CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1762	Date: July 2, 2009
	Change Request 6377

SUBJECT: Appeals Revisions

I. SUMMARY OF CHANGES: This change request makes several changes to the manual in accordance with the 42 Code of Federal Regulations (CFR), Parts 401 and 405 Medicare program, changes to the Medicare Claims Appeals Procedures; Interim Final Rule (IFR). We updated the Glossary and made changes to several sections in order to be consistent with the IFR (i.e., removed physician as it is now defined as a supplier). CMS updated the amount that must remain in controversy to file a level 2 and level 5 appeal and clarified the requirements with regards to overpayment cases that involve multiple beneficiaries. Additionally, CMS is providing instructions on how to handle misrouted requests for appeals, as well as paid claim appeals.

NEW/REVISED MATERIAL
EFFECTIVE DATE: August 3, 2009
IMPLEMENTATION DATE: August 3, 2009

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	29/110/Glossary
R	29/200/CMS Decisions Subject to the Administrative Appeals Process
R	29/210/Who May Appeal
R	29/220/Steps in the Appeals Process: Overview
R	29/270/Appointment of Representative
R	29/270.1.3/How to Make and Revoke an Appointment
R	29/290.2/Letter Format
R	29/300.5/Multiple Beneficiaries
R	29/310.1/Filing a Request for Redetermination
R	29/310.2 /Time Limit for Filing a Request for Redetermination
R	29/310.4/The Redetemination

R	29/310.5/The Redetermination Decision
R	29/310.6/Dismissals
R	29/310.6.3/Dismissal Letters
R	29/310.6.4/Model Dismissal Notices
R	29/310.7/Medicare Redetermination Notice (for partly or fully unfavorable redetermination)
R	29/310.8/Medicare Redetermination Notice (for full favorable redeterminations)
R	29/310.9/Effect of the Redetermination
R	29/320.1/Filing a Request for a Request
R	29/320.3/Contractor Responsibilities - General
R	29/320.8/Tracking Cases
R	29/330.5/Effectuation Time Limits & Responsibilities

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1762	Date: July 2, 2009	Change Request: 6377

SUBJECT: Appeals Revisions

Effective Date: August 3, 2009

Implementation Date: August 3, 2009

I. GENERAL INFORMATION

A. Background: This CR makes several changes to the Pub. 100-04, Claims Processing Manual, in accordance with the 42 Code of Federal Regulations (CFR), Parts 401 and 405 Medicare program, changes to the Medicare Claims Appeals Procedures; Interim Final Rule.

B. Policy: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869 (c) of the Social Security Act (the Act), as amended by BIPA, required changes to the 42 Code of Federal Regulations regarding the appeals process.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6377.1	Contractors shall note changes made to the Glossary.	X	X	X	X	X					
6377.2	Contractors should issue written notice of the redetermination decision only to appellants in overpayment cases involving multiple beneficiaries who have no liability.	X	X	X	X	X					
6377.3	Contractors shall send a copy of the redetermination decision to the beneficiary when liability shifts to the beneficiary in overpayment cases involving multiple beneficiaries.	X	X	X	X	X					
6377.3.1	When liability shifts to the beneficiary in a multiple beneficiary overpayment case, the contractor shall include an explanation for the shift in liability in the redetermination letter sent to the beneficiary.	X	X	X	X	X					
6377.3.2	When liability shifts to the beneficiary in a multiple beneficiary overpayment case, the contractor shall include an explanation of the appeal rights available in the redetermination letter sent to the beneficiary.	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6377.4	Contractors shall not forward requests for reconsideration to the QIC, if a redetermination has not been conducted. The contractor shall conduct a redetermination.	X	X	X	X	X					
6377.5	Contractors shall include in the case all information considered by the appeals adjudicator, including the redetermination decision letter.	X	X	X	X	X					
6377.6	If the contractor receives a valid request for an appeal for a claim that has already been paid, the contractor shall issue an unfavorable decision using the proposed template or a similar language.	X	X	X	X	X					
6377.7	If clarification is needed from the provider/physician/supplier (e.g., splitting charges), the contractor requests clarification as soon as possible and computes the amount payable within 30 calendar days after the receipt of the necessary clarification. The contractor shall consider the date of receipt of the clarification as the date of receipt of the effectuation notice for purposes of effectuation.	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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

Section 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:

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

V. CONTACTS

Pre-Implementation Contact(s): Maria Ramirez (Maria.Ramirez@cms.hhs.gov), Kim Spalding (Kimberly.Spalding@cms.hhs.gov)

Post-Implementation Contact(s): Maria Ramirez, (Maria.Ramirez@cms.hhs.gov), Kim Spalding (Kimberly.Spalding@cms.hhs.gov)

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs), and/or Carriers:*

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

Section B: *For Medicare Administrative Contractors (MACs):*

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted 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.

110 – Glossary

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

Adjudicator – The *entity* 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 Department of Health and Human Services, Office of Medicare Hearings and Appeals.*

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 reaches the same conclusion as that in the prior determination, even though he/she is not bound by the prior determination.

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, 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 *representative of* a proper party.

***Appointed representative** – The individual appointed by a party to represent the party in a Medicare claim or claim appeal.*

***Assignee** – (1) With respect to the assignment of a claim for items or services, the assignee is the supplier who has furnished items or services to a beneficiary and has accepted a valid assignment of a claim*

OR

(2) With respect to an assignment of appeal rights, an assignee is a provider or supplier who is not already a party to an appeal, who has furnished items or services to a beneficiary, and has accepted a valid assignment of the right to appeal a claim executed by the beneficiary.

***Assignment of appeal rights** – The transfer by a beneficiary of his or her right to appeal under the claims appeal process to a provider or supplier who is not already a party, and who provided the items or services to the beneficiary.*

***Assignor** – A beneficiary whose provider of service or supplier has taken assignment of a claim, or assignment of an appeal of a claim.*

Authorized representative *– An individual authorized under State or other applicable law to act on behalf of a beneficiary or other party involved in the appeal. The authorized representative will have all of the rights and responsibilities of a beneficiary or party, as applicable, throughout the appeals process.*

Beneficiary *– Individual who is enrolled to receive benefits under Medicare Part A or Part B.*

Departmental Appeals Board (DAB) Review - *The part of the DAB that reviews Medicare cases is called the Medicare Appeals Council (herein Appeals Council). A party to the ALJ hearing may request review by the Appeals Council within 60 days after receipt of the notice of the ALJ's hearing decision or dismissal. The Appeals Council conducts a de novo review of the ALJ decision, and may adopt, modify or reverse the ALJ's decision, or may remand the case to an ALJ for further proceedings. In reviewing an ALJ's dismissal order, the Appeals Council may deny review or vacate the dismissal and remand the case to an ALJ for further proceedings. The Appeals Council will dismiss a request for review when a party does not have a right to Appeals Council review. The Appeals Council may also dismiss a request for a hearing for any reason the ALJ could have dismissed the request for hearing.*

The Appeals Council may also decide on its own motion to review a decision or dismissal issued by an ALJ within 60 days after the date of the hearing decision or dismissal. In addition, CMS may refer a case to the Appeals Council for it to consider under its own motion review authority within 60 days after the date of the hearing decision or dismissal. This is known as an "Agency Referral". The Appeals Council may adopt, modify, or reverse the ALJ's decision, may remand the case to an ALJ for further proceedings, or may dismiss an Agency Referral request.

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.

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

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.

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to a qualified independent contractor (QIC) if they believe the dismissal is incorrect. If the QIC determines that the contractor incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the contractor for a redetermination. It is mandatory for the contractor to conduct a redetermination on any case that is remanded to it by the QIC and issue a new decision. A QIC's decision upon reconsideration of a contractor's dismissal of a redetermination request, including a QIC's dismissal of the reconsideration request if untimely filed, is binding and not subject to further review.

Limitation on Liability Determination - Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers *and suppliers* by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare *coverage and* 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.

Party - *A person and/or entity normally understood to have standing to appeal an initial determination and/or a subsequent administrative appeal determination or decision. Parties to the initial determination include:*

- *Beneficiaries, who are almost always considered parties to a Medicare determination, as they are entitled to appeal any initial determination (unless the beneficiary has assigned his or her appeal rights).*

- *Providers who file a claim for items or services furnished to a beneficiary.*

- *Participating suppliers.*

Parties to the redetermination and subsequent appeal levels include:

- *The parties to the initial determination, above,*

- *Non-participating suppliers accepting assignment of a claim for items or services (but only for the items or services which they have billed on an assigned basis).*

- *A non-participating physician not billing on an assigned basis but who may be responsible for making a refund to the beneficiary under §1842(l)(1) of the Act for services furnished to a beneficiary that are denied on the basis of section 1862(a)(1) of the Act, has party status with respect to the claim at issue.*

- *A non-participating supplier not billing on an assigned basis, who may be responsible for making a refund to the beneficiary under §1834(a)(18) or §1834(j)(4) of the Act has party status with respect to the claim at issue.*

- *Medicaid State agencies have party status at the redetermination level (and subsequent levels) for claims for items or services involving a beneficiary who is enrolled to receive benefits under both Medicare and Medicaid, but only if the Medicaid state agency has made payment for, or may be liable for such items or services, and only if the State agency has filed a timely request for redetermination for such items or services. See 42 CFR 405.908.*

- *A provider or supplier who has furnished items or services to a beneficiary that does not otherwise have appeal rights, but has accepted an assignment of appeal rights from the beneficiary pursuant to 42 CFR 405.912 (but only with respect to the claims identified in the assignment agreement).*

***Provider** of services (herein provider) – As used in this section, the definition in 42 CFR 405.902 for* provider *applies. Provider* means a hospital, a *critical access hospital (*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.

***Qualified Independent Contractor** (QIC) – Entity that contracts with the Secretary in accordance with the Act to perform reconsiderations and expedited reconsiderations.*

Remand – *An action taken by an adjudicator to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.*

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. *For example, an item or service may be determined to be non-covered as not medically reasonable and necessary (under section 1862(a)(1)(A) of the Act), but Medicare may, nevertheless, make payment for the item or service if the party is found not financially liable after applying the limitation on liability provision (section 1879 of the Act). Thus, the coverage determination is affirmed, but Medicare makes payment as required by statute.*

Revised Determination or Decision - An initial *determination* or decision that is reopened and which results in *the issuance of* a revised determination or decision. A revised determination or decision is considered a separate and distinct determination or decision and may be appealed. *For example, a* post-payment review of an initial determination that *results in a reversal of a previously covered/paid claim (and, potentially, a subsequent* overpayment determination) constitutes a *reopening and a* revised initial determination. The first level of appeal following a *revised initial determination is* a redetermination.

Supplier – *A supplier includes a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under Medicare.* Unless the context otherwise requires, a physician or other practitioner, a facility, or entity (other than a provider) that furnishes items or services under Medicare.

Vacate – To set aside a previous action.

200 - CMS Decisions Subject to the Administrative Appeals Process

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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 *Appeals Council* to review the case. Following the action of the *Appeals Council,* 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 based upon failure to file a proper claim as defined in 42 when the Medicare Secondary Payer recovery claim against the provider or supplier is 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 *contractor* 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 *Appeals Council's* 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 *Appeals Council* 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 *Reopening*

Minor errors or omissions in an initial determination may be corrected only through the contractor's *reopening* 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 *a reopening*. 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 34 of the Claims Processing Manual for more information on the *reopening* process.

210 - Who May Appeal

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

A person *or entity* with a right to appeal an initial determination is *a considered a party to the redetermination (as described in 42 CFR 405.906),* referred to in the remainder of these instructions as a "party." These include:

- A beneficiary;

***NOTE**: In addition to his/her own right to appeal Medicare's decision regarding an initial determination, a beneficiary is a party to any request for redetermination filed by a provider or supplier. 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).*

- A provider *(as defined in Section 110);*

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

- A nonparticipating *supplier who has accepted assignment with respect to items or services furnished to a beneficiary, but only for those items or services billed on an assigned basis;*

- A nonparticipating supplier has the same rights to appeal the contractor's determination in an unassigned claim for medical equipment and supplies if the contractor 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;

- *Non-participating suppliers accepting assignment of a claim for items or services (but only for the items or services which they have billed on an assigned basis);*

- *A non-participating physician not billing on an assigned basis but who may be responsible for making a refund to the beneficiary under §1842(l)(1) of the Act for services furnished to a beneficiary that are denied on the basis of section 1862(a)(1) of the Act, has party status with respect to the claim at issue;*

- 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 *(as defined in Section 110);* 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. CMS *or a contractor may choose to participate in an ALJ hearing,* become a party to an ALJ hearing *(with CMS' approval),* or make an agency referral of an ALJ decision or dismissal to the *Appeals Council and* ask the *Appeals Council 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.

220 - Steps in the Appeals Process: Overview

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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)/*Appeals Council*, 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	None

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
	determination	
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, *2009,* at least $*120* remains in controversy.
4. Departmental Appeals Board (DAB) Review/*Appeals Council*	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of *the Appeals Council* decision or declination of review by DAB	At least $1,050 remains in controversy.* For requests filed on or after January 1, *2009*, at least $1,*220* 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.

270 - Appointment of Representative

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

(See 42 CFR 405.*910*, "Appointment of Representative.")

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

270.1.3 - How to Make and Revoke an Appointment

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

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

signing the appointment, the representative indicates his/her acceptance of being appointed as representative.

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

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

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

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

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

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

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

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

Prohibition Against Charging a Fee for Representation

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

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

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

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

B. Required Elements for Written Request (if not using the CMS-1696 form)

(See 42 CFR 405.910(c))

A written request for an appointment of representation must:

(1) Be in writing and signed and dated by both the party and the beneficiary agreeing to be the representative;

(2) Provide a statement appointing the representative to act on behalf of the party, and in the case of a beneficiary, authorizing the adjudicator to release identifiable health information to the appointed representative;

(3) Include a written explanation of the purpose and scope of the representation;

(4) Contain both the party's and appointed representative's name, phone number, and address;

(5) Identify the beneficiary's Medicare health insurance claim number;

(6) Include the appointed representative's professional status or relationship to the party; and

(7) Be filed with the entity processing the party's initial determination or appeal.

***C*. 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.

290.2 - Letter Format

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

- Numerical dates must not be used (i.e., instead of 6/16/98, use June 16, 1998);
- Type/font size smaller than 12 point must not be used (all responses are to be processed using a font size of 12 and a font style of Universal or Times New Roman or another style for the ease of reading by the beneficiary and the provider);
- When the subject matter is lengthy or complicated, bullet points should be used to clarify, if possible;
- For long letters, headings should be used to break it up (e.g., DECISION, BACKGROUND, RATIONALE);
- If procedure codes are cited, the actual name of the procedure must be associated with the code;
- Span dates may not be used for 1 day of service; and
- Letters that contain all capital letters appear impersonal and computer generated.

The contractor should not use all capital letters.

Where the request for appeal involves multiple beneficiaries, the contractor shall produce separate decision or redetermination letters. This way, on requests with multiple beneficiaries each beneficiary is provided with a copy of their own determination without compromising the privacy of other beneficiaries' claims in the appeal. However, you can continue to send one consolidated letter to the provider. *(Refer to IOM, 100-6, Medicare Financial Management Manual, chapter 6, §460.1, for instructions on how to count requests that involve multiple beneficiaries).*

Refer to §300.5 for instructions on how to handle overpayment cases involving multiple beneficiaries.

300.5 - Multiple Beneficiaries

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

In an overpayment case involving multiple beneficiaries who have no financial liability prior to, and following the redetermination, the contractor mails the decision letter to the appellant or their appointed representative. In this situation, contractors are not required to send the decision letters to beneficiaries who are parties to the redetermination (see 42 CFR 405.956(a)(2)). However, if financial liability shifts from the provider or supplier to the beneficiary, the contractor issues a separate letter to the beneficiary that explains why he/she is liable, and explains the subsequent appeal rights available.

310.1 - Filing a Request for Redetermination

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

A. Written Redetermination Requests Filed on Behalf of the Beneficiary

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

individual filing on behalf of the beneficiary a notice including information on how to become a representative of the beneficiary and what the individual should know if the individual fails to complete the appointment (e.g., that the individual will not receive a decision or other notices, will not be the official representative).

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

Although the contractor may have honored a request for redetermination filed by someone other than the beneficiary or the beneficiary's appointed representative, only the beneficiary or representative should be contacted or consulted for further information when processing the redetermination and when issuing the determination (unless the requestor is the beneficiary's legal guardian, in which case no appointment is required). There will be circumstances where the mental and/or physical incapacity of the beneficiary becomes an issue. Based on all the documented medical information available, the contractor may decide to allow the person submitting the request for redetermination to act on behalf of a beneficiary who is mentally or physically incapacitated. The contractor's decision, as well as the beneficiary's incapacitation, should be documented in the file and supported by relevant medical documentation. (See §270, for more information on this subject.)

1. Requests for Redetermination Submitted by Members of Congress

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

1. A signed copy of correspondence from the beneficiary expressing a desire for the congressional office to obtain information on his/her behalf;

2. A release of information form developed by the congressional office; or

3. A release of information form developed by the contractor for this purpose.

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

B. What Constitutes a Request for Redetermination

1. Written Requests for Redetermination Made by Beneficiaries

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

"Please reconsider my claim."

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

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

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

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

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

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

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

1. Beneficiary name;

2. Medicare health insurance claim (HIC) number;

3. The specific service(s) and/or item(s) for which the redetermination is being requested;

4. The specific date(s) of the service; and

5. 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 request *clearly limited to an update on a previously submitted appeal request or correspondence.* The contractor states in its reply that 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 of a notice; or

- There is not an initial determination *(see 42 CFR 405.924 for Actions that are initial determinations and 42 CFR 405.926 for Actions that are not initial determinations).*

NOTE:

- *If the contractor receives a 'request for reconsideration' (assuming the appellant is using the wrong form or incorrect terminology), but determines that a redetermination has not been conducted, the contractor does not forward the request to the QIC. The contractor shall conduct a redetermination.*

- *If the contractor receives a 'request for reconsideration' as misrouted mail, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file within 30 calendar days of receipt in the corporate mailroom. Refer to §320.1.*

310.2 - Time Limit for Filing a Request for Redetermination

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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) *with the contractor indicated on the notice of initial determination.* The date of filing for requests filed in writing is defined as the date received by the *appropriate* 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 *contractor or* Government agency 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 *contractor or* Government agency in person, the contractor considers good cause for late filing. The contractor may extend the period for filing if it finds the *party* 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 *contractor* finds that the *party* did not have good cause for not requesting a redetermination on time, it may, at its discretion, consider reopening. (See *Pub. 100-4, chapter 34.)*

310.4 - The Redetermination

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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 *contractor* 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, *if applicable,* 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. *All information considered by the appeals adjudicator in conducting the redetermination must be included in the case file.* 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 *or party* upon request. Reviewers must exercise care in determining the weight to give *allegations of* fraud and abuse where the source of the specified information is not provided. Although the name of the beneficiary or other source that provided the information that triggered an investigation is not always provided or necessary when reviewing the evidence, the case file must include information on the independent, subsequently developed investigation that supports denial of the claim(s). (See subsection D, below, for instructions on development of documentation.)

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

C. Elements of the Redetermination

The following elements are essential to performing an adequate redetermination:

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

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

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

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

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

If the appellant challenges the validity of the sampling methodology, the contractor reviews the claims in question as well as any *methodology* used to extrapolate the overpayment amount. For background on how the PSCs use statistical sampling to estimate overpayments, see Pub. 100-08, chapter 3, section 10. If a reconsideration is subsequently requested, the entire case will be sent.

Per Pub. 100-06, chapter 3, sections 70 and 90, the contractor shall consider whether there was an overpayment, whether the amount of the overpayment was correctly calculated and extrapolated (if applicable), whether the appellant is liable for repayment, and whether recovery of the overpayment is waived.

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

D. Requests for Documentation

1. Requesting documentation for State-Initiated Appeals

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

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

For provider, 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 or 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 some situations, a provider or supplier may inform the reviewer that it is having trouble obtaining supporting documentation from another provider or supplier (e.g., an ambulance supplier who is requested to submit hospital admission records). In this situation, the contractor may assist the provider or supplier 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 *paragraph* 4 below for information on *the* extension of the decision making timeframe for additional documentation that is submitted after the request.

3. Requesting documentation for Beneficiary-Initiated Appeals

For provider, 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 or supplier for additional documentation. The beneficiary is advised (either in the letter or during a telephone call) that the provider or 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 and suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.*

310.5 - The Redetermination Decision

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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. *For unfavorable redeterminations, the* contractor mails *the decision letter* to the appellant, and *mails* copies to each party *to the initial determination* (or *the party's* authorized representative *and appointed representative, if applicable).*

For partially favorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative, if applicable) an adjusted MSN or RA and a redetermination letter including the rationale for the decision. The contractor shall ensure that the appropriate MSN or RA messages are included regarding refunds of payments, including when necessary any coinsurance or deductible collected. If a party has an appointed representative, the contractor mails the decision letter to the appointed representative. Sending the decision letter to the appointed representative has the same force and effect as if the letter was sent to the party. In addition, the contractor sends an MSN or RA to each party (or the party's authorized representative, if applicable). The contractor does not send an MSN or RA to an appointed representative.

For fully favorable redeterminations, the contractor mails an MSN or RA reflecting the adjustment action to each party (or the party's authorized representative, if applicable) 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. The contractor does not send an MSN or RA to an appointed representative. Unless otherwise specified in its statement of work, contractors are not required to send a fully favorable letter *to parties* until further notice, except in those situations where the parties will not receive notice of effectuation via *an* MSN or RA (*e.g.,* MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.). *In these cases, the contractor mails a notice to such parties or authorized/appointed representative if applicable, that references the claims appealed, and briefly explains the outcome of the redetermination.*

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 *contractor* 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 *charges* 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 *services (including payment of co-insurance and deductible),* 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 *refund* 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.

C. Paid Claim Appeals

If a contractor receives a valid appeal request on a claim that was processed and paid subsequent to the filing of that appeal but prior to issuance of the Medicare Redetermination Notice, the contractor shall issue an unfavorable decision letter using the following template or something similar to the appellant:

Model Redetermination
Paid Claim Appeal

Medicare Number of Beneficiary:
111111111 A

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

XYZ NAME
Xx Main Street, Suite 000
Town, State 00000

RE:
Beneficiary: John Smith
HIC #: 000000000A
Appellant: Provider/Supplier

Dear Appellant 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 a redetermination, for <SERVICE(s)> on <DATE>.

The redetermination decision is unfavorable. The service(s) in question has already been paid by the FI/CARRIER/MAC on <DATE>. We have evaluated what was submitted and there does not appear to be any errors impacting the payment amount, which is the maximum allowed by Medicare for this service. As a result, we are issuing an unfavorable decision on your request for redetermination on this claim.

If you disagree that the claim in question was previously processed for payment and/or you otherwise disagree with this decision, you may appeal to a Qualified Independent Contractor. You must file your appeal, in writing, within 180 days of receipt of this letter.

[INSERT QIC INFORMATION]

Sincerely,

TITLE
CONTRACTOR NAME

310.6 - Dismissals

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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 *§270* 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, 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.

310.6.3 - Dismissal Letters

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

The contractor *shall* issue a written notice of dismissal to all parties to the appeal. *The dismissal notice must inform parties that they may request the contractor vacate the dismissal within 6 months from the date of the notice of dismissal upon a showing of good and sufficient cause.* 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 *Exhibit 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.

NOTE: *If an appellant requests that the contractor vacates its dismissal action, and the contractor determines that that it cannot vacate the dismissal, it sends a letter a letter notifying the appellant. The contractor shall not issue a second dismissal letter to the appellant since a dismissal should only be issued in response to an appeal request. A request to vacate a dismissal is not a request for an appeal.*

310.6.4 - Model Dismissal Notices

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

Model Redetermination

Dismissal Notice for Incomplete Request

Medicare Number of Beneficiary:
111111111 A

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

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 *this* 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 *their review of this dismissal action.* 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:
111111111 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 *this* 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 *their review of this dismissal action*. 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. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

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

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

A. Redetermination Letterhead

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

Medicare Appeal Decision

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

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

Dear Appellant's Name:

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

The appeal decision is

(Insert either:) **unfavorable.** Our decision is that your claim is not covered by Medicare.
OR
partially favorable. Our decision is that your claim is partially covered by Medicare.

More information on the decision is provided below. If you disagree with the decision, you may appeal to a qualified independent contractor. You must file your appeal, in writing, within 180 days of receiving this letter. However, if you do not wish to appeal this decision, you are not required to take any action. For more information on how to appeal, see the section of this letter entitled, "Important Information About Your Appeal Rights."

A copy of this letter was also sent to (Insert: Beneficiary Name or Provider Name).

(Insert: Contractor Name) was contracted by Medicare to review your appeal.

Summary of the Facts

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

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

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

Decision

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

Explanation of the Decision

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

Who is Responsible for the Bill?

(Instructions: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable*, for example:)*

"After reaching a decision that the service/item will not be covered by Medicare, we must decide who is liable for denied service/item. The instructions contained in Section 1879 of the Social Security Act require two steps. First, we must decide if the beneficiary either knew or could be reasonable expected to know that the service/item would not be covered under §1861(a)(1) or §1861(a)(9) of the Social Security Act. Next, we must decide if the provider either knew or could be reasonably be expected to know that the service/item would not be covered under §1861(a)(1) or §1861(a)(9) of the Social Security Act.

By following these instructions, we have decided (Option 1) that the beneficiary either knew or could be reasonably expected to know that the service/item would not be covered. (Option 2) that the beneficiary did not know nor could reasonably have been expected to know that the service/item would not be covered. ….

CMS has further decided (Option 1) that the provider either knew or could be reasonably expected to know that the service/item would not be covered. (Option 2) that the provider either did not know or could reasonably been expected to know that the service/item would not be covered.

The contractor shall also explain the basis for their determination of knowledge. For example, a CMS publication or a contractor publication, specific policy posted on the contractor's Web site, etc.

Note, under §1879 and 42 CFR 411.402, if the provider is found to be liable, the provider cannot bill the patient for any denied services or for any deductible or coinsurance amounts related to them."

Refer to Pub.100-04, chapter 30, §§40 and 120 for more information.

What to Include in Your Request for an Independent Appeal

(Instructions: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please indicate what documentation would be necessary to pay the claim. Use option 1 if evidence is indicated in this section or option 2 if no further evidence is needed.)

Option 1:

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

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

Option 2:

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

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

Sincerely,

Reviewer Name
Contractor Name
A Medicare Contractor

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision: If you do not agree with this decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The next level of appeal is called reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from (insert: contractor name).

How to Appeal: To exercise your right to an appeal, you must file a request in writing within 180 days of receiving this letter. Under special circumstances, you may ask for more time to request an appeal. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you *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 those listed in item 10 of the enclosed Redetermination Request Form, or other information that explains why this service should be paid. Your doctor may be able to provide supporting materials.

If you want to file an appeal, you should send your request to:

QIC Name
Address
City, State Zip

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

If you want someone to act for you, you may visit http://www.medicare.gov/basics/forms/default.asp to download the "Appointment of Representative" form, which may be used to appoint a representative. Medicare does not require that you use this form to appoint a representative. Alternately, you may submit a written statement containing the same information indicated on the form. If you are a Medicare enrollee, you may also call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

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

Contractor Name,
A Medicare Contractor

Address
City, State Zip

Resources for Medicare Enrollees: If you want help with an appeal, or if you have questions about Medicare, you can have a friend or someone else help you with your appeal. You can also contact your State health insurance assistance program (SHIP). You can find the phone number for your SHIP in your "Medicare & You" handbook, under the "Helpful Contacts" section of www.medicare.gov Web site, or by calling 1-800-MEDICARE (1-800-633-4227). Your SHIP can answer questions about payment denials and appeals.

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

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

Contractor Logo or CMS Logo with Contractor Name and Address

Redetermination/ Appeals Number: XXXXXX

Reconsideration Request Form

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

QIC Name
Address

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

_____

6. Item or service you wish to appeal:_____

_____

7. Date of the service: From____/_____/_____ To_____/_____/_____
8. Does this appeal involve an overpayment? ☐ Yes ☐ No
9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary. _____

_____

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

☐ Medical Records ☐ Office Records/Progress Notes

☐ Copy of the Claim ☐Treatment Plan

☐ Certificate of Medical Necessity

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

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

310.8 - Medicare Redetermination Notice (for full favorable redeterminations)

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

NOTE: Due to budget constraints, this activity is NOT required until further notice*, unless otherwise specified in the contractor's statement of work,* 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 *the contractor* written correspondence requirements, unless otherwise instructed and/or agreed to by CMS.

Model Fully Favorable Redetermination Notice

MEDICARE APPEAL DECISION

Medicare Number of Beneficiary:
111111111 A

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

RE: Include claim identifier or appeal number

Dear Appellant's Name:

This letter is to inform you of the decision on your Medicare Appeal. This appeal decision is **fully favorable** to you. Our decision is that your claim is covered by Medicare. More information on this decision, including the amount Medicare will pay, will follow in a future Remittance Advice or Medicare Summary Notice.

Sincerely.

Reviewer Name
Contractor Name
A Medicare Contractor

310.9 - Effect of the Redetermination

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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 *binding* upon all parties unless a reconsideration is completed or the redetermination is revised as a result of a reopening.

320.1 - Filing a Request for a Reconsideration

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

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

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

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

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

A. Request for Reconsideration (Form CMS-20033)

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

B. Requests Submitted to the Wrong Contractor

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

There may be instances where requests for QIC reconsiderations are misrouted to a contractor location. Contractors shall have standard operating procedures to ensure that misrouted requests are sent/transmitted to the QIC, along with the appropriate case file(s), within 30 calendar days of receipt in the corporate mailroom. The case file must be sent either by an electronic means agreed upon in the joint operating agreements (JOAs) or by a courier service so that the case file is received by the QIC before or on the 31st calendar day after the receipt. There also may be instances where the redetermination decision is issued after May 1, 2005 (for FIs) or January 1, 2006 (for carriers and DMERCs) and the appellant mistakenly requests or misfiles a hearing officer hearing. Contractors shall have standard operating procedures to ensure that these requests are identified and transmitted to the QIC, along with the appropriate case file(s) within 30 calendar days of receipt in the corporate mailroom. Contractors shall track all misfiled and misrouted reconsideration requests to ensure receipt at the proper QIC. The QIC will send the FI, carrier, MAC or DME MAC an acknowledgement of receipt of any misfiled requests. Contractors shall not count such misrouted or misfiled requests as dismissals. The contractor counts the costs associated with misrouted or misfiled requests in the CAFM line designated for preparing/transferring case files to the QIC. To avoid misrouted requests for QIC reconsiderations, contractors shall employ provider education efforts with an emphasis on the dates for transition and filing locations.

NOTE:

- *If the contractor receives a 'request for reconsideration' (assuming the appellant is using the wrong form or terminology), but determines that a redetermination has not been conducted, the contractor does not forward the request to the QIC. The contractor shall conduct a redetermination.*

- *If the contractor receives a 'request for reconsideration' as misrouted mail, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file within 30 calendar days of receipt in the corporate mailroom. Refer to §320.1.*

320.3 - Contractor Responsibilities - General

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

The contractor's responsibilities for reconsiderations are:

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

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

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

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

320.8 - Tracking Cases

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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*, MAC* or *DME MAC* 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).

330.5 - Effectuation Time Limits & Responsibilities

(Rev. 1762, Issued: 07-02-09, Effective: 08-03-09, Implementation: 08-03-09)

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

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

For ALJ decisions issued by HHS OMHA ALJs, the AdQIC will function as the clearinghouse. Once the AdQIC receives the case file and the ALJ decision for a favorable case, the AdQIC will forward an effectuation notice with a summary of the affected claim headers and claim line ICNs to the appropriate contractor for effectuation.

A. No Agency Referral

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

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

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

B. Agency Referral

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

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

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