CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4380	**Date: August 30, 2019**
	Change Request 11352

SUBJECT: Pub. 100-04, Chapter 29 – Appeals Signature Requirement Changes

I. SUMMARY OF CHANGES: This Change Request (CR) updates Pub. 100-04, Chapter 29 with policy updates to remove the previous regulatory requirement for signatures on all appeal requests. There are also some minor technical corrections following the effectuation of CR11042 of this chapter.

EFFECTIVE DATE: July 8, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2019

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/110/Glossary
R	29/200/CMS Decisions Subject to the Administrative Appeals Process
R	29/210/Who May Appeal
R	29/230/Where to Appeal
R	29/240.4/Good Cause - Administrative Relief Following a Disaster
R	29/250.1/Amount in Controversy General Requirements
R	29/270.1/Appointment of Representative - Introduction
R	29/270.1.6/Curing a Defective Appointment of Representative
R	29/310.1/Filing a Request for Redetermination
R	29/310.6.1/Dismissal Letters
R	29/310.6.2/Model Dismissal Notices
R	29/310.6.3/Processing Requests to Vacate Dismissals
R	29/310.7/Medicare Redetermination Notice (For Partly or Fully Unfavorable Redeterminations)
R	29/310.8/Medicare Redetermination Notice (for Fully Favorable Redeterminations)
R	29/310.9/Effect of the Redetermination
R	29/310.10/System and Processing Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities
R	29/310.11/Effectuation of the Redetermination Decision
R	29/310.12/QIC Remands
R	29/320/Reconsideration - The Second Level of Appeal
R	29/320.1/Filing a Request for a Reconsideration
R	29/320.2/Time Limit for Filing a Request for a Reconsideration
R	29/320.3/MAC Responsibilities - General
R	29/320.4/QIC Case File Development
R	29/320.5/QIC Case File Preparation
R	29/320.6/Forwarding QIC Case Files
R	29/320.7/QIC Jurisdictions
R	29/320.8/Tracking Cases
R	29/320.9/Effectuation of Reconsiderations

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4380	Date: August 30, 2019	Change Request: 11352

SUBJECT: Pub. 100-04, Chapter 29 – Appeals Signature Requirement Changes

EFFECTIVE DATE: July 8, 2019
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I. GENERAL INFORMATION

A. Background: This CR incorporates an important policy update. On May 7, 2019, CMS published a final rule, 84 FR 19855, which removes the requirement for signatures on appeal requests that are filed under 42 CFR Part 405, Subpart I. This final rule becomes effective July 8, 2019. MACs have been instructed through previously issued technical direction that effective July 8, 2019, MACs shall no longer dismiss appeal requests for lack of signature. Additionally, this CR includes some minor formatting changes and technical corrections.

B. Policy: CMS-4174-F, 84 FR 19855, published May 7, 2019, effective July 8, 2019

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11352.1	MACs shall no longer require a signature on an appeal request.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Liz Hosna, 410-786-4993 or Katherine.Hosna@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

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(Rev.4380, Issued: 08-30-19)

110 - Glossary

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Adjudicator – The entity responsible for making the decision at any level of the Medicare claim decision making process, from initial determination to the final level of appeal, on a specific claim.

Administrative Law Judge (ALJ) – Adjudicator employed by the Department of Health and Human Services (HHS), Office of Medicare Hearings and Appeals (OMHA) that holds hearings and issues decisions related to level 3 of the appeals process.

Affirmation - A term used to denote that a prior claims determination has been upheld by the current claims adjudicator. Although appeals through the OMHA level are de novo, CMS and its contractors often use this term when an adjudicator reaches the same conclusion as that in the prior determination, even though he/she is not bound by the prior determination.

Amount in Controversy (AIC) - The dollar amount required to be in dispute to establish the right to a particular level of appeal. Congress establishes the amount in controversy requirements.

Appeals Council – The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board, provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment. (See also Departmental Appeals Board.)

Appellant - The term used to designate the party (i.e., the beneficiary, provider, supplier, or other person showing an interest in the claim determination) or the representative of the party that has filed an appeal. The adjudicator determines if a particular appellant is a proper party or representative of a proper party.

Applicable plan – Applicable plan means liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan.

Appointed representative – The individual appointed by a party to represent the party in a Medicare claim or claim appeal.

Assignee – (1) With respect to the assignment of a claim for items or services, the assignee is the supplier who has furnished items or services to a beneficiary and has accepted a valid assignment of a claim;

OR

(2) With respect to an assignment of appeal rights, an assignee is a provider or supplier who is not already a party to an appeal, who has furnished items or services to a beneficiary, and has accepted a valid assignment of the right to appeal a claim executed by the beneficiary.

Assignment of appeal rights – The transfer by a beneficiary of his or her right to appeal under the claims appeal process to a provider or supplier who is not already a party, and who provided the items or services to the beneficiary.

Assignor – A beneficiary whose provider of service or supplier has taken assignment of a claim, or assignment of an appeal of a claim.

Attorney Adjudicator - A licensed attorney employed by OMHA with knowledge of Medicare coverage and payment laws and guidance, authorized to take the actions provided for in 42 CFR 405 subpart I on requests for ALJ hearing and requests for reviews of QIC dismissals.

Authorized representative – An individual authorized under State or other applicable law to act on behalf of a beneficiary or other party involved in the appeal. The authorized representative will have all of the rights and responsibilities of a beneficiary or party, as applicable, throughout the appeals process.

Beneficiary – Individual who is enrolled to receive benefits under Medicare Part A and/or Part B.

Contractor - An entity that contracts with the Federal government to review and/or adjudicate claims, determinations and/or decisions.

Date of Receipt – A determination, decision or notice is presumed to have been received by the party five days from the date included on the determination or decision, unless there is evidence to the contrary.

NOTE: Throughout Chapter 29, reference to day or days means calendar days unless otherwise specified.

Departmental Appeals Board (DAB) Review - The DAB provides impartial, independent review of disputed decisions in a wide range of Department of Health and Human Services programs under more than 60 statutory provisions. The Medicare Appeals Council (herein Appeals Council), a division within the Departmental Appeals Board, provides the final level of administrative review of claims for entitlement to Medicare and individual claims for Medicare coverage and payment. (See section 340 in this chapter.)

De Novo - Latin phrase meaning "anew" or "afresh," used to denote the manner in which claims are adjudicated in the administrative appeals process. Adjudicators at each level of appeal make a new, independent and thorough evaluation of the claim(s) at issue, and are not bound by the findings and decision made by an adjudicator in a prior determination or decision.

Decisions and Determinations -If a Medicare appeal request does not result in a dismissal, adjudication of the appeal results in either a "determination" or "decision." There is no apparent practical distinction between these two terms although applicable regulations use the terms in distinct contexts.

A decision that is reopened and thereafter revised is called a "revised determination."

Dismissal - An action taken by an adjudicator when an appeal will not be conducted as requested. A request for appeal may be dismissed for any number of reasons, including:

1. Abandonment of the appeal by the appellant;
2. A request is made by the appellant to withdraw the appeal;
3. A determination that an appellant is not a proper party;
4. The amount in controversy requirements have not been met; and
5. The appellant has died and no one else is prejudiced by the claims determination.

Limitation on Liability Determination- Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers and suppliers by permitting Medicare payment to be made, or requiring refunds to be made, for certain services and items for which Medicare coverage and payment would otherwise be denied. This section of the Act is referred to as "the limitation on liability provision." Both the underlying coverage determination and the limitation on liability determination may be challenged. For more detailed information see chapter 30 of this manual.

Medicare number and/or Medicare beneficiary identifier (Mbi) - are general terms describing a beneficiary's Medicare identification number. Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes. For the beneficiary population, the term Medicare number is used to describe the Medicare beneficiary identifier (Mbi).

Office of Medicare Hearings and Appeals (OMHA) - The Office of Medicare Hearings and Appeals is responsible for level 3 of the Medicare claims appeal process and certain Medicare entitlement appeals and Part B premium appeals. At level 3 of the appeals process, an appellant may have a hearing before an OMHA ALJ, or review by an attorney adjudicator.

Party - A person and/or entity normally understood to have standing to appeal an initial determination and/or a subsequent administrative appeal determination or decision. (See section 210 in this chapter.)

Provider of services (herein provider) – As used in this section, the definition in 42 CFR 405.902 for provider applies. Provider means a hospital, a critical access hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. NOTE: A non-participating provider, that is, an entity eligible to enter into a provider agreement to participate in Medicare but has not entered into such an agreement, is not considered a provider of services and does not have party status for an initial determination or appeal.

Qualified Independent Contractor (QIC) – Entity that contracts with the Secretary in accordance with the Act to perform level 2 appeals, which are called reconsiderations, and expedited reconsiderations.

Remand – An action taken by an adjudicator to vacate a lower level appeal decision, or a portion of the decision, and return the case, or a portion of the case, to that level for a new decision.

Reopening - See IOM 100-04 Chapter 34.

Reversal - Although appeals in the administrative appeals process are de novo proceedings (i.e., a new determination/decision is made at each level), Medicare uses this term where the new determination/decision is more favorable to the appellant than the prior determination/decision, even if some aspects of the prior determination/decision remain the same.

NOTE: The term reversal describes the coverage determination, not the liability determination. For example, an item or service may be determined to be non-covered as not medically reasonable and necessary (under section 1862(a)(1)(A) of the Act), but Medicare may, nevertheless, make payment for the item or service if the party is found not financially liable after applying the limitation on liability provision (section 1879 of the Act). Thus, the coverage determination is affirmed, but Medicare makes payment as required by statute.

Revised Determination or Decision - An initial determination or decision that is reopened and which results in the issuance of a revised determination or decision. A revised determination or decision is considered a separate and distinct determination or decision and may be appealed. For example, a post-payment review of an initial determination that results in a reversal of a previously covered/paid claim (and, potentially, a subsequent overpayment determination) constitutes a reopening and a revised initial determination. The first level of appeal following a revised initial determination is a redetermination.
Spouse - The word "spouse" as used in this chapter, and as used in sections 405.952, 405.972, 405.1052, and 405.1114 of title 42 of the Code of Federal Regulations (CFR) regarding the dismissal of an appeal includes same-sex spouses as well as opposite-sex spouses. The relationship of two individuals of the same sex will be recognized as a marriage if either (1) the state or territory in which the individuals live recognizes their relationship as a marriage, or (2) the individuals entered into a legally valid marriage under the law of any state, territory, or foreign jurisdiction. Because civil unions and domestic partnerships are not marriages, civil union and domestic partners are not regarded as spouses by CMS.

Supplier –Unless the context otherwise requires, a physician or other practitioner, a facility, or entity (other than a provider of services) that furnishes items or services under Medicare.

Vacate – To set aside a previous action.

200 - CMS Decisions Subject to the Administrative Appeals Process

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A. Entitlement Determinations

In accordance with a memorandum of understanding with the Secretary, the Social Security Administration (SSA) makes initial Part A and Part B entitlement determinations and initial determinations on applications for entitlement. Individuals should contact the SSA for administrative appeals involving entitlement (telephone 1-800-772-1213 (TTY 1-800-325-0778 or access the SSA's website at: http://ssa.gov/pgm/medicare.htm). This would include issues that involve the question of whether the beneficiary:

- Has attained age 65 or is entitled to Medicare benefits under the disability or renal disease provisions of the law;
- Is entitled to a monthly retirement, survivor, or disability benefit;
- Is qualified as a railroad beneficiary;
- Met the deemed insured provisions; and
- Met the eligibility requirements for enrollment under the supplementary medical insurance (SMI) program or for hospital insurance (HI) obtained by premium payment.

If a beneficiary is dissatisfied with the SSA's initial determination on entitlement, he or she may request a reconsideration with the SSA. The SSA performs a reconsideration of its initial determination in accordance with 20 CFR part 404, subpart J. Following the reconsideration, the beneficiary may request a hearing before a HHS Administrative Law Judge (ALJ). If the beneficiary obtains a hearing before an ALJ and is dissatisfied with the decision of the ALJ, he or she may request the Appeals Council to review the case. Following the action of the Appeals Council, the beneficiary may be entitled to file suit in Federal district court.

B. Initial Determinations

The Medicare contractor makes initial determinations regarding claims for benefits under Medicare Part A and Part B. A finding that a request for payment does not meet the requirements for a Medicare claim shall not be considered an initial determination. An initial determination for purposes of this chapter includes, but is not limited to, determinations with respect to:

(1) Whether the items and/or services furnished are covered under title XVIII of the Act;

(2) In the case of determinations on the basis of section 1879(b) or (c) of the Act, whether the beneficiary, or supplier who accepts assignment under 42 CFR 424.55 knew, or could reasonably have been expected to know at the time the services were furnished, that the services were not covered;

(3) In the case of determinations on the basis of section 1842(l)(1) of the Act, whether the beneficiary or supplier knew, or could reasonably have been expected to know at the time the services were furnished, that the services were not covered;

(4) Whether the deductible has been met;

(5) The computation of the coinsurance amount;

(6) The number of days used for inpatient hospital, psychiatric hospital, or post-hospital extended care;

(7) Periods of hospice care used;

(8) Requirements for certification and plan of treatment for physician services, durable medical equipment, therapies, inpatient hospitalization, skilled nursing care, home health, hospice, and partial hospitalization services;

(9) The beginning and ending of a spell of illness, including a determination made under the presumptions established under 42 CFR 409.60(c)(2), and as specified in 42 CFR 409.60(c)(4);

(10) The medical necessity of services, or the reasonableness or appropriateness of placement of an individual at an acute level of patient care made by the Quality Improvement Organization (QIO) on behalf of the contractor in accordance with 42 CFR 476.86(c)(1);

(11) Any other issues having a present or potential effect on the amount of benefits to be paid under Part A or Part B of Medicare, including a determination as to whether there has been an underpayment of benefits paid under Part A or Part B, and if so, the amount thereof;

(12) If a waiver of adjustment or recovery under sections 1870(b) and (c) of the Act is appropriate*:*

(i) when an overpayment of hospital insurance benefits or supplementary medical insurance benefits (including a payment under section 1814(e) of the Act) has been made with respect to an individual, or

(ii) with respect to a Medicare Secondary Payer recovery claim against a beneficiary or against a provider or supplier*;*

(13) Whether a particular claim is not payable by Medicare based upon the application of the Medicare Secondary Payer provisions of section 1862(b) of the Act;

(14) Under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery claim against a provider, supplier, or beneficiary for services or items that have already been paid by the Medicare program, except when the Medicare Secondary Payer recovery claim against the provider or supplier is based upon failure to file a proper claim as defined in 42 CFR part 411 because this action is a reopening*;*

(15) A claim not payable to a beneficiary for the services of a physician who has opted-out. NOTE: A physician who has opted-out of Medicare is not considered a party to the initial determination or any subsequent appeal; and

(16) Under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery claim if Medicare is pursuing recovery directly from an applicable plan. That is, there is an initial determination with respect to the amount and existence of the recovery claim.

C. Actions That Are Not Initial Determinations

Actions that are not initial determinations and are not appealable under this chapter include, but are not limited to—

(1) Any determination for which CMS has sole responsibility, for example: whether an entity meets the conditions for participation in the program; whether an independent laboratory meets the conditions

for coverage of services; or a determination under the Medicare Secondary Payer provisions of section 1862(b) of the Act of the debtor for a particular recovery claim;

(2) The coinsurance amounts prescribed by regulation for outpatient services under the prospective payment system;

(3) Any issue regarding the computation of the payment amount of program reimbursement of general applicability for which CMS or a contractor has sole responsibility under Part B, such as the establishment of a fee schedule set forth in 42 CFR, part 414, subpart B, or an inherent reasonableness adjustment pursuant to 42 CFR 405.502(g) and any issue regarding the cost report settlement process under Part A:

NOTE: For example, section 1848(i)(1) of the Act prohibits administrative and judicial review of the individual components used to compute Medicare physician fee schedule payment amounts. However, a payment amount determination with respect to a particular item or service on a claim is an initial determination that is appealable.

(4) Whether an individual's appeal meets the qualifications for expedited access to judicial review provided in 42 CFR 405.990;

(5) Any determination regarding whether a Medicare overpayment claim should be compromised, or collection action terminated or suspended under the Federal Claims Collection Act of 1966, as amended;

(6) Determinations regarding the transfer or discharge of residents of skilled nursing facilities in accordance with 42 CFR 483.5 (definition of transfer and discharge) and 483.15;

(7) Determinations regarding the readmission screening and annual resident review processes required by 42 CFR part 483, subparts C and E;

(8) Determinations with respect to a waiver of Medicare Secondary Payer recovery under section 1862(b) of the Act;

(9) Determinations with respect to a waiver of interest;

(10) Determinations for a finding regarding the general applicability of the Medicare Secondary Payer provisions (as opposed to the application in a particular case);

(11) Determinations under the Medicare Secondary Payer provisions of section 1862(b) of the Act that Medicare has a recovery against an entity that was or is required or responsible (directly, as an insurer or self-insurer; as a third party administrator; as an employer that sponsors, contributes to or facilitates a group health plan or a large group health plan; or otherwise) to make payment for services or items that were already reimbursed by the Medicare program, except with respect to the amount and existence of a recovery claim under section 1862(b) of the Act where Medicare is pursuing recovery directly from an applicable plan as specified in 42 CFR 405.924(b)(16);

(12) A contractor's, QIC's, ALJ's, OMHA attorney adjudicator’s, or Appeals Council’s determination or decision to reopen or not to reopen an initial determination, redetermination, reconsideration, hearing decision, or review decision;

(13) Determinations that CMS or its contractors may participate in the proceedings on a request for an ALJ hearing or act as parties in an ALJ hearing or Appeals Council review;

(14) Determinations that a provider or supplier failed to submit a claim timely or failed to submit a timely claim despite being requested to do so by the beneficiary or the beneficiary’s subrogee;

(15) Determinations with respect to whether an entity qualifies for an exception to the electronic claims submission requirement under 42 CFR part 424;

(16) Determinations by the Secretary of sustained or high levels of payment errors in accordance with section 1893(f)(3)(B);

(17) A contractor's prior determination related to coverage of physicians' services;

(18) Requests for anticipated payment under the home health prospective payment system under 42 CFR 409.43(c)(ii)(s); and

(19) Claim submissions on forms/formats that are incomplete, invalid, or do not meet the requirements of a Medicare claim and returned or rejected to the provider or supplier.

NOTE: Duplicate items and services are not afforded appeal rights, unless the supplier is appealing whether or not the service was, in fact, a duplicate.

D. Initial Determinations Subject to Reopening

Minor errors or omissions in an initial determination may be corrected only through the contractor's reopening process. Since it is neither cost efficient or necessary for contractors to correct clerical errors through the appeals process, requests for adjustments to claims resulting from clerical errors must be handled and processed as reopenings. In situations where a provider, supplier, or beneficiary requests an appeal and the issue involves a minor error or omission, irrespective of the request for an appeal, contractors shall treat the request as a request for reopening. A contractor must transfer the appeal request to the reopenings unit or other designated unit for processing. See Chapter 34 Section 10.1 Authority to Conduct a Reopening of the Medicare Claims Processing Manual for information specific to conducting a reopening when a redetermination was requested.

210 - Who May Appeal

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A person or entity with a right to appeal an initial determination is considered a party to the redetermination (as described in 42 CFR 405.906), referred to in the remainder of these instructions as a "party."

Parties to the initial determination include:

- Beneficiaries, who are almost always considered parties to a Medicare determination, as they are entitled to appeal any initial determination (unless the beneficiary has assigned his or her appeal rights);

- Providers who file a claim for items or services furnished to a beneficiary. **NOTE:** A non-participating provider, that is, an entity eligible to enter into a provider agreement to participate in Medicare but has not entered into such an agreement, is not considered a provider or provider of service and does not have party status for an initial determination or appeal. Beneficiaries are parties to claims filed for services furnished by a non-participating provider;

- Participating suppliers and non-participating suppliers, but only with respect to items or services furnished to a beneficiary that are billed on an assignment-related basis;

- An applicable plan (as defined in §110) with respect to the amount and existence of a recovery claim under §405.924(b)(16) if Medicare is pursuing recovery directly from the applicable plan.

The applicable plan is the sole party to an initial determination under §405.924(b)(16) and any subsequent appeal.

Parties to the redetermination and subsequent appeal levels include:

- The parties to the initial determination, above;

NOTE: In addition to his/her own right to appeal Medicare's decision regarding an initial determination, a beneficiary is a party to any request for redetermination filed by a provider or supplier. The beneficiary is always a party to an appeal of services rendered on their behalf, at any level (except when the beneficiary has assigned his/her appeal rights to a provider or supplier).

- A nonparticipating supplier has the same rights to appeal the contractor's determination in an unassigned claim for medical equipment and supplies if the contractor denies payment on the basis of §1862(a)(1), §1834(a)(17)(B), §1834(j)(1), or §1834(a)(15) of the Act as a nonparticipating or participating supplier has in assigned claims. These rights of appeal also extend to determinations that a refund is required either because the supplier knew or should have known that Medicare would not pay for the item or service (See §1834(j)(4)), or because the beneficiary was not properly informed in writing with an Advanced Beneficiary Notice of Non Coverage (ABN) that Medicare would not pay or was unlikely to pay for the item or service. While the time limits in §310 apply for filing requests for redetermination, refunds must be made within the time limits specified in Chapter 30. An adverse advance determination of coverage under §1834(a)(15) of the Act is not an initial determination on a claim for payment for items furnished and, therefore, is not appealable;

- A non-participating physician not billing on an assigned basis but who may be responsible for making a refund to the beneficiary under §1842(l)(1) of the Act for services furnished to a beneficiary that are denied on the basis of section 1862(a)(1) of the Act, has party status with respect to the claim at issue;

- A provider or supplier who otherwise does not have the right to appeal may appeal when the beneficiary dies and there is no other party available to appeal. See §210.1 for information on determining whether there is another party available to appeal;

- A Medicaid State agency or party authorized to act on behalf of the State. Medicaid State agencies have party status at the redetermination level (and subsequent levels) for claims for items or services involving a beneficiary who is enrolled to receive benefits under both Medicare and Medicaid, but only if the Medicaid State agency has made payment for, or may be liable for such items or services, and only if the State agency has filed a timely request for redetermination for such items or services. (See 42 CFR 405.908); and

- Any individual whose rights with respect to the particular claim being reviewed may be affected by such review and any other individual whose rights with respect to supplementary medical insurance benefits may be prejudiced by the decision (e.g., an individual or entity liable for payment under 42 CFR subpart E §424.60 in the case of a deceased beneficiary).

Neither the contractor nor CMS is considered a party to an appeal at the redetermination or reconsideration levels, and therefore does not have the right to appeal or to participate as a party at this stage in the administrative appeals process. CMS or a contractor may choose to participate in an ALJ hearing, become a party to an ALJ hearing (with CMS' approval), or may recommend that the Administrative QIC (AdQIC) refer an ALJ decision or dismissal to the Appeals Council for review under its own motion review authority. At times, an ALJ may ask for a contractor's or QIC's input to a hearing. This does not change the contractor's party status.

NOTE: While a representative may request an appeal on behalf of the party that he/she represents, the representative is not a party to the appeal solely by virtue of being a representative. (See §270 for the rights

and responsibilities of a representative.) The provider of the item or service denied may represent the individual, but may not impose any financial liability on the individual in connection with such representation. If limitation on liability is involved, the provider of the item or service may represent the individual only if the provider waives any rights for payment from the individual with respect to the services or items involved in the appeal.

230 - Where to Appeal

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Where a party must file an appeal depends on the level of appeal. The chart below indicates where appellants should file appeal requests for each level of appeal.

CHART 2 - Where to File an Appeal

LEVEL	WHERE TO FILE AN APPEAL		
	Part A*	Part B	DME
Redetermination	MAC	MAC	MAC
Reconsideration	QIC	QIC	QIC
ALJ Hearing	HHS OMHA Central Operations	HHS OMHA Central Operations	HHS OMHA Central Operations
Appeals Council Review	Appeals Council	Appeals Council	Appeals Council

*Includes part B claims filed with the Part A Medicare Administrative Contractor (MAC).

240.4 – Good Cause - Administrative Relief Following a Disaster

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

When a disaster occurs, whether natural or man-made, MACs shall anticipate both an increased demand for emergency and other health care services, and a corresponding disruption to normal health care delivery systems and networks. For appeals purposes, as defined in this IOM, a ‘disaster area’ is declared by the Federal Emergency Management Agency (FEMA). In disaster situations, MACs that process appeals for beneficiaries, providers, and suppliers affected by a disaster shall exercise good cause in accordance with the regulations and follow the guidance below regarding how to process Fee-for-Service appeal requests in an area(s) declared by FEMA as a disaster area.

When a Presidential declaration occurs, the HHS Secretary may, under section 319 of the Public Health Service Act, declare that a Public Health Emergency (PHE) exists in the affected State. Once a PHE is declared, section 1135 of the Social Security Act authorizes the Secretary, among other things, to temporarily modify or waive certain Medicare, Medicaid, CHIP, and HIPAA requirements as determined necessary by CMS.

A. Definition of Disaster

A disaster is defined as any natural or man-made catastrophe (such as hurricane, tornado, earthquake, volcanic eruption, mudslide, snowstorm, tsunami, terrorist attack, bombing, fire, flood, or explosion) which causes damage of sufficient severity and magnitude to partially or completely destroy medical records and associated documentation that could be needed and/or requested by the MACs in the course of the adjudication process, interrupts normal mail service (including US Postal delivery, overnight parcel delivery services, etc.), impacts ability to file appeals in a timely manner, and/or otherwise significantly limit the provider's/supplier's daily operations.

A disaster may be widespread and impact multiple structures (e.g., a regional flood) or isolated and impact a single site only (e.g., water main failure). The fact that a provider/supplier is located in a presidentially declared disaster area under the power of the Stafford Act is not sufficient in itself to justify administrative relief, as not all structures in the disaster area may have been subject to the same amount of damage. Damage must be of sufficient severity and extent to compromise retrieval of medical records. The provider/supplier needs to state that they were impacted by the disaster.

B. Basis for Providing Administrative Relief

In the event of a disaster, MACs shall grant temporary administrative relief to any affected providers and suppliers for up to 6 months (or longer with good cause). Administrative relief is to be granted to providers/suppliers/beneficiaries on a case-by-case basis in accordance with the following guidelines:

1. **Situation:** A provider/supplier/beneficiary in the affected area needs an extension to file a request for an appeal.

   Action: The MAC shall grant an extension to request an appeal under the good cause exception. Please see 42 CFR § 405.942. If the request is related to an overpayment, the MAC shall accept the request and stop recoupment immediately.

2. **Situation:** The MAC has requested or needs to request additional documentation for a pending appeal, but the provider/supplier/beneficiary has been impacted by a disaster.

   Action: The MAC shall hold the request until the documentation can be obtained or submitted. However, to the extent that the contractor can use other data sources that are available to substantiate payment for the claim, it should do so. The CMS will waive the timeliness requirements for processing these appeals.

3. **Situation:** A request for an appeal filed by an appointed representative on behalf of a party contains a missing or defective appointment instrument and the party is in the affected area.

   Action: The contractor shall process the request and attempt to obtain the corrected appointment instrument. If the corrected appointment instrument is not received by the end of the appeals adjudication period, contractors shall send the redetermination decision letter to the appellant party and any other party to the appeal, but not to the individual attempting to act as the representative.

4. **Situation:** A MAC receives a request for redetermination from a provider/supplier/beneficiary in the affected area and the request is missing some of the required elements to make it a valid request. However, the MAC has information in the shared systems that would allow it to identify the missing element(s).

   Action: The MAC shall accept and process the request, using information already available to it via the shared system.

C. Verification

In the case of complete destruction of medical records where no backup records exist, MAC Appeal Units and QICs shall accept an attestation that no medical records exist and consider the services covered and correctly coded.

250.1 - Amount in Controversy General Requirements

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Each calendar year, the dollar threshold for the AIC requirement for ALJ hearing requests or judicial review will be recalculated to reflect the percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average) for July 2003 to the July preceding the year involved. Any amount that is not a multiple of $10 will be rounded to the nearest multiple of $10. Changes to the amount in controversy threshold amounts are published annually in the Federal Register as per 42 CFR 405.1006(b). Current AIC amounts*, along with a link to the current Federal Register AIC Notice,* can be found on the CMS.gov website at: https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/OMHA-ALJ-Hearing.html

270.1 - Appointment of Representative - Introduction

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A party may appoint any individual, including an attorney, to act as his/her representative in dealings with the MAC. Although some parties may pursue a claim or an appeal on their own, others will rely upon the assistance and expertise of others. A representative may help the party during the processing of a claim or claims, and/or any subsequent appeal. (See §270.1.8 for details regarding disclosure of individually identifiable beneficiary information.) The appointment of a representative is valid for one year from the date signed by both the party and the appointed representative (see §270.1.5 below).

NOTE:

- The appointment remains valid for any subsequent levels of appeal on the item/service in question unless the beneficiary specifically withdraws the representative's authority.

- New appeals may be initiated in writing by the representative within the one year timeframe unless the beneficiary provides a written statement of revocation of the representative's authority.

Appeals for other claims may be initiated utilizing an existing appointment instrument within one year of the effective date of the appointment (i.e., the date the appointment instrument is signed by the party and the representative). To initiate a new appeal within the one year timeframe, the representative must file a copy of the completed appointment instrument with the appeal request.

270.1.6 - Curing a Defective Appointment of Representative

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

If any of the required elements listed in §270.1.2 are missing, the appointment of representative form is considered defective.

How a MAC handles these situations depends on the party attempting to make an appointment. When the beneficiary attempts to make the appointment, the MAC provides assistance to the beneficiary and representative in securing the appointment, based on the time frames set forth below. When a provider or physician or other supplier attempts to make the appointment, the MAC provides instruction on the proper and timely completion of the appointment. Where an adjudication time frame applies, the time from the later of the date that a defective appointment of representative was filed or the current appeal request was filed by the prospective appointed representative, to the date when the defect was cured, the party notifies the adjudicator that he or she will proceed with the appeal without a representative, or the 30-day deadline for curing the defect has elapsed with no response, does not count towards the adjudication time frame. The following provides guidance on properly responding to a representative's attempt to submit a request for appeal.

A. Missing or Defective Appointment When a Beneficiary is the Represented Party

1. Defective Appointment of Representative

When an individual is attempting to act as a beneficiary's representative, but submits an incomplete or defective appointment instrument, the MAC shall advise the individual of how to complete the appointment, and shall notify the individual to submit the completed appointment to the MAC within 30 calendar days. The MAC shall advise the individual of what corrections are required to execute a valid appointment and that a decision letter will not be sent to the individual unless a valid appointment is executed. Should the appointment instrument not be corrected within 30 calendar days, the MAC proceeds with processing and rendering a decision on the appeal, unless there is evidence or information to indicate the appeal was not submitted at the request of the beneficiary. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the individual attempting to act as the beneficiary's representative.

This will ensure that the beneficiary receives an appeal decision when it appears that the appeal originated with the beneficiary or was submitted with the beneficiary's knowledge and consent.

When there is information or evidence that the appeal request and/or the appointment of representative instrument was not submitted at the request of the beneficiary, the MAC shall verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary). In order to verify the wishes of the beneficiary, the MAC sends a letter to the beneficiary explaining the situation. The letter shall advise the beneficiary that in order to proceed with an appeal, a valid appointment instrument must be submitted within 30 calendar days. If no response is received within 30 calendar days then the appointment of representative will not be honored, and no redetermination will be performed. The MAC shall handle this as an inquiry.

2. Missing Appointment of Representative

In cases of appeals filed on behalf of the beneficiary, the MAC need not develop an absent appointment of representative if the request for redetermination clearly shows the beneficiary knew of or approved the submission of the request for redetermination. It sends the appeal decision to the beneficiary and any other party to the appeal, but not to the individual attempting to act as the beneficiary's representative. This will ensure that the beneficiary receives an appeal decision when it appears that the appeal was submitted with the beneficiary's knowledge and consent.

When there is information or evidence that the appeal request filed on behalf of the beneficiary was not submitted at the request of the beneficiary, the MAC shall verify the beneficiary's wishes with regard to the appeal (e.g., where more than one member of the beneficiary's family has submitted an appeal or is attempting to act as representative for the beneficiary but does not include an appointment instrument). In order to verify the wishes of the beneficiary, the MAC sends a letter to the beneficiary explaining the situation. The letter shall advise the beneficiary that a valid appointment instrument must be submitted within 30 calendar days in order to process the appeal. If no response is received within 30 calendar days, then the MAC does not conduct a redetermination. The MAC shall handle this as an inquiry.

B. Defective or Missing Appointment When a Provider or Physician, Other Supplier, or Nonbeneficiary is the Represented Party

1. Defective Appointment of Representative

In cases where the represented party is **not** a beneficiary, the MAC notifies both the individual attempting to be the representative and the party of the incomplete or defective appointment. The MAC explains why the appointment is defective, and describes the documentation or missing information that is required to complete the appointment. This may be done by telephone or written notification, and the

method, time and date of any notification shall be documented in the case file. A corrected/completed appointment may be submitted to the MAC by mail, or at the MAC's discretion by facsimile or (if available) secure Internet portal. The MAC allows 30 calendar days for the corrected appointment instrument to be submitted. Should the party fail to notify the MAC to proceed with the appeal without a representative, or the appointment instrument is **not** corrected within the time limit, the MAC **dismisses** the appeal request and sends a dismissal notice to the party (See §310.6.A.4).

2. **Missing Appointment of Representative**

If an individual is attempting to act as a representative of a party that is **not** the beneficiary and fails to include an appointment instrument with the appeal request, the individual lacks the authority to act on behalf of the party, and is not entitled to obtain or receive any information related to the appeal. The MAC shall notify the individual that no redetermination will be performed until a valid request is received from the party or a valid appointment instrument is resubmitted with the redetermination request. The MAC shall handle this as an inquiry (see §310.1.B.*5*).

C. Untimely Appeal Request Submitted With an Incomplete or Defective Appointment

If an untimely-filed appeal request is submitted with an incomplete or defective appointment instrument, the MAC first determines if good cause for late filing exists (See §240). If the MAC finds that good cause for late filing exists, it follows the instructions contained in §270.1.6, above, prior to proceeding with the appeal request. If the MAC does not find good cause to extend the filing time limit, it dismisses the redetermination request. See §310.6.3 and §310.6.A.3.

D. Untimely Appeal Request Submitted With a Missing Appointment

1. **Missing Appointment when the Beneficiary is the Party**

If an untimely-filed appeal request is submitted by an individual attempting to represent a beneficiary and the request does not include an appointment instrument, the MAC first determines if good cause for late filing exists (See §240). If the MAC finds that good cause for late filing exists, it follows the instructions contained in §270.1.6.A.2. prior to proceeding with the appeal request. If the MAC does not find good cause to extend the filing time limit, it dismisses the redetermination request. (See §310.6.3 and §310.6.A.3.)

2. **Missing Appointment When Provider or Physician, Other Supplier, or Nonbeneficiary is the Represented Party**

As explained in §270.1.6.B.2 above, if the individual lacks the authority to act on behalf of the party and is not entitled to obtain or receive any information related to the appeal, do not make a good cause determination; follow the instructions in §270.1.6.B.2. above.

310.1 - Filing a Request for Redetermination

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A request for redetermination must be filed with the contractor in writing. The request may be made by a party to the appeal as defined in §260 and/or the party's representative as defined in §270. Appeal requests submitted electronically via a facsimile or secure Internet portal/application shall be considered to have been received in writing.

NOTE: Contractors are not required to utilize a facsimile and/or a secure Internet portal/application for performing appeals activities. Contractors may not require an appellant to file an appeal electronically (e.g., via facsimile and/or a secure Internet portal/application). Submission of appeal requests via facsimile or a portal/application shall be at the discretion of the appellant. Contractors shall continue to accept appeal requests in hardcopy via mail.

A. Written Redetermination Requests Filed on Behalf of the Beneficiary

Someone other than an appointed representative may submit a written request for redetermination on behalf of a beneficiary. Persons who often act on behalf of a beneficiary in filing a redetermination request include: the spouse, parent, child, sibling, neighbor or friend. Beneficiary advocacy groups and Members of Congress may also submit a request for redetermination on behalf of a beneficiary (see §310.1.A.1 for further discussion on requests submitted by Members of Congress).

The contractor honors the request for redetermination if the request clearly shows the beneficiary knew of or approved the submission of the request for redetermination (e.g., the request is submitted with a written authorization from the beneficiary or with the beneficiary's MSN). However, if the contractor has information that the redetermination request was not submitted at the request of the beneficiary, the contractor does not conduct the redetermination unless and/or until it receives confirmation from the beneficiary that the request was submitted with the beneficiary's approval.

If a redetermination request is submitted by an individual who is not the beneficiary's appointed representative, all written notices related to the appeal are sent only to the beneficiary, not the individual making the request for redetermination. In addition, if the contractor honors a request for redetermination filed by someone other than the beneficiary or the beneficiary's appointed representative, the contractor should contact the beneficiary (or an appointed/authorized representative if applicable) if further information is needed to process the redetermination.

NOTE: An authorized representative is an individual authorized under State or other applicable law to act on behalf of a beneficiary in an appeal, and has all of the rights and responsibilities of a beneficiary with respect to the appeal. An authorized representative does not need to secure an appointment of representative from the beneficiary in order to file an appeal or obtain/receive information related to the appeal. See §270.1.1 for additional information regarding authorized representatives.

The person submitting the request does not automatically become the representative until and unless an appointment of representative form or other written statement is completed (see §270 for instructions on developing an incomplete or absent appointment of representative).

There will be circumstances where the mental and/or physical incapacity of the beneficiary becomes an issue. Based on all the documented medical information available, the contractor may decide to allow the person submitting the request for redetermination to act on behalf of a beneficiary who is mentally or physically incapacitated. The contractor's decision, as well as the beneficiary's incapacitation, should be documented in the file and supported by relevant medical documentation.

1. Requests for Redetermination Submitted by Members of Congress

When the contractor has honored a request for redetermination filed by a Member of Congress pursuant to a Congressional inquiry made on behalf of a beneficiary or provider, physician or other supplier, the contractor may continue to provide the Member of Congress with status information on the appeal at issue. Status information includes the progression of the appeal through the administrative appeals process, including information on whether or when an appeal determination or decision has been issued and what the decision was (e.g., favorable, unfavorable, partially favorable), but does not include release of personal information about a beneficiary that the Member of Congress did not already have in his/her possession. A beneficiary may want a Member of Congress to obtain more detailed information about his/her appeal without appointing the Member of Congress as a representative. In this case, it would be necessary for the beneficiary to sign a release of information. The contractor must accept any of the following as releases of information:

- A signed copy of correspondence from the beneficiary expressing a desire for the congressional office to obtain information on his/her behalf;

- A release of information form developed by the congressional office; or
- A release of information form developed by the contractor for this purpose.

If the Member of Congress expresses an interest in acting as the representative of a beneficiary or of a provider, physician, or other supplier, the party must complete an appointment of representative form or written statement.

B. What Constitutes a Request for Redetermination

1. Written Requests for Redetermination Made by Beneficiaries

Beneficiaries may request a redetermination by submitting a copy of their MSN, by filing a completed Form CMS-20027 or by submitting a letter that indicates dissatisfaction with a claim determination. As noted above, appeal requests received via a facsimile or secure Internet portal/application shall also be considered received in writing. Requests for redetermination may be submitted in situations where beneficiaries assume that they will receive a redetermination by questioning a payment detail of the determination or by sending additional information back with the MSN, but don't actually say: I want a review. For example, a written inquiry stating, "Why did you only pay $10.00?" is considered a request for redetermination. Common examples of phrasing in letters from beneficiaries that constitute requests for redetermination include, but are not limited to the following:

- "Please reconsider my claim."
- "I am not satisfied with the amount paid - please look at it again."
- "My neighbor got paid for the same kind of claim. My claim should be paid too."

The request may contain the word appeal or review. There may be instances in which the word review is used but where the clear intent of the request is for a status report. This should be considered an inquiry.

2. Written Requests for Redetermination Submitted by a State, Provider, Physician or Other Supplier

States, providers, physicians, or other suppliers with appeal rights must submit written requests via mail, facsimile or secure Internet portal/application (if the contractor chooses to receive requests via facsimile or CMS approved secure Internet portal/application) indicating what they are appealing and why. A redetermination request may be submitted using:

a. **A completed Form CMS-20027 constitutes a request for redetermination.** "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request. The form can be found on the CMS website at: http://www.cms.gov/cmsforms/downloads/cms20027.pdf

b. **A written request/letter.** At a minimum, the request must contain the following information:

1. Beneficiary name;
2. Medicare number;
3. The specific service(s) and/or item(s) for which the redetermination is being requested;
4. The specific date(s) of the service; and
5. The name of the party or the representative of the party.

Frequently, a party will write to a contractor concerning the initial determination instead of filing Form CMS-20027. How to handle such letters depends upon their content and/or wording. A letter serves as a

request for redetermination if it contains the information listed above and either: (1) explicitly asks the contractor to take further action, or (2) indicates dissatisfaction with the contractor's decision. The contractor counts the receipt and processing of the letter as an appeal only if it treats it as a request for redetermination.

NOTE: The details of its actions must be detailed (e.g., when action was taken and what was done) for possible subsequent evidentiary and administrative purposes.

c. **A secure Internet portal/application.** If a contractor has received CMS approval for the use of a secure Internet portal/application to support appeals activities, appellants may (but are not required to) submit redetermination requests via the secure Internet portal/application. Written requests submitted via the portal/application shall include the required elements for a valid appeal request as outlined above under §310.1.B.2.b.

NOTE: Some redetermination requests may contain attachments. For example, if the RA is attached to the redetermination request that does not contain the dates of service on the cover and the dates of service are highlighted or emphasized in some manner on the attached RA, this is an acceptable redetermination request.

Where the required information is not listed on the request form but is provided within the documents or attachments submitted with the appeal, the request substantially complies with the requirements established in 42 CFR 405.944. MACs shall not dismiss requests under 42 CFR 405.952(b)(2) when redeterminations substantially comply with requirements.

3. How to Handle Incomplete Requests for Redetermination:

If any of the above information referenced in Section 2 is not included with an appeal request submitted by a party or their representative (other than a beneficiary, or a beneficiary's representative), the request is considered incomplete and the contractor issues a dismissal notice with an explanation of the information that must be included (see §310.6 for more information on dismissals). Contractors should not consider beneficiary requests as incomplete, whether filed by the beneficiary or by their representative. Contractors must contact beneficiaries (or their representatives), when necessary, to obtain missing information needed to process the redetermination.

4. How to Handle Multiple Requests for Redetermination for the Same Item/Service:

a. Duplicate requests (multiple requests from same party) while an appeal is pending. If an appeal for an item or service is pending and the appellant submits a duplicate request for redetermination, the contractor combines the requests into one redetermination. The contractor shall include verbiage indicating that duplicate requests for redetermination had been received (on what dates and via what venues, if multiple venues were utilized). Adjudication time frames are still based on the first request for redetermination. NOTE: See 310.4.D.4 for extending adjudication timeframes if additional information is submitted with the second appeal request.

If the contractor identifies a pattern in which an appellant or groups of appellants are repeatedly submitting duplicate requests for redetermination, the contractor shall take additional steps to educate the appellant regarding the appeals process.

b. Multiple requests from different parties while an appeal is pending. If an appeal for an item or service is pending and another party to the redetermination submits a request for redetermination, the contractor shall combine the redetermination requests and issue a decision within 60 days of the latest filed request, in accordance with 42 CFR 405.944(c).

When issuing the decision or dismissal notice, the contractor shall include verbiage indicating that requests for redetermination had been received from multiple parties (on what dates and via what

venues, if multiple venues were utilized) so that it is clear to the parties that the decision or dismissal was issued timely in accordance with [42 CFR 405.950(b)(2).]

c. Duplicate or multiple requests when an appeal is complete. If a decision or dismissal notice has been issued (including an MSN or RA for a fully favorable decision), and the contractor receives an additional request for redetermination for that item/service (a duplicate request from the appellant or a subsequent request from a different party), the contractor shall treat the additional request as an inquiry. The contractor directs the party to file a request for reconsideration with the appropriate QIC.

d. Workload -Whenever the contractor combines duplicate or multiple requests for redetermination as explained above, the contractor shall ensure that the workload reporting reflects one redetermination receipt and one redetermination completed.

NOTE: If a party files a request for reconsideration with the contractor after a redetermination decision or dismissal notice has been issued, the contractor treats the reconsideration request as misfiled and forwards the request to the QIC for a reconsideration in accordance with §320.1.B.

Contractors **shall not** issue a dismissal notice in response to a duplicate request or multiple requests for redetermination.

NOTE: In accordance with IOM 100-04, chapter 29, section 310.6.3, if an appellant requests that the contractor vacate its dismissal action, or an appellant refiles a corrected appeal in response to a dismissal, and the contractor determines that it cannot vacate the dismissal, then it sends a letter notifying the appellant accordingly. If evidence or information not previously submitted with the redetermination request is submitted with the request to vacate the dismissal, the letter must specifically address that new evidence or information. The contractor shall not issue a second dismissal notice to the appellant.

5. Letters and Calls That Are Considered Inquiries

See IOM 100-09, Medicare Contractor Beneficiary and Provider Communications Manual. The contractor considers the letter or telephone call an inquiry (i.e., not an appeal request) if:

- It is clearly limited to a request for an explanation of how Medicare calculated payment. (For example, if a physician sends a letter inquiring about the payment rate for a particular item or service, but it is not in connection with a claim that has been processed for the item or service, the letter is treated as an inquiry. However, if the physician questions the amount paid for an item or service on a claim that was processed to payment, and asserts additional payment is warranted, the contractor handles this as an appeal of the payment amount, even if the item/service was paid under a fee schedule. See §200.C.3);

- The party is only asking for the status on a previously submitted appeal request or correspondence. The contractor states in its reply that is responding to a status request. It does not use the word "review" in its reply;

- It is a request for information;

- It is a request for redetermination, made by a party other than the appellant, for the same item/service for which a decision or dismissal notice has already been issued. In responding to the inquiry, the contractor shall inform the party making the request that a decision has been issued and the party should file a reconsideration with the appropriate QIC. Contractors shall not issue a dismissal notice.

- It is a request for redetermination, submitted by an individual (who is not an appointed or authorized representative), filed on behalf of a provider, physician, supplier, or other non-

beneficiary party, and the request does not include an appointment instrument (see §270.1.6.B.2). The contractor follows the procedures in §270.1.6.B.2.

- The party asks only for a second copy of a notice.

NOTE:

- If the contractor receives a 'request for reconsideration' (assuming the appellant is using the wrong form or incorrect terminology), but determines that a redetermination has not been conducted, the contractor does not forward the request to the QIC. The contractor shall consider the request as a redetermination request.

- If the contractor receives a 'request for reconsideration' from a party, or a 'request for reconsideration' that was mistakenly directed to them by another contractor, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file within 60 calendar days of receipt in the corporate mailroom. Refer to §320.1.

Parties to a claim must file a request for redetermination with the proper contractor based on the claims processing jurisdiction rules established by the Medicare program. Jurisdiction is established based on either the State where the service was provided (for Part B claims **not** involving DME), the State where the beneficiary resides (for Part B DME claims only), or the location of the A/B MAC (for Part A provider claims). There may be instances where requests for redetermination are directed to the wrong contractor. Contractors shall have standard operational procedures, including maintaining a record of these cases, in place to ensure that misfiled requests are forwarded to the proper contractor jurisdiction within 60 calendar days of receipt.

Refer to § 310.4.A for information on determining whether misfiled requests for appeal are processed in a timely manner.

310.6.1 - Dismissal Letters

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The MAC shall issue in writing and/or otherwise transmit, as noted above, a notice of dismissal to all parties to the appeal. The dismissal notice includes the reason for the dismissal. The dismissal notice must inform parties that they may (1) request the MAC to vacate the dismissal, and (2) may request a QIC reconsideration of the dismissal. The dismissal notice is sent to the party requesting the redetermination at his/her last known address, and/or otherwise transmitted as noted above, as well as to his/her representative and all other parties to the appeal. MACs who utilize an approved CMS secure Internet portal/application to receive and process appeals may provide electronic dismissal notices, if the appeal request was received via a secure portal/application. MACs shall ensure that a hard copy dismissal notice is sent to other parties to the appeal who do not have access to the secure Internet portal/application. See §310.10 for additional requirements related to notices sent via secure portal/ applications.

MACs shall include the following language, or something similar, in dismissal letters (also see the model dismissal letters in Exhibits 2&3):

If you disagree with this dismissal, you have two options:

1. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate good and sufficient cause for <insert reason for dismissal>. Your request to vacate this dismissal must be received at our office within **6 months** of the date of receipt of this notice at the address noted above.

2. If you think we have incorrectly dismissed your request (for example, you believe <insert reason (e.g., you did file your request on time, you were a proper party, the MAC did issue an initial determination on the claim)>), you may request a reconsideration of the dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. The QIC will not consider any evidence for establishing coverage of the claims(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:

   Insert QIC Address

Incomplete Requests - The requirements for written requests for redetermination are found in §310.1.B.2.

NOTE: Beneficiary requests should not be considered incomplete, see §310.1.B.1 and §310.1.B.*3*.

MACs must handle and count incomplete redetermination requests as dismissals. If a party submits an incomplete request for redetermination and the MAC issues a dismissal notice, the party may request the dismissal be vacated, the party may appeal the dismissal, or the party may refile their request if any time remains in the filing period (i.e., 120 days from receipt of the initial determination). When a request is refiled that meets the requirements, the previous dismissal is vacated and reopened. MACs must notify parties of their options in the dismissal notice. Please see the model dismissal notice for an incomplete request in §310.6.2.

310.6.2 - Model Dismissal Notices

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

NOTE: This is a model letter and may need to be adjusted to include additional verbiage/instructions if a MAC has received approval to receive appeal requests via a secure Internet portal/application.

(Start) EXHIBIT 2:

Model Redetermination Dismissal Notice For Incomplete or Invalid Request

MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF BENEFICIARY:

CONTACT INFORMATION:
If you have questions, write or call:
MAC Name
Address
City, State Zip
Telephone number

RE: <Include claim identifier or appeal number>

Dear <Appellant's Name>:
This letter is in response to your appeal request (also known as a redetermination) that was received in our office on <INSERT DATE>. The redetermination was requested for the following dates of service <INSERT DATE(S)>). Your redetermination request has been dismissed because it did not form a valid request for redetermination. In order to process a redetermination request, we need the following item(s) to be addressed:

<INSERT ALL APPLICABLE INFORMATION>:

Missing Information:

- The beneficiary's name;
- The Medicare number of the beneficiary;
- The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service;
- The name of the person filing the redetermination request.

Invalid Request:

- The requestor is not a proper party;
- Defective Appointment of Representation (AOR) <for non-beneficiary submitted claims only>;
- No initial determination on the claim(s) appealed; or
- Beneficiary is deceased with no remaining party or appointed representative with financial interest.

Your request was determined to be invalid as explained above and therefore has been dismissed. You may file your request again if it has been 120 days or less since the date of receipt of the initial determination notice. When you file your request, please make sure you have addressed all of the above listed items and send your request to our office at the address noted above.

If you disagree with this dismissal, you have two additional options:

1. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate that you have good and sufficient cause for failing to submit a valid request. Your request to vacate this dismissal must be received at the address above within 6 months of the date of receipt this notice.

2. If you think we have incorrectly dismissed your request (that is, you believe you did address all of the above listed items in your request), you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address

below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. The QIC will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:

<INSERT QIC ADDRESS>

Sincerely.

NAME, TITLE
MAC NAME

(End) EXHIBIT 2

(Start) EXHIBIT 3:

Model Redetermination Dismissal Notice For An Untimely Appeal

MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF BENEFICIARY:

CONTACT INFORMATION:
If you have questions, write or call:
MAC Name
Address
City, State Zip
Telephone number

RE: <Include claim identifier or appeal number>

Dear <Appellant's Name>:

This letter is in response to your appeal request (also known as a redetermination) that was received in our office on <INSERT DATE>. The redetermination was requested for dates of service <INSERT DATE(S)>. The initial determination for the items/services in dispute was issued on <INSERT DATE OF RA/MSN>.

Your redetermination request has been dismissed because the date(s) of service in question is/are past the time limit to file a request for a redetermination. A redetermination request must be received in our office within 120 days of the date of receipt of the initial determination date on the Medicare Remittance Advice or the Medicare Summary Notice. The date of receipt of the initial determination is presumed to be 5 days after the date of the notice unless there is evidence to the contrary.

When we receive a request that has been filed late, we consider whether the appellant had good cause for filing late. In special circumstances, we may allow additional time to file. In this case, we did not find good cause for filing your request late.

If you disagree with this dismissal, you have two options:

1. You may request that we vacate our dismissal. We will vacate our dismissal if you demonstrate good and sufficient cause for filing late. Your request to vacate this dismissal must be received at the address above within 6 months of the date of receipt of this notice.

2. If you think we have incorrectly dismissed your request (for example, you believe you did file your request on time), you may request a reconsideration of this dismissal by a Qualified Independent Contractor (QIC). Your request must be received by the QIC at the address below within 60 days of receipt of this letter. In your request, please explain why you believe the dismissal was incorrect. Please note that the QIC will not consider any evidence for establishing coverage of the claim(s) being appealed. Their examination will be limited to whether or not the dismissal was appropriate. Please send your request to:

<INSERT QIC ADDRESS>

Sincerely.

NAME, TITLE

MAC NAME

(End) Exhibit 3

310.6.3 – Processing Requests to Vacate Dismissals

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

If a party submits a request to vacate the dismissal, and the request contains sufficient evidence or other documentation that supports a finding of good cause for late filing, the MAC makes a favorable good cause determination. Where a finding for good cause is made, the MAC shall document the reason for that finding in the appeal decision letter, the appeal case file, or both. Once it makes a favorable good cause determination, it considers the appeal to be timely filed, vacates its prior dismissal action, and performs a redetermination. For the purposes of counting workload in CROWD and in the MAS, a determination to vacate a dismissal should be counted as a redetermination and not a reopening.

If the MAC does not find good cause to vacate the dismissal, the dismissal remains in effect. The MAC issues a letter (not a dismissal letter) explaining that good cause has not been established and the dismissal cannot be vacated. Although the appellant may not appeal a MAC's finding that good cause was not established when the appellant requested that the MAC vacate its dismissal, the appellant maintains their right to request a QIC review of the MAC's dismissal action. However, requests for QIC review of a MAC's dismissal action must be received by the QIC within 60 days of the date of receipt of the dismissal notice. For purposes of counting workload in CROWD and in the MAS, a MAC's determination not to vacate a dismissal action is counted as an inquiry, not as a dismissal action.

If an appellant requests that the MAC vacate the dismissal action, and the MAC determines that that it cannot vacate the dismissal, the MAC sends a letter notifying the appellant. The MAC shall not issue a second dismissal notice to the appellant since a dismissal should only be issued in response to an appeal request. A request to vacate a dismissal is not a request for an appeal.

If the contractor determines that the request to vacate the dismissal of the redetermination request does not provide good and sufficient cause to vacate, the contractor shall respond with a letter that addresses why the request to vacate does not meet the criteria for good cause. Any evidence or information not previously submitted with the redetermination request that is submitted with the request to vacate the dismissal shall be addressed by the contractor in their letter. The contractor must explain in clear language why all evidence and information submitted, including what was sent with the request to vacate the dismissal, does not meet the requirement necessary to vacate the dismissal.

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

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The contractor uses the following Medicare Redetermination Notice (MRN) format or something similar and standard language paragraphs whether the redetermination notice is delivered via hard copy mail or via a CMS-approved portal/application.

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. Contractors must also include reference within all appropriate sections of the appeal decision letter that in instances where services are covered (for example, a partially favorable decision is rendered), the beneficiary may also be responsible for any copayments, coinsurance, or deductibles related to the covered portion of the service or item that is payable.

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 contractor to request the case file from.

A. Redetermination Letter

The redetermination letterhead must follow the instructions issued by CMS for contractor written correspondence requirements (see §290), unless otherwise instructed and/or agreed to by CMS.

(Start)
EXHIBIT 4:

Model Redetermination Notice

MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

INFORMATION:

or

MEDICARE NUMBER OF BENEFICIARY:

CONTACT

If you have questions, write

call:
Contractor Name
Address
City, State Zip
Telephone number

RE: <Include claim identifier or appeal number>

MEDICARE APPEAL DECISION

<If the appellant is a provider or supplier, in the beneficiary's letter, contractors must include language to indicate the beneficiary is receiving a copy of the decision. For example, "This is a copy of the letter sent to <your provider> <your physician> <your supplier> <the party who requested this appeal>" or, "Please note that if you did not request this appeal, you are receiving this letter as a copy.">

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: description of item or service>.

The appeal decision is <Insert either: unfavorable. Medicare does not cover the item/service at issue in your appeal OR partially favorable. Medicare covers part of the claim(s) at issue in your appeal.>

<Note: If the issue in the appeal is strictly a payment dispute, the language should read, for unfavorable decisions: “Medicare cannot make payment for the item/service at issue in your appeal” and for partially favorable decisions: “Medicare can make partial payment for the item/service at issue in your appeal.”>

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor (QIC). Your appeal of this decision must be made in writing and received by the QIC within 180 days of receipt of this letter. You are presumed to have received this decision five days from the date of the letter unless there is evidence to show otherwise. 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 this decision, see the section at the end 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: Contractors 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 specific items/services) are not covered by Medicare. We have also determined that (the provider) (the supplier) (the beneficiary) is responsible for the cost of the item(s)/service(s).">

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 the coverage policy (LCD,

NCD), regulations, policy guidance (IOM provisions), and/or laws used to make this determination. Make sure the rationale for the decision is clear and that it includes an explanation of why the claim can or cannot be paid for the particular set of facts at issue in the appeal. For example, the explanation should demonstrate how the beneficiary's condition or circumstances do not meet specific coverage policy requirements. 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: 1. Include, as applicable, information on limitation on liability under §1879 of the Act, physician refund requirements for non-assigned claims under §1842(l) of the Act, DMEPOS supplier refund requirements under §§1834 and 1879(h) of the Act, financial responsibility for benefit category denials (statutory exclusions), and waiver of overpayment recovery under §1870 of the Act.

For example, if the denial reason triggers a liability determination under §1879 of the Act, include the following model paragraphs:

"After determining that the item or service will not be covered by Medicare, we must determine who is financially liable for the denied item or service. When an item or service is denied under §1862(a)(1), §1862(a)(9), or §1879(g) of the Social Security Act (the Act), we must determine if the beneficiary and the provider or supplier either knew or could reasonably be expected to know that the item or service would not be covered. This is known as the limitation on liability provision of §1879 of the Act.

If the beneficiary was informed by their provider or supplier in writing in advance of receiving the item/service that Medicare may not make payment (through receipt of an Advance Beneficiary Notice of Noncoverage (ABN)), the beneficiary may be responsible for the cost of the denied item or service. If the provider or supplier knew or could reasonably be expected to know the item or service would not be covered, but the beneficiary did not have such knowledge, then the provider or supplier may be responsible for the cost of the denied item or service."

2. Include, as applicable, a statement regarding beneficiary knowledge of non-coverage and a statement regarding provider/supplier knowledge of non-coverage when liability under §1879 of the Act is at issue. If the provisions of §1879 of the Act do not apply to the coverage denial, then do not include a discussion of §1879 in the redetermination letter. For additional information regarding the application of §1879, see IOM 100-04, Ch. 30, §§10-30.

Beneficiary model paragraphs for §1879 analysis –

(Beneficiary Option 1) "We have determined that the beneficiary either knew or could reasonably be expected to know that the service/item would not be covered because

[insert reason for determining that the beneficiary knew or could have been expected to know the item/service would not be covered; typically this is established when the provider/supplier delivers a validly executed ABN]."

(Beneficiary Option 2) "There is no evidence to indicate that the (provider) (supplier) notified the beneficiary in advance that the item/service would not be covered by Medicare. Therefore, we have determined that the beneficiary did not know and could not reasonably have been expected to know that the item/service would not be covered."

Provider/Supplier model paragraphs for §1879 analysis –

(Provider/supplier Option 1) "In addition, we have determined that the (provider) (supplier) either knew or could reasonably be expected to know that the service/item would not be covered. [Explain the basis for determining that the provider/supplier knew or should have known the item/service would not be covered]

(Provider/supplier Option 2) "We have determined that the (provider) (supplier) did not know and could not reasonably have been expected to know that the item/service would not be covered.

3. Include a summary paragraph to explain the liability of the parties to the appeal. Model summary paragraph for appeals where liability under §1879 is at issue –

"Since the (beneficiary) (provider) (supplier) has been determined to have had knowledge of the non-covered item/service, the (beneficiary) (provider) (supplier) is liable for the cost of the denied item/service. (The (provider or supplier) (may)(may not) bill the beneficiary for the cost of the denied item/service, and must refund any monies collected from the beneficiary.)"

4. As noted above, the contractor shall (1) explain the basis for their determination of knowledge when making a determination of liability under §1879 of the Act, and (2) state who is responsible for the bill. For example, a regulation, a CMS or contractor publication, or specific policy posted on the contractor's website, etc. may establish knowledge of non-coverage. See IOM 100-04, Chapter 30, §40, et seq. for additional information. If the provider or supplier is held liable under §1879 of the Act for the cost of the item/service, they may not collect from or bill the beneficiary for the cost of the item/service. The provider or supplier must refund any money collected for the item/service, including any coinsurance or deductible.

5. If neither the beneficiary, nor the provider or supplier knew or could reasonably have been expected to know that the item/service would not be covered, then Medicare makes payment for the item/service under §1879 of the Act.

6. If there is evidence to indicate that the beneficiary may have paid in advance for the items/services (e.g., the claim was billed with a GA modifier indicating an ABN was given to the beneficiary), or paid the applicable deductible or coinsurance amounts, and

the provider/supplier is subsequently held liable under §1879 of the Act for the denied items/services, the contractor shall include a statement explaining the provider/supplier's obligation to refund any payments made by the beneficiary, including payment of any deductible or coinsurance. See §310.5.B. See also, 42 CFR 411.402; IOM 100-04, Chapter 30, §30.1.2, §30.2.2, and §100, et seq. for information regarding indemnification procedures and IOM 100-04, Chapter, 30, §§10-40 and 110-150 for more information on liability protections and refund requirements.

7. If the basis for denial does not trigger the limitation on liability provisions of §1879 of the Act, the contractor explains the reason for the denial and includes the following, or similar language:

Since the item/service is (not a covered benefit under Medicare) (excluded from coverage under Medicare), we cannot make payment. The (provider) (supplier) may bill the beneficiary for the denied item/service.

8. Example of a complete financial responsibility section when a supplier is determined to be liable under §1879:

After determining that the item or service will not be covered by Medicare, we must determine who is financially liable for the denied item or service. When an item or service is denied under §1862(a)(1), §1862(a)(9), or §1879(g) of the Social Security Act (the Act), we must determine if the beneficiary and the provider or supplier either knew or could reasonably be expected to know that the item or service would not be covered. This is known as the limitation on liability provision of §1879 of the Act.

If the beneficiary was informed by their provider or supplier in writing in advance of receiving the item/service that Medicare may not make payment (through receipt of an Advance Beneficiary Notice of Noncoverage), the beneficiary may be responsible for the cost of the denied item or service. If the provider or supplier knew or could reasonably be expected to know the item or service would not be covered, but the beneficiary did not have such knowledge, then the provider or supplier may be responsible for the cost of the denied item or service.

There is no evidence to indicate that the supplier notified the beneficiary in advance that the item/service would not be covered by Medicare. Therefore, we have determined that the beneficiary did not know and could not reasonably have been expected to know that the item/service would not be covered.

In addition, we have determined that the supplier either knew or could reasonably be expected to know that the service/item would not be covered by Medicare. Based on the coverage limitations explained in the contractor's Local Coverage Determination (LCD), L11518 (Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea), the supplier knew or should have known the item provided would not be covered.

Since the supplier has been determined to have had knowledge of the non-covered item/service, the supplier is liable for the cost of the denied item/service. The supplier may not bill the beneficiary for the cost of the denied item/service, and must refund any monies collected from the beneficiary.>

WHAT TO INCLUDE IN YOUR REQUEST FOR A RECONSIDERATION OF THIS APPEAL

<Instructions: If the denial was based on insufficient documentation or if specific types of documentation are necessary to issue a favorable decision 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 **decision** 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 the Medicare Appeals Council 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 as indicated in this section should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration **decision** 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 the Medicare Appeals Council 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,

NAME, TITLE

CONTRACTOR NAME

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 qualified independent contractor (QIC), separate and independent of (insert: contractor name).

How to Appeal: To exercise your right to an appeal, you must file a request in writing. Your request must be received by the QIC at the address below within 180 days of receiving this decision. You are presumed to have received this decision five days after the date of the letter unless there is evidence to show otherwise. If you are unable to file your appeal request timely, please explain why you could not meet the filing deadline. 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, 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 Reconsideration 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, 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.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf 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 beneficiary, 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 CMS 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 <alternatively, if using the same address at top of page one of letter, refer to that address rather than repeat the address here> and attach a copy of this letter:

Contractor Name,

A Medicare Contractor

Address

City, State Zip

Resources for Medicare Beneficiaries: 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 website, 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		Redetermination/ Appeals Number: XXXXXX

Reconsideration Request Form

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: ______________________________

____

5a. Telephone Number of the Person Appealing: ______________________________
5b. Email 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

*Please include a copy of the demand letter (if applicable) with your request.

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. Date: ______________

Contractor Number ______________ (Contractor number is optional for contractors with only one location for QICs to request case files)

(End) EXHIBIT 4

310.8 - Medicare Redetermination Notice (for Fully Favorable Redeterminations)

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

NOTE: This activity is NOT required until further notice, unless otherwise specified in the MAC's statement of work, except in those situations when the parties will not receive notice of effectuation via a MSN or RA (MSP overpayments, non-MSP overpayments which do not result in a refund or payment, etc.). MACs will also have to modify the language to ensure that the letter appropriately addresses the MSP overpayment or non-overpayment situations.

The MAC uses the redetermination format below, (or something similar) and standard language paragraphs whether the redetermination notice is delivered via hard copy mail or via a CMS-approved portal/application. The MAC must ensure that the information identified in each section of the model letter below is included and addressed, as needed, in the MRN.

(Start)
EXHIBIT 5:

Model Fully Favorable Redetermination Notice Coverage Decision

MONTH, DATE, YEAR

APPELLANT NAME
ADDRESS
CITY, STATE ZIP

MEDICARE NUMBER OF BENEFICIARY:

CONTACT INFORMATION:

If you have questions, write or call:
MAC Name

Address

City, State Zip

Telephone number

MEDICARE APPEAL DECISION

RE: <Include claim identifier or appeal number>

Dear <Appellant's Name>:

This letter is to inform you of the decision on your Medicare appeal. This appeal decision is **fully favorable to you**. Our decision is that your claim is covered by Medicare. More information on this decision, including the amount Medicare will pay, will follow in a future Remittance Advice or Medicare Summary Notice.

For information about filing a request for redetermination, please visit www.medicare.gov/appeals or http://www.cms.gov/OrgMedFFSAppeals/. Medicare beneficiaries may 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).

Sincerely,

NAME, TITLE

MAC NAME

(End) Exhibit 5

310.9 - Effect of the Redetermination

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

In accordance with section 1869(a)(3)(D) of the Act, once a redetermination is issued, it becomes part of the initial determination. The redetermination is binding upon all parties unless a reconsideration is completed or the redetermination is revised as a result of a reopening.

310.10 - System and Processing Requirements for Use of Secure Internet Portal/Application to Support Appeals Activities

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

MACs who develop and utilize a secure Internet portal/application for appeals purposes shall ensure, at a minimum:

- CMS approves (i.e., contract manager or project officer, if applicable) the proposed portal/application and usage prior to development and implementation.

- The portal/application fully complies with and has been tested to ensure compliance with all CMS system security requirements regarding protected health information prior to implementation/usage.

- The secure Internet portal/application includes a formal registration process that validates *the identity of appellants using the portal*. This process shall include, at a minimum, use of restricted user identities and passwords. A/B MACs (A), (B), (HHH), and DME MACs shall include an indication and/or description of the validation methodology in the appeals case file should a higher level of appeal be submitted.

- Templates for submission of electronic appeal requests shall include, at a minimum, a method for authenticating that the appellant has completed the portal/application registration process and has been properly identified by the system as an appropriate user.

- All MACs utilizing an approved portal/application shall provide education to appellants regarding system capabilities/limitations prior to implementation and utilization of the secure portal/application.

- MACs shall also educate appellants that participation/enrollment in the secure portal/application is at the discretion of the appellant and the appellant bears the responsibility for the authenticity of the information being attested to.

- Appropriate procedures are in place to provide appellants with confirmation of receipt of the appeal request via secure Internet/portal and verbiage instructing the appellant not to submit additional redetermination requests for the same item or service via different venue (hard copy mail or facsimile). This information is necessary to discourage appellants from submitting multiple appeal requests for

the same item/service through the same or multiple venues (i.e., filed via secure Internet portal/application and at a later date via mail).

- MACs utilizing a secure portal/application shall ensure that there is a process in place by which an appellant can submit additional documentation/materials concurrent with the appeal request so as not to cause a delay in the timely processing of the appeal. The portal/application shall have the capability to accept additional documentation and/or other materials to support appeal requests.

- Redetermination decisions and/or dismissal notices transmitted via a secure Internet portal/application shall comply with the timeliness and content requirements as outlined in the IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 29, unless otherwise noted above. In addition, MACs shall provide hard copy decision and/or dismissal notices to parties to the appeal who do not have access to the secure Internet portal/application. The notices must be mailed and/or otherwise transmitted concurrently (i.e., mailed on the same day the notice is transmitted via the secure portal/application).

- MACs shall also ensure that appellants may save and print the decision or dismissal notice and that the secure portal/application includes a mechanism by which the date/time of the notification is tracked/marked both in the system and on any printed decision or dismissal notices so as to adequately inform the appellant of timeframes for ensuring timely submission of future appeal requests.

- If the MAC receives a request for a case file from the QIC, the MAC shall provide the complete case file including a decision or dismissal notice regardless of whether the appeal was processed via a secure Internet portal/application.

310.11 - Effectuation of the Redetermination Decision

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

All MACs are responsible for effectuating redetermination decisions. Effectuation means for the MAC to adjust the claim and issue a payment or to change liability. If the redetermination decision is fully or partially favorable to the appellant and gives a specific amount to be paid, the MAC effectuates within 30 calendar days of the date of the redetermination decision.
If the decision is fully or partially favorable, but the payment amount must be computed or recomputed, the MAC effectuates the decision within 30 days after the payment amount is determined. The payment amount must be computed as soon as possible, but no later than 30 calendar days after the date of the redetermination decision.

310.12 - QIC Remands

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

All MACs shall take appropriate action on review and resolve QIC remands within 60 calendar days of receipt of the remand order from the QIC.

320 - Reconsideration - The Second Level of Appeal

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Section 1869 of the Act entitles any individual dissatisfied with the A/B MAC (A)'s, (B)'s, (HHH)'s, or DME MAC's redetermination to file a request, within 180 days of receipt of the redetermination, for a reconsideration. In accordance with §1869(c), reconsiderations are to be processed within 60 days by entities called qualified independent contractors (QICs). CMS is required to contract with no fewer than four QICs. When a claim is denied on the basis of §1862(a)(1)(A) of the Act, the QIC reconsideration will consist of a panel of physicians and other health professionals. When the panel reviews services or items rendered by a physician or ordered by a physician, the panel will consist of at least one physician.

320.1 - Filing a Request for a Reconsideration

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The request for a reconsideration made by a beneficiary, provider, supplier, or State must be filed with the QIC specified in the redetermination notice. A request from a provider, supplier, or State must be made in writing either on the Form CMS-20033 (the reconsideration request form included with the redetermination), or must contain the following items:

- The beneficiary's name;
- Medicare number;
- The specific service(s) and item(s) for which the reconsideration is requested and the specific date(s) of service;
- The name of the party or representative of the party filing the request; and
- The name of the contractor that made the redetermination.

A request from a beneficiary must be made in writing either on a standard CMS form or another written format indicating dissatisfaction with the redetermination. Requests for reconsideration may be submitted in situations where beneficiaries assume that they will receive a reconsideration by questioning a payment detail of the determination or by sending additional information back with the MSN or MRN, but don't actually say: I want a reconsideration. For example, a written inquiry stating, "Why did you only pay $10.00?" is considered a request for reconsideration. Common examples of phrasing in letters from beneficiaries that constitute requests for reconsideration:

- "Please reconsider my claim."
- "I am not satisfied with the amount paid - please look at it again."
- "My neighbor got paid for the same kind of claim. My claim should be paid too."

The beneficiary's request may contain the word appeal or review. There may be instances in which the word review is used but where the clear intent of the request is for a status report. This should be considered an inquiry.

A. Request for Reconsideration (Form CMS-20033)

The CMS provides a form for filing a request for reconsideration for the convenience of appellants, but appellants are not required to use this form. The form is available on the CMS.gov website at: http://www.cms.gov/Medicare/CMS-Forms/CMS- Forms/Downloads/CMS20033.pdf.

B. Requests Submitted to the Wrong Contractor

Parties must request a reconsideration at the QIC with jurisdiction. Contractors with multiple States may have multiple QICs handling requests and, therefore, must make certain to refer the appellant to the correct QIC. The jurisdiction for all Part A QIC appeals is dependent upon the State where the service or item was rendered. The jurisdiction for all DME and Part B QIC appeals is dependent upon the State where the beneficiary resides. See §320.7 for the specific QIC jurisdictions.

There may be instances where requests for QIC reconsiderations are misfiled with a contractor. Contractors shall have standard operating procedures to ensure that misfiled requests are identified and sent/transmitted to the proper location. If the contractor receives a 'request for reconsideration' from a party, or a 'request for reconsideration' mistakenly directed to them by another contractor, and the contractor has already conducted a redetermination, the contractor shall forward the request to the appropriate QIC, along with the case file(s), within 60 calendar days of receipt in the corporate mailroom. The case file must be sent either by an electronic means agreed upon in the JOAs or by a courier service so that the case file is received by the QIC before or on the 61st calendar day after the receipt. Contractors shall track all misfiled reconsideration requests to ensure receipt at the proper QIC. The QIC will send the MAC or DME MAC an acknowledgement of receipt of any misfiled requests. Contractors shall not count such misfiled requests as dismissals. The contractor counts the costs associated with misfiled requests in the CAFM line designated for preparing/transferring case files to the QIC. To aid in preventing misfiled requests for QIC reconsiderations, contractors shall employ provider education efforts with an emphasis on filing locations, as well as the dates for workload transitions when a MAC jurisdiction is transferred from one contractor to the next at the close of a contract's period of performance.

NOTE: If the contractor receives a 'request for reconsideration' (assuming the appellant is using the wrong form or terminology), but determines that a redetermination has not been conducted, the contractor does not forward the request to the QIC. The contractor shall conduct a redetermination.

320.2 - Time Limit for Filing a Request for a Reconsideration

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A party must file a request for reconsideration within 180 days of the date of receipt of the notice of the redetermination. The date of filing for requests filed in writing is defined as the date received by the QIC in their corporate mailroom. If the party has filed the request in person with the QIC, the filing date is the date of filing at such office, as evidenced by the receiving office's date stamp on

the request. If the party has mailed the request for reconsideration to a CMS, SSA, RRB office, or another government agency in good faith within the time limit, and the request did not reach the appropriate QIC until after the time period to file a request expired, the QIC considers the request as timely filed. Likewise, if the request is filed with CMS, SSA, RRB, or another government agency in person, the QIC considers the request as timely filed.

The QIC may extend the period for filing if it finds the appellant had good cause for not requesting the reconsideration timely. (See §240 for a discussion of good cause.)

320.3 - MAC Responsibilities - General

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

The contractor's responsibilities for reconsiderations are:

1. Preparing and forwarding case files upon request from a QIC in accordance with §§320.4, 320.5, 320.6 and the JOA;

2. Effectuating reconsiderations when notified by the QIC of a favorable decision or unfavorable decision with a change in liability in accordance with § 320.8 and notifying the QIC of receipt of effectuation information;

3. Preparing case files and forward misfiled reconsideration requests in accordance with § 320.1(B); and

4. Entering into JOAs with the appropriate QIC(s) and Administrative QIC (AdQIC); Complying with the appropriate JOAs.

320.4 - QIC Case File Development

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

When the QIC receives a request for reconsideration, it will request the case file from the MAC with jurisdiction using the Redetermination Case File Request Form. The QIC will send the request either by email, telephone, fax, or by any other method agreed upon in the JOAs. (Note: Individually identifiable beneficiary information should not be given in an unsecure email.) If another method is agreed upon in the JOAs, it must meet the privacy requirements of HIPAA.

If agreed upon in the JOAs, the following requirements apply to email, fax and phone requests:

(a) Email requests - MACs shall maintain an email account specifically for the receipt of case file requests from the QIC. If individually identifiable information is given in the request or response, a secure email account must be used. MACs must check this email account at least once daily (every business day). When MACs receive email requests from the QIC, they shall notify the QIC of receipt.

(b) Phone Requests - MACs shall designate and maintain a phone extension specifically for the receipt of case file requests from the QIC. MACs shall designate a main contact person

and back-up contact that is available to take phone calls during core business hours on all business days (unless otherwise agreed upon in the JOAs).

(c) Fax Requests - MACs shall designate and maintain a fax machine for the receipt of case file requests from the QIC.

320.5 - QIC Case File Preparation

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Once a party requests a reconsideration with a QIC, the QIC will need to obtain the case file from the MAC that issued the redetermination decision. The foundation for an effective, efficient and accurate appeals system is the case file. It is essential that the case file contain all relevant information and evidence concerning an appeal in an organized manner so that the QIC can make a correct and fair determination. The MAC prepares the case file by separating procedural documents and medical documents and builds the case file from the bottom up, with the oldest set of documents on the bottom, and the most recent set of documents at the top. However, it does not place the medical documentation on the bottom. Medical documentation does not need to be ordered chronologically, but rather can be included in the case file as submitted by the provider.

For large cases containing multiple beneficiary files, the MAC shall organize the case files by individual beneficiary files in alphabetical order. **A packing list will be included for multiple beneficiary box cases and labeled as "box number x of y."**

As the MACs begin utilizing the MAS for processing redeterminations (timeframe by jurisdiction TBD), the MACs shall work to update their JOAs with QICs to include language indicating that the appeals case file will be obtained via electronic promotion of the level one appeal record within the MAS. The MAC QIC JOAs shall include language to address situations in which the MAS is down or otherwise unavailable for short term and/or long term periods of time. In addition, the JOA shall include language to address processes and procedures for providing case files that are not in the MAS due to the redetermination having been processed prior to the level one MAS implementation and/or the rare instance that the file is otherwise not available in the MAS.

For one QIC case addressing multiple beneficiaries, particularly large multi-beneficiary and overpayment cases, the MAC shall keep the documents relating to each beneficiary together and organized alphabetically by beneficiary last name. Documents relating to each beneficiary will be separated and a complete set of procedural documents will be provided for each beneficiary.

The following is a list of the documents generally included in any case file. Note that there may be others not listed here. For applicable items, the MAC includes originals and retains hard copies of any documents that are not available electronically for its records. Do not send abbreviated versions, or versions of documents that the MAC has retyped or paraphrased for purposes of shortening the document. The MAC must keep an exact copy of the file that is sent to the QIC. (Note: This applies only when documents are not otherwise available electronically.) If it is unable to include the original documents, it includes photocopies that are true facsimiles of the original documents. It arranges the following documents, in descending date order (i.e., the claim form is on the bottom).

Procedural Documents:

- Claim form or printout, if electronically generated (facsimile and/or screen prints are acceptable);
- MSN/RA - older files may contain EOMBs or Denial Letters, which must also be included. (Facsimile and/or screen prints are acceptable);
- Redetermination request;
- Redetermination notice;
- Appointment of representative form (Form CMS-1696) or other written authorization, if applicable;
- All documentation related to the assessment of an overpayment.

Medical Documents:

- Medical records, separated by facility, doctor, or location of service (separated by a colored sheet or a sheet of paper with a heading);
- Referral to/from MAC medical staff (with professional qualifications of the reviewer noted in the document, if applicable)
- MAC medical policies and opinions relevant to claim(s). (In addition to MAC medical policy, the MAC should include in the case file any information it has as background to the particular policy at issue. For example, findings of the MAC advisory committee (CAC) with regard to the policy, including professional publications relied upon to support the policy, opinions from professional medical societies who may have commented on the policy during the development phase, etc.) (See the Program Integrity Manual, Pub. 100-08 for additional information.);*
- A list of relevant portions of the law, regulations, CMS rulings, national coverage determinations/decisions, and CMS manuals;
- Copies of LCDs, newsletters, any other pertinent information that may be used by the QIC;*
- Any other exhibits that the MAC may consider important for the QIC to consider (e.g., certification of reasonable charge, fee schedule information, notices of noncoverage, MAC publications.); and
- Any additional evidence submitted by the appellant.

*If accessible by internet, the MAC that issued the redetermination decision may enter into a joint operating agreement with the QIC to provide a list instead of actual copies.

Assembly Instructions:

- The MAC uses an appropriate file/folder/envelope which will contain necessary documents in proper order, if the case file is not transmitted electronically.

- For combined requests filed by a beneficiary, the MAC keeps the documents relating to treatment from each provider, physician, or supplier together. It separates the documents relating to each provider, physician or supplier by a blank sheet of paper;

- For combined requests filed by a provider, physician, or other supplier, the MAC keeps the documents relating to each beneficiary together and organized alphabetically by beneficiary last name. It separates the documents relating to each beneficiary by a blank sheet of paper. It provides a complete set of procedural documents for each beneficiary; and

- The MAC groups procedural documents together in chronological order and groups medical documents together in chronological order.

Reconsideration Case Transmittal Form

The Reconsideration Case Transmittal Form documents the claim information and the date of the redetermination. It also identifies the MAC that made the redetermination and the QIC with jurisdiction for the reconsideration. The summary sheet should be placed on top of the documents in the case file. The QIC will provide a Reconsideration Case Transmittal Form for use in the JOA.

320.6 - Forwarding QIC Case Files

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

MACs shall send/transmit the case file within 7 calendar days of the date of the QIC's request. The date of QIC's request is defined as the date the phone call is made (if a message is left, it is defined as the date the message was left) or the date of the email request. The case files must be sent either by an electronic means agreed upon in the joint operating agreement or by a courier service so that the case file is received by the QIC before or on the 8th calendar day after its request. The MAC counts the costs associated with sending case files in the Contractor Administrative Budget and Financial Management (CAFM) code designated for preparing/transferring case files to the QIC.

320.7 - QIC Jurisdictions

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

A. Part A QIC Jurisdictions

The Part A QIC jurisdictions are as follows:

Jurisdiction	Normal States	Exceptions
Part A East QIC jurisdiction	Alabama, Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Louisiana, Maine, Maryland, Mississippi, Massachusetts, New Hampshire, New Mexico, New Jersey, New York, Texas, Oklahoma, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Vermont, Virgin Islands, Virginia, West Virginia, and Washington DC and Mutual of Omaha claims where the service was rendered in one of the above listed States.	**Chain Providers (including ESRD)** – the State where the MAC processed the claim. For providers who previously submitted claims to Mutual of Omaha (currently processed by WPS), the jurisdiction continues to be the State where the service was rendered. **Indian Health Services claims Nationwide** **Foreign claims-** Eastern Mexico, Canadian Provinces of New Brunswick, Newfoundland, Nova Scotia, Quebec, and Prince Edward Island **Rural Health Clinic claims Nationwide**
Part A West QIC jurisdiction	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Ohio, Oregon, South Dakota, Utah, Washington, Wisconsin and Wyoming and Mutual of Omaha claims where the service was rendered in one of the above listed States.	**Chain Providers (including ESRD)** - the State where the MAC processed the claim. For providers who previously submitted claims to Mutual of Omaha (currently processed by WPS), the jurisdiction continues to be the State where the service was rendered. **Foreign claims**- Western Mexico, Canadian Provinces of Ontario, Saskatchewan, Alberta, Manitoba, British Columbia, Vancouver, and Yukon Territories.

B. Part B and DME QIC Jurisdictions

There is one DME QIC jurisdiction assigned to process all reconsiderations of DME claims for all states and territories. There are two QIC jurisdictions for Part B claims, a North and a South jurisdiction. Refer to the table below.

Jurisdiction	*Normal States*	*Exceptions*
Part B South Jurisdiction	*Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virginia, West Virginia, Virgin Islands.*	***Note: Railroad Retirement Board reconsiderations are also included in this workload jurisdiction.***
Part B North Jurisdiction	*Alaska, American Samoa, Arizona, California, Connecticut, Delaware, Guam, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Northern Mariana Islands, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Washington, Washington DC, Wisconsin and Wyoming.*	
DME QIC Jurisdiction	*All states and territories*	

320.8 - Tracking Cases

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

Contractors shall track all incoming requests for case files from the QICs. The contractor shall keep a record of the date of the request, the format of the request (e.g., telephone, emails, electronic) the date the case file was forwarded to the QIC, and the means of forwarding (e.g. Fed Ex Same Day, Fed Ex overnight, UPS 2 day). If a courier service is used, the contractor shall utilize the courier service's tracking mechanism to keep a record of the date of receipt at the QIC.

Contractors shall track all misfiled reconsideration requests to ensure receipt at the proper QIC. The QIC will send the MAC or DME MAC an acknowledgement of receipt of any misfiled requests. Contractors shall keep a record of the date of receipt of the misfiled request, the date it was forwarded to the QIC, the means of forwarding, and the date of the QIC's acknowledgement.

Contractors shall track all requests from the QIC for effectuation. The contractor shall make a record of the date of receipt of the QIC's request for effectuation and confirm receipt of the effectuation notice with the QIC. The contractor shall also track the date of effectuation (i.e., issue payment).

320.9 - Effectuation of Reconsiderations

(Rev.4380, Issued: 08-30-19, Effective: 07-08-19, Implementation: 10- 01-19)

In many cases, the QIC's decision will require an effectuation action on the MAC's part. The MAC does not effectuate based on correspondence from any party of the reconsideration. It takes an effectuation action only in response to a formal decision and Reconsideration Effectuation Notice from the QIC. "Effectuate" means for the MAC to adjust the claim and issue a payment or to change liability. If the QIC's decision is favorable to the appellant and gives a specific amount to be paid, the MAC effectuates within 30 calendar days of the date of receipt of the effectuation notice from the QIC.

NOTE: CMS does not anticipate that QICs will specify an amount to be paid in reconsideration notices.

If the decision is favorable, but the payment amount must be computed or recomputed, it effectuates the decision within 30 days after the payment amount is determined. The amount must be computed as soon as possible, but no later than 30 calendar days after the date of receipt of the QIC's effectuation notice. The receipt of effectuation information shall be reported to the appropriate QIC.

If the QIC's decision is unfavorable, but there is a change in liability, the MAC effectuates within 30 calendar days of receipt of the QIC's effectuation notice.