

Medicare Claims Processing Manual

Chapter 29 - Appeals of Claims Decisions

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Adjudicator – The entity responsible for making the decision at any level of the Medicare claim decision making process, from initial determination to the final level of appeal, on a specific claim.

Administrative Law Judge (ALJ) – Adjudicator employed by the Department of Health and Human Services (HHS), Office of Medicare Hearings and Appeals (OMHA) that holds hearings and issues decisions related to level 3 of the appeals process.

Affirmation - A term used to denote that a prior claims determination has been upheld by the current claims adjudicator. Although appeals through the OMHA level are de novo, CMS and its contractors often use this term when an adjudicator reaches the same conclusion as that in the prior determination, even though he/she is not bound by the prior determination.

Amount in Controversy (AIC) - The dollar amount required to be in dispute to establish the right to a particular level of appeal. Congress establishes the amount in controversy requirements.

Appeals Council – The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board, provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment. (See also Departmental Appeals Board.)

Appellant - The term used to designate the party (i.e., the beneficiary, provider, supplier, or other person showing an interest in the claim determination) or the representative of the party that has filed an appeal. The adjudicator determines if a particular appellant is a proper party or representative of a proper party.

Applicable plan – Applicable plan means liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan.

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

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

OR

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

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

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

Attorney Adjudicator - A licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance, authorized to take the actions provided for in 42 CFR 405 subpart I on requests for ALJ hearing and requests for reviews of QIC dismissals.

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

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

Contractor - An entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions.

Date of Receipt – A determination, decision or notice is presumed to have been received by the party five days from the date included on the determination or decision, unless there is evidence to the contrary.

NOTE: Throughout Chapter 29, reference to day or days means calendar days unless otherwise specified.

Departmental Appeals Board (DAB) Review - The DAB provides impartial, independent review of disputed decisions in a wide range of Department of Health and Human Services programs under more than 60 statutory provisions. The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board, provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment. (See section 340 in this chapter.)

De Novo - Latin phrase meaning “anew” or “afresh,” used to denote the manner in which claims are adjudicated in the administrative appeals process. Adjudicators at each level of appeal make a new, independent and thorough evaluation of the claim(s) at issue, and are not bound by the findings and decision made by an adjudicator in a prior determination or decision.

Decisions and Determinations -If a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a “determination” or “decision.” There is no apparent practical distinction between these two terms although applicable regulations use the terms in distinct contexts.

A decision that is reopened and thereafter revised is called a “revised determination.”

Dismissal - An action taken by an adjudicator when an appeal will not be conducted as requested. A request for appeal may be dismissed for any number of reasons, including:

1. Abandonment of the appeal by the appellant;
2. A request is made by the appellant to withdraw the appeal;
3. A determination that an appellant is not a proper party;
4. The amount in controversy requirements have not been met; and
5. The appellant has died and no one else is prejudiced by the claims determination.

Limitation on Liability Determination- Section [1879](#) of the Social Security Act (the Act) provides financial relief to beneficiaries, providers and suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare coverage and payment would otherwise be denied. This section of the Act is referred to as “the limitation on liability provision.” Both the underlying coverage determination and the limitation on liability determination may be challenged. For more detailed information see chapter 30 of this manual.

Medicare number and/or Medicare beneficiary identifier (Mbi) - are general terms describing a beneficiary's Medicare identification number. Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes. For the beneficiary population, the term Medicare number is used to describe the Medicare beneficiary identifier (Mbi).

Office of Medicare Hearings and Appeals (OMHA) - The Office of Medicare Hearings and Appeals is responsible for level 3 of the Medicare claims appeal process and certain Medicare entitlement appeals and Part B premium appeals. At level 3 of the appeals process, an appellant may have a hearing before an OMHA ALJ, or review by an attorney adjudicator.

Party - A person and/or entity normally understood to have standing to appeal an initial determination and/or a subsequent administrative appeal determination or decision. (See section 210 in this chapter.)

Provider of services (herein provider) – As used in this section, the definition in [42 CFR 405.902](#) for provider applies. Provider means a hospital, a critical access hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization *or intensive outpatient* services. NOTE: A non-participating provider, that is, an entity eligible to enter into a provider agreement to participate in Medicare but has not entered into such an agreement, is not considered a provider of services and does not have party status for an initial determination or appeal.

Qualified Independent Contractor (QIC) – Entity that contracts with the Secretary in accordance with the Act to perform level 2 appeals, which are called reconsiderations, and expedited reconsiderations.

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

Reopening - See IOM 100-04 Chapter 34.

Reversal - Although appeals in the administrative appeals process are de novo proceedings (i.e., a new determination/decision is made at each level), Medicare uses this term where the new determination/decision is more favorable to the appellant than the prior determination/decision, even if some aspects of the prior determination/decision remain the same.

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

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

redetermination. **Spouse** - The word “spouse” as used in this chapter, and as used in sections [405.952](#), [405.972](#), [405.1052](#), and [405.1114](#) of title 42 of the Code of Federal Regulations (CFR) regarding the dismissal of an appeal includes same-sex spouses as well as opposite-sex spouses. The relationship of two individuals of the same sex will be recognized as a marriage if either (1) the state or territory in which the individuals live recognizes their relationship as a marriage, or (2) the individuals entered into a legally valid marriage under the law of any state, territory, or foreign jurisdiction. Because civil unions and domestic partnerships are not marriages, civil union and domestic partners are not regarded as spouses by CMS.

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

Vacate – To set aside a previous action.

200 - CMS Decisions Subject to the Administrative Appeals Process *(Rev. 12423; Issued: 12-20-23; Effective: 01-01-24; Implementation: 01-02-24)*

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 contact the SSA for administrative appeals involving entitlement (telephone 1-800-772-1213 (TTY 1-800-325-0778 or access the SSA’s website at: <http://ssa.gov/pgm/medicare.htm>). 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 its initial determination in accordance with [20 CFR part 404, subpart J](#). Following the reconsideration, the beneficiary may request a hearing before a HHS Administrative Law Judge (ALJ). If the beneficiary obtains a hearing before an ALJ and is dissatisfied with the decision of the ALJ, he or she may request the Appeals Council to review the case. Following the action of the Appeals Council, the beneficiary may be entitled to file suit in Federal district court.

B. Initial Determinations

The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment does not meet the requirements for a Medicare claim

shall not be considered an initial determination. An initial determination for purposes of this chapter includes, but is not limited to, determinations with respect to:

- (1) Whether the items and/or services furnished are covered under title XVIII of the Act;
- (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) Periods of hospice care used;
- (8) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, partial hospitalization services, *and intensive outpatient services*;
- (9) 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\(c\)\(4\)](#);
- (10) 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\(c\)\(1\)](#);
- (11) 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;
- (12) 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;
- (13) 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;

- (14) Under the Medicare Secondary Payer provisions of section [1862\(b\)](#) of the Act that Medicare has a recovery claim against a provider, supplier, or beneficiary for 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](#) because this action is a reopening;
- (15) A claim not payable to a beneficiary for the services of a physician who has opted-out. NOTE: A physician who has opted-out of Medicare is not considered a party to the initial determination or any subsequent appeal; and
- (16) Under the Medicare Secondary Payer provisions of section [1862\(b\)](#) of the Act that Medicare has a recovery claim if Medicare is pursuing recovery directly from an applicable plan. That is, there is an initial determination with respect to the amount and existence of the recovery claim.

C. Actions That Are Not Initial Determinations

Actions that are not initial determinations and are not appealable under this 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; or a determination under the Medicare Secondary Payer provisions of section [1862\(b\)](#) of the Act of the debtor for a particular recovery claim;
- (2) The coinsurance amounts prescribed by regulation for outpatient services under the prospective payment system;
- (3) Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a contractor has sole responsibility under Part B, such as the establishment of a fee schedule set forth in [42 CFR, part 414, subpart B](#), or an inherent reasonableness adjustment pursuant to [42 CFR 405.502\(g\)](#) and any issue regarding the cost report settlement process under Part A:

NOTE: For example, section [1848\(i\)\(1\)](#) of the Act prohibits administrative and judicial review of the individual components used to compute Medicare physician fee schedule payment amounts. However, a payment amount determination with respect to a particular item or service on a claim is an initial determination that is appealable.

- (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 483.5](#) (definition of transfer and discharge) and [483.15](#);
- (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 an entity that was or is required or responsible (directly, as an insurer or self-insurer; as a third party administrator; as an employer that sponsors, contributes to or facilitates a group health plan or a large group health plan; or otherwise) to make payment for services or items that were already reimbursed by the Medicare program, except with respect to the amount and existence of a recovery claim under section 1862(b) of the Act where Medicare is pursuing recovery directly from an applicable plan as specified in [42 CFR 405.924\(b\)\(16\)](#);
- (12) A contractor's, QIC's, ALJ's, OMHA attorney adjudicator's, or Appeals Council's determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision;
- (13) Determinations that CMS or its contractors may participate in the proceedings on a request for an ALJ hearing or act as parties in an ALJ hearing or Appeals Council review;
- (14) Determinations that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the beneficiary or the beneficiary's subrogee;
- (15) Determinations with respect to whether an entity qualifies for an exception to the electronic claims submission requirement under [42 CFR part 424](#);
- (16) Determinations by the Secretary of sustained or high levels of payment errors in accordance with section [1893\(f\)\(3\)\(B\)](#);
- (17) A contractor's prior determination related to coverage of physicians' services;
- (18) Requests for anticipated payment under the home health prospective payment system under [42 CFR 409.43\(c\)\(ii\)\(s\)](#); and
- (19) Claim submissions on forms/formats that are incomplete, invalid, or do not meet the requirements of a Medicare claim and returned or rejected to the provider or supplier.

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

D. Initial Determinations Subject to Reopening

Minor errors or omissions in an initial determination may be corrected only through the contractor's reopening process. Since it is neither cost efficient or necessary for contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as 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 34 Section 10.1

Authority to Conduct a Reopening of the Medicare Claims Processing Manual for information specific to conducting a reopening when a redetermination was requested.

210 - Who May Appeal

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

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

Parties to the initial determination include:

- Beneficiaries, who are almost always considered parties to a Medicare determination, as they are entitled to appeal any initial determination (unless the beneficiary has assigned his or her appeal rights);
- Providers who file a claim for items or services furnished to a beneficiary. **NOTE:** A non-participating provider, that is, an entity eligible to enter into a provider agreement to participate in Medicare but has not entered into such an agreement, is not considered a provider or provider of service and does not have party status for an initial determination or appeal. Beneficiaries are parties to claims filed for services furnished by a non-participating provider;
- Participating suppliers and non-participating suppliers, but only with respect to items or services furnished to a beneficiary that are billed on an assignment-related basis;
- An applicable plan (as defined in §110) with respect to the amount and existence of a recovery claim under [§405.924\(b\)\(16\)](#) if Medicare is pursuing recovery directly from the applicable plan. The applicable plan is the sole party to an initial determination under [§405.924\(b\)\(16\)](#) and any subsequent appeal.

Parties to the redetermination and subsequent appeal levels include:

- The parties to the initial determination, above;

NOTE: In addition to his/her own right to appeal Medicare's decision regarding an initial determination, a beneficiary is a party to any request for redetermination filed by a provider or supplier. The beneficiary is always a party to an appeal of services rendered on their behalf, at any level (except when the beneficiary has assigned his/her appeal rights to a provider or supplier).

- A nonparticipating supplier has the same rights to appeal the contractor's determination in an unassigned claim for medical equipment and supplies if the contractor denies payment on the basis of [§1862\(a\)\(1\)](#), [§1834\(a\)\(17\)\(B\)](#), [§1834\(j\)\(1\)](#), or [§1834\(a\)\(15\)](#) of the Act as a nonparticipating or participating supplier has in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service (See [§1834\(j\)\(4\)](#)), or because the beneficiary was not properly informed in writing with an Advanced Beneficiary Notice of Non Coverage (ABN) 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 non-participating physician not billing on an assigned basis but who may be responsible for making a refund to the beneficiary under [§1842\(l\)\(1\)](#) of the Act for services furnished to a beneficiary that are denied on the basis of section [1862\(a\)\(1\)](#) of the Act, has party status with respect to the claim at issue;

- A provider or supplier who otherwise does not have the right to appeal may appeal when the beneficiary dies and there is no other party available to appeal. See §210.1 for information on determining whether there is another party available to appeal;
- A Medicaid State agency or party authorized to act on behalf of the State. Medicaid State agencies have party status at the redetermination level (and subsequent levels) for claims for items or services involving a beneficiary who is enrolled to receive benefits under both Medicare and Medicaid, but only if the Medicaid State agency has made payment for, or may be liable for such items or services, and only if the State agency has filed a timely request for redetermination for such items or services. (See [42 CFR 405.908](#)); and
- Any individual whose rights with respect to the particular claim being reviewed may be affected by such review and any other individual whose rights with respect to supplementary medical insurance benefits may be prejudiced by the decision (e.g., an individual or entity liable for payment under [42 CFR subpart E §424.60](#) in the case of a deceased beneficiary).

Neither the contractor nor CMS is considered a party to an appeal at the redetermination or reconsideration levels, and therefore does not have the right to appeal or to participate as a party at this stage in the administrative appeals process. CMS or a contractor may choose to participate in an ALJ hearing, become a party to an ALJ hearing (with CMS' approval), or may recommend that the Administrative QIC (AdQIC) refer an ALJ decision or dismissal to the Appeals Council for review under its own motion review authority. At times, an ALJ may ask for a 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 he/she 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 MAC must determine whether another party is available to appeal by taking either of the following actions:

- The MAC 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 MAC 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 MAC 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 MAC 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 MAC 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 MAC 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 MAC 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 MAC should allow the provider or supplier 10 days to provide confirmation. If the MAC 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. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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 after 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. 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. Each level is discussed in detail in subsequent sections. If the appellant meets the procedural steps at a specific level (including the amount in controversy (AIC) requirement if applicable), the appellant (and all other parties to the appeal decision) 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 redetermination, 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 or review by an attorney adjudicator (level 3), the QIC must prepare and forward the case file to the OMHA. Further, the contractor may have effectuation responsibilities for decisions made at OMHA, Departmental Appeals Board (DAB)/Appeals Council, and Federal Court levels.

In the chart below, levels 1 – 4 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	Current AIC requirements can be found on CMS.gov at: http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html . See §250 for additional information.
4. Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of the Appeals Council decision	Current AIC requirement can be found on CMS.gov at: http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html . See §345 for additional information

*NOTE: If a party requests QIC review of a contractor's dismissal of a request for redetermination, the time limit for filing a request for reconsideration is 60 days from the date of receipt of the contractor's dismissal notice.

230 - Where to Appeal

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

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 an Appeal

LEVEL	WHERE TO FILE AN APPEAL		
	Part A*	Part B	DME
Redetermination	MAC	MAC	MAC

LEVEL	WHERE TO FILE AN APPEAL		
Reconsideration	QIC	QIC	QIC
ALJ Hearing	HHS OMHA Central Operations	HHS OMHA Central Operations	HHS OMHA Central Operations
Appeals Council Review	Appeals Council	Appeals Council	Appeals Council

*Includes part B claims filed with the Part A Medicare Administrative Contractor (MAC).

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

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A. Time Limits for Each Level of Appeal

The time limits for filing appeals vary according to the 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 §240.1-240.5 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. If a party requests QIC review of a MAC's dismissal of a request for redetermination, the time limit for filing is 60 days from the date of receipt of the MAC's dismissal notice.
- **ALJ Hearing** - The time limit for filing a request for an ALJ hearing is 60 days from the date of receipt of the reconsideration notice.
- **Appeals Council Review** - The time limit for filing a request for review by the Appeals Council is 60 days from the date of receipt of the ALJ's or attorney adjudicator's decision.
- **Judicial Review** - The time limit for filing for judicial review is 60 days from the date of the Appeals Council's decision.

A request filed with the A/B MAC (A), (B), (HHH), or DME MAC is considered to have been filed as of the date the MAC received it. The MAC 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 MAC allows for additional time if there is evidence that the mail delivery was longer than 5 days.

NOTE: When the beneficiary preference is to have all documents converted into an accessible format, MACs shall make allowances for additional delivery time of the accessible format. The MAC shall also provide allowance for a delayed response as a result of a beneficiary having sought and received help from an auxiliary resource (such as a SHIP or senior center), on account of his or her disability, in order to be able to file an appeal (also see §240.2).

When the filing deadline for a redetermination ends on a Saturday, Sunday, legal holiday, or any other nonwork day, the MAC shall apply a rollover period that extends the filing deadline to the first working day

after the Saturday, Sunday, legal holiday, or other nonwork day. For example, if the filing deadline for a redetermination falls on the Saturday before Columbus Day, the filing deadline is extended to the first working day after the Columbus Day holiday.

These time limits may be extended if good cause for late filing is shown. (See §240.1-240.5.) When a redetermination request appears to be filed late, the MAC makes a finding of good cause using the guidelines in §240.2 through §240.4 before taking any other action on the appeal.

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

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 A/B MAC (A), (B), (HHH), or DME MAC 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. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

If an appeal request is filed late, the applicable MAC may extend the time limit for filing an appeal if good cause is shown. The MAC resolves the issue of whether good cause exists before taking any other action on the appeal. Whenever a MAC makes a finding for good cause for late filing, the MAC shall document the reason for that finding in the redetermination decision letter. If no decision letter is issued (i.e., a decision fully favorable to the appellant is made, which currently does not require issuance of a redetermination decision letter), then the reason the MAC found that good cause exists for late filing shall be documented in the redetermination case file.

NOTE: A finding by the MAC 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 - Conditions and Examples That May Establish Good Cause for Late Filing by Beneficiaries

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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 a party receives inaccurate information regarding a filing deadline);

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, natural disaster);
- Unusual or unavoidable circumstances, the nature of which demonstrates 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;
- 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; or
- Delay due to additional time required to produce the beneficiary's Medicare documents (such as an MSN) in an accessible format (e.g., large print, Braille, etc.);
- Delay as the result of an individual having sought and received help from an auxiliary resource (such as a SHIP or senior center), due to his or her disability, in order to be able to file the appeal.

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.

240.3 - Conditions and Examples That May Establish Good Cause for Late Filing by Providers, Physicians, or Other Suppliers (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

In general, A/B MACs (A), (B), (HHH), and DME MACs should not routinely find good cause when a provider, physician or other supplier submits an untimely appeal request. However, 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 MACs, 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 encompass 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 MAC 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.

240.4 – Good Cause - Administrative Relief Following a Disaster (Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

When a disaster occurs, whether natural or man-made, MACs shall anticipate both an increased demand for emergency and other health care services, and a corresponding disruption to normal health care delivery systems and networks. For appeals purposes, as defined in this IOM, a 'disaster area' is declared by the Federal Emergency Management Agency (FEMA). In disaster situations, MACs that process appeals for beneficiaries, providers, and suppliers affected by a disaster shall exercise good cause in accordance with the regulations and follow the guidance below regarding how to process Fee-for-Service appeal requests in an area(s) declared by FEMA as a disaster area.

When a Presidential declaration occurs, the HHS Secretary may, under section 319 of the Public Health Service Act, declare that a Public Health Emergency (PHE) exists in the affected State. Once a PHE is declared, section 1135 of the Social Security Act authorizes the Secretary, among other things, to temporarily modify or waive certain Medicare, Medicaid, CHIP, and HIPAA requirements as determined necessary by CMS.

A. Definition of Disaster

A disaster is defined as any natural or man-made catastrophe (such as hurricane, tornado, earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, or explosion) which causes damage of sufficient severity and magnitude to partially or completely destroy medical records and associated documentation that could be needed and/or requested by the MACs in the course of the adjudication process, interrupts normal mail service (including US Postal delivery, overnight parcel delivery services, etc.), impacts ability to file appeals in a timely manner, and/or otherwise significantly limit the provider's/supplier's daily operations.

A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impact a single site only (e.g., water main failure). The fact that a provider/supplier is located in a presidentially declared disaster area under the power of the Stafford Act is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise retrieval of medical records. The provider/supplier needs to state that they were impacted by the disaster.

B. Basis for Providing Administrative Relief

In the event of a disaster, MACs shall grant temporary administrative relief to any affected providers and suppliers for up to 6 months (or longer with good cause). Administrative relief is to be granted to providers/suppliers/beneficiaries on a case-by-case basis in accordance with the following guidelines:

1. **Situation:** A provider/supplier/beneficiary in the affected area needs an extension to file a request for an appeal.

Action: The MAC shall grant an extension to request an appeal under the good cause exception. Please see 42 CFR § 405.942. If the request is related to an overpayment, the MAC shall accept the request and stop recoupment immediately.

2. **Situation:** The MAC has requested or needs to request additional documentation for a pending appeal, but the provider/supplier/beneficiary has been impacted by a disaster.

Action: The MAC shall hold the request until the documentation can be obtained or submitted. However, to the extent that the contractor can use other data sources that are available to substantiate payment for the claim, it should do so. The CMS will waive the timeliness requirements for processing these appeals.

3. **Situation:** A request for an appeal filed by an appointed representative on behalf of a party contains a missing or defective appointment instrument and the party is in the affected area.

Action: The contractor shall process the request and attempt to obtain the corrected appointment instrument. If the corrected appointment instrument is not received by the end of the appeals adjudication period, contractors shall send the redetermination decision letter to the appellant party and any other party to the appeal, but not to the individual attempting to act as the representative.

4. **Situation:** A MAC receives a request for redetermination from a provider/supplier/beneficiary in the affected area and the request is missing some of the required elements to make it a valid request. However, the MAC has information in the shared systems that would allow it to identify the missing element(s).

Action: The MAC shall accept and process the request, using information already available to it via the shared system.

C. Verification

In the case of complete destruction of medical records where no backup records exist, MAC Appeal Units and QICs shall accept an attestation that no medical records exist and consider the services covered and correctly coded.

240.5 - Procedures to Follow When a Party Fails to Establish Good Cause (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

If a party files an untimely request for redetermination and there is insufficient or no explanation for the delay or no other evidence that establishes the reason for late filing, the MAC dismisses the redetermination request. The MAC explains in the dismissal letter that the party can: 1) request that the MAC vacate the dismissal by providing an explanation for the late filing to the MAC within 6 months of the dismissal of the redetermination request; and 2) request that the QIC review the MAC's dismissal action by filing a request with the QIC within 60 days of the date of receipt of the dismissal notice.

If an explanation or other evidence is submitted within 6 months from the dismissal that contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the MAC (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 its prior dismissal and performs a redetermination (see §310.6.3 Processing Requests to Vacate Dismissals).

The closed date is the date of the dismissal, and the dismissal is reported on the Contractor Reporting of Operational Workload Data (CROWD) in the appropriate appeals report forms (Carriers Appeals Report Form CMS-2590, Monthly Intermediary Part A and Part B Appeals Report Form CMS-2591, or Monthly Statistical Report on Intermediary and Carrier Part A and Part B Appeals Activity Form CMS-2592). The closed date and date of dismissal are also captured in the Medicare Appeals System (MAS) and can be appropriately reported on by the Part A MACs.

250 - Amount in Controversy (AIC) Requirements (Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation:07-23-13)

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

Section 1869 (b)(1)(E) of the Act established amount in controversy threshold amounts for ALJ hearing requests and judicial review at \$100 and \$1,000, respectively. As amended by section 940 of the MMA, this amount will be adjusted annually. In order to continue an appeal following the QIC reconsideration level, a party must have an amount remaining in controversy that meets the threshold requirements.

250.1 - Amount in Controversy General Requirements (Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Each calendar year, the dollar threshold for the AIC requirement for ALJ hearing requests or judicial review will be recalculated to reflect 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. Changes to the amount in controversy threshold amounts are published annually in the Federal Register as per [42 CFR 405.1006\(b\)](#). Current AIC amounts, along with a link to the current Federal Register AIC Notice, can be found on the CMS.gov website at: <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/OMHA-ALJ-Hearing.html>

250.2 - Principles for Determining Amount in Controversy (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

As part of the requirements for a hearing or review before OMHA, a party to a proceeding must meet the AIC provisions at [42 CFR 405.1006](#), including the threshold amount, as adjusted, in accordance with [42 CFR 405.1006\(b\)](#).

The AIC is computed as the actual amount charged the individual for the items and services in question, reduced by

- (a) Any Medicare payments already made or awarded for the items or services; and
- (b) Any deductible and coinsurance amounts that may be collected for the items or services.

In such cases where payment is made for items or services under section [1879](#) of the Act or under [42 CFR 411.400](#) or the liability of the beneficiary is limited under [42 CFR411.402](#), the AIC is computed as the amount that the beneficiary would have been charged for the items or services in question if those expenses were not paid under [42 CFR 411.400](#) or that the liability was not limited under [42 CFR 411.402](#), reduced by any deductible and coinsurance amounts that may be collected for the items or services.

When a matter involves a provider or supplier termination of Medicare-covered items or services that is disputed by a beneficiary, and the beneficiary did not elect to continue receiving the items or services, the amount in controversy is calculated in accordance with [42 CFR 405.1006\(d\)\(1\)](#), except that the amount charged to the individual and any deductible and coinsurance that may be collected for the items or services are calculated using the amount the beneficiary would have been charged if the beneficiary had received the items or services the beneficiary asserts should have been covered based on the beneficiary's current condition, and Medicare payment were not made for the items or services.

When an appeal involves an identified overpayment, the amount in controversy is the amount of the overpayment specified in the demand letter for the items or services in the disputed claim. When an appeal involves an estimated overpayment amount determined through the use of statistical sampling and

extrapolation, the amount in controversy is the total amount of the estimated overpayment determined through extrapolation, as specified in the demand letter.

For appeals filed by beneficiaries challenging only the computation of a coinsurance amount or the amount of a remaining deductible, the amount in controversy is the difference between the amount of the coinsurance or remaining deductible, as determined by the contractor, and the amount of the coinsurance or remaining deductible the beneficiary believes is correct.

For appeals of claims where the allowable amount has been paid in full and the appellant is challenging only the validity of the allowable amount, as reflected on the published fee schedule or in the published contractor-priced amount applicable to the items or services in the disputed claim, the amount in controversy is the difference between the amount the appellant argues should have been the allowable amount for the items or services in the disputed claim in the applicable jurisdiction and place of service, and the published allowable amount for the items or services.

After processing the reconsideration, the QIC shall send written notification to all parties. This notice shall include any information concerning the parties' rights to an ALJ hearing, including the applicable AIC requirements and aggregation provisions.

250.3 - Aggregation of Claims to Meet the Amount in Controversy (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A party appealing a QIC reconsideration to the ALJ level that does not meet the AIC threshold requirements may, under certain circumstances, aggregate claims to meet the requirements set forth in [42 CFR 405.1006](#). Either an individual appellant or multiple appellants may aggregate two or more claims to meet the AIC requirements for an ALJ hearing if -

- a) The claims were previously reconsidered by a QIC;
- b) The request for ALJ hearing lists all of the claims to be aggregated and is filed within 60 days after receipt of all the reconsiderations being appealed; and
- c) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the AIC requirements.

In cases where claims are escalated from the QIC level to the ALJ level (if parties have met all other requirements), aggregating claims may proceed under certain circumstances. Either an individual appellant or multiple appellants may aggregate two or more claims to meet the AIC for an ALJ hearing if -

- (a) The claims were pending before the QIC in conjunction with the same request for reconsideration;
- (b) The appellant(s) requests aggregation of the claims to the ALJ level in the same request for escalation; and
- (c) The ALJ determines that the claims that a single appellant seeks to aggregate involve the delivery of similar or related services, or the claims that multiple appellants seek to aggregate involve common issues of law and fact. Part A and Part B claims may be combined to meet the AIC requirements.

When the appellant(s) seeks to aggregate claims in a request for an ALJ hearing, the appellant(s) must-

- (a) Specify all of the claims the appellant(s) seeks to aggregate; and

(b) State why the appellant(s) believes that the claims involve common issues of law and fact or delivery of similar or related services.

260 - Parties to an Appeal

(Rev. 3549, Issued: 06-24-16, Effective: 07-26-16, Implementation: 07-26-16)

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).

270 - Appointment of Representative

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

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

270.1 - Appointment of Representative - Introduction

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10-01-19)

A party may appoint any individual, including an attorney, to act as his/her representative in dealings with the MAC. Although some parties may pursue a claim or an appeal on their own, others will rely upon the assistance and expertise of others. A representative may help the party during the processing of a claim or claims, and/or any subsequent appeal. (See §270.1.8 for details regarding disclosure of individually identifiable beneficiary information.) The appointment of a representative is valid for one year from the date signed by both the party and the appointed representative (see §270.1.5 below).

NOTE:

- The appointment remains valid for any subsequent levels of appeal on the item/service in question unless the beneficiary specifically withdraws the representative’s authority.
- New appeals may be initiated in writing by the representative within the one year timeframe unless the beneficiary provides a written statement of revocation of the representative’s authority.

Appeals for other claims may be initiated utilizing an existing appointment instrument within one year of the effective date of the appointment (i.e., the date the appointment instrument is signed by the party and the representative). To initiate a new appeal within the one year timeframe, the representative must file a copy of the completed appointment instrument with the appeal request.

270.1.1 - Who May Be an Appointed or Authorized Representative

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

Any individual may be appointed to act as a representative unless he/she is disqualified, suspended, or otherwise prohibited by law from acting as a representative in proceedings before HHS, or in entitlement appeals, before SSA.

A MAC should not accept an appointment of representative if it has evidence that the appointment of representative should not be honored. It should notify the party attempting to be represented and the individual attempting to represent the party that the appointment will not be honored. A specific individual must be named as the representative. An organization or entity may not be named as a representative, but rather a specific member of that organization or entity must be named. This ensures that confidential beneficiary information is released only to the individual so named.

A provider or supplier who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative of the beneficiary. To act as the beneficiary's representative, the provider or supplier must execute a valid appointment as described in this section.

If the requestor is the beneficiary's legal guardian, surrogate decision-maker for an incapacitated beneficiary, an SSA-appointed representative payee (See IOM Pub. 100-01, Chapter 6, §10.K. for information regarding SSA rep payees), or is otherwise authorized under State law, no appointment is necessary, and the requestor is considered an **authorized** representative. All MACs shall document the representative's authority to act on behalf of the beneficiary in the case file. (See §270.1.7 for information on power of attorney.)

NOTE: Billing clerks or billing services employed by the provider or supplier to prepare and/or bill the initial claim, process the payments, and/or pursue appeals act as the agent of the provider or supplier and do not need to be appointed as representative of the provider/supplier. Include evidence in the case file if the physician or other supplier employs a billing clerk or billing service (a screen print showing that payment is made to the billing clerk or billing service is sufficient.) If the billing clerk/billing service is not authorized to receive payment, but is authorized to process payments and/or pursue appeals, include evidence in the case file. If the agreement is on file, make a notation in the case file where the agreement can be located. (See the Medicare General Information, Eligibility, and Entitlement Manual, which allows payment to be made to an agent who furnishes billing or collection services.)

The following is a list of the types of individuals who could be appointed to act as representative for a party to an appeal. This list is not exhaustive, and is meant for illustrative purposes only:

- Congressional staff members;
- Family members of a beneficiary;
- Friends or neighbors of a beneficiary;
- Member of a beneficiary advocacy group;
- Member of a provider or supplier advocacy group;
- Attorneys; and
- Physicians or suppliers.

270.1.2 - How to Make and Revoke an Appointment

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The party making the appointment and the individual accepting the appointment must either complete an appointment of representative form (CMS-1696) or use a conforming written instrument (see subsection B below, for required elements of written instruments). A party may appoint a representative to assist with filing a claim, or at any time during the course of an appeal. In order to constitute a valid appointment, the CMS-1696 or other conforming written instrument must contain signatures of the representative and the party. By signing the appointment, the representative indicates his/her acceptance of being appointed as representative. The form CMS-1696 can be found at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html>

All signatures may be handwritten or electronic, digital, and/or digitized. Electronic, digital, and/or digitized signatures are acceptable for appointment of representative instruments submitted via mail, facsimile, or a CMS-approved secure Internet portal/application.

CMS permits the use of a rubber stamp in lieu of a handwritten signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his or her inability to sign their signature due to their disability. By affixing the rubber stamp, the person is certifying that they have reviewed the document.

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

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

1. The name of the party making the appointment must be clearly legible. If the party being represented is the beneficiary, the Medicare number must be provided. If the party being represented is a provider or supplier, the National Provider Identifier number must be provided. If the party being represented is an applicable plan in an appeal under 42 CFR §405.924(b)(16), the space may be left blank. A Medicare number is required only when the beneficiary is the party appointing a representative.
2. **Completing Section I** – “Appointment of Representative”- The party making the appointment includes their signature, address, and phone number. If the party that wishes to appoint a representative is a beneficiary, then only the beneficiary or the beneficiary’s legal guardian may sign. If the party making the appointment is the provider or supplier, the provider or supplier (or person authorized to act on behalf of the provider or supplier) must sign the form and complete this section. The date the party signs the form must be included.
3. **Completing Section II** – “Acceptance of Appointment”- A specific individual must be named to act as representative in the first line of this section; a party may not appoint an organization or group to act as representative. The name of the individual appointed as representative must always be completed, and his/her relationship to the party entered. The individual being appointed signs the form with a signature, dates and completes the rest of this section.
4. **Completing Section III** – “Waiver of Fee for Representation”- This section must be completed when the beneficiary is appointing a provider or supplier as representative, and the provider or supplier being appointed has furnished the items or services that are the subject of the appeal.
5. **Completing Section IV** – “Waiver of Payment for Items or Services at Issue” – This section must be completed when the beneficiary is appointing a provider or supplier who furnished the items or services that are the subject of the appeal and the appeal involves issues described in §1879(a)(2) of the Act (limitation on liability).

If any of the required elements listed above are missing from the appointment, or are determined to be invalid (e.g., the signatures do not meet the requirements of this section), the appointment is considered defective. See §270.1.6 for additional information on processing appeals with an incomplete or invalid appointment.

Prohibition Against Charging a Fee for Representation

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

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

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

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

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

As set forth in [42 CFR 405.910\(c\)](#), a written request for an appointment of representation must:

1. Be in writing and be signed and dated by both the party and the individual agreeing to be the representative;
2. Provide a statement appointing the representative to act on behalf of the party, and authorizing the adjudicator to release identifiable health information to the appointed representative;
3. Include a written explanation of the purpose and scope of the representation;
4. Contain both the party's and appointed representative's name, phone number, and address;
5. Contain a unique identifier of the party being represented. If the party being represented is the beneficiary, the Medicare number must be provided. If the party being represented is a provider or supplier, the National Provider Identifier number must be provided. (Exception: An applicable plan appointing a representative in an appeal under [42 CFR §405.924\(b\)\(16\)](#) is not required to include a unique identifier);
6. Include the appointed representative's professional status or relationship to the party; and
7. Be filed with the entity processing the party's initial determination or appeal.

Providers or suppliers that are representing a beneficiary and that furnished the items or services at issue must complete a "Waiver of Fee for Representation". In addition, if the appeal involves a liability determination under [§1879](#) of the Act, the provider or supplier must also complete a "Waiver of Payment for Items or Services at Issue". See [§270.1.2.A.4](#) and 5.

C. Revoking an Appointment

The party appointing a representative may revoke the appointment at any time by providing a written statement of revocation to the contractor.

270.1.3 - When and Where to Submit the Appointment (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A representative, beneficiary, or other party may submit the completed appointment to the contractor at the time such person files a claim or request for appeal or at any time during the processing of the appeal. Appointed representatives are responsible for submitting a valid appointment instrument with each new

appeal request. A valid appointment instrument submitted with an appeal request will be included in the appeal case file and is valid for subsequent levels of appeal for the item(s)/service(s)/claims(s) at issue. With each new appeal request, an appointed representative may choose to send either an original appointment instrument, or a photocopy of the original. Should a photocopy of the original appointment instrument be submitted with an appeal request, the original appointment instrument must be maintained by the representative or the party, and produced upon request. If an appeal or other motion is filed by a representative on behalf of a party to the appeal, but does not include an appointment, the contractor takes the actions specified below in §270.1.6 to secure the written appointment.

If a valid CMS-1696, or other conforming written instrument, has previously been filed with the contractor, the representative is encouraged, but not required, to submit a copy at subsequent levels of appeal. A valid appointment instrument will be included in the case file for subsequent levels of the appeal of the item(s)/service(s)/claim(s) at issue. However, if a new appeal for different items/services/claims is initiated during the one year timeframe of the appointment, a copy of the appointment must be filed with the new appeal request.

If a contractor has received CMS approval for, and is accepting appeals through, the use of a secure Internet portal/application (See 310.1.B.2.c), contractors should provide instructions to appellants using the Internet portal/application on how to submit the appointment instrument when submitting an appeal.

270.1.4 - Rights and Responsibilities of a Representative (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

In representing an appellant before a MAC, the representative has certain rights and responsibilities.

A. Authority of an Appointed Representative

A representative may represent a party in an appeal of a claim. An appointed representative may, on behalf of the party; obtain appeal information about the claim to the same extent as the party, submit evidence, make statements about facts and law, and make any request, or give or receive, any notice about the appeal proceedings.

When a MAC takes action or issues a redetermination, it shall send notice to only the appointed representative. Notice shall not be sent to the party if there is an appointed representative.

The MAC shall send any requests for information or evidence regarding an appeal only to the appointed representative.

See also, §270.3 for MSP specific requirements.

B. Responsibilities of an Appointed Representative

An appointed representative must-

- Inform the party of the scope and responsibilities of the representation;
- Inform the party of the status of the appeal and the results of actions taken on behalf of the party such as notification of appeal determinations, decisions, and further appeal rights;
- Disclose to a beneficiary any financial risk and liability of a non-assigned claim that the beneficiary may have;
- Not act contrary to the interest of the party; and
- Comply with all laws and CMS regulations, CMS Rulings, and instructions.

The appointment of a representative by a party must be made freely and without coercion. The MAC should assume that a representative is not making false or misleading statements, representations, or claims about any material fact affecting any person's rights. However, if the MAC has reason to believe that the representative is making false or misleading statements, representations or claims about any material fact affecting any person's rights, it should refer the matter to the Unified Program Integrity Contractor (UPIIC), which were formerly known as Zone Program Integrity Contractors. A representative will have access to personal and confidential medical and other information about a beneficiary. The MAC may assume that the representative will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, it may assume that a representative is not disclosing any personal or confidential medical or other information about a beneficiary(ies) outside of the appeals process.

Unless otherwise directed by the party making the appointment, the MAC need not keep the represented party informed of the purpose of the appointment, the scope of the appointment, and exactly when/under what circumstances the appointment will be exercised, since it may assume the representative has taken on this responsibility. It is the responsibility of the representative to keep the party informed on the progress of an appeal.

C. Delegation of Appointment by Appointed Representative

An appointed representative may delegate the appointment if the following conditions are met;

- The appointed representative provides written notice to the party of the appointed representative's intent to delegate to another individual. The notice must include the name of the designee and the designee's acceptance to be obligated and comply with the requirements or representation under this subpart.
- The party accepts the designation by signing a written statement to that effect. This signed statement is not required when the appointed representative and designee are attorneys in the same law firm or organization.

270.1.5 - Duration of Appointment

(Rev. 2026, Issued: 04-11-14, Effective: 07-14-14, Implementation: 07-14-14)

An appointment is considered valid for 1 year from the date that the CMS-1696 or other conforming written instrument contains the signatures of both the party and appointed representative. Requiring that a new appointment be executed on a yearly basis will help ensure that there is an ongoing relationship between the party and his/her representative.

Appeals for other claims may be initiated utilizing an existing appointment instrument within one year of the effective date of the appointment (i.e. the date a completed appointment instrument is signed by the party and the appointed representative). When initiating a new appeal within the one year timeframe, the representative must file a copy of the completed appointment instrument with the appeal request. Allowing the representative to use the same appointment for up to one year will help reduce the paperwork involved in representing parties. The MAC may also place information about appointment validity in provider newsletters, bulletins, educational materials, etc.

The appointment remains valid throughout any and all subsequent levels of administrative appeal on the claim or claims at issue. Therefore, the representative need not secure a new appointment when proceeding to the next level of appeal on the same items, services or claim(s). This holds true regardless of the length of time it may take to resolve the appeal.

270.1.6 - Curing a Defective Appointment of Representative (Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

If any of the required elements listed in §270.1.2 are missing, the appointment of representative form is considered defective.

How a MAC handles these situations depends on the party attempting to make an appointment. When the beneficiary attempts to make the appointment, the MAC provides assistance to the beneficiary and representative in securing the appointment, based on the time frames set forth below. When a provider or physician or other supplier attempts to make the appointment, the MAC provides instruction on the proper and timely completion of the appointment. Where an adjudication time frame applies, the time from the later of the date that a defective appointment of representative was filed or the current appeal request was filed by the prospective appointed representative, to the date when the defect was cured, the party notifies the adjudicator that he or she will proceed with the appeal without a representative, or the 30-day deadline for curing the defect has elapsed with no response, does not count towards the adjudication time frame. The following provides guidance on properly responding to a representative's attempt to submit a request for appeal.

A. Missing or Defective Appointment When a Beneficiary is the Represented Party

1. Defective Appointment of Representative

When an individual is attempting to act as a beneficiary's representative, but submits an incomplete or defective appointment instrument, the MAC shall advise the individual of how to complete the appointment, and shall notify the individual to submit the completed appointment to the MAC within 30 calendar days. The MAC shall advise the individual of what corrections are required to execute a valid appointment and that a decision letter will not be sent to the individual unless a valid appointment is executed. Should the appointment instrument not be corrected within 30 calendar days, the MAC proceeds with processing and rendering a decision on the appeal, unless there is evidence or information to indicate the appeal was not submitted at the request of the beneficiary. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the individual attempting to act as the beneficiary's representative.

This will ensure that the beneficiary receives an appeal decision when it appears that the appeal originated with the beneficiary or was submitted with the beneficiary's knowledge and consent.

When there is information or evidence that the appeal request and/or the appointment of representative instrument was not submitted at the request of the beneficiary, the MAC shall verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary). In order to verify the wishes of the beneficiary, the MAC sends a letter to the beneficiary explaining the situation. The letter shall advise the beneficiary that in order to proceed with an appeal, a valid appointment instrument must be submitted within 30 calendar days. If no response is received within 30 calendar days then the appointment of representative will not be honored, and no redetermination will be performed. The MAC shall handle this as an inquiry.

2. Missing Appointment of Representative

In cases of appeals filed on behalf of the beneficiary, the MAC 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. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the individual attempting to act as the beneficiary's representative. This will ensure that the beneficiary receives an appeal decision when it appears that the appeal was submitted with the beneficiary's knowledge and consent.

When there is information or evidence that the appeal request filed on behalf of the beneficiary was not submitted at the request of the beneficiary, the MAC shall verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary but does not include an appointment instrument). In order to verify the wishes of the beneficiary, the MAC sends a letter to the beneficiary explaining the situation. The letter shall advise the beneficiary that a valid appointment instrument must be submitted within 30 calendar days in order to process the appeal. If no response is received within 30 calendar days, then the MAC does not conduct a redetermination. The MAC shall handle this as an inquiry.

B. Defective or Missing Appointment When a Provider or Physician, Other Supplier, or Nonbeneficiary is the Represented Party

1. Defective Appointment of Representative

In cases where the represented party is **not** a beneficiary, the MAC notifies both the individual attempting to be the representative and the party of the incomplete or defective appointment. The MAC explains why the appointment is defective, and describes the documentation or missing information that is required to complete the appointment. This may be done by telephone or written notification, and the method, time and date of any notification shall be documented in the case file. A corrected/completed appointment may be submitted to the MAC by mail, or at the MAC's discretion by facsimile or (if available) secure Internet portal. The MAC allows 30 calendar days for the corrected appointment instrument to be submitted. Should the party fail to notify the MAC to proceed with the appeal without a representative, or the appointment instrument is **not** corrected within the time limit, the MAC **dismisses** the appeal request and sends a dismissal notice to the party (See §310.6.A.4).

2. Missing Appointment of Representative

If an individual is attempting to act as a representative of a party that is **not** the beneficiary and fails to include an appointment instrument with the appeal request, the individual lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal. The MAC shall notify the individual that no redetermination will be performed until a valid request is received from the party or a valid appointment instrument is resubmitted with the redetermination request. The MAC shall handle this as an inquiry (see §310.1.B.5).

C. Untimely Appeal Request Submitted With an Incomplete or Defective Appointment

If an untimely-filed appeal request is submitted with an incomplete or defective appointment instrument, the MAC first determines if good cause for late filing exists (See §240). If the MAC finds that good cause for late filing exists, it follows the instructions contained in §270.1.6, above, prior to proceeding with the appeal request. If the MAC does not find good cause to extend the filing time limit, it dismisses the redetermination request. See §310.6.3 and §310.6.A.3.

D. Untimely Appeal Request Submitted With a Missing Appointment

1. Missing Appointment when the Beneficiary is the Party

If an untimely-filed appeal request is submitted by an individual attempting to represent a beneficiary and the request does not include an appointment instrument, the MAC first determines if good cause for late filing exists (See §240). If the MAC finds that good cause for late filing exists, it follows the instructions contained in §270.1.6.A.2. prior to proceeding with the appeal request. If the MAC does not find good cause to extend the filing time limit, it dismisses the redetermination request. (See §310.6.3 and §310.6.A.3.)

2. Missing Appointment When Provider or Physician, Other Supplier, or Nonbeneficiary is the Represented Party

As explained in §270.1.6.B.2 above, if the individual lacks the authority to act on behalf of the party and is not entitled to obtain or receive any information related to the appeal, do not make a good cause determination; follow the instructions in §270.1.6.B.2. above.

270.1.7 - Incapacitation or Death of Beneficiary (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

If at any time after the execution of a valid appointment or **nondurable** power of attorney the beneficiary becomes incapacitated and is unable to manage his/her affairs, the appointment becomes invalid. The MAC shall resolve who has legal authority to act on behalf of the beneficiary before disclosing any further information pursuant to the appointment or nondurable power of attorney.

If the beneficiary has executed a **durable** power of attorney that authorizes the designated person to conduct the beneficiary's affairs, or to make financial decisions on behalf of the beneficiary, the representation does not become invalid upon the beneficiary's subsequent incapacitation.

NOTE: Some durable powers of attorney do not become effective until and unless such an incapacitation occurs.

The death of a party terminates the authority of the appointed representative. However, if an appeal is in progress and another individual or entity may be entitled to receive or obligated to make payment for the items or services that are the subject of the appeal, the appointment remains in effect for the duration of the appeal. See also, §270.3 for MSP specific limitations or additional requirements.

If the beneficiary is deceased, the legal representative of the estate may file an appeal. In the absence of a legal representative, any person who has assumed responsibility for settling the decedent's estate may file the appeal. In these situations, the MAC shall obtain proof that the person has assumed responsibility for settling the decedent's estate (e.g., a will or probate court document). What is acceptable as legal documentation may vary according to State law. The MAC shall notify the person filing the appeal about the documentation needed to show the person is either the legal representative of the estate or the person who has assumed responsibility for settling the decedent's estate and describe the types of documentation needed. Allow at least 14 calendar days for the documentation to be submitted. If, at the end of the time allowed, the documentation needed is not submitted, dismiss the request. If the appellant submits the documentation after the allotted time, the MAC considers good cause for late filing. In such instances, the MAC documents the file to show the basis for that person's filing the appeal.

MACs shall follow state law when determining proper parties to initial determinations and appeals. Legal representatives of deceased beneficiaries can be proper parties to initial determinations and appeals. In order to verify that the requester is the proper representative, MACs shall be aware of the current state laws in their jurisdictions and shall accept any documentation acceptable by the appropriate state. The documentation must be sufficient to verify that the individual making the request is a proper and valid representative for purposes of initial determinations and appeals under 42 CFR Part 405. Examples of proper documentation based on state law include, but are not necessarily limited to:

- Probate court documents (such as, letters of administration or letters of testamentary to an executor named in the deceased beneficiary's will).
- The deceased beneficiary's will naming the executor.
- Appointment of Representative document (CMS-1696 form or other similar document).
- An instrument executed by a beneficiary that confers representative authority in accordance with state law (for example, health care proxy appointment, Power of Attorney form, or Durable Power of Attorney form).

- Representative appointment made by a court of law on behalf of a deceased beneficiary that has not named an executor to handle his or her estate.

Examples of insufficient documentation include:

- Claims against the decedent's estate without an authorized representative listed.
- Any unsigned writing conferring authority on the party to act as a legal representative.
- The beneficiary's certificate of death.

270.1.8 - Disclosure of Individually Identifiable Beneficiary Information to an Appointed Representative

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

In accordance with the provisions of the Privacy Act, before the MAC may release beneficiary-specific information to an appointed representative, the beneficiary or appellant must complete and sign CMS-1696, or other conforming written instrument, naming that individual as his/her representative. The MAC shall use caution in releasing beneficiary-specific information to appointed representatives. The representative is entitled to receive only information that the party (beneficiary or appellant) would be entitled to receive (e.g., the determination letter) and that which is pertinent to the case/claim for which the representative is being appointed.

For more information about the disclosure of identifiable information about beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6: see also §300 below.

270.2 - Assignment of Appeal Rights

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

270.2.1 - Assignment of Appeal Rights - Introduction

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

A beneficiary may assign his or her appeal rights to a provider or supplier who furnished an item or service to the beneficiary that is at issue in an appeal. Only providers or suppliers who are not a party to the initial determination may accept assignment of appeal rights from a beneficiary (See §210 for information on who is a party to an appeal.)

Because beneficiaries have difficulty understanding the term "assignment of appeal rights", we use the term "transfer of appeal rights" on the related form and for communication to beneficiaries. For the remainder of these instructions, we will also use the term "transfer" instead of "assignment" of appeal rights, whenever appropriate. The transfer of appeal rights is valid for the duration of the appeal, unless revoked by the beneficiary.

270.2.2 - Who May Be an Assignee

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

Only a provider or supplier that is not a party to the initial determination and furnished an item or service to the beneficiary may accept the transfer of a beneficiary's appeal rights for that item or service.

An individual or entity who is not a provider or supplier may not accept the transfer. A provider or supplier that furnishes an item or service to a beneficiary may not accept the transfer for that item or service when considered a party to the initial determination.

270.2.3 - How to Make and Revoke a Transfer of Appeal Rights (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The beneficiary making the transfer (assignor) and the provider or supplier accepting the transfer (assignee) must complete the CMS standardized Transfer of Appeal Rights form (Form CMS-20031). This form is entitled, "Transfer of Appeal Rights". **No alternative written instrument may be used.** Signatures may be handwritten, electronic, digital, and/or digitized. By signing the CMS-20031, the provider indicates his/her acceptance of being the assignee. Page two of the form provides information to the beneficiary about transferring appeal rights. The form CMS-20031 is available on the CMS.gov website at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20031.pdf>

A. Completing a valid Transfer of Appeal Rights Form CMS-20031

Form CMS-20031, Transfer of Appeal Rights, is the required form that beneficiaries must use to assign their appeal rights. Following are instructions for completing form CMS-20031.

1. **Completing Section I** - The name of the beneficiary transferring appeal rights must be clearly legible. The beneficiary's Medicare number must be provided in this section. This section includes name, Medicare number, address and phone number, and the item or service that is at issue. The beneficiary must provide a signature on the transfer statement and include the date. Only the beneficiary may sign this section.
2. **Completing Section II** - "Acceptance of Appeal Rights" - The provider or supplier accepting the appeal rights must complete this section. This section includes name, address, and phone number. The provider or supplier must sign this section to accept the transfer of appeal rights and agree not to collect payment (except for any applicable deductible or coinsurance) from the beneficiary for the item or service at issue, unless a valid Advance Beneficiary Notice of Noncoverage (ABN) is in effect.

If an incomplete form is submitted, the adjudicator should contact the party and provide a description of the missing information. Unless the defect is cured, the provider or supplier lacks the authority to accept the appeal rights of the beneficiary, and is not entitled to take action regarding the appeal or obtain or receive any information related to the appeal, including the appeal decision. The adjudicator **should not** dismiss the appeal request because the transfer of appeal rights is not valid.

CMS permits the use of a rubber stamp in lieu of a handwritten signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS MAC of his or her inability to sign their signature due to their disability. By affixing the rubber stamp, the person is certifying that they have reviewed the document.

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

The provider or supplier who accepts the appeal rights must waive the right to collect payment from the beneficiary for the item or service that is the subject of the appeal. The provider or supplier may collect any applicable deductible or coinsurance. The provider or supplier agrees to this waiver by completing and signing Section II of the Transfer of Appeal Rights form. The waiver to collect payment remains in effect regardless of the outcome of the appeal decision.

This waiver remains valid unless the transfer is revoked **by the beneficiary** as described in subsection D, below.

C. Duration of a Valid Transfer of Appeal Rights

Unless revoked, the transfer of appeal rights is valid for all levels of the appeal process including judicial review, even in the event of the death of the beneficiary.

D. Revoking a Transfer of Appeal Rights

The party assigning their appeal rights may revoke the transfer of appeal rights by providing a written statement of revocation to the adjudicator at any time. If revoked, the rights to appeal revert to the beneficiary. The transfer may be revoked in the following ways:

1. In writing by the beneficiary. The revocation must be delivered to the adjudicator and the provider or supplier and is effective on the date of receipt by the adjudicator.
2. By abandonment if the assignee does not file an appeal of an unfavorable decision to the financial interests of the beneficiary.

270.2.4 - When to Submit the Transfer of Appeal Rights (Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

A provider or supplier may submit the completed transfer of appeal rights form to the MAC at the time he or she submits an appeal request. The provider or supplier may obtain the completed transfer of appeal rights form from the beneficiary at the time that the services are provided, and file the previously signed form with the appeal.

270.2.5 - Where to Submit the Transfer of Appeal Rights (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

When the provider or supplier submits the original or a copy of the signed transfer of appeal rights form, the MAC shall place it in the case file. The provider or supplier should also give the beneficiary a copy of the completed form.

If a contractor has received CMS approval for, and is accepting appeals through, the use of a secure Internet portal/application (See 310.1.B.2.c), contractors should provide instructions to appellants using the Internet portal/application on how to submit a copy of the signed transfer of appeal rights form when submitting an appeal.

270.2.6 - Rights of the Assignee of Appeal Rights (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

When a valid transfer of appeal rights is executed, the beneficiary transfers all appeal rights involving the item or service at issue to the provider or supplier.

The transfer of appeal rights by a beneficiary must be made freely and without coercion. The MAC shall assume that a provider or supplier is not making false or misleading statements, representations or claims about any material fact affecting any person's rights. However, if the MAC has reason to believe that the assignee is making false or misleading statements, representations or claims about any material fact affecting any person's rights, it shall refer the matter to the UPIC. A provider or supplier accepting the transfer of appeal rights will have access to personal and confidential medical and other information about a beneficiary. The MAC shall assume that the provider or supplier will not disclose personal or confidential information about a beneficiary except as necessary to pursue an appeal on behalf of the party represented. Further, it shall assume that a provider or supplier is not disclosing any personal or confidential medical or other information about a beneficiary outside of the appeals process.

A beneficiary transfers all appeal rights involving the item or service at issue to the provider or supplier, these include, but are not limited to:

1. Obtaining information about the claim to the same extent as the beneficiary;
2. Submitting evidence;

3. Making statements about facts or law; and
4. Making any request, or giving, or receiving any notice about appeal proceedings.

When a MAC takes action or issues a redetermination, it shall send notice to only the assignee. Notice shall not be sent to the beneficiary if there is an assignee.

The MAC shall send any requests for information or evidence regarding an appeal only to the assignee.

270.2.7 - Duration of Transfer of Appeal Rights

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

Unless revoked the transfer of appeal rights is valid for all levels of appeal including judicial review. This transfer remains in effect even in the event of the death of the beneficiary.

270.2.8 - Curing a Defective Transfer of Appeal Rights

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

If any one of the elements is missing from the CMS-20031, the MAC shall contact the party and provide a description of the missing documentation or information. If the defect is not cured, the prospective assignee of appeal rights lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal, including the appeal decision.

The MAC shall provide help and assistance to the beneficiary and provider or supplier in securing the transfer of appeal rights, based on the time frames set forth below.

A. Timely Filed Appeal Request with a Defective Transfer of Appeal Rights

When an incomplete or defective transfer of appeal rights form is received, the MAC shall notify both the provider/supplier submitting the CMS-20031 and the beneficiary. The MAC shall advise them why the transfer is defective, and describe the missing information that is required to complete the transfer. This may be done by telephone or written notification. The method, time and date of any notification shall be documented in the case file. A corrected/completed transfer may be submitted to the MAC by mail, or at the MAC's discretion, by facsimile or a secure Internet portal/application, within 14 days. Should the CMS-20031 not be corrected within this time limit, the MAC proceeds with processing and rendering a decision on the appeal. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the unauthorized assignee. This will ensure that the beneficiary receives an appeal, as the presumption here is that the appeal originated with the beneficiary and was submitted with the beneficiary's knowledge and consent. However, if the MAC has information or evidence that the transfer was not submitted at the request of the beneficiary, it shall not conduct the appeal unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval.

B. Untimely Appeal Request Submitted With an Incomplete or Defective Transfer

Because an untimely-filed appeal request is not always dismissed (e.g., there could be the finding of good cause for late filing, see §240.1), an incomplete or defective CMS-20031 may, in some cases, need to be corrected. If an incomplete or defective CMS-20031 needs to be corrected, the MAC shall follow the instructions contained in Section A above, prior to proceeding with the appeal request.

C. Untimely Appeal Request Submitted With a Valid Transfer

These cases should be resolved solely on the basis of whether there is good cause. (See §240.1.)

270.2.9 - Disclosure of Individually Identifiable Beneficiary Information to Assignees

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

In accordance with the provisions of the Privacy Act, before the MAC may release beneficiary-specific information to an assignee, the beneficiary must complete and sign a CMS-20031 naming that individual as his/her assignee. The MAC shall use caution in releasing beneficiary-specific information to assignees. The assignee is entitled to receive only information that an appointed representative would be entitled to receive (e.g., the determination letter) and that which is pertinent to the case/claim for which appeal rights have been assigned.

A beneficiary must explicitly authorize the release of any information that is not specific to the case/claim for which appeal rights have been assigned. Any questions as to whether information needs authorization to be released to an assignee can be directed to the appropriate CMS regional office (RO).

For more information about the disclosure of identifiable information about beneficiaries, see the Medicare General Information, Eligibility, and Entitlement Manual, Pub. 100-01, Chapter 6.

270.3 - Medicare Secondary Payer (MSP) Specific Limitations or Additional Requirements with Respect to the Appointment of Representatives (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The following instructions/rules apply with respect to MSP recovery claims, notwithstanding any language to the contrary in other subsections of “Section 270 Appointment of Representative.”

For a MSP recovery claim involving a beneficiary debtor, the representative relationship typically arises in the context of the beneficiary’s claim against a workers’ compensation plan, liability insurance (including self-insurance), or no-fault insurance. The representative is not hired solely to represent the beneficiary with respect to the recovery demand letter/debt at issue on appeal; the representative is routinely hired in connection with an underlying liability, no-fault or workers' compensation claim.

For MSP recovery claims involving a debtor other than a beneficiary or a provider/supplier, follow the instructions in the MSP IOM, Pub. 100-05, Chapter 7, section 10, regarding authorization to represent a debtor. For MSP recovery claims involving a provider/supplier debtor, follow the instructions for non-MSP.

The instructions below contain exceptions or additions to the non-MSP rules for MSP recovery claims **involving a beneficiary debtor.**

A. Appointment of Representative

For MSP recovery claims involving a beneficiary debtor, the representative relationship may be established in the following ways (the document must always include the beneficiary’s Medicare number as well as his/her name):

1. If the representative is an attorney, by:
 - A copy of the fee agreement between the beneficiary and the attorney, signed by the beneficiary and signed/countersigned by the attorney,
 - A statement on the attorney’s letterhead accompanied by a release signed by the beneficiary, or
 - A document compliant with the non-MSP rules.
2. If the representative is a non-attorney, follow the non-MSP rules. However, note that information may be released to a non-representative regardless of whether or not there is a proper appointment of representative if the individual or entity has a proper HIPAA compliant release from the beneficiary.

B. Duration of Appointment

The duration of the appointment lasts until revoked by the beneficiary absent specific language in the appointment document limiting the duration of appointment. This is true regardless of whether or not an appeal has been filed within 1 year of the date of the appointment.

C. Correspondence

Both the beneficiary and the representative shall receive copies of all correspondence (including all appeals determinations).

D. Death of a Beneficiary

The death of the beneficiary terminates the authority of any representative appointed by the beneficiary. The representative must obtain a new appointment from the beneficiary's estate or the individual assuming responsibility for the estate if there is no formally appointed executor.

280 - Fraud and Abuse

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

280.1 - Fraud and Abuse - Authority

(Rev. 2926, Issued: 04-11-14, Effective: 07-14-14, Implementation: 07-14-14)

To protect the Medicare program from fraud and abuse, civil and criminal violation provisions have been included in §§[1107](#), [1128A](#), [1128B](#), [1872](#), and [1877](#) of the Act.

280.2 - Inclusion and Consideration of Evidence of Fraud and/or Abuse

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The MAC shall inquire fully into the matters at issue by receiving, in evidence, the testimony of witnesses and any documents that are relevant to the claims at issue. If the MAC believes that evidence has been tampered with, it shall refer this documentation to either the medical review or the UPIC's units for their follow-up.

The MAC may receive evidence obtained and provided by the UPIC concerning fraud or potential fraud with respect to the claim(s) at issue. If the UPIC provides such evidence, it becomes part of the case file and must be made available for inspection by the appellant prior to the reconsideration. Evidence of this nature is to be evaluated to determine issues such as whether, in conjunction with other credible evidence, the services in question were actually provided or were provided as billed.

NOTE: See §300.3 for additional information regarding fraud and abuse investigations.

280.3 - Claims Where There is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

Where there is a substantial basis for determining that an item or service either was not furnished or was not furnished as billed, the MAC may deny or down-code payment, as appropriate. The reviewer must ensure that the case file clearly documents the evidence that formed the basis for the determination. Appeal rights after such a determination remain the same as they would for any other unfavorable decision. If the MAC has reason to believe or evidence to support that items or services were not furnished or were not furnished as billed, it shall send a copy of the decision to its UPIC.

280.4 - Responsibilities of Adjudicators

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

If, during the course of the redetermination, the reviewer suspects a civil or criminal law violation, the reviewer shall render a decision only on the coverage or payment issues raised by the redetermination request. Although the reviewer cannot make a determination of civil or criminal fraud, he/she may still deny or reduce payment if he/she believes that the items or services at issue were not rendered, or were not rendered as billed (as discussed above). In making this determination, the reviewer may consider all available evidence that is included in the case file, including witness testimony, medical records, and evidence compiled through a fraud investigation, as discussed above. (See §310.4.B below.) In addition to denying the claims because the services were not rendered as billed, if the reviewer suspects fraud, he/she shall forward information regarding the potential civil or criminal violation to the UPIC. For further discussion on Medicare fraud issues, refer to the Medicare Program Integrity Manual, IOM 100-08, Chapter 4.

280.5 - Requests to Suspend the Appeals Process

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

The MAC does not have the authority to suspend redeterminations at the request of the Office of the Inspector General (OIG) or the Department of Justice (DOJ) without approval and direction from CMS central office (CO). If the OIG or DOJ submits a request to suspend a redetermination, the MAC shall first bring that request to the attention of CO through the RO.

280.6 - Continuing Appeals of Providers, Physicians, or Other Suppliers Who are Under Fraud or Abuse Investigations

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

Reviewers shall continue adjudicating the appeals of Medicare claims submitted by a provider, physician, or other supplier who is being or has been investigated, indicted, or convicted for fraud or abuse on other Medicare claims, or who is on Medicare payment suspension, unless the MAC has been informed that the provider, physician, or other supplier has agreed, as part of a settlement with the Government, or as the result of a prosecution, to withdraw the appealed claims or to waive the right to appeal the subject claim(s). If it has received notice of such a settlement, the MAC shall dismiss the appeal based on the fact that the appellant has waived his/her/its right to an appeal, and/or agreed to withdraw appeal of these claims as part of a settlement agreement with the Government. The MAC places a copy of the settlement document or other evidence of a settlement in the file. A reviewer shall remain neutral in the adjudication of claims that involve a provider, physician, or other supplier who is being or has been investigated, indicted or convicted of fraud or abuse.

280.7 - Appeals of Claims Involving Excluded Providers, Physicians, or Other Suppliers

(Rev. 3549, Issued: 06-24-16, Effective: 07-26-16, Implementation: 07-26-16)

The appeals process remains in effect for all claims with service dates prior to the effective date of exclusion. An excluded provider, physician, or supplier, or the beneficiary may appeal such claims. In addition, if the billing privileges of a provider, physician, or supplier are revoked retroactively, and the contractor reopens previously paid claims to assess an overpayment against the excluded party, the excluded party (or the beneficiary) may appeal the revised initial determination and overpayment under the claims appeal process ([42 CFR part 405 subpart I](#)).

NOTE: A provider or supplier's appeal of a revocation or denial of billing privileges is processed in accordance with the procedures set forth in [42 CFR part 405 subpart H](#) and [42 CFR part 498](#) (see also, IOM 100-08, Chapter 15, §15.25). The contractor is bound by the terms of the revocation action unless billing privileges are reinstated under the enrollment appeals process.

290 - Guidelines for Writing Appeals Correspondence (Rev. 1274, Issued: 06-29-07, Effective: 07-01-07, Implementation: 10-01-07)

The guidelines in this section are to be used when preparing appeals correspondence, which includes redeterminations decisions and inquiries about the status of appeals. These shall be handled as expeditiously as possible without lowering the quality of the response. General instructions on responding to beneficiary and provider/supplier communications are found in CMS Medicare Pub. 100-09. All other CMS-issued instructions on correspondence guidelines apply as well, including instructions on correspondence letterhead requirements.

290.1 - General Guidelines (Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

MACs shall prepare appeals correspondence so the appellant can easily understand both the reason why any of the services were not covered or could not be fully reimbursed, and what action the appellant can take if the appellant disagrees with that decision. In addition, the guidelines listed here should be followed to the extent possible:

- Keep the language as simple as possible;
- Do not use abbreviations or jargon;
- Choose a positive rather than a negative tone, whenever possible. Avoid words or phrases that emphasize what cannot be done by the MAC or the appellant;
- If possible, avoid one sentence paragraphs, uneven spacing between paragraphs, etc.;
- Apologize when appropriate, e.g., if the response is late. However, do not apologize for enforcing Medicare guidelines that may be adverse to the appellant's claim;
- Summarize the question before providing a response; and,
- Use correct spelling, grammar, and punctuation.

290.2 - Letter Format (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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

- Numerical dates must not be used (i.e., instead of 6/16/13, use June 16, 2013), except when included in a table;
- Type/font size must be 12 point or larger (all responses are to be processed using a font size of 12 and a font style of Universal or Times New Roman or similar style for the ease of reading by the beneficiary and the provider);
- When the subject matter is lengthy or complicated, bullet points should be used to clarify, if possible;
- For long letters, headings should be used to break it up (e.g., DECISION, BACKGROUND, RATIONALE);

- If procedure codes are cited, the actual name of the procedure must be associated with the code;
- Span dates may not be used for 1 day of service; and
- The MAC should not use all capital letters. Letters that contain all capital letters appear impersonal and computer generated.

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

290.3 - How to Establish Reading Level

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

The MMA requires that appeals correspondence be written in a manner calculated to be understood by beneficiaries. MACs shall write appeals correspondence that is understandable to beneficiaries. The purpose of this section is to provide some guidance to MACs on writing letters that are easy for beneficiaries to understand. To achieve this goal, MACs shall:

(1) Write in plain English/plain language with a clear, simple, conversational writing style with good communication of key points.

(2) Get reading levels of letters as low as you can without losing important content or distorting the meaning and without sounding condescending to the reader.

NOTE: This requirement does not apply to providers. MACs can use a cover sheet for the beneficiary, when sending a copy of the decision.

290.3.1 - Writing in Plain Language

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

The following are some tips to help MACs to write letters in plain language:

- Include definitions or explain terms you must use that are not familiar with your intended audience.
- Use heading, subheadings, or other devices to signal what's coming next. Labels for sections, headings, and subheading should be clear and informative to the intended audience.
- Write in an active voice and in a conversational style. For example, conversational style uses contractions (I'd instead of I would) and informal vocabulary (find out instead of determine).
- Use a friendly and positive tone.
- Use words that are familiar to your intended audience. Shorter words tend to be more common, and they are generally preferable. For example, use doctor instead of physician. Pay back instead of reimburse. Can get instead of eligible. There are exceptions. For example, access is a short word, but it is health care jargon that is hard for many consumers to understand. Organization is a five-syllable word, but is probably familiar to most readers.
- When a term is best known to your intended audience by its acronym, use the acronym and spell out the word that it represents in parenthesis with the letters that form the acronym in bold. For example: PCP (**P**rietary **C**are **P**rovider).
- Be on alert for words that are abstract or vague, or that may mean different things to different people. Replace these words with more specific words to be sure your readers understand the key messages.

- Keep your sentences simple and direct. Most should be reasonably short; about eight to ten words per sentence for most sentences. When sentences are long, the main point gets lost in all the words. Active voice makes the style more direct.
- Vary the length of your sentences. Somewhat longer, natural-sounding sentences of about 12 to 15 words can effectively break up the choppy effect of using many short sentences.
- Paragraphs should be relatively short. Short paragraphs are more inviting to your reader and give the visual appearance of being easier to read.
- Use simpler words rather than technical terms whenever you can without losing the content or distorting the meaning. Sometimes it's important to use a technical term, such as the words mammogram, or cholesterol.
- Appearance should be appealing at first glance. Pages should be uncluttered with generous margins and plenty of white space.
- The graphic design should use contrast, indentation, bullets, and other devices to signal the main points and make the text easier to skim.
- Use a large type and spacing between lines.

290.4 - Required Elements in Appeals Correspondence (Rev. 2926, Issued: 04-11-14, Effective: 07-14-14, Implementation: 07-14-14)

The following should be used in all appeals correspondence:

- The name of the beneficiary/provider/physician/supplier to whom the letter is addressed rather than "Dear Sir/Madam;"
- Correspondence is identified by either the date on written correspondence or the date the written correspondence was received;
- The name of the provider, physician or supplier as well as the date(s) of service;
- When appropriate, an explanation in letters to beneficiaries, explaining why he/she is being sent a letter if the appeal came from the provider, physician or other supplier;
- The appeal determination/decision is placed in the beginning of the letter;
- Explicit rationale that describes why the items or services at issue do not meet Medicare guidelines. Merely stating that an item or service is "not medically reasonable and necessary under §1862(a)(1)" or "not medically reasonable and necessary under Medicare guidelines" does not provide any rationale. The rationale should include a description of the logic that led to the decision, references used to support the decision, and other information that is relevant to support the decision in the case;
- When the appeals correspondence includes Medicare statutory citations, they must be related to the decision in layman's terms. The statutory cite is listed as a parenthetical at the end of the sentence. For example, instead of beginning a sentence with, "§1879 of the Social Security Act states that..." the sentence should start with "Under Medicare law, suppliers must...(§1879 of the Social Security Act)";

- Whenever the person is to receive some further response, such as an MSN (if available), an estimated time frame as to when he/she will receive it is provided;
- Telephone number on all correspondence for additional questions;
- What, if anything, must be done next, and by whom;
- As appropriate, the results of any consultations with professional medical staff;
- When applicable, a statement advising the appellant that upon written request the MAC will provide them copies of regulations, statutes, and guidelines used in making the determination;
- For appeals, if the redetermination is partially or wholly favorable, an explanation about why the new determination is different from the previous determination; and
- The correspondence must be written in a clear manner and with a customer- friendly tone.

300 - Disclosure of Information

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

300.1 - General Information

(Rev. 3549, Issued: 06-24-16, Effective: 07-26-16, Implementation: 07-26-16)

The basis for policy governing the disclosure and confidentiality of information collected by the contractor is §1106 of the Act, the Department's Public Information regulations, as well as the Privacy Act, and the Freedom of Information Act. In general, all information relating to an individual is confidential except as provided by regulation. In the interest of an appellant's right to due process, there are situations where information may be disclosed. The CMS regulations implementing §1106 of the Act can be found at 42 CFR Part 401, Subpart B. (See the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 6.)

In addition, §1106 in title XI of the Act provides penalties for violation of the provisions concerning confidentiality of information. Activities prohibited under the provisions of the Act include, but are not limited to, making false and fraudulent statements, fraudulent concealment of evidence affecting payment benefits, false impersonation of another individual, misuse or conversion of payments for use of another, and improper disclosure of confidential information. (See the Medicare Program Integrity Manual 100-08.)

300.2 - Disclosure of Information to Third Parties

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

If a beneficiary wishes to have his/her information disclosed to a third party without appointing that individual as a representative, this can be accomplished by the beneficiary or third party providing written authorization to the MAC for the release of the information. The written authorization must contain a signature of the beneficiary and an explanation of the type of information the beneficiary agrees to release to the individual. An example of this type of situation is where a beneficiary has asked a Member of Congress for assistance with his/her appeal. In this case, it may be necessary for the Member of Congress to receive the decision; however the Member of Congress does not wish to accept the responsibility associated with being the beneficiary's appointed representative or the beneficiary does not wish to appoint the Member of Congress as his/her representative. See §310.1 for more information on requests for redetermination submitted by Members of Congress. If the beneficiary wishes to appoint a representative, MACs should refer to §270.

300.3 - Fraud and Abuse Investigations

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

Any and all evidence used by the A/B MAC (A), (B), (HHH), or DME MAC to arrive at a determination or decision shall be placed in the appeals case file (copies are acceptable). Information in the case file shall be made available to an appellant upon request. Therefore, the MAC shall be aware that information placed in the case file is accessible to an appellant. The UPIC shall also understand that the MAC may not consider any evidence that has not been made a part of the case file. The UPIC and the MAC shall therefore exercise discretion when deciding whether to place any of the following information into the appeals case file:

- The impetus behind a fraud and abuse investigation;
- The name of the beneficiary or any other person lodging the complaint that triggers the fraud and abuse investigation;
- Notes or transcripts of beneficiary interviews resulting from a fraud and abuse investigation;
- Records or information compiled for law enforcement purposes during a fraud and abuse investigation; or
- The name of a confidential source(s) when confidentiality has been promised by CMS in return for cooperation in a fraud and abuse investigation.

Where the MAC relies upon any of the above information in order to deny a claim or to render a less than fully favorable determination or decision, then an appellant has a due process right to review this information. If information is kept out of an appeals case file for confidentiality reasons, it may not be relied upon to make a coverage decision or deny or reduce payment.

300.4 - Medical Consultants Used

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

The parties are entitled to know the identity and qualifications of any consultant whose evidence the MAC used to support the initial claim determination or the redetermination. If the MAC uses a consultant, it shall include the identity and qualifications of the consultant in the file for possible use by the ALJ, and for the appellant's use upon request. This applies to both external medical consultants and internal staff used to review the claim. An example of this would be the name and title of the medical consultant.

300.5 - Appeal Decision Involving Multiple Beneficiaries

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A. Appeals of Overpayments Involving Multiple Beneficiaries with a Single Account Receivable

If an appellant submits a request for redetermination that involves an overpayment with a single account receivable for claims involving multiple beneficiaries, the MAC shall issue one decision letter to the appellant that includes information specific to the claims for each beneficiary. The summary of facts, coverage, payment and liability decisions for each beneficiary's claim(s) may be included as a separate attachment to the decision letter. Since each beneficiary is a party to the appeal, subject to the exception in §300.5.C below, the MAC shall send each beneficiary a copy of their own determination without compromising the privacy of other beneficiaries in the appeal. (Refer to IOM, 100-06, Medicare Financial Management Manual, Chapter 6, section 460.1, for instructions on how to count requests that involve multiple beneficiaries).

B. Appeals Involving Claims of Multiple Beneficiaries, Other than Overpayments with a Single Account Receivable

If a party files a request for redetermination that involves claims of multiple beneficiaries that do not comprise an overpayment with a single account receivable, the MAC may process the appeal by issuing a

separate decision letter for each beneficiary's claim(s) (i.e., as a split appeal), or the MAC may issue a single letter with attachments for each separate claim, whichever is more efficient.

Example: If a supplier submits a single appeal request involving unrelated claims for various beneficiaries that were denied on prepayment review or through prepayment edits, the MAC may process the appeal as a split and issue separate letters to the supplier-appellant, or the MAC may issue a single letter with attachments for each claim. In either case, the beneficiary, as a party to the appeal, must receive a copy of the decision letter that pertains to his or her claims.

Example: If a supplier submits a single appeal request involving claims reviewed by a recovery auditor on a postpayment basis, resulting in overpayments (not extrapolated) processed as separate accounts receivable, the MAC may issue either a single decision letter to the appellant with attachments for each claim, or separate decision letters, whichever is more efficient. The beneficiary, as a party to the appeal, must receive a copy of the decision letter that pertains to his or her claims, subject to the exception noted in §300.5.C below.

C. Exception to Sending Decision Letters to Beneficiaries in Overpayment Cases

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

Example: During a postpayment review, claims for multiple beneficiaries are initially denied as being not medically reasonable and necessary, and the determination of liability under section [1879](#) of the Act finds the physician financially responsible for the denied services. If during the appeal, the physician demonstrates that a valid ABN was issued for some of the services provided to certain beneficiaries and financial responsibility shifts from the physician to those beneficiaries, the MAC must issue separate decision letters to the affected beneficiaries, but is not required to issue separate decision letters to those beneficiaries whose liability has not changed (i.e., liability remains with the physician).

310 - Redetermination - The First Level of Appeal

(Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

A party dissatisfied with an initial determination may request that the MAC review its determination. A redetermination is the first level of appeal after the initial determination on Part A and Part B claims. It is a second look at the claim and supporting documentation and is made by an employee that did not take part in the initial determination. If an initial determination is not made, there are no appeal rights on that claim (see §200.C for a list of actions that are not initial determinations and therefore do not have appeal rights).

The reviewer must comply with, and is bound by, all applicable statutory and regulatory provisions. The reviewer may not overrule the provisions of the law or interpret them in a way different than CMS; nor may the reviewer comment upon the legality, constitutional or otherwise, of any provision of the Act, regulations, or CMS policy in the review determination. The reviewer is also bound by all CMS-issued policies and procedures, including CMS rulings, Medicare manual instructions, change requests, national coverage determinations, and local coverage determinations. The reviewer must consider the applicability of all CMS-issued policies and procedures to the facts of a given claim. The reviewer may not change the amount required to be paid under the Physician Fee Schedule.

310.1 - Filing a Request for Redetermination

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10-01-19)

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. Appeal requests submitted electronically via a facsimile or secure Internet portal/application shall be considered to have been received in writing.

NOTE: Contractors are not required to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application shall be at the discretion of the appellant. Contractors shall continue to accept appeal requests in hardcopy via mail.

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. Persons who often act on behalf of a beneficiary in filing a redetermination request include: the spouse, parent, child, sibling, neighbor or friend. Beneficiary advocacy groups and Members of Congress may also submit a request for redetermination on behalf of a beneficiary (see §310.1.A.1 for further discussion on requests submitted by Members of Congress).

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.

If a redetermination request is submitted by an individual who is not the beneficiary's appointed representative, all written notices related to the appeal are sent only to the beneficiary, not the individual making the request for redetermination. In addition, if the contractor honors a request for redetermination filed by someone other than the beneficiary or the beneficiary's appointed representative, the contractor should contact the beneficiary (or an appointed/authorized representative if applicable) if further information is needed to process the redetermination.

NOTE: An authorized representative is an individual authorized under State or other applicable law to act on behalf of a beneficiary in an appeal, and has all of the rights and responsibilities of a beneficiary with respect to the appeal. An authorized representative does not need to secure an appointment of representative from the beneficiary in order to file an appeal or obtain/receive information related to the appeal. See §270.1.1 for additional information regarding authorized representatives.

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).

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.

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 the 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:

- A signed copy of correspondence from the beneficiary expressing a desire for the congressional office to obtain information on his/her behalf;
- A release of information form developed by the congressional office; or
- 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 by submitting a copy of their MSN, by filing a completed Form CMS-20027 or by submitting a letter that indicates dissatisfaction with a claim determination. As noted above, appeal requests received via a facsimile or secure Internet portal/application shall also be considered received in writing. 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 the following:

- "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."

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 via mail, facsimile or secure Internet portal/application (if the contractor chooses to receive requests via facsimile or CMS approved secure Internet portal/application) indicating what they are appealing and why. A redetermination request may be submitted using:

- a. A completed Form CMS-20027 constitutes a request for redetermination.** “Completed” means that all applicable spaces are filled out and all necessary attachments are included with the request. The form can be found on the CMS website at:
<http://www.cms.gov/cmsforms/downloads/cms20027.pdf>
- b. A written request/letter.** At a minimum, the request must contain the following information:
1. Beneficiary name;
 2. Medicare number;
 3. The specific service(s) and/or item(s) for which the redetermination is being requested;
 4. The specific date(s) of the service; and
 5. The name of the party or the representative of the party.

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.

NOTE: The details of its actions must be detailed (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.

- c. A secure Internet portal/application.** If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may (but are not required to) submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined above under §310.1.B.2.b.

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.

Where the required information is not listed on the request form but is provided within the documents or attachments submitted with the appeal, the request substantially complies with the requirements established in 42 CFR 405.944. MACs shall not dismiss requests under 42 CFR 405.952(b)(2) when redeterminations substantially comply with requirements.

3. How to Handle Incomplete Requests for Redetermination:

If any of the above information referenced in Section 2 is not included with an appeal request submitted by a party or their representative (other than a beneficiary, or a beneficiary’s representative), the request is considered incomplete and the contractor issues a dismissal notice with an explanation of the information that must be included (see §310.6 for more information on dismissals). Contractors should not consider beneficiary requests as incomplete, whether filed by the beneficiary or by their representative. Contractors must contact beneficiaries (or their representatives), when necessary, to obtain missing information needed to process the redetermination.

4. How to Handle Multiple Requests for Redetermination for the Same Item/Service:

- a. Duplicate requests (multiple requests from same party) while an appeal is pending.** If an appeal for an item or service is pending and the appellant submits a duplicate request for redetermination, the contractor combines the requests into one redetermination. The contractor shall include verbiage indicating that duplicate requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized). Adjudication time frames are still based on the first request

for redetermination. NOTE: See 310.4.D.4 for extending adjudication timeframes if additional information is submitted with the second appeal request.

If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting duplicate requests for redetermination, the contractor shall take additional steps to educate the appellant regarding the appeals process.

b. Multiple requests from different parties while an appeal is pending. If an appeal for an item or service is pending and another party to the redetermination submits a request for redetermination, the contractor shall combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with [42 CFR 405.944\(c\)](#).

When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that requests for redetermination had been received from multiple parties (on what dates and via what venues, if multiple venues were utilized) so that it is clear to the parties that the decision or dismissal was issued timely in accordance with [42 CFR 405.950\(b\)\(2\)](#).

c. Duplicate or multiple requests when an appeal is complete. If a decision or dismissal notice has been issued (including an MSN or RA for a fully favorable decision), and the contractor receives an additional request for redetermination for that item/service (a duplicate request from the appellant or a subsequent request from a different party), the contractor shall treat the additional request as an inquiry. The contractor directs the party to file a request for reconsideration with the appropriate QIC.

d. Workload -Whenever the contractor combines duplicate or multiple requests for redetermination as explained above, the contractor shall ensure that the workload reporting reflects one redetermination receipt and one redetermination completed.

NOTE: If a party files a request for reconsideration with the contractor after a redetermination decision or dismissal notice has been issued, the contractor treats the reconsideration request as misfiled and forwards the request to the QIC for a reconsideration in accordance with §320.1.B.

Contractors **shall not** issue a dismissal notice in response to a duplicate request or multiple requests for redetermination.

NOTE: In accordance with IOM 100-04, chapter 29, section 310.6.3, if an appellant requests that the contractor vacate its dismissal action, or an appellant refiles a corrected appeal in response to a dismissal, and the contractor determines that it cannot vacate the dismissal, then it sends a letter notifying the appellant accordingly. If evidence or information not previously submitted with the redetermination request is submitted with the request to vacate the dismissal, the letter must specifically address that new evidence or information. The contractor shall not issue a second dismissal notice to the appellant.

5. Letters and Calls That Are Considered Inquiries

See IOM 100-09, Medicare Contractor Beneficiary and Provider Communications Manual. 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. (For example, if a physician sends a letter inquiring about the payment rate for a particular item or service, but it is not in connection with a claim that has been processed for the item or service, the letter is treated as an inquiry. However, if the physician questions the amount paid for an item or service on a claim that was processed to payment, and asserts additional payment is warranted, the contractor handles this as an appeal of the payment amount, even if the item/service was paid under a fee schedule. See §200.C.3);

- The party is only asking for the status on a previously submitted appeal request or correspondence. The contractor states in its reply that is responding to a status request. It does not use the word “review” in its reply;
- It is a request for information;
- It is a request for redetermination, made by a party other than the appellant, for the same item/service for which a decision or dismissal notice has already been issued. In responding to the inquiry, the contractor shall inform the party making the request that a decision has been issued and the party should file a reconsideration with the appropriate QIC. Contractors shall not issue a dismissal notice.
- It is a request for redetermination, submitted by an individual (who is not an appointed or authorized representative), filed on behalf of a provider, physician, supplier, or other non-beneficiary party, and the request does not include an appointment instrument (see §270.1.6.B.2). The contractor follows the procedures in §270.1.6.B.2.
- The party asks only for a second copy of a notice.

NOTE:

- If the contractor receives a ‘request for reconsideration’ (assuming the appellant is using the wrong form or incorrect terminology), but determines that a redetermination has not been conducted, the contractor does not forward the request to the QIC. The contractor shall consider the request as a redetermination request.
- If the contractor receives a ‘request for reconsideration’ from a party, or a 'request for reconsideration' that was mistakenly directed to them by another contractor, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file within 60 calendar days of receipt in the corporate mailroom. Refer to §320.1.

Parties to a claim must file a request for redetermination with the proper contractor based on the claims processing jurisdiction rules established by the Medicare program. Jurisdiction is established based on either the State where the service was provided (for Part B claims **not** involving DME), the State where the beneficiary resides (for Part B DME claims only), or the location of the A/B MAC (for Part A provider claims). There may be instances where requests for redetermination are directed to the wrong contractor. Contractors shall have standard operational procedures, including maintaining a record of these cases, in place to ensure that misfiled requests are forwarded to the proper contractor jurisdiction within 60 calendar days of receipt.

Refer to § 310.4.A for information on determining whether misfiled requests for appeal are processed in a timely manner.

310.2 - Time Limit for Filing a Request for Redetermination
(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A party must file a redetermination request within 120 days of the date of receipt of the notice of initial determination (MSN or RA) with the contractor indicated on the notice of initial determination (receipt of the notice of initial determination is presumed to be 5 days after the date of the MSN or RA unless there is evidence to the contrary). The date of filing for requests filed in writing is defined as the date received by the appropriate contractor in the corporate mailroom, the date received via facsimile, or the date received in the secure Internet portal/application, as evidenced by the receiving office’s date stamp on the request. If the party has filed the request in person with the contractor, the filing date is the date of filing at such office, as evidenced by the receiving office’s date stamp on the request. If the party has mailed or filed in person the request for redetermination to a CMS, SSA, RRB office, or another contractor or Government agency

within the time limit, and the request did not reach the appropriate contractor until after the time period to file a request expired, the contractor shall consider the date the request was first filed with a contractor or an official Federal government entity as the date of receipt for purposes of determining if the redetermination request was filed in a timely manner.

When the filing deadline for a redetermination ends on a Saturday, Sunday, legal holiday, or any other nonwork day, the contractor shall apply a rollover period that extends the filing deadline to the first working day after the Saturday, Sunday, legal holiday, or other nonwork day. For example, if the filing deadline for a redetermination falls on the Saturday before Columbus Day, the filing deadline is extended to the first working day after the Columbus Day holiday.

The contractor may extend the period for filing if it finds the party had good cause for not requesting the redetermination timely. (See §240.2 for a discussion of good cause.) In order for good cause to be considered, the appeal request must be in writing, received via hard copy mail, through a facsimile, or through a secure Internet portal/application. If the contractor finds that the party did not have good cause for failing to request a redetermination in a timely manner, it may, at its discretion, consider reopening. (See Pub. 100-04, chapter 34.)

310.3 - Reporting Redetermination on the Appeals Report (Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

The MAC is required to report all appeals related data and information on the CMS Appeals Report. The Report is intended to capture information on appeal requests, including other correspondence that is determined to be a request for redetermination. Correspondence that initially appears to be an inquiry, but is determined to be an appeal request, must be reported as a redetermination receipt and not an inquiry.

310.4 - The Redetermination (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A. Timely Processing Requirements

The contractor must complete and mail a redetermination notice for all requests for redetermination within 60 days of receipt of the request (with the exception of (D)(4) below). The date of receipt for purposes of this standard is defined as the date the request for redetermination is received in the corporate mailroom or the date when the electronic request for appeal is received via facsimile or through the secure Internet portal/application. For misfiled redetermination requests, the proper contractor jurisdiction must complete and mail a redetermination notice within 60 days of receiving the misfiled request in their corporate mailroom.

Completion means:

1. For affirmations (unfavorable decisions), the date the decision letter is mailed to all of the parties (or their representatives). Affirmations processed via a CMS approved secure Internet portal/application shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet portal/application, and a hard copy decision letter is sent to other parties to the appeal who do not have access to the secure Internet portal/application. See §310.10 for additional requirements related to notices sent via secure portal/applications.
2. For partial reversals (partially favorable decisions) and full reversals (fully favorable decisions), when all of the following actions have been completed:
 - a. The decision letter, if applicable, is mailed to the parties. If the redetermination is processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the electronic redetermination notice is transmitted to the appellant through the secure Internet

portal/application, and a hard copy decision letter is sent to other parties to the appeal who do not have access to the secure Internet portal/application. See §310.10 for additional requirements related to notices sent via secure portal/ applications, and

- b. The actions to initiate the adjustment action in the claims processing system are taken. When the adjustment action is completed, this action must be included on the next scheduled release of the MSN/RA. Appropriate follow-up action should be taken to ensure that the adjustment action results in the issuance of proper payment.
3. For withdrawals and dismissals, the date the dismissal notice is mailed. If the redetermination is processed via a CMS approved secure Internet portal/application, it shall be considered complete on the date the notice is transmitted to the appellant through the secure Internet portal/application, and a hard copy decision letter is sent to other parties to the appeal who do not have access to the secure Internet portal/application. See §310.10 for additional requirements related to notices sent via secure portal/applications.

B. Development of the Appeal Case File

The reviewer must obtain and review all available and relevant information needed to make the determination. All information considered by the appeals adjudicator in conducting the redetermination must be included in the case file. Other areas within the contractor may have information relevant to the claim(s) at issue. For example, the medical review area may submit evidence to the reviewer for inclusion in the case file (e.g., documentation and correspondence related to provider education on the issues appealed, any notices of review, and specific documentation requests to the provider and third parties).

In addition, contractors such as Recovery Audit Contractors (RACs), UPICs, or the Supplemental Medical Review Contractor (SMRC) may have other information from their review of claims that they wish to include in the case file. Documentation submitted by a provider, supplier or beneficiary (or other party to the appeal) as part of a prepayment (e.g. medical review or demand bill review) or postpayment (e.g. UPIC reviews) review, including clinical documentation, must be included in the appeals case file for consideration during the redetermination.

If this documentation is not included in the appeals case file, the reviewer shall request the documentation from the claims review contractors (i.e., RACs, UPICs, and SMRCs) prior to rendering the redetermination decision. The timeframes associated with request and delivery of medical records from the CMS claims review contractor to the MAC should be agreed upon in the Joint Operating Agreement (JOA). The MACs should notify the respective Contracting Officer's Representative if there is any difficulty obtaining documentation from the CMS contractors within the agreed upon timeframes established by the JOA.

If the claims review contractor confirms that it did not receive medical records from the provider, supplier, or beneficiary (or other party to the appeal) or the information is otherwise unavailable, and the documentation is needed to support a favorable resolution of the appeals case, then the MAC shall reach out to the provider, supplier, beneficiary (or other proper party to the appeal) to obtain the medical records, and any other supporting documentation, prior to rendering the redetermination decision. The case file and redetermination decision letter shall document all attempts to obtain the medical records and/or any other support documentation prior to rendering the redetermination decision.

The development of the case file is important not only for the redetermination, but also to prepare for a potential appeal to the QIC. Proper development of the case file will assist the contractor in timely transmitting the case file to the QIC upon request. In instances of large overpayment cases involving many claims, this case file development is extremely important.

For example, with respect to overpayments that are determined through statistical sampling and extrapolation, appellants often challenge the sampling methodology and the extrapolation during the reconsideration or an ALJ hearing. To avoid any documentation issues during subsequent appeals,

contractors shall include all information detailed in IOM 100-08, Chapter 8, §8.4.4 related to the sampling methodology and extrapolation in the case file.

When a reconsideration request is filed with the QIC, and the QIC requests a case file for a large overpayment case, it is critical the QIC obtain the case file timely so it can begin adjudication. Therefore, it should be a priority for the contractor to adequately develop case files.

Evidence in the case file must be made available for inspection by an appellant or party upon request. Reviewers must exercise care in determining the weight to give allegations of fraud and abuse where the source of the specified information is not provided. Although the name of the beneficiary or other source that provided the information that triggered an investigation is not always provided or necessary when reviewing the evidence, the case file must include information on the independent, subsequently developed investigation that supports the claim decision (See subsection D, below, for instructions on development of documentation.)

C. Conducting the Redetermination

1. Overview

- The redetermination is an independent review of an initial determination. The individual performing the redetermination must not be the same person who made the initial determination.
- The contractor reviews the evidence and findings upon which the initial determination was based, and any additional evidence the parties submit or the contractor obtains on its own.
- For redeterminations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, MACs shall limit their review to the reason(s) the claim or line item at issue was initially denied. Prepayment reviews occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a UPIC, RAC, MAC, or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. Complex reviews require a manual review of the supporting medical records to determine whether there is an improper payment.

Automated reviews use claims data analysis to identify improper payments. If an appeal involves a claim or line item denied on an automated pre-payment basis, MACs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

Contractors will continue to follow existing procedures regarding claim adjustments resulting from favorable appeal decisions. These adjustments will process through CMS systems and may suspend due to system edits. Claim adjustments that do not process to payment because of additional system imposed payment limitations, conditions or restrictions (for example, frequency limits or National Correct Coding Initiative edits) may result in new denials with full appeal rights (i.e., the new denial will be considered an initial determination with respect to the appeals process).

If a MAC conducts an appeal of a claim or line item that was denied on pre- or post-payment review because a provider, supplier, or beneficiary failed to submit requested documentation, the MAC will review all applicable coverage and payment requirements for the item or service at issue, including whether the item or service was medically reasonable and necessary. As a result, claims initially denied for insufficient documentation may be denied on appeal if additional documentation is submitted and it does not support medical necessity.

- There may be times where the appellant requests a redetermination of an entire claim and there may be times where he/she requests a redetermination of a specific line item on the claim. The contractor should review all aspects of the claim or line item necessary to respond to the appellant's issue. For example, if the appellant questions the amount paid, the contractor must also review medical necessity, coverage, deductible, and limitation on liability, if applicable.
- If the appellant requests a redetermination of a specific line item, the contractor reviews all aspects of the claim related to that line item. If appropriate, it reviews the entire claim. If it reviews more than what the appellant indicated, it includes an explanation in the rationale portion of the redetermination letter of why the other service(s)/item(s) were reviewed.

2. [Reserved]

3. Appeal Requests Filed on Resubmitted Claims

For appeals of a specific line item or service, the date of the first MSN or RA that states the coverage and payment decision is the date of the initial determination. Adjustments to the initial claim or claim resubmissions for the same item/service on the same date of service that are included on subsequent MSNs or RAs, but do not revise the initial determination, do not extend/change the appeal rights on the initial determination.

4. Fraud

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

5. Appeals Involving Overpayments

For appeals that involve overpayments, the contractor shall review all aspects of the overpayment, including the validity of the overpayment, whether the amount of the overpayment was correctly calculated and extrapolated (if applicable), who is responsible for the overpayment, and whether recovery of the overpayment should be waived under §1870 of the Act. For additional information see IOM 100-06 Chapter 3, sections 70 through 110.

If the redetermination involves an extrapolated overpayment and the appellant challenges the validity of the sampling methodology, the contractor reviews the claims in question as well as the methodology used to extrapolate the overpayment amount. For background on how the UPICs use statistical sampling to estimate overpayments, see IOM 100-08, Chapter 8, section 8.4. If a reconsideration is subsequently requested, the entire case will be sent.

6. Evidence

Appellants have the opportunity to submit written evidence and arguments relating to the claim at issue. Contractors must accept and consider any relevant documentation submitted. Contractors may also accept this information via facsimile and/or a secure Internet portal/application.

D. Requests for Documentation

1. Requesting Documentation for State-Initiated Appeals

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

portal/application. Documentation previously submitted by the State or the provider/supplier as part of a demand bill review must be included in the appeals case file for review during the redetermination (see §310.4.B).

2. Requesting Documentation for Provider or Supplier-Initiated Appeals

For provider and supplier initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer notifies the provider or supplier of the timeframe the provider or supplier has to submit the documentation. The reviewer documents the request in the redetermination case file. The requested documents may be submitted via facsimile and/or via a secure Internet portal/application. In some situations, a provider or supplier may inform the reviewer that it is having trouble obtaining supporting documentation from another provider or supplier (e.g., an ambulance supplier who is requested to submit hospital admission records). In this situation, the contractor may assist the provider or supplier in obtaining records. If the additional documentation that was requested is not received within 14 calendar days from the date of request, the reviewer conducts the redetermination based on the information in the file. The reviewer must consider evidence that is received after the 14-day deadline but before having made and issued the redetermination. See §310.4.D.4 below for information on the extension of the decision making timeframe for additional documentation that is submitted after the request.

3. Requesting Documentation for Beneficiary-Initiated Appeals

For beneficiary initiated appeals, when necessary documentation has not been submitted, the reviewer advises the provider or supplier to submit the required documentation. The reviewer documents the request in the redetermination case file. The reviewer notifies the beneficiary (either in writing or via a telephone call) when the reviewer has asked the beneficiary's provider or supplier for additional documentation. The reviewer also notifies the beneficiary that the provider or supplier has 14 calendar days to submit the additional documentation that has been requested, and that if the documentation is not submitted, the reviewer will decide based on the evidence in the case file. If the reviewer sends the beneficiary a letter, it must include a description of the documentation that has been requested. The reviewer shall document all notifications and correspondence to and from the beneficiary in the redetermination case file.

4. Extension for Receipt of Additional Documentation

Contractors shall educate parties to include all supporting documentation with the redetermination requests submitted via mail, facsimile or a secure Internet portal/application. However, when a party submits additional evidence (via mail, facsimile or a secure Internet portal/application) after filing the request for redetermination, the contractor's 60-day decision-making timeframe is automatically extended for up to 14 calendar days for each submission.

This additional time is allowed for all documentation submitted by a party after the request, even when the documentation was requested by the contractor. Although this extension is granted to the contractor for making decisions, it should not routinely be applied unless extra time is needed to consider the additional documentation.

5. General Information

The contractor routinely includes instructions on the appropriate information to submit with appeal requests in its provider newsletters and other educational literature. Providers and suppliers are responsible for providing all the information the contractor requires to adjudicate the claim(s) at issue.

310.5 - The Redetermination Decision

(Rev. 3549, Issued: 06-24-16, Effective: 07-26-16, Implementation: 07-26-16)

A. Redetermination Decision Letters

The law requires contractors to conclude and mail and/or otherwise transmit the redetermination decision within 60 days of receipt of the appellant's request, as indicated in §310.4. For unfavorable redeterminations, the contractor mails the decision letter to the appellant, and mails copies to each party to the initial determination (or the party's authorized representative and/or appointed representative, if applicable).

Contractors shall mail the written decision unless the contractor has received approval from CMS to use a secure Internet portal/application as part of the appeals process and the appellant has submitted the request for appeal electronically. Contractors may transmit appeal decisions (favorable, partially favorable, or unfavorable) via a secure Internet portal/application if the appeal request was received via that mechanism. Contractors shall ensure that a hard copy decision letter is sent to other parties to the appeal who do not have access to the secure Internet portal/application. See §310.10 for additional requirements related to notices sent via secure portal/ applications.

For partially favorable redeterminations, the contractor mails and/or otherwise transmits the decision letter, and an adjusted MSN or RA to the appellant. The contractor mails a copy of the decision letter and mails or otherwise transmits an adjusted MSN or RA to each party to the initial determination (or the party's authorized representative, if applicable). The contractor shall ensure that the appropriate MSN or RA messages are included regarding refunds of payments, including when necessary any coinsurance or deductible collected.

If a party has an appointed representative, the contractor mails the decision letter to the appointed representative (see §270). Sending the decision letter to the appointed representative has the same force and effect as if the letter was sent to the party. The contractor does not send an MSN or RA to an appointed representative.

For fully favorable redeterminations, the contractor mails or otherwise transmits an MSN or RA reflecting the adjustment action to each party (or the party's authorized representative, if applicable) on the next scheduled release. The MSN provides the beneficiary with information as to his/her financial liability with regard to the claim(s) that are now payable (e.g. applicable coinsurance). The contractor does not send an MSN or RA to an appointed representative.

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

B. Determinations That Result in Refunds to a Beneficiary

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

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

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

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

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

1. A nonparticipating physician not accepting assignment who, based on the redetermination, now has a refund obligation under [§1842\(l\)\(1\)](#) of the Act;
2. A nonparticipating supplier not accepting assignment who is determined to have a refund obligation pursuant to [§1834\(a\)\(18\)](#), due to a denial under either [§1834\(a\)\(17\)\(B\)](#) or [§1834\(j\)\(4\)](#) of the Act; or,
3. A denial based on [§1879\(h\)](#) of the Act of an assigned claim submitted by a supplier, where it is determined under [§1834\(a\)\(18\)](#) of the Act that the supplier must refund any payments (including deductibles and coinsurance) collected from the beneficiary.

NOTE: For additional information regarding refund requirements, please refer to IOM 100-04 Chapter 30, sections 140 and 150.

C. Paid Claim Appeals

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

(Start)
EXHIBIT 1:

**Model Redetermination
Unfavorable Decision
for
Paid Claim Appeal**



MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF
BENEFICIARY:

CONTACT INFORMATION:
If you have questions, write or call:
Contractor Name
Address
City, State Zip
Telephone number

RE: <Include claim identifier or appeal number>

Dear <Appellant Name>:

This letter is to inform you of the decision on your Medicare appeal. An appeal (also known as a redetermination) is a new and independent review of a claim. You are receiving this letter because you requested a redetermination for <SERVICE(S)> on <DATE(S)>.

The redetermination decision is unfavorable because the service(s) in question has(have) already been paid by the MAC on <DATE>. We have evaluated the information submitted and there do not appear to be any errors impacting the payment amount, which

is the maximum allowed by Medicare for this service. As a result, we are issuing an unfavorable decision on your request for a redetermination on this claim.

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

[INSERT QIC INFORMATION]

Sincerely,

NAME, TITLE
CONTRACTOR NAME

(End)

Exhibit 1

310.6 - Dismissals

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A. Contractor Dismissal of a Redetermination Request

The contractor may dismiss a request for a redetermination under the following circumstances:

1. Request of a Party - A request for redetermination may be withdrawn at any time prior to the mailing or transmission of the decision via a secure Internet portal/application upon the request of the party or parties filing the request for redetermination. A party may request a dismissal by filing a written notice of such request with the contractor. Contractors may accept requests for withdrawal via facsimile and/or a secure Internet portal/application, if approved by CMS. The dismissal of a request for redetermination is binding unless vacated by the contractor or QIC.
2. Dismissal for Cause - The contractor may dismiss a redetermination request, either entirely or as to any stated issue, under either of the following circumstances:
 - a) Where the party requesting a redetermination is not a proper party, or
 - b) Where the party requesting a redetermination does not otherwise have a right to a redetermination.
3. Failure to File Timely - When a request for redetermination is not filed within the time limit required, and the contractor did not find good cause for failure to file timely, it should dismiss the request.
4. Appointment of Representative is Defective - When an individual who is attempting to act as a representative of an appellant who is not the beneficiary submits an incomplete appointment form and the appointment is not corrected within the time limit discussed above in §270.1.6.B.1, the contractor dismisses the request.

NOTE: If the appellant resubmits an appeal request with an appointment of representative form, the contractor should consider the request as a duplicate and should not count the resubmission as additional workload. (See Pub. 100-06, the Medicare Financial Management Manual, Chapter 6.)

5. Party Failed to Make A Valid Request - When the contractor determines the provider, supplier, or State failed to make out a valid request for redetermination that substantially complies with §310.1.B.1. or §310.1.B.2. A valid request may contain portions of the required information within the documents or attachments submitted with the appeal, so that the request substantially complies with the requirements established in 42 CFR 405.944. MACs shall not dismiss requests under 42 CFR 405.952(b)(2) when redeterminations substantially comply with requirements.
6. Beneficiary Dies While the Request is Pending - When a beneficiary or the beneficiary's representative files a request for redetermination, but the beneficiary dies while the request is pending, the contractor issues a dismissal when all of the following criteria apply:
 - a) The beneficiary's surviving spouse or estate has no remaining financial interest in the case. In deciding this issue, the contractor considers if the surviving spouse or estate remains liable for the services for which payment was denied or a Medicare contractor held the beneficiary liable for subsequent similar services under the limitation on liability provisions based on the denial of payment for services at issue;

- b) No other individual or entity with a financial interest in the case wishes to pursue the appeal; and
 - c) No other party filed a valid and timely redetermination request.
7. There is not an initial determination (see [42 CFR 405.924](#) and §200.B above for actions that are initial determinations and [42 CFR 405.926](#) and §200.C above for actions that are not initial determinations).

B. Appeal Rights for Dismissals

Parties to the redetermination have the right to request a QIC review of the contractor's dismissal of a redetermination request if they believe the dismissal is incorrect. The request for review must be received by the QIC within **60 calendar days** after receipt of the notice of dismissal. The date of receipt of the notice of dismissal is presumed to be 5 calendar days after the date of the notice of dismissal, unless there is evidence to the contrary. When the QIC performs its review 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 a redetermination. It is mandatory for the contractor to issue a new redetermination decision on any case remanded by the QIC. The new decision is counted in CROWD on the 2590, 2591 and 2592 as appropriate as a "redetermination". A QIC's review of a contractor's dismissal of a redetermination request is binding and not subject to any further review.

NOTE: QICs shall not include the "Important Information About Your Appeal Rights" insert when issuing a decision on requests to review a contractor's dismissal of a request for redetermination.

A party to the redetermination may also request that the contractor vacate its dismissal within 6 months of the date of the mailing (and/or other transmission if the contractor is utilizing a CMS approved secure Internet portal/application) of the dismissal notice if good and sufficient cause is established. If the contractor determines that there is good and sufficient cause, the contractor vacates its prior dismissal and issues a redetermination. For the purposes of counting workload in CROWD, this action should be counted as a redetermination and not a reopening. See §310.6.3 Processing Requests to Vacate Dismissals for more information.

310.6.1 - Dismissal Letters

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The MAC shall issue in writing and/or otherwise transmit, as noted above, a notice of dismissal to all parties to the appeal. The dismissal notice includes the reason for the dismissal. The dismissal notice must inform parties that they may (1) request the MAC to vacate the dismissal, and (2) may request a QIC reconsideration of the dismissal. The dismissal notice is sent to the party requesting the redetermination at his/her last known address, and/or otherwise transmitted as noted above, as well as to his/her representative and all other parties to the appeal. MACs who utilize an approved CMS secure Internet portal/application to receive and process appeals may provide electronic dismissal notices, if the appeal request was received via a secure portal/application. MACs shall ensure that a hard copy dismissal notice is sent to other parties to the appeal who do not have access to the secure Internet portal/application. See §310.10 for additional requirements related to notices sent via secure portal/ applications.

MACs shall include the following language, or something similar, in dismissal letters (also see the model dismissal letters in Exhibits 2&3):

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

1. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate good and sufficient cause for <insert reason for dismissal>. Your request to vacate this dismissal must be received at our office within **6 months** of the date of receipt of this notice at the address noted above.
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 MAC did issue an initial determination on the claim)>), you may request a reconsideration of the dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. The QIC 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 should not be considered incomplete, see §310.1.B.1 and §310.1.B.3.

MACs must handle and count incomplete redetermination requests as dismissals. If a party submits an incomplete request for redetermination and the MAC issues a dismissal notice, the party may request the dismissal be vacated, the party may appeal the dismissal, or the party may 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. MACs must notify parties of their options in the dismissal notice. Please see the model dismissal notice for an incomplete request in §310.6.2.

310.6.2 - Model Dismissal Notices

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

NOTE: This is a model letter and may need to be adjusted to include additional verbiage/instructions if a MAC has received approval to receive appeal requests via a secure Internet portal/application.

(Start) EXHIBIT 2:

**Model Redetermination
Dismissal Notice For
Incomplete or Invalid
Request**



MONTH, DATE, YEAR

APPELLANT NAME

ADDRESS

CITY, STATE ZIP

CONTACT INFORMATION:

If you have questions, write or call:

MAC Name

Address

City, State Zip

Telephone number

MEDICARE NUMBER OF
BENEFICIARY:

RE: <Include claim identifier or appeal number>

Dear <Appellant's Name>:

This letter is in response to your appeal request (also known as a redetermination) 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 form a valid request for redetermination. In order to process a redetermination request, we need the following item(s) to be addressed:

<INSERT ALL APPLICABLE INFORMATION>:

Missing Information:

- The beneficiary's name;
- The Medicare 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;
- The name of the person filing the redetermination request.

Invalid Request:

- The requestor is not a proper party;
- Defective Appointment of Representation (AOR) <for non-beneficiary submitted claims only>;
- No initial determination on the claim(s) appealed; or
- Beneficiary is deceased with no remaining party or appointed representative with financial interest.

Your request was determined to be invalid as explained above and therefore has been dismissed. 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 have addressed all of the above listed items and send your request to our office at the address noted above.

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

1. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate that you have good and sufficient cause for failing to submit a valid request. Your request to vacate this dismissal must be received at the address above within 6 months of the date of receipt this notice.
2. If you think we have incorrectly dismissed your request (that is, you believe you did address all of the above listed items in your request), you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. The QIC 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,

NAME, TITLE
MAC NAME

(End) EXHIBIT 2

(Start) EXHIBIT 3:

**Model
Redetermination
Dismissal Notice For
An Untimely Appeal**



MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF
BENEFICIARY:

CONTACT
INFORMATION:
If you have questions, write or
call:
MAC Name
Address
City, State Zip
Telephone number

RE: <Include claim identifier or appeal number>

Dear <Appellant's Name>:

This letter is in response to your appeal request (also known as a redetermination) that was received in our office on <INSERT DATE>. The redetermination was requested for dates of service <INSERT DATE(S)>. The initial determination for the items/services in dispute was issued on <INSERT DATE OF RA/MSN>.

Your redetermination request has been dismissed because the date(s) of service in question is/are past the time limit to file a request for a redetermination. A redetermination request must be received in our office within 120 days of the date of receipt of the initial determination date on the Medicare Remittance Advice or the Medicare Summary Notice. The date of receipt of the initial determination is presumed to be 5 days after the date of the notice unless there is evidence to the contrary.

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. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate good and sufficient cause for filing late. Your request to vacate this dismissal must be received at the address above within 6 months of the date of receipt of this notice.
2. If you think we have incorrectly dismissed your request (for example, you believe you did file your request on time), you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. Please note that the QIC 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.

NAME, TITLE

MAC NAME

(End) Exhibit 3

310.6.3 – Processing Requests to Vacate Dismissals

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

If a party submits a request to vacate the dismissal, and the request contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the MAC makes a favorable good cause determination. Where a finding for good cause is made, the MAC shall document the reason for that finding in the appeal decision letter, the appeal case file, or both. Once it makes a favorable good cause determination, it considers the appeal to be timely filed, vacates its prior dismissal action, and performs a redetermination. For the purposes of counting workload in CROWD and in the MAS, a determination to vacate a dismissal should be counted as a redetermination and not a reopening.

If the MAC does not find good cause to vacate the dismissal, the dismissal remains in effect. The MAC issues a letter (not a dismissal letter) explaining that good cause has not been established and the dismissal cannot be vacated. Although the appellant may not appeal a MAC's finding that good cause was not established when the appellant requested that the MAC vacate its dismissal, the appellant maintains their right to request a QIC review of the MAC's dismissal action. However, requests for QIC review of a MAC's dismissal action must be received by the QIC within 60 days of the date of receipt of the dismissal notice. For purposes of counting workload in CROWD and in the MAS, a MAC's determination not to vacate a dismissal action is counted as an inquiry, not as a dismissal action.

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

If the contractor determines that the request to vacate the dismissal of the redetermination request does not provide good and sufficient cause to vacate, the contractor shall respond with a letter that addresses why the request to vacate does not meet the criteria for good cause. Any evidence or information not previously submitted with the redetermination request that is submitted with the request to vacate the dismissal shall be addressed by the contractor in their letter. The contractor must explain in clear language why all evidence and information submitted, including what was sent with the request to vacate the dismissal, does not meet the requirement necessary to vacate the dismissal.

310.7 - Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations)

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The contractor uses the following Medicare Redetermination Notice (MRN) format or something similar and standard language paragraphs whether the redetermination notice is delivered via hard copy mail or via a CMS-approved portal/application.

NOTE: This is a model letter and should be adjusted on a case by case basis if necessary. Contractors may also include additional resources, including their website address(es) and/or telephone number(s). Appeals that involve issues such as Medicare Secondary Payer (MSP) and overpayment recoveries may require contractors to deviate from the sample given in this manual section. Contractors must also include reference within all appropriate sections of the appeal decision letter that in instances where services are covered (for example, a partially favorable decision is rendered), the beneficiary may also be responsible for any copayments, coinsurance, or deductibles related to the covered portion of the service or item that is payable.

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

A. Redetermination Letter

The redetermination letterhead must follow the instructions issued by CMS for contractor written correspondence requirements (see §290), unless otherwise instructed and/or agreed to by CMS.

(Start)
EXHIBIT 4:

**Model
Redetermination
Notice**



MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

INFORMATION:

or

MEDICARE NUMBER OF
BENEFICIARY:

CONTACT

If you have questions, write

call:

Contractor Name
Address
City, State Zip
Telephone number

RE: <Include claim identifier or appeal number>

MEDICARE APPEAL DECISION

<If the appellant is a provider or supplier, in the beneficiary's letter, contractors must include language to indicate the beneficiary is receiving a copy of the decision. For example, "This is a copy of the letter sent to <your provider> <your physician> <your supplier> <the party who requested this appeal>" or, "Please note that if you did not request this appeal, you are receiving this letter as a copy.">

Dear <Appellant's Name>:

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

The appeal decision is <Insert either: unfavorable. Medicare does not cover the item/service at issue in your appeal OR partially favorable. Medicare covers part of the claim(s) at issue in your appeal.>

<Note: If the issue in the appeal is strictly a payment dispute, the language should read, for unfavorable decisions: "Medicare cannot make payment for the item/service at issue in your appeal" and for partially favorable decisions: "Medicare can make partial payment for the item/service at issue in your appeal.">

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor (QIC). Your appeal of this decision must be made in writing and received by the QIC within 180 days of receipt of this letter. You are presumed to have received this decision five days from the date of the letter unless there is evidence to show otherwise. However, if you do not wish to appeal this decision, you are not required to take any action. For more information on how to appeal this decision, see the section at the end of this letter entitled, "Important Information about Your Appeal Rights."

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

<Insert: Contractor Name> was contracted by Medicare to review your appeal.

SUMMARY OF THE FACTS

<Instructions: Contractors may present this information in this format, or in paragraph form.>

Provider	Dates of Service	Type of Service
<Insert: Provider Name>	<Insert: Dates of Service>	<Insert: Type of Service>

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

DECISION

<Instructions: Insert a brief statement of the decision, for example "We have determined that (the specific items/services) are not covered by Medicare. We have also determined that (the provider) (the supplier) (the beneficiary) is responsible for the cost of the item(s)/service(s).">

EXPLANATION OF THE DECISION

<Instructions: This is the most important element of the redetermination. Explain the logic/reasons that led to your final determination. Explain the coverage policy (LCD, NCD), regulations, policy guidance (IOM provisions), and/or laws used to make this determination. Make sure the rationale for the decision is clear and that it includes an explanation of why the claim can or cannot be paid for the particular set of facts at issue in the appeal. For example, the explanation should demonstrate how the beneficiary's condition or circumstances do not meet specific coverage policy requirements. Statements such as "not medically reasonable and necessary under Medicare guidelines" or "Medicare does not pay for X" provide conclusions instead of explanation, and are not sufficient to meet the requirement of this paragraph.>

WHO IS RESPONSIBLE FOR THE BILL?

<Instructions: 1. Include, as applicable, information on limitation on liability under §1879 of the Act, physician refund requirements for non-assigned claims under §1842(l) of the Act, DMEPOS supplier refund requirements under §§1834 and 1879(h) of the Act, financial responsibility for benefit category denials (statutory exclusions), and waiver of overpayment recovery under §1870 of the Act.

For example, if the denial reason triggers a liability determination under §1879 of the Act, include the following model paragraphs:

“After determining that the item or service will not be covered by Medicare, we must determine who is financially liable for the denied item or service. When an item or service is denied under §1862(a)(1), §1862(a)(9), or §1879(g) of the Social Security Act (the Act), we must determine if the beneficiary and the provider or supplier either knew or could reasonably be expected to know that the item or service would not be covered. This is known as the limitation on liability provision of §1879 of the Act.

If the beneficiary was informed by their provider or supplier in writing in advance of receiving the item/service that Medicare may not make payment (through receipt of an Advance Beneficiary Notice of Noncoverage (ABN)), the beneficiary may be responsible for the cost of the denied item or service. If the provider or supplier knew or could reasonably be expected to know the item or service would not be covered, but the beneficiary did not have such knowledge, then the provider or supplier may be responsible for the cost of the denied item or service.”

2. Include, as applicable, a statement regarding beneficiary knowledge of non-coverage and a statement regarding provider/supplier knowledge of non-coverage when liability under §1879 of the Act is at issue. If the provisions of §1879 of the Act do not apply to the coverage denial, then do not include a discussion of §1879 in the redetermination letter. For additional information regarding the application of §1879, see IOM 100-04, Ch. 30, §§10-30.

Beneficiary model paragraphs for §1879 analysis –

(Beneficiary Option 1) “We have determined that the beneficiary either knew or could reasonably be expected to know that the service/item would not be covered because [insert reason for determining that the beneficiary knew or could have been expected to know the item/service would not be covered; typically this is established when the provider/supplier delivers a validly executed ABN].”

(Beneficiary Option 2) “There is no evidence to indicate that the (provider) (supplier) notified the beneficiary in advance that the item/service would not be covered by Medicare. Therefore, we have determined that the beneficiary did not know and could not reasonably have been expected to know that the item/service would not be covered.”

Provider/Supplier model paragraphs for §1879 analysis –

(Provider/supplier Option 1) “In addition, we have determined that the (provider) (supplier) either knew or could reasonably be expected to know that the service/item would not be covered. [Explain the basis for determining that the provider/supplier knew or should have known the item/service would not be covered]

(Provider/supplier Option 2) “We have determined that the (provider) (supplier) did not know and could not reasonably have been expected to know that the item/service would not be covered.

3. Include a summary paragraph to explain the liability of the parties to the appeal. Model summary paragraph for appeals where liability under §1879 is at issue –

“Since the (beneficiary) (provider) (supplier) has been determined to have had knowledge of the non-covered item/service, the (beneficiary) (provider) (supplier) is liable for the cost of the denied item/service. (The (provider or supplier) (may)(may not) bill the beneficiary for the cost of the denied item/service, and must refund any monies collected from the beneficiary.)”

4. As noted above, the contractor shall (1) explain the basis for their determination of knowledge when making a determination of liability under §1879 of the Act, and (2) state who is responsible for the bill. For example, a regulation, a CMS or contractor publication, or specific policy posted on the contractor’s website, etc. may establish knowledge of non-coverage. See IOM 100-04, Chapter 30, §40, et seq. for additional information. If the provider or supplier is held liable under §1879 of the Act for the cost of the item/service, they may not collect from or bill the beneficiary for the cost of the item/service. The provider or supplier must refund any money collected for the item/service, including any coinsurance or deductible.

5. If neither the beneficiary, nor the provider or supplier knew or could reasonably have been expected to know that the item/service would not be covered, then Medicare makes payment for the item/service under §1879 of the Act.

6. If there is evidence to indicate that the beneficiary may have paid in advance for the items/services (e.g., the claim was billed with a GA modifier indicating an ABN was given to the beneficiary), or paid the applicable deductible or coinsurance amounts, and the provider/supplier is subsequently held liable under §1879 of the Act for the denied items/services, the contractor shall include a statement explaining the provider/supplier's obligation to refund any payments made by the beneficiary, including payment of any deductible or coinsurance. See §310.5.B. See also, 42 CFR 411.402; IOM 100-04, Chapter 30, §30.1.2, §30.2.2, and §100, et seq. for information regarding indemnification procedures and IOM 100-04, Chapter, 30, §§10-40 and 110-150 for more information on liability protections and refund requirements.

7. If the basis for denial does not trigger the limitation on liability provisions of §1879 of the Act, the contractor explains the reason for the denial and includes the following, or similar language:

Since the item/service is (not a covered benefit under Medicare) (excluded from coverage under Medicare), we cannot make payment. The (provider) (supplier) may bill the beneficiary for the denied item/service.

8. Example of a complete financial responsibility section when a supplier is determined to be liable under §1879:

After determining that the item or service will not be covered by Medicare, we must determine who is financially liable for the denied item or service. When an item or service is denied under §1862(a)(1), §1862(a)(9), or §1879(g) of the Social Security Act (the Act), we must determine if the beneficiary and the provider or supplier either knew or could reasonably be expected to know that the item or service would not be covered. This is known as the limitation on liability provision of §1879 of the Act.

If the beneficiary was informed by their provider or supplier in writing in advance of receiving the item/service that Medicare may not make payment (through receipt of an Advance Beneficiary Notice of Noncoverage), the beneficiary may be responsible for the cost of the denied item or service. If the provider or supplier knew or could reasonably be expected to know the item or service would not be covered, but the beneficiary did not have such knowledge, then the provider or supplier may be responsible for the cost of the denied item or service.

There is no evidence to indicate that the supplier notified the beneficiary in advance that the item/service would not be covered by Medicare. Therefore, we have determined that the beneficiary did not know and could not reasonably have been expected to know that the item/service would not be covered.

In addition, we have determined that the supplier either knew or could reasonably be expected to know that the service/item would not be covered by Medicare. Based on the coverage limitations explained in the contractor's Local Coverage Determination (LCD), L11518 (Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep

Apnea), the supplier knew or should have known the item provided would not be covered.

Since the supplier has been determined to have had knowledge of the non-covered item/service, the supplier is liable for the cost of the denied item/service. The supplier may not bill the beneficiary for the cost of the denied item/service, and must refund any monies collected from the beneficiary.>

WHAT TO INCLUDE IN YOUR REQUEST FOR A RECONSIDERATION OF THIS APPEAL

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

Option 1:

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

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

Option 2:

<SPECIAL NOTE TO Medicare physicians, providers, and suppliers ONLY> Any additional evidence as indicated in this section should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration **decision** is issued. If all evidence is not submitted prior to the issuance of the reconsideration decision, you will not be able to submit any new evidence to the administrative law judge or the Medicare Appeals Council unless you can demonstrate good cause for withholding the evidence from the qualified independent contractor.

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

Sincerely,

NAME, TITLE

CONTRACTOR NAME

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

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

How to Appeal: To exercise your right to an appeal, you must file a request in writing. Your request must be received by the QIC at the address below within 180 days of receiving this decision. You are presumed to have received this decision five days after the date of the letter unless there is evidence to show otherwise. If you are unable to file your appeal request timely, please explain why you could not meet the filing deadline. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you can write a letter. You must include: your name, the name of the beneficiary, the Medicare number, a list of the service(s) or item(s) that you are appealing and the date(s) of service, and any evidence you wish to attach. You must also indicate that (insert: contractor name) made the redetermination. You may also attach supporting materials, such as those listed in item 10 of the enclosed Reconsideration Request Form, or other information that explains why this service should be paid. Your doctor may be able to provide supporting materials.

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

<QIC Name

Address

City, State Zip>

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

If you want someone to act for you, you may visit <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> to download the “Appointment of Representative” form, which may be used to appoint a representative. Medicare does not require that you use this form to appoint a representative. Alternately, you may submit a written statement containing the same information indicated on the form. If you are a

Medicare beneficiary, you may also call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

Other Important Information: If you want copies of statutes, regulations, policies, and/or manual instructions CMS used to arrive at this decision, or if you have any questions specifically related to your appeal, please write to us at the following address <alternatively, if using the same address at top of page one of letter, refer to that address rather than repeat the address here> and attach a copy of this letter:

Contractor Name,

A Medicare Contractor

Address

City, State Zip

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

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

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

Contractor Logo or CMS
Logo with Contractor
Name and Address

Redetermination/
Appeals Number:
XXXXXX

Reconsideration Request Form

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

QIC Name
Address

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

- 5a. Telephone Number of the Person Appealing: _____
- 5b. Email Address of the Person Appealing: _____
6. Item or service you wish to appeal: _____
7. Date of the service: From _____ To _____
8. Does this appeal involve an overpayment? Yes No
*Please include a copy of the demand letter (if applicable) with your request.
9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary.)

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

- Medical Records Office Records/Progress Notes
- Copy of the Claim Treatment Plan
- Certificate of Medical Necessity

11. Name of Person Appealing: _____

12. Date: _____

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

310.8 - Medicare Redetermination Notice (for Fully Favorable Redeterminations)

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

NOTE: This activity is NOT required until further notice, unless otherwise specified in the MAC's statement of work, except in those situations when the parties will not receive notice of effectuation via a MSN or RA (MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.). MACs will also have to modify the language to ensure that the letter appropriately addresses the MSP overpayment or non-overpayment situations.

The MAC uses the redetermination format below, (or something similar) and standard language paragraphs whether the redetermination notice is delivered via hard copy mail or via a CMS-approved portal/application. The MAC must ensure that the information identified in each section of the model letter below is included and addressed, as needed, in the MRN.

(Start)
EXHIBIT 5:

Model Fully Favorable Redetermination Notice Coverage Decision



MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF
BENEFICIARY:

CONTACT INFORMATION:

If you have questions, write or
call:

MAC Name

Address

City, State Zip

Telephone number

MEDICARE APPEAL DECISION

RE: <Include claim identifier or appeal number>

Dear <Appellant's Name>:

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

For information about filing a request for redetermination, please visit www.medicare.gov/appeals or <http://www.cms.gov/OrgMedFFSAppeals/>. Medicare beneficiaries may also contact your State health insurance assistance program (SHIP). You can find the phone number for your SHIP in your "Medicare & You" handbook, under the "Helpful Contacts" section of www.medicare.gov Web site, or by calling 1-800-MEDICARE (1-800-633-4227).

Sincerely,

NAME, TITLE

MAC NAME

(End) Exhibit 5

310.9 - Effect of the Redetermination

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

In accordance with section 1869(a)(3)(D) of the Act, once a redetermination is issued, it becomes part of the initial determination. The redetermination is binding upon all parties unless a reconsideration is completed or the redetermination is revised as a result of a reopening.

310.10 - System and Processing Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

MACs who develop and utilize a secure Internet portal/application for appeals purposes shall ensure, at a minimum:

- CMS approves (i.e., contract manager or project officer, if applicable) the proposed portal/application and usage prior to development and implementation.
- The portal/application fully complies with and has been tested to ensure compliance with all CMS system security requirements regarding protected health information prior to implementation/usage.
- The secure Internet portal/application includes a formal registration process that validates the identity of appellants using the portal. This process shall include, at a minimum, use of restricted user identities and passwords. A/B MACs (A), (B), (HHH), and DME MACs shall include an indication and/or description of the validation methodology in the appeals case file should a higher level of appeal be submitted.
- Templates for submission of electronic appeal requests shall include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.
- All MACs utilizing an approved portal/application shall provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.
- MACs shall also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.
- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request via secure Internet/portal and verbiage instructing the appellant not to submit additional redetermination requests for the same item

or service via different venue (hard copy mail or facsimile). This information is necessary to discourage appellants from submitting multiple appeal requests for the same item/service through the same or multiple venues (i.e., filed via secure Internet portal/application and at a later date via mail).

- MACs utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.
- Redetermination decisions and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements as outlined in the IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 29, unless otherwise noted above. In addition, MACs shall provide hard copy decision and/or dismissal notices to parties to the appeal who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).
- MACs shall also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.
- If the MAC receives a request for a case file from the QIC, the MAC shall provide the complete case file including a decision or dismissal notice regardless of whether the appeal was processed via a secure Internet portal/application.

310.11 - Effectuation of the Redetermination Decision

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

All MACs are responsible for effectuating redetermination decisions. Effectuation means for the MAC to adjust the claim and issue a payment or to change liability. If the redetermination decision is fully or partially favorable to the appellant and gives a specific amount to be paid, the MAC effectuates within 30 calendar days of the date of the redetermination decision.

If the decision is fully or partially favorable, but the payment amount must be computed or recomputed, the MAC effectuates the decision within 30 days after the payment amount is determined. The payment amount must be computed as soon as possible, but no later than 30 calendar days after the date of the redetermination decision.

310.12 - QIC Remands

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

All MACs shall take appropriate action on review and resolve QIC remands within 60 calendar days of receipt of the remand order from the QIC.

320 - Reconsideration - The Second Level of Appeal

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Section [1869](#) of the Act entitles any individual dissatisfied with the A/B MAC (A)'s, (B)'s, (HHH)'s, or DME MAC'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. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The request for a reconsideration made by a beneficiary, provider, supplier, or State 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 the Form CMS-20033 (the reconsideration request form included with the redetermination), or must contain the following items:

- The beneficiary's name;
- Medicare number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name of the party or representative of the party filing the request; 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."

The beneficiary's 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. The form is available on the CMS.gov website at: <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS20033.pdf>.

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 Part A QIC appeals is dependent upon the State where the service or item was rendered. The jurisdiction for all DME and Part B QIC appeals is 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 misfiled with a contractor. Contractors shall have standard operating procedures to ensure that misfiled requests are identified and sent/transmitted to the proper location. If the contractor receives a 'request for reconsideration' from a party, or a 'request for reconsideration' mistakenly directed to them by another contractor, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file(s), within 60 calendar days of receipt in the corporate mailroom. The case file must be sent either by an electronic means agreed upon in the JOAs or by a

courier service so that the case file is received by the QIC before or on the 61st calendar day after the receipt. Contractors shall track all misfiled reconsideration requests to ensure receipt at the proper QIC. The QIC will send the MAC or DME MAC an acknowledgement of receipt of any misfiled requests. Contractors shall not count such misfiled requests as dismissals. The contractor counts the costs associated with misfiled requests in the CAFM line designated for preparing/transferring case files to the QIC. To aid in preventing misfiled requests for QIC reconsiderations, contractors shall employ provider education efforts with an emphasis on filing locations, as well as the dates for workload transitions when a MAC jurisdiction is transferred from one contractor to the next at the close of a contract's period of performance.

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

320.2 - Time Limit for Filing a Request for a Reconsideration (Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

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 a 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 the request as timely filed. Likewise, if the request is filed with CMS, SSA, RRB, or another government agency in person, the QIC considers the request as timely filed.

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.)

320.3 - MAC Responsibilities - General (Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The contractor's responsibilities for reconsiderations are:

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

2. Effectuating reconsiderations when notified by the QIC of a favorable decision or unfavorable decision with a change in liability in accordance with § 320.8 and notifying the QIC of receipt of effectuation information;
3. Preparing case files and forward misfiled reconsideration requests in accordance with § 320.1(B); and
4. Entering into JOAs with the appropriate QIC(s) and Administrative QIC (AdQIC); Complying with the appropriate JOAs.

320.4 - QIC Case File Development

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

When the QIC receives a request for reconsideration, it will request the case file from the MAC with jurisdiction using the Redetermination Case File Request Form. The QIC will send the request either by email, telephone, fax, or by any other method agreed upon in the JOAs. (Note: Individually identifiable beneficiary information should not be given in an unsecure email.) If another method is agreed upon in the JOAs, it must meet the privacy requirements of HIPAA.

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

(a) Email requests - MACs shall maintain an email 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 email account must be used. MACs must check this email account at least once daily (every business day). When MACs receive email requests from the QIC, they shall notify the QIC of receipt.

(b) Phone Requests - MACs shall designate and maintain a phone extension specifically for the receipt of case file requests from the QIC. MACs 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 - MACs shall designate and maintain a fax machine for the receipt of case file requests from the QIC.

320.5 - QIC Case File Preparation

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Once a party requests a reconsideration with a QIC, the QIC will need to obtain the case file from the MAC that issued the redetermination decision. 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 in an organized manner so that the QIC can make a correct and fair determination. The MAC prepares the case file by separating procedural documents

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

For large cases containing multiple beneficiary files, the MAC shall organize the case files by individual beneficiary files in alphabetical order. **A packing list will be included for multiple beneficiary box cases and labeled as “box number x of y.”**

As the MACs begin utilizing the MAS for processing redeterminations (timeframe by jurisdiction TBD), the MACs shall work to update their JOAs with QICs to include language indicating that the appeals case file will be obtained via electronic promotion of the level one appeal record within the MAS. The MAC QIC JOAs shall include language to address situations in which the MAS is down or otherwise unavailable for short term and/or long term periods of time. In addition, the JOA shall include language to address processes and procedures for providing case files that are not in the MAS due to the redetermination having been processed prior to the level one MAS implementation and/or the rare instance that the file is otherwise not available in the MAS.

For one QIC case addressing multiple beneficiaries, particularly large multi-beneficiary and overpayment cases, the MAC shall keep the documents relating to each beneficiary together and organized alphabetically by beneficiary last name. Documents relating to each beneficiary will be separated and a complete set of procedural documents will be provided for each beneficiary.

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 MAC 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 MAC has retyped or paraphrased for purposes of shortening the document. The MAC 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.) 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) 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 MAC medical staff (with professional qualifications of the reviewer noted in the document, if applicable)
- MAC medical policies and opinions relevant to claim(s). (In addition to MAC medical policy, the MAC should include in the case file any information it has as background to the particular policy at issue. For example, findings of the MAC 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, Pub. 100-08 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 may be used by the QIC;*
- Any other exhibits that the MAC may consider important for the QIC to consider (e.g., certification of reasonable charge, fee schedule information, notices of noncoverage, MAC publications.); and
- Any additional evidence submitted by the appellant.

*If accessible by internet, the MAC that issued the redetermination decision may enter into a joint operating agreement with the QIC to provide a list instead of actual copies.

Assembly Instructions:

- The MAC 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 MAC 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 MAC 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 MAC 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 MAC 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. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

MACs 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 email 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 day after its request. The MAC 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.

320.7 - QIC Jurisdictions

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A. Part A QIC Jurisdictions

The Part A QIC jurisdictions are as follows:

Jurisdiction	Normal States	Exceptions
Part A East QIC jurisdiction	Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Louisiana, Maine, Maryland, Mississippi, Massachusetts, New Hampshire, New Mexico, New Jersey, New York, Texas, Oklahoma, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virgin Islands, Virginia, West Virginia, and Washington DC and Mutual of Omaha claims where the service was rendered in one of the above listed States.	<p>Chain Providers (including ESRD) – the State where the MAC processed the claim. For providers who previously submitted claims to Mutual of Omaha (currently processed by WPS), the jurisdiction continues to be the State where the service was rendered.</p> <p>Indian Health Services claims Nationwide</p> <p>Foreign claims- Eastern Mexico, Canadian Provinces of New Brunswick, Newfoundland, Nova Scotia, Quebec, and Prince Edward Island</p> <p>Rural Health Clinic claims Nationwide</p>
Part A West QIC jurisdiction	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Ohio, Oregon, South Dakota, Utah, Washington, Wisconsin and Wyoming and Mutual of Omaha claims where the service was rendered in one of the above listed States.	<p>Chain Providers (including ESRD) - the State where the MAC processed the claim. For providers who previously submitted claims to Mutual of Omaha (currently processed by WPS), the jurisdiction continues to be the State where the service was rendered.</p> <p>Foreign claims- Western Mexico, Canadian Provinces of Ontario, Saskatchewan, Alberta, Manitoba, British Columbia, Vancouver, and Yukon Territories.</p>

B. Part B and DME QIC Jurisdictions

There is one DME QIC jurisdiction assigned to process all reconsiderations of DME claims for all states and territories. There are two QIC jurisdictions for Part B claims, a North and a South jurisdiction. Refer to the table below.

Jurisdiction	Normal States	Exceptions
Part B South Jurisdiction	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia, Virgin Islands.	Note: Railroad Retirement Board reconsiderations are also included in this workload jurisdiction.
Part B North Jurisdiction	Alaska, American Samoa, Arizona, California, Connecticut, Delaware, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Northern Mariana Islands, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Washington, Washington DC, Wisconsin and Wyoming.	
DME QIC Jurisdiction	All states and territories	

320.8 - Tracking Cases

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

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

Contractors shall track all misfiled reconsideration requests to ensure receipt at the proper QIC. The QIC will send the MAC or DME MAC an acknowledgement of receipt of any 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. The contractor shall make a record of the date of receipt of the QIC's request for effectuation and confirm receipt of the effectuation notice with the QIC. The contractor shall also track the date of effectuation (i.e., issue payment).

320.9 - Effectuation of Reconsiderations

(Rev. 4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

In many cases, the QIC's decision will require an effectuation action on the MAC's part. The MAC 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 MAC to adjust the claim and issue a payment or to change liability. If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, the MAC effectuates within 30 calendar days of the date of receipt of the effectuation notice from the QIC.

NOTE: CMS does not anticipate that QICs will specify an amount to be paid in reconsideration notices.

If the decision is favorable, but the payment amount must be computed or recomputed, it effectuates the decision within 30 days after the payment amount is determined. The amount must be computed as soon as possible, but no later than 30 calendar days after the date of receipt of the QIC's effectuation notice. The receipt of effectuation information shall be reported to the appropriate QIC.

If the QIC's decision is unfavorable, but there is a change in liability, the MAC effectuates within 30 calendar days of receipt of the QIC's effectuation notice.

330 - Administrative Law Judge (ALJ) Hearing or Attorney Adjudicator Review at the Office of Medicare Hearings and Appeals (OMHA) - The Third Level of Appeal

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A party to a QIC reconsideration may request a hearing before an ALJ if the party files a written request for an ALJ hearing within 60 days after receipt of the notice of the QIC's reconsideration and the amount in controversy requirement is met*. A party who files a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the QIC's decision-making timeframe has a right to a hearing before an ALJ if the party files a written request with the QIC to escalate the appeal to the ALJ level after the adjudication period expires and the QIC does not issue a final action within 5 days of receiving the request for escalation. A party wishing to escalate an appeal must also meet the amount in controversy requirement*. A party to a QIC's dismissal of a request for reconsideration has a right to have

the dismissal reviewed by an ALJ or attorney adjudicator if the party meets the amount in controversy requirement*.

*See §250 for AIC information. The current amount in controversy requirements can be found on the CMS.gov claims appeals webpage: <http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Downloads/AppealsProcessFlowchart-FFS.pdf>

330.1 - Requests for an ALJ Hearing

(Rev. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A. Where Parties File Requests

To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other parties. Failure to do so will toll the ALJ's 90-day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing. Also, if the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the ALJ's deadline for deciding the appeal begins on the date the entity specified in the QIC's reconsideration (i.e., the appropriate OMHA office) receives the request for hearing.

The QICs will specify the appropriate OMHA office as the filing location for ALJ hearing requests.

B. Timely Filing Requirements

A party must file an ALJ request within 60 days of the date of their receipt of the QIC's decision. It is presumed that the appellant received the QIC's decision within five days of the date of the QIC's decision, unless there is a reasonable showing by the appellant to the contrary.

C. Content of the Request

The request for an ALJ hearing must be made in writing. The request must include all of the following:

1. The name, address, and Medicare number of the beneficiary whose claim is being appealed,
2. The name and address of the appellant, when the appellant is not the beneficiary,
3. The name and address of the designated representative, if any,
4. The document control number assigned to the appeal by the QIC, if any,

5. The dates of service,
6. The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

For the convenience of parties, OMHA provides forms that may be used to request a Medicare ALJ hearing. It is not necessary, however, that this form be used to make a written request.

- The request for hearing form "OMHA-100":

<https://www.hhs.gov/sites/default/files/OMHA-100.pdf>

- In addition, the form OMHA-100A is used as an attachment to form OMHA-100 to identify multiple beneficiaries or enrollees associated with a single request for an ALJ hearing or a review of dismissal. The direct link to form "OMHA-100A":

<https://www.hhs.gov/sites/default/files/OMHA-100A-Multiple-Claim-Attachment.pdf>

- The link to OMHA's webpage containing all forms:

<https://www.hhs.gov/about/agencies/omha/filing-an-appeal/forms/index.html>

To request that OMHA make a decision without a hearing based only on the information that's in the appeal record, an appellant must submit the information required for an ALJ hearing request and one of these:

- The "Waiver of Right to an Administrative Law Judge (ALJ) Hearing" form (Form OMHA-104) available at https://www.hhs.gov/sites/default/files/OMHA-104_Waiver_of_Right_to_an_ALJ_Hearing%200328.pdf; or
- A written request stating that you don't wish to appear before an ALJ at a hearing (including a hearing held by phone or video-conference), and explaining why you decided to waive the hearing.

Even if a waiver of hearing is requested, a hearing may still be held by an ALJ if the other parties in the case don't also waive the ALJ hearing, or if the ALJ believes a hearing is necessary to decide the case.

330.2 - Forwarding Requests to OMHA

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

Requests for ALJ hearings are to be filed with the OMHA office at the address specified in the QIC's reconsideration notice. However, there may be times when parties incorrectly file requests for hearings with either the MAC or QIC. When a MAC receives such a misfiled request, it forwards the misfiled request to the OMHA Central Docketing location within 30 calendar days of receipt. All MACs shall maintain a record of these cases.

Requests for all ALJ hearings must be filed at the following location:

OMHA Centralized Docketing
200 Public Square, Suite 1260
Cleveland, OH 44114-2316

330.3 - Review and Effectuation of OMHA Decisions

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The Administrative QIC (AdQIC) is the clearinghouse for all Original Medicare (Part A and Part B) claim case files and decisions from the OMHA field offices as well as any decisions and case files from the Appeals Council. The AdQIC reviews OMHA decisions for possible agency referral to the Appeals Council. For Appeals Council decisions and for OMHA decisions when no agency referral is planned, the AdQIC will send the MAC an effectuation notice, a copy of the decision, and a summary of the associated claims from the MAS.

The MAC only effectuates based on documentation received from the AdQIC; the MAC does not effectuate based on correspondence from any party to the ALJ hearing or attorney adjudicator review. "Effectuate" means for the MAC to issue a payment or change liability.

In the event that the MAC's claims payment review finds the OMHA or Appeals Council decision to be inconsistent or inaccurate in comparison to claims history the MAC may request assistance from the AdQIC in seeking clarification from OMHA or the Appeals Council.

330.4 - Effectuation Time Limits & Responsibilities

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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

If OMHA's decision is partially or wholly favorable to the appellant and gives a specific amount to be paid, the MAC effectuates within 30 calendar days of receipt of the effectuation notice from the AdQIC. The MAC must acknowledge receipt of the AdQIC effectuation per the JOA with the AdQIC.

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

For effectuation of decisions that involve overpayments or underpayments where the limitation on recoupment provision applies (Section 935 of MMA), refer to IOM Pub. 100-06, Chapter 3, §200 for further instruction.

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

330.5 - Duplicate OMHA Decisions

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

If the MAC becomes aware of a duplicate decision from OMHA on the same case, it must bring this to the attention of the AdQIC immediately. In these cases the AdQIC will take the necessary steps to resolve the issue.

330.6 - Payment of Interest on OMHA Decisions

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

For guidance on how to make payment of interest subsequent to a decision from OMHA, refer to chapter 3 of the Medicare Financial Management Manual, Pub. 100-06 (<http://www.cms.gov/manuals/downloads/fin106c03.pdf>).

340 - Departmental Appeals Board - Appeals Council - The Fourth Level of Appeal

(Rev. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The level of administrative review available to parties after the ALJ hearing decision, OMHA attorney adjudicator review, or dismissal order has been issued, but before judicial review is available, is Appeals Council review.

A party to an ALJ hearing or an OMHA attorney adjudicator review, may request review by the Appeals Council within 60 days after receipt of the notice of OMHA's decision or dismissal. If a party requests the Appeals Council to review an ALJ's or attorney adjudicator's decision, the Appeals Council may conduct a de novo review of the decision and may adopt, modify, or reverse the ALJ's or attorney adjudicator's decision, or remand the case to an ALJ or attorney adjudicator for further proceedings. See, in general [42 CFR 405.1108](#). The Appeals Council will dismiss a request for review when a party does not have a right to Appeals Council review.

When a party requests that the Appeals Council review an ALJ's or attorney adjudicator's dismissal, the Appeals Council may deny review or remand the case to an ALJ or attorney adjudicator for further proceedings. The Appeals Council may also dismiss a request for a hearing for any reason the ALJ or attorney adjudicator could have dismissed the request for hearing. In addition, the Appeals Council will decide cases that are escalated from the OMHA level without an ALJ or attorney adjudicator decision or dismissal.

See [42 CFR 405.1108\(d\)](#). The Appeals Council may also decide on its own motion to review a decision or dismissal issued by an ALJ or attorney adjudicator within 60 days after the date of the decision or dismissal.

340.1 - Recommending Agency Referral of OMHA Decisions or Dismissals

(Rev. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

CMS may refer a case to the Appeals Council for it to consider under its own motion review authority within 60 days after the date of the ALJ hearing or attorney adjudicator decision or dismissal. This is known as an "agency referral". The Appeals Council may adopt, modify, or reverse OMHA's decision, may remand the case to an ALJ or attorney adjudicator for further proceedings, or may dismiss an agency referral request. For OMHA decisions issued by OMHA ALJs and attorney adjudicators, the AdQIC will be responsible for reviewing ALJ and attorney adjudicator decisions and determining whether an agency referral is appropriate.

During the effectuation of an ALJ or attorney adjudicator decision, if the MAC's medical director disagrees with the decision and wishes to discuss the decision for potential referral to the Appeals Council, the medical director shall contact the AdQIC.

340.2 - Effectuation of Appeals Council Orders and Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

When a MAC receives an effectuation notice from the AdQIC regarding an Appeals Council decision that requires effectuation, it initiates effectuation within 30 days of its receipt of the effectuation notice, and completes effectuation within 60 days. Any questions regarding effectuation should be directed to the AdQIC for guidance.

340.3 - Requests for Case Files

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

When the Appeals Council receives a request for review from an appellant, in most instances it will not have a copy of OMHA's decision or dismissal, or the case file. The Appeals Council will request all case files from the AdQIC.

340.4 - Payment of Interest on Appeals Council Decisions

(Rev. 985, Issued: 06-16-06; Effective/Implementation Dates: 07-17-06)

For guidance on how to make payment of interest subsequent to an Appeals Council decision, refer to chapter 3, of the Medicare Financial Management Manual, Pub. 100-06.

345 - U.S. District Court Review - The Fifth Level of Appeal

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

The circumstances allowing for an appeal or escalation to the U.S. District Court level of review are limited, and articulated in [42 CFR 405.1136](#).

345.1 - Requests for U.S. District Court Review by a Party

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

Following issuance of a decision by the Appeals Council, a party may request judicial review of the Appeals Council's decision. A MAC cannot accept requests for judicial review. The appellant must file the complaint with the U.S. District Court. See [42 CFR 405.1136](#). If a party files a request for judicial review with a MAC, the MAC must immediately notify the appellant that the complaint must be filed with the appropriate U.S. District Court (i.e., the district court for the judicial district in which the party resides or where such individual, institution, or agency has its principal place of business). However, the appellant is responsible for determining where the complaint must be filed. MACs shall not forward the complaint to a district court as a courtesy to the appellant.

The amount remaining in controversy must meet the required threshold. Current amount in controversy threshold figure available on the CMS website at:

<http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html>. See §250.

If a MAC receives a copy of a summons or complaint for judicial review in federal district court, and it does not appear that a copy was sent to the following address, the MAC shall send the original to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, S.W.
Washington, D.C. 20201

The MAC retains a copy and notifies its Contracting Officer's Representative (COR) immediately. The CMS COR should alert the CMS Central Office Counsel that a complaint has been forwarded by the MAC to the HHS General Counsel's office.

345.2 - Effectuation of U.S. District Court Decisions (Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

The U.S. District Court may remand the case to the Appeals Council or ALJ for further proceedings. In rare cases, the U.S. District Court will issue an order that will require effectuation by a MAC. In this situation, the MAC immediately contacts its Contracting Officer's Representative/Contractor Manager for further instructions before taking any action.

345.3 - Payment of Interest of U.S. District Court Decisions (Rev. 862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For guidance on how to make payment of interest subsequent to a U.S. District Court decision, refer to chapter 3 of the Medicare Financial Management Manual, Pub. 100-06.

350 - Workload Data Analysis (Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

Data analysis involves collecting relevant data, analyzing the data, identifying trends and aberrancies, and making conclusions based on the data collected. Data analysis should be performed, as needed, at all relevant operational sites to identify inefficiencies or problems with appeals. Within the constraints of the current operating environment, MACs should work to address and resolve concerns. Significant issues should be raised to CMS, preferably through the COR or Contract Manager.

360 - Managing Appeals Workloads (Rev. 675, Issued: 09-16-05, Effective: 10-01-05, Implementation: 10-03-05)

360.1 - Standard Operating Procedures (Rev. 2729, Issued: 06-21-13, Effective: 07-23-13, Implementation: 07-23-13)

The priorities set forth in this section are to be used by MACs as a guide in establishing standard operating procedures for managing an appeals workload when the budget amount is

insufficient to adequately perform the required functions. In general, MACs should use a first-in, first-out method to process appeals and manage workload; however, during times of limited resources it may become necessary to prioritize the processing of appeals to more efficiently manage the workload. While CMS continues to recommend the priorities listed in this section, there may be instances where MACs find it more effective and efficient to prioritize in a different manner. Also, MACs may choose to establish standard operating procedures for managing an appeals workload that deviate from the priorities listed in this section. In both these cases, MACs should submit a copy of their prioritization plan to the Contracting Officer's Representative/Contractor Manager and obtain written approval for this variation within 30 days of the start of the fiscal year or period of performance.

360.2 - Execution of Workload Prioritization

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

A. Budget Related Workload Prioritization

Whenever it appears that the budget amount is insufficient to adequately perform the required functions and the need for additional funds can be adequately documented, MACs shall submit a Supplemental Budget Request (SBR) in accordance with the IOM Pub. 100-06 Medicare Financial Management Manual, chapter 2 §120. As a result of an SBR, or during the course of CMS' evaluation of an SBR, CMS may find it necessary that the MAC execute prioritization of workload in accordance with this section or in accordance with the MAC's standard operating procedures. The MAC should discuss possible alternatives for resolution in the SBR. If it becomes necessary to abate activities, MACs must submit proper notification in accordance with the terms of the Cost of Administration Article in the Contract/Agreement and begin processing work in accordance with this PM until a final agreement is reached between the MAC and CMS. As a result of an abatement, CMS may find it necessary that the MAC continue processing work in accordance with this manual instruction.

B. Other Circumstances That May Lead to Workload Prioritization

In circumstances other than those described above, it may become apparent that prioritization of workload is necessary because a MAC is unable to complete the incoming or pending workload within the time frames described in this manual. In these situations the MAC must either consult with the COR immediately for guidance or notify the COR that they plan to initiate their workload prioritization plan. An example of a situation that may lead to workload prioritization is an uncharacteristic, unanticipated increase in receipts over a two-month period, coupled with, insufficient staff or other resources that will impede you from completing the increased volume of appeals receipts in a timely manner.

360.3 - Workload Priorities

(Rev. 4278, Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

- Priority 1-** Finalize effectuation of all redetermination, reconsideration, ALJ and Appeals Council decisions and process redeterminations and forward reconsideration case files to the QIC timely on overpayment determinations (including CERT contractor appeals).

- Priority 2-** Prepare, assemble, and forward case files to the QIC in accordance with the timeframes described in §320.6

- Priority 3-** Adjudicate redeterminations from beneficiaries or their appointed beneficiary representatives in the timeframes described in §310.4.

- Priority 4-** Adjudicate requests for redeterminations from providers, suppliers, or other appellants, including States or their third party agents, that are submitted with necessary documentation in the timeframes prescribed in §310.4.

- Priority 5-** Adjudicate written requests for redeterminations from providers, suppliers, or other appellants, including States or their third party agents, that are submitted without necessary documentation in the timeframes prescribed in §310.4.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R12423CP</u>	12/20/2023	Enforcing Billing Requirements for Intensive Outpatient Program (IOP) Services with New Condition Code 92	01/04/2024	13222
<u>R4380CP</u>	08/30/2019	Pub. 100-04, Chapter 29 – Appeals Signature Requirement Changes	10/01/2019	11352
<u>R4278CP</u>	04/12/2019	Pub. 100-04, Chapter 29 – Appeals of Claims Decisions - Revisions	06/13/2019	11042
<u>R3549CP</u>	06/24/2016	Pub. 100-04, Chapter 29 – Appeals of Claims Decisions Update: Revisions to Timeliness Requirements for Forwarding Misfiled Appeal Requests, Reconsideration Request Form, and Guidelines for Writing Appeals Correspondence	07/26/2016	9600
<u>R2926CP</u>	04/11/2014	Chapter 29 Appeals Update (Includes Post-DOMA Guidance and Signature Requirement for Appointment of Representatives and Assignment of Appeal Rights)	07/14/2014	8588
<u>R2729CP</u>	06/21/2013	Appeals Revisions-Final Regulation	07/23/2013	7840
<u>R1986CP</u>	06/11/2010	Guidelines to Allow Contractors to Develop and Utilize Procedures for Accepting and Processing Appeals Via Facsimile and/or Via a Secure Internet Portal/Application	10/01/2010	6958
<u>R1965CP</u>	05/07/2010	Appeals Revisions-AIC Requirements	08/09/2010	6894
<u>R1878CP</u>	12/18/2009	Revisions in Timeliness Requirements for Forwarding Misfiled Appeal Requests	01/19/2010	6701
<u>R1762CP</u>	07/02/2009	Appeals Revisions	08/03/2009	6377

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R1688CP</u>	02/20/2009	Clarification of the Medicare Redetermination Notice for Partly or Fully Unfavorable Redetermination	03/20/2009	6302
<u>R1676CP</u>	01/30/2009	Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals	05/04/2009	6295
<u>R1485CP</u>	03/28/2008	Chapter 29 Clean-Up	07/07/2008	5899
<u>R1457CP</u>	02/22/2008	Redeterminations of Overpayments	03/24/2008	5859
<u>R1437CP</u>	02/05/2008	Change in the Amount in Controversy Requirement for Administrative Law Judge Hearings and Federal District Court Appeals	05/05/2008	5897
<u>R1408CP</u>	01/11/2008	Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)	02/11/2008	5836
<u>R1329CP</u>	08/31/2007	Modifications to the Timeliness Requirements for Contractors Forwarding Reconsideration Requests Submitted to the Wrong Contractor	10/01/2007	5602
<u>R1276CP</u>	06/29/2007	Waiving Medicare Fee-for-Service Appeals Requirements	07/30/2007	5322
<u>R1274CP</u>	06/29/2007	Appeals of Claims Decisions: Appointment of Representatives; Fraud and Abuse; Guidelines for Writing Appeals Correspondence; Disclosure of Information	10/01/2007	5460
<u>R1229CP</u>	04/27/2007	Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations) and the ALJ Filing Locations Where the Place of Service Was in Delaware, Kentucky, Puerto Rico, Virginia, &/or the US Virgin Islands	07/02/2007	5554

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R1211CP</u>	03/30/2007	Change in the Amount in Controversy Requirement for Federal District Court Appeals	07/02/2007	5518
<u>R1136CP</u>	12/22/2006	Revisions to Procedure to Establish Good Cause and Qualified Independent Contractor Jurisdictions	04/02/2007	5386
<u>R1069CP</u>	09/29/2006	Reopenings and Revisions of Claim Determinations and Decisions	11/29/2006	4147
<u>R985CP</u>	06/16/2006	Appeals Updates	06/01/2006	5058
<u>R862CP</u>	02/17/2006	Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review	03/17/2006	4152
<u>R724CP</u>	10/21/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006	12/16/2005	3939
<u>R697CP</u>	10/07/2005	Appeals of Claims Decision: Redeterminations and Reconsiderations (Implementation Date: May 1, 2005)	01/09/2006	3942
<u>R695CP</u>	10/07/2005	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)	01/09/2006	4019
<u>R688CP</u>	09/23/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Dates for All Requests for Redetermination Received by FIs on or After May 1, 2005 and All Requests for	12/16/2005	3944

Rev #	Issue Date	Subject	Impl Date	CR#
		Redetermination Received by Carriers on or After January 1, 2006)		
<u>R687CP</u>	09/23/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006	12/16/2005	3939
<u>R679CP</u>	09/16/2005	Medicare Redetermination Notice and Effect of the Redetermination	12/19/2005	4006
<u>R678CP</u>	09/16/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Dates for All Requests for Redetermination Received by FIs on or After May 1, 2005 and All Requests for Redetermination Received by Carriers on or After January 1, 2006)	12/16/2005	3944
<u>R677CP</u>	09/16/2005	Appeals of Claims Decisions: Redeterminations and Reconsiderations Dates for FI Initial Determinations Issued on or After May 1, 2005 and Carrier Initial Determinations Issued on or After January 1, 2006	05/01/2005	3939
<u>R675CP</u>	09/16/2005	Changes to Appeals of Claims Decisions: Redeterminations and Reconsiderations (Implementation Date: October 1, 2005)	10/03/2005	3943
<u>R381CP</u>	11/26/2004	Revisions and Corrections to Chapter 29 of the IOM Claims Processing Manual-Appeals	01/10/2005	3127
<u>R1CP</u>	10/01/2003	Initial Release of Manual	N/A	N/A

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