CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1276	Date: JUNE 29, 2007
	Change Request 5322

NOTE: This is being re-communicated to remove the requirements for the AB MAC and DME MAC.

SUBJECT: Waiving Medicare Fee-for-Service Appeals Requirements

I. SUMMARY OF CHANGES: Due to funding shortfalls in Medicare fee for service appeals, contractors will not be held accountable for meeting certain requirements contained in sections 310 and 320 of the IOM, Pub. 100-4, chapter 29, with limited exceptions, until further notice. The requirements are outlined in this Change Request.

NEW / REVISED MATERIAL
EFFECTIVE DATE: July 30, 2007
IMPLEMENTATION DATE: July 30, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/310.5/The Redetermination Decision
R	29/310.8/Medicare Redetermination Notice (for fully favorable redeterminations)
R	29/320.8/Tracking Cases

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1276	Date: June 29, 2007	Change Request: 5322

NOTE: This is being re-communicated to remove the requirements for the AB MAC and DME MAC.

SUBJECT: Waiving Medicare Fee for Service Appeals Requirements

EFFECTIVE DATE: July 30, 2007

IMPLEMENTATION DATE: July 30, 2007

I. GENERAL INFORMATION

A. Background: Due to funding shortfalls in Medicare fee-for-service appeals, contractors will not be held accountable for meeting certain requirements currently outlined in the IOM, Pub. 100-0 4, chapter 29, sections 310 and 320, until further notice. The requirements are outlined in this change request.

B. Policy: The BIPA and the MMA provisions have resulted in changes at various levels of the Medicare fee-for-service appeals process, resulting in new requirements for intermediaries and carriers. Due to funding constraints in Medicare fee-for-service appeals, contractors will not be required to follow some requirements until further notice.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5322.1	IOM, Pub.100-04, chapter 29, section 310.5 indicates that the contractor mails a fully favorable redetermination to the appellant or authorized representative. A sentence is being added to indicate that the requirement to send a fully favorable letter shall not be required until further notice.			x	x	x	x		x	x	x	
5322.2	IOM, Pub.100-04, chapter 29, section 310.5A contains a requirement to mail the appellant or appointed representative a brief notification of the decision within 60 days of receipt of the request. A sentence is being added to indicate that the requirement to send a fully favorable letter shall not be required until further notice.			x	x	x	x		x	x	x	
5322.3	IOM, Pub. 100-04, chapter 29, section 310.8			x	x	x	x		x	x	X	

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	indicates that contractors are not required to send a letter for fully favorable decisions in FY 2006. The reference to FY 2006 is being updated to reflect the current year.											
5322.4	Due to funding constraints in Medicare fee-for-service appeals, contractors shall not be required to send a decision letter for fully favorable decisions until further notice. The requirement to do so is outlined in IOM, Pub.100-04, chapter 29, section 310.8.			x	x	x	x		x	x	x	
5322.5	IOM, Pub. 100-04, chapter 29, section 320.8 requires contractors to keep record of the date on which the QIC was notified that payment was made. Due to funding constraints in Medicare fee-for-service appeals, contractors are not required to inform the QIC that effectuation has been completed until further notice. As such, shall not be required to track the date that the QIC was advised of the effectuation until further notice.			x	x	x	x		x	x	x	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	None.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Kristie McCarthy (410) 786-7139

Post-Implementation Contact(s): Kristie McCarthy (410) 786-7139
Lisa Childress (410) 786-6956

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),*** **use only one of the following statements:**

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC),*** **use the following statement:**

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts alloted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

310.5 - The Redetermination Decision

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

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

A. Favorable Determinations

If the determination is a full reversal (i.e., is fully favorable meaning when the Medicare approved amount minus any cost sharing provisions (insurance, deductibles, etc.) has been found payable), the contractor mails the appellant or appointed representatives a brief notification of the decision within 60 days of receipt of the request. *This requirement to send a fully favorable letter is not required until further notice due to budget constraints, except in those situations where the parties will not receive notice of effectuation via a MSN or RA (MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.).* It sends an adjusted MSN or RA on the next scheduled release. The MSN provides the beneficiary with information as to his/her financial liability with regard to the claim(s) that are now payable.

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

B. Determinations That Result in Refund Requirements

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

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

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

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

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

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

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

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

3. A denial based on §1879(h) of the Act of an assigned claim submitted by a supplier, where it is determined under §1834(a)(18) of the Act that the supplier must refund any payments (including deductibles and coinsurance) collected from the beneficiary.

310.8 - Medicare Redetermination Notice (for fully favorable redeterminations)

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

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

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

A. Redetermination Letterhead

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

Model Fully Favorable Redetermination Notice

Medicare 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.

Reviewer Name
Contractor Name

A Medicare Contractor

320.8 - Tracking Cases

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

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

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

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