CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 1485 **Date: March 28, 2008**

CHANGE REQUEST 5899

NOTE: This is a correction to transmittal 1485, Change Request 5899, dated March 28, 2008. The only change is on the transmittal page under Section II. Section 50.7.4 was inadvertently left off, section 40.1.6, Where Good Cause Is Not Found, should be section 40.1.5.6, sections 40.8 and 70 were erroneously misnamed. The Transmittal Number, Date Issued and all other material remain the same.

SUBJECT: Chapter 29 Clean-Up

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). Section 1869 (c) of the Social Security Act (the Act), as amended by BIPA, required changes to the 42 Code of Federal Regulations regarding the appeals process.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2008
IMPLEMENTATION DATE: July 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
D	29/1/Foreword
D	29/10/CMS Decisions Subject to the Administrative Appeals Process
D	29/20/Who May Appeal
D	29/20.1/Provider or Supplier Appeals When the Beneficiary is Deceased
D	29/30/Where to Appeal and Initial Determinations
D	29/30.1/Social Security Office (SSO)
D	29/30.2/Part A Fiscal Intermediary (FI)
D	29/30.2.1/FI Initial Determinations With Respect to Beneficiaries
D	29/30.2.2/Provider's Right to Appeal Certain Initial Determinations
D	29/30.2.3/Appeals That Involve an Adverse Utilization Review Committee

	(URC) Decision
D	29/30.3/Part B Carrier (or FI Acting as a Carrier)
D	29/30.4/Quality Improvement Organization (QIO)
D	29/30.4.1/QIO Reconsiderations and Appeals
D	29/30.5/Managed Care Organizations - Health Maintenance Organizations HMO) and Medicare+Choice Organizations
D	29/30.6/The Regional Office (RO) Responsibility
D	29/30.6.1/Assisting FIs to Obtain Documentation
D	29/30.6.2/Congressional Requests for Part A Reconsideration
D	29/30.7/Time Limits for Filing Appeals
D	29/30.8/Amount in Controversy Requirements
D	29/30.9/Limitation on Liability
D	29/40/Part A Appeals Procedures
D	29/40.1/Finding Good Cause for the Late Filing of Part A Redetermination Requests
D	29/40.1.1/General
D	29/40.1.2 /Establishment of Time Limit for Filing
D	29/40.1.3/Conditions Which Establish Good Cause
D	29/40.1.4/Procedures to Establish Good Cause
D	29/40.1.5/Examples of Situations Where Good Cause Exists
D	29/40.1.5.6/Where Good Cause Is Not Found
D	29/40.1.6/Assisting Handicapped Beneficiaries
D	29/40.2/Reconsideration of a Part A Payment Determination
D	29/40.2.1/Place and Manner of Filing Requests for Reconsideration and What Constitutes a Request for Reconsideration
D	29/40.2.2/Assisting a Beneficiary to Complete Form CMS-2649, Request for Reconsideration of Part A Health Insurance Benefits
D	29/40.2.3/Routing the Reconsideration Request
D	29/40.2.4/Acknowledging Receipt
D	29/40.2.5/Transferring and Dismissing Requests Which Involve Partial or No Jurisdiction, More Than One Component, Stay, or Issue
D	29/40.2.6/Handling of Request - Beneficiary Appeals Before Initial Determination Is Made or After Initial Favorable Determination Is Made, But Before They Are Notified
D	29/40.2.7/Withdrawal of Request

D	29/40.2.8/Notifying Provider or Beneficiary Where There Is a Withdrawal
D	29/40.3/Documenting Part A Reconsideration Requests
D	29/40.3.1/Documentation Sources
D	29/40.3.2/Assembling the File
D	29/40.3.3/Development
D	29/40.4/Evaluating the Evidence and Making the Reconsideration Determination
D	29/40.4.1/Evaluating the Evidence
D	29/40.4.2/Review Prior to Reversal of Initial Payment Determination
D	29/40.4.3/Preparing the Determination
D	29/40.4.4/Completing the Determination
D	29/40.4.5/Notice of Further Appeal Rights
D	29/40.4.6/Preventing Duplicate Payment in Reversal Cases
D	29/40.4.7/Effect of a Reconsideration Determination and Effectuation
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D	29/40.4.8/Reconsideration Guide Language
D	29/40.4.8.1/Sample Paragraphs to Be Used by FIs in Sequence as Shown Below
D	29/40.4.8.2/Model Medicare Redetermination Notice
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D	29/40.9/Right to Representation Under Part A
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D	29/60.20.1/Review and Effectuation of ALJ Decisions - General
D	29/60.20.2/Effectuation Time Limits
D	29/60.20.4/Misrouted ALJ Case Files
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D	29/70.1/Workload Data Analysis Program
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D	29/80.2/Execution of Workload Prioritization
D	29/80.3/Workload Priorities
D	29/100/List of Exhibits
D	29/Exhibit 18/Special Notice to Providers, Physicians, Suppliers and Other Independent Practitioners
D	29/Exhibit 19/Reopenings Policy

III. FUNDING:

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs)*, use the following statement:

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:

X	**Business Requirements**
	Manual Instruction

	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1485	Date: March 28, 2008	Change Request: 5899

NOTE: This is a correction to transmittal 1485, Change Request 5899, dated March 28, 2008. The only change is on the transmittal page under Section II. Section 50.7.4 was inadvertently left off, section 40.1.6, Where Good Cause Is Not Found, should be section 40.1.5.6, sections 40.8 and 70 were erroneously misnamed. The Transmittal Number, Date Issued and all other material remain the same.

SUBJECT: Chapter 29 Clean-Up

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background: This CR deletes several outdated sections of Chapter 29, Appeals of Claims Decisions of the Claims Processing Manual.

B. Policy: 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, required changes to the 42 Code of Federal Regulations regarding the appeals process.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5899.1	Contractors shall note that several sections of the manual have been deleted.	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE:

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Maria Ramirez , 410-786-1122
Post-Implementation Contact(s): Maria Ramirez, 410-786-1122

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

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.