CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 695

Department of Health & Human Services

Centers for Medicare & Medicaid Services

Date: OCTOBER 7, 2005

CHANGE REQUEST 4019

SUBJECT: General Appeals Process in Initial Determinations (Implementation Dates for FI Initial Determinations Issued on or After May 1, 2005, and Carrier Initial Determinations Issued on or After January 1, 2006).

I. SUMMARY OF CHANGES: 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, requires a new second level in the administrative appeals process called a reconsideration. This new reconsideration is different from the previous first level of appeal for Part A claims performed by FIs. Reconsiderations will be processed by qualified independent contractors.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : May 1, 2005

IMPLEMENTATION DATE : January 9, 2006

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:

R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	29/Table of Contents
N	29/200/CMS Decisions Subject to the Administrative Appeals Process
N	29/210/Who May Appeal
N	29/210.1/Provider or Supplier Appeals When the Beneficiary is Deceased
N	29/220/Steps in the Appeals Process: Overview

N	29/230/Where to Appeal
N	29/240/Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals
N	29/240.1/Good Cause
N	29/240.2/General Procedure to Establish Good Cause
N	29/240.3/Conditions and Examples That May Establish Good Cause for Late Filing by Beneficiaries
N	29/240.4/Conditions and Examples That May Establish Good Cause for Late Filing by Providers, Physicians, or Other Suppliers
N	29/240.5/Good Cause Not Found for Beneficiary, or for Provider, Physician, or Other Supplier
N	29/250/Amount in Controversy Requirements
N	29/260/Parties to an Appeal

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 695	Date: October 7, 2005	Change Request: 4019

SUBJECT: General Appeals Process in Initial Determinations (Implementation Dates for FI Initial Determinations Issued on or After May 1, 2005, and Carrier Initial Determinations Issued on or After January 1, 2006).

I. GENERAL INFORMATION

A. Background: 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, requires a new second level in the administrative appeals process called a reconsideration. This new "reconsideration" is different from the previous first level of appeal for Part A claims performed by fiscal intermediaries (FIs). Reconsiderations will be processed by qualified independent contractors (QICs).

B. Policy: The purpose of this CR is to notify FIs and carriers about the upcoming transition to the new second level of the appeals process. For Part A and Part B redeterminations issued and mailed by FIs on or after May 1, 2005, the parties to the redetermination will have the right to appeal to a QIC. For Part B redeterminations issued and mailed by Carriers on or after January 1, 2006, the parties to the redetermination will have the right to appeal to a QIC. All FI redeterminations issued and mailed before May 1, 2005, will have appeal rights to the Administrative Law Judge for Part A claims and to the hearing officer (HO) for Part B claims. All carrier redeterminations issued and mailed before January 1, 2006 will have appeal rights to the HO for Part B claims.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4019.1	The Medicare contractor shall make initial determinations regarding claims for benefits under Medicare Part A and Part B.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4019.2	Minor errors or omission in an initial determination shall be corrected only through the contractor's reopenings process.	X	X	X	X					
4019.3	Requests for adjustments to claims resulting from clerical errors shall be handled and processed by the contractor through reopenings.	X	X	X	X					
4019.4	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.	X	X	X	X					
4019.5	A contractor shall transfer the appeal request to the reopenings unit or other designated unit for processing. See chapter 33, of the Claims Processing Manual, for more information on the reopenings process.	X	X	X	X					
4019.6	When a provider or supplier appeals on behalf of a deceased beneficiary and the provider or supplier otherwise does not have the right to appeal, the contractor shall determine whether another party is available to appeal.	X	X	X	X					
4019.7	Contractors shall not 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.	X	X	X	X					
4019.8	When an appellant requests a reconsideration with a QIC (level 2), the contractor shall prepare and forward the case file to the QIC in accordance with the appropriate manual section and the Joint Operating Agreement (JOA).	X	X	X	X					
4019.9	The contractor shall compute the time limit for requesting a redetermination by allowing 5 additional days beyond the time limit (120 days for a redetermination) from the date of the	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	previous notice. This allows a 5-day period for mail delivery. The contractor shall allow for additional time if there is evidence that the mail delivery was longer than 5 days.									
4019.10	These time limits may be extended if good cause for late filing is shown. (See §240.1-240.8.) When a redetermination request appears to be filed late, the contractor shall make a finding of good cause using the guidelines in §240.3) before taking any other action on the appeal.	X	X	X	X					
4019.11	When a provider, physician, or other supplier has failed to establish that good cause for late filing of an appeal request exists, the contractor shall dismiss the appeal request as untimely filed.	X	X	X	X					
4019.12	If the provider, physician, or other supplier submits evidence to the contractor within 6 months of its dismissal that supports a finding of good cause for late filing, the contractor shall make a favorable good cause determination.	X	X	X	X					
4019.13	If the contractor makes a favorable good cause determination, it shall consider the appeal to be timely filed and proceed with conducting the redetermination. If it does not find good cause, the dismissal remains in effect.	X	X	X	X					
4019.14	The contractor shall not find good cause where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused the late filing.	X	X	X	X					
4019.15	When the contractor does not grant a request for extension of time limit for filing a request for redetermination, it shall advise the beneficiary, or provider, physician or other supplier.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4019.16	Contractors shall send a written notice stating that the request for extension has been denied, that the request for redetermination has been dismissed, and provides the reason why good cause was not found.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4019.17	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X					

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 1, 2005 **Implementation Date:** October 7, 2005 **Pre-Implementation Contact(s):** Tara Boyd or Jennifer Frantz **Post-Implementation Contact(s):** Contact your local regional office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

Table of Contents
(Rev. 695, 10-03-05)

200 - CMS Decisions Subject to the Administrative Appeals Process
(Rev. 695, Issued: 10-07-05; Effective: 05-01-05; Implementation: 01-09-06)

A. Entitlement Determinations

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

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

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

B. Initial Determinations

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

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

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

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

(4) Whether the deductible has been met;

(5) The computation of the coinsurance amount;

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

(7) The number of home health visits used;

(8) Periods of hospice care used;

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

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

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

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

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

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

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

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

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

C. Actions That Are Not Initial Determinations

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

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

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

(3) Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a carrier has sole

responsibility under Part B, such as the establishment of a fee schedule set forth in 42 CFR, part 414, subpart B or an inherent reasonableness adjustment pursuant to 42 CFR 405.502(g) and any issue regarding the cost report settlement process under Part A;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Initial Determinations Subject to Reopenings

Minor errors or omissions in an initial determination may be corrected only through the contractor's reopenings process Since it is neither cost efficient or necessary for

contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as reopenings. In situations where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for reopening. A contractor must transfer the appeal request to the reopenings unit or other designated unit for processing. See Chapter 33 of the Claims Processing Manual for more information on the reopenings processs.

210 - Who May Appeal

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

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

- *A beneficiary:*

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

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

- *An institutional provider*

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

- *A nonparticipating physician has the same rights to appeal the carrier's determination in an unassigned claim for physicians' services if the carrier denies or reduces payment on the basis of §1862(a)(1) as a nonparticipating or participating physician has in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the physician knew or should have known that*

Medicare would not pay for the service, or because the beneficiary was not properly informed in writing in advance that Medicare would not pay or was unlikely to pay for the service or, if so informed, did not sign a statement agreeing to pay. While the time limits in §240 apply for filing requests for redetermination and hearing, refunds must be made within the time limits specified in Chapter 30. Section 1842(l)(1) gives party status to nonparticipating physicians, for example, where:

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

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

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

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

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

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

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

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

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

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

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

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

210.1 - Provider or Supplier Appeals When the Beneficiary is Deceased

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

When a provider or supplier appeals on behalf of a deceased beneficiary and the provider or supplier otherwise does not have the right to appeal, the contractor must determine whether another party is available to appeal by taking either of the following actions:

- *The contractor may send a letter to the last known address of the beneficiary, or to the beneficiary's estate, if known. The letter should advise the beneficiary's estate (or anyone taking responsibility for the deceased's bills for medical or other health services) of the right to appeal the claim denial. The letter also should provide information that the provider or supplier wishes to appeal. The letter should provide the beneficiary's estate with the following three options:*
    - *Option 1: I wish to appeal this claim.*
    - *Option 2: I am not available to appeal, please process the provider's appeal and let me know of the result.*
    - *Option 3: I am available to appeal, but do not wish to exercise my right to appeal.*

The contractor should allow the estate at least 10 days to respond, or the remainder of the time frame for requesting an appeal -- whichever is greater. If the estate does not respond in the allotted time frame, the contractor should annotate the file that no other party is available to appeal and continue to process the provider's or supplier's appeal.

If the estate responds that it is available and wishes to appeal, the contractor should continue with the appeal and notify the provider or supplier of the results. If the estate indicates that it is not available to appeal, then the contractor should continue to process the appeal and notify the beneficiary's estate of the decision. If the estate indicates that it is available, but does not want to appeal, the contractor should dismiss the provider or supplier's request on the basis that there is another party available, even though the party does not intend to pursue the appeal; or

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

220 - Steps in the Appeals Process: Overview

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

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

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

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

When an appellant requests a reconsideration with a QIC (level 2), the contractor must prepare and forward the case file to the QIC. Further, the contractor may have effectuation responsibilities for decisions made by the QIC. The contractor, however, does not have responsibility for reviewing the QIC's decision for accuracy. When an appellant requests an Administrative Law Judge (ALJ) hearing (level 3), the QIC must

prepare and forward the case file to the HHS Office of Medicare Hearings and Appeals (OMHA). Further, the contractor may have effectuation responsibilities for decisions made at the ALJ, Departmental Appeals Board (DAB), and Federal Court levels.

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

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

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

** Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.*

230 - Where to Appeal

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

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

CHART 2 - Where to File and Appeal

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

**Includes part B claims filed with the FI.*

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

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

A. Time Limits For Each Level of Appeal

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

- ***Redetermination****- The time limit for filing a request for redetermination is 120 days from the date of receipt of the Medicare Summary Notice (MSN) or Remittance Advice (RA). See §240.1-240.8 for clarifications and exceptions to this rule.)*
- ***QIC Reconsideration****- The time limit for filing a request for reconsideration is 180 days from the date of receipt of the notice of the redetermination.*
- ***ALJ Hearing****- The time limit for filing a request for ALJ hearing is 60 days after the date of receipt of the reconsideration notice.*
- ***Departmental Appeals Board (DAB) Review****- The time limit for filing for a review by the DAB of the decision of the ALJ presiding at the hearing is 60 days from the date of receipt of the ALJ decision.*
- ***Judicial Review****- The time limit for filing for judicial review is 60 days from the date of the DAB's decision. A request filed with the contractor is considered to have been filed as of the date the contractor received it.*

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

These time limits may be extended if good cause for late filing is shown. (See §240.1-240.8.) When an redetermination request appears to be filed late, the contractor makes a

finding of good cause using the guidelines in §240.3) before taking any other action on the appeal.

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

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

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

240.1 - Good Cause

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

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

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

240.2 - General Procedure to Establish Good Cause

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

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

If the appellant is a beneficiary, and there is insufficient or no explanation for the delay or no other evidence that establishes the reason for late filing, the contractor explains in the dismissal letter that the beneficiary can show that good cause exists for late filing, that the beneficiary may forward the explanation to the contractor within 6 months of the dismissal of the redetermination request. If an explanation or other evidence is then submitted at a later date, but within 6 months from the dismissal that contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the contractor (as applicable) makes a favorable good cause determination. Once it makes a favorable good cause determination, it considers the appeal to be timely filed and proceeds to vacate the dismissal and perform a reopening.

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

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

If the provider, physician, or other supplier submits evidence to the contractor within 6 months of its dismissal that supports a finding of good cause for late filing, the contractor makes a favorable good cause determination. However, for late filings of providers, physicians or other suppliers, it should not routinely find good cause. If the contractor makes a favorable good cause determination, it must consider the appeal to be timely filed and proceed with conducting the redetermination. If it does not find good cause, the dismissal remains in effect. There is no appeal of a finding that good cause was not established.

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

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

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

A. Conditions

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

- *Circumstances beyond the beneficiary's control, including mental or physical impairment (e.g., disability, extended illness) or significant communication difficulties.*
- *Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the beneficiary (e.g., a party is not notified of her appeal rights or of the time limit for filing).*

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

- *Delay resulting from efforts by the beneficiary to secure supporting evidence, where the beneficiary did not realize that the evidence could be submitted after filing the request;*
- *When destruction of or other damage to the beneficiary's records was responsible for the delay in filing (e.g., a fire);*

- *Unusual or unavoidable circumstances, the nature of which demonstrate that the beneficiary could not reasonably be expected to have been aware of the need to file timely;*
- *Serious illness which prevented the party from contacting the contractor in person, in writing, or through a friend, relative, or other person;*
- *A death or serious illness in his or her immediate family; or*
- *A request was sent to a Government agency in good faith within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired.*

B. Examples

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

- *Beneficiary was hospitalized and extremely ill, causing a delay in filing;*
- *Beneficiary is deceased. Her husband, as representative of the beneficiary's estate, died during the appeals filing period. Request was then filed late by the deceased husband's executor;*
- *The denial notice sent to the beneficiary did not specify the time limit for filing for the redetermination; and*
- *The request was received after, but close to, the last day to file, and the beneficiary claims that the request was submitted timely.*

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

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

A. Conditions

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

- *Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources (CMS, the contractor, or the Social Security Administration) to the provider, physician, or other supplier; or,*
- *Unavoidable circumstances that prevented the provider, physician, or other supplier from timely filing a request for redetermination. Unavoidable circumstances encompasses situations that are beyond the provider, physician or supplier's control, such as major floods, fires, tornados, and other natural catastrophes.*

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

where the provider, physician, or other supplier claims that lack of business office management skills or expertise caused the late filing.

B. Examples

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

- *A fire destroys the physician's records; and*
- *A flood closes a supplier's office for an extended period of time, or such other natural catastrophe.*

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

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

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

250 - Amount in Controversy Requirements

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

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

Beginning in 2005, for requests made for an ALJ hearing or judicial review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10.

260 - Parties to an Appeal

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

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