

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 1408</b>	<b>Date: JANUARY 11, 2008</b>
	<b>Change Request 5836</b>

**SUBJECT: Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)**

**I. SUMMARY OF CHANGES:** The purpose of this change request is to modify the Reconsideration Request Form included with the model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations).

**NEW / REVISED MATERIAL**

**EFFECTIVE DATE: JANUARY 1, 2008**

**IMPLEMENTATION DATE: February 11, 2008**

*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**

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
<b>R</b>	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: 1408	Date: January 11, 2008	Change Request: 5836
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**SUBJECT: Modification to the Model Medicare Redetermination Notice (for partly or fully unfavorable redeterminations)**

**Effective Date: January 1, 2008**

**Implementation Date: February 11, 2008**

## 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). This change request modifies the Reconsideration Request Form that is included with the Medicare Redetermination Notice (MRN) to clarify which elements on the form must be completed, at a minimum, for the request to be considered a valid request for reconsideration. This change is necessary as the current manual instructions do not clearly identify all of the required elements for a valid reconsideration request.

**B. Policy:** The Reconsideration Request Form included with the MRN shall be modified to clarify which elements are required, at a minimum, for the reconsideration request to be considered valid in accordance with §405.964(b).

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
5836.1	Contractors shall modify the existing Reconsideration Request Form included with the MRN as follows:	X	X	X	X	X					
5836.1.1	Modify the paragraph with the directions for completing the form as follows:  "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."	X	X	X	X	X					

## III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
5836.2	A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLN MattersArticles/">http://www.cms.hhs.gov/MLN MattersArticles/</a> shortly after the CR is released. You will receive notification of	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M E  M A C	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

#### IV. SUPPORTING INFORMATION

**Section A: For any recommendations and supporting information associated with listed requirements, use the box below:**

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	N/A

**Section B: For all other recommendations and supporting information, use this space:**

N/A

#### V. CONTACTS

**Pre-Implementation Contact(s):** Kathleen McCracken, [Kathleen.McCracken@cms.hhs.gov](mailto:Kathleen.McCracken@cms.hhs.gov)

**Post-Implementation Contact(s):** Kathleen McCracken, [Kathleen.McCracken@cms.hhs.gov](mailto:Kathleen.McCracken@cms.hhs.gov)

#### VI. FUNDING

**Section A: For Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (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. 1408, Issued: 01-11-08, Effective: 01-01-08, Implementation: 02-11-08)*

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. 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) are 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.

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 (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**

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. 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'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

### 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)