CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1688	Date: February 20, 2009
	Change Request 6302

SUBJECT: Clarification of the Medicare Redetermination Notice for Partly or Fully Unfavorable Redeterminations

I. SUMMARY OF CHANGES: Changes are being made to the Medicare Redetermination Notice, in order to clarify where beneficiaries may best obtain additional information about Medicare appeals.

NEW / REVISED MATERIAL
EFFECTIVE DATE: March 20, 2009
IMPLEMENTATION DATE: March 20, 2009

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/310.7/Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations)

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: 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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1688	Date: February 20, 2009	Change Request: 6302

SUBJECT: Clarification of the Medicare Redetermination Notice for Partly or Fully Unfavorable Redeterminations

Effective Date: March 20, 2009

Implementation Date: March 20, 2009

I. GENERAL INFORMATION

A. Background: This instruction is being provided in order to revise the decision letters sent by Medicare contractors to appellants. These letters advise appellants of the contractor's redetermination decision, along with the appellant's rights with regard to the decision. They also provide resources available to appellants seeking information about their specific appeal and about the appeals process in general.

B. Policy: The contractor shall revise the Medicare Appeal Decision letter, including the "IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS" section, as detailed in this revision to chapter 29, section 310.7, of the Claims Processing Manual.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6302.1	The contractor shall revise the "Medicare Appeal Decision" letter in accordance with chapter 29, section 310.7, of the Claims Processing Manual.	X	X	X	X	X					
6302.2	The contractor may include additional resources, including their Web site address(es) and/or telephone number(s).	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

							FISS	MCS	VMS	CWF	
	None										

IV. SUPPORTING INFORMATION

None.

V. CONTACTS

Pre-Implementation Contact(s): Kim Spalding kimberly.spalding@cms.hhs.gov
Post-Implementation Contact(s): Regional offices for FIs and carriers; project officers for A/B MACs, and DME MACs.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Intermediaries (RHHIs)*:

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

Section B: *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.

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

(Rev.1688, Issued: 02-20-09, Effective: 03-20-09, Implementation: 03-20-09)

The contractor uses the following Medicare Redetermination Notice (MRN) format or something similar and standard language paragraphs.

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.

The fill-in-the-blank information (specific to each redetermination) *is* in italics. 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 FI or carrier to request the case file from.

A. Redetermination Letterhead

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

Medicare Appeal Decision

MONTH, DATE, YEAR
APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

(If the appellant is a provider or supplier, in the beneficiary's letter, include the following statement:) **This is a copy of the letter sent to your provider/physician/supplier.**

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: name of item or service).

The appeal decision is

(Insert either: **unfavorable.** Our decision is that your claim is not covered by Medicare.

OR

partially favorable. Our decision is that your claim is partially covered by Medicare.

More information on the decision is provided below. If you disagree with the decision, you may appeal to a qualified independent contractor. You must file your appeal, in writing, within 180 days of receiving this letter. 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, see the section 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: You 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 above claim is not covered by Medicare. We have also determined that you are responsible for payment for this service."*)*

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 what policy (LCD, NCD), regulations and/or laws were used to make this determination. Make sure that the explanation contained in this paragraph is clear and that it includes an explanation of why the claim can or cannot be paid. 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: Include information on limitation of liability, waiver of recovery, and physician/supplier refund requirements as applicable.*)*

What to Include in Your Request for an Independent Appeal

*(*Instructions: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision, please 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 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 further appeal 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 should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration 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 further appeal 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,

Reviewer Name
Contractor Name
A Medicare Contractor

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 company that is independent from *(*insert: contractor name*)*.

How to Appeal: To exercise your right to an appeal, you must file a request in writing within 180 days of receiving this letter. Under special circumstances, you may ask for more time to request an appeal. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you *may* 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 Redetermination 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, you should 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.medicare.gov/basics/forms/default.asp 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 enrollee, 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 we 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 and attach a copy of this letter:

Contractor Name,
A Medicare Contractor

Address
City, State, Zip

Resources for Medicare Enrollees: 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 Web site, 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	**Reconsideration Request Form**	Redetermination/ Appeals Number: XXXXXX

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:_____

_____

6. Item or service you wish to appeal:_____

_____

7. Date of the service: From____/_____/_____ To_____/_____/_____

8. Does this appeal involve an overpayment? ☐ Yes ☐ No

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)