CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 468 **Date: FEBRUARY 4, 2005**

CHANGE REQUEST 3635

SUBJECT: Appeals Transition- BIPA Section 521 Appeals

I. SUMMARY OF CHANGES: The purpose of this CR is to notify Carriers and DMERCs about the upcoming transition to the new second level appeal process.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: 01/01/05
IMPLEMENTATION DATE: 07/05/05

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**
	Recurring Update Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 468	Date: February 4, 2005	Change Request 3635

SUBJECT: Appeals Transition- BIPA Section 521 Appeals

I. GENERAL INFORMATION

A. Background: The Medicare claims appeal process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, section 521). Section 1869(b) of the Act, as amended by BIPA, calls for a new second level in the administrative appeals process called a reconsideration (please note there is a distinction between this "reconsideration" and the previous first level of appeal for Part A claims). Reconsiderations will be processed by Qualified Independent Contractors (QICs).

The purpose of this CR is to notify Carriers and DMERCs about the systems changes related to the upcoming transition to the new second level appeal process. Beginning for Part B redeterminations issued and mailed by Carriers and DMERCs on or after January 1, 2006, the parties to the redetermination will have the right to appeal to a QIC. All redeterminations issued and mailed before January 1, 2006 will have appeal rights to the hearing officer (HO). **Additional instructions regarding non-systems changed associated with the transition will be released in an upcoming CR**.

Note: This CR does not apply to fiscal intermediaries (FIs) and/or redeterminations processed by FIs. For FI redeterminations, please refer to CR 3530.

B. Policy:

1. Redetermination Letters - New Language

For redetermination decisions issued and mailed on or after January 1, 2006, Carriers and DMERCs shall change the language in the Medicare Redetermination Notice (MRN) as follows (see model in exhibit 1):

(a) Contractors shall remove language on the first page of the notice about the amount in controversy. This is no longer needed, as there is not a minimum amount in controversy required for a QIC reconsideration.

(b) Contractors shall change the level of appeal insert to a Qualified Independent Contractor and change the time frame to appeal to 180 days of receiving this letter. The new paragraph should read as follows:
"More information on the decision is provided below. You are not required to take any action. However, 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."

(c) Contractors shall include the request for reconsideration form with the MRN.

(d) Contractors shall include the following text in the "What to Include in Your Request for an Independent Appeal "section:
"**Special Note to Medicare Physicians and Suppliers Only**: Any evidence indicated in this section should be submitted with the request for reconsideration. All evidence, including evidence indicated in this section, must be presented before the reconsideration is issued. If all evidence is not submitted, you will not be able to submit any new evidence to the Administrative Law Judge (ALJ) or at further levels of appeal unless you can demonstrate good cause for withholding the evidence from the Qualified Independent Contractor."

(e) Contractors shall change the language on the "On the Important Information About Your Appeal Rights" page as follows:

(i) Section Title "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 claims so far. The next level of appeal is called a reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from <Insert Contractor's name>." (Note: Contractors shall delete the language about the amount in controversy and aggregation.)

(ii) Section Title "How to Appeal"

To exercise your right to appeal, you must file a request 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 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: the name of the contractor*) made the redetermination. You may also attach supporting materials such as medical records, doctors' letter, 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, ZipCode

(iii) Section titled "Aggregating Claims"

Contractors shall delete this section.

2. Redetermination Letters for Fully Favorable Cases

Previously, some contractors had elected to notify parties of a fully favorable decision through the Medicare Summary Notice (MSN) and the Remittance Advice (RA) rather than a formal decision letter. The statute, however, requires that all decisions be mailed within 60 days of receipt of the redetermination request. Accordingly, contractors will need to mail a fully favorable decision, as well as, all unfavorable decisions within 60 days. This means that contractors will no longer be able to notify parties of a fully favorable decision through only the MSN and RA. While it is not necessary for contractors to send the complete MRN for fully favorable decisions, contractors must send a brief written notification to the appellant informing them that the redetermination is favorable and that a MSN and/or RA will follow. In cases where the appellant has a representative, the notification is sent to the representative (with the exception of Medicare Secondary Payer cases, the notification is sent to both the appellant and the representative). See exhibit 2 for a model of a fully favorable redetermination. Please note that exhibit 2 is only a model and contractors may choose to include additional information as necessary (e.g, beneficiary name or date of service).

Fully favorable means when the Medicare approved amount minus any cost sharing provisions (insurance, deductibles, etc.) has been found payable.

3. Reporting a Redetermination

Previously, contractors considered a reconsideration or review cleared (i.e., completed) when the final determination was printed or typed, or upon notification of withdrawal by the appellant. According to the statute a redetermination must be mailed before the conclusion of the 60-day period. Accordingly, a redetermination should be reported as cleared under line 6 of the CMS 2590 when the redetermination is mailed to the appellant or parties, as applicable.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3635.1	**Carriers and DMERCs shall make necessary language changes to the MRN.**			X	X		X	X		
3635.1.2	Carriers and DMERCs shall include the reconsideration request form with the MRN.			X	X		X	X		
3635.1.2.1	Carriers and DMERCs shall include the contractor logo or CMS logo with the contractor number and address on the reconsideration request form for identification purposes. This logo will be used by the QIC to identify which Carrier or DMERC to request the case file from.			X	X		X	X		
3635.1.2.2	Carriers and DMERCs shall include an appeal number on the reconsideration request form for identification of the exact appeal. This number will be used by the QIC to request a case file.			X	X		X	X		
3635.2	Carriers and DMERCs shall mail notification of a fully favorable redetermination within 60 days of receipt of the request.			X	X		X	X		
3635.3	Carriers and DMERCs shall report a redetermination cleared under line 6 of the CMS 2590 when the redetermination is mailed to the appellant or parties, as applicable.			X	X		X	X		

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Jennifer Eichhorn Frantz, JFrantz@cms.hhs.gov **Post-Implementation Contact(s):** Jennifer Eichhorn Frantz, JFrantz@cms.hhs.gov or Maria Ramirez, MRamirez@cms.hhs.gov	**Medicare Contractors shall implement these instructions within their current operating budgets.**

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

Exhibit 1: Model Redetermination Notice

Medicare Number of Beneficiary:
111-11-1111 A

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

MEDICARE APPEAL DECISION

MONTH, DATE, YEAR

APPELLANT'S NAME
ADDRESS
CITY, STATE ZIP

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 made 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. You are not required to take any action. However, 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.

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. For more information on how to appeal, see the section titled "Important Information About Your Appeal Rights."

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 (including local medical review policy, regional medical review policy, and/or national coverage policy), 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
Instruction: 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.

Special Note to Medicare Physicians and Suppliers Only: Any evidence indicated in this section should be submitted with the request for reconsideration. All evidence, including evidence indicated in this section, must be presented before the reconsideration is issued. If all evidence is not submitted, you will not be able to submit any new evidence to the Administrative Law Judge (ALJ) or at further levels of appeal unless you can demonstrate good cause for withholding the evidence from the Qualified Independent Contractor.

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 a reconsideration. A reconsideration is a new and impartial review performed by a company that is independent from <Insert Contractor's 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 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 medical records, doctors' letters, 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 and your appointed representative must sign, date and send us a statement naming that person to act for you. Call us to learn more about how to name a representative.

Help With Your Appeal: 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 call 1-800-MEDICARE (1-800-633-4227) for information on how to contact your local SHIP. Your SHIP can answer questions about payment denials and appeals.

Other Important Information: If you want copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision, please write to us at the following address and attach a copy of this letter:

Contractor Name,
A Medicare Contractor
Address
City, State Zip

If you need more information or have any questions, please call us at the phone number provided (insert location of address).

Other Resources To Help You:

1-800-MEDICARE (1-800-633-4227), TTY/TDD: 1-800-486-2048

Contractor Logo or CMS Logo with Contractor Name and Address

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form or a **copy** of this form to:

QIC Name
Street Address
City State Zip

1. Provider Name:_____

2. Name of Beneficiary:_____

3. Medicare Number:_____

4. Your Address:_____

_____

5. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary.)

_____

_____

6. Signature:_____ 7. Date: _____

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

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

For questions, call <Insert contractor 1-800 number)1-800-XXX-XXXX.

Appeal Number:
XXXXXX