CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 862

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: FEBRUARY 17, 2006

Change Request 4152

SUBJECT: Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review

I. SUMMARY OF CHANGES: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). These changes manualize CMS 4064-IFC, published in the Federal Register on March 8, 2005. The instructions in this change request (CR) include the administrative law judge, the departmental appeals board, and the U.S. District Court review sections.

NEW/REVISED MATERIAL
EFFECTIVE DATE: May 1, 2005
IMPLEMENTATION DATE: March 17, 2006

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:
R = REVISED, N = NEW, D = DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	29/Table of Contents
N	29/330/Administrative Law Judge (ALJ) - The Third Level of Appeal
N	29/330.1/Right to an ALJ Hearing
N	29/330.2/Requests for an ALJ Hearing
N	29/330.3/Forwarding Request to HHS/OMHA
N	29/330.4/Review and Effectuation of ALJ Decisions
N	29/330.5/Effectuation Time Limits & Responsibilities
N	29/330.6/Duplicate ALJ Decisions

N	29/330.7/Payment of Interest on ALJ Decisions
N	29/340/Departmental Appeals Board - The Fourth Level of Appeal
N	29/340.1/Recommending Agency Referral of ALJ Decisions or Dismissals
N	29/340.2/Effectuation of Departmental Appeal Board Orders and Decisions
N	29/340.3/Requests for Case Files
N	29/340.4/Payment of Interest on DAB Decisions
N	29/345/U.S. District Court Review - The Fifth Level of Appeal
N	29/345.1/Requests for U.S District Court Review by a Party
N	29/345.2/Effectuation of U.S District Court Decisions
N	29/345.3/Payment of Interest of U.S. District Court Decisions

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 862	Date: February 17, 2006	Change Request 4152

SUBJECT: Appeals of Claims Decisions: Administrative Law Judge; Departmental Appeals Board; U.S. District Court Review

I. GENERAL INFORMATION

A. Background: The Medicare claim appeals process was amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). Section 1869(c) of the Social Security Act (the Act), as amended by BIPA, requires a new second level in the administrative appeals process called a reconsideration.

B. Policy: The purpose of this CR is to notify FIs and carriers about changes to the manual provisions that address Administrative Law Judge, departmental appeals board and U.S District Court review levels of appeal.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4152.1	For Part A and Part B redeterminations issued before May 1, 2005, contractors shall continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.	X	X							
4152.2	Contractors shall continue to follow instructions in the Claims Processing Manual, chapter 29, §§50 and 60 in preparing case files.	X	X	X	X					
4152.3	For Part B redeterminations issued before January 1, 2006, contractors will continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing.			X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4152.4	Carrier and DMERC contractors shall continue to follow instructions in the Claims Processing Manual, chapter 29, § 60 in preparing case files.			X	X					
4152.5	The contractor shall forward a misfiled request for ALJ hearing within 14 calendar days of its receipt of the request in the corporate mail room.	X	X	X	X					
4152.6	The contractor shall contact beneficiary appellants and clarify whether the beneficiary wishes to request an ALJ hearing when the beneficiary contacts the contractor after a reconsideration to express their dissatisfaction but does not clearly request an ALJ hearing.	X	X	X	X					
4152.7	If the ALJ decision is partially or wholly favorable, gives a specific amount to be paid, and there is no agency referral to the DAB, the contractor shall effectuate within 30 days of the receipt of the official ALJ decision. The official ALJ decision is a signed copy of the ALJ decision.	X	X	X	X					
4152.8	If the ALJ decision is partially or wholly favorable and no agency referral is made, but the amount must be computed by the contractor, contractors shall effectuate the decision within 30 days after it computes the amount to be paid to the appellant.	X	X	X	X					
4152.9	Contractors shall compute the amount as soon as possible, but no later than 30 calendar days of the date of receipt of the official ALJ decision or effectuation notice from the AdQIC.	X	X	X	X					
4152.10	Contractors shall immediately notify the AdQIC upon receipt of duplicate ALJ decisions on the same case.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4152.11	Contractors shall not be responsible for reviewing ALJ decisions issued by HHS ALJs to determine if an agency referral is appropriate.	X	X	X	X					
4152.12	Contractors shall initiate effectuation within 30 days of receipt of a DAB decision that requires contractor effectuation, and shall complete effectuation within 60 days.	X	X	X	X					
4152.13	Contractors shall not accept a request for U.S District Court review by a party.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4152.14	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: May 1, 2005 **Implementation Date:** March 17, 2006 **Pre-Implementation Contact(s):** Tara Boyd at tara.boyd@cms.hhs.gov or Jennifer Frantz at jennifer.frantz@cms.hhs.gov. **Post-Implementation Contact(s):** Contact your regional office.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Claims Processing Manual
Chapter 29 - Appeals of Claims Decisions

Table of Contents
(Rev.862, 02-17-06)

330 - Administrative Law Judge (ALJ) - The Third Level of Appeal

(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

Fiscal Intermediaries *- For Part A and Part B redeterminations issued before May 1, 2005, contractors will continue to be responsible for accepting Administrative Law Judge (ALJ) hearing requests and for preparing case files for the hearing. Contractors shall continue to follow instructions in the Claims Processing Manual, chapter 29, §§50 and 60, in preparing case files. For redeterminations issued on or after May 1, 2005, the QIC is responsible for accepting ALJ hearing requests and for preparing case files for the hearing.*

Carriers & DMERCs *- For Part B redeterminations issued before January 1, 2006, contractors will continue to be responsible for accepting ALJ hearing requests and for preparing case files for the hearing. Contractors shall continue to follow instructions in the Claims Processing Manual, chapter 29, §60, in preparing case files. For redeterminations issued on or after January 1, 2006, the QIC is responsible for accepting ALJ hearing requests and for preparing case files for the hearing.*

330.1 - Right to an ALJ Hearing

(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

There are three situations where a party can request a hearing before an ALJ: (1) A party to a QIC reconsideration may request a hearing before an ALJ if the party files a written request for an ALJ hearing within 60 days after receipt of the notice of the QIC's reconsideration and the amount in controversy requirement is met; (2) A party who files a timely appeal before a QIC and whose appeal continues to be pending before a QIC at the end of the QIC's decision-making timeframe has a right to a hearing before an ALJ if the party files a written request with the QIC to escalate the appeal to the ALJ level after the adjudication period expires and the QIC does not issue a final action within 5 days of receiving the request for escalation. A party wishing to escalate an appeal must also meet the amount in controversy requirement*; and (3) A party to a QIC's dismissal of a request for reconsideration has a right to have the dismissal reviewed by an ALJ if the party meets the amount in controversy requirement*.*

The amount remaining in controversy requirement for requests made before January 1, 2006 was $100. The amount in controversy requirement increased to $110 for requests made on or after January 1, 2006.

** For requests made for an ALJ hearing or judicial court review, the dollar amount in controversy requirement is increased by 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. The amount will be computed annually and CMS will notify the Medicare contractors of the new amount.*

330.2 - Requests for an ALJ Hearing

(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

A. Where Parties File Requests

To receive an ALJ hearing, a party to the QIC's reconsideration must file a written request for an ALJ hearing with the entity specified in the QIC's reconsideration. The appellant must also send a copy of the request for hearing to the other parties. Failure to do so will toll the ALJ's 90-day adjudication deadline until all parties to the QIC reconsideration receive notice of the requested ALJ hearing. Also, if the request for hearing is timely filed with an entity other than the entity specified in the QIC's reconsideration, the ALJ's deadline for deciding the appeal begins on the date the entity specified in the QIC's reconsideration (i.e., the appropriate Office of Medicare Hearings and Appeals (OMHA) field office) receives the request for hearing.*

The QICs will specify the appropriate OMHA field office as the filing location for ALJ hearing requests.

B. Timely Filing Requirements

A party must file an ALJ request within 60 days of the date of their receipt of the QIC's decision. It is presumed that the appellant received the QIC's decision within five days of the date of the QIC's decision, unless there is a reasonable showing by the appellant to the contrary.

C. Content of the Request

The request for an ALJ hearing must be made in writing. The request must include all of the following:

1. *The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed,*
2. *The name and address of the appellant, when the appellant is not the beneficiary,*
3. *The name and address of the designated representative, if any,*
4. *The document control number assigned to the appeal by the QIC, if any,*
5. *The dates of service,*
6. *The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and*
7. *A statement of any additional evidence to be submitted and the date it will be submitted.*

For the convenience of parties, HHS provides a form that may be used to request a Medicare ALJ hearing. The contractor provides copies of the form to parties upon request. It is not necessary, however, that this form be used to make a written request.

See http://new.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf for the hearing request form used when the request follows a QIC reconsideration and http://new.cms.hhs.gov/cmsforms/downloads/cms5011a-b.pdf for the hearing request form used when the request follows a carrier hearing officer hearing or FI reconsideration.

330.3 - Forwarding Requests to HHS/OMHA

(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

Requests for ALJ hearings are to be filed with the entity specified in the QIC's reconsideration notice. The QICs will specify the OMHA field office with jurisdiction as the filing location for hearing requests. However, there may be times when parties incorrectly file requests for hearings with either the contractor or QIC. When a contractor receives such a misfiled request, it forwards the misfiled request to the appropriate OMHA field office within 14 calendar days of receipt.

A. Address for OMHA

*Requests for ALJ hearings must be filed at the following locations depending on the **place of service**. For DMEPOS claims, the place of service is defined as the beneficiary's address of record, residence, or, if the item or supply was provided in a facility, then the facility address.*

HHS OMHA Field Office Mailing Address	***Jurisdiction (Based on the place of service)***			
• ***Cleveland, Ohio*** *BP Tower & Garage* *200 Public Square, Suite 1300* *Cleveland, Ohio, 44114-2316*	*Connecticut* *Maine* *Massachusetts* *New Hampshire* *Rhode Island* *Vermont*	*New York* *New Jersey* *Puerto Rico* *Virgin Islands*	*Pennsylvania* *Virginia* *West Virginia*	*Illinois* *Indiana* *Ohio* *Michigan* *Minnesota* *Wisconsin*
• ***Miami, Florida*** *100 SE 2nd Street, Suite 1700* *Miami, FL 33131-2100*	*Alabama* *Florida* *Georgia* *Kentucky* *Mississippi* *North Carolina* *South Carolina* *Tennessee*	*Arkansas* *Louisiana* *New Mexico* *Oklahoma* *Texas*		
• ***Irvine, California*** *27 Technology Drive, Suite 100* *Irvine, CA 92618-2364*	*Iowa* *Kansas* *Missouri* *Nebraska*	*Colorado* *Montana* *North Dakota* *South Dakota* *Utah* *Wyoming*	*Arizona* *California* *Hawaii* *Nevada* *Guam* *Trust Territory of*	*Alaska* *Idaho* *Oregon* *Washington*

			the Pacific Islands American Samoa	
• ***Arlington, Virginia*** *1700 N. Moore St., Suite 1600, Arlington, VA 22209*	*Delaware Maryland District of Columbia*			

B. Implied Requests for ALJ Hearings

Sometimes beneficiary appellants will send a letter to the contractor after a reconsideration or hearing officer hearing expressing their dissatisfaction with the decision, but do not clearly state that they are requesting an ALJ hearing. In this instance, the contractor must contact the beneficiary appellant and clarify whether the beneficiary wishes to request an ALJ hearing. The contractor informs the beneficiary of what the beneficiary needs to do to request an ALJ hearing. To prove timely filing, the contractor instructs the beneficiary to include their original letter that was sent to the contractor as part of the ALJ hearing request.

Note that only the ALJ or the Departmental Appeals Board (DAB) has the authority to dismiss a request for ALJ hearing. This applies even when it appears that the request does not meet the content requirements or jurisdictional requirements for requesting an ALJ hearing (e.g., the amount in controversy or timely filing requirements do not appear to have been met).

330.4 - Review and Effectuation of ALJ Decisions

(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

The Administrative QIC (AdQIC) will receive all case files and decisions from the OMHA field offices as well as any decisions and case files from the DAB. The AdQIC will fill out an effectuation form with the necessary information for the FI or carrier to effectuate the decision. The AdQIC will fax or mail this effectuation form to the carrier or FI within 10 calendar days from the date the AdQIC receives the case from OMHA or the DAB.

330.5 - Effectuation Time Limits & Responsibilities

(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

In most cases, an ALJ will either: (1) issue a decision based on the request for an ALJ hearing; or (2) issue an order of dismissal of the appellant's request for ALJ hearing; or (3) remand the case to the QIC.

The ALJ's decision will often require an effectuation action on the contractor's part. The contractor does not effectuate based on correspondence from any party to the ALJ hearing. It takes an effectuation action only in response to a formal effectuation notice from the AdQIC. "Effectuate" means for the contractor to take the necessary actions to issue a payment or change liability.

Prior to paying a provider in full or partial reversal cases where the beneficiary was previously liable, the FI must ascertain whether the provider has been reimbursed for the previously denied services from another source and, if so, will withhold the Medicare reimbursement until the party has assured, in writing, that the prior payment has been refunded.

For ALJ decisions issued by HHS OMHA ALJs, the AdQIC will function as the clearinghouse. Once the AdQIC receives the case file and the ALJ decision for a favorable case, the AdQIC will forward an effectuation notice with a summary of the affected claim headers and claim line ICNs to the appropriate contractor for effectuation.

A. No Agency Referral

If the ALJ decision is partially or wholly favorable to the appellant, gives a specific amount to be paid, and there is no agency referral to the DAB, the contractor effectuates within 30 calendar days of the effectuation notice from the AdQIC. The contractor must acknowledge receipt of the AdQIC effectuation form within 7 calendar days.

If the decision is partially or wholly favorable and no agency referral is made, but the ***amount must be computed*** *by the contractor, it effectuates the decision within 30 days after it computes the amount to be paid to the appellant. The amount must be computed as soon as possible, but no later than 30 calendar days of the date of receipt of the effectuation notice from the AdQIC.*

If clarification from the AdQIC is necessary, the contractor considers the date of the clarification the final determination for purposes of effectuation. If clarification is needed from the provider/physician/supplier (e.g., splitting charges), the carrier requests clarification as soon as possible and computes the amount payable within 30 calendar days after the receipt of the necessary clarification. The contractor considers the date of receipt of the clarification as the date of the final determination for purposes of effectuation.

B. Agency Referral

Where the AdQIC submitted an agency referral to the DAB, the contractor does not effectuate until it receives notification from the AdQIC.

1. *If the DAB accepts the agency referral for review, the AdQIC advises the contractor to delay effectuation until the DAB takes further action.*
2. *If the DAB declines to review the agency referral, the AdQIC advises the contractor to effectuate the decision.*

330.6 - Duplicate ALJ Decisions
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

If the contractor becomes aware of a duplicate ALJ decision on the same case, it must bring this to the attention of the AdQIC immediately. In these cases the AdQIC will take the necessary steps to resolve the issue.

330.7 - Payment of Interest on ALJ Decisions
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For guidance on how to make payment of interest subsequent to an ALJ decision, refer to chapter 3 of the Medicare Financial Management Manual.

340 - Departmental Appeals Board - The Fourth Level of Appeal
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

The level of administrative review available to parties after the ALJ hearing decision or dismissal order has been issued, but before judicial review is available, is DAB review. The DAB evaluates requests for review, and makes final decisions whether to review, or to decline to review, decisions of ALJs as well as orders of dismissal by ALJs.

340.1 - Recommending Agency Referral of ALJ Decisions or Dismissals
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For ALJ decisions issued by HHS OMHA ALJs, the AdQIC will be responsible for reviewing ALJ decisions and determining whether an agency referral is appropriate. For all ALJ decisions issued by SSA ALJs, the contractor remains responsible for this activity.

340.2 - Effectuation of DAB Orders and Decisions
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

When a contractor receives an effectuation notice from the AdQIC regarding a DAB decision that requires effectuation, it initiates effectuation within 30 days of its receipt of the effectuation notice, and completes effectuation within 60 days. Any questions regarding effectuation should be directed to the AdQIC for guidance.

340.3 - Requests for Case Files
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

When the DAB receives a request for review from an appellant, in most instances it will not have a copy of the ALJ's decision or dismissal, or the case file. The DAB will request all case files from the AdQIC.

340.4 - Payment of Interest on DAB Decisions
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For guidance on how to make payment of interest subsequent to a DAB decision, refer to chapter 3 of the Medicare Financial Management Manual.

345 - U.S. District Court Review - The Fifth Level of Appeal
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

The circumstances allowing for an appeal or escalation to the U.S. District Court level of review are limited, and articulated in 42 CFR 405.1136.

345.1 - Requests for U.S. District Court Review by a Party
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

Following issuance of a decision by the DAB, a party may request court review of the DAB's decision. A contractor cannot accept requests for court review. The appellant must file the complaint with the U.S. District Court. If a party files a request for court review with a contractor, the contractor must instruct the appellant to re-file with the U.S. District Court.

If a contractor receives, either directly or by copy, a summons or complaint due to a party's request for U.S. District Court review, and it does not appear that a copy was sent to the following address, the contractor shall send the original to:

Department of Health and Human Services
General Counsel
200 Independence Avenue, S.W.
Washington, D.C. 20201

The contractor retains a copy and notifies its RO immediately.

345.2 - Effectuation of U.S. District Court Decisions
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

The U.S. District Court may remand the case to the DAB or ALJ for further proceedings. In rare cases, the U.S. District Court will issue an order that will require effectuation by

a contractor. In this situation, the contractor contacts its RO appeals contact for further instructions before taking any action.

345.3 - Payment of Interest of U.S. District Court Decisions
(Rev.862, Issued: 02-17-06, Effective: 05-01-05, Implementation: 03-17-06)

For guidance on how to make payment of interest subsequent to a U.S. District Court decision, refer to chapter 3 of the Medicare Financial Management Manual.