

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4278	Date: April 12, 2019
	Change Request 11042

SUBJECT: Pub. 100-04, Chapter 29 – Appeals of Claims Decisions - Revisions

I. SUMMARY OF CHANGES: This Change Request (CR) updates Pub. 100-04, Chapter 29 with several policy updates, including electronic signatures, limiting scope of redetermination review in certain instances, application of good cause for late filing involving beneficiary accessibility, as well as application of good cause where there is a declared disaster. As more Medicare Administrative Contractors (MACs) are brought on board to the Medicare Appeals System (MAS), instruction is being added related to MAS processing functions. In addition, the requirement for both signatures on an appointment of representative instrument and the Assignment of Appeal Rights form to be made within 30 days of each other is being removed. There are also minor grammar or formatting corrections made throughout the chapter. Changes in the appeals regulations at 405 subpart I are incorporated, which include tolling an adjudication timeframe when trying to cure a defective appointment form, as well as changes relative to the third level of appeals handled by the Office of Medicare Hearings and Appeals (OMHA).

EFFECTIVE DATE: June 13, 2019

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

IMPLEMENTATION DATE: June 13, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/Table of Contents
R	29/110/Glossary
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R	29/210/Who May Appeal
R	29/220/Steps in the Appeals Process: Overview
R	29/230/Where to Appeal
R	29/240/ Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals
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R	29/240.3/Conditions and Examples That May Establish Good Cause for Late Filing by Providers, Physicians, or Other Suppliers
R	29/240.4/Good Cause - Administrative Relief Following a Disaster
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R	29/250.1/Amount in Controversy General Requirements
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R	29/270.1.1/Who May Be an Appointed or Authorized Representative
R	29/270.1.2/How to Make and Revoke an Appointment
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R	29/270.2.3/How to Make and Revoke a Transfer of Appeal Rights
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R	29/280.2/Inclusion and Consideration of Evidence of Fraud and/or Abuse
R	29/280.3/ Claims Where There is Evidence That Items or Services Were Not Furnished or Were Not Furnished as Billed

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/280.4/Responsibilities of Adjudicators
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R	29/310.1/Filing a Request for Redetermination
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R	29/310.4/The Redetermination
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R	29/310.6.2/Model Dismissal Notices
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R	29/310.7/Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations)
R	29/310.9/Effect of the Redetermination
R	29/310.11/Effectuation of the Redetermination Decision
R	29/320/Reconsideration - The Second Level of Appeal
R	29/320.1/Filing a Request for a Reconsideration
R	29/320.3/MAC Responsibilities – General
R	29/320.5/QIC Case File Preparation
R	29/320.7/QIC Jurisdictions
R	29/320.9/Effectuation of Reconsiderations
R	29/330/Administrative Law Judge (ALJ) Hearing or Attorney Adjudicator Review at Office of Medicare Hearings and Appeals (OMHA) - The Third Level of Appeal
R	29/330.1/Requests for an ALJ Hearing
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R	29/330.4/Effectuation Time Limits & Responsibilities
R	29/330.5/Duplicate OMHA Decisions
R	29/330.6/Payment of Interest on OMHA Decisions
R	29/340/Departmental Appeals Board - Appeals Council - The Fourth Level of Appeal
R	29/340.1/Recommending Agency Referral of OMHA Decisions or Dismissals
R	29/340.3/Requests for Case Files

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R	29/345/U.S. District Court Review - The Fifth Level of Appeal
R	29/345.1/Requests for U.S. District Court Review by a Party
R	29/350/Workload Data Analysis
R	29/360.2/Execution of Workload Prioritization
R	29/360.3/Workload Priorities

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4278	Date: April 12, 2019	Change Request: 11042
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SUBJECT: Pub. 100-04, Chapter 29 – Appeals of Claims Decisions - Revisions

EFFECTIVE DATE: June 13, 2019

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IMPLEMENTATION DATE: June 13, 2019

I. GENERAL INFORMATION

A. Background: This CR incorporates several policy updates such as the policy on electronic signatures, timing of signatures on transfer of appeal rights and the appointment of representative forms, tolling an adjudication timeframe when trying to cure a defective appointment form, limiting scope of redetermination review in certain instances, application of good cause for late filing involving beneficiary accessibility, as well as application of good cause where there is a declared disaster. Additionally, MACs are more frequently using the MAS, so instruction is being added related to MAS processing functions. Finally, there are numerous minor grammar or formatting corrections made throughout the chapter.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
11042.1	Contractors shall observe that these instructions are effective based on date of receipt.	X	X	X	X						
11042.2	Contractors shall observe that the terms Medicare number/Medicare beneficiary identifier (Mbi) and attorney adjudicator have been added in the Glossary.	X	X	X	X						
11042.3	Contractors shall observe the inclusion throughout the chapter of the inclusion of “Medicare number” in this chapter, which incorporates both the health insurance claim number (HICN) and the new non-Social Security Number based Medicare Beneficiary Identifier.	X	X	X	X						
11042.4	<i>240 - Time Limits for Filing Appeals & Good Cause for Extension of the Time Limit for Filing Appeals –</i> Contractors shall observe the instruction to allow for good cause in instances of beneficiary document	X	X	X	X						

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
	conversion to an accessible alternate format, and to allow good cause for beneficiary late response when there is awareness of an alternate format preference.										
11042.5	<i>240.1 - Good Cause</i> - Contractors shall observe the instruction to document where good cause was found for late filing on the appeal decision letter or the appeal case file.	X	X	X	X						
11042.6	<i>240.4 – Good Cause - Administrative Relief Following a Disaster</i> - Contractors shall observe the addition of procedures to follow for appeals when a natural or man-made disaster occurs.	X	X	X	X						
11042.7	<i>240.5 - Procedures to Follow When a Party Fails to Establish Good Cause</i> – Contractors shall observe the relocation to subsection 240.5 of procedures to follow when good cause is not found.	X	X	X	X						
11042.8	<i>270.1.2 - How to Make and Revoke an Appointment</i> – Contractors shall observe the amendments to accepted forms of signatures.	X	X	X	X						
11042.9	<i>270.1.6 - Curing a Defective Appointment of Representative</i> – Contractors shall observe tolling of timeframe when attempting to cure a defective appointment instrument.	X	X	X	X						
11042.10	<i>270.1.6 - Curing a Defective Appointment of Representative</i> – Contractors shall observe requirement to document in the case file any attempts made to cure a defective appointment instrument.	X	X	X	X						
11042.11	<i>270.1.7 - Incapacitation or Death of Beneficiary</i> – Contractors shall observe enhanced guidance to determine proper parties.	X	X	X	X						
11042.12	<i>270.2.3 - How to Make and Revoke a Transfer of Appeal Rights</i> - Contractors shall observe the amendments to accepted forms of signatures.	X	X	X	X						
11042.13	<i>270.2.5 - Where to Submit the Transfer of Appeal Rights</i> - Contractors shall advise appellants using a contractor portal of appellant's ability to submit the Transfer of Appeal Rights form through the portal.	X	X	X	X						

Number	Requirement	Responsibility										
		A/B MAC			D M E M A C	Shared- System Maintainers				Other		
		A	B	H H H		F I S S	M C S	V M S	C W F			
11042.14	<i>310.1 - Filing a Request for Redetermination –</i> Contractors shall observe the amendments to accepted forms of signatures.	X	X	X	X							
11042.15	<i>310.1 - Filing a Request for Redetermination –</i> Contractors shall observe instruction to document any submitted new evidence or information in letter advising contractor cannot vacate the dismissal.	X	X	X	X							
11042.16	<i>310.1 - Filing a Request for Redetermination -</i> Contractors shall observe instructions related to information included with an appeal request that substantially complies with requirements.	X	X	X	X							
11042.17	<i>310.4 - The Redetermination -</i> Contractors shall observe instruction on development of the appeal case file and obtaining materials from claims review contractors.	X	X	X	X							
11042.18	<i>310.4 - The Redetermination -</i> Contractors shall observe instruction on limiting review in certain instances.	X	X	X	X							
11042.19	<i>310.6.3 – Processing Requests to Vacate Dismissals -</i> Contractors shall observe that information previously contained under §240.5 is now in new subsection 310.6.3.	X	X	X	X							
11042.20	<i>310.7 - Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations) -</i> Contractors shall observe that redetermination decision letters must include a reference to a beneficiary's responsibility for copays, coinsurance and/or deductibles that may be applicable where a beneficiary was found to be responsible for cost or payment.	X	X		X							
11042.21	<i>320.5 - Qualified Independent Contractor (QIC) Case File Preparation -</i> Contractors shall observe instruction to update Joint Operating Agreements (JOAs) to include MAS case file promotion procedures.	X		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E D I	C M E D I
		A	B	H H H		
11042.22	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Liz Hosna, 410-786-4993 or Katherine.Hosna@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 29 - Appeals of Claims Decisions

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110 - Glossary

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

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 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 post-payment review of an initial determination that results in a reversal of a previously covered/paid claim (and, potentially, a subsequent overpayment determination) constitutes a reopening and a revised initial determination. The first level of appeal following a revised initial determination is a redetermination.

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

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\(d\)\(1\)](#) 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, and partial hospitalization 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. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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.

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

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
Redetermination	MAC	MAC

Reconsideration	QIC	QIC
ALJ Hearing	HHS OMHA Central <i>Operations</i>	HHS OMHA Central <i>Operations</i>
Appeals Council Review	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. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)*

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, including the appellant's signature, 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. In the case of a missing signature, MAC shall accept and process the request, and attempt to obtain the appellant's signature when mail service resumes.*

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.*

250.1 - Amount in Controversy General Requirements

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

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\(b\)](#). The amount in controversy thresholds figures are published annually in the Federal Register (<http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR>). Current AIC amounts 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 CFR 411.402](#), 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.

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 (UPIC), 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.

270.1.6 - Curing a Defective Appointment of Representative

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

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.6).

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.*

270.2.3 - 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.

270.2.5 - 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.

270.2.8 - 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.)

270.3 - 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, not withstanding 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.

280.2 - 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.

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.

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.

300.5 - 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).

310.1 - Filing a Request for Redetermination

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

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 signed copy of their MSN, by filing a completed Form CMS-20027 or by submitting a signed 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 and signature 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. Requirements for a Valid Signature on an Appeal Request:

For appeal purposes, the acceptable methods of documenting the appellant's signature on the appeal request *are*: written, digital, digitized, or electronic signature.

- A **written signature** may be received via hard copy mailed correspondence or as part of an appeal request submitted via facsimile.
- An **electronic, digital, and/or digitized signature** is an acceptable signature on a request submitted via *mail, facsimile, or* a CMS-approved secure Internet portal/application. *This would include such applications as the Electronic Submission of Medical Documentation System (esMD). Information on esMD can be found at www.cms.gov/esmd.* The secure Internet portal/application shall include a date, timestamp, and statement regarding the responsibility and authorship related to the electronic, digital, and/or digitized signature within the record. At a minimum, this shall include a statement indicating that the document submitted was, “electronically signed by” or “verified/approved by” etc.
- A **stamp signature or other indication that a “signature is on file”** on the CMS 20027 form or other documentation (such as a blank claim form) submitted to support the appeal request **shall not** be considered an acceptable/valid signature regardless of whether the appeal request is submitted via hard copy mail, facsimile, *or a CMS-approved secure Internet portal/application.*

4. 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.

5. 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.

6. 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.)

310.4 - 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 *UPIC*s 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.

310.6 - 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. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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.4.

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

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 and signature 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. 4278., Issued: 04-12-19, Effective: 06-13-19, Implementation: 06-13-19)

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

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, your signature, the name of the beneficiary, the Medicare number, a list of the service(s) or item(s) that you are appealing and the date(s) of service, and any evidence you wish to attach. You must also indicate that (insert: contractor name) made the redetermination. You may also attach supporting materials, such as those listed in item 10 of the enclosed 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. Signature of Person Appealing: _____ Date: _____
- Contractor Number _____ (Contractor number is optional for contractors with only one location for QICs to request case files)

310.9 - Effect of the Redetermination

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

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.

310.11 - Effectuation of the Redetermination Decision

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

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.

320 - Reconsideration - The Second Level of Appeal

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

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

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 and signature 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.

320.3 - MAC Responsibilities - General

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

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.

320.5 - QIC Case File Preparation

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

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.

320.7 - QIC Jurisdictions

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

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.

<i>Jurisdiction</i>	<i>Normal States</i>	<i>Exceptions</i>
<i>Part B South Jurisdiction</i>	<i>Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia, Virgin Islands.</i>	<i>Note: Railroad Retirement Board reconsiderations are also included in this workload jurisdiction.</i>
<i>Part B North Jurisdiction</i>	<i>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.</i>	
<i>DME QIC Jurisdiction</i>	<i>All states and territories</i>	

320.9 - Effectuation of Reconsiderations

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

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-teleconference), 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.

340.3 - 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.

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.

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.

360.2 - 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.