



# MLN Matters®



Information for Medicare Fee-For-Service Health Care Professionals

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## **MMA - Changes to Chapter 29 – Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review**

**Note:** This article was updated on October 23, 2012, to reflect current Web addresses. All other information remains unchanged.

### **Provider Types Affected**

Physicians, providers, and suppliers who submit Part A or Part B Fee-for-Service claims to Medicare for services

### **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*. It 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).

The purpose of this article is to notify you about changes to the manual provisions that address Administrative Law Judge, Departmental Appeals Board, and U.S. District Court review levels of appeal.

### **Key Points**

#### ***Administrative Law Judge (ALJ) - The Third Level of Appeal***

Parties to an appeal who are not satisfied with decisions made by the QIC at the second level of appeal (reconsideration), have the right to request an ALJ hearing as long as all of the ALJ hearing request requirements are met (see *Medicare Claims Processing Manual*, Chapter 29, Section 330 for details). Outlined below is some pertinent information about the ALJ level of the appeal process.

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**ALJ Hearing Amount in Controversy**

Parties requesting an ALJ Hearing must meet the Amount in Controversy requirements:

- The amount remaining in controversy requirement for requests made before January 1, 2006 is \$100.
- The amount remaining in controversy will increase to \$110 for requests made on or after January 1, 2006.
- Beginning in 2005, for requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement will increase by the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of \$10 will be rounded to the nearest multiple of \$10.

**Time Limits and Responsibilities**

**Decisions:** The official ALJ decision is a signed copy of the ALJ decision. When issuing decisions, the ALJ will either:

- Issue a decision based on the request for ALJ hearing; or
- Issue an order of dismissal of the appellant's request for ALJ hearing.

**Effectuation (No Agency Referral):** Often, the ALJ's decision will require an effectuation action (payment of the claim) on the Medicare contractor's part. Contractors will effectuate ALJ decisions within 30 days of the receipt of the official ALJ decision if:

- The decision is partially or wholly favorable;
- The decision gives a specific amount to be paid; and
- There is no agency referral to the DAB.

**Computation of the Amount (No Agency Referral):** If the amount must be computed by the Medicare contractor, the decision must be effectuated within 30 days after the contractor computes the amount to be paid to the appellant. The computation should be done as soon as possible, but no later than 30 calendar days of the date of receipt of the official ALJ decision or effectuation notice.

**Clarification (No Agency Referral):** If clarification from the ALJ is necessary, then the date of the clarification is considered to be the final determination for purposes of effectuation.

If clarification is needed from the physician/supplier (e.g., splitting charges), this clarification should be requested as soon as possible and the amount payable should be computed within 30 calendar days after the receipt of the necessary

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### ***Departmental Appeals Board (DAB) - The Fourth Level of Appeal***

The DAB evaluates requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs.

***DAB Effectuation Time Limits:*** DAB decisions requiring contractor effectuation must be initiated within 30 days of receipt of a DAB decision. Effectuation must be completed within 60 days.

### ***U.S. District Court: The Fifth Level of Appeal***

A party may request court review of the DAB's decision. Medicare contractors are not responsible for reviewing ALJ decisions issued by the Department of Health and Human Services (HHS) ALJs to determine if an agency referral is appropriate, and will not accept a request for U.S District Court review by a party.

## **Relevant Links**

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The official instruction issued to your FI including Regional Home Health Intermediaries (RHHIs), or carrier including DMERCs, regarding this change may be found by going to <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R862CP.pdf> on the CMS website. The new sections of Chapter 29 of the Medicare Claims Processing Manual are attached to CR4152.

Please refer to your local FI/RHHI or carrier/DMERC if you have questions about this issue. To find the toll free phone number, go to <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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