CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 724

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: OCTOBER 21, 2005

CHANGE REQUEST 3939

NOTE: *Transmittal 687, dated September 23, 2005 is rescinded and replaced with Transmittal 724, dated October 21, 2005. There were changes to the policy section of the business requirements that addressed two different implementation dates. All other information remains the same.*

SUBJECT: Appeals of Claims Decisions: Redeterminations and Reconsiderations (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). These changes manualize CMS 4064- IFC, published in the Federal Register on March 8, 2005. The instructions in this change request (CR) include redeterminations, reconsiderations, quality improvement, and workload priorities. Other changes to the appeals process, including parties the appeals, appointment of representative, fraud and abuse, etc. will be manualized in another CR. Until the issuance of such CR, FIs are to follow the current manual sections or CR 3530.

NEW/REVISED MATERIAL

EFFECTIVE DATE: FI initial determinations issued on or after May 1, 2005 and Carrier initial determinations issued on or after January 1, 2006

IMPLEMENTATION DATE: FIs December 16, 2005 and carriers initial determinations issued on or after January 1, 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	29/310.1/Filing a Request for Redetermination
N	29/310.6.1/Appeal Rights for Dismissals
N	29/310.6.3/Dismissal Letters
N	29/310.6.4/Model Dismissal Notices
N	29/320/Reconsideration - The Second Level of Appeal
N	29/320.1/Filing a Request for a Reconsideration
N	29/320.2/Time Limit for Filing a Request for a Reconsideration
N	29/320.3/Contractor Responsibilities - General
N	29/320.4/QIC Case File Development
N	29/320.5/QIC Case File Preparation
N	29/320.6/Forwarding QIC Case Files
N	29/320.7/QIC Jurisdictions
N	29/320.8/Tracking Cases
N	29/320.9/Effectuation of Reconsiderations

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: 724	Date: October 21, 2005	Change Request 3939

NOTE: Transmittal 687, dated September 23, 2005 is rescinded and replaced with Transmittal 724, dated October 21, 2005. There were changes to the policy section of the business requirements that addressed two different implementation dates. All other information remains the same.

SUBJECT: Appeals of Claims Decisions: Redeterminations and Reconsiderations.

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. This CR contains instructions on filing requests for redeterminations and on the reconsideration (2nd level in the appeals process).

In accordance with the implementation approach provided in the March 8, 2005, Federal Register notice (Vol. 70, No. 44, page 11425), this CR contains two different implementation dates. CMS Pub. 100-4, chapter 29, §310.1 is based on 42 CFR 405.944(a) & (b) and therefore must be implemented for FI initial determinations issued on or after May 1, 2005 and for carrier initial determinations issued on or after January 1, 2005. CMS Pub.100-4, §§ 310.6.1, 310.6.3, 310.6.4, 320-320.8 are based on 42 CFR 405.970-986 and therefore must be implemented May 1, 2004 for redeterminations issued by FIs and January 1, 2006 for redeterminations issued by carriers.

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	
3939.1	The FI or Carrier shall accept redetermination requests made on behalf of a beneficiary as described in §310.1 A.	x	x	x	x					
3939.2	The FI or carrier shall accept request for redeterminations submitted by Members of Congress as described in §310.1 (A) (1).	x	x	x	x					
3939.3	The FI or carrier shall accept written redetermination requests from beneficiaries made on Form CMS-10115 or other types written requests described in §310.1(B).	x	x	x	x					
3939.4	The FI or carrier shall accept written redetermination requests from a State, provider, physician, or other supplier when they complete the Form CMS-20027 or another written request that contains the beneficiary name, Medicare health insurance claim (HIC) number, specific service(s) and/or items(s) for which the redetermination is being requested, the specific date(s) of service; and the name an signature of the party or the representative of the party.	x	x	x	x					
3939.5	The FI or carrier shall consider letters or calls as inquiries as described in §310.1(B)(3).	x	x	x	x					
3939.6	The FI or carrier shall reopen any case that is remanded to it by a QIC because the dismissal was incorrect and shall issue a new decision on the case.	x	x	x	x					
3939.7	The FI or carrier shall issue a written notice of a dismissal to all parties to the appeal.	x	x	x	x					
3939.8	The FI or carrier shall include the language/information described in §310.6.3 in dismissal letters.	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	
3939.9	The FI or carrier shall handle and count incomplete redetermination requests as dismissals as described in §310.6.3.	x	x	x	x					
3939.10	The FI or carrier shall use the model dismissal letters in § 310.6.4 or something similar.	x	x	x	x					
3939.11	The FI or carrier shall refer the appellant to the QIC with jurisdiction in the redetermination letter.	x	x	x	x					
3939.12	The FI or carrier shall have standard operating procedures to ensure that misrouted reconsideration requests are sent/transmitted to the QIC, along with the appropriate case file(s), within 14 calendar days of receipt in the corporate mailroom.	x	x	x	x					
3939.13	The FI or carrier shall send misrouted reconsideration case files by an electronic means agreed upon in the joint operating agreements (JOAs) or by a courier service so that the case file is received by the QIC before or on the 15th calendar day after receipt.	x	x	x	x					
3939.14	The FI or carrier shall have standard operating procedures to ensure that misfiled reconsideration requests are sent/transmitted to the QIC, along with the appropriate case file(s), within 14 calendar days of receipt in the corporate mailroom.	x	x	x	x					
3939.15	The FI or carrier shall send misfiled reconsideration case files by an electronic means agreed upon in the joint operating agreements (JOAs) or by a courier service so that the case file is received by the QIC before or on the 15th calendar day after receipt.	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	
3939.16	The FI or carrier shall not count misfiled or misrouted reconsideration requests as dismissals. The FI or carrier shall count costs associated with misrouted or misfiled request in the CAFM line designated for preparing/transferring case files to the QIC.	x	x	x	x					
3939.17	The FI or carrier shall employ provider education efforts with an emphasis on the dates for transition and filing location.	x	x	x	x					
3939.18	The FI or carrier shall prepare and forward case files upon request from a QIC in accordance with §§320.1, 320.5, and 320.6.	x	x	x	x					
3939.19	The FI or carrier shall effectuate reconsiderations when notified by the QIC of a favorable decision or liability change in accordance with §320.8 and notify the QIC of the payment action taken.	x	x	x	x					
3939.20	The FI or carrier shall prepare case files and forward misrouted reconsideration requests in accordance with §320.1(B).	x	x	x	x					
3939.21	The FI or carrier shall enter into a Joint Operating Agreements (JOAs) with the appropriate QIC(s) and AdQIC.	x	x	x	x					
3939.22	The FI or carrier shall comply with the appropriate JOA.	x	x	x	x					
3939.23	The FI or carrier shall send/transmit a case file requested by a QIC within 7 calendar days of the date of the QIC's request.	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	
3939.24	The FI or carrier shall track all incoming requests from the QIC for case files in accordance with § 320.7.	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	
	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: Section 310.1- FI initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006. Sections 310.6.1, 310.6.3, 310.6.4, & 320-320.8- FI redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006. **Implementation Date:** **FIs** – December 16, 2005 Carrier - Section 310.1- initial determinations issued on or after January 1, 2006. - Sections 310.6.1, 310.6.3, 310.6.4, & 320-320.8- redeterminations issued on or after January 1, 2006. **Pre-Implementation Contact(s):** Tara Boyd at 410-786-2069 or Jennifer Frantz at 410-786-9531 **Post-Implementation Contact(s):** Contact your local regional office	**Funding for implementation activities will be provided to contractors through the regular budget process.**

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

Table of Contents
(Rev. 724, 10-21-05)

310.1 - Filing a Request for Redetermination

(Rev. 724, Issued: 10-21-05; Effective: FIs initial determinations issued on or after May 1, 2005 and carrier initial determinations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers initial determinations issued on or after January 1, 2006)

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

A. Written Redetermination Requests Filed on Behalf of the Beneficiary

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

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

Although the contractor may have honored a request for redetermination filed by someone other than the beneficiary or the beneficiary's appointed representative, only the beneficiary or representative should be contacted or consulted for further information when processing the redetermination and when issuing the determination (unless the requestor is the beneficiary's legal guardian, in which case no appointment is required).

There will be circumstances where the mental and/or physical incapacity of the beneficiary becomes an issue. Based on all the documented medical information available, the contractor may decide to allow the person submitting the request for redetermination to act on behalf of a beneficiary who is mentally or physically incapacitated. The contractor's decision, as well as the beneficiary's incapacitation, should be

documented in the file and supported by relevant medical documentation. (See §270, for more information on this subject.)

1. Requests for Redetermination Submitted by Members of Congress

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

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

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

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

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

B. What Constitutes a Request for Redetermination

1. Written Requests for Redetermination Made by Beneficiaries

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

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

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

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

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

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

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

- *Beneficiary name;*
- *Medicare health insurance claim (HIC) number;*
- *The specific service(s) and/or item(s) for which the redetermination is being requested;*
- *The specific date(s) of the service; and*
- *The name and signature of the party or the representative of the party.*

NOTE: *Some redetermination requests may contain attachments. For example, if the RA is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.*

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a request for redetermination if it contains the information listed above and either (1) explicitly asks the contractor to take further action or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination. It must note the details of its actions (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.

How to handle incomplete requests*: If any of the above information referenced in Section 2 is not included with the appeal request, the contractor dismisses it to the State or provider with an explanation of the information that must be included (See §310.6 for more information on dismissals). For beneficiary requests, please refer to § 310.1(B)(1) and § 310.6.3.*

3. Letters and Calls That Are Considered Inquiries *- See CMS Pub. 100-9.The contractor considers the letter or telephone call an inquiry (i.e., not an appeal request) if:*

- *It is clearly limited to a request for an explanation of how Medicare calculated payment;*
- *It is a status request. The contractor states in its reply that it is responding to a status request. It does not use the word "review" in its reply;*
- *It is a request for information;*

- *The party asks only for a second copy of a notice; or*
- *There is not an initial determination.*

For more information on inquiries, refer to Medicare Pub 100-9.

310.6.1 - Appeal Rights for Dismissals

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to the QIC. A party to the redetermination may appeal the dismissal if they believe the dismissal is incorrect. The reconsideration request must be filed at the QIC within ***60 days*** *of the date of the dismissal. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the contractor incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the contractor for reopening. It is mandatory for the contractor to reopen any case that is remanded to it and issue a new decision. The new decision is counted in Contractor Reporting of Operational and Workload Data (CROWD) on the 2590 or 2591 as a "post-review reopening" or "post-reconsideration reopening." A QIC's reconsideration of a contractor's dismissal of a redetermination request is final and not subject to any further review.*

310.6.3 - Dismissal Letters

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

The contractor must issue a written notice of dismissal to all parties to the appeal. It must include in the notice the information that, at the request of a party and for good and sufficient cause shown, it may vacate its dismissal of a request for redetermination at any time within 6 months from the date of its mailing of the notice of dismissal. The dismissal notice is sent to the party requesting the redetermination at his/her last known address, as well as to his/her representative and all other parties to the appeal. The dismissal notice includes the reason for the dismissal.

Contractors shall include the following language, or something similar, in dismissal letters (also see the model dismissal letter in Eexhibit 4):

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

1. If you think you have good and sufficient cause for <insert reason for dismissal>, you may ask us to vacate our dismissal. We will vacate our dismissal if we determine you have good and sufficient cause. If you would like to request us to vacate this dismissal, you must file a request within ***6 months*** *of the date of this notice. In your request, please explain why you believe you have good and sufficient cause. Please send your request to:*

Insert AC Address

2. If you think we have incorrectly dismissed your request (for example, you believe <insert reason (e.g. you did file your request on time, you were a proper party, the contractor did issue an initial determination on the claim)>), you may request a reconsideration of the dismissal by a Qualified Independent Contractor. Your request must be filed within ***60 days*** *of receipt of this letter. The Qualified Independent Contractor will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the Qualified Independent Contractor will not consider any evidence for establishing coverage of the claims(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:*

Insert QIC Address

Incomplete Requests*- The requirements for written requests for redetermination are found in §310.1(B)(2) (Note: Beneficiary requests are never considered incomplete, see § 310.1(B)(1)). Contactors must handle and count incomplete redetermination requests as dismissals. The above requirements under § 310.6.2 for vacating and appealing dismissals apply to incomplete requests as well. Parties to the redetermination also have the option to refile their request if any time remains in the filing period (i.e., 120 days from receipt of the initial determination). When a request is refiled that meets the requirements, the previous dismissal is vacated and reopened. Contractors must notify parties of their options in the dismissal notice. Please see the model dismissal notice for an incomplete request in §310.6.4.*

310.6.4 - Model Dismissal Notices

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

Medicare Number of Beneficiary:
111-11-1111 A

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

Model Redetermination

Dismissal Notice for Incomplete Request

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

Dear Appellant's Name:

This letter is in response to your redetermination request that was received in our office on (insert date). The redetermination was requested for the following dates of service (insert date(s)). Your redetermination request has been dismissed because it did not contain all the information we need to process your request. In order to process a redetermination request, we need the following pieces of information:

- *The beneficiary's name;*
- *The Medicare health insurance claim number of the beneficiary;*
- *The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service; and*
- *The name and signature of the person filing the redetermination request.*

Your request has been dismissed because it did not contain (insert the item that was missing).

You may file your request again if it has been 120 days or less since the date of receipt of the initial determination notice. When you file your request, please make sure you include all the above listed items. Please send your request to:

Insert AC Address

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

1. *If you think you have good and sufficient cause for failing to include all these items in your request, you may ask us to vacate our dismissal. If you would like us to vacate our dismissal,* ***you must file a request within 6 months of the date of receipt this notice****. In your request, please explain why you believe you have good and sufficient cause for failing to include the proper information in your request. Please send your request to:*

Insert QIC Address

2. *If you think we have incorrectly dismissed your request (that is, you believe you did include all the above listed items in your request), you may request a reconsideration of the dismissal by a Qualified Independent Contractor. Your request must be filed within **60 days** of receipt of this letter. The Qualified Independent Contractor will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the Qualified Independent Contractor will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:*

Insert Address

Sincerely.

Review Name
Contractor Name
A Medicare Contractor

Medicare Number of Beneficiary:
111-11-1111 A

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

Model Redetermination
Dismissal Notice For An Untimely Appeal

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

Dear Appellant's Name:

This letter is in response to your redetermination request that was received in our office on (insert date). The redetermination was requested for the following dates of service (insert date(s)). Your redetermination request has been dismissed because the denial of the date(s) of service in question is/are past the time limit to file a request for a redetermination. A redetermination must be requested within 120 days of receipt of the initial determination date on the Medicare Remittance Notice or the Medicare Summary Notice.

When we receive a request that has been filed late, we consider whether the appellant had good cause for filing late. In special circumstances, we may allow additional time to file. In this case, we did not find good cause for filing your request late.

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

1. *If you think you have good and sufficient cause for filing late, you may ask us to vacate our dismissal. We will vacate our dismissal if we determine you have good and sufficient cause for filing late. If you would like to request us to vacate this dismissal,* ***you must file a request within 6 months of the date of receipt of this notice****. In your request, please explain why you believe you have good and sufficient cause for filing late. Please send your request to:*

   Insert AC Address

2. *If you think we have incorrectly dismissed your request (for example, you believe you did file your request on time), you may request a reconsideration of the dismissal by a Qualified Independent Contractor. Your request must be filed within* ***60 days*** *of receipt of this letter. The*

Qualified Independent Contractor will have 60 days to complete the reconsideration. In your request, please explain why you believe the dismissal was incorrect. Please note that the Qualified Independent Contractor will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:

Insert QIC Address

Sincerely.

Review Name
Contractor Name
A Medicare Contractor

320 - Reconsideration- The Second Level of Appeal

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

Section 1869 of the Act entitles any individual dissatisfied with the contactor's redetermination to file a request, within 180 days of receipt of the redetermination, for a reconsideration. In accordance with §1869(c), reconsiderations are to be processed within 60 days by entities called qualified independent contractors (QICs). CMS is required to contract with no fewer than four QICs. When a claim is denied on the basis of §1862(a)(1)(A) of the Act, the QIC reconsideration will consist of a panel of physicians and other health professionals. When the panel reviews services or items rendered by a physician or ordered by a physician, the panel will consist of at least one physician.

320.1 - Filing a Request for a Reconsideration

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

The request for a reconsideration made by a beneficiary, provider, supplier, or State and must be filed with the QIC specified in the redetermination notice. A request from a provider, supplier, or State must be made in writing either on a standard CMS form (CMS 20033), the reconsideration request form included with the redetermination, 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 14 calendar days of receipt in the corporate mailroom. The case file must be sent either by an electronic means agreed upon in the joint operating agreements (JOAs) or by a courier service so that the case file is received by the QIC before or on the 15th calendar day after the receipt. There also may be instances where the redetermination decision is issued after May 1, 2005 (for FIs) or January 1, 2006 (for carriers and DMERCs) and the appellant mistakenly requests or misfiles a hearing officer hearing. Contractors shall have standard operating procedures to ensure that these requests are identified and transmitted to the QIC, along with the appropriate case file(s) within 14 calendar days of receipt in the corporate mailroom. Contractors shall track all misfiled and misrouted reconsideration requests to ensure receipt at the proper QIC. The QIC will send the carrier or DMERC an acknowledgement of receipt of any misfiled requests. Contractors shall not count such misrouted or misfiled requests as dismissals. The contractor counts the costs associated with misrouted or misfiled requests in the CAFM line designated for preparing/transferring case files to the QIC. To avoid misrouted requests for QIC reconsiderations, contractors shall employ provider education efforts with an emphasis on the dates for transition and filing locations.

320.2 - Time Limit for Filing a Request for a Reconsideration

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

A party must file a request for reconsideration within 180 days of the date of receipt of the notice of the redetermination. The date of filing for requests filed in writing is defined as the date received by the QIC in their corporate mailroom. If the party has filed the request in person with the QIC, the filing date is the date of filing at such office, as evidenced by the receiving office's date stamp on the request. If the party has mailed the request for reconsideration to CMS, SSA, RRB office, or another Government agency in good faith within the time limit, and the request did not reach the appropriate QIC until after the time period to file a request expired, the QIC considers good cause for late filing (See § 240 for more information on good cause). Likewise, if the request is filed with CMS, SSA, RRB, or another Government agency in person, the QIC considers good cause for late filing

The QIC may extend the period for filing if it finds the appellant had good cause for not requesting the reconsideration timely. (See §240 for a discussion of good cause.) In order for good cause to be considered, the appeal request must be in writing. If the QIC finds that the appellant did not have good cause for not requesting a reconsideration on time, it may, at its discretion, consider reopening. (See Chapter 33)

320.3 - Contractor Responsibilities – General

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

The contractors responsibilities for reconsiderations are:

- *Preparing and forwarding case files upon request from a QIC in accordance with §§320.4, 320.5, 320.6 and the Joint Operating Agreement (JOA);*
- *Effectuating reconsiderations when notified by the QIC of a favorable decision or unfavorable decision with a change in liability in accordance with § 320.8 and notifying the QIC of the final payment adjustment;*
- *Preparing case files and forward misrouted or misfiled reconsiderations requests in accordance with § 320.1(B).*
- *Entering into JOAs with the appropriate QIC(s) and AdQIC; and;*
- *Complying with the appropriate JOAs.*

320.4 - QIC Case File Development

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

When the QIC receives a request for reconsideration, it will request the case file from the contractor with jurisdiction using the Redetermination Case File Request Form. The

QIC will send the request either by electronic mail (e-mail), telephone, fax, or by any other method agreed upon in the JOAs. (Note: Individually identifiable beneficiary information should not be given in an unsecure e-mail) If another method is agreed upon in the JOAs, it must meet the privacy requirements of HIPAA. Contractors shall send/transmit the case file within 7 calendars days of the date of the QIC's request. The date of QIC's request is defined as the date the phone call is made (if a message is left, it is defined as the date the message was left) or the date of the e-mail request. The case files must be sent either by an electronic means agreed upon in the JOAs or by a courier service so that the case files are received by the QIC before or on the 8th calendar days after its request. The contractor counts the costs associated with sending case files in the Contractor Administrative Budget and Financial Management (CAFM) code designated for preparing/transferring case files to the QIC.

If agreed upon in the JOAs, the following requirements apply to e-mail, fax and phone requests:

***(a) E-mail requests**-Contractors shall maintain an e-mail account specifically for the receipt of case file requests from the QIC. If individually identifiable information is given in the request or response, a secure e-mail account must be used. Contractors must check this e-mail account at least once daily (every business day). When contractors receive e-mail requests from the QIC, they shall notify the QIC of receipt.*

***(b) Phone Requests**-Contractors shall designate and maintain a phone extension specifically for the receipt of case file requests from the QIC. Contractors shall designate a main contact person and back-up contact that is available to take phone calls during core business hours on all business days (unless otherwise agreed upon in the JOAs).*

***(c) Fax Requests**-Contractors shall designate and maintain a fax machine for the receipt of casefile requests from the QIC.*

320.5 - QIC Case File Preparation

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

Once a party requests a reconsideration with a QIC, the QIC will need to obtain the case file from theFI, Carrier, or DMERC. The foundation for an effective, efficient and accurate appeals system is the case file. It is essential that the case file contain all relevant information and evidence concerning an appeal so that the QIC can make a correct and fair determination. The contractor builds the case file from the bottom up, with the oldest set of documents on the bottom, and the most recent set of documents at the top. However, it does not place the medical documentation on the bottom. Medical documentation goes in a separate and distinct section of the case file. Medical

documentation does not need to be ordered chronologically, but rather can be included in the case file as submitted by the provider.

The following is a list of the documents generally included in any case file. Note that there may be others not listed here. For applicable items, the contractor includes originals and retains hard copies of any documents that are not available electronically for its records. Do not send abbreviated versions, or versions of documents that the contractor has retyped or paraphrased for purposes of shortening the document. The contractor must keep an exact copy of the file that is sent to the QIC. (Note: This applies only when documents are not otherwise available electronically.) The contractor retains the copies for at least 6 months. If it is unable to include the original documents, it includes photocopies that are true facsimiles of the original documents. It arranges the following documents, in descending date order (i.e., the claim form is on the bottom).

Procedural Documents:

- *Claim form or printout, if electronically generated (facsimile and/or screen prints are acceptable);*
- *MSN/RA - older files may contain EOMBs or Denial Letters, which must also be included. (Facsimile and/or screen prints are acceptable);*
- *Redetermination request;*
- *Redetermination notice;*
- *Appointment of representative form (Form CMS-1696-U4 or Form SSA-1696-U4) or other written authorization, if applicable;*
- *All documentation related to the assessment of an overpayment.*

Medical Documents:

- *Medical records, separated by facility, doctor, or location of service (separated by a colored sheet or a sheet of paper with a heading);*
- *Referral to/from contractor medical staff (with professional qualifications of the reviewer noted in the document, if applicable);*
- *Contractor medical policies and opinions relevant to claim(s). (In addition to contractor medical policy, the contractor should include in the case file any information it has as background to the particular policy at issue. For example, findings of the Contractor Advisory Committee (CAC) with regard to the policy, including professional publications relied upon to support the policy, opinions from professional medical societies who may have commented on the policy during the development phase, etc.) (See the Program Integrity Manual for additional information.);**
- *A list of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, and CMS manuals;*
- *Copies of LCDs, newsletters, any other pertinent information that maybe used by the QIC*;*
- *Any other exhibits that the contractor may consider important for the QIC to consider (e.g., certification of reasonable charge, fee schedule information, notices of noncoverage, contractor publications.); and*
- *Any additional evidence submitted by the appellant.*

**If accessible by internet, the FI, carrier or DMERC enter into a joint operating agreement with the QIC to provide a list instead of actual copies.*

Assembly Instructions:

- *The contractor uses an appropriate file/folder/envelope which will contain necessary documents in proper order, if the case file is not transmitted electronically.*
- *For combined requests filed by a beneficiary, the contractor keeps the documents relating to treatment from each provider, physician, or supplier together. It separates the documents relating to each provider, physician or supplier by a blank sheet of paper;*
- *For combined requests filed by a provider, physician, or other supplier, the contractor keeps the documents relating to each beneficiary together and organized alphabetically by beneficiary last name. It separates the documents relating to each beneficiary by a blank sheet of paper. It provides a complete set of procedural documents for each beneficiary; and*
- *The contractor groups procedural documents together in chronological order and groups medical documents together in chronological order.*

Reconsideration Case Transmittal Form

The Reconsideration Case Transmittal Form documents the claim information and the date of the redetermination. It also identifies the FI, Carrier or DMERC that made the redetermination and the QIC with jurisdiction for the reconsideration. The summary sheet should be placed on top of the documents in the case file. The QIC will provide a Reconsideration Case Transmittal Form for use in the JOA.

320.6 - Forwarding QIC Case Files

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

Contractors shall send/transmit the case file within 7 calendar days of the date of the QIC's request. The date of QIC's request is defined as the date the phone call is made (if a message is left, it is defined as the date the message was left) or the date of the e-mail request. The case files must be sent either by an electronic means agreed upon in the joint operating agreement or by a courier service so that the case file is received by the QIC before or on the 8th calendar days after its request.

320.7 - QIC Jurisdictions

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

A. FI QIC Jurisdictions

The FI QIC jurisdictions are as follows:

Jurisdiction	*Normal States*	*Exceptions*
East QIC jurisdiction (Maximus)	*Colorado, New Mexico, Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Georgia, Florida, Tennessee, South Carolina, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New Jersey, New York, Delaware, Maryland, Pennsylvania, Washington DC and Mutual of Omaha claims were the service was rendered in one of the above listed states.*	***Chain Providers (including ESRD)**- the state where the FI processes the claim. For Mutual of Omaha claims, the jurisdiction continues to be the state were the service was rendered.* ***Indian Health Services Nationwide**- processed by TrailBlazers* ***Foreign claims**- Eastern Mexico (processed by Trailblazer), Canadian Provinces of New Burnswick, Newfoundland, Nova Scotia, Quebec, and Prince Edward Island (processed by AHS)* ***Rural Health Clinics Nationwide**- processed by Anthem, Highmark, TrailBlazer, and Riverbend* ***Federal Qualified Health Centers**- in accordance with normal jurisdiction (processed by UGS)*
West QIC jurisdiction (First Coast Service Options)	*Washington, Idaho, Montana, North Dakota, South Dakota, Iowa, Missouri, Kansas, Nebraska, Wyoming, Utah, Arizona, Nevada, California, Alaska, Hawaii, Oregon, Kentucky, Ohio, Indiana, Illinois, Minnesota, Michigan, Wisconsin, Guam, Northern Mariana Islands, American Samoa, and Mutual of Omaha claims were the service was rendered in one of the above listed states.*	***Chain Providers (including ESRD)**- the state where the FI processes the claim. For Mutual of Omaha claims, the jurisdiction continues to be the state were the service was rendered.* ***Foreign claims**- Western Mexico (processed by NHIC), Canadian Provinces of Ontario (processed by UGS) Saskatchewan, Alberta Manitoba (processed by BC of Montana), British Columbia, Vancouver, and Yukon Territories (processed by Noridian).* ***Federal Qualified Health Centers**- in accordance with normal jurisdiction (processed by UGS)*

B. Carrier and DMERC QIC Jurisdictions:

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

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

320.8 - Tracking Cases

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

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

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

Contractors shall track all requests from the QIC for effectuation (see §320.8). The contractor shall make a record of the date of receipt of the QIC's request for effectuation, the date of effectuation (i.e., issue payment), and the date of the notification to the QIC that effectuation is complete.

320.9 - Effectuation of Reconsiderations

(Rev. 724, Issued: 10-21-05; Effective: FIs redeterminations issued on or after May 1, 2005 and carrier redeterminations issued on or after January 1, 2006; Implementation: FIs 12/16/05 and carriers redeterminations issued on or after January 1, 2006)

In many cases, the QIC's decision will require an effectuation action on the contractor's part. The contractor does not effectuate based on correspondence from any party of the reconsideration. It takes an effectuation action only in response to a formal decision and Reconsideration Effectuation Notice from the QIC. "Effectuate" means for the contractor

to take the necessary actions to issue a payment or change liability. If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, the contractor effectuates within 30 calendar days of the date of the QIC's decision. (Note: CMS does not anticipate that QICs will specify an amount to be paid in reconsideration notices.) If the decision is favorable, but the contractor must compute the amount, it effectuates the decision within 30 days after it computes the amount to be paid. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the QIC's decision. The amount of payment and date of effectuation shall be reported to the appropriate QIC within 14 days of the date the effectuation has been finalized. The QIC will forward a copy of all decisions to the AC.