Related MLN Matters Article #: MM5460

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Related CR #: 5460

Appeals Transition - Benefits Improvement and Protection Act (BIPA), Section 521 Appeals

Key Words

MM5460, CR5460, R1274CP, Appeals, Transition, BIPA, Section, 521, Appeals

Provider Types Affected

Physicians, providers, and suppliers submitting claims to Medicare Carriers, Durable Medical Equipment Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Part A/B Medicare Administrative Contractors (A/B MACs), and/or Regional Home Health Intermediaries (RHHIs) for services provided to Medicare beneficiaries

Key Points

- The effective date of the instruction is July 1, 2007.
- The implementation date is October 1, 2007.
- The Medicare appeals process was amended by the Medicare, Medicaid State Children's Health Insurance Program, BIPA, and the Medicare Prescription Drug Improvement and Modernization Act (MMA). Section 1869(c) of the Social Security Act (as amended by BIPA and MMA) requires changes to the Code of Federal Regulations (Title 42) regarding:
  - Appointment of representatives;
  - Fraud and abuse;
  - Guidelines for writing appeals correspondence; and
  - The disclosure of information.
- The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 5460 to revise provisions in Chapter 29 of the *Medicare Claims Processing Manual* that address these changes and to notify Medicare contractors that they need to comply with changes.

CR5460 Instructions to Medicare Contractors

- Follow the procedures that define who may be a representative and how a representative is appointed, using the Appointment of Representative (AOR) form (CMS-1696):
  - Do not accept an appointment if the contractor has evidence that the appointment should not be honored;
  - Send notice only to the representative, when the contractor takes action or issues a redetermination (if there is an appointed representative);
  - Provide assistance in completing the CMS-1696 form, as needed; and
  - Do not release beneficiary-specific information to a representative before the beneficiary or appellant and the prospective representative have completed and signed the CMS-1696 or other conforming written instrument.

Note: The AOR applies to all services, claims, and appeals submitted on behalf of the beneficiary for the duration of the AOR.

- Follow the procedures that describe the process a beneficiary must use to assign their appeal rights to a provider, using the Transfer of Appeal Rights form (CMS-20031):
  - For each new appeal request, a form needs to be submitted. This form is valid for all levels of the appeal process, including judicial review, even in the event of the death of the beneficiary;
  - If a provider furnishes the service, he/she would be a party to the initial determinations. Only providers or suppliers who are not a party may accept assignment of appeal rights from a beneficiary. That is, assignment of appeal rights applies only to providers and suppliers who are never a party to an appeal because they do not participate in Medicare and have not taken the claim on assignment; and
  - The provider or supplier who accepts the appeal rights 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.
  - Provide redetermination letters that are understandable to beneficiaries.

Note: An Assignment of Appeal Rights is valid for the duration of an appeal, unless it is revoked by the beneficiary.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5460.pdf* on the CMS website.

The official instruction (CR5460) issued regarding this change may be viewed at *http://www.cms.hhs.gov/Transmittals/downloads/R1274CP.pdf* on the CMS website. The revised portions of the *Medicare Claims Processing Manual* are attached to that CR.