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MEDICARE FACT SHEET

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IMPLEMENTING A NEW MEDICARE CLAIMS APPEALS PROCESS

Background: In Section 521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Congress required a major restructuring to improve the process that Medicare beneficiaries can use to appeal claims denials. The law includes a series of structural and procedural changes to the appeals process, including:

- Uniform appeal procedures for both Part A and Part B claims;
- Reduced decision-making time frames for most administrative appeals levels, as well as the right to escalate a case that is not decided on time to the next appeal level;
- The establishment of new entities, Qualified Independent Contractors (QICs), to conduct reconsiderations of claims denials made by fiscal intermediaries, carriers, and quality improvement organizations;
- Use of QIC review panels, which include medical professionals, to reconsider all cases involving medical necessity issues; and
- A requirement for appeals-specific data collection by CMS.

On December 8, 2003, following publication of the proposed rule, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) was enacted. The MMA includes a number of provisions that affect the Medicare claim appeals process. Most notably the new law includes:

- Revised redetermination and reconsideration decision-making time frames;
- A reduction in the minimum required number of QICs from 12 to 4;
- A requirement to transfer the ALJ function from SSA to HHS no earlier than July 1, 2005, but not later than October 1, 2005;

- Revised requirements for appeals decision notices;
- A requirement for providers and suppliers to present any evidence for an appeal no later than the QIC reconsideration level, unless there is good cause that prevented the timely introduction of the evidence; and
- The establishment of a process for the correction of minor errors or omissions without pursuing an appeal.

Several of these changes were already part of CMS' proposed rule. To the extent that the new statutory requirements have required revisions or additions to our proposed regulations to ensure that they conform to the MMA, we have incorporated the needed changes into the interim final rule, and discussed them in the appropriate section of the preamble.

Since the enactment of BIPA and MMA, CMS has been working aggressively to implement the substantial changes required by the law. For example, changes we have already implemented include:

- Development of a case-specific appeals data base;
- Award of contracts to the new required appeals entities—Qualified Independent Contractors (QICs); and
- Implementation of new improved notice requirements for current Medicare contractors.

Today, CMS published an interim final rule that will enable us to complete implementation of the new appeals process.

Implementation

The statutory appeals provisions dramatically reduce the time frames for adjudicating fee-for-service Medicare claims appeals – a process that now can exceed 1,000 days must be reduced to 300 days. This change requires a substantial overhaul of the appeals process – a complicated restructuring involving all levels of the Medicare appeals process. CMS has worked aggressively to implement these mandatory changes, culminating in this regulation.

Today, CMS is publishing an interim final rule that establishes new regulations for implementing the new appeals process for claims denials required by section 521 of BIPA and the MMA. This final rule sets forth in one location all regulations covering administrative appeals of Medicare Part A and Part B claims, including for the first time Medicare-specific procedures for carrying out ALJ hearings. The interim final rule sets forth regulations to implement all structural and procedural changes to the existing appeals process. Implementation of these new procedures will take place in two stages. First, beginning on May 1, 2005, all first level appeals

(“redeterminations”) carried out by fiscal intermediaries (generally Part A appeals) will be subject to QIC reconsiderations. These appeals generally involve Medicare Part A services, such as services furnished by hospitals, skilled nursing facilities, and home health agencies. Then, beginning January 1, 2006, appeals of redeterminations carried out by Medicare carriers (Part B appeals, involving physician services and durable medical equipment items, for example) will be subject to QIC reconsiderations. The new ALJ rules will be in effect for all appeals that come through the QICs. Thus, in 2006, the new Medicare appeals process will take effect for all Part A and B Medicare claims.

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