are frequently reversed at the redetermination level
- Reasons for dismissals
- Types of services and/or issues that are appealed most frequently
- Types of services and/or issues that are overturned most frequently
- The percentage of redeterminations that result in full reversals, partial reversals, and complete affirmations (e.g. no change was made)

C. HO Hearing Decisions

Data Analysis on HO hearings should focus on identifying:

- The reasons for full or partial reversals, such as:

    - Reviewer errors;
    - Submission of documentation that should have been submitted with the initial claim; and
- Claims that were denied due to medical review edits and the outcomes of these claims on appeal
- Providers, suppliers and/or physicians who submit a high volume of requests for HO hearings and whose initial claim denials are frequently reversed at the HO Hearing level
- Reasons for dismissals
- Types of services and/or issues that are appealed most frequently
- Types of services and/or issues that are overturned most frequently
- The percentage of hearings that result in full reversals, partial reversals, and complete affirmations (e.g. no change was made)

D. ALJ Decisions

Data Analysis on ALJ Decisions should focus on identifying:

- Reversals where it appears that the contractor Hearing Officer or redetermination adjudicator made an error;
- Reversals that reference §1879 of the Act as the reason for the reversal; and
- Reversals from ALJs who frequently disagree with your determinations or HO decisions.

70.2 - Quality Improvement Activities

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

Quality Improvement program must involve four general functions:

A. Corrective Action

A Quality Improvement program takes **corrective actions** in response to any problems identified by the results of the contractor's Data Analysis program. Examples of corrective actions that may take place as a result of Data Analysis include:

- Educating providers, physicians, suppliers, intermediary/carrier staff, and/or beneficiaries;
- Correcting claims processing errors, if applicable;
- Reevaluating contractor policy that results in a high reversal rate; and

Evaluating the effectiveness of edits.

NOTE: Some corrective actions only require contractors to notify the appropriate program area of what action(s) need to be taken. The costs and workload associated with identifying problems and referring issues to the appropriate must be charged to CAFM code 12090. If the corrective action is completed in the appeal unit without assistance of another unit, the cost is assigned to CAFM code 12090. However, if the problem is

referred to another area for corrective action, the cost and workload associated with that action must be assigned to the appropriate code. For example, if a provider education issue is identified and referred to the provider communications unit and the staff in the provider communications unit generates a bulletin, the cost would not be an appeals cost.

B. Quality Control Checks

The second function of a Quality Improvement program involves quality control checks. This includes performing quality checks on decision letters for accuracy/correctness, responsiveness, and tone/clarity. On a monthly basis, contractors must perform quality checks on at least a 5 percent or 25 case sample (whichever is less) of decision letters at each level of appeal. The sample of cases used for quality control checks can be chosen using a random method or by any other method at the contractor's discretion. For redeterminations, the contractor checks only partially or wholly unfavorable determinations. The findings of the quality checks should be communicated to the appropriate contractor staff as part of the internal feedback function.

Examples of assessment criteria for quality checks of appeal decision letters include:

<u>Accuracy & Responsiveness</u>

- All issues raised by the appellant were addressed
- Claim was adjusted correctly
- Determination made was correct
- Decision was sent to all parties
- Decision was effectuated timely
- Privacy of parties was protected
- Decision letter contains:
- Description of the issues
- Rationale
- Offers to provide copies of Medicare statute, regulations, and guidelines used in determination
- Liability determination, if necessary
- Appropriate language for further appeal rights
- A statement that third parties may be available to help with subsequent appeals

<u>Tone/Clarity</u>

- Issue was clearly stated
- Jargon or inappropriate abbreviations were not used
- Tone is professional and customer friendly

<u>Accuracy & Correctness</u>

- Spelling
- Grammar
- Punctuation
- Capitalization
- Medical Terminology

C. Internal Feedback System

The on-going Internal Feedback System has four components:

- The first component involves communicating the results of Data Analysis to the contractor employees affected as part of an internal feedback system (claims processing, medical review, appeals adjudicators, and professional relations staff/provider education). Contractors must send copies of the findings from data analysis to the manager of the claims processing units for use in the claims examiner education and training process. Also, the contractor sends copies of the reversal analyses and any supporting statistics to the Medical Review manager for use in the Medical Review strategy and to evaluate the effectiveness of Medical Review edits. Contractors should also participate in periodic meetings held by your provider/supplier communication unit to provide input on areas that need provider/supplier education. In addition to providing feedback to other units, contractors should make the results of their Data Analysis available to all appeals adjudicators.
- The second component involves giving appeals adjudicators an opportunity to see why their cases were overturned in subsequent levels of appeal in order to improve future decisions. Contractors must develop and implement some type of feedback on redeterminations, HO hearing decisions, and ALJ decisions to the staff responsible for conducting the prior level of appeal.
- The third component in the internal feedback system involves providing appeals adjudicators with feedback from the quality control checks.
- The last component of the internal feedback system involves ALJ decisions. For ALJ Decisions contractors must:
    - Notify their CMS Regional Office (RO) if they find a pattern of ALJ reversals that disagrees with CMS' policy.
    - Make sure at least one copy of the findings from the analysis of ALJ reversals is sent to the manager of the HO hearing unit for Part B cases or the manager of the Part A appeal unit for part A cases. The manager will circulate a copy to all of the HOs or redetermination adjudicators.
    - In those cases where the HO or redetermination adjudicator is located off-site, the contractor makes copies available to each HO or redetermination adjudicator.
    - If there are continued reversals of CMS' policy, the contractor reexamines the policy and brings it to the attention of its RO.

D. RO Examination of Redetermination and Hearing Officer Hearing 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 and/or Hearing Officer hearing decision letters. The sample will consist of at least ten (10) of each type of decision letter 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

70.3 - Submitting Summary Report to CMS

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

The Summary Report is a brief synopsis of the outcomes of the contractor's Quality Improvement and Data Analysis Program. Below is a list of items that should be included in the contractor's Summary Report. CMS will periodically request all documentation from the Quality Improvement and Data Analysis programs in addition to the Summary Report.

The contractor's Summary Report includes an overview of the following items:

Data Analysis

Types of initial determinations that are appealed most often (e.g., denial due to lack of documentation or Certificate of Medical Necessity (CMN), frequency exceeded, fraud/abuse, non-covered service, etc.)

Types of services most frequently appealed

Most frequent reasons for reversals

Most frequent reasons for dismissals

An estimate of the total number of full reversals, partial reversals and complete affirmation decisions with the percentage breakdown

Quality Improvement

A description of what efforts or corrective actions the contractor has taken to minimize appeal problems in the period (**NOTE:** the contractor's approach may change periodically)

An explanatory narrative of the results of the contractor's analysis (e.g., trends it has discovered)

A summary of the findings of quality checks on appeal determinations

A summary of the impact of the contractor's quality improvement program (e.g., changes in trends, decreases in number of reversals, decreases in appeal requests, etc.)

Costs (Only required on the last report of the FY)

All costs associated with the contractor's workload data analysis program, including associated number of FTEs

All cost associated with the contractor's quality improvement activities, including associate number of FTEs

A breakout of costs associated with activity versus cost of all other appeals Quality Improvement activities you performed prior to these instructions (e.g. MCM § 12040)

Contractors must submit their Summary Report to their RO according to the following schedule:

Months to Include in Report	Due Date
October, November, December, January, February, March	May15th
April, May, June, July, August, September	November 15th

CMS reserves the right to request more reports, as necessary. Contractors may request to submit more reports if agreed upon with the RO.

80 - Managing Appeals Workloads

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

80.1 - Standard Operating Procedures

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

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.

80.2 - Execution of Workload Prioritization

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

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 PM.

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 your 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.

80.3 - Workload Priorities

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

Priority 1-- Finalize effectuation of all redetermination, Hearing Officer, ALJ and Departmental Appeals Board (DAB) decisions, respond to requests from the DAB for case files in the timeframes prescribed below, and process redeterminations and hearings on overpayment determinations.

Priority 2-- Adjudicate all requests for telephone appeals (if applicable) in the timeframes prescribed below.

Priority 3-- Adjudicate written redetermination, and Hearing Officer (HO) hearings from beneficiaries or their appointed beneficiary representatives in the timeframes prescribed below.

Priority 4-- Adjudicate written requests for redeterminaton, and HO hearings from providers, suppliers, or other appellants, including States or their third party agents, that are submitted with necessary documentation in the timeframes prescribed below.

Priority 5-- Adjudicate written requests for redetermination and HO hearings from providers, suppliers, or other appellants, including States or their third party agents, that are submitted without necessary documentation in the timeframes prescribed below.

Priority 6-- Prepare, assemble, and forward Part A and Part B ALJ hearing case files that contain necessary documentation in the timeframes prescribed below.

Priority 7-- Prepare, assemble, and forward Part A and Part B ALJ hearing case files that do not contain necessary documentation in the timeframes prescribed below.

Priority 8-- Submit agency referrals to the DAB.

90 - Reopening and Revision of Claims Determinations and Decisions

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

When a determination is made on a claim for services, the beneficiary (and the provider, physician or other supplier of medical services) should be able to rely on it with respect to the coverage of the services and the amount of payment. Occasionally, information disclosing an error in the determination comes to light after the claim has been denied. The regulations do not permit unrestricted reopening of determinations and decisions. They do set specific circumstances under which a determination or decision may be reopened.

When appeal rights have expired on a claim, the contractor reopens only if the new information is significant and material, or discloses an error on the face of the record. A reopening is not an appeal right. It is a discretionary action as defined in 42 CFR 405.841 & 405.750, which the contractor or HO takes if good cause exists. It is an action which the contractor or HO takes on its own volition or following a written request of the party when refusal to reopen would either inflate costs to the Government without a commensurate benefit to the party, or deprive the party of rightful payment. The contractor or HO will not grant a reopening in the absence of additional and relevant information or a clear error. The contractor or HO decision not to reopen is not subject to appeal.

Generally, contractors do not conduct a reopening in response to an appeal request if appeal rights are available. However, a reopening should be conducted for claims prior to a redetermination when there are errors that be can corrected easily to avoid a redetermination (e.g., claims processing errors which can be corrected by mass adjustment). There are some instances where an appeal request will bring to the contractor's attention error(s) in the previous claim determination based on information shown on the record and the contractor made the error in processing the claim), these situations are to be handled as reopenings.

Historically, some contractors have a variety of informal procedures under the general heading of “reopenings,” “re-reviews,” “informal redeterminations,” etc. Providers, physicians and suppliers may have come to view these as appeal rights. These are not part of the appeals process. They are not a party’s right. They are not additional levels of

appeal. Contractors and HOs should not use them to provide an appeal when a formal appeal is not available. If the reason for denial is appealable to SSA rather than to the contractor, the contractor refers the reopening request to SSA. It notifies the party that the request is being referred to SSA for consideration. The following are appealable only to SSA:

- Beneficiary is not entitled to Part A or Part B; and
- Beneficiary is not eligible for benefits.

If a claim requiring medical documentation is submitted without documentation, and the beneficiary is otherwise entitled and eligible, the medical review department will issue an Additional Documentation Request (ADR). If no response is received within 45 days of the date of the request, the medical review department will deny the services as not reasonable and necessary. If the medical review department receives the requested documentation (and the documentation is not submitted with a request for redetermination) after an initial determination has been issued, but within a reasonable number of days (see PIM chapter 3 §4.1.4), the contractor may reopen the claim. Section 100, Exhibit 18 explains the policy on reopenings and appeal rights, and that appellant physicians/suppliers are responsible for providing the information needed to support the appeal. Exhibit 19 is a CMS policy statement on reopenings to help the contractor respond to requests for reopenings prior to the expiration of appeal rights.

Following a HO hearing, and pending a requested ALJ hearing, the contractor may receive information that might affect payment. It reviews it, but does not reopen its decision. The ALJ has jurisdiction. The contractor counts and charges the activity as ALJ case preparation on line 2 of the Administrative Budget and Cost Report.

It forwards the information for incorporation into the hearing file. It reviews its copy of the file to ensure that the file sent to the ALJ is complete. A test for complete information is whether or not someone not involved in the ALJ review process can understand what the contractor or HO did, why it did it, and the basis for its decision. ALJs are not required to defer to contractor or HO rationale. They may defer to it, if they understand why the contractor or HO decided as it did.

90.1 - Development of Appeals

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

Providers, physicians and suppliers are responsible for providing the information needed to adjudicate their claims. The contractor will instruct them to provide the information with the claim filing. Failing that, if they appeal the contractor decision, they must provide relevant information. If the party is the beneficiary, the contractor develops the claim. For all parties, the contractor develops information that is in its, CMS', or SSA's files.

The contractor includes in physician's or other supplier's denial notice, or other communication it deems more appropriate, a list of documents needed to support the appeal, such as: physician orders, test results, consultation reports, physician certifications of medical necessity. (§100, Exhibit 16 provides a list for the contractor to modify based upon its experience.) If a physician has not been successful in obtaining

necessary documentation and requests help, the contractor will provide it. If for example, a hospital has failed to supply the information, the contractor will contact it on the physician's behalf. The contractor will facilitate, but not initiate.

If, subsequent to the redetermination or HO hearing, additional information is submitted, the contractor is not required to grant a reopening. It considers a reopening only where appeal rights have expired or have been exhausted.

If a request for an ALJ hearing has been filed, regardless of whether or not the time limit has expired, the ALJ has jurisdiction.

90.2 - How Issues May Arise

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

A party whose right to appeal has expired may express dissatisfaction with a denial or the amount of the payment, or additional evidence may be brought to light. If dissatisfaction is expressed after the right to appeal has expired and no extension has been granted, or if the contractor or a HO thinks that a determination or decision may be erroneous and should be reopened, it follows §§90.3-90.16. f a decision is reopened as a result of a beneficiary request and a less favorable determination is suggested, the contractor follows §60.11.4(c) or §40.4.1B.

90.3 - Summary of Conditions Under Which a Determination or Decision May Be Reopened

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

A FI or carrier may reopen an appeal it has conducted under the following conditions: (See §90.6 for necessary actions.)

- Within 12 months after the date of the determination or decision for any reason;
- After such 12-month period, but within 4 years after the date of the initial determination, for good cause; or
- At any time (see §90.9), if:
    - Such appeal determination was procured by fraud or similar fault of the beneficiary or some other person; or
    - The decision is unfavorable to the party or parties, in whole or part (for definition of an unfavorable determination, see §90.8), but only for the purpose of correcting a clerical error or error on the face of the evidence on which the determination or decision or an unfavorable part was based.

90.4 - Determining Date of Initial or Appeal Determination or Decision

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

The date of the initial determination is the date of the MSN or RA.

The date of the appeal determination or decision is the date the contractor sends the notice of the determination or decision to the appellant or his/her representative.

90.5 - Who May Reopen an Initial Appeal Determination or Decision

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

Only the contractor may reopen an initial appeal determination or decision. Only the HO may reopen his/her decision, unless that HO is unavailable for reasons of death, termination of employment, illness, or leave of absence. In such event, another HO selected by the contractor may reopen the decision.

90.6 - Actions to Permit Reopening Within the l-Year or 4-Year Period

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

To reopen a determination or decision, other than at the initiative of the contractor or HO, a party to the determination or decision, or the party's authorized representative, must file a written request within the applicable time limit specified in the regulations.

The decision to conduct a sample study of a physician's or supplier's claims constitutes a reopening of all determinations in the population from which the sample is drawn, but only when such a decision is documented and is clearly intended to question the correctness of all such determinations. The contractor sends a notice to the physician or supplier as soon as possible explaining:

- The reason for the study (e.g., possible overutilization of services),
- The period to which the results of the sample study will be applied, and
- The sampling procedure, including the method used to select the sample and an explanation that the sample findings will be projected to the entire population of claims for the period in question.

The contractor does not send a notice if the study is being performed because fraud is suspected.

A QIO recommendation questioning a previous determination or decision constitutes a basis for reopening within the 4-year period only if the recommendation is based on new and material evidence. The determination or decision will be considered reopened as of the date the contractor or the HO accepts such a recommendation rather than as of the date of any action by the QIO group.

90.7 - Good Cause for Reopening

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

Good cause for reopening exists where:

- New and material evidence, not readily available at the time of the determination, is furnished;
- There is an error on the face of the evidence on which such determination or decision is based; or
- There is a clerical error in the claim file.

90.8 - Definitions

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

A. "New and Material Evidence"

Includes any evidence which was not considered when the previous determination or decision was made and which shows facts not available and that may result in a conclusion different from that reached in the determination or decision. Thus, the submittal of any additional evidence is not a basis for reopening. The information must be "new," i.e., not readily available or known to exist at the time of the initial determination.

The evidence may justify or even require further development before a proper revised determination or decision is made. If the reopening is requested by a provider, physician, or other supplier, any additional development is to be done by the party. If the party cannot complete the development, the contractor assists to the extent it can.

B. "Clerical Error"

The term, for purposes of reopening a determination or decision within the periods specified in §90.4, includes such human and mechanical errors as mathematical or computational mistakes, inaccurate coding, card punching, computer errors, misapplication of the fee schedule, or misapplication of reasonable charge profiles or screens.

C. "Error on Face of the Evidence"

This exists if it is clear that the determination or decision was incorrect based on all evidence in file on which the determination or decision was based, or any evidence of record anywhere in the contractor's Medicare file or in the SSA or CMS files at the time such determination or decision was made. (RRB records are considered as a part of the SSA records for this purpose.)

Illustrations of "Error on Face of the Evidence" - An error is considered to be an "error on the face of the evidence" in situations such as the following:

1. Reopening Within Four Years Only
    - Payment of a bill without reducing the amount payable on account of a deductible or coinsurance requirement;
    - A duplicate payment;
    - Payment to a person who did not bill for, and was not entitled to, the benefit; or
    - Payment for a service which the evidence in file clearly shows is not covered by reason of a specific exclusion (e.g., payment for services paid for by the Federal Government or payment for items shown in the file to be covered by Workers Compensation (WC)).
2. Reopening at Anytime
    - The person for whom the services were paid was not entitled to Part A or Part B, but impersonated another who was entitled to Part A or Part B;
    - The decision is unfavorable to the beneficiary or assignee, and there is an error on the face of the record on which the decision was based;

- The contractor applied an excessive deductible or coinsurance amount based on incorrect information on file; or
- The contractor failed to pay for services or items that the evidence in file clearly shows to be covered.

NOTE: Errors on the face of the record are not determined following a reevaluation of the information in file. The errors are obvious and easily seen once brought to the attention of the contractor or HO.

D. "Unfavorable Determination"

This exists if the party is paid less than the amount allowed minus any applicable deductible or coinsurance.

90.9 - Unrestricted Reopening

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

A. Fraud or Similar Fault

A determination or decision may be reopened at any time if it was procured by fraud or similar fault, regardless of whether criminal prosecution has been or will be instituted. The fraud or similar fault may be that of the beneficiary, provider, physician, or other supplier, or any other person. It includes:

- Deception by a person who knows that the deception may result in unauthorized benefits to someone;
- An act that approximates fraud, i.e., the furnishing of information which the individual knows is incorrect or incomplete, or the deliberate concealment of information, with or without a judicial finding of fraud;
- A pattern of program abuse by providers, physicians or other suppliers resulting from practices that are inconsistent with accepted sound fiscal, business, or medical practice, such as:
    1. The furnishing of services in excess of the individual's needs, or of a quality that does not meet professionally recognized standards of health care; or
    2. The submission of incorrect, incomplete or misleading information that results in payment for services:
        a. That were not furnished;
        b. That were more expensive than those furnished;
        c. That were not furnished under the conditions indicated on the bill.
    3. The submission of, or causing the submission of, bills or requests for payment containing charges for Medicare patients that are substantially in excess of the amounts the provider, physician or other supplier customarily charges.

- An act or pattern of program abuse involving collusion between the provider, physician, or other supplier and the recipient that results in higher costs or charges to the program;
- Any act that constitutes fraud under Federal or State law.

B. A Determination that "Fraud or Similar Fault"

A determination that "fraud or similar fault" is present depends on the facts. For example, a claim may be reopened more than four years after payment was approved, if the evidence establishes a pattern of billing by a physician for weekly routine visits to patients in a nursing home for whom, under established standards of good medical practice, not more than one visit a month was medically reasonable and necessary.

90.10 - Reopening an Initial Decision

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

The contractor may reopen at its own initiative an initial determination to correct a processing error. However, except as provided in §90.9, a determination may not be reopened at the party's request unless:

1. The party supplies new, substantive, and material information that may cause a full or partial reversal of the determination, or

2. There was a clerical error or an error on the face of the evidence on which the decision was based which caused the contractor to make an incorrect decision.

Following an initial determination that is a denial, if the party expresses dissatisfaction or requests a reevaluation within the 120-day time frame for appeal, the contractor generally should conduct a redeterminaiton rather than a reopening when there are appeal rights available. However, there are some instances where an inquiry will bring to the contractors attention (1) an obvious error in the claim determination based on information shown on the record and (2) the error was a result of an error in processing the claim. In these instances, a reopening is appropriate.

When a contractor reopens an initial determination, the new result of the reopening is called a revised initial determination. See §90.13 for a description on the appeal rights for a revised initial determination.

90.11 - Reopening a Redetermination

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

The contractor may reopen a redetermination. However, except as provided in § 90.9, a determination may not be reopened at the party's request unless:

1. In general, when appeals have been exhausted or have expired, and

2. The party supplies new, substantive, and material information that may cause a full or partial reversal of the determination, or

3. There is a clerical error or an error on the face of the evidence on which the decision was based which caused the contractor to make an incorrect decision.

Following a redetermination, if the party expresses dissatisfaction or requests a reevaluation within the appropriate time frame for appeal, the contractor would not conduct another redetermination. In the case of a part B redetermination, it would forward the claim to the HO for a HO hearing.

The contractor may revise a redetermination if it determines, based on the review of evidence, that a full reversal would result, thereby obviating the need for the HO hearing. It revises the decision only if an appeal has not been filed. If the party has requested the HO hearing, the contractor revises the claim after its return by the HO. The HO will have explained to the party in the dismissal letter that the claim is being returned to the contractor for payment. (If a full reversal is not indicated, the HO will proceed with the HO hearing.)

90.12 - Reopening a Hearing Officer Hearing Decision

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

While a HO's decision is final and binding, the regulations provide for a reopening and revision under certain circumstances. However, a reopening can be conducted only if the criteria in §90.3 are met. Either upon the motion of the HO or upon petition of any party to a hearing, a HO may reopen and revise his/her decision in accordance with 42 CFR 405.841. A decision by a HO may be reopened and revised only by that HO unless that HO is unavailable for reasons including death, termination of employment, illness, or leave of absence. In that event, a decision may be reopened and revised by another HO selected by the contractor.

If the HO reopens a decision, the HO notifies the party, or his/her representative, in writing that a revision of the decision is proposed with respect to a specific finding. The HO asks the party or his/her representative if he/she has further documentary evidence or testimony to submit. If the HO revises the decision, he/she sends a notice of the revised decision to each party.

If an ALJ hearing has been requested, the HO does not retain jurisdiction and may not reopen unless the ALJ remands the case to the HO (see 12019.7(a)(2).

90.13 - Notice of Results of Reopening

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

Parties with an interest in a claim receive notice of the reopening decision if it changes the original decision. The contractor or HO captions a revised decision as such, but the extent of actual revision depends upon the particular case. Generally, it is sufficient to refer to the date of the original decision and that part which the contractor or the HO plans to revise. The reasons for the revision are given, including applicable law, a summary of additional evidence and rationale, and the specific finding as revised. Any additional evidence, as well as the revised decision, is incorporated as part of the record.

If the reopening does not result in a revision, appeal rights are not mentioned because the party has no remaining appeal rights with the exception in §90.17 below.

Part B

1. The revised initial determination must convey that, if the party is dissatisfied and the amount in controversy is $100 or more, the party has a right to a HO hearing. For a revised initial determination, if the amount in controversy is less than $100, he/she has the right to a redetermination.

2. The revised redetermination must convey that, if the party is dissatisfied and the amount in controversy is $100 or more, the party has a right to a HO hearing.

3. The revised HO hearing determination must convey that, if the party is dissatisfied and the amount in controversy is $100* or more, the party has a right to request an ALJ hearing.

Part A

1. The revised initial determination must convey that, if the party is dissatisfied, they have the right to a redetermination.

2. The revised redetermination must convey that, if the party is dissatisfied and the amount in controversy is over $100*, then the party has a right to request an ALJ hearing.

NOTE: For revised decisions, if the amount in controversy is less than $100 (with the exception of a revised initial determination), there are no other appeal rights available, unless the appellant combined claims to meet the $100 threshold.

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

90.14 - Exception to Sending Notice of Revision to Parties - Cases Involving Limitation on Recovery from Beneficiary

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

The contractor waives recovery of an overpayment from a beneficiary who is without fault where the determination or decision that the services were not covered was made in the fourth calendar year after the year in which the contractor approved the payment. If a revised determination or decision results in a finding of overpayment for which the beneficiary would be liable, but it appears that the conditions for automatic consideration of waiver are met, the contractor does not send a notice of the revision to any party. It refers the overpayment to CMS. See the Medicare Financial Management Manual, Chapter 3.

90.15 - Refusal to Reopen Is Not an “Initial Determination"

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

A finding that a prior determination or decision may not be reopened is not an “initial determination or decision.” No right to appeal from such a finding exists. Accordingly, the contractor or HO does not include a statement concerning the right to an appeal in any letter sent to the parties to such a determination or decision.

90.16 - Revised Determination or Decision

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

A revised determination or decision is one in which:

1. The end result is changed (e.g., a service previously found to be covered is now found not to be covered or the reasonable charge for the service is determined to be incorrect); or

2. The end result is not changed, but a party might be disadvantaged by the revision (e.g., a request for payment on an assigned claim previously disallowed because the services were not medically necessary and therefore subject to the limitation on liability provisions, is now to be disallowed on a basis that precludes consideration of limitation on liability).

90.17 - Reopened HO Decision as a Result of an ALJ Remand

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

If an ALJ remands a claim to the HO, the HO must reopen his/her decision. (Note: A decision by a HO may be reopened only by the HO who made the decision, unless he/she is unavailable for reasons of death, termination of employment, illness, or leave of absence. In such an event, the decision may be reopened by another HO selected by the contractor). If the end result is not changed (e.g., an unfavorable decision remains unfavorable or partially unfavorable decision remains partially unfavorable) the HO must still issue a revised determination. Regardless of whether the reopening results in a revision, there are still appeal rights to the ALJ if the dollar threshold is met.

100 - List of Exhibits

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

Exhibit 1 Appointment of Representative - Form CMS-1696-U4
(Available at http://www.cms.hhs.gov/forms/)

Exhibit 2 Request for Review - Part B Medicare Claim - Form CMS-1964
(Available at http://www.cms.hhs.gov/forms/)

Exhibit 3 Request for Hearing - Part B Medicare Claim - Form CMS-1965
(Available at http://www.cms.hhs.gov/forms/)

Exhibit 4 Request for Part B Medicare Hearing by an ALJ - Form CMS-5011B
(Available at http://www.cms.hhs.gov/forms/)

Exhibit 17 Recommended Responses to Requests for Reopenings

Exhibit 18 Special Notice to Physicians Suppliers and Other Independent Practitioners

Exhibit 19 Reopenings Policy

Exhibit 17 - Recommended Responses to Requests for Reopenings

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

Model Paragraphs

Additional Information - Refusal to Reopen - Appeals Process Available

You are not entitled to a reopening as specified in Federal regulations since there are administrative appeals available to you. We are, therefore, considering your letter a request for (here, specify the type and level of appeal, e.g., redetermination, HO hearing, or hearing by an Administrative Law Judge).

Additional Information - Refusal to Reopen

We understand that you are still dissatisfied with the final decision in your case and that you have exhausted your appeal rights. Medicare policy, however, is to reopen final decisions only to correct clear errors in those decisions. These errors include:

- Factual errors which are found when new and material evidence, which was not available when the final decision was made, is presented;
- Clerical or computational errors;
- Errors on the face of the evidence; and
- Errors caused by fraud or similar fault.

Since your present request for reopening does not include evidence to indicate that any of these types of errors were made in your case, we are denying your request to reopen. If, however, you have such evidence, please submit it to us, and we will consider your request for reopening again.

Exhibit 18 - Special Notice to Providers, Physicians, Suppliers and Other Independent Practitioners

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

The purpose of this notice is to inform you of your appeal rights under Part B of the Medicare Program.

Appeals

Law and regulations provide specific redress for parties who are dissatisfied with Medicare determinations. Through these appeals, the Government seeks to ensure the correct payment is made, or a clear and adequate explanation is given as to why payment is not made.

Part B Appeals

As a provider, physician or supplier providing items and services to Medicare beneficiaries payable under Part B, you may appeal an initial determination if you:

- Accepted assignment on the claim; or
- The provider/physician/supplier did not accept assignment on the claim and we denied the claim as not reasonable and necessary, and the beneficiary did not know and could not have been expected to know that the service would not be covered, requiring you to return to the beneficiary any money you have collected for these services; or
- You are acting as the duly authorized representative of the beneficiary.

If you are dissatisfied with Medicare's initial determination and the determination is subject to appeal, you may request a redetermination. This request must be in writing, signed, and filed within 120 days after the date of the initial determination.

If you remain dissatisfied after the redetermination, and the amount in controversy is at least $100, you may request a Hearing Officer (HO) hearing. Requests for HO hearings must be filed, in writing, within 6 months following the date of the redetermination. You may combine this claim with other claims to meet the $100 amount in controversy requirement as long as the appeal is timely filed for all claims at issue and all claims at issue are at the proper level of appeal. You may request a hearing in-person, by telephone, or on-the-record. If you request an in-person or telephone hearing, it will be scheduled.

If you are still dissatisfied with the determination made by the Hearing Officer, and the amount in controversy is at least $100*, you may request an in-person hearing before an Administrative Law Judge of the Social Security Administration. The request must be in writing and filed within 60 days of the date of the contractor's HO hearing decision of record.

You may combine this claim with other claims to meet the $100* amount in controversy requirement as long as the appeal is timely filed for all claims at issue and all claims at issue are at the proper level of appeal.

* Beginning in 2005, for requests made for an ALJ hearing or judicial court 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.

Development of Appeals

For individual claims submitted by providers, physicians, and others who furnish items and services to Medicare beneficiaries, the responsibility for gathering and submitting documentation that supports claims and appeals rests with the provider/physician/supplier. We will offer guidance and assistance as necessary, but the responsibility for identifying what is needed and where it is located is your responsibility. If you have made efforts to secure essential documentation, but are unable to secure the information, we will try to assist you. Attached is a list of documentation sources that have proven useful to providers/physicians/suppliers. If you have any questions on other kinds of information that may be necessary, let us know. We will assist to the extent we can.

Reopenings

Reopenings are not, in a legal sense, appeals. They are actions taken after a claim is closed to correct an error, in response to suspected fraud, or in response to the receipt of information not available or known to exist at the time the claim was initially processed.

Reopenings should be done rarely, on individual cases, or on a group of cases adversely affected by a systems error.

Some FIs and carriers have developed a variety of informal procedures under the general heading of “reopenings.” These informal actions can extend the appeals process by subjecting claims to unnecessary and superfluous levels of review which delay access to the formal levels of appeal, with their respective procedural safeguards.

The cause for these reopenings has frequently been the failure of parties to submit supporting documentation on time. The timely submittal of documentation not only negates the perceived need for “reopenings,” but also helps to ensure the timely payment of claims.

The effect on you as appellants will be minimal because you may appeal through the regular appeals process. Reopenings are not appeals. They are discretionary actions, initiated by us at our own volition or in response to a request by a beneficiary or provider, physician, or other supplier, and then only after the appeal rights provided by law are exhausted.

Exhibit 19 - Reopenings Policy

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

Reopenings Policy

This paper outlines the legal and policy bases for our position on contractor reopenings, and for the restriction on quasi-appeals (informal reopenings) of claims.

Parties with appeal rights may wish to revisit the determination once these appeal rights are exhausted. However, although the party has the right to request a reopening, the case law makes it clear that a reopening is not a matter of right, but is a decision left to the discretion of the Secretary. The Supreme Court has held that the Secretary's decision not to reopen a case is entirely a matter of the Secretary's discretion, and is not an appealable determination. "Califano v. Sanders," 430 U.S. 99, 97 S. Ct. 980 (1977); "Lopez v. Heckler," 469 U.S. 1082, 105 S. Ct. 583 (1984). (Although the regulations specifically authorize the Secretary to reopen decisions within one year for any reason, the Supreme Court has held that the Secretary's decision not to reopen a case, unless challenged on constitutional grounds, is entirely a matter of the Secretary's discretion, not reviewable by the courts.) "Califano v. Sanders, supra."

Thus, the Secretary can be held to only his own criteria for reopening, as set forth at 42 CFR 405.841, and the good cause provision in 20 CFR 404.989.

A reopening of a contractor claim decision, irrespective of the level to which the decision is appealed, is conducted at the discretion of the Secretary or the Secretary's agents (contractors, hearing officers, Administrative Law Judges, and the DAB).

The 42 CFR 405.841 permits the contractor to reopen:

1. Within 12 months of the date of the initial or revised determination for any reason acceptable to it.

2. After 12 months, but before four years of the date of notice of the initial or revised determination, for good cause, which is defined at 20 CFR 404.989 as:

    a. New and material evidence;

    b. Clerical or computational error; or

    c. The evidence that was considered clearly shows on its face that an error was made.

3. At any time:

    a. When a decision is unfavorable, to correct a clerical error or error on the face of the evidence;

    b. For fraud or similar fault; or

    c. In response to a court order.

The CMS policy is to reopen only after appeal rights are exhausted, or the time limit for requesting an appeal has expired.

If the reason for denial is appealable to SSA rather than to you, refer the reopening request to SSA, and advise the party of your action. Following are the two denial reasons appealable to SSA:

a. Beneficiary is not entitled to Part B; and

b. Beneficiary is not eligible for benefits.

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

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
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. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

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 explains in the dismissal letter that the beneficiary can show that good cause exists for late filing, that the beneficiary may forward the explanation to the contractor within 6 months of the dismissal of the redetermination request. If an explanation or other evidence is then submitted at a later date, but 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 the dismissal and perform a reopening.

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, then they the provider, physician, or other supplier must submit the evidence 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 and proceed with conducting the redetermination. If it does not find good cause, the dismissal remains in effect. There is no appeal of a finding that good cause was not established.

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

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.)

270.1.1 - Appointment of Representative - Introduction

(Rev.)

270.1.2 - Who May be a Representative

(Rev.)

270.1.3 - How to Make and Revoke an Appointment

(Rev.)

270.1.4 - When to Submit the Appointment

(Rev.)

270.1.5 - Where to Submit the Appointment

(Rev.)

270.1.6 - Rights and Responsibilities of a Representative

(Rev.)

270.1.7 - Duration of Appointment

(Rev.)

270.1.8 - Curing a Defective Appointment of Representative

(Rev.)

270.1.9 - Incapacitation or Death of Beneficiary

(Rev.)

270.1.10 - Disclosure of Individually Identifiable Beneficiary Information to Representative

(Rev.)

270.2.1 - Assignment of Appeal Rights - Introduction

(Rev.)

270.2.2 - Who May be an Assignee

(Rev.)

270.2.3 - How to Make and Revoke a Transfer of Appeal Rights

(Rev.)

270.2.4 - When to Submit the Transfer of Appeal Rights

(Rev.)

270.2.5 - Where to Submit the Transfer of Appeal Rights

(Rev.)

270.2.6 - Rights of the Assignee of Appeal Rights

(Rev.)

270.2.7 - Duration of Transfer of Appeal Rights

(Rev.)

270.2.8 - Curing a Defective Transfer of Appeal Rights

(Rev.)

270.2.9 - Disclosure of Individually Identifiable Beneficiary Information to Representative

(Rev.)

280 - Fraud and Abuse

(Rev.)

280.1 - Fraud and Abuse - Authority

(Rev.)

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

(Rev.)

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

(Rev.)

280.4 - Responsibilities of Adjudicators

(Rev.)

280.5 - Requests to Suspend the Appeals Process

(Rev.)

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

(Rev.)

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

(Rev.)

290 - Guidelines for Writing Appeals Correspondence

(Rev.)

290.1 - General Guidelines

(Rev.)

290.2 - Letter Format

(Rev.)

290.3 - How to Establish Reading Level

(Rev.)

290.4 - Required Elements in Appeals Correspondence

(Rev.)

300 - Disclosure of Information

(Rev.)

300.1 - General Information

(Rev.)

300.2 - Disclosure of Information to Third Parties

(Rev.)

300.3 - Fraud and Abuse Investigations

(Rev.)

300.4 - Medical Consultants Used

(Rev.)

300.5 - Multiple Beneficiaries

(Rev.)

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, etc.).

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, please refer to § 310.1(B)(1) and § 310.6.3.

3. 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. 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 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 correctness of the reasonable charge, 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 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.

- 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.

- Correctness of Initial Determination is Questioned- While it is not the intent of the appeals process to audit favorable initial determinations, there may be times when the contractor questions the correctness of the initial payment decision. Since the contractor already notified the parties that part of the claim was covered, a subsequent denial could cause problems affecting the physician or other supplier and/or the beneficiary. When the contractor discovers that a claim or line items was previously paid in error, the contractor must take action to resolve the issue. If the contractor has reason to believe the initial determination should be reversed (i.e., ultimately making it more adverse to the party than the initial determination), it proceeds as follows:

- It reviews the file carefully, with particular attention to the evidence that supported the original payment decision. It uses the payment policies that were in effect at the time the initial determination was made or the date of services as applicable.

- If it believes that payment of a previous claim or line item(s) is not justified and this issue involved clinical judgment, it refers the case to a consultant for an opinion on whether the service(s)/item(s) was/were covered.

- When the appeals staff confirms that a claim or line item(s) was/were paid in error, it should make a decision only on the originally noncovered services at issue in the redetermination. Next it should return the claim to overpayments to collect the overpayment and to issue a demand letter.

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. 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 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 favorable redetermination to the appellant or authorized representative. For fully favorable, the contractor also 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. It also 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. 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)

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to the QIC. A party to the redetermination may appeal the dismissal if they

believe the dismissal is incorrect. The reconsideration request must be filed at the QIC within **60 days** of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the contractor incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the contractor for reopening. It is mandatory for the contractor to reopen any case that is remanded to it and issue a new decision. The new decision is counted in Contractor Reporting of Operational and Workload Data (CROWD) on the 2590 or 2591 as a "post-review reopening" or "post-reconsideration reopening." A QIC's reconsideration of a contractor's dismissal of a redetermination request is final and not subject to any further review.

310.6.2 - Vacating a Dismissal

(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 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 reopens the dismissal and issues a new decision.

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. Please 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)

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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

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. 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) 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. 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 carrier written correspondence requirements, unless otherwise instructed and/or agreed to by CMS.

Medicare Number of Beneficiary:
111-11-1111 A

Medicare Appeal Decision

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

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

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.

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

Summary of the Facts

Instructions: You may present this information in this format, or in paragraph form.

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

- A claim was submitted for (insert: kind of services and specific number).
- An initial determination on this claim was made on (insert: Date).

- The (insert: service(s)/item(s) were/was) denied because (insert: reason).
- On (insert: date) we received a request for a redetermination.
- (Insert: list of documents) was submitted with the request.

Decision

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

Explanation of the Decision

Instructions: This is the most important element of the redetermination. Explain the logic/reasons that led to your final determination. Explain what policy (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

Instruction: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim. 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 and Suppliers Only: Any evidence indicated in this section should be submitted with the request for reconsideration. All evidence, including evidence indicated in this section, must be presented before the reconsideration is issued. If all evidence is not submitted, 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.

Option 2:

Special Note to Medicare Physicians and Suppliers Only: All 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, 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.

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's name>.

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

If you do not use this form, you can write a letter. You must include: your name, your signature, the name of the beneficiary, 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 medical records, doctors' letters, 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 and your appointed representative must sign, date and send us a statement naming that person to act for you. Call us to learn more about how to name a representative.

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

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

Contractor Name,
A Medicare Contractor

Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of address).

Other Resources To Help You:

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

Contractor Logo or CMS Logo with Contractor Name and Address

Redetermination/ Appeal Number: XXXXXX

Reconsideration Request Form

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

QIC Name
Address

1. Name of Beneficiary: _____
2. Medicare Number:_____
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. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary. _____

_____

9. 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

10. Printed Name of Person Appealing:_____

11. 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. 679, Issued: 09-16-05, Effective: FIs-05-01-05/Carrier-01-01-06, Implementation: FIs-12-19-05/Carrier-01-01-06)

NOTE: This activity is NOT required in FY 2006.

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 Number of Beneficiary:

111-11-1111 A

Contact Information

If you have questions, write or call:

Contractor Name

Street Address

MEDICARE APPEAL DECISION

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.

Review 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. 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 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, <u>or</u> 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 14 calendar days of receipt in the corporate mailroom. The case file must be sent either by an electronic means agreed upon in the joint operating agreements (JOAs) or by a courier service so that the case file is received by the QIC before or on the 15th 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 14 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 carrier or DMERC 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. 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 contractors responsibilities for reconsiderations are:

- 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);
- 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 the final payment adjustment;
- Preparing case files and forward misrouted or misfiled reconsiderations requests in accordance with § 320.1(B).
- Entering into JOAs with the appropriate QIC(s) and AdQIC; and;

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 <u>list</u> 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. 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. 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, 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.	**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) 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:

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 West QIC jurisdiction is comprised of all DME claims and 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.

320.8 - Tracking Cases

(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 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, etc). 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, the date of effectuation (i.e., issue payment), and the date of the notification to the QIC that effectuation is complete.

320.9 - Effectuation of Reconsiderations

(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)

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 take the necessary actions 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 amount of payment and date of effectuation shall be reported to the appropriate QIC within 14 days of the date the effectuation has been finalized. The QIC will forward a copy of all decisions to the AC.

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

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 requests made before January 1, 2006 was $100. The amount in controversy requirement increased to $110 for requests made on or after January 1, 2006.

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

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* *Virginia* *West Virginia*	*Illinois* *Indiana* *Ohio* *Michigan* *Minnesota* *Wisconsin*
• ***Miami, Florida*** *100 SE 2nd Street, Suite 1700* *Miami, FL 33131-2100*	*Alabama* *Florida* *Georgia* *Kentucky* *Mississippi* *North Carolina* *South Carolina* *Tennessee*	*Arkansas* *Louisiana* *New Mexico* *Oklahoma* *Texas*		
• ***Irvine, California*** *27 Technology Drive, Suite 100*	*Iowa* *Kansas* *Missouri*	*Colorado* *Montana* *North Dakota*	*Arizona* *California* *Hawaii*	*Alaska* *Idaho* *Oregon*

Irvine, CA 92618-2364	*Nebraska*	*South Dakota* *Utah* *Wyoming*	*Nevada* *Guam* *Trust Territory of the Pacific Islands* *American Samoa*	*Washington*
• ***Arlington, Virginia*** *1700 N. Moore St., Suite 1600, Arlington, VA 22209*	*Delaware* *Maryland* *District of Columbia*			

B. Implied Requests for ALJ Hearings

Sometimes beneficiary appellants will send a letter to the contractor after a reconsideration or hearing officer hearing expressing their dissatisfaction with the decision, but do not clearly state that they are requesting an ALJ hearing. In this instance, the contractor must contact the beneficiary appellant and clarify whether the beneficiary wishes to request an ALJ hearing. The contractor informs the beneficiary of what the beneficiary needs to do to request an ALJ hearing. To prove timely filing, the contractor instructs the beneficiary to include their original letter that was sent to the contractor as part of the ALJ hearing request.

Note that only the ALJ or the Departmental Appeals Board (DAB) has the authority to dismiss a request for ALJ hearing. This applies even when it appears that the request does not meet the content requirements or jurisdictional requirements for requesting an ALJ hearing (e.g., the amount in controversy or timely filing requirements do not appear to have been met).

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

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 take the necessary actions 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.

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 DAB, the contractor effectuates within 30 calendar days 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 DAB, the contractor does not effectuate until it receives notification from the AdQIC.

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

2. *If the DAB 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. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

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 DAB review. The DAB evaluates requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs.

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 DAB Orders and Decisions

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

When a contractor receives an effectuation notice from the AdQIC regarding a DAB 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. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

When the DAB 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 DAB will request all case files from the AdQIC.

340.4 - Payment of Interest on DAB 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 DAB 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. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

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.

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

The U.S. District Court may remand the case to the DAB 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 <u>with</u> 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 <u>without</u> necessary documentation in the timeframes prescribed in §320.6.